

**DELIVERY AND UTILISATION OF VOLUNTARY HIV COUNSELLING AND  
TESTING SERVICES AMONG FISHING COMMUNITIES IN UGANDA**

by

**EMMANUEL MUGISHA**

Submitted in accordance with the requirements

for the degree of

**DOCTOR OF LITERATURE AND PHILOSOPHY**

in the subject

**HEALTH STUDIES**

at the

**UNIVERSITY OF SOUTH AFRICA**

**PROMOTER: DR GH VAN RENSBURG**

**JOINT PROMOTER: PROF E POTGIETER**

NOVEMBER 2008

Student number: 41709144

## DECLARATION

I declare that **DELIVERY AND UTILISATION OF VOLUNTARY HIV COUNSELLING AND TESTING SERVICES AMONG FISHING COMMUNITIES IN UGANDA** is my own work and that all the sources used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



SIGNATURE

(EMMANUEL MUGISHA)

DATE .....

# DELIVERY AND UTILISATION OF VOLUNTARY HIV COUNSELLING AND TESTING SERVICES AMONG FISHING COMMUNITIES IN UGANDA

STUDENT NUMBER: 41709144  
STUDENT: EMMANUEL MUGISHA  
DEGREE: D LITT et PHIL  
DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA  
PROMOTER: DR GH VAN RENSBURG  
JOINT PROMOTER: PROF E POTGIETER

## ABSTRACT

The study explored, described and explained the current models of voluntary counselling and testing services delivery and analysed the extent to which a given VCT model had influenced uptake of VCT services in the fishing communities along the shores of Lake Victoria, in Wakiso District, with an aim of designing optimal VCT service delivery strategies. The study was therefore exploratory, descriptive and explanatory, and collected both qualitative and quantitative data in a three-phased approach. Phase I involved the Kasenyi fishing community respondents, while phases II and III involved VCT managers and VCT counsellors at the Entebbe and Kisubi Hospitals.

The findings indicated that VCT services are generally available onsite at health facilities, and in the field through mobile VCT outreach or home-based VCT services provided at clients' homes. Both client-initiated and health provider-initiated VCT services are available and services are integrated with other health services. Despite the availability of VCT, only about half of the respondents in phase I had accessed VCT services although almost all indicated a willingness to undergo HIV testing in the near future. The main challenges to service delivery and utilisation included limited funding and staffing as well as limited awareness in target communities. The strategies drawn are based on the need to increase availability, accessibility, acceptability and utilisation of VCT services.

### Key concepts

Uganda, voluntary counselling and testing, fishing communities, HIV and AIDS, hospital, strategy, VCT service delivery, VCT service utilisation, integration, mobile VCT.

## ACKNOWLEDGEMENTS

First of all, my grateful thanks to God, without whose grace and love neither this study nor I would have been conceived.

*There is a saying that no feast comes to the table on its own legs, and so it is with this thesis. I therefore wish to express my thanks and appreciation to the following people whose hands and hearts have touched my life and this work:*

- Dr GH van Rensburg and Prof E Potgieter, my promoters, for their guidance, support and all I learned from them
- The University of South Africa (UNISA) and the Uganda National Council for Science and Technology (UNCST), for permission to conduct the study
- My late father Paul, and my mother Sophia, for their example, love and encouragement
- Annet, my wife, and Roland, Rachael and Rebecca, our children, for their love, patience, prayers, and belief in me
- Prosper, Diana, Frances and Jane, my siblings, for their encouragement, sense of humour, and support
- All my friends and colleagues, for their encouragement and prayers
- The VCT managers and VCT counsellors, for cheerfully, generously and willingly sharing their experience, knowledge and information with me
- The respondents at Kasenyi fish landing site, for their humour, courage and input, and for allowing me a peek into their lives
- Mrs R Coetzer, for professionally formatting and finalising the manuscript
- Ms I Cooper, for critically and professionally editing the manuscript

# Dedication

To my dear wife, Annet, our children Roland, Rachael and Rebecca, my siblings Prosper, Diana, Frances and Jane, and my mom, Sophia with love and appreciation

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## List of abbreviations

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AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retro-Viral Therapy
BA	Bachelor of Arts
BB	Bachelor of Business
BMU	Beach Management Unit
CDC	Centre for Disease Control
CRHCS	Commonwealth Regional Health Community Secretariat
CSW	Commercial sex worker
D Litt et Phil	Doctor of Literature and Philosophy
FAO	Food and Agricultural Organisation
FHI	Family Health International
FRRRI	Fisheries Resources Research Institute
GDP	Gross Domestic Product
GoU	Government of Uganda
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
IAVI	International AIDS Vaccine Initiative
ILO	International Labour Organization
LC	Local Council
MA	Masters of Arts
MAAF	Ministry of Agriculture, Animal husbandry and Fisheries
MChB	Bachelor of Medicine and Bachelor of Surgery
MoE&S	Ministry of Education and Sport
MoH	Ministry of Health
MPA	Masters of Arts in Public Administration
MPH	Masters of Public Health
NGO	Non Governmental Organisation
NIH	National Institutes of Health
ORC	Opinion Research Corporation
PhD	Doctor of Philosophy
PLHA	Person living with HIV/AIDS
PLI	Philly Lutaya Initiative
PMTCT	Prevention of Mother to Child Transmission program
PSI	Population Service International.
RICHHS	Rural Information Centre Health Service

## List of abbreviations

---

SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TAP	The Access Project
TASO	The AIDS Support Organisation
TB	Tuberculosis
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNCST	Uganda National Council for Science and Technology
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
USAID	United States Agency for International Development
UVRI	Uganda Virus Research Institute
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZERHP	Zambia Emory University HIV Research Project

## List of annexures

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Annexure A	Individual verbal consent
Annexure B	Phase I: Kasenyi community structured interview
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# CHAPTER 1

## Orientation to the study

### 1.1 INTRODUCTION

After thirty years of the Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) pandemic, approximately 40 million people are living with the virus that causes AIDS. Sub-Saharan Africa is the worst hit. In 2006, 34% of all AIDS-related deaths occurred in Sub-Saharan Africa. HIV has seriously impacted on the health, financial, political and social sectors (Joint United Nations Program on HIV/AIDS (UNAIDS) & World Health Organization (WHO) 2006:3). Although the terms “HIV/AIDS” or “HIV and AIDS” are both acknowledged, throughout this study the term “HIV/AIDS” is used.

In Uganda, the adult HIV prevalence rates dropped from 18% in the early 1990’s to the current 6% (Ministry of Health [MoH] & ORC Macro 2006:97). Despite the general reduction, the HIV prevalence is still high among some populations such as the fishing communities (Kissling, Allison, Seeley, Russell, Bachmann, Musgrave & Heck 2005:1942). In a study in four fishing villages in Western Uganda, Kipp, Kabagambe and Konde-Lule (2002:702) recorded an HIV prevalence of 24%, compared to 4% in thirteen typical rural villages in the same area.

Several measures have been put in place to curb the spread of the deadly virus, including delivery of free or highly subsidised quality Voluntary HIV Counselling and Testing (VCT) services. Despite the usefulness of VCT services as an entry point to prevention for uninfected people and care, treatment and support for those who test positive, the fishing communities have not used this service as expected (Ministry of Agriculture, Animal Husbandry and Fisheries [MAAF] 2005:14; MoH 2004:2). The present study reviewed and analysed the model of VCT service delivery to the fishing communities and the extent to which this affects the utilisation patterns of residents of Kasenyi, a fish landing site on the shores of Lake Victoria in Wakiso District in order to suggest alternative strategies.

## 1.2 BACKGROUND TO THE STUDY

HIV/AIDS is a global crisis. According to the International Labour Organization [ILO] (2005:1), the earliest and most serious epidemics occurred in sub-Saharan Africa, where the disease has reduced life expectancy from over 60 years to about 45 years. HIV/AIDS brings personal suffering and hardship to millions of Africans. In addition, the epidemic destroys development gains achieved over generations because it reinforces all the problems that connect ill health to poverty, consequently making it a development crisis (UNAIDS & WHO 2006:5).

HIV/AIDS in Uganda was detected as early as 1982 in Kashenshero, a small fishing village in Rakai District, which became the epicentre of the epidemic in Uganda. The number of HIV cases soon increased in the neighbouring fishing villages, and later in urban centres. Before long HIV infection spread throughout the country, rising to 18% in the early 1990's before finally dropping to 6.0% in 2006. In order to prevent further spread of HIV, therefore, prevention efforts remain critical for mitigating its impact (MAAF 2005:5; MoH & ORC Macro 2006:97).

In 2004, an estimated 38 million people worldwide were directly engaged in fishing as a full- or part-time occupation (Food and Agriculture Organisation [FAO] 2005a:5; ILO 2005:34). In Uganda, approximately 2.5 million people are engaged in the fishing sector, contributing significantly to food security, foreign exchange, employment and local government revenue, generating export earnings which are 20% of Uganda's total exports second only to coffee. Overall, fishing contributed 3% of the Gross Domestic Product (GDP) in 2001/2002. Fishing remains a major source of livelihood for rural and peri-urban communities situated around Lake Victoria and other smaller lakes in Uganda. The fisheries sub-sector is of strategic importance not only as a means of increasing household incomes but also as a critical resource in fulfilling the nutritional needs of the family and the country as a whole (Government of Uganda [GoU] 2002:21-22; Grellier, Tanzarn, Lamberts & Howard 2004:16; MAAF 2005:8).

If the HIV/AIDS epidemic remains uncontrolled in these fishing communities, then, it will drastically affect the economy. Moreover, the industry attracts many unskilled workers and is often a lifelong livelihood entailing long absences of the workers from home. Fish landing sites are dynamic centres of activity, attracting different types of people –

fulltime fishermen, traders, and fish processors as well as commercial sex workers (Sambrook & Tanzarn 2003:4). According to Allison and Seeley (2004a:217), this kind of population mix, coupled with low or no use of condoms and alcoholism, creates a fertile ground for HIV transmission. For some reason, HIV prevention programmes in Uganda have failed to control the transmission of HIV in the fishing population.

VCT is internationally recognised as an effective and important strategy for both HIV/AIDS prevention and care (De Cock, Marum & Mbori-Ngacha 2003:1847; De Zoysa, Phillips & Kamenga 1995:99). Furthermore, VCT has been found to be a cost-effective strategy for facilitating behaviour change (Forsythe, Arthur, Ngatia, Mutemi, Odhiambo & Gilks 2002:188; Sweat, Gregorich, Sangiwa, Furlonge, Balmer, Kamenga Grinstead & Coates 2000:115). VCT is, in fact, a core intervention in the comprehensive strategy of the government of Uganda and its development partners to address HIV/AIDS (MoH 2003a:1).

VCT services would be excellent if it were made known to the target populations, and they in turn fully utilise the services. According to Uganda VCT policy guidelines, once VCT service is available to a given community, it is important that the community is informed about the service (MoH 2003a:1). VCT services nevertheless remain minimally known and used by the fishing communities. Bukuluki, Mugisha and Kafuko (2003:16) found that only 7.7% men and 22.7% women were aware of VCT services in the islands of Lake Victoria. This raises the question of whether the problem is with the VCT service provider or with the user.

According to the MoH (2003a:xi), VCT is a confidential dialogue between a person and a care provider aimed at enabling the person to make an informed decision to take an HIV test and receive the test results. VCT serves an important role in knowing one's HIV status and making important decisions. De Cock et al (2003:1848) emphasise that individuals and their sexual partners are better equipped to make appropriate HIV prevention decisions if they know their HIV status. During a counselling session, individuals are given important information on HIV prevention methods such as abstinence from sex, being faithful to one's sex partner and using condoms (FHI & USAID 2004:3; MoH 2003a:7). Those who test HIV positive receive a package that includes information and education on nutritional requirements, the need for early access to care (including use of antiretroviral therapy [ART]) and prevention of HIV-

related illnesses. They also receive emotional and psychological support in order to cope with HIV-related anxiety; awareness of safer options for reproduction and infant feeding; and motivation to initiate or maintain safer sexual behaviours (Yoder, Katahoire, Kyaddondo, Akol, Bunnell & Kaharuza 2006:7). How and where fishermen receive this information remains unknown.

Although fishing communities are close to Kampala and Wakiso districts, and have ready access to hospital services including HIV-related services such as VCT, prevention of mother-to-child transmission, and ART, they nevertheless make minimal use of the services (MAAF 2005:14). Consequently, this study wished to explore the factors contributing to this minimal utilisation.

VCT services can be defined by type and location including stand-alone sites, integrated sites, and private clinics. Integrated sites are normally operated by government where VCT is provided along with other health services. In most integrated sites, VCT service is provided in a health facility. Mobile outreach and home-based VCT take VCT service to people in their communities. Finally, VCT is also available in private clinics purely on a commercial basis (Asiimwe, Kibombo & Matsiko 2005:2; FHI 2005b:3; FHI & USAID 2004:37; MoH 2003a:1; PSI 2006:1; Were, Mermin, Bunnell, Ekwaru & Kaharuza 2003:1569).

The model of VCT service delivery available to the marginalised and often mobile fishing communities is believed to highly influence utilisation patterns of the service, hence the core area of emphasis in this study. Out of fear of stigmatisation, some individuals prefer having VCT in places where they are less known, while others prefer the nearest place. For example, in South Africa, Van Dyk and Van Dyk (2003:7) found that 61.6% preferred the nearest VCT centre. However, Kippax (2006:231) and Vermund and Craig (2002:1186) found that individuals prefer having VCT far from where they stay.

This study was guided by a theoretical framework for healthcare services utilisation and access that explains health delivery and utilisation by integrating factors at macro (health policy), meso (characteristics of the health delivery system) and micro (characteristics of the target population) level while identifying key factors affecting utilisation of the health services and showing their interrelationship (Aday & Anderson



1974:212; Aday & Awe 1997:505; Aday, Anderson & Fleming 1980:26; Anderson 1973:184-195). This study was also guided by the ecological framework, which explains individual behaviour and practices as influenced by a complex social environment at the different levels in which the individual lives (Franklin 1988:340; McLeroy, Bibeau, Steckler & Glanz 1988:354; Ostrom 1998:6).

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

In Uganda, the fishing industry is an important source of food and employment for many, yet the spread of HIV in these communities remains a major threat to their survival and existence. HIV prevention programmes have failed to target the fishing communities whose infection rate is escalating. The highest HIV prevalence in the country was recorded in districts along the shoreline of Lake Victoria, which raises the need to understand why prevention interventions such as use of VCT have not had an impact on this sub-population (GoU 2002:40; Kissling et al 2005:1944).

While Uganda has moved ahead in combating the deadly pandemic, there is concern that the presence of high prevalence reservoirs in some fishing communities will erode the positive results (MAAF 2005:22). The majority of fisher folk are young (18-30 years), sexually active and mobile, going beyond the fishing villages to other parts of the country where they have sexual partners (ILO 2005:34; Pickering, Okong, Bwanika, Nnalusiba & Whitworth 1997a:15). The close sexual relationships of the fishermen with partners in surrounding communities as well as limited condom use favour HIV transmission (Grellier et al 2004:18; Pickering et al 1997a:13; Sambrook & Tanzarn 2003:3). Seeley and Allison (2005a:691) emphasise that poor VCT service utilisation makes it harder to deliver other AIDS-related care and treatment services since the prerequisite is knowing one's HIV status.

The Ugandan government and its development partners have made serious efforts to ensure all Ugandans get VCT services whenever and wherever they want (MoH 2004:15). Consequently, different models of VCT service delivery have been implemented, including integrated and stand-alone sites, outreach and private services. The model of VCT service delivery affects accessibility to VCT services, which could explain why in Uganda, only 13% of women aged 15-49 and 11% of men aged 15-49 have been tested for HIV and received results (MoH & ORC Macro 2006:98). The

implementation of the different VCT service delivery models depends largely on the type of target population to be served. Limited literature is available on the rationale for the choice of model of VCT service delivery targeting the fishing communities and how this influences utilisation patterns (Nsabagasani & Yoder 2006:22).

Admassu and Fitaw (2006:27) and Bukuluki et al (2003:16) point out that educational level, gender and religion influence VCT utilisation. In Uganda, a high educational level, being female, being Christian, residing in urban areas, and being wealthy have been linked to willingness to test and receive results (MoH 2005:98). Seeley and Allison (2005b:23) found no mention of the influence of institutional factors, such as the model of VCT service delivery, on willingness to test for HIV, and no reference to the fishing communities, who are considered special populations.

#### **1.4 AIM OF THE STUDY**

This study aimed to explore and describe the current models of VCT service delivery and analyse the extent to which a given VCT model influenced uptake of VCT services in the fishing communities along the shores of Lake Victoria, in Wakiso District in order to design suitable VCT delivery strategies.

#### **1.5 OBJECTIVES OF THE STUDY**

In order to achieve the overall aim, the objectives of the study were to

- establish the different VCT delivery models available in and around Kasenyi fish landing site
- determine the extent to which a given VCT delivery model influences utilisation patterns in the target community
- identify other factors that influence VCT service utilisation among the fishing communities
- formulate strategies to improve VCT service delivery and utilisation among fishing communities

## 1.6 SIGNIFICANCE OF THE STUDY

The contribution of the fishing industry to the economy cannot be overemphasised. According to the MAAF (2005:19), a hypothetical decrease of 10% in fishing efforts as a result of HIV/AIDS and with a proportionate impact on value added would be equivalent to a loss of 28.5 billion Ugandan shillings in value addition. Consequently, fishing communities need to be studied as a special population with regard to VCT use as an HIV prevention strategy.

Models of VCT service delivery have changed over time, with more and appropriate models introduced for different populations for the purpose of increasing uptake of VCT services. An assessment of the available VCT service delivery models available to the fishing communities and how they have influenced uptake is important in order to make a contribution to an appropriate VCT service delivery strategic plan.

Accordingly, there is no best approach or model for VCT service delivery that fits all. Each model has its strengths and weaknesses in a given population; hence there is a need to study the existing models available to the fishing communities. When appropriate VCT service delivery strategies are designed, maximised utilisation is expected as accessibility and acceptability are improved. (Summers, Spielberg, Collins & Coates 2000:130).

The World Health Organization (WHO) (2003:4; 2004a:12) calls for initiatives to increase access through innovative, ethical and practical models of HIV testing and counselling. The study therefore proposed new strategies for making VCT accessible and acceptable to the fishing communities, thereby optimising utilisation and uptake levels. The adoption of the VCT service delivery strategies suggested would be of great value and assistance to the fisheries sector, the Ministry of Health and Uganda's development partners for HIV/AIDS prevention programming that specifically targets fishing communities.

Finally, the study will lead to the development of new knowledge and hence adding to the body of existing knowledge about VCT service delivery and utilisation. This will particularly be important for the managers and planners involved in HIV related interventions. The knowledge gained will also be important for education purposes

especially for students interested in this area, which is likely to stimulate further research into this topic.

## 1.7 RESEARCH DESIGN AND METHODOLOGY

According to Babbie (2008:122), a research design is the process of focusing one's perspectives for the purposes of the study and involves a set of decisions regarding what is to be studied, in which population and the methods to use. The present study was exploratory, descriptive and explanatory, and collected both qualitative and quantitative data, using a three-phase approach. In order to achieve the objectives and ensure that the study process was coherent, three different study populations were involved in the selection, sampling, and data collection and analysis (see table 1.1). This was done in order to achieve methodological triangulation, which ensures the validity and trustworthiness of results. Chapter 3 presents the research design and methodology in detail.

**Table 1.1 Study populations and sources of data**

	<b>Phase I</b>	<b>Phase II</b>	<b>Phase III</b>
<b>Source of data</b>	Residents of Kasenyi fish landing site	VCT managers at Kisubi and Entebbe Hospitals	VCT counsellors at Kisubi and Entebbe Hospitals
<b>Method of data collection</b>	Structured interview	Interview guide	Interview guide
<b>Nature of data</b>	Quantitative data	Qualitative data	Qualitative data

### 1.7.1 Phase I

Phase I was quantitative and the study population consisted of the residents of Kasenyi fish landing site. In order to collect data on individual attributes, the researcher used probability sampling to ensure an unbiased sample (Russell 2000:144-147). The researcher used the residents' register to list all the residents from which a sample was randomly drawn. A total of 127 respondents (66 men and 61 women) were included in the final sample (see chapter 3). Individuals who were below 18 years of age (based on the village register) at the time of interviews were excluded from the study.

The data was collected by means of face-to-face interviews, where the researcher asked and recorded answers in a structured manner. The data was crosschecked for completeness, coded and captured, using the Epi-data version 3.1 computer program. A statistician analysed the data, using the Statistical Package for Social Sciences (SPSS) version 12.0. Statistical calculations were done for both descriptive statistics and inferential statistics. The results were presented in graphs tables and pie charts. . Chi-square values were also calculated to assess the association between key variables (Babbie 2008:443; Russell 2000:526; Sanders & Pinhey 1983:359; Schutt 2001:347; Wysocki 2001:281).

### **1.7.2 Phases II and III**

The study populations for phases II and III consisted of VCT managers and VCT counsellors, respectively, at two research sites, namely Kisubi and Entebbe Hospitals. Non-probability sampling was used in these phases. The researcher studied the entire population of VCT managers at the research sites, but purposively selected the VCT counsellors at the sites for inclusion. To be selected, counsellors had to be based at either Entebbe or Kisubi Hospital; to have worked as a counsellor for at least two years, and be willing to be interviewed.

Phases II and III involved collection of qualitative data using an interview guide. The data collected was transcribed, coded and analysed. Analysis involved creating categories, refining them and grouping them into themes and sub-themes before presentation, interpretation and discussion (Behr 1983:40; Black 2002:21; Burgess 1984:112; Martinez-Pont 1997:20; Russell 2000:526; Schutt 2001:347; Wysocki 2001:281).

## **1.8 RESEARCH SETTING**

Kasenyi fish landing site is located 25 kilometres away from Kampala city, in Katabi Sub-district, Wakiso District. It has an estimated population of 1 500 people and the main economic activity is fishing, fish processing and trading although other support services are provided (MAAF 2005:34). Kasenyi fish landing site is a centre of activity, attracting different types of people such as fulltime fishermen, traders, and fish processors as well as commercial sex workers (Sambrook & Tanzarn 2003:4). This

kind of population mix, coupled with low or no use of condoms and alcoholism, creates a fertile ground for HIV transmission (Allison & Seeley 2004a:217).

Kisubi Missionary Hospital is located about 25 kilometres from the main Kampala–Entebbe Road, in Busiro South Health Sub-district, Wakiso District (Kirenga 2006:2). It is a private non-profit hospital founded in 1905 and owned by the Kampala Roman Catholic Archdiocese. It is a 90-bed hospital offering both curative and preventive services. Entebbe Hospital is a 140-bed hospital, currently the only government hospital in Wakiso District. It was built in 1904 and provides both in- and out-patient services (MoH 2004:33).

## **1.9 ETHICAL CONSIDERATIONS**

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual”.

To ensure that the study met the prescribed ethical standards, the researcher obtained permission to conduct the study from the University of South Africa (UNISA) and the Uganda National Council for Science and Technology (UNCST), a body that provides ethical clearance for all research in Uganda (Schutt 2001:300; UNCST 2007:5; Wysocki 2001:57). Furthermore, the researcher respected the respondents’ and participant’s right to self-determination and voluntary participation; fair treatment and protection from harm (beneficence), and anonymity, confidentiality and privacy.

### **1.9.1 Right to self-determination and voluntary participation**

The right to self-determination is based on respect for persons and indicates that people are capable of controlling their own destiny. They should be treated as autonomous agents, who have the freedom to conduct their lives as they choose without external controls (Burns & Grove 1999:158). Explaining the purpose and significance of the study, and potential benefits, if any, to the respondents and participants ensured the right to self-determination. The researcher also informed them that participation was voluntary, required their consent, and they could choose to participate or not. Furthermore, they had the right to withdraw from the study at any

time without penalty.

### **1.9.2 Fair treatment and protection from harm (beneficence)**

The right to protection from discomfort and harm is based on the ethical principle of beneficence. The principle of beneficence states that one should do good and, above all, do no harm (Burns & Grove 1999:165).

Discomfort and harm can be physical, emotional, economic, social or legal. In this study, there were no risks of exposing the respondents and participants to discomfort or harm.

### **1.9.3 Privacy, confidentiality and anonymity**

Privacy is the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns & Grove 1999:158). Respondents' and participant's privacy is protected if informed consent to participate is given and signed voluntarily before participation.

Confidentiality means that information provided by participants will not be divulged or made available to any other person. Anonymity is when even the researcher cannot trace the data to specific subjects (Brink 1996:51).

To ensure the respondents' and participant's anonymity, they were not asked to provide their names. Instead, the researcher assigned numbers to the interviews. The researcher emphasised that all information would be treated as strictly confidential.

## **1.10 SCOPE AND LIMITATIONS OF THE STUDY**

This study was limited to VCT service delivery and utilisation in and around Kasenyi fish landing site, in Wakiso district. At the same time, the study did not include other fish landing sites based on the islands of Lake Victoria, whose characteristics related to VCT delivery and utilisation might have differed from those of other landing sites.

There are only two VCT service providers targeting Kasenyi fish landing site, which limits comparison of the data across other health facilities in relation to how they provide VCT services. At the same time, research in marginalised communities like fishing communities could sometimes raise false expectations about immediate plans for assistance. Accordingly, the researcher clearly explained the purpose of the research; made no promises of assistance, but stressed that the findings would be presented to policy makers for policy change or programme design.

### 1.11 DEFINITION OF KEY CONCEPTS

Russell (2000:36) defines conceptual definitions as “constructs or ideas that are articulated in words in order to facilitate understanding” and operational definitions as “a set of instructions on how to measure a variable which has been conceptually defined; in other words, the context in which variables are used”. In this study, the following concepts are used as defined below:

- *Beach Management Unit (BMU)*. A BMU is an administrative structure establishment under the Fisheries Rules of 2003, Statute no. 35. The role of the BMU is to provide local governance and mobilisation for civil society cooperation aimed at HIV/AIDS prevention and or mitigation (MAAF 2005:10).
- *Commercial sex worker (CSW)*. A CSW is person who is involved in offering sex in exchange for money or any other type of remuneration.
- *Consent*. *Collins English Dictionary* (1991:341) defines consent as “To give assent or permission (to do something); agree; accede; acquiescence to or acceptance of something done or planned by another”. In VCT service, consent is a voluntary agreement by a sane, adult person to have a procedure (VCT) performed. It may also imply agreement to give personal information (MoH 2003b:7).
- *Counselling*. Counselling is “systematic guidance offered by social workers, doctors, etc., in which a person’s problems are discussed and advice is given” (*Collins English Dictionary* 1991:363). In HIV/AIDS services, counselling is a



confidential dialogue between a client and a health care provider to enable the client to consent to take an HIV test and receive test results (MoH 2003a:2)

- *Fishing communities.* In this study, fishing communities refers to all those who live in communities where the main livelihood activity is fishing, fish trading and fish processing (Seeley & Allison 2005a:694).
- *Fishing crew.* Fishing crews are individuals, in most cases young men, who go on the lake, casting nets, catching fish and transporting them to the fish landing sites. They are paid on a daily basis and usually have cash at hand (Seeley & Allison 2005a:694).
- *Health facility.* A health facility is an establishment where healthcare services are provided. In Uganda, health facilities are defined according to the level and type of services they provide (MoH 2003a:1).
- *HIV/AIDS care and support.* HIV/AIDS care and support are comprehensive services provided to people living with HIV/AIDS (PLHA). These services include ongoing counselling, nursing care, diagnosis, treatment and prevention of AIDS-related infections (Kaleeba, Kalibala, Kaseje, Ssebbanja, Anderson, Van Praag, Tembo & Katabira 1997:10).
- *HIV/AIDS counsellor.* A HIV/AIDS counsellor is a health cadre (trained professional) who provides HIV counselling. They are trained and qualified to offer the service (MoH 2003a:2).
- *HIV/AIDS couple counselling.* This refers to offering counselling services to sexual partners or intending sexual partners together at the same time, place and by the same counsellor.
- *Local Council 1 (LC1).* This is the lowest level of political administration, operating at village level, composed of nine committee members (MAAF 2005:20).
- *VCT client.* A VCT client is a person seeking or using VCT services.

- *VCT site managers*. These are individuals who oversee VCT services at a health facility linking service delivery to VCT policy guidelines. They may include hospital superintendents and VCT coordinators.

## **1.12 OUTLINE OF THE STUDY**

Chapter 1 introduces the problem under investigation, outlines the background to the problem; states the aim and objectives of the study, and briefly describes the research design and methodology.

Chapter 2 discusses the literature review on VCT service delivery and utilisation. This enabled the researcher to compare and contrast the findings of this study.

Chapter 3 describes the research design and methodology, including the population, sampling, data collection and analysis, as well as validity, reliability and trustworthiness, and discusses the ethical considerations.

Chapter 4 presents the data analysis and interpretation and findings of phase I (data collected from the respondents at Kasenyi fish landing site).

Chapter 5 presents the data analysis and interpretation and findings of phase II (data collected from the VCT managers at Entebbe and Kisubi Hospitals) including a literature control.

Chapter 6 presents the data analysis and interpretation and findings of phase III (data collected from the VCT counsellors at Entebbe and Kisubi Hospitals) including a literature control.

Chapter 7 summarises the findings in phases I, II and III and then discusses, compares and contrasts them. Based on the findings of the study, chapter 7 presents strategies to increase accessibility, acceptability and utilisation of VCT services.

Chapter 8 concludes the study, describes its limitations, and makes recommendations for further research.

### **1.13 CONCLUSION**

This chapter described the research problem, the aim, objectives, significance and design and methodology of the study, and ethical considerations, and defined key concepts. HIV/AIDS remains a major problem, especially in Sub-Saharan Africa. Certain marginalised populations such as fishing communities appear to be affected most. In Uganda, despite efforts to reduce HIV transmission with programmes such as VCT, these interventions do not appear to reach fishing communities effectively. It is unclear whether their low VCT service utilisation arises from the model of VCT service delivery or the characteristics of the target population.

Chapter 2 discusses the literature review on VCT service delivery and utilisation undertaken for the study.

## **CHAPTER 2**

### **Literature review**

#### **2.1 INTRODUCTION**

This chapter discusses the literature review undertaken for the study. A literature review is undertaken to assist researchers to comprehend and extend their knowledge of the phenomenon under study (Polit & Beck 2008:105). According to Babbie and Mouton (2001:565), the purpose of a literature review is “to determine the extent to which the topic under study is covered in the existing body of knowledge”. The literature review in this study covered VCT service delivery models, including the settings, resources and general environment in which VCT is provided, and the utilisation level, which embraced the characteristics of the target populations; barriers to, and promoters of VCT in a given population – the fishing communities.

The literature review focused on the aim and objectives of the study and covered theories, concepts, models and frameworks; research articles and published reports, and lastly policies, guidelines and recommendations (Galvan 2006:3).

#### **2.2 THEORETICAL PERSPECTIVES OF VOLUNTARY COUNSELLING AND TESTING (VCT) SERVICE DELIVERY AND UTILISATION**

Theories involve constructing abstract interpretations that can be used to explain a variety of situations in the social world. Some theories involve macro level analysis where large-scale social systems are involved such as government systems that include laws, policies and guidelines; for example, policies that guide VCT service delivery. Other theories concern micro level systems, which include individual everyday behaviours in face-to-face interactions, thus questions such as why some people go for VCT while others do not, and what the influencing factors are. Lastly, some theories relate to the meso level, between the macro and micro level, focusing on social groups and organisations; for example, health facilities that provide VCT services. Some theories combine all three levels in explaining behaviour. In this study, theories that

take the three levels into account were used to describe VCT service delivery and utilisation patterns (Wysocki 2001:20). The researcher recognises the fact that there are many other models but the three chosen best apply to the current study in view of the research objectives.

### **2.2.1 Framework for health services delivery and utilisation**

In 1974, Aday and Anderson (1974:212) developed a framework to explain health services delivery and utilisation, using three different levels – the macro, meso and micro level. The framework explains the interrelationship between health service delivery and utilisation patterns. The macro level can be regarded as the policy level, the meso as characteristics of the healthcare delivery system, and the micro as characteristics of the population at risk and the consumer. This framework was based on Anderson's (1973:184) one, which explained health services utilisation using five different approaches, namely the socio-cultural; socio-demographic; social-psychological; organisational, and social systems approach.

According to Aday and Anderson (1974:213), at macro level, access to health services is considered mainly in a political context, where governments have the power and mandate to direct healthcare systems through health policy. The effect of health policy in altering and influencing access to health services cannot be overemphasised hence health planners and policy makers' concern with its evaluation. Aday et al (1980:26) assert that access should be seen as those dimensions that describe the potential and actual entry of a given population or group to a healthcare delivery system. Policies may sometimes conflict with culture and may therefore be unpopular. Regarding policies on AIDS in Africa, De Cock, Mbori-Ngacha and Marum (2002:67) found that the global response to HIV/AIDS encompassed contradictory approaches to the epidemic, and advocate the reconsideration of policy and practices in HIV testing and partner notification.

The meso level considers the health delivery system as those arrangements for the potential rendering of care to consumers, which involve two main elements, namely the available resources and the structure of the organisation, that is, how the organisation uses the resources – such as time, human resources, equipment, and finances. The resources component includes both the volume and the distribution of medical

resources in an area (Aday & Anderson 1974:213). Darmody, Hook, Westphal and Henriques (2007:40) add that inputs to produce a healthcare service include building/facility, equipment, supplies, and labour. Labour includes the particular skills mix of workers as well as the time and salary for each job classification of a worker.

At the micro level, Aday and Anderson (1974:214) considers two main elements, namely the characteristics of the target population at risk and consumer satisfaction. Characteristics of the population at risk include predisposing, enabling and need components as the individual determinants of health service utilisation. The predisposing factors encompass those variables that describe the tendency of individuals to use services, which may include elements such as age, sex, race, religion and values concerning health. Consumer satisfaction refers to the attitudes toward the medical care system of those who have experienced contact with it. It views users' satisfaction with the service in terms of quantity or quality of health care actually received (Anderson 1973:186).

Using the health services delivery and utilisation model to describe a number of empirical economic evaluations, Van Velden, Severens and Novak (2005:1076) found a need for that economic health care decision-making to move towards multi-level ecological approaches that include a focus on the macro, meso and micro level. There is a need to address individual knowledge levels and attitudes (micro level issues), while concurrently tackling issues that are more embedded in meso level (such as relationships with parents and the community) and macro level structures (such as poverty, social norms, availability of youth sexual health services). In South Africa, Rohleder and Swartz (2005:401) found that counsellors had a strong feeling that they were not being appreciated or given due recognition by others, particularly the government using terms such as "lay" counsellors to denote non-professional. This affected counsellors' self-esteem and thus the quality of VCT services.

### **2.2.2 The social ecological model**

The social ecological approach recognises that individual health behaviours and practices, such as going for VCT service, are actually influenced at different levels in a complex environment. Ecological theories focus on context; assuming that individual attitudes, behaviours and practices are shaped by the settings in which individuals live

and work. In other words, there is interdependence of persons and settings in which they live, behaviours being influenced at different levels by different factors (Franklin 1988:340; McLeroy et al 1988:354; Ostrom 1998:6).

Breinbauer and Maddaleno (2005:3) view health behaviours as a function of individuals and the environments in which they are embedded, namely the family, social networks, communities, civil society, organisations, institutions and societies as a whole. Individuals' behaviour is influenced by aspects of the external environment, which, in turn, influences individuals to behave the way they do. These may include for example key stakeholders, funders, government structures and the nature of the VCT target communities that VCT sites serve. A community's values and norms provide a framework for determining attitudes and behaviours acceptable within a given context. For example, it is thought that when beliefs favour VCT practices, they can facilitate quality VCT service delivery at institutional level and VCT utilisation at individual level, and vice versa (Breinbauer & Maddaleno 2005:3). With regard to counselling relationships, Reeve (2000:680) found that counsellors' unresolved prejudices and negative attitudes about disabled people was a major deterrent to VCT whereas counsellors (and supervisors) who understood disability as a social construct were most likely to move their clients towards self-empowerment.

At the organisational level, the dominant values and beliefs within an organisation dictate employee attitudes and behaviours. The beliefs within the institutional environment impact on the organisational structures and functions as well as staff beliefs and behaviours. Wegge, Schmidt, Parkes and Van Dick (2007:84) found that the absence of institutional control policies have a substantial impact on employee absenteeism. While the settings in which VCT staff operate on a day-to-day basis play an important role in shaping their attitudes, these settings are in turn embedded in a larger environment, namely the factors, forces and events outside of the immediate social system (Schein 1990:111). Regarding health workers' resistance to integrating reproductive health services, family planning, VCT and antiretroviral therapy (ART), Asimwe et al (2005:35) found that nurses and midwives were negative towards providing services to HIV/AIDS patients, often sending them to The AIDS Support Organisation (TASO), an organisation that cares for HIV/AIDS patients in Uganda. Grusky, Roberts, Swanson, Joniak, Leich, McEvoy, Murphy, Schilt and Wilson (2005:161) found organisational preference and pressure to provide confidential VCT

whereas counsellors and clients favour anonymous VCT. According to Rohleder and Swartz (2005:401), counsellors felt that nursing managers were more concerned about clinic statistics (how many people were tested) than the nature and needs of the counsellor and the person being counselled, thus influencing the way they dealt with clients.

The social ecological model explains individual behaviour in various circumstances. Describing the dynamics of social ecological factors that lead to individual behaviour change as well as communities and networks that reinforce the change, can develop more effective and sustainable HIV prevention interventions (Latkin & Knowlton 2005:110). Hovel, Hillman, Blumberg, Sipan, Hatkins, Hofstetter and Myers (1974:277) used the social ecological model to explain adolescents' sexual behaviour. They found that techniques for controlling teen pregnancy and HIV require community-wide interventions that change normative reactions to both risky and protective behaviour. Similarly, Miller and Willoughby (1997:83) emphasise that curbing substance abuse requires greater attention to the community context within which substance abuse occurs, including identification of culture-specific resources that can stimulate and support change. Latkin and Knowlton (2005:S107) refer to a study using the social ecological model in Bangladesh, which demonstrated the importance of settings, network structure and choice of peers in sexual behaviour change. Latkin and Knowlton (2005:S107) compared network versus non-network peer education interventions and found that the network compared to non-network peer education intervention was more effective in promoting family planning, where a network was defined as an individual linked to a focal individual by a particular behaviour or interaction.

Sherman, Hua and Latkin (2004:1205) highlight the usefulness of ecological approaches to HIV-prevention intervention in the United States of America (USA) urban, drug-use prevalent community, where they targeted drug users and their risk network members in which the outcome was positive. Shoveller, Johnson, Savoy and Pietersma (2006:174) maintain that ecological interventions need to be designed to address micro, meso and macro level factors, and be operationalised at these three levels. The social ecological model and the health services provocation and utilisation framework are intertwined.



### 2.2.3 Health Belief Model (HBM)

The Health Belief Model (HBM) is a psychological model that explains and predicts health behaviours by focusing on individuals' attitudes and beliefs (Janz & Becker 1984:1). The HBM was developed in the 1950s by social psychologists in response to the failure of a free tuberculosis health-screening programme in the USA. Since then, the HBM has been used to explore a variety of health behaviours such as sexual risk behaviours and transmission of HIV/AIDS. The model initially had four key concepts: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. The concept of cues for action was added later as a stimulant to behaviour change. Finally, in 1988, the concept of self-efficacy was added to address the issues of an individual's belief of having the power to change a given behaviour (Brown 2005:114; Hochbaum 1956:378; Janz, Champion & Strecher 2002:47).

The HBM includes three major levels of interaction between variables, namely background, personal perceptions and action. It is based on the understanding that people will take a health-related action if they feel that a negative health condition can be avoided; have a positive expectation that by taking a recommended action, they will avoid a negative health condition, and believe that they can successfully take a recommended health action.

Lin, Simoni and Zemon (2005:471) cite Rosenstock (1974b) who maintains that in order for individuals to take action to avoid a disease, they need to believe that:

- They are susceptible to the disease (perceived susceptibility).
- The disease could have at least a moderately severe impact on some component of their life (perceived severity).
- Certain behaviours could be beneficial in reducing their perceived susceptibility or severity in the event of trouble with the disease (perceived benefits).
- These behaviours would not be impeded by factors such as cost, pain and embarrassment (perceived barriers).

Health behaviours are a result of a set of core beliefs, which is why the model has been found useful in predicting individual health behaviours (Janz & Becker 1984:2). This model assumes that individuals weigh the costs and benefits of a given behaviour and

then perform the response that maximises benefits and minimises costs (Hovel et al 1974:272).

The HBM has been applied to a broad range of health behaviours and population studies. These include preventive health behaviours, which encompass health-promotion (for example, VCT) and health-risk (for example, HIV) behaviours as well as vaccination and contraceptive practices; sick role behaviours, which refer to compliance with recommended medical regimens, usually following professional diagnosis of illness, and clinic use, which includes visits to a health facility for a variety of reasons (Conner & Norman 1996:1; Janz & Becker 1984:3; Paone 1999:4).

In Tanzania, De Paoli, Manongi and Klepp (2004:422) found that the HBM could explain 42% of women's expressed willingness to accept VCT. Perceived high personal susceptibility to HIV/AIDS, an expressed need for guaranteed confidentiality, necessity of partner involvement, and religion were all shown to be associated with willingness to accept VCT. Gage and Ali (2005:167) add that willingness to test could be considered a stage of contemplation, and perceptions of susceptibility and concern for others are among the factors likely to shape favourable attitudes towards HIV testing.

Willingness to test may differ from actual testing, however, which reflects that a concrete action – VCT – has taken place, which is why barriers to action cannot be ignored in the HBM (Fako 2006:201). Khan and Bhardwaj (1994:64) list the number of providers, their geographical distribution, the model of VCT, the organisational arrangement of providers and the scope of services they provide as some of the barriers to VCT.

Not all aspects of the model may work to explain behaviour. In a study in Taiwan, Lin et al (2005:479) found that efficacy constructs were the most reliable predictors of immigrants' sexual behaviour compared to the rest of the elements in the HBM model.

The health care service delivery and utilisation framework, the social ecological model, and the health belief model do not on their own explain behaviour. For example, Shoveller et al (2006:174) maintain that ecological interventions need to be designed to address micro, meso and macro level factors (which are components of the health services service delivery and utilisation framework). Heflinger and Christens (2006:384)

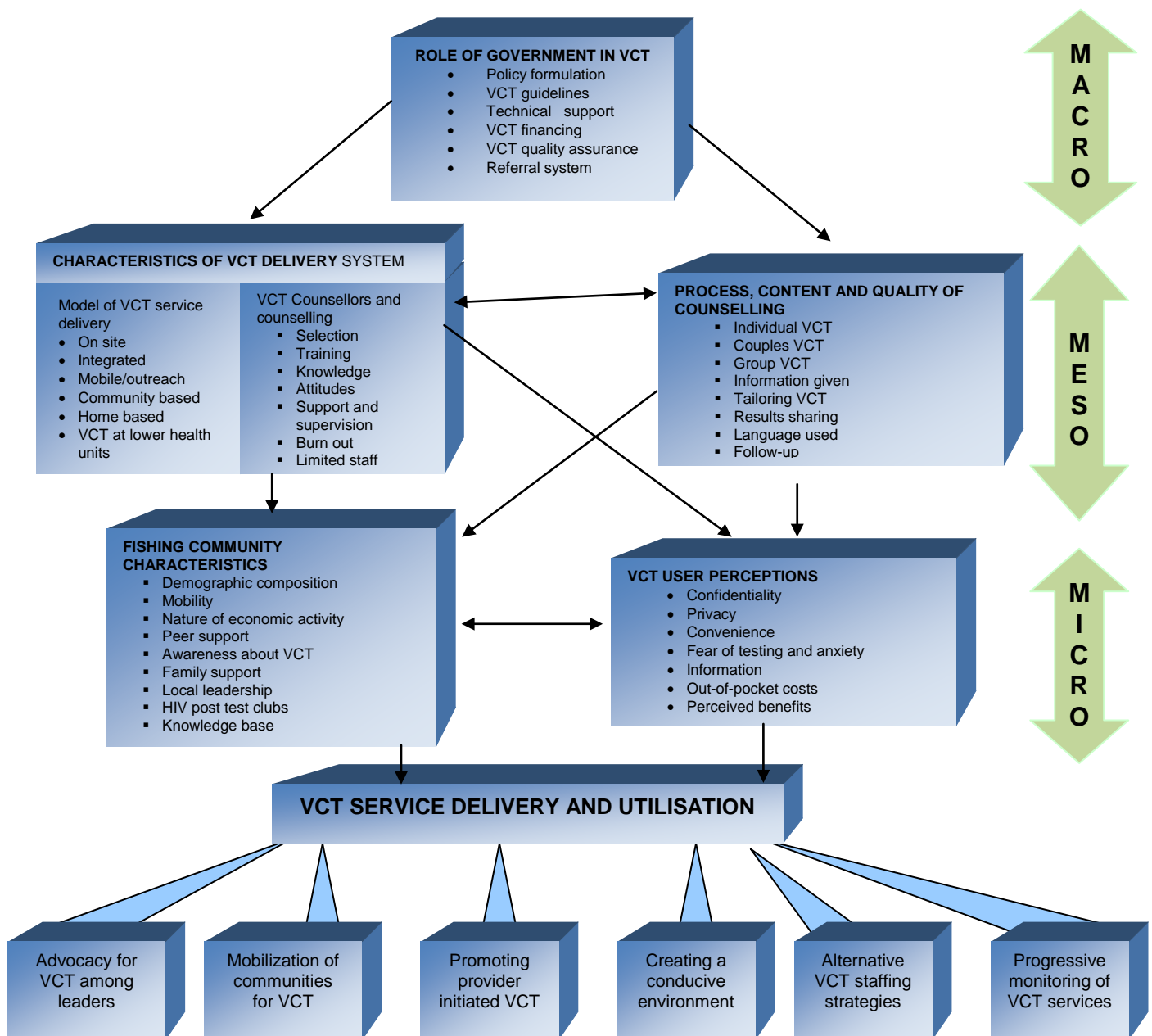
emphasise that when an entire community is suffering from similar problems, the HBM approach is less helpful and continuing to focus primarily on the individual within a disadvantaged group or community is to indirectly “blame the victim”.

For these reasons, then, the researcher decided to use three theoretical frameworks in constructing the conceptual framework (see figure 2.1).

### **2.3 CONCEPTUAL FRAMEWORK FOR VCT SERVICE DELIVERY AND UTILISATION**

A conceptual framework is a set of coherent ideas or concepts organised in a manner that makes them easy to communicate to others. It is often used to outline possible courses of action or to present a preferred approach regarding a health intervention. It helps researchers to understand and use the ideas of others who have done similar research before (Botha 1989:51).

The construction of the conceptual framework in this study was based on integrating different operational levels, institutions, behaviours, functions, relationships and objects, all related to VCT service delivery and utilisation. The literature review enabled the researcher to understand the different elements involved in VCT service delivery and utilisation, how they are interlinked and how they ultimately affect the outcome; that is, the nature of VCT service delivery and patterns of utilisation. The researcher was then able to explore the current models of VCT service delivery and analyse the extent to which a given VCT model had influenced uptake of VCT services in the fishing communities. Figure 2.1 illustrates the conceptual framework constructed for this study.



**Figure 2.1 Conceptual framework for VCT service delivery and utilisation**

## 2.4 MACRO LEVEL – GOVERNMENT ROLE IN VCT SERVICES

Every government strives to provide the best healthcare to its citizens, ensuring that policies and guidelines to guide service delivery and use are put in place. These guidelines may be at local, national or regional levels in the form of administrative laws and policies, which in turn guide decision-making that affects access, availability and delivery of health services (Green & Kreuter 2005:34). Policies may be influenced at different levels by national and international media, professional organisations and other national groups or organisations, mainly through advocacy. Rural health service

delivery, however, is dependent on the beliefs of policy-makers and administrators who decide what constitutes good care in rural areas, although their points of view may sometimes conflict with local needs (Blank, Fox, Hargrove & Turner 1995:513). In a study on patient safety in the USA, Mello, Kelly and Brennan (2005:381) found conflict between patient safety measures and the law, and top-down regulation was not always harmonious.

The health-sector approach to HIV/AIDS started with a medical response in the late 1980s, evolved to public health in the early 1990s, and finally to multi-sectoral response from 1995 onwards (Commonwealth Regional Health Community Secretariat [CRHCS] 2002:7). The development of policies and guidelines arose from donor pressure coupled with the increasing need to provide a legal framework for implementing programmes. With the advent of the multi-sectoral approach, VCT was embraced as a strategic intervention and is a component of all HIV/AIDS strategic plans in most African countries. The main and commonest components of the VCT policy include voluntary HIV testing to be made universally available and accessible; informed consent with counselling, and confidentiality to be observed in all voluntary HIV testing; HIV testing not to be included as part of a routine medical examination without the knowledge and consent of the client (Grellier et al 2004:18; MoH 2003a:1). Kipp et al (2002:705) point out the need for staff policies to provide clear guidelines on confidentiality of client information. Njagi and Maharaj (2006:120) found that ensuring privacy and reducing waiting time at a VCT centre are two ways of ensuring confidentiality and anonymity.

Funding for VCT has largely been the role of donor agencies while governments' contribution has mainly been the provision of personnel and physical space. Besides the financial support, donor agencies in Uganda, such as the Centre for Disease Control and prevention (CDC), offer technical support in terms of VCT quality assurance and quality control through training and monitoring VCT activities (CRHCS 2002:6; MoH & ORC Macro 2006:8). Churches and religious organisations play a significant role in mitigating the impact of HIV. In a study in Mozambique, Agadjanian and Sen (2007:365) found that more HIV/AIDS services were provided by religious organisations than public organisations. Their involvement varied between urban and rural areas. Irrespective of the source of funding, Stroul and Friedman (1986:xxiv) maintain that there should be full participation of the service providers and recipients in all aspects of planning and delivery of services.

## **2.5 MESO LEVEL**

At the meso level, the elements considered include the models of VCT service delivery, the counsellors who provide VCT service, the nature of counselling they give, and the support they receive as VCT counsellors.

### **2.5.1 VCT service delivery models**

Different models of VCT service delivery exist in different places depending on the provider and the target population. Family Health International (2005:1) emphasises that in setting up VCT service centres, one should take into consideration the cost, cost-effectiveness, sustainability, affordability, appropriateness to the target group, epidemiological profile, the socio-political situation, and convenience to the clients. This leads to different VCT service delivery models, namely integrated, quasi-integrated, stand-alone and mobile VCT services.

#### ***2.5.1.1 Integrated VCT service delivery model***

In the integrated VCT service delivery model, VCT service is based in a health facility, usually a district hospital or health centre. The VCT service is usually provided along with other routine health services, such as reproductive health, by trained counsellors, who are in most cases nurses (Asiimwe et al 2005:2). Integration involves training health care providers in multiple skills to enable them to deliver all the services within the same facility, which makes the facility a “one-stop” centre (Askew & Berer 2003:54; CRHCS 2002:11; UNAIDS & WHO 2004:215).

A one-stop centre is likely to spread more information about availability of VCT services, particularly by word of mouth. Gage and Ali (2005:163) found that neighbourhood knowledge of a test site was one of the strongest predictors of HIV testing, especially where dissemination of information about VCT services was by word of mouth, thereby heightening awareness of the benefits of HIV testing. Furthermore, integrating VCT services into existing health centres could provide an entry point to VCT services use, linked to care and treatment for those who are infected. It would also help to reduce concerns about confidentiality and stigmatisation, which are barriers to

the utilisation of VCT services. In a study in Ethiopia, an overwhelming majority (83%) preferred the hospital as a site for VCT services (Dejene 2001:32).

### ***2.5.1.2 Stand-alone or freestanding VCT service delivery model***

In a stand-alone or freestanding VCT service delivery model, VCT service is provided on its own and not normally associated with a health unit. As such, VCT is the only service these sites offer (MoH 2005:1). At these VCT sites, the personnel are dedicated to providing HIV counselling and testing on a full-time basis. The sites are usually operated by non-governmental organisations (NGOs). According to the CRHCS (2002:13), for reasons of cost effectiveness, stand-alone sites are usually located in highly populated areas and in most cases where HIV infection rates are high.

Although the VCT quality may be high because personnel are dedicated to the service, clients may not be sure of confidentiality, which may affect utilisation. According to Fylkesnes and Siziya (2004:570), an important underlying reason for the low response to site-based VCT is associated with confidentiality, due to factors such as the likelihood of individuals' meeting someone known to them at the local clinic and fear of breach of confidentiality by site staff. Gage and Ali (2005:167) maintain that stand-alone VCT sites are more likely to raise concerns about confidentiality and stigmatisation and thus offer less in terms of support or care for those who test HIV positive. McCauley (2004a:6), however, found that youth embraced youth-friendly corners at stand-alone VCT sites in Uganda, as they expressed relief that they did not have to wait or be counselled with adults.

### ***2.5.1.3 Quasi-integrated VCT service delivery model***

The quasi-integrated VCT service delivery model involves an NGO providing VCT in a government health facility and both the NGO and the government contribute to managing the VCT services. This model capitalises on the strengths of both stand-alone and integrated VCT models but its success greatly depends on the quality of the partnership. Thailand and Uganda effectively utilise the quasi-integrated VCT model because many NGOs are linked to government health facilities. According to FHI (2005b:3), the benefits of the quasi-integrated VCT service delivery model include

chances of reaching many clients through both client-initiated and provider-initiated VCT.

In addition, quasi-integrated VCT service is usually better funded and managed than if the government alone was running it. Rohleder and Swartz (2005:402) found that counsellors who worked in quasi-integrated VCT structures felt more supported by others in the workplace compared to those in stand-alone or integrated sites, which in turn raised their motivation. Youth-friendly services in many countries are an example of quasi-integrated VCT services, because the youth are often reluctant to use formal health services, but require special services. In a study at two clinics in Uganda, McCauley (2004b:5) found that introducing youth-friendly corners attracted more youth to VCT compared to the normal clinics. However, FHI (2005b:3) warns that the major challenge of quasi-integrated VCT is that VCT services can suffer from the difficulties of ineffective partnership, thus lowering quality.

#### **2.5.1.4 Outreach VCT**

Outreach VCT means taking VCT services to the people (PSI 2006:2). There are two main VCT service delivery methods considered in outreach VCT services, namely community-based mobile VCT services and home-based VCT service.

##### **➤ Community based mobile VCT**

Community-based VCT works by staging vans at crowded places such as market places and offering educational talks followed by counselling and testing. In this model, a team of providers (usually a counsellor, a laboratory attendant and a mobiliser) set up a temporary site where they offer services to small groups of people found at that site (FHI 2005b:3). This model is usually used for the hard-to-reach groups such as injection drug users, sex workers, truck drivers, street boys or those with no fixed address.

In mobile VCT service delivery, churches provide the space for the service in collaboration with local partners who mobilise the local population to embrace VCT. In South Africa and Swaziland, for example, VCT providers work with churches and faith-based organisations, while in Côte d'Ivoire and Rwanda, military barracks and their



facilities are used. In Mozambique and Swaziland, partnerships with the local Ministry of Health staff help provide space in health units, while in Uganda, local council committee members help mobilise the local populations (PSI 2006:1). Mobile VCT has the advantage of greater accessibility and no transport costs for the community and thus increases usage. Asingwire (2004:68) found that the mobile van for VCT services is an appropriate form of delivering the service to the “hard-to-reach” populations, although the van requires substantial resources, time and community support. At the same time, however, mobile VCT can easily suffer from branding the services as just “AIDS” and thus some people may feel reluctant to come forward for testing for fear of being stigmatised and discriminated against (Asingwire 2004:41).

➤ ***Home-based VCT***

Home-based VCT is the second type of mobile VCT. It is a relatively new VCT service delivery model that involves moving from home to home, offering VCT in the home to family members, including children, where appropriate (FHI 2005b:4; Wolff, Nyanzi, Katongole, Ssesanga, Ruberantwari & Whitworth 2005:110). Fylkesnes and Siziya (2004:570) found that VCT acceptability was 4.7 times higher in a group randomly allocated to the services at an optional location (usually at home) compared to a group randomised for clinic-based service. Wolff et al (2005:111) observed a dramatic and statistically significant increase in uptake of HIV results rates in the home delivery intervention compared to site-based VCT, due to its advantages in terms of travel distance, time and general convenience of getting results. However, FHI (2005b:5) found home-based VCT challenging in that family disclosure, especially of parents to children, may be difficult as the parents have to deal with the knowledge of their status first, and more so, testing everyone in a family at the same time may mean unintended premature disclosure. Similarly, Wolff et al (2005:114) found home-based VCT did not benefit youth due to the possibility of increasing domestic conflict resulting from disclosure.

## **2.5.2 Nature of VCT**

VCT services can also be described according to the number or relationships of clients receiving VCT at the same time. Thus VCT may be described as individual, couple, family or group VCT. Normally, VCT is provided to an individual, on a one-to-one basis.

However, in situations where resources (especially the number of available counsellors) are limited, group counselling can be offered in order to maximise the number of people having access to VCT. Groups may be formed on the basis of language, age or sex to allow for homogeneity of the members, which may allow free discussion. Although group work has been used successfully as part of pre-test preparation, caution should be taken to ensure that it does not replace individual post-test counselling. Everyone tested therefore should have the opportunity for individual post-test counselling (Cohen, MacKinnon, Dent, Mason & Sullivan 1992:729).

While group counselling may encourage discussion among group members by stimulating their thinking through group interaction, some individuals may find it difficult to discuss personal issues or personal fears in a group setting or may easily feel swayed by the opinion of the group. In addition to individual counselling skills, the counsellor who leads the group session will need skills to cope with the complex dynamics that may arise in a group (Cohen et al 1992:730). Fabiani, Cawthorne, Nattabi, Ayella, Ogwang and Declich (2007:737) found that low acceptance of VCT among women seeking antenatal services could partly be attributed to group pre-test counselling being offered, which perhaps denied women privacy and confidentiality in those sessions.

In certain instances, pre- and post-test VCT may be offered to more than one individual in the same session, thus VCT may be offered to a couple or a family (MoH 2003b:7). The main reason is to share results in order to prevent further spread of the virus as well as ensure social and psychological support, thus approaching HIV/AIDS as a family and society disease. In couple counselling, VCT is offered to individuals having or intending to have sexual relationships. Before couples embark on long-term relationships it is advisable that each should be aware of their HIV status and that of their partner to avoid further adult and paediatric infections. In Rakai District, Uganda, for example, the overall yearly incidence of HIV infection from the infected to the non-infected sexual partner was 12% and it increased with the viral load in the infected person (De Cock et al 2002:70). In Nigeria, Uneke, Alo and Ogbu (2007:119) found that infections were averted when HIV serology tests revealed HIV discordance among intending couples who got to know their intended partner's status. In Uganda, Bunnell, Nassozi, Marum, Mubangizi, Malamba, Dillon, Kalule, Bahizi, Musoke and Mermin (2005:1006) found that none of the married couples considered that they might have

entered their relationship with discordant HIV status, which resulted in reactions of accusations of infidelity on the part of the HIV-positive partner. According to De Paoli et al (2004:421), community education promoting counselling of couples may also be a viable strategy for increasing male participation.

Family VCT is normally carried out when children and youth are tested for HIV and serves for purposes of consent or assent and disclosure. It also prepares a family for offering emotional, social and psychological support in case a member tests HIV positive. Most HIV-infected children are born to women who are unaware of their infection status. In Malawi, Mphaya (2006:80) found that parents were not comfortable discussing sexual health with their children. In Zambia, Denison, Nalakwanji, Wendy, Dunnett-Dagg, McCauley and Sweat (2006:7) found that whereas the youth interviewed had overwhelmingly positive interactions with their families, only about half of the HIV-positive adolescents disclosed their status to a family member, and several informants did not intentionally want to share their VCT experiences with their families for fear of negative repercussions. Therefore, strategies involving families in young people's VCT and care experiences need to be developed with caution to avoid negative consequences resulting from disclosure.

### **2.5.3 VCT changing trends**

VCT service delivery is a dynamic field. Since the onset of HIV/AIDS, the standard practice in HIV testing has been client-initiated, meaning that individuals who wish to know their status ask for the test. However, this means that some clients who are ignorant about the test may go without being tested. In view of this therefore, in November 2006, the WHO and UNAIDS issued operational recommendations for an approach to HIV testing designed to redress this in countries with generalised epidemics, such as those in sub-Saharan Africa (Bass 2006:760).

The provider-initiated HIV testing and counselling approach is recommended, in which the health-care workers should encourage their patients in wards and clinics to be tested for HIV even if they do not present with HIV/AIDS symptoms. This strategy is gradually being implemented in Uganda, where results have already shown that more people have been tested beyond the usual. This would seem to indicate that more people would use VCT services if they were aware of them. Grover and Petterson

(2005:366) found that of 364 women offered HIV screening, 248 (68%) accepted and underwent testing and only 116 (32%) refused testing. Some health workers and activists are nevertheless not happy with this approach. According to Bass (2006:760), health workers argue that it is unethical to approach VCT in this manner. Kippax (2006:232) recommends more research on the impact of testing, particularly routine or provider-initiated testing before proceeding with the new approach as it may result in more stigma and discrimination.

#### **2.5.4 VCT site operational structure**

VCT services need to be accessible and convenient to the users. The location of a VCT centre is an important factor to consider when setting it up. If the VCT facility is far from clients' homes, people will find it difficult to access the services because they will need transport and more time to reach the VCT centre. It is even more problematic especially in developing countries where transport systems are often poor (Sato, Keiwkarnka, Isaranurug, Pattara-Archachai, Yanai & Tsunekawa 2005:39). Access may not only be in terms of distance but the ease of reaching a counsellor. Fylkesnes and Siziya (2004:571) found that ease of access to a counsellor in one's home in mobile-based VCT contributed significantly to a marked difference in VCT acceptability between clinic-based and household-based VCT service. VCT utilisation increased greatly in South Africa when it was made accessible to poor South African communities at home (Pronyk, Kim, Makhubele, Hargreaves, Mohlala & Hausler 2002:863). In Uganda, Asingwire (2004:30) found that a significant proportion of community people were prompted to use the mobile van VCT services because it brought services to their community, which saved them the cost and time of moving to the static VCT site. However, Kippax (2006:231) and Vermund and Craig (2002:1186) found that where stigma is high, individuals may prefer having VCT far from where they stay if they are unsure of confidentiality.

Accessibility to VCT services may also mean the available window in which VCT services can be provided. Opening hours need to be flexible and to take into account the needs of the clients. For example, to allow easy access for working people, lunchtime, early evening and weekend services should be considered, while for individuals with irregular work schedules such as the fishing communities, VCT service providers should not demand appointments for providing VCT, but allow for an "open

door” policy (Seeley & Allison 2005a:690). VCT for women or families should provide space where children can play unsupervised to minimise interruption to the counselling sessions (Juan, Chinaglia, Lippman, Pulerwitz, Ogura & Mello 2006:6). Fox, Blank, Rovnyak and Barnett (2001:428) found the hours of operation a barrier to accessing health services.

Privacy in VCT service delivery is essential in ensuring that VCT is carried out correctly and effectively. When discussing risk factors and sexual relationships, which are essential components of VCT for example, key information essential to the process should not be elicited unless people can discuss these issues in private. In Zambia, Fylkesnes and Siziya (2004:570) found that people place a high value on privacy, which needs careful thought when VCT is offered, adding that practices that maximise the autonomy of the client seem to correspond well with high demand for VCT services. According to UNAIDS and WHO (2000:18), private space may not necessarily mean an expensive place but anything that can prevent interference and eavesdropping.

The VCT waiting area and counselling rooms are another essential element in VCT service delivery. The waiting area should be well ventilated, especially since tuberculosis (TB) is commonly associated with HIV and as such people with reduced immunity are particularly vulnerable to TB infection. While people wait for their turn to have VCT, where resources allow, educative materials such as pamphlets (if they can read) or even videos in a language understood by most of the waiting clients should be provided (Juan et al 2006:5). In rural Uganda, communities felt that counselling and testing should take place at a neutral site in private rooms where confidentiality could be assured (Kipp et al 2002:703). They did not consider open places like churches or schools appropriate for counselling. However, counsellors were not always allocated appropriate workstations. In South Africa, Rohleder and Swartz (2005:402) found a lack of a designated counselling space, little or no understanding of the importance of privacy by other clinic staff, and the use of shared space in the VCT clinic.

Many developing countries are undergoing health reforms that include a degree of cost sharing for medical services. It is thus common for most VCT providers to charge user fees, although others may provide VCT services free. The cost of VCT is a major factor in utilisation. The high cost of VCT discourages poor people from accessing it. At the same time, client fees are considered a way to attach value to the services, thus

individuals bearing the cost themselves may be motivated to return to the VCT centre for their results when single visit results are not available. In addition, client fees could also help discourage inappropriate utilisation of the service (Pronyk et al 2002:862). In Japan, Sato et al (2005:138) attributed a 75% increase in clients presenting themselves voluntarily for HIV testing partly due to increased local accessibility of VCT at health facilities, reductions in direct (user fees) and indirect (transport) patient costs

Simple, rapid HIV tests providing immediate results without need for running water, electricity or laboratories have greatly increased VCT uptake (CRHCS 2002:16). Clients can see their own tests being done, thus increasing trust while at the same time reducing provider errors. Since the test is simple to perform and less sophisticated, non-laboratory staff can do the tests accurately, which lowers costs (De Cock et al 2003:1848). In some areas in the USA where same-day services are not available, only 63% of people who undergo HIV testing at publicly funded HIV testing centres return for post-test counselling (Njagi & Maharaj 2006:117). In Botswana, however, when the test results waiting time was reduced, the test-receiving outcomes did not differ between clinic-based participants who were offered same-day results and home-based participants who had a one-day delay in receiving the result (Fylkesnes & Siziya 2004:571).

Although HIV testing methods are continuously modified and made less sophisticated, without rigorous quality control, high numbers of false positive and negative results are common. False results are extremely damaging for individuals and can also easily undermine the credibility of the service if other clients find out. It is particularly important when deciding on a testing method to crosscheck with recommended reference centres (UNAIDS & WHO 2000:18).

Existence of linkages to facilitate referrals is an essential element in VCT service delivery (FHI 2005a:54). VCT is more effective when developed in conjunction with support services (medical, emotional and social, family planning, STIs, antenatal, home-based care and palliative care services), spiritual services, and PHA support groups. It is essential for counsellors to be aware of the different resources available in a given community so as to make appropriate referrals. Some interventions are directed at streamlining referral networks but barriers are often encountered when clients face bureaucratic red tape as they move between providers, some of them refusing to

release information on their clientele (Foster-Fishman, Salem, Allen & Fahrbach 1999:787).

### **2.5.5 VCT counsellors and counselling**

Counselling in voluntary HIV testing serves three main purposes, namely providing education; providing information for reducing the risk of HIV infection, and referring clients to support services and follow-ups, if necessary (Yoder & Matinga 2004:15). According to the CRHCS (2002:11), counselling should be recognised as a specialised profession, with a defined career path and different categories of counsellors created and accredited at different levels of VCT service.

Training of VCT counsellors is an important component of VCT and should be conducted by a recognised institution providing comprehensive knowledge and skills in the field of counselling (MoH 2003b:4). VCT training for counsellors normally consists of basic information on HIV, transmission routes, risk factors, possible and available interventions, and the role and processes of pre- and post-test as well as ongoing counselling. The Ugandan Ministry of Health recommends that VCT counsellors should be trained for not less than 21 days, although some centres offer longer and more in-depth training (MoH 2003b:4). Strong (2006:1010) emphasises the need for continuous training and support for counsellors. In Uganda, all the groups stressed that HIV counselling and testing should be provided by counsellors who had passed an examination and had the required skills (Kipp et al 2002:702).

Counselling should not be a mandatory part of work, but rather assigned to health care workers who feel committed to doing it. Sometimes managers select counsellors without evaluation or strong consideration of their needs, responsibilities, interest, ability and training and as such they are forced to offer VCT services because of the nature of their work or because they are nurses (Van Dyk & Van Dyk 2003:5). In such circumstances, counsellors may offer poor quality VCT services due to lack of skills and interest. Kipp et al (2002:703) found that most participants preferred counselling to be done by community health workers, followed by religious leaders, village leaders, teachers and others.

Counsellors do not need to have a medical background but could be lay counsellors, people living with HIV/AIDS or people from other professions, such as teachers, who are trained in the field of counselling, sometimes referred to as micro counsellors (Kabura, Fleming & Tobin 2006:68). Using paraprofessionals or micro counsellors can serve as an important link to the community, in which the intervention is provided, enabling providers to tailor prevention services more effectively and sensitively to the needs of the community, thus making the service cost effective (Cabral, Galavotti, Gargiullo, Armstrong, Cohen, Gielen & Watkinson 1996:82). In the Philippines, people with the same cultural background, experience and lifestyles were found to be more effective educators in that group compared to outsiders (Morisky, Ang, Coly & Tiglao 2004:75). In Kenya, in Project CARES, counselling is delivered by peer health advocates, paraprofessionals who have had some experience working with health, social, or community programmes, many having personal and/or family histories similar to communities they serve (Cabral et al 1996:76). The World Fish Centre (2006:49) recommends that fishermen be given specialist training to act as peer educators and offer counselling on vessels during their offshore periods. In their study, Kipp et al (2002:702) found that counsellors should be non-residents of the area, as non-residents were considered more credible and would offer greater confidentiality than residents.

#### **2.5.5.1 Counsellors' attitudes**

Counsellors' attitudes are an important factor in VCT service delivery. Counsellors receive VCT clients from different backgrounds and with different health and social beliefs that differ from their own yet they are expected to be welcoming, friendly, sensitive and non-judgmental towards clients, irrespective of their background. However, some counsellors may hold strong beliefs about certain groups of people or certain practices such as condom use (due to their upbringing or religious beliefs). Such counsellors' attitudes may strongly influence VCT utilisation (Dejene 2001:18). Asingwire (2004:40) found that counsellors' compliance with counselling requirements in order to provide quality VCT has more to do with their attitudes than with their bias towards particular population groups.

It is therefore essential that counsellors receive training in communication skills with groups such as sex workers, drug users, disabled persons or young people. It requires



the counsellor to be aware of and work with the inherent power imbalance between the 'trained' counsellor and 'vulnerable' client (Reeve 2000:670). Health care providers may be disapproving of early sexual activity among young people and this may discourage them from offering VCT services (Oberzaucher & Baggaley 2002:23; Njagi & Maharaj 2006:117). The attitudes of service providers may also reflect society's stigma towards people seeking VCT services. In South Africa, counsellors found it stressful to give positive results to a fellow community member because they (the counsellors) found themselves emotionally involved beyond their professional limits (Pronyk et al 2002:861). Counsellors should be HIV-positive persons in order to give more authentic information to those who test positive (Kipp et al 2002:703).

### ***2.5.5.2 Counsellors' support and follow-up***

Many counsellors experience considerable stress, commonly referred to as "burnout", as a result of full-time counselling for HIV. Held and Brann (2007:213) found several stressors such as clients divulging more or less information than needed, the need to keep confidentiality and not sharing life experiences, being empathetic, to mention but a few. Counsellors' burnout may be related to their selection or lack of interest and commitment to offering the service or because there is a complete lack of support and de-briefing services (Fylkesnes & Siziya 2004:568; Van Dyk & Van Dyk 2003:5).

In order to minimise burnout and avoid losing valuable and experienced staff, regular support and supervision should be planned and provided. This has proven effective and feasible even in busy hospitals that provide care in high HIV prevalence communities. Burnout may be caused by counsellors' prejudices or their beliefs and attitudes, which could be minimised during training. Furthermore, some of the issues they will be expected to discuss (such as condom use or safer sex practices) may go against their own religious beliefs. It has also been reported that when counsellors begin to discuss HIV issues with their patients, their own anxieties and vulnerabilities to HIV may surface more especially if they are living with HIV/AIDS (Murgatroyd 1983:132).

In some countries, counsellors form groups to provide mutual support and discuss complex cases. In South Africa, Pronyk et al (2002:861) found that 40% of the counsellors reported finding counselling stressful, citing concerns about conveying positive results to community members. Pronyk et al (2002:863) emphasise that it is

important to mentor and support health workers performing VCT in order to maintain motivation, reduce stress and burnout thereby sustaining quality service.

### **2.5.6 Process, content and quality of VCT counselling**

HIV-related counselling can be divided into pre-test, post-test and follow-up counselling. The process relates to waiting time, privacy and the nature of information provided during pre- and post-test counselling, and the manner in which discussions between client and counsellor take place (Van Dyk & Van Dyk 2003:8). Interpersonal relationships such as building rapport, being non-judgmental, engaging and actively listening to the client play an important role in counselling. Information given out about HIV-related issues needs to be appropriate, simple and clear, making clarifications and repeating statements where necessary including checking understanding. Accommodative language should be used when dealing with special groups, and care taken when talking about sensitive issues. Language should be appropriate to the culture, educational level and beliefs (spiritual and traditional) of the client (Juan et al 2006:6).

Kippax (2006:232) contends that a clinic does not provide the context for effective prevention because clients are positioned as patients, as passive recipients of information and advice, which is not a favourable characteristic of effective education. Furthermore, such positioning, is disempowering in the sense that it is “top down”, and pays little attention to the ways in which the VCT messages are received, interpreted and understood by the clients. Kipp et al (2002:702) found that few people believe that counsellors intentionally give HIV-infected persons negative results so as to avoid bad consequences such as committing suicide or deliberately spreading HIV/AIDS.

#### **2.5.6.1 Confidentiality**

Anonymity and confidentiality strongly impact on demand for VCT services including ongoing counselling and guidance (Asingwire 2004:41). For VCT to be easily accepted, confidentiality must be guaranteed to those who use the service. HIV remains a stigmatising condition in most countries, especially developing ones, and as such uptake of VCT services will be minimal if it is not known that confidentiality will be respected. Therefore, a system must be in place to avoid breaches of confidentiality at

all stages in the VCT process. In group counselling, participants should be made to agree that personal information disclosed in the group should remain confidential to the group. Practices that maximise the autonomy of the client correspond well with high VCT service demand while those that minimise autonomy correspond with low VCT demand. An important underlying reason for the low response to clinic-based integrated VCT is associated with confidentiality. Factors such as the likelihood of meeting someone known to the individual at the local clinic and fear of breach of confidentiality by clinic staff were factors that could influence acceptability negatively (Van Dyk & Van Dyk 2003:5).

Confidentiality and poor quality VCT cause low uptake of integrated VCT (Fylkesnes & Siziya 2004:570). Some communities do not support the notion of confidentiality. For example, Kipp et al (2002:703) found that some people felt that the public should be informed of the HIV test results in order to warn people not to engage in sexual relations with individuals who have tested HIV positive. Based on their study Kipp et al (2002:705) maintain that it is important to initiate counselling supervision to enforce client confidentiality.

#### **2.5.6.2 VCT for special groups**

Generalising VCT service delivery to all categories of people may not be a good strategy for reaching out to special and vulnerable populations such as commercial sex workers. It is therefore necessary to consider special VCT services for such groups of people particularly affected by HIV. Experience from working with sex workers in southern Africa shows that VCT services must be carried out sensitively (Stilwell 2002:68). The language used for individual and group counselling must be agreed upon and adhered to; the group leader should be aware of the participants' educational background and ensure the use of clear, jargon-free language (UNAIDS & WHO 1997:81-82). In many communities, everyone is seen as having a right to VCT and should therefore receive it in an appropriate manner. In their study, Kipp et al (2002:703) did not single out any specific population groups as needing special HIV counselling and testing compared to others.

## **2.6 MICRO LEVEL**

At micro level, the community and individual's knowledge and perceptions can influence VCT utilisation.

### **2.6.1 Fishing communities**

As mentioned earlier, fishing communities are vulnerable and susceptible to HIV/AIDS. In their study in Uganda and Namibia, the Food and Agriculture Organisation of the United Nations (FAO 2003:7) revealed that HIV/AIDS on average caused 50% of the reported deaths across all rural livelihood groups, but in the fishing community studied on Lake Victoria, it accounted for 57.8% of deaths and 26.3% of illnesses. Fishing communities are characterised by poor social cohesion because they contain a large proportion of migrant fishermen. This particularly reduces opportunities for especially women to benefit from traditional social safety nets, which exist in more stable rural communities (Grellier et al 2004:17).

#### **2.6.1.1 Local administration**

Administratively, fishing communities have been organised in form of local units known as Beach Management Units (BMU). BMU is a recent administrative strategy to manage fishing communities. BMUs consist of representatives from community members involved within the fisheries sector such as fishermen, boat owners, boat builders, fish processors and traders (Grellier et al 2004:21). Their roles range from taxation to mitigation of the impact of HIV/AIDS. In some fishing communities, the revenue gained from taxes is also meant for supporting poorer members of the communities through educational support funds for orphans, payment of medical bills or paying transport costs for sick members returning to their home communities. In some communities, it has been said that the BMUs know the problems of the fishermen better compared to government officials who just sit in offices and are never on the ground (Grellier et al 2004:40-41). Other administrative units include local council leaders while other leaders such as religious leaders also exist in these communities.

### **2.6.1.2 Limited family and community support**

Fishing communities are characterised by very poor family ties and a limited sense of community belonging which limit social cohesion and family and community support (Sambrook & Tanzarn 2003:3). Family and community safety nets function to differing extents in assisting households and individuals affected by crises, sometimes offering continued counselling and support to those who test HIV positive. In other words, support from community groups and individuals work together to cushion the shocks of HIV/AIDS. In a study by Foster (2007:59), it was found that the informal groups provided income-generating activities, counselling, public education, material support and home care, all of which are likely to promote VCT service utilisation. Besides, peer and family support has been documented as key to testing. In a study by Maman, Mbwambo, Hogan, Kilonzo and Sweat (2001:598) in Tanzania, it was found that for many participants, family, friends and other community members played a significant role in recommending VCT services. In their study, Heflinger and Christens (2006:384) concluded that the family has traditionally been a provider of care for behavioural health concerns of rural youth, as well as playing the role of gatekeeper for any formal service delivery.

### **2.6.1.3 Lifestyle**

Many fishing communities are geographically mobile, seasonal or long-term migrants. Previous research findings suggest that mobility and migration separates people from their social support structures, which in turn creates an environment in which they are more likely to engage in risky behaviour, in turn leading to spreading HIV in other areas (Chandrasekaran, Dallabetta, Loo, Rao, Gayle & Alexander 2006:512, Seeley & Allison 2005a:690). In other words, social mobility is another marked HIV transmission factor and is also likely to influence VCT service utilisation (Beyrer 2007:985). Mobility also separates men from their families and they thus lack the support to take an HIV test (Seeley & Allison 2005b:23). Communication with sexual partners is strongly associated with HIV testing. In studies by Gage and Ali (2005:162) and Nsabagasani and Yoder (2006:21), it was found that men who had discussed HIV with their spouses were 1.6 times more likely to test than men who had not had such discussions.

#### **2.6.1.4 Social support**

According to Sambrook and Tanzarn (2003:3), social support mechanisms are lacking in fishing communities. In the study by Admassu and Fitaw (2006:24), it was found that the absence of community support was negatively associated with VCT acceptance ( $p$ -value $<0.01$ ). According to Kaleeba et al (1997:19), it was for example noted that revealing sero-status to a spouse and family members, continuing to work, and caring for oneself were the best ways for coping with HIV/AIDS. At the same time, involvement in drama groups provided social contacts and emotional support for those who test positive. Drama performances depict different scenarios of living with HIV/AIDS, with the aim of creating awareness and acceptance of people living with HIV/AIDS. Drama presentations usually come along with individuals sharing their personal experiences and how they have managed to cope with HIV/AIDS. The AIDS Information Centre (AIC) in Uganda has come up with a support system of post-test clubs (irrespective of the HIV test result) and the Philly Lutaya Initiative (PLI) specifically for those who test HIV positive and publicly announce their sero-positivity (Horizons Program 2001:3).

#### **2.6.1.5 Sharing results**

With limited social support and poor social cohesion, sharing of HIV test results is very unlikely. Sharing results of an HIV test is a desire for all counsellors as it is expected to change an individual's sexual behaviour and thus reduce HIV transmission. Sharing results especially with sexual partners is likely to lead partner/s to be tested as well. It has also been shown that people with HIV often gain much support if they are able to share knowledge of their infection with partners, friends or family members. The greatest opportunity for sharing results is when couples or family members go together to take an HIV test. Generally, there have been low levels of partner notification and subsequent partner testing, evidenced at VCT sites targeting women for mother-to-child transmission where it has been shown that the proportion of men who accepted VCT after their spouses tested positive did not exceed 1% in West Africa and 5% in South Africa (De Cock et al 2002:70). However, in Zambia and Uganda, although people were often reluctant to share their test results initially, over time more people were able to discuss results with their partners and the vast majority was able to tell someone about their test result. Cultural and social factors usually play a big role in determining partner

notification, for example it may be appropriate for women not to reveal their status as pressurising them to do so may lead to abuse, violence or even death. Fears of disclosure have been tied to domestic violence, abandonment or murder, although the frequency of these adverse events is uncertain (Maman et al 2001:599; Nsabagasani & Yoder 2006:33).

#### **2.6.1.6 Follow-up care and support**

As earlier noted, fishing communities are highly mobile and thus are not likely to benefit from follow up care and support. Proper follow up and support of people who test for HIV, more especially those who test positive is very important. There have been debates as to whether it is ethical to introduce VCT services in areas without basic HIV care and support services (Campbell, Marum, Alwano-Edyegu, Dillon, Moore & Gumisiriza 1997:98). Feelings of fatalism and depression have been reported for people who test HIV positive and believe that there is nothing that they can do about AIDS (Van Dyk & Van Dyk 2003:5). Therefore, for people to benefit fully from VCT, it is important that they have access to further emotional, medical and social support. In addition, even people who test HIV negative, follow-ups for repeat testing need to happen at regular intervals, more especially in cases of risky behaviour or impending life decisions such as marriage (De Cock et al 2002:70; Nsabagasani & Yoder 2006:25). According to a study by Kipp et al (2002:703), it was clear that most discussants wanted continued service delivery of HIV counselling and testing services rather than a programme which is only available once. It was mentioned that VCT services should be available at least on two or three occasions per month.

Not all members in the community view VCT as a positive step towards HIV prevention. There are fears that knowing one's results, especially HIV positive results, is dangerous and increases the spread of HIV/AIDS. In a study by Kipp et al (2002:703), some discussants were worried that people who found out that they were HIV infected would go on 'rampage' and therefore spread HIV/AIDS further.

#### **2.6.2 Individual VCT service utilisation**

Although it is increasingly recognised that VCT plays a critical role in HIV-1 prevention, individuals have varied reasons for taking or not taking an HIV test.

### **2.6.2.1 Reasons for testing**

The most common reasons given for seeking VCT include “planning for the future”, “marriage”, “worry” and “curiosity”. Sato et al (2005:132) list fifty-six variables related to VCT acceptance grouped under accessibility and quality of services; social circumstances; personal concern, and decision-making. Downing, Knight, Reiss, Vernon, Mulia, Ferreboeuf, Carroll and Vu (2001:566) identify the desire to protect others, such as a partner and a baby, and peer encouragement and support as important demographic and behavioural factors associated with testing.

### **2.6.2.2 Concerns about VCT**

With regard to barriers young people face in terms of seeking VCT, adolescents (ages 12 to 19) in Mpigi District in Uganda expressed interest in HIV testing, but were concerned about confidentiality, the testing process, the accuracy of test results, and the cost of the services (McCauley 2004a:3). Both actual and perceived risk of and knowledge about HIV are among the factors associated with HIV testing (Downing et al 2001:565; Maman et al 2001:598).

### **2.6.2.3 Barriers to VCT services utilisation**

Perceived HIV risk is one of the barriers preventing fishing communities from accessing and using VCT services. Some individuals might not perceive themselves to be at risk for HIV and therefore convince themselves that they do not need VCT services, because they do not realise that HIV risk can be derived from a partner’s high-risk behaviour. Denial of risk is a common coping mechanism (Vermund & Craig 2002:1187). Other barriers to the utilisation of VCT services include fear of partners’ reactions; partners’ attitudes towards HIV-1 testing; fear of infection, and stigma of HIV or fear of positive diagnosis (Downing et al 2001:566; Maman et al 2001:598; Nsabagasani & Yoder 2006:24).

Another common barrier to VCT arises in cases where individuals have had risky behaviours. Fears about a positive result are often related to past sexual experiences. In Trinidad, Tanzania and Kenya, that individuals’ positive results were strongly related



to variables such as break-up of marriage and being neglected or disowned by their families (Kippax 2006:232).

#### **2.6.2.4 Attitudes towards VCT service**

Negative attitudes towards VCT service also have a negative effect on the use of the service. In Ethiopia, many people believed that community members would have a negative attitude towards those willing to be tested (Admassu & Fitaw 2006:30). Community members might disseminate rumours against would-be testers if they learnt of their testing. It was felt that to be seen going for VCT was a sign of no confidence in individuals' past and if they had HIV, they were considered promiscuous (Admassu & Fitaw 2006:30). Attitudes towards testing differ, depending on the community and medical resources available to the HIV-infected person. In developed countries, fear of adverse consequences is sometimes balanced by awareness of the benefits of HIV-related medical assistance. In developing countries, however, lack of expected benefits from VCT may reinforce the decision not to seek or accept the test (Vermund & Craig 2002:1186). In South Africa, Pronyk et al (2002:863) found very low VCT support scores at one site resulting from clients who had been counselled by a nurse who was unsupportive of VCT services. This indicates the importance of counsellors' training and attitudes.

#### **2.6.2.5 Stigma**

Although human rights and legal prohibitions can protect HIV-infected people against discrimination in society, they cannot protect against stigma, which is a social rather than a structural or physical problem. Stigma emerged universally at the onset of HIV/AIDS as a powerful force that is an important barrier in prevention efforts (De Cock et al 2002:69). HIV/AIDS-associated stigma refers to attitudes or perceptions of shame, disgrace, blame, or dishonour associated with HIV/AIDS (De Cock et al 2002:67). In Ethiopia, fear of rejection by the community and uncertainty about the outcome of the result were the two major reasons given for not being willing to talk to others about their decision to be tested. In another study however, about 80.2% of the respondents said that whatever the outcome, they were ready to reveal the result of their HIV test (Dejene 2001:36). Kippax (2006:232) holds that stigma poses considerable barriers to seeking VCT in South Africa and elsewhere in Africa. Nevertheless, in Uganda, Gage

and Ali (2005:167) found that AIDS-related stigma at community level did not decrease the likelihood of HIV testing and willingness to test, although they acknowledge that this is contrary to most literature.

#### **2.6.2.6 Willingness to test**

Willingness to take an HIV test can be affected by socio-demographic background, family coherence, interpersonal relations, sexual experience and knowledge about sexual health, gender, age, history of weight loss, injecting drugs, and STDs. In Botswana, Fako (2006:203) found a significant relationship between gender and willingness to test for HIV infection among students ( $p$ -value=0.001). Girls tended to be more willing to test for HIV infection (56.8%) than boys (47.6%). However, willingness to test for HIV infection was negatively associated with being sexually active or having a number of sexual partners. Gage and Ali (2005:156) found that testing rates decreased with advancing age but increased with socio-economic status and education level, higher rates being reported among men with secondary or higher education and those from wealthier households.

#### **2.6.2.7 Client satisfaction**

The purpose of going for VCT service is to enable those who have taken the test to know their HIV status, understand what it means and obtain appropriate and timely assistance. If this is not achieved, clients are more likely to be dissatisfied with the services. For those who test sero-negative, the main aim of VCT is to enable them to make decisions about their sexual (or other risk) behaviour and to remain negative. For those who test HIV positive, it is hoped that they can access treatment, care and support at an earlier stage, cope better emotionally with the infection and prevent HIV transmission to sexual partners, especially if they are sexually active. Receiving a positive HIV result is commonly accompanied by negative consequences such as depression, anxiety and possibly stigma, discrimination and maltreatment of those whose results become known outside the VCT centre. Admassu and Fitaw (2006:26) found that individuals who were concerned about their community knowing their HIV sero status (either through intentional or unintentional disclosure) were 0.4 times less likely to accept VCT ( $p$ -value<0.001).

## **2.7 GAPS IN THE LITERATURE REVIEWED**

Fish landing site communities are described as marginalised communities and in most cases hard to reach with HIV/AIDS prevention programmes. HIV/AIDS prevention programmes and particularly VCT have been tailored for specific populations such as the youth, pregnant and nursing women, or other high-risk people like commercial sex workers, but not much has been done towards tailoring VCT programmes for the highly mobile and high risk fishing communities. Fishing communities have no fixed address, which raises the question of which VCT model would best serve them. In addition, little is known about the extent to which interpersonal relationships play a role in VCT utilisation in fishing communities given their migratory nature (Seeley & Allison 2005a:690).

Being a marginalised community, there is a need to know the extent to which VCT programmes, guidelines and policies affect the fishing communities. It is unclear whether social support groups such as post-HIV test clubs and drama groups exist in the fishing communities, and if they do, how much they influence the uptake of VCT services in these communities, which have been seen to lack social cohesion (Sambrook & Tanzarn 2003:3). Most studies evaluating factors affecting VCT use have looked mainly at populations other than the fishing communities. The current study is therefore vital to explore how best to implement VCT in these communities and at the same time fill the gaps identified in the literature.

## **2.8 CONCLUSION**

This chapter presented and discussed the literature review conducted for the study. VCT service delivery and utilisation is affected by interplay of interrelated factors at macro, meso and micro level. At macro level VCT service delivery is affected by policies and guidelines, while at meso level, it is affected by the characteristics of the service provider, both the organisation and the counsellors who offer VCT services. At the micro level, community characteristics and individual knowledge and perceptions, which are in turn influenced by age, sex, gender and educational level, play a big role in influencing an individual's decision to go for VCT services. The researcher therefore developed and based a conceptual framework at these three levels.

Chapter 3 describes the research design and methodology.

## **CHAPTER 3**

### **Research design and methodology**

#### **3.1 INTRODUCTION**

This chapter discusses the research design and methodology including data collection and analysis, population and sample, measures taken to ensure validity, reliability and trustworthiness, and ethical considerations. Both quantitative and qualitative approaches were used and are discussed in detail below.

#### **3.2 RESEARCH METHODOLOGY**

Research methodology is a plan of how the research is to be conducted, or the procedures that are to be used to collect and analyse data. According to Wysocki (2001:6) and Schutt (2001:396), research methodology is a plan of action including a set of skills, insights and tools needed to help understand the what, how and why of research. Babbie (2008:6) defines research methodology as “the science of finding out”. Blaikie (1993:7) defines methodology as “the analysis of how research should and does proceed including discussions of how theories are generated and tested, the kind of logic used and how particular theoretical perspectives can be related to particular research problems”. In order to review and describe the current models of VCT service delivery and analyse the extent to which a given VCT model has influenced uptake of VCT service in the fishing communities, the current study used three methodological approaches, namely exploratory, descriptive and explanatory, soliciting both quantitative and qualitative data.

##### **3.2.1 Exploratory**

The exploratory approach investigates the nature of a phenomenon, the manner of existence, and related factors as well as characteristics in order to gain additional information on the situation. Exploratory research is done to increase the researcher’s knowledge on the phenomenon and provides valuable information for further

investigations and usually asks the “how” questions (Babbie 2008:97; Polit & Beck 2006:21). The current study asks how VCT service is provided and utilised.

### **3.2.2 Descriptive**

Descriptive research attempts to systematically describe a situation (including attitudes towards a situation) or phenomenon or service usually asking “what” questions (Kumar 1999:9; Polit & Beck 2006:189). According to Babbie (2008:99), descriptive studies define situations and events. The descriptive approach was therefore used to describe how VCT service is provided and utilised by the targeted users. Questions such as what influences VCT service utilisation aimed at describing VCT service delivery and utilisation were included in the current study.

### **3.2.3 Explanatory**

The explanatory approach attempts to explain “why” for example people act or feel the way they do, by linking different variables together and explaining one using the other. An example in this study is why gender is more likely to influence VCT service use. Explanatory research displays a relationship and clarifies how and why there is a relationship between two aspects of a situation or phenomenon (Babbie 2008:99; Salazar, Crosby & Diclemente 2006:34).

## **3.3 PHILOSOPHICAL PARADIGMS**

A paradigm is described as a general perspective on the complexities of the real world. For human inquiry paradigms are often characterised in terms of the ways in which they respond to basic philosophical questions on ontology, epistemology, axiology and methodology (Polit & Beck 2008:13). In the research setting it forms the assumptive base from which the researcher goes about producing knowledge (Saks & Allsop 2007:17). For the purpose of this study two broad paradigms were used, namely the positivist paradigm and the naturalistic paradigm.

### **3.3.1 The positivist paradigm**

The researcher took a positivist approach in the methodological design of the quantitative phase, that is, data collection from Kasenyi fish landings site. According to Walsh (2001:12), a positivist approach is where researchers maintain a distance between themselves as research experts and the goings-on in the research settings. In the current study, the researcher took a position of an interested outsider in that the information given by respondents was all treated with utmost respect. Besides, careful construction and pre-testing of the interview schedule ensured objectivity. According to Russell (2000:15), a positivist approach helps the researcher to maintain objectivity and avoids influencing or being influenced by the respondents.

### **3.3.2 The naturalistic paradigm**

During the qualitative phases, phases II and III, the researcher took the naturalistic approach. According to Walsh (2001:12), the naturalistic approach is based on the “idea that knowledge is something that people create continuously and that no fixed objective reality exists independently of peoples culture”. The researcher did not set out to get generalisable facts on VCT delivery but rather to gain complete knowledge of how the two hospitals deliver the VCT service to their target populations. Unstructured in-depth interviews were carried out at the hospitals in participants’ normal work environment (Russell 2000:130).

## **3.4 AIM AND OBJECTIVES OF THE STUDY**

The aim of the present study was to explore and describe the current models of VCT service delivery and analyse the extent to which a given VCT model influences utilisation of VCT service in the fishing community of Kasenyi along the shores of Lake Victoria, in Wakiso District and devise suitable VCT service delivery strategies to make it accessible and acceptable. In order to achieve the overall aim of the research, the objectives of the study were to

- establish the different VCT service models available in and around Kasenyi fish landing site

- determine the extent to which a given VCT service delivery model influences utilisation patterns in the target community
- identify other factors that influence VCT service utilisation among the fishing communities
- formulate strategies to improve VCT service delivery and utilisation among fishing communities

### **3.5 RESEARCH DESIGN**

The main purpose of a research design is to explain how one is to obtain answers to the research question. According to Schutt (2001:396), a research design refers to “deciding how to measure empirical phenomena, how to identify causal connections and how to generalise findings”. Salazar et al (2006:75) define a research design as “the strategy the investigator chooses for answering the research question. Its ultimate use is to guide data collection and analysis.” Mouton (2003:24) refers to research design as a plan or blueprint of how researchers intend to conduct their research in a given environment, while Kumar (1999:74) defines a research design as a procedural plan adopted by researchers to answer questions validly, objectively, accurately and economically. A research design thus refers to identifying and developing the procedures required to undertake a study, namely conceptual and operational plans, and emphasises the importance of quality in these procedures to ensure validity, reliability and trustworthiness (Kumar 1999:16).

Existing literature was reviewed for purposes of informing the study design as well as tools for data collection. According to Royse (2008:24), the general purpose of a literature review is to gather previously published and unpublished material in the research field, which will in turn inform the study design. Babbie (2008:124) points out that reviewing the designs of previous studies using the same technique may give researchers a head start in planning a study. The literature review also informed the researcher on sampling techniques, and data-collection methods including the design of the structured interview schedule for quantitative research (phase I).

The study was cross-sectional designed in three phases. Cross-sectional studies are commonly used in social science research, measuring a phenomenon at one point in time in a section of the population. Such studies are sometimes called one-shot

studies (Hakim 2000:178). Kumar (1999:81) defines cross-sectional studies as “studies that define a phenomenon by taking a section of it at one time”.

The current study followed a three-phased approach, sampling and collecting data from Kasenyi fish landing site residents in phase I, VCT managers in phase II and VCT counsellors in phase III. While phase I employed quantitative techniques, phases II and III employed qualitative techniques to sample, collect and analyse the data (see table 3.1).

**Table 3.1 Phases of data collection**

	<b>Phase I</b>	<b>Phase II</b>	<b>Phase III</b>
<b>Approach</b>	Quantitative	Qualitative	Qualitative
<b>Population</b>	Kasenyi fishing community	VCT managers at Entebbe and Kisubi Hospitals	VCT counsellors at Entebbe and Kisubi Hospitals
<b>Sampling method</b>	Stratified random sampling	Purposive (whole population)	Convenient sampling
<b>Sample</b>	127 members of the Kasenyi fishing community (61 women and 66 men)	VCT managers	VCT counsellors
<b>Instrument</b>	Structured interview	Interview guide	Interview guide
<b>Data analysis</b>	EPI data version 3 and SPSS version 12.0	Word processor	Word processor

### 3.5.1 Quantitative

Quantitative research gathers data using mainly numeric variables and enables researchers to quantify variation in a phenomenon during analysis. According to Cargan (2007:47), a study that is quantitative uses a system of counting using standardised measuring instruments. Burns and Grove (2001:20) point out that quantitative research uses structured tools to generate numerical data and uses statistics to interpret, organise and represent collected data. Phase I of this study was quantitative as it used a standard instrument to collect data (the structured interview).

Statistical calculations were done for both descriptive statistics and inferential statistics. Descriptive statistics generally describe the basic features of the data in a study. They provide simple summaries about the sample and the measures. In the current study, these included tables indicating frequencies and percentage, pie charts and graphs.



Inferential statistics normally help in trying to reach conclusions that extend beyond the immediate data alone. In the current study, these included chi-square calculations, giving probability values (p-value) (Polit & Beck 2004:451-510).

### **3.5.2 Qualitative**

In qualitative research, data is gathered and measured using nominal or ordinal scales, also referred to as qualitative measurement scales. Cargan (2007:47) points out that qualitative research obtains data by interviewing with open-ended questions. Phases II and III of this study were qualitative as they obtained textual data from VCT managers and counsellors using an interview guide.

## **3.6 TRIANGULATION**

Triangulation involves using different designs to study the same phenomenon. According to Salazar et al (2006:165), triangulation is a way to obtain a multidimensional view of phenomena of interest involving multiple data sources and methods. Babbie and Mouton (2001:275) refer to triangulation as “the use of multiple data-collection methods” while Babbie (2008:123) refers to it as “the use of several different research methods”. Researchers should always endeavour to engage different methods of data collection while studying a particular phenomenon (Guion 2002:2; Kumar 1999:10; Pope, Ziebland & Mays 2000:115; Schutt 2001:168 & 209; Wysocki 2001:82).

This study was triangulated because it collected both qualitative and quantitative data and used different methods of data collection. At the same time, different pieces of data were collected from different populations. For example, in phase I data was collected from the Kasenyi community, in phase II from VCT managers, and in phase III from VCT counsellors. Using two design approaches in a study enables researchers to check consistency and validity of the research outcome. In other words, triangulation makes the researcher confident of the validity of the findings (Salazar et al 2006:165). This study used triangulation as the methods had their various strengths and weaknesses, hence using both quantitative and qualitative approaches reduced weakness while maximising the strengths (Babbie 2008:123). Whereas qualitative data is more rich, it is time consuming, and less able to be generalised. On the other hand,

whereas quantitative data is more efficient in testing hypotheses, it may miss contextual detail.

### **3.7 ORGANISATION OF THE STUDY**

The study followed a phased approach and different populations were studied in each phase. Schutt (2001:110) defines a study population as “the entire set of individuals or other entities to which study findings are to be generalised”.

The study population in phase I was Kasenyi landing site residents; VCT managers in phase II, and VCT counsellors at both Kisubi and Entebbe Hospitals in phase III. Because of the different approaches and the uniqueness of the approaches and for the sake of clarity, phase I is presented and described differently from phases II and III which are described together.

### **3.8 PHASE I: KASENYI FISH LANDING SITE**

Phase I involved sampling, collecting and analysing data from the residents of Kasenyi fish landing site.

#### **3.8.1 Kasenyi fish landing site**

Kasenyi fish landing site is located 25 kilometres from Kampala City, in Katabi Sub-county, Wakiso District in Uganda. The fish landing site has a population of approximately 1 500 people and the main economic activity is fishing and fish processing and trading, although other support services exist (MAAF 2005:34). Kasenyi is generally considered a large landing site, having over 50 boats. General facilities at Kasenyi fish landing site include 150 retail shops, 50 bars, 3 drug shops/clinics, 1 police post, and beach recreational facilities (Fisheries Resources Research Institute [FRRI] 2002:32).

Kasenyi landing site was selected for this study based on easy access, a relatively large population size, average developed infrastructure and available general health and VCT service for the fishing community. The landing site is served by two major hospitals, namely Kisubi Missionary Hospital (about 4 kilometres from Kasenyi) and

Entebbe Government Hospital (about 7 kilometres away). Apart from integrated VCT service provided at both hospitals, Kisubi Missionary Hospital provides the Kasenyi fish landing site community with outreach (mobile) and home-based VCT service (Kirenga 2006:3).

### **3.8.2 Sampling**

It is logistically difficult to interview every individual in a study population. For this reason, a representative sample was selected. Cargan (2007:235) defines sampling as “a means used to draw a representative number of elements from a larger population”. Kumar (1999:19) emphasises that in sampling, it is essential to avoid bias in the selection of a sample and necessary to achieve maximum precision for a given outlay of resources. A small but representative number of units are scientifically selected to provide a fairly true reflection of the sampled population being studied.

The general rule is to use the largest sample size possible. Cargan (2007:237) maintains that the larger the sample, the more representative it is of the population and the more likely results will be accepted. Nevertheless, it is advisable to make an extra effort to obtain a representative rather than a very large sample size. Therefore, the eventual sample size is usually a compromise between what is desirable and what is feasible. The main aspects considered in determining sample size from a population include the objectives of the study, the need for more variation in the sample, and the ease of handling data collected.

In order to collect data on individual attributes, researcher used the stratified random sampling, in which two strata were selected based on gender, thus the men’s strata and the women’s strata (Welman & Kruger 2001:55). From each stratum, an almost equal number were selected randomly. Probability sampling ensures an unbiased sample, where each individual in the population has an equal chance of being selected (Babbie 2008:238; Russell 2000:144-147). Stratification helped ensure that a representative sample was selected from each stratum. The decision to stratify by gender was based on the literature reviewed, which indicated that VCT service utilisation is likely to be influenced by sex (Bukuluki et al 2003:16; Yoder & Matinga 2004:29).

Chadwick, Bahr and Albrecht (1984:68) point out that sample size in social research should not be less than 100 units and perhaps not more than 200 units, depending on the variability in the population. A sampling frame (residents' register) was obtained from the BMU and the LC1, at Kasenyi fish landing site. Schutt (2001:110) defines a sampling frame as "a list of all units containing the elements of the population". When a list of all Kasenyi fish landing site residents was obtained, the researcher grouped men and women separately and then assigned numbers to each group. Individuals who were below 18 years of age (based on the village register) at the time of interviews, were excluded from the sampling frame. The fish bowl technique was used, where the researcher assigned numbers to each person, folded and placed the papers in a bowl and thereafter drew papers from the bowl until the desired sample in each group was obtained. Initially, an equal sample of 60 men and 60 women were drawn. However, 7 respondents whom the researcher had initially failed to trace and had replaced, finally showed up and asked to be included, bringing the total to 127 (61 women and 66 men). In their studies on VCT, Campbell (2005:143), Nsabagasani and Yoder (2006:14) and Orr and Langefeld (1994:875) used similar sample sizes to obtain findings.

### **3.8.3 Locating and approaching respondents**

Making contact with potential interviewees is a crucial aspect of research. According to Boynton (2005:73), a letter or a phone call that is well thought about and presented in an interesting way is likely to gain a person's approval. In this study, the researcher obtained an introduction letter as well as a researcher identity card from the Uganda National Council for Science and Technology, the body that approves research in Uganda. The researcher therefore presented the two items to the local administration office at Kasenyi to gain entry into the community and get the local mobilisers to assist in locating the sampled respondents. The Local Council 1 (LC1) office together with friends made during the research helped in locating the selected participants for interviews. Only two attempts were made to locate an interviewee, who was then replaced by randomly drawing a replacement.

### **3.8.4 Data collection**

The researcher collected data from the residents at Kasenyi fish landing site through directly interviewing the respondents using a structured interview schedule. In a

structured interview the interviewer asks the same questions in the same order with no variation in the questions asked (Cargan 2007:105). Interviews are one of the most common procedures in research. One of the advantages of interviews is giving the researcher an opportunity to observe the subject's non-verbal language. Because of the ease of use and wide applicability in demographics, attitude, social relationship and social environment, interviews dominate social sciences measurements of the verbal type (Salazar et al 2006:80).

Structured interviews with individuals are designed to obtain information on why, what, where, when and how, mainly through closed questions that have logical (yes/no, true/false, agree/disagree), numeric, and/or other answers that can be easily coded for tabulation (Boynton 2005:29; WHO 1996:26). According to Babbie (2008:291), interviews can be done by telephone, face to face or by means of postal questionnaires.

The researcher used face-to-face structured interviews due to their feasibility in the fishing communities. According to the MAAF (2005:13), many fishing villages including Kasenyi landing site have had no access to education and illiteracy levels are high. Therefore a self-administered questionnaire would not have been feasible. Moreover, fishing communities have no fixed address (Seeley & Allison 2005a:690). Babbie (2008:291) emphasises that face-to-face interviews reduce misunderstandings, as there is a chance to explain the question, and decrease the possibility of many "don't knows". The disadvantage however is that physically locating respondents can be challenging and interviews may interfere with their work, whereas they can complete the self-administered questionnaire during their free time.

### **3.8.5 Interview schedule**

According to Oppenheim (1992:100), a questionnaire refers to a self-administered and postal questionnaire while an interview schedule is administered face to face. In this study, the researcher used structured interview schedules to ask a set of structured questions while recording the answers. Use of structured interview schedules assumes that the interviewer has control over a set list of questions that have been formulated and which are to be answered as they are rather than being rephrased or reordered, discussed or analysed (Cargan 2007:105). In order to do this, Burgess (1984:103)

emphasises that researchers must make sure that the interview schedule is validly designed. The design of the structured interview schedule followed the theoretical framework for healthcare services utilisation and access, the ecological framework, and the HBM (Aday & Anderson 1974:212; Franklin 1988:340; McLeroy et al 1988:354; Ostrom 1998:6).

The data-collection instrument was a 69-item structured interview schedule (see annexure B). It consisted of six sections, namely social demographics; knowledge and use of VCT services; HIV testing; campaigns; VCT awareness, and suggestions for improving VCT services. The interview schedule was based on the literature review (see chapter 2) and closely related to VCT service delivery and utilisation (MoH & ORC Macro 2006:174-193; UNAIDS & WHO 2000:47).

### **3.8.6 Pre-testing of data-collection tool**

Wording of questions is crucial in determining the nature of data collected. Salazar et al (2007:98) maintain that it is usually necessary to conduct a pre-test before the final instrument is prepared. Babbie (2008:283) points out that the surest protection against errors is to pre-test the questionnaire in full or part. According to Polit and Beck (2006:296), a pre-test is a small-scale trial of the data-collection instrument to determine clarity of questions and whether the instrument elicits the desired information.

In this study, the data-collection instruments were pre-tested in order to determine whether all respondents would understand the questions and instructions in the same way, and how relevant the questions were. Ten individuals were randomly selected from Ggaba fish landing site in Kampala, Uganda, a fish landing site closest to Kasenyi fish landing site, the study area. Based on the responses obtained, the interview schedule was revised before embarking on full data collection. Pre-testing the instruments therefore was another way of increasing their validity and reliability.

### **3.8.7 Data analysis**

Black (2002:21) points out that numbers and statistics by themselves are of little interest and are difficult to make any sense of. Thus data analysis is a critical step in

research. Russell (2000:419) defines data analysis as “the search for patterns in the data and for ideas that help explain why those patterns are there in the first place”.

Once data was collected during phase I, it was coded, collated, entered into a computer using Epi data version 3.0, and finally transformed before analysis, using the Statistical Package for Social Sciences (SPSS) version 12.0. Coding involved deciding in advance in which columns in the data set each variable was to appear; collation involved arranging all the collected information uniformly; data entry involved entering data into the computer using a computer keyboard terminal, and finally data transformation involved correlating different variables in the data set (Martinez-Pont 1997:20).

Both descriptive and inferential statistics were calculated. The data was displayed using graphs, tables and pie charts, often indicating proportions (percentage). Chi-square values were also calculated to obtain probability values (p-value) in order to assess the relationship between key variables (Behr 1983:40; Polit & Beck 2004:451-510, Russell 2000:526; Schutt 2001:347; Wysocki 2001:281).

### **3.8.8 Validity of the study**

Validity has to do with truth, strength and value. Validity therefore relates more to the strength of the conclusions, inferences or propositions. Russell (2000:46-47) defines validity as the “accuracy and trustworthiness of instruments, data, and findings in research”. According to Guion (2002:2), ensuring validity helps make researchers’ evaluation more credible and thus provides information they can defend with confidence. In this study, several forms of validity are discussed below and how the researcher dealt with each to minimise the threats. Furthermore, the study promoters and two specialists in the area of HIV/AIDS reviewed the interview schedule and made suggestions, which the researcher included.

#### **3.8.8.1 Face validity**

Face validity refers to subjective judgment on whether the research instrument appears to measure what it is supposed to measure (Burns & Grove 2001:400; Cargan 2007:232). In this study, face validity was maintained by constructing questions relevant to the study aim and objectives.

### **3.8.8.2 Content validity**

Content validity relates to knowing whether the entire interview items reflect the entire range of meanings (Cargan 2007:232). This ensures that all items to be included in the instrument are included without missing any. The researcher developed the interview schedule after the literature review as mentioned above.

### **3.8.8.3 Construct validity**

Construct validity measures whether concepts relate to each other as expected (Cargan 2007:232). Construct validity emphasises that concepts are measured adequately and logically and relationships between variables are identified with the instrument. Burns and Grove (2001:232) add that construct validity includes the definition of variables in line with existing literature and differentiates between respondents who possess the trait and those without the trait. In this study, the interview schedule was based on the literature reviewed and the theoretical framework.

Threats to construct validity may include inadequate pre-operational explication of constructs where a researcher does not define concepts very well before measuring them. The researcher operationally defined all concepts (see chapter 1, section 1.7). The other threat to construct validity relates to social threat such as hypothesis guessing, where participants base their behavioral responses on what they think ones study is about. At the same time, participants may be fearful of ones study to the point that it influences their response. The researcher avoided these threats by standardising the interview schedule, and assuring the participants of confidentiality and anonymity.

### **3.8.8.4 Internal validity**

Internal Validity asks if there is a relationship between the program and the outcome seen. In other words, it looks at causal relationships (Polit & Beck 2004:214).

#### **➤ Threats to internal validity**

Polit and Beck (2004:213-219) recognise several threats to internal validity. History threat occurs when an historical event affects one's study group such that it leads to the



outcome. The current study was undertaken at a time when there was no historical event at Kasenyi fish landing site, and so this did not affect internal validity. Similarly, maturation threat, which usually occurs within the participants during the course of time as a result of passage of time, did not occur as this was a cross-sectional study done over a fairly short period of time.

Another threat to internal validity is the testing threat, which occurs when the act of taking a pre-test affects how that group does on the post-test. The researcher guarded against this type of threat by avoiding pre-testing of the interview schedule in the same populations under study. Instead, the researcher pre-tested the interview schedule in a different fish landing site close to Kasenyi fish landing site.

A mortality threat to internal validity occurs when subjects drop out of the study, and this leads to an inflated measure of the effect. The current study was cross sectional in nature and therefore it did not suffer this type of threat. Although some participants could leave the interview when called for duty, all of them returned a few minutes later to complete the interviews.

#### **3.8.8.5 External validity**

According to Polit and Beck (2004:217) external validity refers to the “generalisability of the research findings to other setting or samples”. In other words, how well the results tell us about other related settings. Findings can only be generalised to other populations if the sampling was random. The current study employed random sampling techniques to select the final sample, achieving external validity.

##### **➤ Threats to external validity**

A threat to external validity is an explanation of how one might be wrong in making a generalisation. There are mainly three major threats to external validity because there are three ways a researcher could be wrong – people, places or times. According to Burns and Grove (2001:232), threats may relate for example to settings where interviews are conducted from and key events in the study area. Threats may also relate to a possibility that there are unusual types of people who were included in the study.

The researcher employed several measures to overcome threats to external validity. First was the sampling techniques used. Cluster sampling, and random selection of the sample within each cluster, ensured equal chances of being included into the sample. Secondly, interviews were not all conducted in one day but rather spread out to different days and times. More so, the researcher, through the literature review, described the ways the context of the current study may differ from the others. Information about the degree of similarity between various groups of people, places even times with regard to VCT delivery and utilisation were explained.

### **3.8.9 Reliability of the study**

Reliability is the consistency of one's measurement, or the degree to which an instrument measures something the same way each time it is used under the same condition with the same subjects (Polit & Beck 2004:416). In other words, it is the repeatability of ones measurement. Although the researcher did not employ stability tests and internal consistence estimations, the interview schedule was subjected to several pre testing and revisions that ensured a reliable tool was used to collect the data. Experts were asked to review and advise on the interview schedule. Besides, the strategies used to improve face validity and content validity described above also helped reduce threats to reliability.

### **3.8.10 Purpose of a literature review in quantitative research**

In this study, the researcher conducted a literature review on themes related to the objectives of the study, namely VCT service delivery models, including the settings, resources and general environment in which VCT is provided; and the utilisation level, including the characteristics of the target population, and barriers to and promoters of VCT in a given population – the fishing communities (see chapter 2, section 2.1).

Royse (2008:24) points out that the general purpose of a literature review is to gather previously published and unpublished material in the research field, which will in turn inform the study design. Reviewing the designs of previous studies using the same technique can give researchers a head start in planning their study (Babbie 2008:124). The literature review enabled the researcher to identify existing gaps, which helped to formulate the general objectives of the study. The literature review also familiarised the

researcher with the study population, sampling techniques, data collection, interview schedule design, and data analysis.

### **3.9 PHASE II AND PHASE III (VCT MANAGERS AND COUNSELLORS)**

Data for phases II and III was collected from staff at Entebbe and Kisubi Hospitals, in Wakiso district, that provide VCT service in and around Kasenyi fish landing site.

#### **3.9.1 Kisubi Missionary Hospital**

Kisubi Missionary Hospital is a private non-profit hospital founded in 1905 and owned by Kampala Archdiocese. It is a 90-bed hospital offering both curative and preventive services. The hospital is the last referral facility and headquarters for Busiro South Health Sub-district in Wakiso District. The hospital has a vibrant facility and community-oriented HIV/AIDS programmes in addition to in- and out-patient services. Over the years, Kisubi Hospital has attracted funding to implement mobile VCT service in and around Wakiso District (Kirenga 2006:2).

#### **3.9.2 Entebbe Government Hospital**

Entebbe Government Hospital is a 140-bed government hospital built in 1904, located 40 kilometres from the Kampala–Entebbe Road and is the only government hospital in Wakiso District, currently providing both in- and out-patient services. The hospital serves people from other districts such as Kampala and the Island district of Kalangala (located in Lake Victoria). The hospital serves a population of over 2 million people. VCT services were initiated at the hospital in August 2003 to help people seeking the services because there was no VCT centre in Entebbe at the time. However, the hospital is now overwhelmed by the number of clients who come for VCT service (MoH 2004:33).

#### **3.9.3 Study populations**

In phase II, VCT managers formed the study population. These managers are the persons responsible for planning and overseeing VCT service delivery in a health facility, and may include hospital superintendents, VCT programme coordinators,

and/or directors at NGO settings that provide VCT service. They usually provide liaison between the health facility and the central government, thus enforcing government policies and guidelines for VCT service as well as quality control are among their main roles. They also make important decisions in hiring and supervising VCT counsellors.

In phase III, VCT counsellors formed the study population. They are health cadres who provide HIV pre- and post-test counselling, who are trained and qualified to offer the service (MoH 2003a:2). Sometimes VCT counsellors provide other health services alongside counselling, depending on their training and the site they work in. Therefore, both VCT managers and counsellors directly or indirectly influence VCT service accessibility, acceptability and utilisation of the services

### **3.9.4 Sampling procedures**

According to Schutt (2001:117-119), sampling strategies in qualitative research are purposive and are referred to as non-probability sampling. Non-probability sampling denotes any technique of sampling where samples are selected in some way not suggested by probability theory (Babbie 2008:203).

#### **3.9.4.1 Selection of participants**

In non-probability sampling, participants' selection is based on specific predetermined criteria in order to cover a range of constituencies. Selection of participants is therefore purposive. Salazar et al (2006:303) point out that purposive sampling targets and prescribes specific criteria for recruiting the sample. Recruitment of participants is therefore based on the characteristics they exhibit in relation to the research problem. Pope et al (2000:115) point out that where smaller numbers are involved, usually qualitative inquiry aimed at providing in-depth description of the phenomena is preferred.

#### **3.9.4.2 VCT managers**

In phase II, given that there is only one VCT manager per hospital (Entebbe and Kisubi hospitals) and only two hospitals were studied, VCT managers were studied as a whole population and no sampling was done.

### **3.9.4.3 VCT counsellors**

Through the literature review, the researcher identified VCT counsellors as the critical element in the study because they give practical counsel, sometimes test, and give clients the results. They are in direct touch with VCT clients. Counsellors' training, knowledge, skills and perceptions directly determine the quality and sometimes the quantity, of VCT service provided, and, in turn affects the level of satisfaction derived by the service users and ultimately VCT utilisation patterns. For this reason, the VCT counsellors were selected and included in the sample.

To be selected, counsellors had to be based at either Entebbe or Kisubi Hospital; to have worked as a counsellor for at least two years, and be willing to be interviewed. A total of 10 counsellors were approached for interviews but three said they did not have time for interviews. Finally, a total of 7 counsellors were interviewed at both hospitals (3 at Kisubi and 4 at Entebbe Hospital).

### **3.9.5 Data-collection instrument**

The researcher set the agenda with the help of the interview guides (see annexures C and D). According to Babbie (2008:335), an interview guide is “a general plan of inquiry including the topics to be covered”. Interviews of this nature rely on the interviewer following up with probes to get in-depth information on topics of interest (The Access Project [TAP] 1999:10).

The main advantage of using an interview guide was that the researcher was able to solicit in-depth and rich information about VCT service delivery and utilisation. At the same time, both verbal and non-verbal communication was observed, recorded and used in the analysis. The challenge, however, was that the researcher had to deal with volumes of textual data during the analysis.

### **3.9.6 Data collection**

One-on-one in-depth interviews, using an interview guide, were used to collect data from the participants. According to Babbie (2008:336), a qualitative interview is “essentially a conversation in which an interviewer establishes the general direction. In-

depth interviews provide an opportunity of obtaining more details about an issue and are especially useful for exploring experiences of care. They have an additional benefit of uncovering issues or concerns that had not been anticipated or considered by the researcher.” According to Pope, Van Rooyen and Baker (2002:148), in-depth interviews are “typically based on a flexible topic guide of open-ended questions to explore experiences and attitudes”. Babbie (2008:272) defines open-ended questions as ones in which participants are asked to provide their own answers to the questions.

The researcher conducted the interviews with the VCT managers in their offices. Although there were interruptions with managers receiving telephone calls during the interview, they did not affect the course of the interview.

The researcher conducted the interviews with the counsellors in places with minimal disruption. At each of the hospitals the hospital administration made arrangements for a venue that was free of interruptions. At one hospital, the interviews were conducted in a counselling room that had been earmarked and designated for interviews on that day while at another hospital interviews were done in an office that was not occupied at the time.

#### **3.9.6.1 *Recording interviews***

Babbie (2008:340) emphasises that the greatest advantage of field research is the presence of an observing; thinking, and recording researcher and not even tape recorders can capture all that. The researcher asked the questions and recorded all the answers in writing. A research assistant, who also took notes during the interviews, assisted the researcher. The researcher had earlier trained the research assistant on the aim and objectives of the study, research design and methodology, and his role as a note taker. In taking notes, verbal and non-verbal expressions were recorded (see annexures H, I and J).

The researcher did not use a tape recorder. While tape-recording interviews may have the advantage of getting more accurate data than relying on notes and memory, it can also present challenges in some situations. According to Weaver (2003:164), although tape recording may appear the best approach to recording an interview, many interviewees are uncomfortable with recording and are more likely to withhold

controversial views in favour of saying what they think they should say. The participants might worry about being put on permanent record and about who else might hear the tape.

Before ending the interview, the interviewer made sure that all the items on the interview guide had been covered in the course of the conversation, and any remaining topics were addressed before leaving the field (Boynton 2005:30; Pope et al 2002:2). In addition, as a way of verifying the responses, the researcher summarised the main aspects before leaving the participant. The researcher transcribed all the data as soon as possible after the interviews. The data obtained was transcribed and captured on computer, using Microsoft Word 2003 (Babbie 1989:278).

### **3.9.7 Data analysis**

Data collected during phase II and phase III from health facilities (from the VCT managers and VCT counsellors, respectively) was analysed qualitatively. Qualitative data analysis in this study was explicit and strongly informed by the aim and objectives of the study.

Data analysis in these qualitative phases started as soon as the researcher had the first transcripts. Data analysis in qualitative research begins when data collection begins. In addition, analysis continued as the researcher committed to fully understanding what the data said (Lofland, Snow, Anderson & Lofland 2006:151). Babbie (2008:415) defines qualitative data analysis as “the non-numerical examination and interpretation of observations for purposes of discovering underlying meanings and patterns”.

The analysis involved inductive and deductive reasoning (Pope et al 2000:115). Data analysis was determined by both the research objectives (deductive method) and multiple readings and interpretations of the raw data (inductive method). Thus the findings were derived from both the research objectives and the findings arising directly from the analysis of the raw data. Since there were only a few interviewees, the transcripts were not voluminous and computer software was used to facilitate data searching, sorting and copying into separate files (Babbie 2008:414).

### **3.9.7.1 Data coding**

Babbie (2008:422) defines coding as “classifying or categorizing different pieces of data in order to be able to easily retrieve pieces of information one may be interested in later”. Coding followed Strauss and Corbin’s (1998:54) three steps, namely open, axial and selective coding. Babbie (2008:422) defines open coding as “the initial classification and labelling of concepts”; axial coding as “a re-analysis of the results in open coding aimed at identifying the important general concepts”, and selective coding as “building on the results of open and axial coding to identify the central concepts. Polit and Beck (2004:584) describe open coding as “where data are broken down into different parts while comparing differences and similarities” axial coding as “where the researcher develops categories and links them together” and lastly selective coding as “where the findings are integrated and refined”.

In open coding, the researcher coded data in margins of the transcripts on the same page. The researcher highlighted texts with different colours to represent different themes. Subsequently, ideas were jotted down, thereby generating themes and sub-themes as they emerged. Similar topics were then classified and grouped accordingly before preliminary analysis was carried out. In axial coding, the researcher started fitting themes, sub-themes and units together to provide a general explanation of the context of VCT service delivery. According to Strauss and Corbin (1998:21), each piece has its exact location in the overall explanation theory and must fit with the others to make an integrated whole. Lastly, in selective coding, the researcher reviewed issues related to VCT services delivery and utilisation that appeared more frequently. Subsequently, data was categorised and organised into themes and sub-themes.

### **3.9.7.2 Themes emerging from the data**

In phase II, two themes emerged from the data collected from VCT managers, namely VCT service delivery models and factors influencing VCT services delivery and utilisation. Sub-themes as well as meaning units were identified (see chapter 5, section 5.2.3). In phase III, five themes emerged from the data collected from VCT counsellors, namely aptness of VCT counsellors; models of offering VCT services; institutional environment for counselling; factors likely to affect client satisfaction, and the ideal VCT service. Here too, sub-themes emerged (see chapter 6, section 6.2.8).



### **3.9.8 Trustworthiness**

In qualitative research, validity and reliability relate to whether the findings of the study are true and certain, commonly known as trustworthiness (Guion 2002:1). Findings are true if they accurately reflect the real situation, and are certain if they are backed by evidence. In other words, there are no good grounds for doubting the results of a study. According to Rolfe (2006:305), trustworthiness can be divided into credibility, which corresponds with the concept of internal validity; dependability, which relates to reliability; and confirmability, which is largely an issue of presentation. Trustworthiness therefore enables the readers not to doubt the findings, conclusion, or recommendations based on the data (TAP 1999:9).

#### **3.9.8.1 Dependability**

Dependability includes activities that increase the probability that credible findings will be produced. Polit and Beck (2004:434) refer to dependability as “evidence that is consistent and stable; that is to say, stability of data over time and conditions”. In this study, the researcher carefully logged all sessions dealing with interpretation of data and kept track of how coding evolved. All notes were saved for future reference. Moreover, the researcher ensured that all interviews were transcribed as soon as possible, within the same day.

#### **3.9.8.2 Confirmability**

Confirmability refers to the objectivity or neutrality of the data to allow for agreement between two or more independent people about the relevance or meaning of the data. Polit and Beck (2004:435) define confirmability as “the degree to which study results are derived from characteristics of participants and the study context, not from bias of the researcher, and may involve a deliberate systematic collection of materials and documentation right from data collection, through analysis and report writing”.

In this study, both the researcher and the research assistant generated field notes and interview transcripts, which were used during analysis. Moreover, at the end of the interview, the researcher went over the main points with the interviewer, as a way to re-confirm certain pieces of information. The researcher generated notes on verbal and

non-verbal communication and documented the entire process of interviewing, such as when and where interviews were done. Data analysis and report writing was an all-involving process in which the researcher immersed himself in the data and documented all the processes (Polit & Beck 2004:435).

### **3.9.8.3 Credibility**

Polit and Beck (2004:434) define credibility as “the criteria for evaluating data quality in qualitative research, referring to confidence of truth of the data or the faith that can be put in the researcher and this may relate to the researcher’s qualification and experience”. In this study, the researcher holds a Master’s degree in Public Health, which training included qualitative research methods, and has had over ten years’ working experience in the HIV/AIDS field. The researcher trained the research assistant in qualitative research techniques. In addition, during the interviews, the researcher endeavoured to avoid leading questions. The researcher conducted interviews in a relaxed environment and ensured that he transcribed the interview notes as soon as possible, within the same day.

### **3.9.8.4 Triangulation**

Triangulation involves using different designs to study the same phenomenon. According to Salazar et al (2006:165), triangulation is a way to obtain a multidimensional view of phenomenon of interest involving multiplicity in data sources and methods. Babbie and Mouton (2001:275) refer to triangulation as the use of multiple data collection methods while Babbie (2008:123) refers to it as the use of several different research methods. According to Polit and Beck (2004:430), triangulation can also enhance credibility, as its aim is to overcome the intrinsic bias that comes from single method, single observer and single theory studies.

Different types of triangulation may be considered such as method, data, and analysis triangulation. In method triangulation, the researcher used both quantitative and qualitative methods to study VCT service delivery and utilisation (see section 3.4). In data triangulation, which is the use of multiple sources of data for purposes of validating conclusions, the researcher used both interviews and observation and also recorded verbal and non-verbal communication. In other triangulations, the researcher

interviewed participants at different times of the day and dates (time triangulation), collected data from two different study sites (space triangulation) and collected data from different levels of individuals (person triangulation) that is the VCT managers (phase II) and the VCT counsellors (phase III) (Polit & Beck 2004:431).

In analytic triangulation, the researcher used three main data analysis techniques to analyse the same data set. The researcher used thematic analysis, an inductive process where the themes emerged from the data and were not imposed by the researcher. The researcher collected and analysed data concurrently, which helped link what is known and what was needed to know. In comparative analysis, the researcher continuously compared and contrasted data from different participants until the researcher was satisfied that no new issues arose. Finally, the researcher used content analysis, where data was coded by content before it was analysed (Morse, Barrett, Mayan, Olson, & Spiers 2002:8; Polit & Beck 2004:431).

### **3.10 ETHICAL CONSIDERATIONS IN ALL THREE PHASES**

Ethics deals with matters of right and wrong. *Collins English Dictionary* (1991:533) defines ethics as “a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual”. Polit and Beck (2008:167) emphasise that when people are used as participants, “care must be exercised in ensuring that the rights of the participants are protected”. To ensure that the study met the prescribed ethical standards, the researcher upheld the following: approval and permission to conduct the study; participants’ voluntary informed participation; well being; anonymity; justice, and confidentiality (Schutt 2001:300; UNCST 2007:4; Wysocki 2001:57).

#### **3.10.1 Research approval**

When the research proposal was fully developed, the researcher applied to the Department of Health Studies, University of South Africa (UNISA), to conduct the study and received a letter of approval (see annexure F). Once approval was obtained from UNISA, the proposal was submitted to the Uganda National Council for Science and Technology (UNCST) for country level approval, and the researcher received a letter of approval (see annexure E) and a research identity card (UNCST 2007:3).

### **3.10.2 Voluntary informed consent**

According to Boynton (2005:91), voluntary informed consent refers to participants' being fully aware of the research they are about to be involved in. This ensures that they participate voluntarily after giving informed consent. In accordance with the UNCST guidelines (UNCST 2007:4), in ensuring voluntary participation, the participants were informed of the purpose of the study, how and why they were selected to participate, and their right not to participate at all. They were also informed that they are under no obligation to answer all questions as well as their right to withdraw from the study if they so wished. An informed consent document was developed for this purpose (see annexure A) and used for all three phases.

### **3.10.3 Participants' well being**

The UNCST (2007:4) defines the principle of subjects' well being as "doing no harm and avoiding deliberate infliction of harm or evil on participants". To ensure the respondents' and participant's well being and avoid physical or psychological harm, the researcher avoided questions that were likely to cause psychological discomfort. For example, the researcher avoided asking their HIV status.

### **3.10.4 Anonymity**

Research subjects need to be reassured that they will not to be identified through the research; in other words, they should remain anonymous (Boynton 2005:101). The respondent's and participant's names and identity were not disclosed, but descriptive titles were used such as VCT managers and VCT counsellors in phases II and III (Wysocki 2001:58). The research assistant was well trained on measures for keeping anonymity such as the use of pseudo names while taking notes.

### **3.10.5 Confidentiality**

Boynton (2005:101) points out that participants need to be reassured that what they reveal during the interview will be treated as private information. The researcher ensured that all information collected from the respondents and participants was kept confidential. Accordingly, the researcher tried to expunge possible identifying materials

when presenting the research findings. Both the researcher and the research assistant had to acquaint themselves with national guidelines for research involving humans as research participants, published by the UNCST (2007:1-223).

### **3.10.6 Justice**

Justice refers to the ethical obligation to treat each person in accordance with what is morally right and proper and to give each person what is due to him or her (UNCST 2007:4). The researcher informed the respondents and participants that refusal to participate in the study would not mean denial of other benefits they would otherwise be entitled to receive.

## **3.11 FIELD EXPERIENCES AND CHALLENGES**

Some of the experiences from the field were unexpected, although they did not warrant changing the research design. Sampling frames were obtained from multiple sources, not only one source as earlier anticipated. Some of the pre-selected respondents were difficult to trace therefore the researcher replaced them. However, some re-appeared towards the end of the interviews and asked to be included in the study. Therefore, finally six men and one woman were included in the interviews.

Privacy during interviews also proved to be challenging. At Kasenyi fish landing site, occasionally during an interview, other respondents would want to listen. The interviewer then had to explain that the interviews were private and confidential. Other Kasenyi residents, who were not included in the sample, wondered why they had not been selected and asked if they too could be interviewed as well.

## **3.12 CONCLUSION**

This chapter described the research design and methodology of the study in detail. The study used a phased approach in collecting, processing and analysing both quantitative data (phase I) and qualitative data (phases II and III) in three different phases.

Phase I involved respondents from Kasenyi fish landing site; phase II involved VCT managers at two research sites, and phase III involved VCT counsellors at the two sites.

The next chapter (chapter 4) discusses the phase I data analysis and interpretation (Kasenyi fish landing site).

## CHAPTER 4

### Phase I data analysis and interpretation and findings

#### 4.1 INTRODUCTION

This chapter presents the data analysis and interpretation and findings of phase 1: the respondents at Kasenyi fish landing site. Data was collected from 127 respondents (61 women and 66 men). The data-collection instrument was a 69-item structured interview schedule, consisting of six sections: social demographics; knowledge and use of VCT services; HIV testing; campaigns; VCT awareness, and suggestions for improving VCT services (see annexure B).

The researcher asked the questions and recorded the answers, which were later entered into the EpiData 3.1 program and univariate and bivariate analysis was done using the SPSS version 12.0 program. The interview schedule included a few open-ended questions. These were coded and assigned numerical codes before analysis. Descriptive statistics (frequencies and percentages) and inferential statistics (chi-square) were calculated. Data was presented using mainly tables, pie charts and graphs. Reference was made to the literature reviewed, where applicable. To avoid repetition, the total number of respondents who answered an item, is only mentioned when fewer respondents than the total sample (127 respondents) answered.

This phase achieved the objectives to

- establish the different VCT service delivery models available in and around Kasenyi fish landing site
- determine the extent to which a given VCT service delivery model influences utilisation patterns in the target community
- identify other factors that influence VCT service utilisation among the fishing communities

The objectives were achieved by describing the respondents' characteristics, knowledge and perceptions of VCT as well as barriers to VCT utilisation; the models of VCT services available to the Kasenyi fish landing site community, and other factors that influence VCT utilisation.

**4.2 SECTION 1: SOCIAL DEMOGRAPHIC DATA**

The social demographic data covered the respondents' gender, age, commonly spoken language, school attendance, level of education, reading level, marital status, and length of stay at Kasenyi, occupation and religious affiliation.

**4.2.1 Item 1: Respondents' gender**

Of the 127 respondents, 66 (52%) were men and 61 (48%) were women (see table 4.1). The researcher initially intended to have an equal number of men and women (60 of each gender) but six men and one woman, who had earlier been replaced for failure to be located, arrived at the end of the interviews and asked to be interviewed.

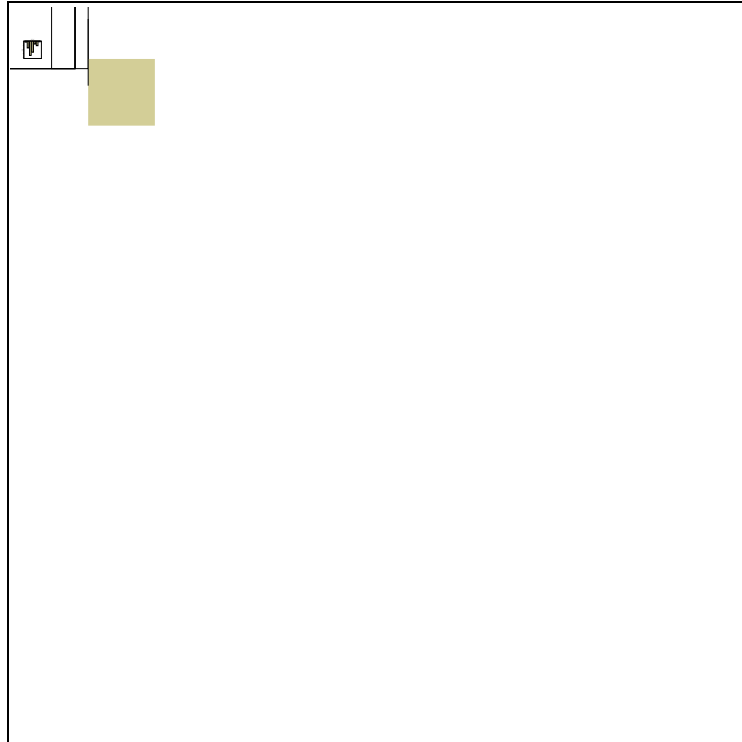
**Table 4.1 Respondents' gender (N=127)**

<b>Gender</b>	<b>Frequency</b>	<b>Percent</b>
Men	66	52.0
Women	61	48.0
<b>Total</b>	<b>127</b>	<b>100.0</b>

**4.2.2 Item 2: Respondents' age**

The respondents' ages ranged from 16 to 44 years, with a mean age of 29.8 years, median age of 29 years and a mode of 27 years. This indicated a fairly normal curve of age distribution, because the mean, median and mode were almost the same (Russell 2000:521). Of the respondents, 44 (34%) were aged 25-29; 34 (28.5%) were 30-34; 3 (2.4%) were 15-19, and 2 (1.6%) were 45-49 (see figure 4.1).





**Figure 4.1 Respondents' age (N=127)**

#### **4.2.3 Item 3: Commonly used language**

The most common language used at Kasenyi fish landing site was Luganda, and 106 (83.5%) of the respondents indicated they spoke this language; 8 (6.3%) spoke English (the official language in Uganda); 8 (6.3%) spoke Runyakitara, and 5 (3.9%) spoke Lusoga (see table 4.2).

**Table 4.2 Commonly used languages at Kasenyi (N=127)**

<b>Commonly used language</b>	<b>Frequency</b>	<b>Percent</b>
English	8	6.3
Luganda	106	83.5
Runyakitara	8	6.3
Lusoga	5	3.9
<b>Total</b>	<b>127</b>	<b>100.0</b>

#### 4.2.4 Items 4 and 5: School attendance and level of education

Of the respondents, 120 (94.5%) were not attending school at the time of interview and 7 (5.5%) were attending school at the time. Most of the respondents, 65 (51.2%) had obtained secondary level education; 49 (38.6%) had obtained primary level; 12 (9.4%) had obtained tertiary level education, and only 1 (0.8%) had had no education at all (see table 4.3). In Uganda, primary education, the first level of education, comprises seven years of schooling; secondary education comprises six years, and tertiary education ranges from two to five years' education (Ministry of Education and Sports [MOE&S] 2007:5). Generally, the respondents' education levels were average.

**Table 4.3 Respondents' school level (N=127)**

<b>School level attained</b>	<b>Frequency</b>	<b>Percent</b>
No schooling	1	0.8
Primary	49	38.6
Secondary	65	51.2
Tertiary	12	9.4
<b>Total</b>	<b>127</b>	<b>100.0</b>

#### 4.2.5 Item 6: Respondents' reading level

Of the respondents, 84 (66.2%) could read fluently and easily; 39 (30.7%) could read with difficulty, and 4 (3.1%) could not read at all. Having many community members able to read easily could be an opportunity for passing on VCT messages. Hutchinson, Mahlalela and Yukich (2007:499) found that women with higher education easily understood and disclosed their HIV test results. According to Grellier et al (2004:23), education provides a favourable environment in which to introduce health programmes and has the potential to impact positively on prevention, treatment and mitigation of HIV/AIDS for both the poor and rural people.

**Table 4.4 Respondents' reading status (N=127)**

<b>Respondents reading status</b>	<b>Frequency</b>	<b>Percent</b>
Can't read	4	3.1
Read easily	84	66.2
Read with difficulty	39	30.7
<b>Total</b>	<b>127</b>	<b>100.0</b>

#### **4.2.6 Item 7: Respondents' marital status**

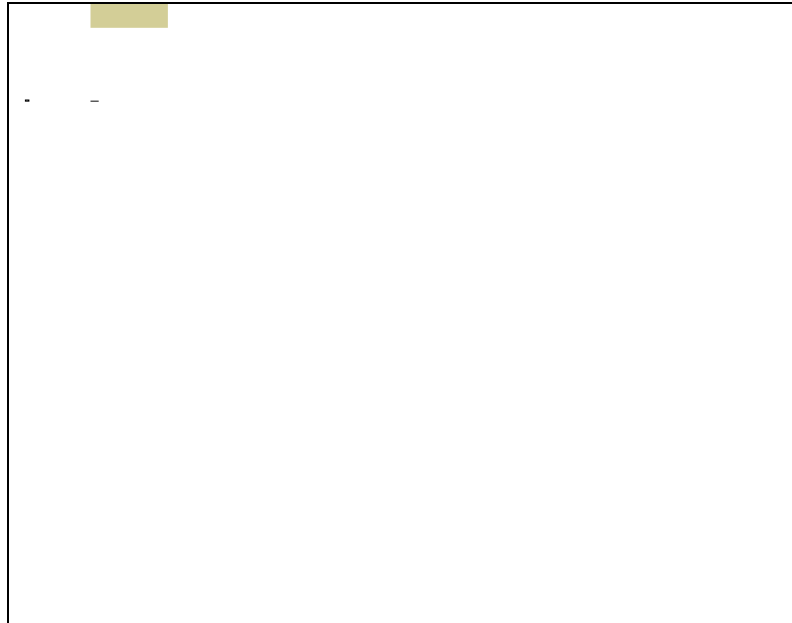
Of the respondents, 85 (66.5%) were married; 25 (19.7%) were single; 13 (10.2%) were divorced, and 4 (3.1%) were widowed (see table 4.5). The married category included those married in church, married customarily, or cohabiting.

**Table 4.5 Respondents' marital status (N=127)**

<b>Marital status</b>	<b>Frequency</b>	<b>Percent</b>
Single	25	19.7
Married	85	66.9
Divorced	13	10.3
Widowed	4	3.1
<b>Total</b>	<b>127</b>	<b>100.0</b>

#### **4.2.7 Item 8: Number of years lived at Kasenyi fish landing site**

This question was asked to gauge how mobile the fishing population was. Of the respondents, 96 (75.6%) had lived at Kasenyi fish landing site for a period of more than three years; 14 (11%) had lived there for two to three years; 9 (7.1%) had lived there for one to two years, and only 8 (6.3%) had lived there for less than a year. The respondents at Kasenyi had generally stayed for more than three years (see figure 4.2). This was contrary to Seeley and Allison's (2005a:690) finding that fishing communities were highly mobile populations.



**Figure 4.2 Respondents' duration of stay at Kasenyi fish landing site (N=127)**

#### **4.2.8 Item 9: Respondents' occupation**

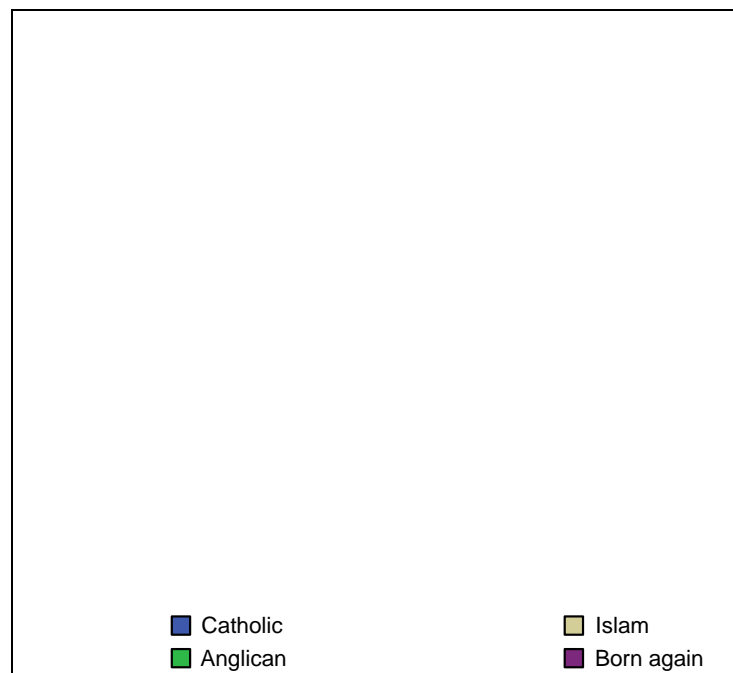
An open-ended question enquired about the different activities Kasenyi respondents were engaged in to earn a living. The responses were later condensed into two occupational categories, namely fishing business and support services. The fishing business included activities such as catching fish, selling and buying fish, making fish nets, as well as making and repairing fishing boats. Support services included shop-keeping, bar and hotel facilities, driving services, and selling vital goods such as charcoal, food, firewood, and clothes. Of the respondents, 71 (55.9%) were engaged in the fishing business and 56 (44.1%) were engaged in the support services (see figure 4.3).



**Figure 4.3 Respondents' occupations (N=127)**

#### 4.2.9 Item 10: Respondents' religious affiliation

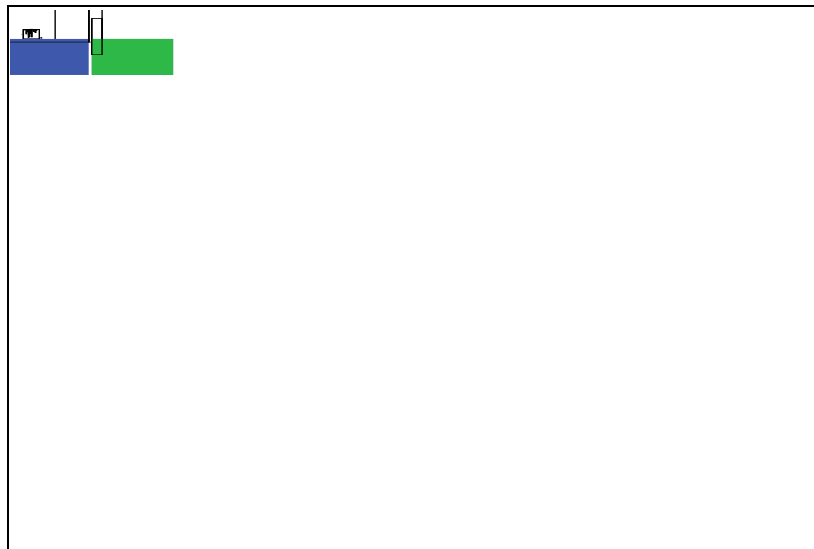
The respondents were fairly equally distributed among the three main religions. Of the respondents, 46 (36.2%) were Catholics; 38 (29.9%) were Anglicans; 37 (29.1%) were Moslems, while only 6 (4.7%) were Born Again Christians (see figure 4.4).



**Figure 4.4 Respondents' religious affiliation (N=127)**

#### 4.2.10 Items 1-10: All respondents' social demographic data compared together

A comparison of items 1 (gender) and 2 (age) across all age groups, indicated an unequal distribution of men and women. Of the 21 respondents aged 20-24, 66.6% were men and 33.4% were women; of the 44 aged 25-29, 54.5% were men 45.5% were women. Of the 34 respondents aged 30-34, 61.7% were women and only 38.3% were men. However, of the 14 aged 35-39, 71.4% were men and 28.6% were women (see figure 4.5).



**Figure 4.5 Respondents' age and gender (N=127)**

In terms of the respondents' age group (item 2) and marital status (item 7), and gender (item 1), of the 85 respondents who were married, 44 (51.7%) were men while 41 (48.3%) were women. In terms of age group and marital status, of the 85 respondents who were married, 31 (36.5%) were aged 25-29, and 28 (32.9%) were aged of 30-34. The remaining 26 (30.6%) respondents were fairly evenly distributed among the rest of the age groups. It was noted that the respondents aged 35-49 were less likely to be married than those aged 20-34 (p-value<0.05). Table 4.6 illustrates the relationship between age and marital status.

**Table 4.6 Respondents' age and marital status (N=127)**

Marital status	Age group							Total
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Single	1	13	8	2	1	0	0	25
Married	2	8	31	28	4	10	2	85
Divorced	0	0	5	3	2	3	0	13
Widowed	0	0	0	1	2	1	0	4
<b>Total</b>	<b>3</b>	<b>21</b>	<b>44</b>	<b>34</b>	<b>9</b>	<b>14</b>	<b>2</b>	<b>127</b>

The analysis of occupation and gender indicated that of the 71 respondents engaged in fishing activities, 42 (63.6%) were men. Of the 56 respondents engaged in providing support services, however, 32 (52%) were women. The difference between gender and occupation was statistically significant ( $p\text{-value} < 0.05$ ), in that men were more likely to engage in fishing activities compared to women. According to the Fisheries Resources Research Institute (2002:10), the fishing business still remains a male-dominated activity.

In terms of occupation and age groups, there were marked occupational differences across all age groups. Of the 71 respondents engaged in fishing business, 35.2% were aged 25-29; 29.6% were aged 30-34; 14.1% were 20-24; 12.7% were 40-44, while only 1.4% were 45-49, and no one was 15-19 (see figure 4.6).



**Figure 4.6 Respondents' occupation and age (N=127)**

The level of education (item 5) had no influence on the commonly used language (item 3), although 65 (51.2%) of the respondents had achieved secondary education level and 12 (9.4%) had tertiary level education, at which levels they are expected to express themselves adequately in the English language. Moreover, unlike most sectors of the economy where education level influences occupation, in the Kasenyi fish landing site, education level did not influence the occupation of the respondents with tertiary and secondary education and those with no or primary level education (p-value=0.601). However, there was a statistically significant difference when comparing level of education achieved for men and women, where the men were more likely than the women to have achieved secondary and tertiary level education (p-value=0.017).

Length of stay at Kasenyi fish landing site (item 8) was compared to occupation (item 9) and gender (item 1). Consequently, length of stay at Kasenyi fish landing site was not necessarily dependant on one's occupation (p-value=0.262) or even gender (p-value=0.611). This was in contrast to Seeley and Allison's (2005a:690) finding that fishing communities and, especially the men, were highly mobile. However, duration of stay was found to be influenced by marital status, with more married respondents having remained at Kasenyi for more than three years compared to unmarried respondents (p-value=0.000), who had stayed less than 3 years.

#### **4.3 SECTION 2: KNOWLEDGE OF HIV/AIDS AND VCT**

This section of the interview examined the respondents' knowledge of HIV/AIDS and VCT services.

##### **4.3.1 Item 11: Knowledge of HIV transmission**

In an open-ended question, the respondents were asked to mention at least two ways they knew that HIV is transmitted. All the respondents were able to give two correct answers on how HIV is transmitted. Ways of HIV transmission mentioned included having unprotected sex with an infected partner (85%); sharing sharp instruments with an infected person (8.2%); using unsterilised needles (3.3%); through blood transfusion (2.7%), and mother-to-child transmission (0.8%). This was consistent with the MoH and ORC Macro (2006:44) sero behavioural survey findings where 98% were able to mention at least two ways of HIV transmission.



#### 4.3.2 Item 12: Knowledge of HIV prevention

The respondents were asked about ways of avoiding HIV and all mentioned at least two ways of avoiding HIV infection. The ways of HIV prevention mentioned included the consistent use of a condom (89.7%); abstinence (6.2%); being faithful to one partner (2.2%), and not breastfeeding if infected with HIV (1.9%).

This knowledge about HIV acquisition and prevention was consistent with the MoH and ORC Macro (2006:44) findings. Beyrer (2007:984) found that male condom use is a highly regarded tool against HIV acquisition and transmission and other sexually transmitted infections.

#### 4.3.3 Item 13: Ways of knowing HIV status

Of the respondents, 96 (75.6%) pointed out that people could know if they were infected with HIV through HIV testing, while 30 (23.6%) stated that people could know their HIV status through signs and symptoms assumed to be related to HIV (see table 4.7).

**Table 4.7 Ways of knowing HIV status (N=127)**

<b>Ways of knowing HIV status</b>	<b>Frequency</b>	<b>Percent</b>
Through HIV testing	96	75.6
Through signs and symptoms	30	23.6
Don't know/not sure	1	0.8
<b>Total</b>	<b>127</b>	<b>100.0</b>

#### 4.3.4 Items 14 and 15: Knowledge of VCT

When asked whether they knew what VCT was, 92 (72.4%) of the respondents said they knew what VCT meant while 35 (27.6%) said they did not know what it meant. However, when asked to explain their understanding (item 15), the 92 respondents made no reference to “voluntary”, but instead described VCT as free HIV testing and education. In general, for many people, VCT is synonymous with a free HIV test and

this dates back to when VCT was introduced in the public sector as a complimentary service, supposed to be provided free of charge (MoH 2003a:5).

#### **4.3.5 Items 16 and 17: Knowledge of VCT sites**

Of the respondents, 113 (89%) knew sites where people could have an HIV test if they wanted or needed to. Furthermore, the respondents were required to name the site(s) where people could have an HIV test done (item 17). Of the 113 respondents, 53 (41.7%) indicated Entebbe Hospital; 27 (21.3%) named Kisubi Hospital; 23 (18.1%) named the Uganda Virus Research Institute, and 12 (9.4%) stated the AIDS Information Centre. These sites are government hospitals, missionary hospitals or NGO VCT sites, respectively. There was no mention of any private testing site.

#### **4.3.6 Item 18: Willingness to pay for VCT services**

Of the respondents, 89 (70.1%) were not willing to pay for VCT and only 28 (22%) were willing to pay. Of those who were willing to pay, however, 18 (64.4%) were only willing to pay less than 5,000 Ugandan shillings (US \$3.00); 4 (14.2%) were willing to pay between 5,000 and 10,000 Ugandan shillings; only 1 (3.6%) was willing to pay more than 10,000 Ugandan shillings, while 5 (17.8%) did not know how much they could pay. Gender, age, or occupation made no difference to willingness to pay ( $p\text{-value}>0.05$ ).

These findings could be related to the respondents' understanding of VCT services as a free service, and that no one should be asked to pay for it (item 15). At the same time, user fees are additional to other costs clients are already paying, such as transport. In rural South Africa, Pronyk et al (2002:862) attributed a 75% increase in clients presenting themselves voluntarily for HIV testing partly due to reductions in direct fees (user fees).

#### **4.3.7 Items 19 and 20: Encouraging others to test for HIV**

Of the respondents, 120 (94.5%) were willing to encourage a friend or a relative to go for HIV testing while only 5 (5.5%) said they would not (see table 4.8).

**Table 4.8 Encouraging others to have an HIV test (N=127)**

<b>Would you encourage others to test for HIV?</b>	<b>Frequency</b>	<b>Percent</b>
Yes	120	94.5
No	6	4.7
Don't know/not sure	1	0.8
<b>Total</b>	<b>127</b>	<b>100.0</b>

Regarding why they would encourage others to test for HIV (item 20), the respondents stated that it was good to have an HIV test in order to knowing one's sero status. Of the 6 respondents who said they would not encourage others to have an HIV test, 5 (83.3%) said people would die faster if they knew they were infected with HIV and 1 (16.7%) said that people would intentionally spread HIV if they knew they were infected with HIV. This concurred with Kipp et al (2002:702) finding that clients who found they were HIV positive would intentionally infect others.

#### **4.3.8 Items 21 and 22: Respondents' lifestyle and risk of HIV infection**

The respondents were asked whether they felt their lifestyles put them at risk of acquiring HIV. Of the respondents, 104 (81.9%) did not think so; 21 (16.5%) thought their lifestyle could lead to their being infected with HIV, and 2 (1.6%) were not sure. In fishing communities where HIV incidence is high, most people could be expected to report being at risk of HIV infection. According to Vermund and Craig (2002:1187), however, avoiding realisation of HIV infection risk in a population with high HIV prevalence rates could be a coping strategy.

When asked the reason their lifestyle could put them at risk of HIV infection (item 22), 3 (14.1%) said because they did not live with their sex partners and sometimes were tempted; 5 (23.8%) said the kind of environment they lived was tempting; 2 (9.5%) said their alcohol drinking habits. The final 11 (47.6%) respondents gave the following reasons: having many sexual partners; getting the HIV infection from their sexual partner; doing "silly things", and being under pressure to offer sex to workmates and others. These risks for HIV infection concurred with those found among fishing communities by Beyrer (2007:985); Chandrasekaran et al (2006:512) and Seeley and Allison (2005a:690).

#### **4.3.9 Items 1, 2 and 22: Gender, age and lifestyle related to risk of HIV infection**

Among the respondents, more men compared to women felt their lifestyle put them at risk of acquiring HIV (p-value=0.017). Moreover, respondents aged 20-29 felt they were at higher risk of acquiring HIV due to their lifestyle compared to those aged 30-49 (p-value=0.015). There were no other marked statistical differences in this aspect with regard to marital status, occupation, religion or number of years they had lived in Kasenyi (p-value>0.05). More men compared to women said they were at risk of acquiring HIV. Maman et al (2001:602) and De Paoli, Manongi and Klepp (2004:419) found that more women than men thought they were at risk of acquiring HIV.

#### **4.3.10 Items 5 and 13: Knowledge of ways of knowing sero status and education level**

The respondents' knowledge of ways of knowing their HIV sero status was compared with their educational level and there was a statistical significant difference (p-value=0.029), with more respondents in secondary and tertiary levels indicating HIV testing as the way of knowing their HIV status compared to those with primary level who stated through signs and symptoms assumed to be related to HIV. Unless people realise that an HIV test is important to know their HIV status, they might not seek VCT services. According to De Paoli et al (2004:415), knowledge of HIV/AIDS is linked to HIV testing.

### **4.4 SECTION 3: REASONS FOR AND EXPERIENCE OF VCT SERVICE UTILISATION**

This section of the interview examined the respondents' experience of VCT service utilisation, concentrating mainly on those who had an HIV test.

#### **4.4.1 Item 23: Respondents who had tested for HIV**

The respondents were asked whether they had had an HIV test or not, and at the time of interviewing, 60 (47.2%) had had an HIV test and 67 (52.8%) had never had an HIV test (see table 4.9). These findings were far below those of the national HIV/AIDS

behavioural survey, where 60.2% of the respondents had been tested for HIV (MoH & ORC Macro 2006:70).

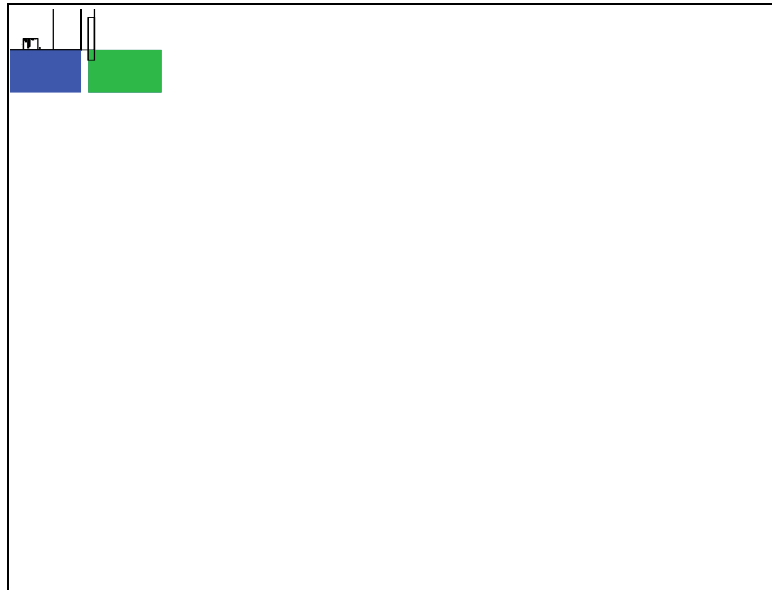
**Table 4.9 Respondents ever had an HIV test (N=127)**

Ever tested for HIV	Frequency	Percent
Yes	60	47.2
No	67	52.8
<b>Total</b>	<b>127</b>	<b>100.0</b>

**4.4.2 Item 23 and Section 1: HIV testing and its relationship to the respondents’ social demographic characteristics**

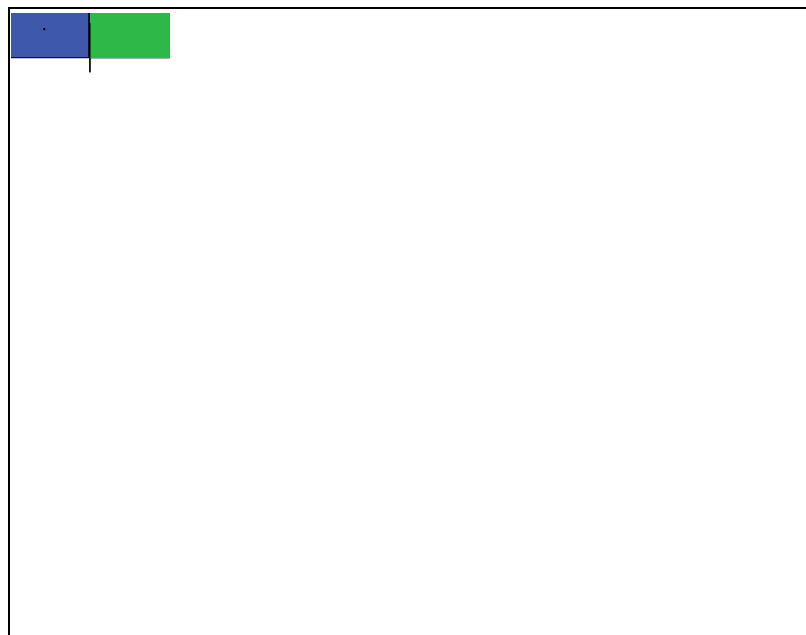
The analysis revealed that the male and female respondents had equally had an HIV test (50% men and 50% women). Fako (2006:203) found a significant relationship between gender and willingness to test for HIV infection among students in Botswana (p-value=0.001), where girls tended to be more willing to test for HIV infection (56.8%) than boys (47.6%). In this study, however, there was no significant statistical difference in relation to having had an HIV test across gender (p-value>0.05), as an equal number of women and men had tested for HIV. Furthermore, while the access to HIV testing in men was close to the 56.5% finding in the HIV/AIDS behavioural survey in Uganda, access to testing in women in the current study fell far below the national finding of 63.8% (MoH & ORC Macro 2006:70)

In terms of marital status, of the 25 respondents who were single, 16 (64%) had ever had an HIV test; of the 85 who were married, only 36 (42.4%) ever had an HIV test, and of the 13 who were divorced, 7 (53.8%) ever had an HIV test (see figure 4.7).



**Figure 4.7 Respondents who had tested for HIV and marital status (n=60)**

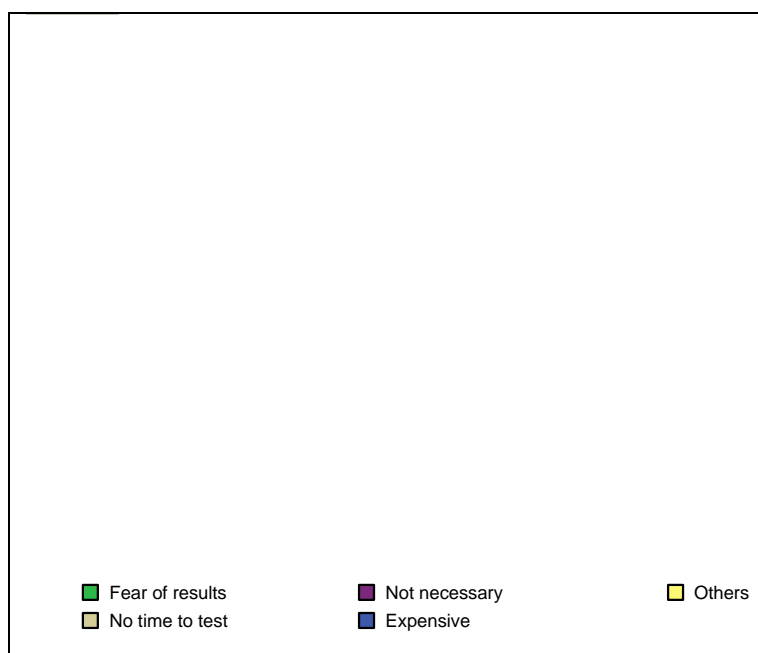
With regard to age, of the 21 respondents aged 20-24, 13 (61.9%) had tested for HIV while of the 44 aged 25-29, only 16 (36.4%) had tested. Having tested was found to increase with age, with peak testing at 25-29 and 30-34 and then decreasing with advancing age (see figure 4.8). This concurred with Gage and Ali's (2005:156) finding that testing rates decreased with age.



**Figure 4.8 Age group and having ever tested for HIV (n=60)**

#### 4.4.3 Items 23 and 24: Respondents who had never tested and reasons why

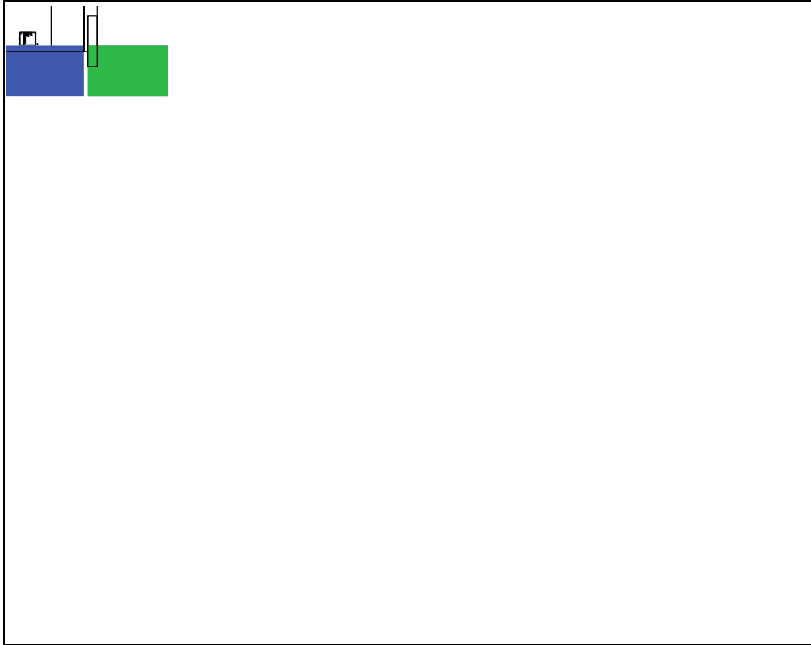
In order to understand the barriers to accessing HIV testing services, the respondents who had never tested for HIV were asked the reason why. Of the 67 respondents who had never tested, 38 (56.7%) said they feared HIV test results; 15 (22.4%) had no time for an HIV test; 9 (13.4%) did not consider it necessary; 4 (6%) said HIV testing was expensive, and 1 (1.5%) gave other reasons (see figure 4.9).



**Figure 4.9 Reasons for never having had an HIV test (n=67)**

Downing, Knight, Reiss, Vernon, Mulia, Ferreboeuf, Carroll and Vu (2001:566) and Maman et al (2001:598) found a range of factors associated with HIV testing, which were mainly actual and perceived risk of and knowledge about HIV. In the Mpigi District of Uganda, adolescents (ages 12 to 19) were interested in HIV testing but concerned about confidentiality, the testing process, the accuracy of the test results, and the cost of VCT services (McCauley 2004a:3). People who do not regard HIV testing as necessary might not perceive themselves to be at risk of HIV and therefore convince themselves that they do not need VCT services. They may not realise that HIV risk can be derived from a sexual partner's high-risk behaviour.

Barriers to HIV testing were analysed in relation to the respondents' gender, comparing men and women. Accordingly, of the 38 respondents who feared an HIV test results, 21 (55.2%) were men and 17 (44.8%) were women. Of the 15 respondents who had no time to test, 8 (53.3%) were men and 7 (46.7%) were women (see figure 4.10).



**Figure 4.10 Reasons for never having had VCT (n=67)**

The findings indicate the highest fear of HIV test results among the respondents engaged in the fishing business compared to those in support services. Of the 38 respondents who feared test results, 24 (58.3%) were engaged in the fishing business and 14 (41.7%) were engaged in support services.

According to Downing et al (2001:566), Maman et al (2001:598) and Nsabagasani and Yoder (2006:24), fears of a positive result are related to past sexual experiences and the consequences of a test result, such as fear of partner's reaction, attitude towards a positive HIV test result and the stigma that comes with it. According to the MoH and ORC Macro (2006:71), the main reasons for not testing for HIV in Uganda included don't need the test (38.4%), not knowing where to get a test from (20.8%), no knowledge of HIV testing (15.4%), and fear of knowing results (12.6%).



#### **4.4.4 Items 25 and 26: Voluntary or required HIV testing**

Of the 60 respondents who had had an HIV test, 45 (75%) had done so voluntarily while 15 (25%) had been required to have the test. Requiring people to take an HIV test against their will is against human rights. HIV testing in whatever form should be voluntary and not included as part of a routine medical examination without clients' knowledge and consent (Grellier et al 2004:18; MoH 2003a:1).

Of the 15 respondents who were required to have an HIV test, 9 (60%) felt happy afterwards but 6 (40%) felt it was a violation of their rights. Men compared to women were more likely to report being required to undergo HIV testing ( $p\text{-value}<0.043$ ). The requirement to have an HIV test could be due to health provider-initiated HIV testing, a form of testing where a physician or nurse attending to a patient requests an HIV test for better patient management. This form of VCT is recommended in places with generalised HIV epidemics (Bass 2006:760).

#### **4.4.5 Items 27, 28 and 29: Receiving HIV test results**

The 60 respondents who had had an HIV test answered these items. This study did not intend to find out who had received negative or positive HIV results, therefore the respondents were asked whether they had received their results, and all 60 (100%) confirmed receiving them. Chances of testing and getting results could be attributed to the availability of single visit rapid tests. According to the CRHCS (2002:16), simple, rapid HIV tests providing immediate results have greatly increased VCT uptake. The CDC (2006:3) confirms that rapid HIV testing can increase the number of persons who are willing to be tested and the proportion of persons tested who receive their results.

The 60 respondents were asked how they felt after receiving their test results and 57 (95%) indicated they felt happy, while 3 (1 woman, 2 men) felt angry about the results. This happiness should nevertheless not automatically be interpreted as a result of receiving HIV-negative results, but could be due to the fact that counselling was well done to absorb the shock of a positive result or that post-test counselling assistance was well offered for those who tested HIV positive. According to Kaleeba, Kalibala, Kaseje, Ssebbanja, Anderson, Van Praag, Tembo and Katabira (1997:19), social

support begins with good counselling for the client to accept especially an HIV-positive result.

#### **4.4.6 Items 30 and 31: HIV testing and receiving counselling**

Of the 60 respondents who had tested, 57 (95%) had received counselling and 3 (5%) had not. Further analysis indicated that the 3 respondents who were unhappy with the HIV test results were the ones who had not received counselling during the testing. This re-confirmed the role of counselling in HIV testing. Cohen et al (1992:729) emphasise that everyone being tested should have an opportunity for individual post-test counselling.

Of the 57 respondents who had received counselling, 36 (63.3%) had received the counselling as individuals; 18 (31.7%) had received counselling as couples, and 3 (5%) had received counselling as a group. This indicated less use of group counselling and more use of individual and couple counselling, the preferred modes of counselling. Cohen et al (1992:729) and Fabiani et al (2007:737) attributed low acceptance of VCT among women seeking antenatal services to the use of group counselling.

It should be noted that 31.7% of the respondents had received counselling as couples. Counselling and testing couples is a golden opportunity for direct partner notification and is therefore a chance to reduce further adult and paediatric infections in case of HIV discordance, since HIV discordant couples are one of the most vulnerable groups in Africa (De Cock et al 2002:70). Moreover, of the married respondents, 55.6% had been tested as couples, which meant that 44.4% had been tested as individuals although they were married. Community education therefore needs to focus on promoting counselling of couples, which may also be a strategy for increasing men's participation (De Paoli et al 2004:421).

#### **4.4.7 Item 32: Trends in accessing and using VCT services**

A trend in accessing VCT services was indirectly measured among the 60 respondents who had been tested. The respondents were asked when they last had their HIV test, and 8 (13.3%) had had an HIV test in 2004 or before; 13 (10.2%) in 2005; 14 (10.9%) in 2006, and 25 (41.7%) had their last HIV test in 2007 (see figure 4.11). HIV testing thus

appeared to be increasing, which could possibly be related to increased knowledge of VCT services. Gage and Ali (2005:163) found that neighbourhood knowledge of a test site was one of the strongest predictors of HIV testing.

Of the 8 respondents who had tested in 2004 and before, 5 (62.5%) were women, and 3 (37.5%) were men. Of the 25 respondents who tested in 2007, 11 (44%) were women while 14 (56%) were men. This means that HIV testing trends were increasing equally among men and women.

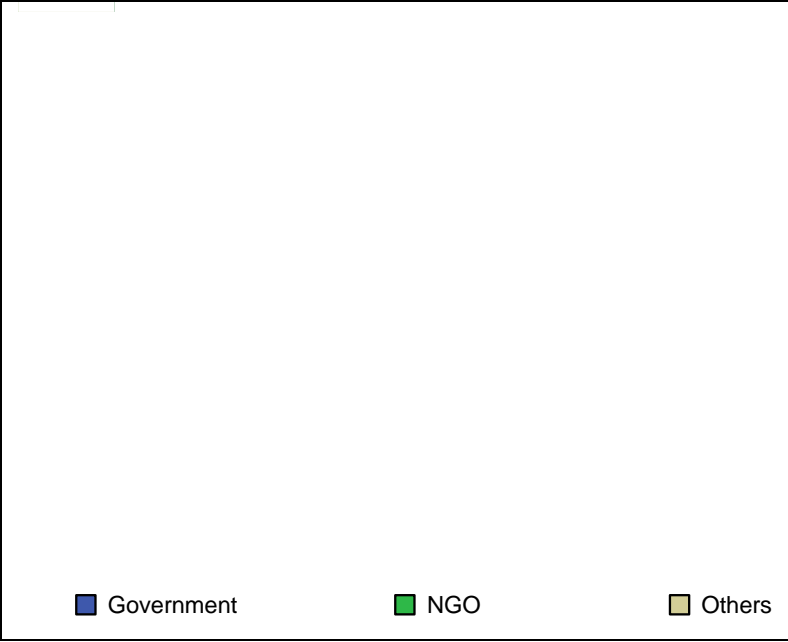


**Figure 4.11 Trends in HIV testing and gender (n=60)**

**4.4.8 Items 33 and 34: Respondents’ last HIV test site**

The 60 respondents who had ever had an HIV test answered items 33 and 34. The respondents were asked where they had had their last test and 49 (81.7%) indicated that they had their HIV test at a health facility; 9 (15%) had their last HIV test at a workplace; 1 (0.8%) had the test at home, and 1 (0.8%) had the test in some other place but did not indicate where. Preference for having an HIV test at a health facility could be related to the need to access more services, especially if an individual tests HIV positive. According to Vermund and Craig (2002:1186), expected benefits from VCT may reinforce the decision to seek or accept an HIV test.

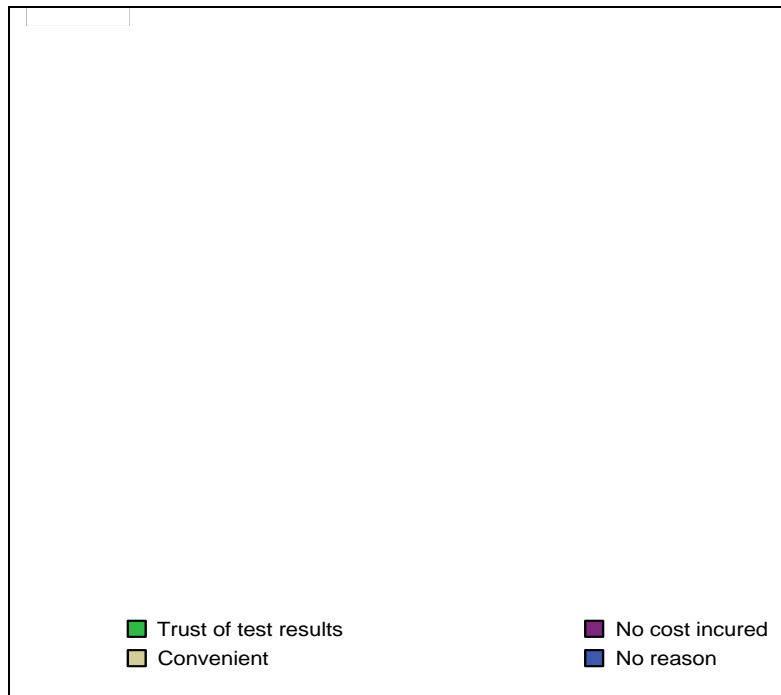
The 49 respondents who had an HIV test at a health facility then answered item 34: the type of health facility. Of the respondents, 39 (79.6%) indicated they had their test at a government hospital; 8 (16.3%) indicated an NGO setting, and 2 (4.1%) indicated a pharmacy and a private clinic, respectively (see figure 4.12). In Ethiopia, an overwhelming majority (83%) preferred the hospital as a site for VCT service (Dejene 2001:32). Asingwire (2004:30) found that clients would travel longer distances for VCT if they were unsure of confidentiality.



**Figure 4.12 Sites where respondents had their last HIV test (n=60)**

**4.4.9 Item 33: Respondents’ reason for selecting VCT site**

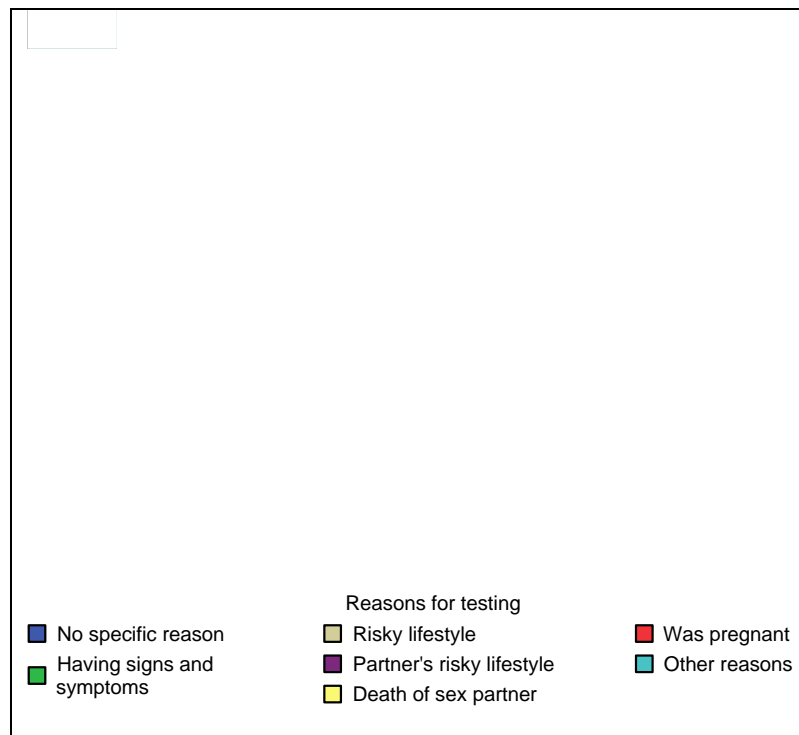
All the respondents who had ever tested answered item 33 on the reason for selecting an HIV test site. Of the 49 respondents who had HIV test at a health facility, 25 (51%) indicated that they trusted the results from a health facility; 19 (31.7%) indicated it was convenient, and 3 (5%) gave no reason (see figure 4.13). There was no mention of confidentiality issues. This was contrary to Fylkesnes and Siziya’s (2004:570) finding of a low response at site-based VCT due to the likelihood of meeting someone known to the individual at the local clinic.



**Figure 4.13 Respondents' reasons for testing at a health facility (n=49)**

#### **4.4.10 Item 36: Respondents' reason for having the HIV test**

Of the respondents, 12 (20%) indicated having lived a risky lifestyle; 10 (16.7%) had experienced signs and symptoms assumed to be related to HIV/AIDS; 9 (15%) indicated their sex partners' risky lifestyle; 8 (13.3%) indicated the death of the sex partner; 5 (8.3%) tested during pregnancy; 12 (20%) had no specific reason for having had an HIV test, and 4 (6.7%) indicated other reasons (see figure 4.14). Sato, Keiwkarnka, Isaranurug, Pattara-Archachai, Yanai and Tsunekawa (2005:132) found the most common reasons were planning for the future, worry and curiosity. Karamagi, Tumwine, Tylleskar and Heggenhougen (2005:6) found that very few women accepted to test for HIV because of the fear of knowing that they were HIV positive, which would cause them to worry and die.



**Figure 4.14 Respondents' reason for having an HIV test (n=60)**

The most common reasons for seeking HIV testing were compared across gender (item 1, section 1). Among the 30 men who had tested for HIV, 9 (30%) had tested after experiencing signs and symptoms possibly linked to HIV/AIDS; 7 (23.3%) had lived a risky life style; 4 (13.3%) had lost a sex partner; 2 (6.7%) feared their sex partners' lifestyle; 5 (16.7%) had no specific reason, and 3 (10%) had other reasons. Of the 30 women who had tested for HIV, 7 (23.3%) feared their sex partners' lifestyle; 5 (16.7%) had lived a risky lifestyle; 5 (16.7%) tested during pregnancy; 4 (13.3%) tested after losing a sex partner; 7 (23.3%) had no specific reason; 1 (3.3%) tested after experiencing signs and symptoms thought to be related to HIV/AIDS, and 1 (3.3%) indicated other reasons.

There was a marked significant statistical difference when comparing the reasons given by the men for seeking VCT services and those given by the women. More men reported seeking VCT because of signs and symptoms related to HIV/AIDS whereas more women reported fear of their sex partners' lifestyle (p-value=0.015) (see figure 4.15). These findings concurred with Sato et al's (2005:132) finding that the most common reasons people give for seeking VCT included being worried and curious.



**Figure 4.15 Respondents' reasons for having VCT across gender (n=60)**

#### **4.4.11 Item 37: Respondents' rating of the basics of VCT service**

The respondents (n=60) were asked how they liked or did not like certain basic aspects of VCT services during their visit. Of the respondents, 59 (98.3%) liked the explanation of VCT results, the information received and the overall services. Then 58 (96.7%) liked the counsellors' attitude; 57 (95%) liked the language used in counselling; 57 (95%) liked the confidentiality, and 54 (93.3%) liked the waiting area. Regarding the VCT aspects least liked, of the respondents, 37 (61.7%) indicated the distance to VCT sites; 18 (30%) indicated the time spent at the VCT site, and 48 (80%) indicated the courtesy of site staff (see table 4.10).

**Table 4.10 Respondents' rating of basic VCT elements (n=60)**

Basic VCT element (n=60)	Rating of the VCT service	
	Liked the basic element – n (%)	Did not like the basic element – n (%)
Courtesy of facility staff	48 (80.0)	12 (20)
Distance to VCT site	23 (38.3)	37 (61.7)
Explaining VCT results	59 (98.3)	1 (1.7)
Information given	59 (98.3)	1 (1.7)
Confidentiality	57 (95.0)	3 (5.0)
Cost	50 (83.3)	10 (16.7)
Counsellor attitude	58 (96.7)	2 (3.3)
Language used in counselling	57 (95.0)	3 (5)
Privacy	55 (91.7)	5 (8.3)
Time spent at clinic	42 (70.0)	18 (30)
Waiting area	56 (93.3)	4 (6.7)
Overall service	59 (98.3)	1 (1.7)

Liking basic elements in VCT services is critical in service delivery. According to the MoH (2005:19), going for a VCT service should enable those who have taken the test to know their HIV status, know what it means and get appropriate and timely assistance, all done in good time with confidentiality. The MoH (2005:19) adds further that should this not happen, clients will not be satisfied with the VCT service and will not return for follow-up or recommend their friends for VCT services.

The respondents' overall satisfaction with the basic aspects of VCT was generally good, with almost all reporting satisfaction with confidentiality, cost, counsellors' attitude, courtesy at health facility, counsellors' explanation of VCT results, information given, privacy and waiting area. Based on this, the researcher concluded that the respondents who had had contact with VCT services generally felt satisfied with the service. If the VCT facility is far from clients' homes, people find it difficult to access the services because they need more money for transport and more time to reach the VCT centre, which is a serious problem in developing countries where transport systems are often poor (Sato et al 2005:39). However, Asingwire (2004:30) found that clients preferred travelling longer distances for VCT if they were unsure of confidentiality and where stigma is high.



#### 4.4.12 Items 38, 39 and 40: Sharing HIV test results

The 60 respondents who had been tested were asked whether they had shared their HIV test results with others (item 38). Of the respondents, 55 (91.7%) had informed someone of their HIV test results and only 5 (8.3%) had not done so. Item 39 asked with whom they had shared their HIV test results. Of the respondents, 37 (67.3%) had shared the results with a sexual partner; 16 (29.1%) with a friend, and 2 (3.6%) with others, including relatives (see figure 4.16). Sharing HIV test results could also be attributed to good counselling. Counsellors normally encourage the VCT clients to share their HIV test results with those close to them (Horizons Program 2001:3).



**Figure 4.16** *People with whom respondents shared HIV test results (n=55)*

According to De Cock et al (2002:70), sharing HIV test results should change an individual's sexual behaviour and in the process reduce HIV transmission. This study found that sharing test results was common among the respondents, including with their sex partners. This contradicted De Cock et al (2002:70), Maman et al (2001:599) and Nsabagasani and Yoder (2006:33) findings of limited sharing of test results, particularly among sexual partners for fear of violence.

The five respondents who did not share results with anyone pointed out that it was not necessary to share the results. Of these, 3 (60%) were men and 2 (40%) were women.

#### **4.4.13 Items 41 and 42: Receiving VCT and change of lifestyle**

Of the 60 respondents, 41 (68.3%) indicated that receiving VCT services had changed their lifestyle in many ways, and 31 (19%) reported no change in lifestyle after VCT service. Among the respondents who changed their lifestyle and those who did not, across gender, women unlike men were two times more likely to change their lifestyle after VCT service (p-value=0.016). However, there were no significant statistical differences in reported change of lifestyle in terms of age group, marital status, educational level and religion.

VCT is internationally recognised as an effective and important strategy for both HIV/AIDS prevention and care. De Cock et al (2003:1847) and De Zoysa et al (1995:99) found that VCT changed individual behaviour to avoid HIV/AIDS. Furthermore, VCT is a cost-effective strategy for facilitating behaviour change (Forsythe et al 2002:188; Sweat et al 2000:115).

### **4.5 SECTION 4: POTENTIAL FOR FUTURE HIV TESTING AND RELATED BARRIERS**

This section of the interview examined the respondents' possibility of being tested for HIV in the future and the likely motivators or barriers to accessing VCT services.

#### **4.5.1 Item 43: Discussing HIV/AIDS related issues with anyone**

The respondents were asked whether they ever discussed HIV-related issues, and if so, with whom, such as friends, sexual partners, religious leaders or other people. Of the respondents, 104 (81.9%) had discussed HIV/AIDS related issues with a sex partner while 23 (18.1%) had not; 81 (63.8%) had discussed with a friend while 46 (36.2%) had not; 45 (35.4%) had discussed with a relative and 82 (64.6%) had not; only 11 (8.7%) had discussed with a religious leader and 116 (91.3%) had not, and only 13 (10.2%) had discussed with a health worker while 114 (89.8%) had not. This indicated

that many of the Kasenyi residents were more likely to discuss HIV/AIDS-related issues with a sex partner, a friend or a relative.

Assessing whether discussion of HIV/AIDS issues could have an influence on accessing and using VCT services, it was found that of the 60 respondents who had ever tested for HIV (item 23), 58 (96.7%) had actually discussed HIV/AIDS-related issues either with a sexual partner, a friend, a relative, a health worker or a religious leader. This concurred with Nsabagasani and Yoder (2006:21) who found that discussing HIV/AIDS-related issues (with anyone) could influence individuals to have an HIV test. Gage and Ali (2005:162) found that men who had discussed HIV with their spouses were 1.6 times more likely to test than men who had not.

#### **4.5.2 Items 44, 45 and 46: Respondents' site preference for future HIV testing**

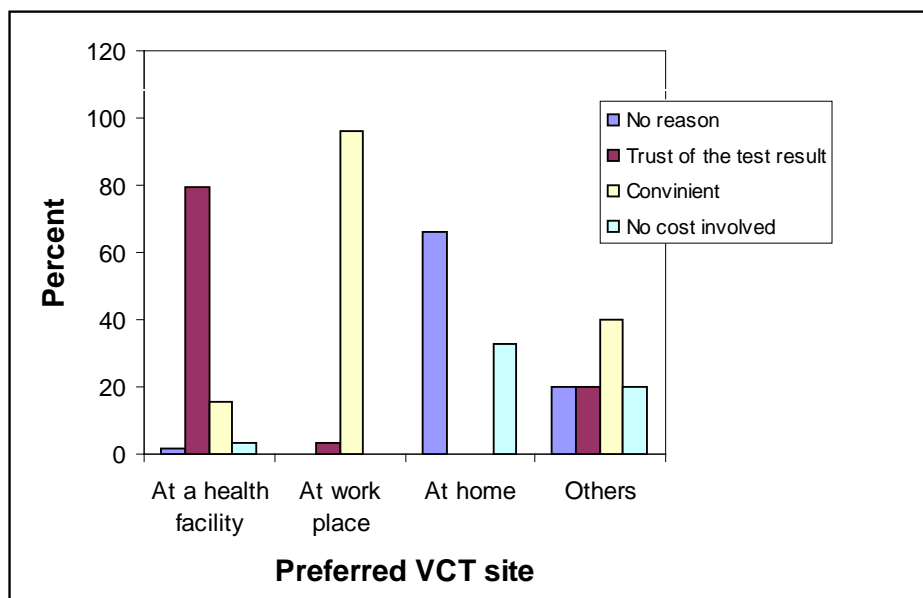
The respondents were asked about their preferred VCT site if they were to have an HIV test in the near future. Of the respondents, 64 (50.4%) indicated they would prefer to have VCT service at a health facility; 55 (43.3%) would prefer having VCT at their workplace, and only 3 (2.4%) would prefer to have VCT at their home. The FHI (2005b:5) and Wolff et al (2005:114) found that home-based VCT offers challenges with regard to confidentiality and disclosure.

Item 45 asked the respondents' reasons for their preferences. Of the respondents, 65 (51.2%) indicated convenience in terms of the location of the site; 54 (42.6) indicated trust of the results obtained; 4 (3.1%) indicated the costs involved, and 4 (3.1%) gave no reason (see figure 4.17).



**Figure 4.17 Respondents' reasons for preference of a certain VCT site (N=127)**

A comparison of the preferred site for future HIV testing (item 44) and the reasons for the preference (item 45) indicated that of the 64 respondents who preferred a health facility, the main reason given by 51 (79.7%) was trust of the test results. Of the 55 respondents who preferred having VCT at workplace, 54 (98.2%) gave the convenience as the main reason (see figure 4.18).



**Figure 4.18 Respondents' preferred VCT site and reason why (N=127)**

Generally, convenience in getting to the VCT site and the dependability of the site in giving accurate test results largely influence where people go for VCT services. Convenience should be considered not only as distance to the VCT site, but also as ease of getting to a counsellor, privacy and confidentiality (Admassu & Fitaw (2006:30).

The 64 respondents who preferred a health facility were further asked what type of health facility they preferred (item 46). Of the respondents, 39 (57.4%) preferred a government health facility; 15 (22.1%) preferred an NGO; 12 (17.6%) preferred both NGO and government facility, and 1 (1.5%) preferred other types (see table 4.11). Preference for NGO and government may be suggestive of a quasi-integrated VCT site. According to the FHI (2005b:3), quasi-integrated VCT is where an NGO is linked to a government health facility.

**Table 4.11 Respondents' preferred site for future HIV test (N=127)**

<b>Preferred VCT site</b>	<b>Frequency</b>	<b>Percent</b>
Government	39	57.4
NGO	15	22.1
Mixed (Government and NGO)	12	17.5
Others	1	1.5
Don't know	1	1.5
<b>Total</b>	<b>68</b>	<b>100.0</b>

#### **4.5.3 Items 47 and 48: HIV test for respondents' sexual partner**

All the respondents answered item 47, irrespective of their marital status. With regard to whether they knew if their sexual partner had ever tested for HIV or not, 49 (38.9%) said their sex partners had never been tested for HIV; 43 (34.1%) indicated their sex partners had been tested; 32 (25.4%) did not know, and 2 (1.6%) indicated they did not have sexual partners.

A comparison of this (item 47) and having ever had an HIV test (item 23) indicated that the sexual partners of the respondents who had had an HIV test were more likely to have been tested as well (p-value=0.00). The 43 respondents who said they knew their sexual partners had been tested for HIV (item 47) were further asked if they had shared the test results together (item 48). Of the respondents, 39 (90.6%) said they had

shared HIV test results with their sexual partners and thus knew their sexual partner's HIV status.

As mentioned earlier, the study found that sharing test results was generally common, even with a sexual partner. This was contrary to previous findings that sharing test results was very limited, and even more limited amongst sexual partners for fear of violence (De Cock et al 2002:70; Maman et al 2001:599; Nsabagasani & Yoder 2006:33).

#### **4.5.4 Items 49 and 50: Respondents' feelings about sharing HIV test results**

The respondents were asked their views about sharing HIV test results. Of the respondents, 118 (92.9%) indicated that it is a very good idea to share HIV test results while only 9 (7.1%) said that it is bad to share HIV test results (see table 4.12).

**Table 4.12 Respondents' views on sharing HIV test results (N=127)**

<b>Sharing HIV test results</b>	<b>Frequency</b>	<b>Percent</b>
It is a good idea	118	92.9
It is a bad idea	9	7.1
<b>Total</b>	<b>127</b>	<b>100.0</b>

The respondents were asked to explain why they thought it a good or a bad idea to share HIV test results (item 50). The respondents' reasons for why it is good to share HIV tests results included increased the sexual partner's trust, gave courage to the rest of the community members to go for VCT services, and the need to know those who are HIV positive so that they can be helped. The 9 respondents who considered it bad to share HIV test results indicated fear that individuals would die faster if the community knew they tested HIV positive, possibly due to stigma. Despite awareness and availability of HIV/AIDS treatment services in Uganda, the stigma associated with HIV still remains a barrier to seeking VCT services (Kippax 2006:231).

#### 4.5.5 Item 51: How easy or difficult it is to take an HIV test

The respondents were asked how easy or difficult it would be for someone to have an HIV test in the near future. Of the respondents, 114 (89.8%) indicated that it would be easy for them to go for an HIV test; 19 (7.1%) said it would be difficult, and 4 (3.1%) could not tell. A decision to take a test may depend on the anticipated benefits, more especially if people test HIV positive. Vermund and Craig (2002:1186) point out that the differences in attitudes towards testing depend on the community and medical resources available to the HIV-infected person. In developed countries, fear of adverse consequences may be balanced by an awareness of the benefits of HIV-related medical assistance, while the reverse may be true in a poor developing country; where the lack of expected benefits from VCT may reinforce the decision not to seek or accept the test (Vermund & Craig 2002:1186).

#### 4.5.6 Items 52 and 53: Community attitude towards those who go for VCT

Items 52 and 53 attempted to gauge community attitudes towards VCT. Of the respondents, 69 (54.3%) thought they might be supported if their friends knew they had an HIV test; 25 (19.7%) felt that they could be rebuked, and 33 (26%) could not tell (see table 4.13). More women (56%) compared to men (44%) indicated they would be rebuked. Fear of being rebuked can be a barrier to seeking VCT services (Nsabagasani & Yoder 2006:24).

**Table 4.13 Respondents' anticipated reaction from friends (N=127)**

Anticipated reaction from friends	Frequency	Percent
Rebuke me	25	19.7
Support me	69	54.3
Don't know	33	26.0
<b>Total</b>	<b>127</b>	<b>100.0</b>

In a follow-up question, the respondents were asked to substantiate their responses. The respondents who thought that they would be rebuked if community members knew they had had an HIV test indicated they would be suspected of being at high risk for HIV infection, or assumed to be infected with HIV. Those who thought that they would

be supported indicated that people knew that VCT was something good to do and if people tested positive, they could start on antiretroviral treatment in time. This indicated how community attitudes could influence a decision to test or not. Community support is important in influencing accessibility and acceptability of VCT services. Admassu and Fitaw (2006:24) found that the absence of community support was negatively associated with VCT acceptance ( $p$ -value $<0.01$ ).

#### **4.5.7 Items 54 and 55: Respondents' attitudes towards VCT**

At an individual level, all the respondents were asked how they themselves felt about accessing VCT services. Of the respondents, 124 (97.6%) said that having VCT was good while 3 (2.4%) said it was a bad thing. Of the 124 respondents who said VCT was a good thing, 84 (67.7%) said that it helped people plan for the future while 40 (32.3%) said that an HIV test was the only way people could know of their status. Of the 3 respondents who considered it a bad thing, 2 (66.6%) stated that individuals died faster if they tested and found they were HIV positive, and 1 (33.4%) indicated that individuals could spread HIV if they knew their HIV status. Kipp et al (2002:703) found that some people were worried that persons found to be HIV infected and told so would go on a "rampage" and therefore further spread HIV/AIDS.

#### **4.5.8 Items 56 and 57: Receiving advice on VCT**

The respondents were asked if they had ever received advice on VCT and if so, the nature of advice (item 56). Of the respondents, 98 (77.2%) indicated that they had received advice on VCT while 29 (22.8%) had not. Furthermore, of the respondents, 95 (96.9%) indicated that the advice they had been given related to the importance of VCT, and 3 (3.1%) indicated that the advice had related to the bad side of VCT services (see table 4.14).

In Tanzania, Maman et al (2001:598) found that for many participants, family, friends and other community members played a significant role in recommending VCT services.



**Table 4.14 Respondents' advice received on VCT services (n=98)**

<b>Nature of advice</b>	<b>Frequency</b>	<b>Percent</b>
Importance of VCT	95	96.9
Bad side of VCT	3	3.1
<b>Total</b>	<b>98</b>	<b>100.0</b>

**4.5.9 Items 58 and 59: Stigma related to HIV/AIDS and VCT services**

This study measured the stigma related to HIV/AIDS among the respondents. The respondents were asked whether individuals in their community who received an HIV-positive result would prefer people in the community to know about it or not. Of the respondents, 75 (60%) indicated it would be a good idea while 48 (38.4%) indicated it would not be a good idea.

When asked the reason for their responses, of the 75 respondents who indicated it would be a good idea, 56 (74.6%) said they would want HIV test results to be made public as they would want to offer support to the individual. Of the 48 respondents who did not want results made public, 39 (81.3%) feared that such a practice would discourage others from going for VCT.

These findings indicated that pockets of stigma associated with HIV testing and receiving positive HIV test results still existed and could have a direct influence on VCT services use. Admassu and Fitaw (2006:26) found that people who were concerned about their community knowing their HIV sero status (either though intentional or unintentional disclosure) were 0.4 times less likely to accept VCT (p-value<0.001). However, in Uganda, Gage and Ali (2005:167) did not find that AIDS-related stigma at the community level decreased the likelihood of HIV testing and willingness to test although they acknowledge that this was contrary to many studies. Wanting to help those found HIV positive could be related to community cushioning practices that exist in some communities. Foster (2007:59) found that informal groups in communities provided counselling and education for those in trouble, among other things.

#### 4.5.10 Item 60: Respondents' influencers on health-related issues

The respondents were asked who influenced them in health-related matters. Of the respondents, 71 (55.9%) indicated their sexual partners influenced them; 36 (28.3%) indicated a friend; 6 (4.7%) were influenced by relatives, and 14 (11%) were not influenced by anyone.

In this regard, more men (64.3%) than women (35.7%) were influenced by their sexual partners, while more women (63.9%) than men (36.1%) were influenced by their friends (see figure 4.19). Sato et al (2005:137) found women more knowledgeable about health issues, especially VCT, and normally passed that knowledge on to men.



*Figure 4.19 Sources of advice on health matters (N=127)*

#### 4.6 SECTION 5: VCT AWARENESS CAMPAIGNS

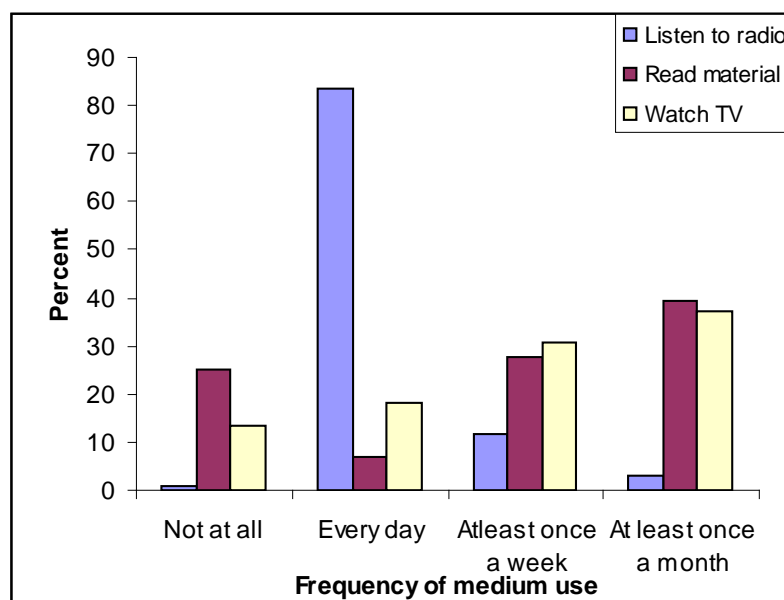
This section examined the awareness campaigns for VCT to which the respondents had been exposed. This helped the researcher to understand the social environmental barriers to accessing VCT services.

#### 4.6.1 Items 61, 62 and 63: Respondents' exposure to reading materials

All the respondents answered these items. Of the respondents, only 9 (7.1%) read printed material on a daily basis; 36 (28.3%) read at least once a week; 50 (39.4%) read at least once a month, while 32 (25.2%) did not read printed material at all. Access to reading material such as newspapers is generally very limited in rural areas.

With regard to listening to the radio, of the respondents, 106 (83.5%) listened to the radio on a daily basis; 16 (12.6%) listened at least once a week; 4 (3.1%) listened at least once a month, while 1 (0.8%) did not listen to the radio at all. This indicated that the radio plays a big role in the lives of rural communities and could be a good channel for delivering HIV/AIDS messages. In Nigeria, Falobi, Olufemi-Kayode, Gold and Frohardt (2002) found a huge potential for mobilising masses against AIDS through the radio, although many radio stations lacked the capacity to provide quality coverage of HIV/AIDS.

Regarding watching television, only 23 (18.1%) respondents watched television every day; 40 (31.5%) watched at least once a week; 47 (37%) watched at least once a month, and 17 (13.4%) did not watch television at all (see figure 4.20).



**Figure 4.20** The medium of communication respondents were exposed to (N=127)

#### **4.6.2 Item 64: Respondents' exposure to VCT messages**

The respondents were asked whether they had heard or read any message about VCT in the three months prior to the study. Of the respondents, 75 (60%) said they had not; 47 (38.6 %) had heard or read something about VCT, and 5 (1.4%) could not recall.

The 47 respondents who had heard a message about VCT indicated that the messages included a call to go for VCT; the need for testing early and knowing ones' HIV status, and need to get more up-to-date information on HIV/AIDS prevention, care and treatment.

#### **4.6.3 Sections 5 and 1: Analysis of VCT messaging and social demographics**

Generally, the respondents listened to the radio almost on a daily basis. Reading of printed materials was also common among some of the respondents. The respondents with secondary and tertiary education were more likely to read newspapers compared to those with primary or no education (p-value=0.000). This may be attributed to poor comprehension skills. Moreover, the respondents with primary or no education were more likely to listen to radio regularly compared to those with secondary and tertiary education (p-value=0.000).

Contrary to the advice that VCT services should be made known to the target population, VCT services did not appear to be well advertised in Kasenyi fishing community. According to Uganda VCT policy guidelines, once VCT services are available to a given community, it is important that the community should be informed about the service, and the commonest ways of informing communities about VCT is through radio, television or printed media, specifically newspapers (MoH 2003a:1).

### **4.7 SECTION 6: RESPONDENTS' SUGGESTIONS FOR IMPROVING VCT ACCESSIBILITY**

The final section of the interview examined respondents' suggestions for improving accessibility to VCT, plus any questions or comments they had. These were open-ended questions, which were later coded and numerical values assigned. This section

fed into the design of the VCT service accessibility and acceptability strategies (chapter 7), one of the study objectives.

#### **4.7.1 Item 66: Respondents' views on what local leaders can do to increase VCT accessibility and acceptability**

The respondents were asked what they would want their community leaders to do in order to promote VCT in Kasenyi. Of the respondents, 85 (67.5%) said there was nothing their local leaders could do to increase access to VCT services; 35 (27.8%) said their leaders could encourage residents to go for HIV testing; 3 (2.4%) said their leaders could ensure VCT services were brought to Kasenyi fish landing site, and 3 (2.4%) said that, besides telling people to protect themselves from HIV/AIDS and to abstain from sex, their leaders themselves should take part in teaching others about HIV/AIDS. This indicated a strong feeling on the part of the respondents that help needs to come from outside the community.

#### **4.7.2 Item 67: Respondents' general suggestions of ways to increase VCT accessibility and acceptability**

Of the respondents, 94 (74%) said there was a need for sensitisation about HIV/AIDS and VCT services; 17 (13.4%) said VCT services should be brought to Kasenyi residents; 2 (1.6%) suggested equipping hospitals with enough medicines and recruiting more doctors, and 14 (11%) had no suggestions (see table 4.15). It should be noted that the respondents wanted more sensitisation about HIV/AIDS in general and VCT in particular.

**Table 4.15 Respondents' suggestion for making VCT accessible and acceptable (N=127)**

<b>Suggestions</b>	<b>Frequency</b>	<b>Percent</b>
Sensitise people about VCT services	94	74.0
Bring VCT services to Kasenyi	17	13.4
Other	2	1.6
No suggestion	14	11.0
<b>Total</b>	<b>127</b>	<b>100.0</b>

#### **4.7.3 Item 68: Respondents' comments about VCT services**

Towards the end of the interview, the respondents were asked to comment on VCT services in general. Of the respondents, although 83 (6.3%) had no comments, 29 (22.8%) emphasised that everyone should know that VCT is a good thing to do, and 15 (11.8%) commented that the health systems should be strengthened by recruiting more health workers, availing health workers to Kasenyi, building more health centres and hospitals in Kasenyi, setting specific days for VCT and making all VCT services free, and that all people who test should be told the truth. Many of the respondents believed that when VCT counsellors found clients had tested HIV positive, they did not tell the truth about the results but instead informed them that they were HIV negative, to avoid negative consequences. In Uganda, Kipp et al (2002:702) found that many believed that counsellors intentionally gave HIV-infected persons negative results in order to avoid suicide and other negative consequences. Van Dyk and Van Dyk (2003:5) found feelings of fatalism and depression among people who tested HIV positive and believed there was nothing they could do about AIDS. Some pregnant women expressed willingness to accept VCT, but their acceptance was contingent upon receiving benefits such as free antiretroviral drugs and infant feeding counselling (De Paoli et al 2004:420). Karamagi et al (2005:6) found that most women (82%) said they were not afraid of being tested for HIV if they were offered the opportunity.

#### **4.7.4 Item 69: Respondents' questions about VCT services**

Finally, the researcher wished to find out whether the respondents had any questions related to VCT services and the study in general. Of the respondents, 93 (73.2%) had no questions; 4 (3.2%) asked whether doctors told the truth about HIV test results; 4 (3.2%) asked why the government had neglected fishing communities; 3 (2.4%) asked whether ARVs were free in hospitals; 3 (2.4%) asked when the researcher would be coming back to test them for HIV, and 20 (15.6%) asked whether the researcher would inform the government about Kasenyi fishing community problems, and the possible help they could get from the current study.

## 4.8 CONCLUSION

This chapter presented and discussed the findings in phase I systematically according to the sections and items in the interview schedule. The interview also included open-ended questions, which were coded and assigned numerical codes before analysis. Analysis was done using the SPSS version 12.0 program. Descriptive statistics (frequencies and percentages) and inferential statistics (chi-square) were calculated. Frequency distributions, percentages and chi-square were presented. Reference was made to the literature reviewed, where applicable.

The findings indicate that the respondents' age was normally distributed across all age groups, most were married, and had obtained a primary or secondary education. The commonly used language at Kasenyi fish landing site was Luganda and many of the respondents could read written material.

About half of the respondents had tested for HIV, and this was fairly equally distributed across gender, marital status and religious affiliation. The majority of those who had tested had done so at a health facility and most had been tested after counselling. The respondents were generally happy with the service, apart from complaints about too much time spent at a health facility as well as long distances to a facility, which could be a deterrent to the would-be VCT service users.

Most of the respondents who had not been tested before mentioned fear of positive HIV test results. This, then, was a major barrier to accessing VCT services, although the majority mentioned their willingness to take an HIV test in the future, especially if the VCT services are delivered at a workplace. Pockets of stigma related to HIV testing, particularly to receiving a positive HIV test, still exist among the Kasenyi residents, which is why many feared undergoing HIV testing.

Finally, there was a need for more sensitisation campaigns about the importance of VCT to the residents and radio broadcasting would perhaps reach more people than television or printed material as more listened to the radio than read newspapers or watched television.

Chapter 5 presents the data analysis and interpretation and findings of phase II from VCT managers at both Entebbe and Kisubi Hospitals including a literature control.



## **CHAPTER 5**

### **Phase II data analysis and interpretation and findings**

#### **5.1 INTRODUCTION**

This chapter discusses the data analysis and interpretation and findings of phase II: the VCT managers at Entebbe and Kisubi Hospitals. These two hospitals are located in Wakiso district, the district in which the Kasenyi fish landing site is located.

This phase achieved the objectives to

- establish the different VCT service delivery models available in and around Kasenyi fish landing site
- determine the extent to which a given VCT service delivery model influences utilisation patterns in the target community
- identify other factors that influence VCT service utilisation among the fishing communities

#### **5.2 DATA COLLECTION**

In phase II qualitative data was collected from VCT managers at the two hospitals that provide the VCT services that target the Kasenyi fish landing site.

The researcher approached the two VCT managers with the UNCST letter of approval (see annexure E). Having previously worked in Wakiso district, where the research sites were located, the researcher knew the VCT managers at these hospitals who were thus not difficult to locate and interview. However, prior knowledge about the VCT managers had no influence on the results as the researcher extricated himself from previous knowledge. Once the interview schedule was prepared, the researcher telephoned the VCT managers and arranged an appointment to meet and interview them.

The interviewer explained the purpose of the research and read out the consent document (see annexure A) before asking questions. The two participants accepted and consented to the interview. The researcher then built rapport by asking a few background questions, which were recorded as field notes. Each of the interviews lasted approximately one hour.

The researcher asked the questions and recorded the answers in writing (see annexure H). According to Babbie (2008:336), a qualitative interview is essentially a conversation in which an interviewer establishes a general direction for the conversation and discusses specific topics raised by the participants. This enabled the participants to tell their story in a narrative fashion on issues related to VCT service delivery and utilisation (see annexure C).

After the interviews, the data was transcribed and captured on computer, using Microsoft Word 2003.

### **5.3 DATA ANALYSIS**

Data analysis commenced simultaneously with data collection, and continued after fully transcribing the interviews. A literature control was also done, using sources related to the VCT service delivery model, which includes the settings, resources and the general environment in which VCT is provided. According to Creswell (2004:11) in qualitative research, literature should be used in a manner consistent with the methodological assumptions of the research paradigm.

Three main coding methods were used in the analysis, namely open, axial, and selective coding (Strauss and Corbin (1998:54). Salient issues related to VCT service delivery and utilisation slowly emerged from the data to form themes and sub-themes (see table 5.1).

**Table 5.1 Emerging themes and sub-themes**

Theme	Sub-theme
VCT service delivery models	<ul style="list-style-type: none"> <li>• Site based VCT (integrated VCT)</li> <li>• Off-site (Mobile, home-based and community VCT)</li> <li>• Health providers initiating testing (provider initiated VCT)</li> </ul>
Factors influencing VCT services delivery and utilisation	<ul style="list-style-type: none"> <li>• Inadequate VCT policies and guidelines</li> <li>• Multi-tasked and busy counsellors</li> <li>• Concerns about privacy and confidentiality</li> <li>• Special services for certain groups</li> <li>• Limited financing for VCT services</li> <li>• HIV testing methods</li> <li>• Poor referral systems</li> <li>• Limited advertising for VCT services</li> <li>• Increasing trends and users of VCT services</li> <li>• Creating a conducive environment for testing</li> <li>• The ideal VCT service</li> </ul>

**5.4 DATA ORGANISATION AND PRESENTATION**

The data was organised and presented according to the main themes and sub-themes. At the same time, given that only one participant was interviewed at each of the research sites, data was presented both in text and matrices (tables) that directly compared the two participants. According to Miles and Huberman (1994:302), data can be presented in two main ways, namely as text or organised displays such as matrices. Onwuegbuzie and Dickinson (2008:208) add that visual data displays can be constructed for one case at a time, known as single case displays, or for two or more cases at a time, known as cross-case displays. The findings in this phase were largely presented as cross-case displays, given that only two cases, each representing a research site, were interviewed.

Visual data displays helped the researcher draw coherent meanings from data, confirm and deepen understanding, and reach conclusions. The matrices were presented according to the themes that emerged from the data analysis in thematic conceptual matrices. According to Miles and Huberman (1994:130), conceptually ordered matrices are matrices organised per person and per theme (see table 5.9). Where possible, direct quotes from the participants are presented as well as the relevant literature, which served as literature control.

## 5.5 THEME 1: MODELS OF VCT SERVICE DELIVERY AT THE HOSPITALS

The ways by which VCT service is provided emerged as a theme, and achieved the objective of establishing the different VCT service delivery models available in and around Kasenyi fish landing site. The VCT managers at both research sites indicated that VCT service is provided in two ways: on-site, which is normally integrated, and off-site, sometimes called mobile VCT service. Either of these services can be client initiated (requested by the client) or provider initiated (requested by the health care provider). Table 5.2 presents the models of VCT service.

**Table 5.2 Models of VCT service delivery**

Theme	Sub-theme
Models of VCT service	<ul style="list-style-type: none"> <li>• Site-based VCT (integrated VCT)</li> <li>• Off-site (mobile, home-based and community VCT)</li> <li>• Health care providers initiating HIV testing</li> </ul>

### 5.5.1 Site-based VCT (integrated VCT)

According to the participants, VCT service is provided at the hospital by the hospital staff. In most cases the service is not a stand-alone service, but rather provided alongside the existing health services, otherwise called integrated VCT service delivery. Table 5.3 compares the two cases at the research sites with regard to on-site VCT.

**Table 5.3 On-site VCT services**

Sub-theme	Meaning unit	Participant	What was revealed	Illustration
On-site VCT services	VCT services provided at the research sites, which are integrated with other services	Participant at site A	On-site VCT is provided through integrated model. Provided along with FP, ART, and PMTCT services	<i>"VCT found us here, we were already working and established, so it was an add-on to the existing programmes."</i>
		Participant at site B	On-site VCT is provided through integrated model. Provided along with FP, ART, PMTCT and post rape services	<i>"We provide VCT through family planning services, under prevention of mother-to-child transmission, under ART programme, under post-rape programme, also available in out-patient."</i>

Provision is made in each health department in the hospital to provide VCT services, thus VCT can be provided along with other existing hospital services, provided by the same staff that provides other services. According to the Uganda Ministry of Health (2003:5), the most common method of making VCT service available is by providing it through existing public health systems where the service is integrated into general health care. Asiimwe et al (2005:3) report that integrated VCT service delivery is the commonest form of VCT service delivery in Uganda.

Integrated VCT service delivery can be provided according to different arrangements. The participants indicated that VCT could be offered through the prevention of mother-to-child transmission (PMTCT) programme, antiretroviral therapy (ART), or family planning (FP) services (see table 5.4).

**Table 5.4 Core programme in which VCT is integrated**

<b>Services in which VCT is integrated</b>	<b>Participant A</b>	<b>Participant B</b>
1. VCT services under prevention of mother-to-child transmission (PMTCT)	<ul style="list-style-type: none"> <li>Some women coming for antenatal services do accept VCT services when asked. <i>"Perhaps about 70% or so accept."</i></li> </ul>	<ul style="list-style-type: none"> <li>Many women coming for antenatal services do accept VCT services <i>"Approximately 90% accept to be tested."</i></li> </ul>
2. VCT services under family planning services	<ul style="list-style-type: none"> <li>It is mainly women who are targeted for VCT under FP, as men do not usually attend. <i>"Men in FP services, they are very rare to see."</i></li> </ul>	<ul style="list-style-type: none"> <li>Use of FP service in Uganda is generally low, and usually only women attend. <i>"Sometimes when women are informed of VCT, they say 'we want to consult our husbands', and they never come back."</i></li> </ul>
3. VCT and antiretroviral therapy (ART)	<ul style="list-style-type: none"> <li>Knowledge of availability of ARVs encourages testing. <i>"People who come for testing already suspect they are infected and so they even ask if there is ART services before they get their results."</i></li> </ul>	<ul style="list-style-type: none"> <li>Knowledge of availability of ARVs encourages testing. <i>"Sometimes patients come asking for ARVs and we ask them, 'Have you tested'? And they tell you, 'You know, my wife died' or 'I have HIV symptoms' etc."</i></li> <li>Tuberculosis treatment is also offered. <i>"about 80% of TB patients have HIV"</i></li> </ul>
4. Post-rape programme	<ul style="list-style-type: none"> <li>There is no programme for rape victims at this research site.</li> </ul>	<ul style="list-style-type: none"> <li>Rape victims are offered VCT services. <i>"Girls who come in having been raped, we refer them to the Hope after Rape project for support and testing."</i></li> </ul>
5. Out-patient VCT	<ul style="list-style-type: none"> <li>Clients come to the hospital specifically for VCT services. <i>"We have outpatient VCT; patients come on their own and access VCT services."</i></li> </ul>	<ul style="list-style-type: none"> <li>Clients come to the hospital specifically for VCT services. <i>"Outpatient VCT, where people come specifically for VCT services, we have a VCT centre."</i></li> </ul>

Table 5.4 indicates that VCT services under the PMTCT are a good avenue for HIV testing, especially for women. When approached, many women usually accept counselling and testing. Fabiani et al (2007:737) refers to findings that among antenatal attendees in sub-Saharan Africa, the VCT uptake was at least 70%. In rural eastern Uganda, Karamagi, Tumwine, Tylleskar and Heggenhougen (2005:7) found that while most pregnant women (97%) attended antenatal clinics in government or private institutions, only 4% completed the PMTCT programme procedures, which include VCT, thereby indicating very low utilisation.

With regard to VCT services under family planning, their attendance is rather low and is largely female attendance. Targeting VCT services under family planning services is unlikely to take on many, given that some of the women would want to consult their husbands first. This is an indication that men still have a significant role to play in influencing women's decisions on whether to test for HIV or not. In Tanzania, Kominami, Kawata, Ali, Meena and Ushijima (2007:291) found that women needed to consult their husbands before being tested, which is one of the reasons for refusing HIV testing. In Uganda, moreover, the demand for family planning services is very low and total fertility rate is among the highest in the world, currently standing at 6.6 children per woman of childbearing age (UNICEF 2007:137).

Knowledge of the availability of ART at a given hospital is likely to attract many people to HIV testing. This indicates the urgent need to have ART services wherever there are VCT services, otherwise the service will be incomplete. Karamagi et al (2006:6) found that women felt it was useless to test if they could not be treated in case they were found HIV positive. However, many were relieved when they tested HIV negative. This could mean that some individuals believe they are HIV infected while they are not, and therefore stresses the need to have the HIV test as the only way to determine HIV status. In phase I, 30 (23.6%) of the respondents reported that they could tell their HIV status without necessarily being tested.

VCT service is also offered to individuals accessing TB treatment services. According to the WHO (2004b:36), about 11.5 million HIV-infected people worldwide are also infected with TB, and 70% of these people live in sub-Saharan Africa.

The participants were asked to indicate the strengths and challenges of offering on-site VCT (see table 5.5).

**Table 5.5 Strengths and challenges of offering on-site VCT**

Participant	Strengths/illustration	Challenges/illustration
Participant at site A	<ul style="list-style-type: none"> <li>No extra staff were hired but rather existing staff were used. <i>"We did not need to hire extra staff but rather trained those who were already in service."</i></li> <li>Many people access VCT services. <i>"Of course, a few refuse but the majority accept. Perhaps about 70% or so accept."</i></li> </ul>	<ul style="list-style-type: none"> <li>Very limited staff <i>"We have less staff doing too many things."</i></li> <li>Limited funds <i>"The biggest problem is funds, we do not get funds from government, instead we just get a few things in kind."</i></li> <li>Time factor <i>"Integration results in delay of some clients; e.g., it is the same nurse counselling, the same nurse delivering women, and the same nurse vaccinating."</i></li> </ul>
Participant at site B	<ul style="list-style-type: none"> <li>Many people access VCT services.</li> <li>Existing staff were trained to offer the services.</li> </ul> <p><i>"The biggest problem we have in Uganda is limited health manpower. So if one can do all jobs, become a Jack of all trades, it is great."</i></p> <ul style="list-style-type: none"> <li>VCT service is accessed, which would otherwise have remained un-accessed. <i>"90% accept to be tested and get Niverapine. We try to ask them to bring their husbands."</i></li> </ul>	<ul style="list-style-type: none"> <li>Very limited staff <i>"Very limited staff and lack of funds are the major problems."</i></li> <li>Competing priorities <i>"Let me ask you, since you are a health worker, if you are a nurse in a hospital and you have a VCT client and all of a sudden they bring in a woman in labour or even an accident victim, whom do you attend to first? Definitely you will deal first with the emergency and come back later to VCT, but a [VCT] client may not understand that."</i></li> <li>Time factor <i>"Clients wanting to rush the process, wanting to spend as little time there as possible."</i></li> </ul>

Not only are the hospitals understaffed, but the available nurses have to offer a wide range of services, which could affect the quality of VCT services and be a barrier to accessing VCT services. The integration of services, where new services are introduced but no additional staff added, worsens the situation. The limited public health funding further exacerbates this, and no more staff can be hired. Khan and Bhardwaj (1994:64) found the number of providers, their geographical distribution, the model of VCT service delivery, the organisational arrangement of providers and the scope of services they provide were among the factors influencing VCT service delivery. Asiimwe et al (2005:7) found staff shortages in Uganda due to the integration of VCT services.

## 5.5.2 Off-site (mobile, home-based and community VCT)

In off-site VCT service, the service is literally taken to the people. Both research sites offer off-site VCT service (see table 5.6).

**Table 5.6 Structure of off-site VCT services**

Structure	Participant	What was revealed	Illustration
Hospital team literally takes VCT services to the people in the community, at their workplace, or even in their homes.	Participant at site A	<ul style="list-style-type: none"> <li>• Field team composed of at least two counsellors</li> <li>• Most outreaches taken to lower level health centres</li> <li>• Work very closely with community leaders</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“This is where we visit smaller health facilities on a given day and offer VCT services.”</i></li> <li>• <i>“The other form of VCT is community, where a field team, normally consisting of at least two counsellors, visits a community and offers VCT services.”</i></li> </ul>
	Participant at site B	<ul style="list-style-type: none"> <li>• Field team is normally composed of at least four multi-professional members</li> <li>• Work very closely with community leaders</li> </ul>	<ul style="list-style-type: none"> <li>• <i>“You literally take the services to the people. You have a field team, which decides when they will go and where. They plan this with the local leaders and administration.”</i></li> </ul>

Off-site VCT, sometimes called mobile or outreach VCT services, can take three main different forms, namely community-based, home-based, or health facility-based (see table 5.7).

**Table 5.7 Models of mobile VCT service delivery**

Model of mobile VCT service	Structural set-up	Illustration
Community VCT	<ul style="list-style-type: none"> <li>• VCT that targets places with a sizeable population, such as markets or trading centres</li> </ul>	<i>“There are different forms of mobile [VCT]; e.g., home-based, door-to-door. But here we only do the community outreach, where a community is organised and called to one place.”</i> Participant B
Home-based VCT	<ul style="list-style-type: none"> <li>• The VCT team moves from home to home testing family members.</li> </ul>	<i>“This door-to-door was first piloted in a rural area in Bushenyi, and so we wanted to pilot it here in a semi-urban setting.”</i> Participant A
Lower health units VCT	<ul style="list-style-type: none"> <li>• Hospital VCT team selectively visits smaller health units on a given day and offers VCT services</li> </ul>	<i>“We visit smaller health facilities on a given day and offer VCT services.”</i> Participant A

The participants reported on the strengths and challenges of offering off-site VCT services as indicated in table 5.8.



**Table 5.8 Strengths and challenges of the different VCT service delivery models**

Model of mobile VCT service	Strengths	Challenges
Community VCT	<ul style="list-style-type: none"> <li>• More people are reached for VCT within a short time.</li> <li>• Clients do not incur any cost to access services.</li> </ul> <p><i>“If money was to be available, this would be a very good form of VCT.”</i> Participant B</p>	<ul style="list-style-type: none"> <li>• Very costly and time consuming <i>“The costs to the hospital are high. You need transport, you need to send your personnel there a full day, and provide lunch.”</i> Participant B</li> <li>• Limited appropriate venues <i>“Problems like finding an appropriate venue, rain, etc.”</i> Participant B</li> <li>• <i>“Most of the off-site VCT programmes depend on availability of funds.”</i> Participant A</li> <li>• Sometimes there is a low turnout <i>“In some places, response may be low despite mobilisation.”</i> Participant A</li> <li>• Limited privacy in some places <i>“someone told me that he can always tell who receives a positive or a negative result by seeing how he makes his face after getting results”</i> Participant A</li> </ul>
Home-based VCT	<ul style="list-style-type: none"> <li>• Demand is high. <i>“The demand for the service far exceeded the planned target that even neighbouring villages demanded for the service.”</i> Participant A</li> </ul>	<ul style="list-style-type: none"> <li>• Transport problems <i>“Another challenge is transport; you need very good transport, a good van, preferably a four wheel drive.”</i> Participant A</li> </ul>
Lower health units VCT	<ul style="list-style-type: none"> <li>• This form of VCT normally comes with other services that clients would normally access at a major hospital. <i>“We have set up special services for special groups, such as the youth, pregnant mothers, etc.”</i> Participant A</li> </ul>	<ul style="list-style-type: none"> <li>• Staffing problems since it is the same hospital staff moving to lower health units. <i>“We have less staff doing too many things, and funders do not want to fund manpower. This is worsened by poor remuneration.”</i> Participant A</li> </ul>

Community mobile VCT offers many advantages to the client, providing an environment conducive to testing, but exerts a lot pressure on the service providers in terms of staffing and transport demands. According to Asingwire (2004:68), although mobile VCT is seen as an appropriate form of VCT service, it requires enormous resources, community support and involvement, while limited privacy and confidentiality are likely to be a barrier to potential VCT clients. Moreover, mobile VCT can easily suffer from being branded as just “AIDS” services. Some people might therefore be reluctant to come forward for testing for fear of being stigmatised and discriminated against (Asingwire 2004:41).

Although there was a high demand for home-based VCT services, offering this form of service requires substantial human and financial resources. Furthermore, home-based VCT, a form of mobile VCT, is challenging in terms of disclosure and confidentiality in a home, where family members may be present (FHI 2005b:5). For youth, fear of stigma is a barrier to home-based VCT (Wolff et al 2005:114).

Offering VCT service at lower units, which are within easy reach of the target community, could be an inducement to testing, for those who cannot travel to a major hospital. In phase I of this study, the respondents at Kasenyi strongly preferred having VCT at a health facility, perhaps due to a wide range of services that could be offered. Dejene (2001:32) too in a study in Ethiopia found that an overwhelming majority (83%) preferred the hospital as a health facility for VCT service.

### **5.5.3 Health care providers initiating HIV testing**

At both research sites, the participants indicated that every individual who comes to the hospital is informed about VCT services and the importance of having an HIV test. One of the participants noted that some people who come to the hospital were already aware of this service and were not shocked when asked to take the HIV test, although a few were still surprised. The other participant reported that when patients were told of the need for VCT services, some immediately concluded that the doctor suspected that they were infected with HIV, which seemed to annoy them:

*One time I told a patient that it would be good for him to have an HIV test and he got so annoyed and argued that he had come for malaria treatment and how could I immediately suspect he had HIV when he was living in a faithful relationship.*

Provider-initiated testing and counselling is normally recommended during clinical care service delivery by health care providers to enable them to decide on specific clinical actions to be taken, which would not be possible without knowledge of the person's HIV status. Many health workers previously feared provider-initiated VCT service would cause problems and therefore hesitated to advise patients to go for VCT, yet patients easily accepted. Grover and Petterson (2005:366) found that most women offered HIV screening accepted and underwent testing and only a minority refused. In this study,

the participants indicated that healthcare providers felt free to ask clients for the HIV test. Bass (2006:760), however, found that health workers maintained that it was unethical to approach VCT in this manner.

## **5.6 THEME 2: FACTORS INFLUENCING VCT SERVICE DELIVERY AND UTILISATION**

The second theme that emerged from the data was the identification of factors likely to influence the nature of VCT service delivery and how it would be accessed, accepted and used by the target community. Table 5.9 presents these factors.

**Table 5.9 Factors influencing VCT service delivery and utilisation, comparing two case studies**

Factors affecting VCT service delivery and utilisation	Participant A	Participant B	Conclusions
1 VCT policies and guidelines	<ul style="list-style-type: none"> <li>• VCT policies are too general. <i>“These are just general, and so we have to sometimes interpret them for the specifics, depending on circumstances.”</i></li> <li>• The guidelines are outdated. <i>“The HIV field is changing so fast and likewise VCT service; new research results are being released, hence we need to move with what is more practical.”</i></li> <li>• Policies not applicable to all situations. <i>“For example, someone under 12 years must come with a parent if she wants to test, but what happens when you have girls as young as 11 years falling pregnant, yet they may need PMTCT?”</i></li> </ul>	<ul style="list-style-type: none"> <li>• There is a policy, but needs constant updating. <i>“We have policy guidelines that we follow. However, VCT and HIV are ever changing and so perhaps we need a new policy every month.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• The policies governing VCT are too general for HIV/AIDS; they are inadequate and outdated.</li> <li>• VCT is changing very fast as new research results come out and constant updates are needed.</li> </ul>
2 Counsellors	<ul style="list-style-type: none"> <li>• Few counsellors</li> <li>• Multi-tasked and overworked counsellors <i>“It is the same nurse counselling, the same nurse delivering women, the same nurse vaccinating, and doing everything.”</i></li> <li>• Counsellors started counselling after VCT services were integrated into the existing services.</li> <li>• Counsellors received training and are offered some support <i>“We closely monitor the counsellors, have</i></li> </ul>	<ul style="list-style-type: none"> <li>• Limited health manpower, including counsellors.</li> <li>• Counsellors do more than one job.</li> <li>• Emergencies other than VCT take priority. <i>“The problem is when one is doing VCT and an emergency case comes up elsewhere.”</i></li> <li>• Counsellors started counselling after VCT services were integrated into the existing services.</li> </ul>	<ul style="list-style-type: none"> <li>• Counsellors started counselling when VCT services were integrated into the existing services.</li> <li>• Counsellors are multi-tasked and thus handle much more than VCT.</li> <li>• They are overworked and sometimes have less time for counselling.</li> <li>• Counsellors sometimes abandon counselling to deal with</li> </ul>

Factors affecting VCT service delivery and utilisation	Participant A	Participant B	Conclusions
	<p><i>meetings where we review issues and concerns. Of course, we also have general personnel evaluations and appraisals.</i></p>	<p><i>“By the time VCT was introduced, we already had the nurses and those were the ones who were trained to offer VCT.”</i></p> <ul style="list-style-type: none"> <li>• Counsellors received training but they have limited support.</li> </ul> <p><i>“We treat counselling as any other duty at the hospital.”</i></p>	<p>emergencies.</p> <ul style="list-style-type: none"> <li>• Counsellor support is limited, and when it occurs, it is handled as general. This is likely to affect the quality of counselling.</li> </ul>
3 Privacy and confidentiality	<ul style="list-style-type: none"> <li>• Very good counselling rooms <i>“We have very good counselling rooms, where those waiting can’t hear the conversations in the room.”</i></li> <li>• Everyone trained in ensuring confidentiality of clients. <i>“Everyone here is trained on confidentiality issues; not only in VCT, but in all hospital set-ups.”</i></li> <li>• Community not sure of confidentiality. <i>“I know the community still think there is no privacy in VCT.”</i></li> <li>• Confidentiality and privacy are compromised in mobile VCT. <i>“Someone told me that he can always tell who receives a positive or a negative result by seeing how he makes his face.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Privacy and confidentiality are core courses in counsellor training</li> <li>• All staff here cautious about confidentiality.</li> <li>• Have designated places for counselling despite space problems. <i>“We have places for counselling, not just under the shade, where one can’t eavesdrop, although we have space problems here.”</i></li> <li>• Community fears <i>“Some people think when Dr So-and-So or Nurse X counsels me and gives me positive results, he or she will inform my community.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Counsellor training emphasises privacy and confidentiality.</li> <li>• Maximum confidentiality is kept, not only in VCT but all departments.</li> <li>• Despite space problems, there are designated counselling places.</li> <li>• Communities seem to perceive a lack of confidentiality at VCT sites.</li> <li>• Mobile VCT poses privacy and confidentiality challenges in some settings.</li> </ul>
4 Handling of special groups	<ul style="list-style-type: none"> <li>• There are special VCT services for the youth and especially those who are pregnant. <i>“We have set up special services for special groups, such as the youth.”</i></li> <li>• Everyone else receives ordinary VCT services.</li> </ul>	<ul style="list-style-type: none"> <li>• Special groups are handled under specific programmes such as Hope after Rape, and PMTCT. <i>“A few cases, like those who are raped, we have a centre for Hope after Rape, and then, say, those who are pregnant are handled under PMTCT.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• There are efforts to give special consideration to certain populations, such as the youth and rape victims but not other vulnerable groups like fishing communities.</li> <li>• Groups such as sex workers are</li> </ul>

Factors affecting VCT service delivery and utilisation	Participant A	Participant B	Conclusions
	<p>"A sex worker would not want to be identified as such."</p>		not given special treatment for fear of raising stigma.
5 Financing VCT services	<ul style="list-style-type: none"> <li>• Very limited funding from the Ugandan government.</li> <li>• Sometimes assistance comes in kind, such as test kits.</li> </ul> <p><i>"The biggest problem is funds. We do not get funds from government, instead we just have a few things in kind, e.g., test kits."</i></p> <ul style="list-style-type: none"> <li>• Cost-sharing across programmes</li> <li>• Charge user fees</li> </ul> <p><i>"Normally, we allocate a few funds from other programmes. We also charge a very small user fee. This is not big enough to deter people."</i></p>	<ul style="list-style-type: none"> <li>• The Ugandan government is the main source of funding.</li> <li>• There are some research partners who also fund VCT activities.</li> <li>• Integration of VCT services requires sharing costs across departments.</li> </ul> <p><i>"VCT here is integrated into other services, so there are no funds strictly for VCT. But each department is supposed to earmark some funds for VCT."</i></p> <ul style="list-style-type: none"> <li>• No user fees are charged, all VCT is provided free.</li> </ul> <p><i>"The government banned user fees and so VCT patients do not pay any money."</i></p>	<ul style="list-style-type: none"> <li>• Government and other donors fund VCT, but at one research site, user fees are charged. This may be a deterrent to poor users.</li> <li>• Funding sources are irregular, although external donors try to fill the gap.</li> <li>• With the integrated VCT model, every department is required to allocate a portion of funds for VCT.</li> </ul>
6 HIV testing methods	<ul style="list-style-type: none"> <li>• Single visit, rapid testing offered</li> <li>• Three different test kits used to confirm positive tests</li> <li>• Use of less invasive method especially in mobile VCT although communities doubt its sensitivity</li> </ul> <p><i>"Many clients doubted the test results when a needle-stick (finger prick) was used instead of the usual vein-puncture. They could not believe that such a simple test could accurately convey such serious information as an HIV result."</i></p> <ul style="list-style-type: none"> <li>• There are means of internal quality assurance but not external.</li> </ul>	<ul style="list-style-type: none"> <li>• Single visit, rapid testing offered.</li> <li>• Three different test kits used to confirm positive tests.</li> <li>• Strictly follow government guidelines and supplied test kits to ensure quality.</li> </ul> <p><i>"We use approved kits, etc. We use well-trained and qualified laboratory staff."</i></p> <ul style="list-style-type: none"> <li>• External quality assurance measures are employed.</li> </ul> <p><i>"With regard to quality, we take samples to UVRI."</i></p> <ul style="list-style-type: none"> <li>• Generally have had no problems with HIV testing, although occasionally they do.</li> </ul>	<ul style="list-style-type: none"> <li>• Rapid, single visit tests are used, which saves time and resources.</li> <li>• Some clients, however, feel the methods used may not be appropriate for serious tests like HIV.</li> <li>• Quality assurance may be internal (relying mainly on the available expertise) or external (using other HIV testing centres).</li> <li>• Generally, quality of HIV testing is adhered to, given the severity of the infection.</li> <li>• Bad client reactions to positive HIV</li> </ul>

Factors affecting VCT service delivery and utilisation	Participant A	Participant B	Conclusions
	<p><i>"We ensure quality, we use approved kits, etc. We use well-trained and qualified laboratory staff and good clinical practice."</i></p>	<p><i>" We generally do not have problems with test results."</i></p> <ul style="list-style-type: none"> <li>• There are occasional problems with results.</li> </ul> <p><i>"At one time a client came to my office crying, telling me that my staff had given her the wrong result: that she was positive. I followed up the case and also ended up counselling her."</i></p>	<p>test results are sometimes experienced.</p>
7 Referral systems	<ul style="list-style-type: none"> <li>• There are internal referrals for cases that can be handled and only refer the complicated ones.</li> </ul> <p><i>"We have internal referral, i.e., referrals within our system. Then we also refer some patients outside the hospital, those we cannot manage."</i></p> <ul style="list-style-type: none"> <li>• Poor documentation hinders appropriate and effective referrals.</li> </ul> <p><i>"We tried to ask for feedback on external referrals, but it has not succeeded due to documentation problems."</i></p>	<ul style="list-style-type: none"> <li>• Internal referral are made</li> </ul> <p><i>"This is a hospital and we deal with all cases and only refer those we can't handle."</i></p> <ul style="list-style-type: none"> <li>• Limited staffing leads to poor referral systems.</li> </ul> <p><i>"Very limited staff and lack of funds are the main problem, because how do you follow up?"</i></p> <ul style="list-style-type: none"> <li>• Sometimes refer clients to specific specialised centres.</li> </ul> <p><i>"All counsellors are trained to handle children, although sometimes we refer them to Mildmay."</i></p>	<ul style="list-style-type: none"> <li>• Internal referrals seem to work well.</li> <li>• There is ineffective external referral process, no feedback as to whether clients actually received services where they were referred.</li> <li>• Limited staff and resources are attributed causes of poor referral mechanisms.</li> <li>• Poor coordination mechanisms amongst hospitals limit effective referrals.</li> </ul>
8 VCT service advertising	<ul style="list-style-type: none"> <li>• The government generally advertises VCT services.</li> <li>• A few information and education materials are printed and distributed.</li> </ul> <p><i>" We print some IEC materials. Also have mobilisers for off-site VCT."</i></p> <ul style="list-style-type: none"> <li>• Word of mouth creates awareness about VCT services.</li> </ul>	<ul style="list-style-type: none"> <li>• There is no need for advertising</li> </ul> <p><i>"VCT no longer needs advertising. Almost everyone knows that every hospital in Uganda is supposed to provide VCT services"</i></p> <ul style="list-style-type: none"> <li>• Limited funds for advertising.</li> </ul> <p><i>"Even if we wanted to, where would we get the money from?"</i></p>	<ul style="list-style-type: none"> <li>• There is no hospital-specific advertising, but rely on the general government advertising.</li> <li>• For mobile VCT, however, there is active mobilisation that includes some form of advertising in printed materials.</li> <li>• Word of mouth is relied on as a</li> </ul>

Factors affecting VCT service delivery and utilisation	Participant A	Participant B	Conclusions
	<p><i>“Even people go and tell others whenever they test, so word of mouth plays a role.”</i></p>		<p>means of spreading information on VCT.</p>
<p>9 Trend and users of VCT services</p>	<ul style="list-style-type: none"> <li>• Experiencing increasing numbers of clients asking for VCT <i>“We have offered VCT to about 30,000 people this year, but last year, we offered to about 15,000 people.”</i></li> <li>• Increasing demand for VCT is due to reducing stigma. <i>“I think stigma also continues reducing.”</i></li> <li>• Fishing communities in Kasenyi are targeted for VCT services. <i>“We also have the fishing villages in Kasenyi. These fishing villages have been earmarked as places with high incidence, and that is why many come knowing they are positive, and come asking for ARVs.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Experiencing increasing numbers of clients asking for VCT. <i>“About more than 15,000 people have accessed VCT service this year (2007) compared to about 8,000 people last year (2006).”</i></li> <li>• Increased knowledge about the importance of VCT is contributing to increased demand. <i>“People are now aware that when you test early, there are advantages.”</i></li> <li>• VCT service is used by not only surrounding communities, but even those outside catchment area. <i>“Even some people come from as far as Kampala. Sometimes people do not want to test where they are known.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• VCT use is increasing over time comparing previous years.</li> <li>• Surrounding communities, including fishing communities, and also individuals outside the catchment area, use VCT service.</li> <li>• Increase in VCT service demand could be attributed to reducing stigma, availability of ARVs, and increased awareness about the importance and availability of VCT services.</li> </ul>
<p>10 Conducive environment for testing</p>	<ul style="list-style-type: none"> <li>• Availability of related services, especially for those testing positive. <i>“I think because of awareness and availability of ARV for those who test positive.”</i></li> <li>• Internal referral systems are well operational, although there are some shortfalls with external referrals. <i>“We have tried to ask for feedback on external referrals, but it has not succeeded due to documentation problems”</i></li> </ul>	<ul style="list-style-type: none"> <li>• There is no direct inducement but creating a good testing environment. <i>“My friend, an inducement in a government facility? You must be dreaming!”</i></li> <li>• Good waiting areas. <i>“We now have a good waiting place where even VCT clients watch TV while they wait, to reduce stress.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Although they do not give incentives, hospitals tend to create an enabling environment for testing.</li> <li>• Client waiting areas strategically provide additional information inform of videos and other reading materials</li> </ul>



Factors affecting VCT service delivery and utilisation	Participant A	Participant B	Conclusions
11 The ideal VCT service	<ul style="list-style-type: none"> <li>• There is a need for more funding for health services.</li> <li>• Need for more resources to hire more staff.</li> <li>• Set up health facilities in fishing communities.</li> </ul> <p><i>“There is a need for more funding for health services. It would be good to set up health facilities in most hard-to-reach populations like the fishing communities.”</i></p>	<ul style="list-style-type: none"> <li>• Need to set up more health facilities at health centres</li> </ul> <p><i>“Put more health units there and you will solve a lot of problems, including poverty.”</i></p> <ul style="list-style-type: none"> <li>• Need to initiate and implement village health teams</li> </ul> <p><i>“We can also revitalise the village health team. I think it is a good concept.”</i></p>	<ul style="list-style-type: none"> <li>• There is a need for more resource allocation and adequate staffing for especially counsellors.</li> <li>• If government prioritised health, they would definitely allocate more resources. Hence advocacy is needed.</li> <li>• The need to think of alternatives to the human resource shortages such as volunteer community counsellors.</li> </ul>

Table 5.9 indicate that inadequate and outdated policies and guidelines may hamper service delivery in health programmes, especially where the health environment is constantly changing. Regarding policies on AIDS in Africa, De Cock et al (2002:67) found the global response to HIV/AIDS and its application highly contradictory and therefore argue for a reconsideration of policy and practices. In general, VCT programme implementation has been guided more by lessons learned in pilot and research projects than by national policy (MoH 2003a:6).

The Uganda government's plan for integrated VCT service delivery has not taken into account its inability to provide additional staff. This has meant that hospitals have had to use the existing staff to offer VCT services. Understaffing in hospitals and public service as a whole is a major problem in Uganda (Asiimwe et al 2005:25). In this study, the VCT managers emphasised a lack of qualified health staff and that resources to recruit more are inadequate.

Beside the staffing problem, support supervision for VCT counsellors is also lacking. The findings indicate that even where support supervision occurs, it is not specific to counselling but generalised. Rohleder and Swartz (2005:403) found that in VCT clinics, the primary task for the nursing manager is to get a number of people tested and educated about HIV/AIDS, but for the counsellor, the primary task is to provide emotional support for the client. In such a case, performance measurement becomes complicated.

Privacy and confidentiality were ensured as essential elements in counselling in the research sites. However, the participants expressed concern that the target communities were doubtful about privacy and confidentiality. Lack of privacy and confidentiality in VCT is a major hindrance to VCT utilisation (Kipp et al 2002:705, Njagi & Maharaj 2006:120). Availability of space is also essential in VCT service delivery. Juan, Chinaglia, Lippman, Pulerwitz, Ogura and Mello (2006:6) maintain that VCT for women or families, in particular, should provide space where children can play unsupervised to minimise interruption to the counselling sessions.

Special VCT to certain populations, such as marginalised or stigmatised or even high-risk groups is an important factor in VCT utilisation. Sometimes offering specialised VCT services to certain populations, especially the youth, increases VCT utilisation

(McCauley 2004b:5). In Uganda, McCauley (2004a:6) found that youth embraced youth-friendly corners at stand-alone VCT sites.

Financing VCT services is still a major problem. In this study, the participants indicated that they would wish to hire more staff, do more VCT awareness and mobilisation. but funds were a limiting factor. Charging user fees to finance VCT services could instead be a barrier to seeking VCT services, especially for those who unable to afford them. In phase I, the respondents explained VCT as free HIV testing and education and therefore no money should be charged for VCT services. According to the MoH (2003b:11), VCT service should be considered a public health care and preventive service and, like other health services, should be free in public health facilities. In phase I of this study, the majority of the respondents (70.1%, n=89) were not willing to pay for VCT. In Tanzania, Thielman, Chu, Ostermann, Itemba, Mgonja, Mtwewe, Bartlett, Shao and Crump (2006:115) found that the periods of peak attendance of VCT corresponded with the days when testing was offered free, increasing from a mean standard deviation of 4.1  $\pm$ 2.5 clients per day in the pre-free testing period to 15.0  $\pm$ 4.8 and 7.1  $\pm$ 2.6 clients per day during free and post-free testing periods respectively. In rural South Africa, Pronyk et al (2002:862) attributed a 75% increase in clients presenting themselves voluntarily for HIV testing partly due to reductions in direct fees (user fees).

The study found that the research sites are experiencing funding problems. According to Rau (2006:295) between one-third and over a half of the populations in fourteen African states supported diverting funds to HIV/AIDS from other areas.

Single visit HIV testing, offered at hospitals, might be an incentive to testing, although some might doubt the accuracy of the results. Rietmeijer and Thrun (2006:1667) found false positives with a rapid HIV test due to operational errors as well as intrinsic problems with the use of oral fluid specimens due to cross-reacting antibodies. Nevertheless, CRHCS (2002:16) and De Cock et al (2003:1848) report that rapid testing has proven the preferred method in most settings. It is necessary to cross-check with recommended reference centres when deciding on a testing method (UNAIDS 2000:18). For this reason, too, internal and external quality assurance and control need to be adhered to.

The problems experienced with referrals have been experienced elsewhere. According to Foster-Fishman et al (1999:787), barriers are often encountered with referral systems when clients face bureaucratic red tape as they move between providers, with some refusing to release information on their clientele.

Advertising VCT services makes the services known to the target communities. Advertising may take different forms depending on the availability of funds and the target community. Advertising may increase VCT access and utilisation levels. The phase I findings indicate that the respondents who knew where VCT service was offered were more likely to test. Gage and Ali (2005:163) found that neighbourhood knowledge of a test site was one of the strongest predictors of HIV testing and especially where dissemination of information about VCT services was by word of mouth.

The demand for VCT at both research sites increased since 2006 and 2007. This, according to the VCT managers could be attributed to increased awareness of VCT service and its benefits. Knowledge of the availability of ARVs, for example, is likely to compel many to test for HIV. Karamagi et al (2006:6) report that women felt it was useless to test if they were not going to be treated in case they were found HIV positive. Realisation of HIV risk, perhaps due to increased awareness, is likely to force some individuals to testing. Sahay, Phadke, Brahme, Paralikar, Joshi, Sane, Risbud, Mate and Mehendale (2007:44) found that 73.3% of HIV test seekers reported some risk behaviour, either of their own (61.3%) or being a spouse of high-risk individual (12%).

With regard to the ideal VCT, especially among fish landing site communities like Kasenyi, who are high-risk populations, the VCT managers recommended that they be prioritised and offered more health services including VCT services. Health volunteers could be trained to offer VCT services in such high-risk communities. Harris and Larsen (2007:852) found that peer counselling relieved health professionals of the burden, and also helped peer counsellors to feel good knowing they were helping others in difficult situations. Some peers suggested that it increased their personal value, or self-worth, and gave them meaning and purpose in their lives.

Kabura et al (2006:69) refer to micro counselling. According to them, informal helpers from different professions, with different educational backgrounds, can be specially

trained in communication skills and in a variety of contexts to offer counselling services. In Kenya, peer health advocates, paraprofessionals with some experience working with health, social, or community programmes, do counselling (Cabral et al 1996:76). According to the World Fish Centre (2006:49), some of the fishermen could be given specialised training to act as peer educators and offer counselling on fishing boats.

## **5.7 CONCLUSION**

This chapter discussed the phase II data analysis and interpretation and findings. Qualitative data was obtained from the VCT managers at the two research sites, and presented as case studies. Two main themes emerged from the data, namely models of VCT service delivery at the hospitals, and factors influencing VCT service delivery and utilisation.

VCT service is generally available on-site or off-site through mobile VCT. There is an ever-increasing demand for VCT therefore the participants were of the opinion that such an increase should be matched with increased staffing levels and appropriate policy guidelines. Although the integration of VCT services with related services is good, it has put a strain on other services, because it has not been matched with funding and staffing demands. Factors influencing VCT service delivery and utilisation may be external, or internal. Barriers could also be related to negative community perceptions such as uncertainty about confidentiality and mistrust of test results.

The next chapter (chapter 6) presents the phase III data analysis and interpretation and findings.

## **CHAPTER 6**

### **Data analysis and interpretation and findings of phase III**

#### **6.1 INTRODUCTION**

This chapter discusses the data analysis and interpretation and findings of phase III: the qualitative data collected from the VCT counsellors, otherwise known as phase III participants, from both Entebbe and Kisubi Hospitals.

This phase achieved the objectives to

- establish the different VCT service delivery models available in and around Kasenyi fish landing site
- determine the extent to which a given VCT service delivery model influences utilisation patterns in the target community

#### **6.2 RESEARCH DESIGN AND METHODOLOGY**

The researcher adopted a phased approach (see chapter 3). Phase III involved collecting qualitative data from the VCT counsellors from Entebbe and Kisubi Hospitals. These two hospitals provide VCT services to populations in and around Entebbe including the Kasenyi fish landing site, studied in phase I.

##### **6.2.1 Study population**

VCT counsellors formed the study population in phase III. These are the persons who directly provide VCT services to the clients at a health facility. Besides VCT services, counsellors provide other health services in the hospital, depending on their professional qualifications. Although many of the counsellors in hospitals are trained in the medical sciences such as nursing, others may be non-medical persons. In this study, the counsellors worked at the Kisubi Missionary Hospital and the Entebbe Government Hospital.

## **6.2.2 Sampling**

The participants were selected by means of purposive sampling, based on specific predetermined criteria such as duration of employment at the hospital, in order to cover the range of issues in the study. A total of 11 counsellors were approached for interviews; 3 said they did not have time for interviews, and 1 who had accepted was called back on duty just at the start of the interviews. Finally, a total of 7 counsellors were interviewed at the two hospitals.

## **6.3 DATA COLLECTION**

The researcher used one-on-one in-depth interviews using an interview guide to collect data from the participants (see annexure D). The researcher conducted the interviews and, as in phase II, a trained research assistant was used to record the responses in writing (see annexure I). The participants were interviewed on the main issues related to the objectives of the study.

### **6.3.1 Permission to collect data**

Besides the letter of approval from the UNCST, which the researcher carried along, permission to interview participants in this phase was obtained from the hospital superintendents at the respective hospitals. Having been informed in advance, the hospital superintendents were conversant with the study and helpful in locating participants. Once the participant was located, the researcher red out the consent form (see annexure A), emphasising the purpose of the study and the rights of the participants.

### **6.3.2 Interview guide**

An interview guide with guiding questions was used to collect the data (see annexure D). Items on the interview guide included the participants' background, selection, and training; the nature of counselling offered; when and how done, and the challenges faced. Probes were used in order to solicit additional useful information.

### **6.3.3 Conducting the interviews**

Informed consent was obtained from each participant before the interview. A total of seven participants were interviewed, by which time data saturation was achieved, meaning no new information emerged from the data (Ibale 1998:28, Pickering, Okong, Ojwiya, Yirrell & Whitworth 1997b:496). All the interviews were conducted in English, as this was the participants' preferred language. The interviews lasted an average of forty-five minutes

### **6.3.4 Transcription of interviews**

At the end of the interviews, all the data obtained was transcribed and captured on computer using Microsoft Word 2003.

## **6.4 DATA ANALYSIS**

Data analysis commenced simultaneously with data collection, and continued after fully transcribing the interviews. Three main coding methods were used in the analysis, namely open, axial, and selective coding (Strauss & Corbin 1998:54). Salient issues related to VCT service delivery and utilisation slowly emerged from the data to form themes and sub-themes (see table 6.1). A literature control was done, using sources related to the VCT service delivery model, which includes the settings, resources and the general environment in which VCT is provided. Creswell (2004:11) argues that in qualitative research, literature should be used in a manner consistent with the methodological assumptions of the research paradigm, and should be done inductively.



**Table 6.1 Emerging themes and sub-themes**

<b>Theme</b>	<b>Sub-themes</b>
1. Aptness of VCT counsellors	<ul style="list-style-type: none"> <li>• Selection of counsellors</li> <li>• Counsellor training</li> </ul>
2. Models of offering VCT services	<ul style="list-style-type: none"> <li>• Individual counselling</li> <li>• Group counselling</li> <li>• Couples' counselling</li> <li>• Family counselling</li> <li>• Special populations' VCT</li> <li>• Mobile VCT services</li> </ul>
3. Institutional environment for counselling	<ul style="list-style-type: none"> <li>• Support supervision</li> <li>• Counselling aids</li> <li>• Institutional pressure</li> </ul>
4. Factors likely to affect client satisfaction	<ul style="list-style-type: none"> <li>• Pre and post test counselling</li> <li>• Information sharing during VCT sessions</li> <li>• Waiting time at VCT sites</li> <li>• Test results</li> <li>• Clients' anxiety</li> <li>• Privacy and confidentiality</li> <li>• Tailoring counselling</li> <li>• Counsellor burn-out</li> <li>• Counsellor attitudes</li> </ul>
5. The ideal VCT service	<ul style="list-style-type: none"> <li>• Increasing accessibility and acceptability</li> </ul>

The data was organised and presented according to the major themes and sub-themes presented in table 6.1. Where possible, direct quotes from the participants were presented as well as the relevant literature. For the purpose of confidentiality and anonymity, individual participant identifiers were used instead of their names.

## **6.5 PARTICIPANTS' BACKGROUND**

All 7 participants interviewed at Entebbe and Kisubi Hospitals were females, and it was established later that all VCT counsellors at the two hospitals were females. Almost all the participants, except one, had background training in the medical sciences and 4 had worked in the respective hospitals for more than five years. The youngest participant was 28 years old while the oldest was 54, giving an age range of 26 years. The average age was 40.2 years (see table 6.2).

**Table 6.2 Participants' background**

Participant identifier	Gender	Age	Background professional training	Years in VCT counselling
Participant 1	Female	54	Midwife	> 5 years
Participant 2	Female	28	Midwife	3 years
Participant 3	Female	47	Nurse/Midwife	> 5 years
Participant 4	Female	33	Midwife	2 years
Participant 5	Female	49	Nurse/Midwife	> 5 years
Participant 6	Female	32	Enrolled Nurse	4 years
Participant 7	Female	39	Administration	> 5 years

## 6.6 THEME 1: VCT COUNSELLORS' APTNESS

The participants' aptness was one of the main themes that emerged during data analysis. This theme examined how qualified the participants were to offer counselling services, their ability and willingness to offer the services at their respective sites. Two sub-themes emerged in this theme, namely counsellor selection and counsellor training (see table 6.3).

**Table 6.3 Participants' aptness**

Theme	Sub-theme
Aptness of VCT counsellors	6.6.1 Selection of VCT counsellors 6.6.2 Counsellor training

### 6.6.1 Selection of VCT counsellors

The selection of the counsellors to be involved in voluntary counselling and testing emerged as a sub-theme, which gave an insight into how the participants became involved in offering counselling. VCT services were introduced into the hospitals in early 2003 and the existing staff was selected to offer counselling services. All the participants stated that their selection as counsellors was based on the fact that they interacted with patients at several points – in- and out-patient – and therefore had the opportunity to counsel clients. The VCT counsellors did not apply to do counselling, but rather happened to be working in the departments when and where VCT services were introduced.

Integration of VCT services into the existing services meant that health workers were obliged to offer VCT services in their departments. According to a participant:

*Now that HIV/AIDS services have been integrated into many of the existing services, it is inevitable to give counselling.*

Integration of services emerged as a meaning unit. This is where VCT services are usually provided along with other routine health services, usually reproductive health services, but provided by trained counsellors, who in most cases are nurses (Asiimwe et al 2005:2). A meaning unit is a word or the collection of words or statements that relate to the same central meaning, or a word that has some connotations (Graneheim & Lundman 2003:106).

### **6.6.2 Counsellor training**

All except one of the participants had background training in the medical sciences. Despite this, they all had to go through formal counselling training. The AIDS Support Organisation (TASO) trained those who trained in the early 1990s. They pointed out that the training at that time was very vigorous and lasted over six months whereas those who trained in the 2000s were trained by the AIDS Information Centre (AIC) and the training was less vigorous, often lasting one month but with follow-up supervision. Generally, all the participants had received adequate training, although some noted that supervision while at work as part of training was not happening as expected, possibly due to limited resources for supervision.

Both TASO and the AIC are accredited by the Uganda Ministry of Health to train VCT counsellors. According to the MoH (2005:4), counsellor training generally has four phases:

- HIV/AIDS, family planning, sexually transmitted infections (STIs) and tuberculosis (TB) as well as communication and counselling skills
- practical training
- trainee supervision while at work
- a one-week training course, which covers advanced counselling skills

However, some specialised institutions like TASO offer more skills in patient care and treatment. In Uganda, Asiimwe et al (2005:21) found wide variations in the training received across the three integrated areas of VCT, PMTCT and ART.

Follow-up training, sometimes referred to as refresher training, emerged as a meaning unit. The participants mentioned they had undergone follow-up training, commonly known as refresher training, some as many as five times. At both hospitals, the participants indicated that whenever there was a new project that involved VCT, refresher training was offered as an internal activity. Externally, the MoH frequently conducts counsellor workshops often lasting three days.

*When the Ministry [Ministry of Health] gets funds, they organise refresher courses and invite us for training but, as you know, because we are few staff, not all of us can go at the same time.*

Follow-up training is in line with the MoH recommendation. Furthermore, counsellors should undergo follow-up trainings to ensure quality in counselling (MoH 2003b:7).

**6.7 THEME 2: MODELS OF OFFERING VCT SERVICES**

During data analysis, the model of offering VCT at Kisubi and Entebbe Hospitals was identified as one of the major themes. The participants constantly compared different modes of counselling. It was clear that different modes of VCT counselling services were available at both Entebbe and Kisubi Hospitals. Table 6.4 lists the themes and sub-themes that emerged.

**Table 6.4 Modes of offering VCT services**

Theme	Sub theme
Models of offering VCT services	6.7.1 Individual counselling
	6.7.2 Group counselling
	6.7.3 Couple counselling
	6.7.4 Family counselling
	6.7.5 Special populations VCT
	6.7.6 Outreaches/mobile VCT

### **6.7.1 Individual counselling**

At both research sites, the commonest approach to VCT counselling was individual counselling. In this approach, individuals go through pre- and post-test counselling alone. This form of counselling is also referred to as one-on-one counselling. According to the participants, ideally, every individual who accesses VCT services should have a one-on-one session, especially during post-test counselling.

*You would be mad to call a group of clients, stand in front of all of them and begin reading out: for you, you are positive; you are negative, and so on. Can you imagine the commotion that you would cause?*

This emphasised the importance of individual counselling, especially during the post-test counselling sessions. In phase I the findings indicated that 63.3% of the respondents had received counselling as individuals. According to Cohen et al (1992:729), everyone being tested should have the opportunity for individual post-test counselling.

### **6.7.2 Group counselling**

The participants talked about their experience with group counselling, and had all been trained in group counselling. At both hospitals, pre-test counselling was sometimes offered to a group, depending on how many clients were available, although it was noted that when receiving results, individuals received their results separately, unless they asked to receive them together as in the case of couples or family VCT. In phase I, only 5% of the respondents indicated that they had received counselling as a group.

It was established that although group counselling offers VCT to several people at the same time, it poses serious challenges with regard to group dynamics. Some individuals do not want to speak out at all, however much one tries to get them to speak while others want to dominate the discussion, often talking endlessly. According to a participant:

*In a group, getting the silent ones to talk is difficult, while silencing the talkative ones earns you enemies. It is a delicate balance a counsellor has to keep.*

With regard to measures in place to deal with group dynamics, the participants indicated that when there were many clients, groups were formed according to gender or even estimated age to minimise negative group dynamics.

The group dynamics that occur with most groups are significantly different, especially if their social, economic and demographic backgrounds differ (Cohen et al 1992:729). The Uganda VCT policy provides that in situations where resources (especially the number of available counsellors) are limited, group counselling can be offered in order to maximise the number of people having access to VCT, but emphasises that HIV test results should not be given in a group but to individuals (MoH 2003b:6).

Group counselling may sometimes provide a favourable environment for accepting HIV testing. In India, Gupta, Lhewa, Viswanath, Jacob, Parameshwari, Radhakrishnan, Seidel, Frenkel, Samule and Melvin (2007:193) found that of 215 mothers attending antenatal services who were offered group counselling, 210 (97.6%) accepted HIV testing. Gupta et al (2007:193) attributed this to the value of group assimilation, which could have influenced some who would have otherwise have declined testing.

### **6.7.3 Couples' counselling**

The data indicated that clients were increasingly testing as couples. The participants indicated that offering couples VCT was the best way to offer VCT to individuals in sexual relationships, especially in a country where HIV transmission was still largely through sexual transmission. The participants at least one or two couples received VCT every week, many of who received concordant HIV negative or positive results, although discordant results sometimes occurred.

The major challenge in couple counselling mentioned were cases of those who received discordant results:

*Oh my, the worst time in couple counselling is when couples receive discordant results! You first deal with partner blaming and potential of violence, especially if a woman is the one who is HIV positive, then go on to explaining the reasons, some of which are too scientific for the clients to understand. You can even spend two hours just explaining.*

The participants mentioned that they occasionally had to consult other counsellors on how to help the couple cope with their results. With the consent of the couples in question, a counsellor may call in a fellow counsellor to join in the discussion. The most demoralising event mentioned by participants was when after all the various efforts have been made to explain and counsel on the need for protected sex, the couples make a conclusion that since the HIV negative partner has not been infected despite having unprotected sex, it actually means one is resistant to HIV infection and thus no need for further protection when having sex. This commonly happens when a man is positive and a woman is HIV negative.

*Others tell you they must have babies even if it means getting infected with HIV.*

This was a major challenge in counselling, where, despite information given and the need to remain HIV negative, clients still feel they can continue with unprotected sex, in the hope that HIV transmission will not occur. Bunnell et al (2005:1006) found difficulties in counselling discordant couples in Uganda. According to the AIDS Information Centre (AIC), among the most challenging cases are couples that arrive seemingly healthy and discover they are discordant — one partner is HIV-positive, the other is HIV-negative (Alwano-Edyegu & Marum 1999:31).

In this study, the findings in phase I indicated that of the respondents who had tested at Kasenyi fish landing site, 31.7% had tested as couples, although the researcher did not establish whether they had been concordant or discordant. This was considered a positive move towards VCT as potential infections were averted. In Uganda, most couples get married without knowing their HIV status, thus increasing infections (Bunnell et al 2005:1006). In Nigeria, Uneke et al (2007:119) found that HIV infections were averted when HIV serology tests revealed HIV discordance among couples intending to marry.

#### **6.7.4 Family counselling**

Family VCT is normally carried out when children and youth are tested for HIV and because they are under age and cannot consent on their own, a family member has to consent on their behalf. Although the participants had received training in handling family VCT, most said that family VCT, especially involving children, was rarely offered at both hospitals.

Children VCT emerged as a meaning unit in the analysis. The participants indicated that family VCT involving children was another challenging form of VCT, because in some cases parents or guardians had the children tested, not for the purpose of helping them, but in order to abandon them. In most cases, clients requiring this form of VCT service involving children were referred to the Mild May Centre, a centre that has excelled in handling children's cases. Mild May Centre emerged as a meaning unit, as a centre that counsels, tests and cares for HIV-positive children. In Uganda, no form of assistance is given to children, even those orphaned by HIV/AIDS and it is becoming increasingly difficult for the care takers, who are often grandmothers, to take care of the orphans therefore some children are abandoned on the streets (Mugambe 2006:2).

According to the MoH (2005:7), HIV testing for children under 12 years should only be done with the knowledge and consent of parents or guardians, and the testing must be done for the benefit of the child.

Family VCT sometimes occurs at post-test counselling, when clients wish to share their test results with family members. At the AIDS information Centre (AIC), clients registered as individuals sometimes request to have someone else such as a family member witness their test results with them, as a way of disclosure (Alwano-Edyegu & Marum 1999:28).

#### **6.7.5 VCT for special populations**

Besides mothers who are offered VCT under PMTCT programmes, other categories of VCT clients given special attention are disabled people, rape victims, and youth. One of the hospitals has established a centre for rape victims, where they receive specialised counselling and thereafter are tested for HIV and other STIs. Special treatment, as a meaning unit, refers to giving clients priority for VCT services or even special attention



like not queuing for VCT. Bulterys, Jamieson, O'Sullivan, Mardge, Maupin, Nesheim, Webber, Van Dyke, Wiener and Branson (2004:221) found that women in labour had their HIV test results run and delivered within half the time it normally took a normal testing process.

The youth, too, are a special group because of the sensitivity involved in HIV testing such as being seen by their parents or relatives at VCT sites. The participants indicated that the youth did not want to mix with the adults during VCT. In phase II, the participants revealed that youth services were attracting many youth to HIV testing. At two clinics in Uganda, McCauley (2004b:5) found that introducing youth-friendly corners attracted more youth to VCT compared to normal clinics.

#### **6.7.6 Mobile/outreach VCT**

Mobile VCT or outreach VCT was also identified as a sub-theme in this phase, as well as in phase II (see chapter 5). The participants in phase III gave additional information with regard to their experiences with mobile VCT services. Mobile VCT services, also known as outreach VCT services, are offered at both research sites.

Besides the advantages identified in phase II, the phase III participants added that many clients are reached through mobile VCT, therefore it is a more fulfilling model of VCT service. According to a participant:

*With mobile VCT, you feel happy as a counsellor seeing as many people as possible receiving VCT.*

Getting as many people as possible receiving VCT services was therefore the wish of most of the participants, and seemed to work well with mobile VCT. According to the phase I findings, however, only 9 (15%) respondents had their last HIV test at a workplace, presumably under mobile VCT services.

The challenges of mobile VCT included the high demand for VCT in certain communities, where everyone who came expected to be served. As counsellors, the participants sometimes felt under pressure to serve everyone who came, despite going beyond the recommended number of clients to counsel per hour per day.

*When people decide to have VCT, they feel they should have it there and then, and do not even want to be promised to return the following day.*

As to how such cases were handled, the participants stated that clients who missed out on mobile VCT were given coupons to go to the hospital to receive free VCT, and once they came, they were given priority. The participants in phase III concurred with the phase II participants that sometimes privacy and hence confidentiality might be compromised in mobile VCT, especially where huge numbers come for VCT services or when using a venue with limited facilities.

*Mobile VCT can be challenging sometimes. For example, you go to a place and the best place you can get for VCT is a school or church without doors and windows. And as you give results, you see some other people trying to peep in, to see if he [VCT client] is crying or smiling. If he is crying, then they say, "Hey, that one is positive" and if they see he is smiling, they know he is negative.*

Worthington and Myers (2002:542) found that participants were very concerned about being tested in the open, for fear of other community members listening to what was being discussed. Asingwire (2004:41) found that mobile van VCT services could easily suffer from being branded as just "AIDS service". Consequently, some people might be reluctant to come forward for testing for fear of being stigmatised and discriminated against.

## **6.8 THEME 3: INSTITUTIONAL ENVIRONMENT FOR COUNSELLING**

The participants alluded to the fact that offering VCT service was sometimes influenced by the environment in which they operated. The institutional environment in which the counsellors' operate was therefore another theme identified during data analysis. This was further sub-divided into three sub-themes, namely support supervision, counselling aids, and institutional pressure (see table 6.5).

**Table 6.5 Institutional environment for counselling**

Theme	Sub theme
Institutional environment for counselling	6.8.1 Counsellor support supervision
	6.8.2 Counselling aids
	6.8.3 Institutional pressure

**6.8.1 Counsellor support and supervision**

The participants indicated that counsellor support took different forms, such as weekly meetings where previous work and challenges were reviewed, taking staff out for retreats, and being given time to attend counselling-related workshops and seminars. At one research site, weekly meetings were not common, and when they were held, they did not look at counselling issues per se but dealt with all issues affecting the hospital. These meetings were normally short due to the need to attend to patients. At the other research site, meetings were normally held to review progress, especially when VCT was being offered under a specific project. The participants mentioned no other forms of supervision.

This meant that counsellor support supervision was not standardised across hospitals and there appeared to be differences between government-operated hospitals and missionary-operated hospitals, with missionary hospitals offering more in terms of counsellor support and supervision.

*Normally, we have weekly meetings, where we sit with everyone involved and review the week’s activities and the challenges and some possible solutions. But this is common when we have special funding for VCT.*

Harrington and Harrigan (2006:109) and Held and Brann (2007:213) emphasise that counsellor support and supervision is an essential part of a counselling career. Moreover, counsellors should be offered adequate support supervision to avoid burnout, a common occurrence in VCT counselling, that affects quality of VCT services. Rohleder and Swartz (2005:404) found that some counsellors felt that senior staff members in health clinics as well as government lacked appreciation for their work as well as understanding of the needs of clients.

### **6.8.2 Institutional pressure**

The participants were of the opinion that when counselling was done as a project, there was more emphasis on numbers than the quality of counselling. According to them, a common question in project VCT services was “How many have you tested this week?” However, in regular counselling, there was no emphasis on numbers and they felt relaxed and did a better job. A participant at one of the research sites mentioned that during a home-based VCT project at their site, two teams went into the field and each had to report at weekly meetings how many clients had been counselled and tested, which was sometimes demoralising.

*If your team tested fewer patients, so you would feel demoralised, as if you are competing.*

Rohleder and Swartz (2005:403) found organisational pressure to offer VCT in a way against counsellors' preference. Counsellors complained of conflict with the nursing managers, whose concern was the number of people who needed to be tested. This indicated that the counsellors were often rushed to finish off counselling sessions. Grusky et al (2005:161) found organisational preference and pressure to provide confidential VCT (where VCT clients' identifying information is collected) whereas counsellors and clients favoured anonymous VCT (where VCT clients' identifying information was not collected).

### **6.8.3 Counselling aids**

Although many of the participants at both research sites relied on face-to-face, counsellor-client delivery of information, a few aids were provided to enhance the quality of counselling. The term IECs, namely information, educational and communication materials (IECs) that are given to clients who come for VCT services, was identified as a meaning unit. At one of the research sites, for example, pamphlets with more information on HIV prevention, care and treatment were distributed at the end of the counselling session to reinforce key messages.

*We avoid giving out pamphlets at the start of the sessions so that the clients can be attentive and listen to what the counsellor is telling them,*

*and the pamphlets come at the end just to drive the message home. When they read about what you have already told them, they tend to trust more.*

The government of Uganda normally develops materials distributed to clients although at one of the research sites, they have developed a few other materials on their own (Juan et al 2006:5). According to one of the respondents, normally, the MoH provides pamphlets with educative messages, not only about HIV/AIDS but general health as well, and clients read them at the health facilities or take some to friends and colleagues. The participants stated that clients occasionally came with very challenging questions, probably downloaded from the Internet, and want to test the counsellors' level of understanding. Counsellors therefore have to stay well informed on HIV/AIDS.

Both research sites owned video equipment, therefore educative films related to HIV/AIDS and general health issues were screened while clients waited. This is a regular occurrence in many Ugandan VCT sites. For example, in the waiting room at the AIDS Information Centre, HIV/AIDS education brochures are available for reading, health education posters decorate the walls, and a variety of HIV/AIDS and other locally produced health education videos are shown (Alwano-Edyegu & Marum 1999:26).

## **6.9 THEME 4: FACTORS LIKELY TO AFFECT CLIENT SATISFACTION**

Another theme identified during the data analysis was the counselling-related factors likely to affect accessibility and acceptability of VCT services. These were further broken down into 8 sub-themes (see table 6.6).

**Table 6.6 Factors likely to affect client satisfaction**

<b>Theme</b>	<b>Sub theme</b>
Factors likely to affect client satisfaction	6.9.1 Pre- and post-test counselling
	6.9.2 Information sharing during VCT sessions
	6.9.3 Waiting time at VCT sites
	6.9.4 Giving test results
	6.9.5 Clients' anxiety
	6.9.6 Privacy and confidentiality
	6.9.7 Tailoring counselling
	6.9.8 Counsellor burnout
	6.9.9 Counsellor attitudes

### **6.9.1 Pre- and post-test counselling**

The participants described the process right from the time clients present at reception until they leave the hospital. The process at both research sites was similar. New clients are registered and assigned a number, but if clients had been to the hospital before they present a patient card. In order to build rapport, the counsellor greets the clients, asks how they feel, and enquires about the family. Then the counsellor educates them about the test process in order to obtain their consent. Once the clients agree, they are given more information before being sent to laboratory to have blood drawn. While the test is running, usually about 30 minutes, the counsellor assesses clients' risk for HIV infection and discusses reducing HIV infection risk with them.

When the test results are ready and have been delivered to the counsellor, the counsellor first revises the meaning of different results such as positive, negative or indeterminate before giving the clients their results. If clients are negative, the counsellor's messages emphasise prevention and the need to return after three months. If the results are positive, the counsellor emphasises the need to protect others plus care and treatment options available. If the results are indeterminate, clients are given another appointment to receive confirmatory test results. This process is in line with the recommended process for VCT services in Uganda, conforming to the policy guidelines (MoH 2005:7).

The entire process normally lasts between one and one and a half hours, but clients were normally told that the entire process lasted not more than two hours. The participants indicated that the time spent at a health unit depended on the volume of clients. At the same time, the length of time spent depended on what other services the clients had come for, especially in integrated VCT service delivery.

### **6.9.2 Information sharing during VCT sessions**

The participants described different techniques to retrieve useful information from clients. The participants created a relaxed environment for the client, which included treating the client in a friendly manner, sitting face-to-face with a client and always showing signs of approval while the client was talking. Some of the participants

stressed that the best way of creating a relaxed environment and getting information from clients was to avoid blaming them for any behaviour they might be engaging in.

At both research sites, different participants used different strategies to retrieve information from clients. Some of the participants pointed out, however, that there are cases of “stubborn” clients who, in spite of all the techniques used, refused to divulge useful information and were therefore given general counselling and not counselling based on their problems and needs, sometimes referred to as client centred counselling. According to some participants:

*The training I got, we are advised to build rapport with the client, by asking him about his family, his work, how he feels. Depending on what he tells you, you crack some simple jokes, and all this gets him talking.*

*I tell you, some people come here, especially those who are looking healthy and they do not want to be asked anything. All they tell you is, “Madam, I have come to get tested and get results, why are you asking me if I have a wife, girlfriend, who I slept with etc. Please test me and I can go.” In fact, it’s a challenge.*

The type and nature of information passed on to clients during counselling sessions included but was not limited to information about HIV transmission and prevention; risk-free and safer sex options; other sexually transmitted and blood-borne diseases; the need and skills for disclosure, especially those who are married, and descriptions or demonstrations of how to use condoms correctly. Although at one research site they did not distribute condoms at the research site but only in the field, due to their religious values, they still provided information on condom use to those who came to the hospital for VCT.

Information retrieval and giving is part and parcel of VCT sessions. According to Juan et al (2006:5), besides face-to-face encounters with a counsellor, information can also be provided in a pamphlet, brochure or video. Furthermore, information should be provided in a manner appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level.

### 6.9.3 Waiting time

The length of time clients spend at VCT sites emerged as a sub-theme. The entire process of VCT services may take between one and one and a half hours. The participants had mixed reactions on whether the waiting time was too long, short, or just appropriate. A participant noted:

*We need to give enough education to the client, prepare him for his results, and so the time is very appropriate, it's not too much time, but just enough.*

While some of the participants maintained that the waiting time was ideal and only seemed long for the clients due to anxiety, others stated that when there was a high turnout for VCT services, clients sometimes had to wait for up to three hours before receiving their results:

*There are times when, for example, too many mothers delivering come and we have to deal with those first and so VCT clients may wait slightly longer.*

The VCT managers also indicated that VCT clients always wanted to spend as little time at the VCT centres as possible. However, the integration of services without necessarily having additional staff frequently means long waiting times. Asimwe et al (2005:7) found staff shortages due to integration of VCT services in Uganda.

### 6.9.4 Test results

Another sub-theme identified was test results. With regard to giving test results, the participants at both research sites praised the move to same-day testing because it had several advantages. Rapid testing emerged from the data as a meaning unit. According to the participants, all clients who were tested could now receive their results without the need to come back and there was no loss of follow-up. This, in turn, saved funds for both the organisation and the client. For the organisation, funds for testing were not wasted on clients who did not return while for the clients, they did not spend money on transport twice. Moreover, the possibility of engaging in risky sex while waiting for test



results had been eliminated. Therefore couples who came in for testing just days before their wedding could have their results immediately.

The participants described their experiences with different test results. According to them, delivering a negative HIV test result was the best moment in counselling. However, when it came to giving HIV-positive results, it became complicated as they were sometimes surprised by the clients' reactions, even though some were anticipated. The most common reactions were anger and blaming either self or the sex partner for the infection. One of the participants described her experience when she gave positive results to a client:

*When the results were brought to me, the gentleman was full of joy, expecting a negative result. But I took him back to the basics of what results to expect, and what he would do and he gave a good response. Oh my God, the moment I gave him the positive result, I thought the man was going to strangle me! He quickly stood up and said, "Foolish!", and off he ran. I tried calming him but he was gone, just in a second.*

Pugh, Ramsay and Catalan (1994:6) found that patients' reactions to HIV testing included anxiety, denial, anger, despair, and sometimes thought of suicide.

Another big challenge with results, basically due to rapid single visit testing, is a situation when clients receive indeterminate results and are asked to come back for another test, usually a month later. The participants pointed out that this normally raised a lot of questions and many clients felt that the counsellors were afraid to tell them that they were HIV positive. Some of the participants emphasised that the issue of indeterminate results was not good for the community in that it caused mistrust of all test results. In Uganda, Kipp et al (2002:702) found that some people believed that HIV-infected persons were intentionally given negative results by the counsellors so as to avoid bad consequences such as committing suicide or deliberately spreading HIV/AIDS.

### **6.9.5 Clients' anxiety**

Another challenge mentioned at both research sites was anxiety while clients waited for their test results:

*The moment blood is drawn for HIV testing, that's the time reality sets in and the client begins reflecting all about his behaviours, major or minor, and begins imagining himself living with HIV/AIDS.*

This anxiety, according to the participants, makes communication very challenging, in that when the counsellor is preparing a client for the results, the client is often preoccupied and has to be reminded:

*The time before you give results, you often see a client looking at you like a picture and often have to repeat every statement and even responses being given become uncoordinated.*

This indicated that being tested for HIV raises a lot of anxiety. As to the cause of anxiety, some participants attributed it to the anticipation of a positive test result, which might pose challenges such as disclosure, complete change of lifestyle and sense of guilt. In India, Sahay et al (2007:45) found the likelihood of anxiety, depression and distress among 65 HIV-infected individuals ranged between 49.2% and 55.4%.

Anxiety may be a barrier to seeking VCT services. Admassu and Fitaw (2006:26) found that anticipation of a positive result was commonly accompanied by negative consequences such as depression and anxiety and possibly stigma.

### **6.9.6 Privacy and confidentiality**

Privacy and confidentiality emerged as a sub-theme. The participants at both research sites indicated that clients' privacy and confidentiality was key to VCT service delivery. Waiting areas at both hospitals shielded clients from the rest of the waiting patients or visitors. Although confidential counselling as opposed to anonymous HIV testing was offered at both research sites, confidentiality was nevertheless ensured. At both research sites, although their names are recorded, VCT clients are given numbers and

the numbers rather than names used when calling them into the waiting or counselling room. According to Asingwire (2004:41), in confidential HIV testing, clients' names and contact addresses are obtained for future follow-up whereas in anonymous testing, clients would be tested without necessarily knowing their names or contact information, as the only information the hospital retained was their number.

The participants indicated that clients sometimes did not give their actual names and during the testing process, they forgot the names they had given. At the same time, a few who test under false names sometimes give their actual names after they have received negative HIV results:

*One time I counselled a man and after giving him his negative results, he burst out in praise and started asking for forgiveness for having lied to me his name and contact information, and so we had to fill in another form.*

Regarding how such situations were handled, the participants reported different approaches. At one research site, most of the participants said they repeated some of the major points of the counselling session, and tried to find out more about the clients' demographic characteristics. At the other research site, a few of the participants said they just corrected the name and address while others indicated that it was a very annoying situation and sometimes they just left it at that.

The participants at both sites indicated that they had encountered accusations of breach of confidentiality. Several of the participants admitted that they often received requests from third parties, asking to know the HIV test results of certain clients. Furthermore, this was very common in sexual relations where for example a wife tested for HIV and a husband happened to know but feared to ask the test results from the sex partner, or if he did ask, the wife refused to reveal the results, telling him to go and find out from where the test was done. In addition, when some clients are told the results, they still want to prove that their spouse received a negative or positive result and therefore confronted the VCT centres asking for their sex partners' HIV test results. According to one participant:

*A man came here sometime ago asking me for the results of his wife and I told him I do not know his wife and cannot tell whether she tested or not, and even if I knew, I am under obligation not to tell. But he insisted and even wanted to bribe me with money, but still I refused because I have to adhere to confidentiality.*

This was an example of where sexual partners fear to test on their own, and would rather learn of their own HIV status through their spouses' HIV test results. Clients have been found to accuse health workers and particularly VCT counsellors of breaching confidentiality (Fylkesnes & Siziya 2004:568; Van Dyk & Van Dyk 2003:5). Njagi and Maharaj (2006:120) emphasise that unless clients are assured of privacy and confidentiality, use of VCT services may be lower than expected.

### **6.9.7 Tailoring counselling**

The participants stated that they normally tried to tailor counselling to clients' background conditions although in certain instances, this might be difficult. For example, although the majority of VCT clients coming to the research sites for VCT services spoke either English, Luganda or Runyakitara, in which most of the counsellors are fluent, there were isolated cases of less common languages. In such cases, some of the participants stated that an interpreter would be sought and if not available, the client might be referred to another testing centre, after ascertaining that they were able to assist him/her. The participants indicated they had no problems with religious or cultural differences of the clients although they always endeavoured to establish a client's background and to tailor messages as far as possible to the client's background.

The findings from the phase I respondents indicated that Luganda was the language most used by the residents (83.5%) followed by English (6.3%), Runyakitara (6.3%) and Lusoga (3.9%). The VCT counsellors were fluent in these languages. According to the CDC (2006:8), in order to maximise access and utilisation of VCT services, the service should be tailored to the client's culture, language, sex, sexual orientation, age, and developmental and educational level, as these factors could affect how the client seeks, accepts, and understands HIV services. Juan, Chinaglia, Lippman, Pulerwitz, Ogura and Mello (2006:6) emphasise that language should be appropriate to the culture,

educational level and beliefs (spiritual and traditional) of the client. Striley, Margavio and Cottler (2006:51) found that counsellor-concordant (same race and sex) respondents were more likely to desire matched-counsellors than discordant. However, the CDC (2006:18) does not support an explicit risk-reduction need or benefit to matching clients with counsellors based on same or similar backgrounds such as sex, ethnicity or age.

### **6.9.8 Counsellor burnout**

Counsellors experience forms of burnout related to doing VCT counselling. Almost all the participants admitted having had emotional stress with some clients who told them about their life experiences, especially those who tested positive. According to the participants, this situation was worse if the counsellors knew them:

*When I see someone I know, I normally do not counsel that person but pass him on to my colleague. Even when we meet our clients out there in the community, we try as much as possible to avoid them unless they themselves initiate the contact.*

Some of the participants said they experienced emotional stress whenever they dealt with young adolescents who were sexually abused and they felt that they could not help due to confidentiality:

*Sometimes a young girl comes here for VCT and tells you she is being sexually abused by an uncle, and you want to help but you can't due to confidentiality issues.*

Several of the participants at both research sites indicated that they did not like counselling someone they knew. Kipp et al (2002:702) found that counsellors should be non-residents of the area, as non-residents were considered more credible and would offer greater confidentiality than residents. The World Fish Centre (2006:49) nonetheless recommends peer-to-peer counselling. According to Held and Brann (2007:213), sources of stress may include VCT clients' giving more or less information than needed and the need for counsellors to be empathetic to clients.

### **6.9.9 Counsellor attitudes towards counselling**

The participants generally felt happy about counselling for VCT. Some indicated that the reason for this was that they did not do counselling per se on a daily basis but combined it with other hospital duties. For the medical workers involved in counselling, counselling was often done on a rotational basis, meaning that each of the nurses had two or three days on which to do counselling and spent the rest on other hospital duties. All the participants stated that they felt the joy of counselling when they counselled clients and they accepted to have VCT services, especially mothers coming for PMTCT or family planning services.

This study found that all the participants concurred that their work was well respected and recognised. In South Africa, however, Rohleder and Swartz (2005:401) found that counsellors had a strong feeling that they were not appreciated or given due recognition by the government using terms such as a “lay” counsellors to denote non-professional. This could affect counsellors’ self-esteem and result in poor quality VCT services. Rohleder and Swartz (2005:401) found that counsellors pointed out that the term “lay counsellor” was synonymous with being lazy, uneducated, and doing “dirty work” with emotionally stressed people.

### **6.10 THEME 4: THE IDEAL VCT SERVICE**

The ideal VCT emerged as a major theme because the participants referred to what they felt should be the best way to provide VCT services. The sub-themes identified related to ways and means of increasing accessibility and acceptability of the services. The theme relates to what would be the ideal situation that would promote accessibility and acceptability of VCT services. This theme partially answered the objective to *“formulate strategies to improve VCT service delivery and utilisation among fishing communities”*.

The participants described possible ways of making VCT service more accessible and acceptable in general and to fishing communities like Kasenyi fish landing site in particular. The participants generally felt that there was a need for more education on the importance of VCT services. According to the participants, the time spent on counselling clients would be reduced if the clients were well educated and informed

about the service. Like the participants in phase II, the participants in this phase called upon the government to hire more health workers so that they, in turn, could have more counsellors. In the light of limited funds to hire more staff, the participants suggested training community volunteers in counselling in order to provide pre-test counselling. Clients would then come to the hospital for testing and post-test counselling, which would take less time.

The participants made suggestions to increase VCT service accessibility and acceptability between fishing communities, and particularly Kasenyi fish landing site. Some of the participants stated that all fishing villages needed a health centre within the community, so that residents could have VCT services within easy reach and could use the VCT services whenever they wished. One of the participants emphasised this, indicating that the decision to test may be spontaneous:

*The decision to have VCT sometimes is a spontaneous one, and so if someone wakes up and wants to have VCT, he should have it there and then.*

Preventive services are not an emergency situation. In the case of VCT services, however, there could be a sudden urgent need for VCT services and if individuals do not obtain the service at that particular time, they will forget about VCT services. In this study, findings in phase I indicate that among the 60 respondents who had tested for HIV, 12 (20%) had indicated they did not have any specific reason for taking an HIV test. This could be equated to spontaneous HIV testing. In Tanzania, Maman et al (2001:599) found that men might decide to take an HIV test just because they saw it being offered, not necessarily having to think deeply about it.

## **6.11 CONCLUSION**

This chapter presented a brief methodological approach including sampling, and data collection and analysis for phase III. The themes and sub-themes identified during the data analysis were discussed.

The participants indicated that they took care and time to offer VCT services, trying as much as possible to understand clients' background, retrieving the necessary

information from clients and passing on the appropriate information to help the clients. The participants offered VCT services together with other health services in the hospitals, which meant that VCT service was integrated in the health services. Almost all the participants had background training in medical sciences and due to the nature of their training, including follow-up training, the participants maintained that the quality of counselling offered to clients was good and adequate.

The major challenges the VCT counsellors met included dealing with clients' anxiety shortly before receiving HIV test results, dealing with discordant couples, especially when the infected partner was a female, and dealing with clients with indeterminate results. Other challenges included big turnouts of individuals requiring VCT services, especially during mobile VCT service, and they had to turn them away. Suggested ways of solving some of these problems related to increasing the human resources and establishing health centres in places of dire need, such as in the fishing villages.

The participants indicated that they experienced emotional stress arising from the nature of their work, and this might compromise the quality of VCT services. However, the participants generally received little support supervision and rarely had meetings to review counselling issues. Offering VCT services on a rotational basis helped relieve the stress. Most of the participants were very appreciative of their work despite the challenges.

Chapter 7 summarises, discusses, compares and contrasts the findings in phases I, II and III. Strategies to increase accessibility, acceptability and utilisation of VCT service are also presented.



## CHAPTER 7

### Conclusions and strategies for increasing VCT service delivery and utilisation

#### 7.1 INTRODUCTION

This chapter presents strategies for increasing VCT services accessibility, acceptability and utilisation. The strategies design was based on the study findings, the literature review and input from a selected team of experts who reviewed and advised on the strategies. The ultimate aim of the study was to formulate strategies for VCT service delivery targeting the fishing communities at Kasenyi fish landing site. This chapter, then, achieves the objective to *“Formulate strategies to improve VCT services delivery and utilisation among fishing communities”*. Before presenting the strategies, the major findings in phases I, II and III are compared.

#### 7.2 CONCLUSIONS OF KEY FINDINGS

The study was exploratory, descriptive and explanatory and involved three phases. Phase I involved quantitative data collection and analysis and findings from the Kasenyi fish landing site communities (see chapter 4). Phase II involved qualitative data collection and analysis and findings from the VCT managers at two hospitals (see chapter 5). Phase III involved qualitative data collected from the VCT counsellors at the same hospitals (see chapter 6).

##### 7.2.1 VCT service delivery

VCT service is provided at the hospital sites as part of an integrated model. According to the findings from phases II and III, VCT service is available either on-site, mainly in the form of integrated VCT services, or off-site. VCT service is integrated into the main services at the hospitals, such as the PMCT, ART and family planning services.

Off-site VCT service is provided through what is commonly termed mobile or outreach VCT services, by which services are literally taken to the people. Individuals, who might not visit hospitals, are offered an opportunity to access VCT through mobile VCT. According to the VCT managers in phase II, mobile VCT service is sometimes provided at workplaces, markets and churches, or can be home-based VCT provided in clients' homes or VCT provided by a hospital but using lower health units (see chapter 5, section 5.5.2).

Special VCT programmes are provided for certain vulnerable populations. This eases VCT accessibility for the special populations, such as the youth. For example, youth-friendly VCT services appeared to be attracting more youth to HIV testing (see chapter 5, section 5.4.1). Among the respondents in phase I who had tested for HIV, the majority were single and young (see chapter 4, section 4.4.2).

Asking clients to test for HIV while at health facilities, also called provider-initiated VCT service, is one of the means of getting individuals to test. It is practical and a welcome idea to potential VCT clients as long as it goes hand in hand with counselling and confidentiality. According to the VCT managers in phase II, whenever individuals visited a hospital, they were asked if they could be tested for HIV and although some refused, the majority tested, especially pregnant mothers (see chapter 5, section 5.5.3).

### **7.2.2 VCT service utilisation**

Although a wide range of avenues for VCT are available, not everyone in the target community had tested for HIV. VCT service was not well utilised by the target communities. The findings from the Kasenyi fish landing site in phase I indicated that of the 127 respondents, only about half, 47.2% of the respondents had tested for HIV (see chapter 4, section 4.4.2).

Although men and women were equally likely to test for HIV, unmarried individuals were more likely to test compared to married ones. In addition, younger age groups were likely to test for HIV. Based on the phase I findings, among those who were single (not married), 64% had ever had an HIV test while among those aged 20-24, 61.9% had ever tested for HIV (see chapter 4, section 4.4.2).

Mobile VCT services have the advantage of accessing many VCT clients at the same time. However, this form of VCT service delivery presents several logistical challenges. Their huge resource requirements and compromised privacy and confidentiality are likely to affect their success. The VCT managers in phase II noted that although mobile VCT yielded increased accessibility to many clients, it posed challenges in terms of cost, human resources requirements and transport. There was also a possible lack of privacy and confidentiality, especially in community VCT, due to lack of proper venues for testing. The managers also indicated that there was low turnout at mobile VCT sites, which could be attributed to lack of confidentiality and poor mobilisation of the community to participate in VCT service activities (see chapter 5, section 5.5.2).

Despite the above, the VCT counsellors in phase III preferred mobile VCT services because mobile VCT provided an opportunity for many clients to come for testing at the same time (see chapter 6, section 6.7.6)

Individuals who had visited hospitals and been asked by health workers to test for HIV had received VCT. This helped individuals to access VCT, which they would otherwise not have had. The phase I findings indicated that among the respondents who had tested for HIV, 25% had been asked to do so. Nonetheless, they were subsequently happy to have tested and received results (see chapter 4, section 4.4.4).

Discussing HIV/AIDS-related issues with someone, especially a sexual partner or colleague would likely lead individuals to access VCT services. Among the phase I respondents who had tested for HIV, 81.9% had discussed HIV/AIDS-related issues with a sex partner (see chapter 4, section 4.5.1).

### **7.2.3 Information provided during counselling**

Counsellors endeavour to retrieve useful information from clients as well as pass on relevant and adequate information during counselling sessions. Besides face-to-face interaction, information is provided to clients during counselling by other means such as pamphlets and flyers. The VCT counsellors in phase III indicated that they listened attentively, motivated clients to give more relevant information and respected clients' concerns, all of which were primarily aimed at providing appropriate assistance to clients, which, in turn, would probably reduce HIV risk (see chapter 6, section 6.9.1). Of

the respondents in phase I, the majority (98.3%) were satisfied with the information given during counselling sessions. The counsellors also noted the importance of keeping up to date with the latest information on HIV/AIDS (see chapter 4, section 4.4.11).

Change in lifestyle and ultimately behaviour change that would reduce people's risk of acquiring HIV infection is the intended outcome of VCT services and these are normally stressed during counselling. The VCT counsellors in phase III indicated that during counselling sessions, change in lifestyle to avoid HIV/AIDS (for those uninfected) or to avoid spreading the virus (for those infected) was emphasised (see chapter 6, section 6.9.1). The findings from the respondents in phase I likewise indicated that of those who had had VCT, 68.3% reported a change in lifestyle after VCT, although this study did not measure whether this change would be maintained over time (see chapter 4, section 4.4.13).

#### **7.2.4 Trends for VCT service utilisation**

Both VCT service use and the demand for the services increased over time (see chapter 4, section 4.4.7). This could be partially explained by the fact that most people testing at hospitals were highly suspicious of having been infected with HIV and were only seeking treatment services. The VCT managers in phase II indicated that clients asking for VCT services believed they were already infected and were only coming to confirm their HIV-positive status and thus access ARVs (see chapter 5, section 5.5.1).

The increasing demand for VCT services was not matched by an increase in quantity and improved quality of services as well as the required resources. The VCT managers in phase II and counsellors in phase III expressed concern about the serious staff shortages for offering the services. To them, this had been worsened by integration of services. For example, 30% of the respondents in phase I reported spending long times at VCT centres (see chapter 5, section 5.5.1 and chapter 6, section 6.9.3)

## **7.2.5 Preferred sites for VCT**

Testing at a health facility appeared to be the most preferred site for HIV testing. Among the respondents in phase I who had tested for HIV, the majority (81.7%) had done so at a health facility, which in most cases was a hospital. When all the respondents (whether previously tested for HIV or not) were asked about their future testing preference with regard to testing site, the majority (50.4%) indicated they would prefer having their test done at a health facility (on-site VCT) as opposed to being tested by mobile VCT (see chapter 4, sections 4.4.8 and 4.5.2).

Trust of results and perceived benefits from testing at a health facility are likely to be the reasons individuals prefer testing at a health facility. Besides the phase I respondents' trust of results at a health facility, their preference for a health facility could be related to the wide range of HIV/AIDS-related services offered, especially if people tested HIV positive. According to the VCT managers in phase II, it was only when clients perceived the immediate benefits of accessing VCT services (such as ART if they test HIV positive) that they went to be tested. The VCT managers also referred to mistrust of field results, for example during home-based VCT where "simple" tests were used, but were doubted by clients (see chapter 5, section 5.5.2).

## **7.2.6 Factors affecting VCT accessibility, acceptability and utilisation**

The factors that affected VCT service delivery and utilisation were summarised according to the three levels in the health services delivery and utilisation framework, namely macro, meso and micro level (see chapter 2, section 2.2.1).

### **7.2.6.1 *Macro level***

The macro level involved analysis of the large-scale social systems involved in VCT delivery such as government policies and guidelines. At the same time, funding for VCT service is largely determined at the macro level. Accordingly, at macro level, access to health services has been considered mainly in a political context, where governments have the power and mandate to direct healthcare systems through health policy. (Aday & Anderson 1974:213; Aday & Awe 1997:505; Murray & Elston 2005: 703-705; Wynne 2003: 98-103)

➤ ***Inadequate VCT guidelines***

Although VCT service utilisation trends are changing, they are not equally matched by policy adjustments. This is likely to hamper service delivery. The VCT managers in phase II held that current VCT policy guidelines were not adequate for VCT service delivery at the present time. The VCT counsellors in phase III felt that the guidelines were not applicable to all the situations they dealt with. The VCT counsellors cited the example of minors being required to have a parent's or guardian's consent in order to be tested for HIV, which could be difficult (see chapter 5, section 5.5.1 and chapter 6, section 6.9.1).

➤ ***Poor funding for VCT services***

Financing VCT services remains a major problem. For example, the VCT managers indicated that they would wish to hire more staff, and do more VCT awareness and mobilisation, but funds were a limiting factor. Charging user fees to finance VCT services could be a barrier to seeking VCT services, especially for those who could not afford to pay. When asked to explain VCT, the phase I respondents described it as "free HIV testing and education" and therefore no money should be charged for VCT services (see chapter 4, section 4.3.4).

➤ ***Poor referral systems***

Comprehensive service delivery appeared to work well in an integrated system, with opportunities for making internal referrals. However, poor follow-up of external referrals could reduce client satisfaction and hence utilisation. According to the VCT managers in phase II, there was no effective external referral system for cases which the hospitals could not handle, and even when referrals were made, there was no follow-up to know that the referrals had actually happened (see chapter 5, section 5.5.2).

### ***7.2.6.2 Meso level***

The meso level focuses on organisations, for example health facilities that provide VCT services. It considers the health delivery system as those arrangements for the potential

rendering of care to consumers, which mainly involve the available resources and the structure of the organisation (Darmody et al 2007:40).

➤ ***VCT counselling modes***

When being counselled for HIV testing, clients were mostly counselled as individuals during pre- and post-test counselling. However, some clients were offered pre-testing as a group or were given both pre- and post testing as couples. Although challenging, the VCT counsellors found couples' VCT rewarding as it rendered immediate disclosure of HIV status between couples. According to the findings from the phase I respondents, among those who had tested, 63.3% had received counselling as individuals, 31.7% had received results as couples, and only 5% had received counselling as a group. Some of the counsellors in phase III pointed out that receiving VCT as couples would eliminate cases of sexual partners going to VCT centres to ask for partners' HIV test results. Although most of the counsellors in phase III reported that couples' counselling was beneficial, HIV-discordance remained a big challenge to both counsellor and clients, as it required special counselling skills, without which some HIV-discordant couples would be isolated by their own test results (see chapter 6, section 6.7).

Counsellors at the research sites appeared to be matched with their target population, especially with regard to the common languages used by the respondents in phase I and those used by the counsellors. This would ease communication between clients and counsellors. The findings from phase I indicated that the commonly spoken language was Luganda (83.5%), followed by English (6.3%) and Runyakitara (6.3%). Likewise, the VCT counsellors in phase III indicated that they were fluent in those three languages and did not experience any language barrier with their clients (see chapter 4, sections 4.2.3, 4.4.11 and chapter 6, section 6.9.7).

➤ ***Limited staff for VCT services***

The study found a shortage of VCT counsellors at the hospitals. In addition, the few available were required to offer a wide range of other health services in the same environment. This could affect the quality of VCT services provided and be a barrier to accessing VCT services. For example, the VCT managers in phase II indicated that counsellors were sometimes called for emergencies while counselling clients, and

therefore had to temporarily abandon VCT clients. Both the VCT managers (phase II) and VCT counsellors (phase III) suggested that community volunteers be identified and trained to offer counselling (see chapter 5, sections 5.5.1 and 5.6 and chapter 6, section 6.8).

Volunteer VCT counsellors should be readily available in the communities with education moderate levels. For example, about half (51.2%) of the respondents in phase I had obtained secondary level education and another 9.4% had obtained tertiary level education (see chapter 4, section 4.2.4).

➤ ***Compromised VCT quality***

Ensuring quality of VCT services should be key to VCT service delivery. This would ensure trust in the test results. False results were extremely damaging for individuals and could easily undermine the credibility of the service if other clients find out. The findings from the respondents in phase I indicated that some clients doubted VCT results, assuming that counsellors sometimes gave negative results to clients who tested positive, for fear of negative repercussions such as suicide. The VCT managers in phase II revealed that quality assurance was limited although they noted that some clients denied their test results, especially HIV-positive results (see chapter 5, sections 5.5.1 and chapter 6, section 6.9.4).

➤ ***Limited counsellor support***

Lack of counsellor support could create counsellor burnout and in the process reduce the quality of VCT services. The findings indicated that counsellor support was almost non-existent at the research sites. The VCT managers in phase II had no clear means of measuring counsellors' performance or offering them support supervision. To them, this was complicated by the nature of integrated service delivery. The VCT counsellors in phase III stated that although staff meetings took place, they reviewed general issues, not necessarily VCT-related issues in particular. Furthermore, supervisors emphasised numbers tested rather than considering the quality of counselling offered (see chapter 6, section 6.6.1).



➤ ***Motivation to offer VCT services***

Motivation in performing duties at the job ensures delivery of quality services. The VCT counsellors in phase III at both hospitals were highly motivated to offer VCT services and many indicated they had not been stressed despite the existence of stressors. Many of the counsellors in phase III indicated they enjoyed their work. Among the respondents in phase I who had accessed VCT services, there was a general feeling of satisfaction with the way VCT services were delivered, apart from complaints about the long time spent waiting at the hospitals (see chapter 6, section 6.9.8 and chapter 4, section 4.4.11).

➤ ***Simple HIV testing methods***

Same-day, single visit VCT is one of the ways of ensuring that most clients who test receive their test results, as they did not have to return another day. Moreover, individuals who need to make immediate decisions based on HIV test results find single visit testing more convenient. The VCT counsellors in phase III felt that rapid testing had assisted many people to access their results and helped to save resources for both the service providers and services users. The respondents in phase I who had tested for HIV had received their HIV test results because they had tested and received results the same day during the same visit (see chapter 6, section 6.9.4).

### ***7.2.6.3 Micro level***

The micro level considers two main elements namely the characteristics of the target population at risk and consumer satisfaction. The characteristics of the population at risk include predisposing, enabling and need components as the individual determinants of health service utilisation. The predisposing factors include variables that describe the tendency of individuals to use or not to use the services. Consumer satisfaction refers to the attitudes towards the medical care system of those who have experienced contact with it (Aday & Anderson 1974:214; Joshi 2000:52).

➤ ***Limited knowledge and awareness about VCT services***

Limited knowledge and awareness of VCT services in the target communities could affect VCT service utilisation. If individuals do not know about the service or its benefits, utilisation could be low. According to the VCT managers in phase II, the Ugandan government advertised VCT services (see chapter 5, section 5.5.1). Knowledge of the importance and benefits of VCT services and where they were provided was nevertheless limited among respondents in phase I. The majority (60%) of the respondents in phase I indicated they had not heard or read anything concerning VCT in the three months prior to the study. Only 38.6% had heard or read something about VCT in that period (see chapter 4, section 4.6.2).

Although people were generally well aware of HIV/AIDS, its spread and prevention, there was limited knowledge of the benefits of testing for HIV. This could create a false belief among individuals that they were already infected with HIV even before testing or that they were not infected whereas they might be. This study found that while the respondents in phase I knew about HIV acquisition and prevention, a quarter of the respondents still believed it was possible to tell people's HIV status just by looking at signs and symptoms (see chapter 4, section 4.3.3.). This possibly accounted for the majority of the Kasenyi residents attending VCT centres when they found signs and symptoms presumably associated with HIV/AIDS. In addition, the VCT managers in phase II pointed out that many clients who accessed VCT services believed that they were infected with HIV and were only looking for ART services (see chapter 5, section 5.5.1).

➤ ***Fear of HIV test results***

Clients' fear of test results was one of the major challenges in counselling. Fear of HIV testing frequently translated into anxiety and interfered with delivery of key messages. The fear associated with self-diagnosis of HIV based on mere signs and symptoms presumably related to HIV creates anxiety, which could be a hindrance to accessing HIV testing. Fear of the test results was one of the major barriers to testing raised by the respondents in phase I. According to the VCT counsellors in phase III, clients' anxiety was a major challenge, which interfered with delivery of key messages (see chapter 6, section 6.9.5). This anxiety was due to anticipation of HIV-positive results.

Likewise, when asked the reasons for testing (among those respondents who had an HIV test), most men said that they tested after getting signs and symptoms possibly related to HIV/AIDS (see chapter 4, section 4.4.3).

➤ ***Community attitudes towards VCT services***

Stigma related to HIV testing appeared to be lessening in communities and discussing HIV/AIDS-related issues with community members could have a positive impact on taking an HIV test. The findings indicated that of the respondents in phase I, 97.6% agreed that HIV testing was a good thing and 94.5% were willing to refer others for testing. Furthermore, 60% of the respondents in phase I indicated that they had no problems with their HIV test results being known in their communities (see chapter 4, sections 4.5.6 and 4.3.7).

➤ ***Problem of waiting time***

Although the respondents in phase I complained of long waiting hours, the VCT counsellors in phase III did not agree that the waiting time was always long despite emergency situations that might arise. Instead, they reported that clients accessing VCT services experienced abnormally high anxiety, which to clients made the waiting time seem much longer. In addition, the VCT managers in phase II stated that VCT clients always wanted to be served as soon and quickly as possible (see chapter 6, section 6.9.3).

➤ ***Willingness to test for HIV***

Under favourable conditions individuals would be encouraged to consider testing for HIV. Many of the respondents in phase I, both who had and who had not tested before, indicated that they were willing to test and would find it easy to test. Moreover, most of the respondents agreed that HIV testing was a good thing and were willing to refer others for testing (see chapter 4, sections 4.4.2 and 4.5.9).

### 7.3 STRATEGIES FOR IMPROVING VCT ACCESSIBILITY AND ACCEPTABILITY

Soanes and Hawker (2005:528) define a strategy as “a plan designed to achieve a particular long-term aim”. According to Porter (1996:61), a strategy is “a way of comparing an organisation’s strengths with the changing environment in order to get an idea of how best to fulfil or meet client needs. A strategy therefore addresses issues of how to develop, manage and deliver planned activities in a cost-effective manner.” The process for developing the strategies for improving VCT services delivery and utilisation was based on the theoretical understanding as well as the key results of the current study, as explained below.

The strategies developed for VCT service delivery and utilisation drew from three theoretical frameworks – the socio-ecological model, the health services delivery framework, and the health belief model (see chapter 2). The socio-ecological model capitalises on modifying the social environmental factors to make them favourable for VCT service delivery and utilisation. The health service delivery and utilisation framework explains the characteristics of the service providers and the services provided, while the health belief model explains the individual’s perceived barriers and benefits related to VCT services. Accordingly, the researcher developed the following six strategies. (Aday & Anderson 1974:213; Aday & Awe 1997:505; Janz et al 2002:47; Ostrom 1998:6).

Based on the results of the current study from all three phases as summarised above, the researcher was able to identify the strength, weakness and opportunities for the delivery and utilisation of VCT services. These were categorised in three main areas, namely the macro level, meso level and macro level.

The macro level involved analysis of the large-scale social systems involved in VCT delivery such as government policies and guidelines. Tackling the macro level aspects is expected to lead to the development of favourable and more applicable policies and guidelines for VCT service delivery, guidelines which the VCT managers and counsellors felt were outdated and inadequate. At the same time, results from the interviews indicated serious shortage of funding to improve VCT services, and the researcher noted that it is at the macro level that funding for VCT service is largely determined, and therefore advocacy for funding needs to largely target this level.

At the meso level, focus was placed onto organisations or the hospitals that deliver VCT services. Results from the three phases indicated that manpower shortages and infrastructural challenges exist, which all affect the quantity and quality of VCT service provided. Strategies were hence developed to create a favourable environment for clients seeking VCT service. The process for developing strategies at this level included review of the suggestions from both the service providers and the service users.

Lastly, at the micro level, the researcher took into account the characteristics of the population, critically reviewing factors that favour or do not favour VCT service use. The study explored and described reasons why certain individuals accessed and used VCT service and why others did not use the services. The strategies targeted at this level include the need to increase awareness and mobilise communities.

### **7.3.1 Improve advocacy for VCT among leaders**

In order to increase VCT service delivery and utilisation among the marginalised communities such as fishing communities, strong advocacy at all levels and synergising strategic approaches and efforts of various sectors, including the media and key ministries is essential.

Advocacy should increase the volume and quality of VCT services. Promotional campaigns for counselling and testing should aim at changing norms, reducing stigma, and increasing support for utilisation of VCT services. In addition, good advocacy among policy makers would emphasise the importance of VCT services in HIV prevention. This would encourage policy makers to commit and allocate the much-needed additional resources to support VCT services.

Hospitals should conduct campaigns to educate people at all levels about the benefits of VCT services. According to Harrington and Harrigan (2006:112), it is the responsibility of practitioners to take a leadership role in advocacy to promote counselling and testing. One of the expert reviewers indicated that health workers lacked advocacy skills. Therefore, in order to reap the benefits of advocacy, health workers need to be trained in the art of advocacy.

### **7.3.2 Increase awareness and mobilise communities**

There is a need to increase awareness of VCT services through mobilising communities. Mobilising communities should consider involving them in the planning and implementation processes. Breckon, Harvey and Lancaster (1998:58) define community mobilisation as “making it possible for individuals or groups of people to make good things happen in their lives”. One of the good things to happen in this case is accessing and utilising VCT services. Mobilising communities enables members to make informed decisions about VCT, thereby assisting in normalising the services. If VCT service is taken as a norm in communities, community involvement and participation in VCT services will materialise, which will reduce fear of HIV testing, increase uptake of the services, thereby reducing denial, stigma and discrimination. Elimination of fear of testing is important, as 56.7% of the respondents in phase I reported fear of HIV results.

The respondents in phase I indicated there was limited awareness about VCT services and communities were not well mobilised for VCT services. The VCT managers in phase II emphasised that the success of mobile VCT services depended largely on the local leaders' input. Social mobilisation for VCT therefore needs to provide the community with adequate information on and support for all aspects of the services (MoH 2005:11). For example, using the radio would be more appropriate to this population, where 83.5% of the respondents in phase I indicated they commonly listened to the radio almost daily.

Community mobilisation for HIV testing and counselling should address stigma, discrimination and fear of disclosure, including the benefits of HIV testing and counselling. In Uganda, mass media and marketing approaches have proved successful in improving people's perceptions of the benefits of knowing their status and increasing the uptake of VCT in some communities (MoH 2005:15). VCT staff, especially counsellors who have had interactions with clients, should be involved in designing communication messages and promotional activities.

The findings indicated a link between discussing HIV/AIDS issues with colleagues and testing, and that encouraging communities to talk about HIV testing and counselling was a good approach. Nsabagasani and Yoder (2006:42) nevertheless emphasise that

this must be handled with sensitivity and respect. People working with communities must understand the facts and issues around VCT before they encourage community members to talk about them.

According to the FHI (2004:71), effective communication for increasing demand for VCT services may include offering information on where VCT service is available, including availability of related HIV/AIDS services; addressing the benefits of HIV testing; encouraging target populations to access and utilise VCT services; encouraging sustained behaviour change after a person has been tested, and encouraging counselling and testing as a routine component of health-seeking behaviour.

Although the respondents in phase I were highly knowledgeable about HIV/AIDS, with regard to spread and prevention, one of the expert reviewers advised that it is important that while designing communication strategies, key messages should include the basics on HIV/AIDS as there could be individuals in the communities less knowledgeable about HIV/AIDS.

### **7.3.3 Promote provider-initiated HIV counselling and testing**

Whenever individuals arrive at a health centre, whether seeking health services or escorting patients, they should be informed of the availability of VCT services and the importance of testing for HIV and then be tested. It is a basic responsibility of health care providers to recommend HIV testing and counselling as part of routine clinical management. Although this already happened in most hospitals, it should be intensified. Grellier et al (2004:18) maintain that VCT should be made routine as long as clients are well informed and it is voluntary.

Patients attending hospitals for other services would be likely to take a test if health providers informed them about it. The VCT managers in phase II indicated that they asked patients to take an HIV test. The phase I findings indicated that 25% of the respondents who had tested for HIV had been asked to do so. Nonetheless, they were subsequently happy to have tested and received the results.

Health providers should note that whether an HIV test is requested by a health provider or not, pre-test counselling should always be provided, confidentiality ensured, and

voluntary consent obtained. Patients might take the doctors' word as final and consequently consider VCT as being "forced" to take a test. Caution should therefore be taken to avoid "forcing" patients, which could affect utilisation of other hospital services. According to the MoH (2003a:7), provider-initiated HIV testing and counselling is voluntary and follows the principles of informed consent, counselling and confidentiality.

When approached for VCT services, clients have the option to "opt-in" or "opt-out". "Opt-in" generally refers to counselling and testing where a client explicitly consents to the test, whereas "opt-out" allows individuals to specifically decline the HIV test having received pre-test information. Nevertheless, regardless of whether they test right away, the information received is likely to influence them to test in the future. Grover and Petterson (2005:366) found that of 364 women offered HIV screening during a six-month period, 248 (68%) accepted and underwent testing.

#### **7.3.4 Create an environment conducive to clients seeking VCT services**

Individuals are more likely to demand for VCT services on their own if the environment was conducive to taking the test. Assuring potential clients of privacy and confidentiality could increase utilisation of VCT services. Strategies to raise awareness of the availability and benefits of VCT services should be introduced, including campaigns that promote VCT services. At community meetings for example, leaders could take the opportunity of talking about VCT services. The findings from the phase I respondents indicated that 75% had tested on their own without being asked.

Making conditions conducive to testing involves changing and promoting the core principles of HIV testing such as ensuring confidentiality, privacy and respect for human rights. The VCT counsellors in phase III indicated that privacy and confidentiality were compromised during mobile VCT. The respondents in phase I emphasised the need for privacy and confidentiality in testing. Furthermore, the majority (97.6%) of the respondents indicated that VCT was a good service and they would therefore not expect any bad feelings from their community members if they were seen accessing VCT services. Awareness of VCT services could encourage more individuals to use them. The CDC (2006:3) stresses that, particularly in areas with a high HIV prevalence such as Sub-Saharan Africa, individuals should routinely test for HIV.



Besides giving more information on the benefits of testing and the services available particularly for those who test HIV positive, it is important to increase a wide range of HIV/AIDS-related services available. If they benefit after testing, HIV-positive clients are more likely to recommend VCT services for friends and colleagues. Vermund and Craig (2002:1186) found that a lack of expected benefits from VCT could deter clients from seeking or accepting the test.

Mobile VCT that makes services available within easy reach of communities could be offered at community gatherings, at lower health units, or at home. However, home-based VCT should be less emphasised, as only a minority of the respondents in phase I had actually tested from home and indicated home-based VCT as their future preferred testing site. The FHI (2005b:5) found home-based VCT challenging in terms of family disclosure. Wolff et al (2005:114) found that home-based VCT did not benefit the youth due to potential increased domestic conflict resulting from disclosure. Although the participants in phase II as well as the experts indicated that mobile VCT service were expensive and demanding and the resources limited, the researcher is of the opinion that strategies such as advocacy and community volunteer counsellors would prove effective as ways of dealing with limited resources (see sections 7.3.5 and 7.3.6).

The findings in phase II indicated frequent poor turnout for mobile VCT services due to poor mobilisation. Consequently, whatever the form of mobile VCT services, they should be organised with input from community members, to advise the health workers on the best available locations, seasons of the year, days of the week, and time of day during when most community members can be reached. At the same time, mobile VCT should be linked to the nearest care and support organisation through a strong referral system.

### **7.3.5 Explore other VCT staffing alternatives**

Alternative ways of increasing the counselling staff should be explored in order to increase the volume and quality of VCT services. This stems from the fact that there was a shortage of adequate and well-trained VCT personnel. In addition, VCT clients do not like spending unnecessary time at VCT sites resulting from staff shortages.

Community volunteer counsellors could be a cheaper alternative source for the much needed staff.

Both the VCT managers and VCT counsellors in phases II and III underscored the need for extra staff to assist with VCT services. The VCT managers in phase II were of the opinion that the government had not prioritised VCT and thus allocated limited funds. Given the limited resources, therefore, recruitment of extra staff could be difficult, but other strategies for providing services could be explored. Community volunteers, sometimes referred to as peer counsellors or paraprofessionals, living and working in their communities could be identified and trained to offer VCT services in high-risk communities. Community volunteer counsellors could provide an invaluable service to the community, providing counselling services to many, at no cost, who would otherwise not be able to obtain such support.

There appeared to be a pool of potential volunteers among the phase I respondents. Of the respondents in Kasenyi fish landing site, 51.2% had obtained secondary level and 38.6% had obtained primary level education. This level of education in this population would be ideal for selection of community volunteer counsellors.

Harris and Larsen (2007:852) point out that volunteer peer counselling not only relieves health professionals of the burden, but also helps peer counsellors, who feel good knowing they are helping others in difficult situations. Kabura et al (2006:69) refer to micro-counsellors and describe them as helpers from different professions, with different educational backgrounds, who are specially trained in communication skills and in a variety of contexts to offer counselling services. In Kenya, Cabral et al (1996:76) found that peer health advocates, who were paraprofessionals who have had some experience working with health, social, or community programmes, deliver counselling. One or more of the fishermen at Kasenyi and other fish landing sites could be given specialised training to act as peer educators and offer counselling on fishing vessels during their offshore periods (World Fish Centre 2006:49).

The selection of community counsellors should be done with great care to avoid negative outcomes and ensure that they are accepted in their communities. In their study, Kipp et al (2002:702) found that some participants recommended that counsellors be non-residents of the area, as non-residents were considered more

credible and would offer greater confidentiality than residents. In this study, the VCT counsellors reported finding it difficult to counsel clients they knew. Increased awareness and normalisation of VCT services, however, would possibly reduce stigma, subsequently making resident peer counsellors more acceptable.

### **7.3.6 Implement progressive monitoring of VCT services**

There is a grave need to progressively monitor VCT services delivery at the hospitals through collecting and evaluating basic statistics of VCT services delivery. The best way to understand and improve the quality of VCT is to continuously assess the services and collection of essential basic data as one way of assessing the performance of VCT services if improvements are to be implemented. For example, in order to modify inadequate policies and guidelines requires supporting data for the revision.

Progressive programme monitoring would need to involve the ongoing collection of information to determine if programmes are operating according to plan, which, in turn, would furnish ongoing information on programme implementation and functioning. There is a need for supervising and offering support plus immediate feedback to counsellors while periodic client satisfaction evaluations should be undertaken. This would ensure that counselling matched the needs and requirements of the VCT clients.

Evaluations need not be massive and expensive, but rather simple strategies like brief surveys or exit interviews. For example, one of the expert reviewers proposed the use of suggestion boxes, which could be installed at strategic points and patients informed about their use and importance in as far as service delivery is concerned. Health workers could also be trained how to accept and use the criticisms from clients.

The collection of data would allow VCT clients' satisfaction and utilisation to be measured; indicate counsellors' challenges and the support they need; determine when to provide counsellor follow-up training, and provide information to communities according to their preference. Periodic client satisfaction should be evaluated to match the needs and requirements of the VCT clients. These evaluations could also provide important feedback to counsellors who might otherwise not be aware of the benefits of what they do or the unintended mistakes they make.

According to the FHI (2003:6), monitoring and evaluation is a critical component of VCT service delivery and should address two relevant areas for service providers and policy makers. For service providers, it should examine how well VCT service is provided while for policy makers, it should determine programme effectiveness, and the impact of VCT on the population receiving the service.

#### **7.4 LINKING THE STRATEGIES TO THE THEORETICAL FRAMEWORK**

According to the health services delivery framework, VCT service delivery can be explained at three levels, namely the macro, meso and micro level. Strategies to improve VCT service therefore need to be aimed at the three different levels (Aday & Anderson 1974:213; Aday & Awe 1997:505; Murray & Elston 2005: 703-705; Wynne 2003: 98-103).

More so, the strategies are based on the HBM which emphasises the fact that people will take a health-related action if they feel that a negative health condition can be avoided, have a positive expectation that by taking a recommended action, they will avoid a negative health condition, and believe that they can successfully take a recommended health action (Brown 2005:114; Hochbaum 1956:378; Janz et al 2002:47).

Lastly, the strategies drew from the social ecological theory, which emphasises that health behaviour is a function of individuals and the environments in which they are embedded, namely the family, social networks, communities, civil society, organisations, institutions and societies as a whole (Breinbauer & Maddaleno 2005:3; Franklin 1988:340; McLeroy et al 1988:354; Ostrom 1998:6).

The strategies for improving VCT services were also based on the theoretical framework. Accordingly, VCT service delivery can be explained at three levels, namely the macro, meso and micro level. Strategies to improve VCT service therefore need to be aimed at the three levels (Aday & Anderson 1974:212; Aday & Awe 1997:505).

The macro level involves analysis of the large-scale social systems involved in VCT delivery such as government policies and guidelines. The strategy to improve advocacy for VCT among leaders would address the macro level. This is expected to lead to the

development of favourable and more applicable policies and guidelines for VCT service delivery. At the same time, it is at the macro level that funding for VCT service is largely determined and therefore advocacy for funding needs to largely target this level.

The meso level focuses on organisations for example health facilities that provide VCT services. Strategies targeted at this level aim at increasing the quantity, opportunities and quality of VCT service provided. Strategies that address the meso level include promoting provider-initiated HIV counselling and testing; creating a favourable environment for clients seeking VCT; exploring other VCT staffing alternatives, and lastly progressively monitoring VCT services.

The micro level includes characteristics of the population, factors such as predisposing, enabling, and need components as the individual determinants of health service utilisation. At this level, strategies aim at changing some of the characteristic of the individuals targeted for VCT service. The study explored and described reasons why certain individuals accessed and used VCT services and why others did not use the services. The strategies targeted at this level include the need to increase awareness and mobilise communities.

## **7.5 EXPERTS' REVIEW OF THE STRATEGIES**

Once the strategies for increasing VCT accessibility and acceptability were drafted based on the study findings and the literature review, the researcher presented them to a selected team of experts in different fields for purposive review. This was done in order to assess whether the strategies could be acceptable as described, acceptable but with recommendation, or not acceptable at all.

### **7.5.1 Criteria for rating the strategies**

Agreement and consensus building are complex processes that require good thought of what is to be measured or is intended to be assessed. According to Tastle, Wierman and Dumdum (2005:97) tools are necessary for identifying agreement during the convergent processes in problem analysis. The convergent process includes consensus formation regarding issues that need to be addressed, their priority level and the most efficacious means to address them. Tastle et al (2005:97) add that consensus

is a function of shared team feelings towards an issue, and this feeling can be captured by using a scale to measure the extent to which a person agrees or disagrees with the issues put forward.

The researcher developed a matrix to measure convergence among a team of experts which was based on key areas of a good strategy. A good strategy should be clear, appropriate, comprehensive, adaptable and practical. These are the criteria the researcher took into consideration to be measured by the experts after reading and internalising the strategies that were developed for improving VCT delivery and utilisation. To facilitate a well informed analysis, the researcher provided the experts with the findings of the study.

**7.5.2 Selection of the experts**

The process of expert review involved selecting the experts, designing a matrix for data collection, and analysing the responses. Five experts were purposively selected in the areas of academic, HIV/AIDS, community, policy, and counselling (see table 7.1). They were asked to read a summary of the research findings, review the draft strategies and give their comments on the assessment form. The form included demographic data, area of expertise and a matrix table with variables on which to rate the strategies (see annexure G). The responses were tabulated, analysed and fed into the design of the strategies.

**Table 7.1 Selected experts**

<b>Expert</b>	<b>Qualifications</b>	<b>Area of expertise/current occupation</b>
1	BB, MA, MPA, PhD	Professor of Sociology
2	BA	Community Expert
3	BA, MA	Programme Officer/Counsellor
4	MChB, MPH	Health Service Delivery and Policy
5	BA, MA	HIV/AIDS Specialist

Table 7.2 illustrates the five experts’ rating of the strategies for increasing VCT utilisation formulated on the findings of the study. Based on the ratings, none of the aspects of the strategies was rated as “not acceptable or needs major revision” (see table 7.2).

**Table 7.2 Experts' rating of the strategies (N=5)**

Criteria	Not acceptable or needs major revision	Acceptable with recommended changes	Acceptable as described	Some of the paraphrased comments from expert reviews
<b>Clarity, simplicity and consistency (N=5)</b>	0 (0%)	1 (20%)	4 (80%)	Most people take doctors' words as final, be sure not to 'force' VCT as it may affect other services.
<b>Appropriateness and relevance (N=5)</b>	0 (0%)	3 (60%)	2 (40%)	Even in fishing communities, some communities may be different.
<b>Comprehensiveness (N=5)</b>	0 (0%)	2 (40%)	3 (60%)	Monitoring, for example, is critical in service delivery although sometimes ignored.
<b>Adaptability and generalisability (N=5)</b>	0 (0%)	1 (20%)	4 (80%)	
<b>Practicality and usefulness (N=5)</b>	0 (0%)	1 (20%)	4 (80%)	The use of mobile clinics may need a lot of money that may not be available.
<b>Importance for research, practice and education (N=5)</b>	0 (0%)	0 (0%)	5 (100%)	Fishing communities need special attention.
<b>Validity or trustworthiness (N=5)</b>	0 (0%)	1 (20%)	4 (80%)	Because the strategies are based on research findings from both service providers and users.

## 7.6 CONCLUSION

This chapter discussed the strategies developed to increase accessibility, acceptability and utilisation of VCT services. The suggested strategies evolved from a review and comparison of the phases I, II and III findings.

VCT accessibility and acceptability, which, in turn, determine utilisation patterns are affected at different levels by different factors. At the individual level, individuals' knowledge, perceptions and consumer satisfaction mainly determine VCT service use. At the health facility level, the model of VCT service delivery may be a factor. The strategies to improve VCT service delivery and utilisation were therefore designed based on the need to address individual knowledge levels, attitudes and relationships within a community (micro-level issues), while concurrently tackling meso-level issues, such as the availability of a wide range of services as well as institutions (hospitals) which directly provide services including VCT; and macro-level structures, such as the resources to provide services as well as policies and guidelines for service provision.

In order to increase access, acceptability and therefore utilisation of VCT services, no single approach or service delivery model is suitable for all populations or feasible in all settings. Consequently, multiple approaches should be considered. The suggested VCT service delivery strategies emphasise improving advocacy for VCT among leaders; promoting provider-initiated HIV counselling and testing; promoting client-initiated VCT; increasing awareness and mobilising communities; exploring VCT staffing alternatives; and implementing progressive monitoring of VCT services.

Chapter 8 concludes the study, describes its limitations, and makes recommendations for practice and further research.



## **CHAPTER 8**

### **Conclusion, limitations and recommendations**

#### **8.1 INTRODUCTION**

This chapter presents the major conclusions and key findings of the study, briefly discusses its limitations, and makes recommendations for practice and further research.

#### **8.2 AIM AND OBJECTIVES OF THE STUDY**

The conclusions are presented according to the aim and objectives the study. The overall aim of the study was to explore and describe the current models of VCT service delivery and analyse the extent to which a given VCT model had influenced uptake of VCT services in the fishing communities along the shores of Lake Victoria, in Wakiso District, in order to design suitable VCT delivery strategies.

The objectives were to

- establish the different VCT service delivery models available in and around Kasenyi fish landing site
- determine the extent to which a given VCT service delivery model influenced utilisation patterns in the target community
- identify other factors that influence VCT service utilisation among the fishing communities
- formulate strategies to improve VCT service delivery and utilisation among fishing communities

#### **8.3 RESEARCH DESIGN AND METHODOLOGY**

The study was exploratory, descriptive and explanatory and adopted a three-phased approach, to collect data from Kasenyi fish landing site residents in phase I, and data

from VCT managers in phase II and VCT counsellors in phase III. Phase I collected quantitative data and phases II and III collected qualitative data.

### **8.3.1 Phase I**

The phase I population consisted of Kasenyi fish landing site residents. Kasenyi fish landing site is located in Katabi Sub-county, Wakiso District, 25 kilometres from Kampala, the capital city of Uganda. The researcher selected 127 respondents (66 men and 61 women) by means of random sampling. Data was collected in structured interviews and analysed using the SPSS program. The results were presented in graphs and tables (see chapter 4).

### **8.3.2 Phase II**

The phase II population consisted of VCT managers, who were selected at the Entebbe and Kisubi Hospitals as case studies. A VCT manager at each of the hospitals was interviewed and qualitative data collected (see chapter 5).

### **8.3.3 Phase III**

The phase III population consisted of VCT counsellors at the Kisubi and Entebbe Hospitals. The researcher purposively selected 7 VCT counsellors at the hospitals and collected, analysed and interpreted qualitative data from them (see chapter 6).

## **8.4 SUMMARY OF THE FINDINGS**

The findings of the study from the three phases are summarised and presented according to the study objectives.

### **8.4.1 Establish the different VCT service delivery models available in and around Kasenyi fish landing site**

The findings indicate that this objective was achieved. An array of VCT service delivery models and HIV testing technologies available in Uganda has expanded, enhancing accessibility and acceptability of VCT services. The VCT managers and VCT

counsellors at both hospitals revealed that VCT service is available in different models, which ensures that most people have access to the services in their vicinity.

VCT services at both hospitals are provided alongside other services, in integrated VCT service delivery. Accordingly, mothers visiting antenatal clinics are given the opportunity to be counselled and tested for HIV so as to introduce them to the PMTCT programme in case they test positive.

Patients coming to the hospitals for any other services such as family planning, STI treatment and any other related services are likewise made aware of VCT services and offered the opportunity to access the services. At the same time, the VCT managers and counsellors indicated that the integration of VCT services with other services without additional staff has added to staff shortages.

Single visit, same-day testing opportunities are provided mainly using rapid HIV testing. Rapid HIV testing allows clients to receive results the same day, which is useful in urgent medical circumstances and in settings where clients tend not to return for HIV test results (see chapter 6, section 6.9.4).

Provider-initiated VCT is practised at the hospitals, in which health providers may approach anyone who comes to the hospital seeking other health services to undergo counselling and take an HIV test. The participants concluded that provider-initiated HIV testing and counselling is recommended as long as it is voluntary and follows the principles of informed consent, counselling and confidentiality.

Off-site VCT service, also called mobile or outreach VCT is also provided. Individuals, who might not have visited hospitals, are offered an opportunity to access VCT through mobile VCT (mobile, home-based and community VCT) (see chapter 5, sections 5.5.1 and 5.5.2).

Finally, it was established that VCT services at the hospitals are not generally advertised through mass media. Based on the information from the VCT managers, advertising for VCT services is limited; relying only on word of mouth therefore the services remain largely unknown (see chapter 5, section 5.5.1).

#### **8.4.2 Determine the extent to which a given VCT service delivery model influences utilisation patterns in the target community**

The findings indicated how a given model of VCT service delivery at Kisubi and Entebbe Hospitals influenced the utilisation patterns of VCT services in the Kasenyi fish landing site.

It was established that the integration of VCT services into existing services at the hospitals without additional staff meant staff shortages. For example, the VCT counsellors and managers indicated they prioritised emergencies. In such cases, VCT clients were abandoned temporarily to attend to the emergencies first, as VCT is not an emergency and clients could wait (see chapter 6, section 6.9.5).

VCT sites are located far from their target communities, thus creating accessibility problems. Many of the respondents in phase I complained of long distances to testing sites. Despite the long distances, however, when asked where they would prefer to have VCT in the future, the majority of the respondents preferred hospital-based sites. The main reasons for preference of a health facility were trust of the test results, service delivery of care and treatment, and appropriate referrals if people tested HIV positive (see chapter 4, section 4.4).

It was found that mobile VCT services suffer logistical and technical problems that, in turn, reduced the quantity and compromised the quality of the services provided. Mobile VCT services require enormous financial and human resources, yet are sometimes less utilised. For example, the VCT managers in phase II indicated that there was frequently a poor response in the communities for VCT due to poor mobilisation of the individuals in the target communities (chapter 5, see section 5.5.2).

Mobile VCT service delivery has raised doubts about privacy and confidentiality. The VCT counsellors in phase III indicated that acquiring a convenient place that offered adequate privacy and confidentiality while in the field was a challenge. The respondents in phase I emphasised the need for privacy and confidentiality in testing, irrespective of where it was done. The VCT managers in phase II indicated that some clients doubted the accuracy of the results of the simple techniques used in outreach VCT (see chapter 5, section 5.5.2).

Since health providers can approach and ask patients at the hospitals to go for VCT, this could encourage clients at hospitals to undergo HIV testing. The respondents in phase I indicated that 25% of those who had tested had been asked to do so, and most were happy to have been tested.

It was established that in whatever form VCT service is delivered to the target population, there were challenges to the quality and quantity of the services provided. There is limited awareness of the VCT services in the target communities, which contributes to low usage. For example, the Kasenyi respondents indicated that 27.6% were not aware of VCT services (see chapter 5, section 5.5.1).

Another serious challenge in VCT service delivery is the limited human resources, aggravated by the introduction of VCT services without the provision of additional human resources. For example, the respondents who had accessed VCT services complained of long waiting times while at the sites.

Monitoring the quality of VCT services delivery was non-existent at both hospitals. Counsellor support through supervision was found lacking at the VCT sites and this could compromise the quality of services delivered. The VCT managers in phase II indicated that they found it hard to supervise VCT counsellors in the integrated model.

Despite the challenges, the study found a positive attitude towards testing and an indication of willingness to test. In phase 1, most of the 127 respondents indicated that VCT was a good service. The majority of those who had undergone VCT reported a change in lifestyle to avoid practices that put them at risk of acquiring HIV (see chapter 4, sections 4.5.6 and 4.3.7).

The findings indicate that if communities are well mobilised and made aware of VCT services they are more likely to use the services. The majority of the respondents indicated that it would be easy for them to go for HIV testing if conditions were favourable.

Furthermore, some community members were positive and supportive of utilising VCT services and the majority of the respondents in phase I were willing to encourage others to go for HIV testing. In addition, most of the respondents in phase I indicated that it

was a good idea to share HIV test results, many thought their friends be supportive if they knew they had had an HIV test, and very few thought they would be rebuked if their colleagues knew they had had an HIV test.

### **8.4.3 Identify other factors that influence VCT service utilisation among the fishing communities**

Besides the mode of delivering VCT services influencing utilisation of the services, the study identified other factors that could influence VCT service utilisation. Despite the evidence that early HIV testing is very important as an entry point to prevention and treatment, it was found that most people with HIV are unaware of their HIV status. From the research findings, about half (47.2%) of the respondents in phase I, had not accessed VCT services even though the services were available within their communities (see chapter 4, section 4.4.1).

The researcher concluded that an encounter with VCT services could create a positive image about the services. Generally, most of the respondents in phase I who had encountered VCT services were happy to have accessed the services and were satisfied with the overall basic elements of VCT services. Of the 60 respondents in phase I who had accessed VCT services, 75% had voluntarily undergone the testing and received their results (see chapter 4, section 4.4.4).

Marital status appeared to play a role in VCT service utilisation. Individuals who were not married and those in their twenties made more use of VCT services. The majority of the respondents in phase I who had tested were unmarried and aged 20-24 years. There were no significant differences between those who had undergone VCT and those who had not in relation to gender, occupation and religious affiliation (see chapter 4, section 4.4.2).

High levels of awareness of HIV/AIDS transmission and prevention might not necessarily translate into increased VCT accessibility and utilisation. Despite high levels of awareness of HIV/AIDS in general with regard to transmission modes and prevention methods among the respondents in phase I, there was limited awareness about the role of VCT services in prevention and care. Several of the respondents in

phase I believed that people could tell their HIV status through signs and symptoms, without necessarily undergoing HIV testing (see chapter 4, sections 4.3.4 and 4.3.5)

Mistrust of the testing process and test results still exists. Several of the respondents in phase I appeared to mistrust the testing process, maintaining that counsellors sometimes intentionally gave negative results to people who tested positive for fear of negative repercussions, like committing suicide. Furthermore, some of the respondents doubted the privacy, confidentiality and rapid test results. One of the VCT managers in phase II indicated that during home-based HIV testing, some clients doubted the simple HIV testing methods.

Limited messages in target communities limit awareness about VCT services. Among the respondents in phase I, 60% had not heard or read any message about VCT in the three months prior to the study.

It was established that the major barrier to testing is fear of HIV test results. For the 60 respondents in phase I who had never tested for HIV, the major barrier to testing was fear of HIV test results. Other barriers to testing included having no time for VCT (22.4%), VCT not necessary (13.4%), and VCT being expensive (6.0%) (see chapter 4, section 4.4.3).

Time spent at a clinic was found to be a barrier to accessing and using VCT services. Limited VCT counsellors at testing sites mean that clients will have to spend more time at VCT sites. For example, among the respondents who had tested, 30% did not like the long time they spent at VCT sites.

Different factors could lead people to test. For example, discussing HIV-related issues was found to be associated with HIV testing, as 96.7% of respondents in phase I who had tested had discussed HIV issues with someone. Increased knowledge of VCT services should also contribute greatly to testing (see chapter 4, section 4.5.1).

#### **8.4.4 Formulate strategies to improve VCT service delivery and utilisation among the fishing communities**

The findings of the study enabled the researcher to devise ways and means of increasing VCT accessibility, acceptability and utilisation in fishing communities. These strategies are based on the finding that the VCT providers at hospitals are willing to increase the quantity and quality of VCT services to the target communities. At the same time, the respondents from the target community in phase I indicated a willingness to access VCT services. This therefore clearly indicated the need for the strategies. The strategies address the inefficiencies in the delivery of VCT services and relate to ways of creating a favourable and enabling environment for accessing VCT on the part of the potential clients.

Six strategies for increasing VCT accessibility, acceptability and utilisation are suggested: improving advocacy for VCT among leaders, increasing awareness and mobilising communities, promoting provider-initiated HIV counselling and testing, creating a favourable and enabling environment for clients seeking VCT, exploring other VCT staffing alternatives, and progressively monitoring of VCT services (see table 8.1).

##### ***8.4.4.1 Strategic plan for VCT service delivery***

Based on the findings of this study as well as the strategies designed in chapter 7 for improving VCT services acceptability, accessibility and utilisation, the researcher formulated a strategic plan.

The strategic plan is aimed at increasing accessibility and acceptability of VCT services that, in turn, should increase utilisation of the service among the residents at Kasenyi fish landing site. This would enable them access VCT services wherever and whenever they wished. This would entail increasing the volume and quality of VCT services at health facilities as well as creating an enabling environment for individual potential clients for the services. The CDC (2006:3) emphasises that individuals, especially in areas with a high HIV prevalence, such as Sub-Saharan Africa, should routinely test for HIV.



**Table 8.1 Strategic framework for improving VCT accessibility and acceptability**

	<b>Strategy</b>	<b>Justification</b>	<b>Key findings that support the strategy</b>	<b>Recommendations for service delivery (practice)</b>
1	Improve advocacy for VCT among leaders	<ul style="list-style-type: none"> <li>• Advocacy is likely to increase the volume and quality of VCT services.</li> <li>• Involvement of local leaders in VCT programmes is important</li> <li>• Advocacy of relevant key stakeholders is likely to generate support and funding for VCT services</li> </ul>	<ul style="list-style-type: none"> <li>• Respondents indicated the significant role their local leader could play in increasing VCT accessibility.</li> <li>• VCT managers indicated that sometimes there is poor response in community VCT due to poor mobilisation.</li> <li>• VCT managers indicated limited resources for VCT services and yet they believe if VCT are prioritised, there is likely to be financial support.</li> </ul>	<ul style="list-style-type: none"> <li>• There is a need to understand the appropriate medium of communication for different stakeholders.</li> <li>• Hospitals should conduct promotional campaigns for counselling and testing, aimed at raising support for VCT services.</li> <li>• Strong advocacy and synergising strategic approaches and efforts of various sectors, including the media, should be designed and implemented.</li> <li>• Health workers need to be trained in advocacy skills.</li> </ul>
2	Increase awareness and mobilise communities	<ul style="list-style-type: none"> <li>• Awareness of VCT services and the benefits of testing is a major factor in accessing and using the services.</li> <li>• When communities are mobilised, it enables the members to make informed decisions about VCT utilisation.</li> <li>• Talking freely about HIV/AIDS reduces stigma and increases chances of testing.</li> </ul>	<ul style="list-style-type: none"> <li>• Among the Kasenyi respondents, 23.6% thought that people could tell HIV status without necessarily testing.</li> <li>• 11% did not know where to access VCT services.</li> <li>• If well mobilised, 89.8% of the respondents said it would be easy for them to go for an HIV test.</li> <li>• VCT managers indicated that advertising for VCT services is limited, relying only on word of mouth.</li> <li>• Findings from respondents in phase I indicate that 27.6% are not aware of VCT services.</li> <li>• Radio is listened to by 83.5% of participants at Kasenyi.</li> <li>• 56.7% indicated fear of HIV results as a major barrier to testing.</li> <li>• 60% of respondents had not heard any message about VCT in the last 3 months.</li> <li>• Discussing issues related to HIV was found to be associated with HIV testing, as 96.7% of respondents who had tested had discussed</li> </ul>	<ul style="list-style-type: none"> <li>• Communities should continuously be given enough information so as to see VCT as a norm, which will reduce fear for HIV testing, reduce stigma and increase uptake of the services.</li> <li>• The use of radio in transmitting VCT messages would be the best medium of communication for the Kasenyi fish landing community.</li> <li>• It is important to encourage community members to talk about HIV in general and VCT in particular as it is likely to lead to testing.</li> <li>• Involve individuals in the target communities in the planning and implementation of VCT services.</li> </ul>

	<b>Strategy</b>	<b>Justification</b>	<b>Key findings that support the strategy</b>	<b>Recommendations for service delivery (practice)</b>
			HIV issues with someone.	
3	Promote provider-initiated HIV counselling and testing	<ul style="list-style-type: none"> <li>It is a basic responsibility of health care providers to recommend HIV testing and counselling as part of routine clinical management.</li> <li>Patients attending hospitals for health services could decide to take a test if health providers inform them about it.</li> </ul>	<ul style="list-style-type: none"> <li>According to the VCT managers, mothers coming for antenatal services are told of VCT services and the majority accept and are tested.</li> <li>Findings from the Kasenyi respondents indicated that 25% of those who had tested had been asked to, but were happy to have tested.</li> <li>VCT managers indicated that provider-initiated HIV testing and counselling is recommended as long as it is voluntary and follows principles of informed consent, counselling and confidentiality.</li> </ul>	<ul style="list-style-type: none"> <li>Whenever individuals attend a health centre, whether seeking health services or escorting a patient, they should be informed of the availability of VCT services and the importance of testing for HIV.</li> <li>Whether an HIV test is requested by a health provider or not, pre-test counselling should always be provided and confidentiality ensured.</li> </ul>
4	Create an environment conducive to clients seeking VCT services	<ul style="list-style-type: none"> <li>Individuals are more likely to demand VCT services on their own if there is an enabling, favourable environment.</li> <li>If potential clients are assured of privacy and confidentiality, utilisation of VCT services is likely to increase.</li> </ul>	<ul style="list-style-type: none"> <li>There is a positive attitude towards testing. Of the Kasenyi respondents, 97.6% indicated that VCT is a good service.</li> <li>There is a need to create a favourable environment. For example, some of the Kasenyi respondents emphasised the need for privacy and confidentiality in testing.</li> <li>At testing sites, VCT counsellors indicated their efforts to making VCT service responsive to client and community needs and priorities.</li> </ul>	<ul style="list-style-type: none"> <li>There is a need to improve other health services as well, not just VCT services.</li> <li>Mobile VCT services should be considered for special populations such as people in remote rural areas and without access to health services, so as to make it easy for them to access VCT services.</li> <li>Assurances of privacy and confidentiality as well as trustworthiness are key factors in individuals' decision to test.</li> <li>Testing should be voluntary and routinely offered to clients rather than clients having to request it.</li> </ul>
5	Explore other VCT staffing alternatives	<ul style="list-style-type: none"> <li>Lack of adequate and well-trained VCT personnel is a major challenge in health services delivery.</li> <li>VCT clients do not like spending unnecessary time at VCT sites.</li> </ul>	<ul style="list-style-type: none"> <li>VCT managers and counsellors indicated that integration of VCT services with other services without additional staff has created staff shortages.</li> <li>VCT staffing shortages were evident, when VCT counsellors and managers indicated they prioritise emergencies and VCT is not an emergency.</li> <li>VCT counsellors indicated that community members could be trained to at least offer pre-counselling services in their communities</li> </ul>	<ul style="list-style-type: none"> <li>With limited funding, use of community volunteers could be considered as an option.</li> <li>Community volunteer counsellors could be a cheaper alternative source for the much needed human resources.</li> <li>Great care needs to be taken while selecting community volunteers to ensure that they will be accepted in their communities.</li> </ul>

	Strategy	Justification	Key findings that support the strategy	Recommendations for service delivery (practice)
			<ul style="list-style-type: none"> <li>• The availability of averagely educated residents at Kasenyi could be a potential for working as community volunteer counsellors.</li> <li>• Limited staff means more time clients spend at VCT sites. For example, 30% of respondents did not like the long time they spent at VCT sites.</li> </ul>	
6	Progressive monitoring of VCT services	<ul style="list-style-type: none"> <li>• The best way to understand and improve the quality of VCT is to continuously assess the services.</li> <li>• Collection of essential basic data is one of the ways of assessing the performance of VCT services</li> <li>• When funds are limited, as in this case, monitoring does not need to be massive and expensive, but just collection of basic data.</li> </ul>	<ul style="list-style-type: none"> <li>• Collection of basic statistics on VCT services utilisation was not done at VCT sites.</li> <li>• Client satisfaction assessments as a means of improving VCT quality are not often done.</li> <li>• Some respondents who had accessed VCT services were not happy with certain elements of VCT services, such as too much time spent at the site.</li> <li>• Counsellor support supervision was noted to be missing at the VCT sites.</li> </ul>	<ul style="list-style-type: none"> <li>• Support supervision and giving immediate feedback to VCT counsellors is of great value.</li> <li>• Periodic client satisfaction should be evaluated to match the needs and requirements of the VCT clients.</li> <li>• Counsellors should be interested in learning new counselling skills, be comfortable in discussing specific HIV risk behaviours, and receive periodic support supervision</li> <li>• Simple methods of monitoring VCT service delivery such as exit interviews or suggestion boxes could be used.</li> </ul>

#### **8.4.4.2 Resources for implementation the strategic plan**

Resources for implementing a strategic plan should be a key consideration. Resources for the implementation of the VCT strategic plan include financial resources, human resources and materials to be used.

Although many settings with a high HIV burden face substantial human and financial constraints that limit the feasibility of implementing new health plans on a large scale, some strategies can nevertheless be implemented on a small scale (UNAIDS 2004:217). The resources component includes the volume, quality and distribution of health workers in an area (Aday & Anderson 1974:213, Aday & Awe 1997:505). Effective referral mechanisms that ensure feedback could be put in place so that the limited resources could be identified and shared appropriately, to ensure synergies between providers, and avoid duplication of services. Health professionals together with community members should equally be involved in planning for the implementation of the strategy.

Financial resources can be mobilised through external and internal means through fund raising activities. Externally, donors and researchers could be approached to contribute to VCT services. Both hospitals in the study have been able to attract funding for certain programmes, although the sustainability of this funding is sometimes uncertain, as indicated by one of the VCT managers in phase II. User fees should not be seen as a possible alternative to financing VCT services, as they greatly reduce uptake.

Materials to be used in VCT promotion and awareness building should depend on the strategies selected. According to the VCT managers and counsellors, educational materials are largely available, mainly provided by the MoH, although adaptation and distribution to the target communities may be needed.

#### **8.4.4.3 Monitoring and evaluation**

Monitoring and evaluation should form an essential and ongoing part of strategic plan implementation in order to maintain the quality and quantity of VCT services. VCT services should continually be evaluated to improve services to clients and provide accountability to stakeholders. Evaluation should be interactive, involving individual

persons and organisations affected by the services. All VCT service providers should conduct routine, periodic assessments for quality assurance to ensure that the counselling being provided includes the recommended, essential counselling elements. These periodic assessments could, for example, involve short client exit interviews. VCT managers need to be aware of HIV prevention counselling goals and necessary counsellor skills, so that they can adequately support them later alone and monitor their performance accurately.

Monitoring should include the collection of essential data such as the number of clients counselled and tested, discordance rates, and the number of negative and positive clients. This data collected should be analysed in a timely manner for the purpose of extracting useful information to improve VCT service.

VCT quality assurance should also be an integral part of the VCT service monitoring and evaluation. This may for example include reviewing and assessing counsellor training needs, providing support supervision through strategies such as supervisor observation, and giving immediate feedback to counsellors. Other areas of monitoring and evaluation include periodic evaluation of physical space, client flow, time concerns, and client satisfaction evaluation.

#### ***8.4.4.4 Linking the strategic plan to the theoretical framework***

The strategic framework presented was based on the theoretical framework (see chapter 2, section 2.2). According to the health services delivery framework, VCT service delivery can be explained at three levels, namely the macro, the meso and the micro level. Strategies to improve VCT service therefore need to be aimed at the three different levels (Aday & Anderson 1974:213; Aday & Awe 1997:505; Murray & Elston 2005: 703-705; Wynne 2003:98-103).

Furthermore, strategies were based on the HBM which emphasises the fact that people will take a health-related action if they feel that a negative health condition can be avoided; have a positive expectation that by taking a recommended action, they will avoid a negative health condition, and believe that they can successfully take a recommended health action (Brown 2005:114; Hochbaum 1956:378; Janz et al 2002:47).

Lastly, the strategies drew from the social ecological theory, which emphasises that health behaviours is a function of individuals and the environments in which they are embedded, namely the family, social networks, communities, civil society, organisations, institutions and societies as a whole (Breinbauer & Maddaleno 2005:3; Franklin 1988:340; McLeroy et al 1988:354; Ostrom 1998:6). The strategies drawn are targeted at the different levels suggested by the social ecological theory.

The macro level involves analysis of the large-scale social systems involved in VCT delivery such as government policies and guidelines. The strategy to improve advocacy for VCT among leaders would address the macro level. This is expected to lead to development of favourable and more applicable policies and guidelines for VCT service delivery. At the same time, it is at the macro level that funding for VCT service is largely determined and therefore advocacy for funding needs to largely target this level.

The meso level focuses on organisations for example health facilities that provide VCT services. Strategies targeted at this level aim at increasing the quantity, opportunities and quality of VCT service provided. Strategies that address the meso level include promoting provider-initiated HIV counselling and testing; creating a favourable and enabling environment for clients seeking VCT; exploring other VCT staffing alternatives, and progressively monitoring of VCT services.

The micro level includes characteristics of the population, factors such as predisposing, enabling, and need components as the individual determinants of health service utilisation. At this level, strategies aim at changing some of the characteristic of the individuals targeted for VCT service. The study explored and described reasons why certain individuals accessed and used VCT services and why others did not. The strategy to increase awareness and mobilise communities is aimed at the micro level.

## **8.5 LIMITATIONS OF THE STUDY**

This study was limited to VCT service delivery and utilisation in and around Kasenyi fish landing site, in Wakiso district. Other fish landing sites based on the islands of Lake Victoria, whose characteristics related to VCT delivery and utilisation might have differed, were not included. There are only two VCT service providers targeting Kasenyi

fish landing site, which limits comparison of the data across other health facilities in relation to how they provide VCT services.

The respondents in Kasenyi fish landing site and the participants at the hospital facilities expressed expectations that the study would result in the implementation of a programme to assist in expanding the much needed VCT services in the area. The researcher explained that no short-term benefits were likely, but that the research might attract long-term benefits in terms of policy change or attracting funds. Their expectations could therefore perhaps have influenced the respondents' and the participants' responses to some degree.

Although not required during the study, some individuals disclosed that they were HIV positive. In fact, many thought that the researcher would bring VCT services for the residents. Divulging personal sensitive information like HIV status could thus have been intended to facilitate immediate assistance and perhaps have influenced the way questions were answered.

Despite the limitations, the findings from the study are reliable, valid and trustworthy. Triangulation of the methods (qualitative and quantitative) and the different phases of data collection increased the validity, reliability and trustworthiness of the results.

## **8.6 RECOMMENDATIONS**

Based on the findings of this study, the researcher makes the following recommendations for practice and further research.

### **8.6.1 Practice**

In addition to the recommendations in table 8.1, the researcher recommends that the strategic plan should be used not only in Kisubi and Entebbe Hospitals but in other hospitals and clinics providing VCT services in the country as well.

Skills development for VCT service providers is essential to ensure the effectiveness and utilisation of VCT services. If VCT is to create positive behavioural change, VCT counsellors need to be trained and skilled in client-centred HIV prevention counselling,

and risk-reduction counselling (Cabral et al 1996:82). VCT managers too should receive counselling training and be updated on key facts about VCT.

Besides training, VCT counsellors should believe that counselling could make a difference; be interested in and motivated to offer counselling; have skills in active listening, and the ability to build rapport with clients to sustain useful conversations. At the same time, counsellors should have the ability to provide a supportive atmosphere and build trust with the client. They should also be taught new counselling skills, kept abreast of specific HIV transmission risks, and be comfortable discussing specific HIV risk behaviours (Pronyk et al 2002:861).

VCT service providers should conduct routine periodic assessments to ensure that quality VCT services are provided. For example, only MoH approved HIV test kits should be used and the recommended testing algorithm followed. Laboratory personnel should be well trained in good clinical practice to ensure quality tests. False positives should be avoided as far as possible as they are extremely disruptive to service delivery (MoH 2003a:17).

Lastly, VCT services should be monitored and evaluated, including periodic evaluation of physical space, client flow, and time concerns. Counselling sessions should be conducted in a private space where discussion cannot be overheard. Clients should not wait for long periods between testing and counselling, and additional information could be provided during waiting times for example through videos. Periodic time-flow analyses or client surveys can be used to evaluate these issues (MoH 2003a:15-18).

### **8.6.2 Further research**

The findings of this study indicate that VCT service delivery and utilisation is a rapidly changing field requiring constant research. The researcher recommends that further research aimed at understanding and improving VCT service delivery and utilisation be conducted on the following:

- An evaluation study should be done after the strategic plan has been implemented with the purpose of understanding how suitable the strategic plan



works when implemented. The researcher is planning on applying the strategic plan and anticipates to evaluate the strategies as a post doctorate study.

- Strategies to strengthen human resource and infrastructure, especially ways to increase the number of trained VCT staff, taking into consideration limited public health funding.
- A study of other fish landing sites based on the islands of Lake Victoria, whose characteristics related to VCT delivery and utilisation might differ.
- An evaluation of other VCT service providers targeting other marginalised or special populations.
- A comparative study of other health facilities in relation to how they provide VCT services.
- A review of alternative mechanisms for VCT staffing, such as community volunteers and paraprofessionals.

## **8.7 CONCLUSION**

In the communities that have been longest and hardest hit by the HIV/AIDS epidemic, an increasing number of people need to have access to prevention, care, treatment and support services. This will only be possible if people access and fully utilise VCT services. Accessibility, acceptability and utilisation of VCT services depends on two main factors, namely the service provider characteristics, with regard to the model of providing the VCT services, and the target community's knowledge of, attitudes towards and perceptions of VCT services. Understanding the interplay of these two levels and how they can better be influenced was the basis of the present study.

With regard to VCT services delivery, the Entebbe Hospital and Kisubi Missionary Hospital, both in Entebbe, Wakiso District, are the main providers of VCT services to the residents at Kasenyi fish landing site, a predominantly fishing community. VCT service is available at these hospitals, mainly through integrated service delivery, and also to the community by means of mobile or outreach VCT.

Challenges such as limited staff and resources hamper service delivery, thus affecting the quantity and quality of the VCT services delivered to the target populations. Service users fail to utilise even the available VCT services, mainly due to their knowledge and perception of VCT services. Only half of the respondents at Kasenyi

had accessed VCT services in their lifetime. Although the majority agreed that accessing VCT services was a good thing to do, as confirmed by those who had accessed the services, the majority of those who had never tested expressed fear of test results.

The researcher is of the opinion that the strategies designed will significantly contribute to accessibility and utilisation of VCT services by increasing both the quantity and quality of VCT services. The findings of the study and the strategies should be of value and assistance to health service providers and policy makers.

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# **ANNEXURE A**

**Individual verbal consent**

# **ANNEXURE B**

**Phase I: Kasenyi community structured interview**

# **ANNEXURE C**

**Phase II: VCT managers' interview guide**



# **ANNEXURE D**

**Phase III: VCT counsellors' interview guide**

# **ANNEXURE E**

**Uganda National Council of Technology Ethical  
Clearance Letter**

# **ANNEXURE F**

**Health Studies: Research and Ethics Committee:  
Clearance Certificate**

# **ANNEXURE G**

**Experts opinion on strategies for improving VCT  
accessibility and acceptability**

# **ANNEXURE H**

**An example of interview with a  
VCT manager under phase II**

# **ANNEXURE I**

**An example of interview with a  
VCT counsellor under phase III**

# **ANNEXURE J**

**An example of field notes**

## ANNEXURE A

### INDIVIDUAL VERBAL CONSENT

Title: A study to find out how voluntary HIV counselling and testing services are provided and used in Kasenyi fishing communities.

#### Introduction

Good Morning/afternoon/evening. My name is ..... Thank you for taking time to talk to me. I am conducting a research on ANALYSIS OF EXTENT TO WHICH VOLUNTARY HIV COUNSELLING AND TESTING (VCT) PROVISION MODEL INFLUENCES UTILISATION PATTERNS AMONG FISHING COMMUNITIES IN UGANDA as part of my studies. Before we proceed, I am required to seek your consent. I will read for you the following and ask you at the end if you agree or not.

---

#### Purpose of the Study

This study aims at reviewing the current models of VCT service provision and analysing the extent to which a given VCT model has influenced uptake of VCT services in the fishing communities along the shores of Lake Victoria, in Wakiso Districts. Results of this study will inform policy makers on VCT services programming.

#### Procedures

Participation in this study is purely voluntary. The purpose of this form is to obtain your consent to participate. If you choose to participate, I will ask you some questions and record the answers. The record of the information you give will be stored in a safe place and will not be accessible to anyone else other than the researcher himself. It will take you between 30 and 45 minutes to answer the questions. For most of the questions, there is no right or wrong answer, but what is important is your opinion. Your name will not appear anywhere on the questionnaire and it will not be possible to know which responses came from any individual.

There are no known risks in participating in this study. The research has been cleared by the body which approves all research in this country known as National Council for Science and Technology (UNCST).

If you start the interview and wish to stop at any time, you are free to do so. If you do not wish to participate, please let me know. Your decision to participate or not participate will not affect your position in this institution.

If you have any questions before you proceed, please ask me. If you would like more information about the study or its results, please feel free to contact: Mr Julius Ecuru, Deputy Director, UNCST, P. O. Box 6884 Kampala, Tel 0414-250499.

Do you agree to participate?



**ANNEXURE B**

**PHASE I. KASENYI COMMUNITY STRUCTURED INTERVIEW**

<b>INTERVIEW NUMBER</b>	
-------------------------	--

DATE OF INTERVIEW	DAY	<input type="text"/> <input type="text"/>	MONTH	<input type="text"/> <input type="text"/>	YEAR	<input type="text"/> <input type="text"/>
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**A : SOCIAL DEMOGRAPHIC INFORMATION**

<b>NO.</b>	<b>QUESTIONS AND FILTERS</b>	<b>CODING CATEGORIES (circle)</b>
1.	<b><i>Check without asking if the respondent is a man or a woman</i></b>	MAN .....0 WOMAN.....1
2.	How old were you on your last birthday?	AGE IN COMPLETED YEARS <input type="text"/> <input type="text"/>
3.	What language do you use most often?	ENGLISH .....1 LUGANDA .....2 RUNYANKITARA.....3 LUSOGA .....4 OTHER (Specify) .....7
4.	Are you currently attending school?	NO.....0 YES.....1
5.	What is your highest level of education?	NO SCHOOL .....0 PRIMARY.....1 SECONDARY .....2 TERTIARY .....3
6.	Can you read and understand written materials such as a letter or newspaper?	CANNOT READ.....0 READS EASILY .....1 READS WITH DIFFICULTY .....2
7.	What is your marital status? <b><i>(Married category includes married in church, married customarily or cohabiting)</i></b>	SINGLE .....0 CURRENTLY MARRIED .....1 DIVORCED .....2 WIDOWED.....3
8.	How many years have you lived here?	LESS THAN 1 YEAR .....1 1 YEAR OR LESS THAN 2 YEARS .....2 2 YEARS OR LESS THAN 3 YEARS .....3 3 YEARS OR MORE .....4
9.	What do you do for a living? .....	
10.	What is your religious affiliation?	CATHOLIC .....1 PROTESTANT .....2 ISLAM .....3 BORN AGAIN .....4 OTHER (Specify) .....7

**B: KNOWLEDGE AND USE OF VCT SERVICES**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
11	How is HIV contracted?	1 ..... 2 .....
12	How can HIV be avoided?	1 ..... 2 .....
13	How can one know if he/she is infected with HIV or not?	HIV TESTING ..... 1 NOT POSSIBLE TO KNOW ..... 2 BY SIGNS & SYMPTOMS..... 3 OTHER, (Specify) ..... 7 DON'T KNOW/NOT SURE ..... 8
14	Do you know what voluntary counseling and testing is?	NO..... 0 YES..... 1
15	If yes, explain your understanding.....	
16	Do you know a place where you can go to be tested for HIV?	NO..... 0 YES..... 1
17	If Yes, can you tell me where?	KISUBI HOSPITAL ..... 1 ENTEBBE HOSPITAL ..... 2 AIDS INFORMATION CENTRE ..... 3 OTHER (Specify) ..... 7 CANNOT RECALL ..... 8
18	How much money would you be willing to pay for VCT?	NOTHING ..... 0 BELLOW USHS 5,000..... 1 BETWEEN USHS 5100 & 9999..... 2 MORE THAN USHS 10,000 ..... 3 DON'T KNOW..... 8
19	Would you encourage your friends and relatives to be tested for HIV?	NO..... 0 YES..... 1 DON'T KNOW/NOT SURE ..... 8
20	Please explain your answer. ....	
21	Do you feel your lifestyle puts you at risk of getting infected with HIV?	NO..... 0 YES..... 1 DON'T KNOW/NOT SURE ..... 8
22	If yes, explain your answer .....	

**C: EVER HAD AND HIV TEST**

23	I don't want to know the result, but have you ever been tested for HIV?	NO..... 0 YES..... 1
24	If NO, tell why you have never been tested for HIV?  <b><u>PLEASE SKIP TO QUESTION 43</u></b>	IT IS VERY EXPENSIVE ..... 1 FEAR OF RESULTS ..... 2 NO TIME TO TEST ..... 3 NOT NECESSARY ..... 4 OTHER (Specify) ..... 7

25	Did you voluntarily undergo the HIV test?	NO, IT WAS REQUIRED OF ME.....0 YES, VOLUNTARILY..... 1
26	If REQUIRED OF YOU, how did it make you feel?	VIOLATION OF MY RIGHTS..... 1 IT WAS JUSTIFIED .....2 FELT BETRAYED.....3 I FELT HAPPY .....4
27	Please do not tell me the result, but did you find out the result of your HIV test?	NO.....0 YES..... 1
28	If YES, how did you feel about the test result?	ANGRY ..... 1 HAPPY.....2
29	If NO, why did you not find out the test result?	EXPENSIVE TO GO BACK FOR RESULT ..... 1 FEARED THE RESULT .....2 NO TIME TO PICK RESULT .....3 I WAS NOT TREATED WELL .....4 NOT NECESSARY .....5 OTHER (Specify) .....7
30	Was counseling offered to you?	NO.....0 YES..... 1
31	If YES, how was counseling offered?	INDIVIDUALLY ..... 1 IN A GROUP.....2 AS A COUPLE .....3 AS A FAMILY .....4
32	When did you have your last HIV test?	DURING 2007..... 1 DURING 2006.....2 DURING 2005.....3 DURING 2004 OR BEFORE .....4
33	Where did you have your last HIV test?	AT A HEALTH FACILITY ..... 1 AT WORK PLACE .....2 AT HOME .....3 OTHER (Specify) .....7
34	If at a health facility, what type of health facility is it?	GOVERNMENT ..... 1 NGO.....2 MIXED (1&2) .....3 OTHER (Specify) .....7 DON'T KNOW .....8
35	What was the reason for having a test where you had it from?	NO REASON ..... 1 TRUST OF TEST RESULTS .....2 CONVENIENT .....3 NO COSTS INVOLVED .....4 TESTING HOURS CONVENIENT .....5 OTHER (Specify) .....7

36	Why did you have the last HIV test?	NO REASON ..... 1 GOT SIGNS & SYMPTOMS ..... 2 RISKY LIFESTYLE ..... 3 RISKY LIFESTYLE OF PARTNER..... 4 DEATH OF PARTNER ..... 5 OTHER (Specify) ..... 7																																							
37	The last time you had VCT, did you like the service in relation to:	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>PRIVACY?</td> <td>1</td> <td>0</td> </tr> <tr> <td>WAITING AREA?</td> <td>1</td> <td>0</td> </tr> <tr> <td>CONFIDENTIALITY?</td> <td>1</td> <td>0</td> </tr> <tr> <td>DISTANCE?</td> <td>1</td> <td>0</td> </tr> <tr> <td>COST?</td> <td>1</td> <td>0</td> </tr> <tr> <td>INFORMATION GIVEN?</td> <td>1</td> <td>0</td> </tr> <tr> <td>EXPLAINING RESULTS?</td> <td>1</td> <td>0</td> </tr> <tr> <td>COUNSELLOR ATTITUDE?</td> <td>1</td> <td>0</td> </tr> <tr> <td>OVERALL SERVICE?</td> <td>1</td> <td>0</td> </tr> <tr> <td>COURTESY?</td> <td>1</td> <td>0</td> </tr> <tr> <td>TIME SPENT AT CLINIC?</td> <td>1</td> <td>0</td> </tr> <tr> <td>LANGUAGE USED?</td> <td>1</td> <td>0</td> </tr> </tbody> </table>		YES	NO	PRIVACY?	1	0	WAITING AREA?	1	0	CONFIDENTIALITY?	1	0	DISTANCE?	1	0	COST?	1	0	INFORMATION GIVEN?	1	0	EXPLAINING RESULTS?	1	0	COUNSELLOR ATTITUDE?	1	0	OVERALL SERVICE?	1	0	COURTESY?	1	0	TIME SPENT AT CLINIC?	1	0	LANGUAGE USED?	1	0
	YES	NO																																							
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TIME SPENT AT CLINIC?	1	0																																							
LANGUAGE USED?	1	0																																							
38	When you had an HIV test, did you inform anyone about the results?	NO..... 0 YES..... 1																																							
39	If yes, who did you inform?	SEXUAL PARTNER ..... 1 FRIEND ..... 2 OTHER, (Specify) ..... 7																																							
40	If no, why did you not inform anyone?	IT WAS NOT NECESSARY ..... 1 FEAR OF REJECTION ..... 2 FEAR TO BE ASKED WHY I TESTED ..... 3 NO ONE TO SHARE RESULTS WITH ..... 4 OTHER (Specify) ..... 7																																							
41	Did receiving VCT change your lifestyle?	NO..... 0 YES..... 1																																							
42	If yes, how? .....																																								

**D: GETTING HIV TEST IN THE FUTURE**

43	Have you ever discussed HIV/AIDS related issues with any of the following?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>SEXUAL PARTNER</td> <td>1</td> <td>0</td> </tr> <tr> <td>FRIENDS</td> <td>1</td> <td>0</td> </tr> <tr> <td>RELATIVES</td> <td>1</td> <td>0</td> </tr> <tr> <td>HEALTH WORKER</td> <td>1</td> <td>0</td> </tr> <tr> <td>RELIGIOUS LEADER</td> <td>1</td> <td>0</td> </tr> <tr> <td>OTHER (Specify).....</td> <td></td> <td></td> </tr> </tbody> </table>		YES	NO	SEXUAL PARTNER	1	0	FRIENDS	1	0	RELATIVES	1	0	HEALTH WORKER	1	0	RELIGIOUS LEADER	1	0	OTHER (Specify).....		
	YES	NO																					
SEXUAL PARTNER	1	0																					
FRIENDS	1	0																					
RELATIVES	1	0																					
HEALTH WORKER	1	0																					
RELIGIOUS LEADER	1	0																					
OTHER (Specify).....																							
44	If you were to have an HIV test in the near future, where would you prefer to have done from?	AT HEALTH FACILITY ..... 1 AT WORK PLACE ..... 2 AT HOME ..... 3 OTHER (Specify) ..... 7																					

45	Please give reason for your preference.	NO REASON ..... 1 TRUST OF TEST RESULTS ..... 2 CONVENIENT ..... 3 NO COSTS INVOLVED ..... 4 TESTING HOURS GOOD ..... 5 OTHER (Specify) ..... 7
46	If at a health facility, what type of health facility?	GOVERNMENT ..... 1 NGO ..... 2 MIXED (1&2) ..... 3 OTHER (Specify) ..... 7 DON'T KNOW ..... 8
47	Has your sexual partner(s) ever been tested for HIV?	NO ..... 0 YES ..... 1 DON'T KNOW ..... 8 NOT APPLICABLE ..... 9
48	If yes, did he/she share with you the test results?	NO ..... 0 YES ..... 1
49	What is your feeling towards sharing test results?	IT IS A BAD IDEA ..... 0 IT IS A GOOD IDEA ..... 1
50	Please explain your answer. ....	
51	If you wanted to get tested for HIV soon, do you think it would be easy?	DIFFICULT ..... 0 EASY ..... 1 DON'T KNOW/NOT SURE ..... 8
52	What would be the reaction of your friends if they knew you had an HIV test?	REBUKE ME ..... 0 SUPPORT ME ..... 1 DON'T KNOW ..... 3 NO RESPONSE ..... 4
53	Give reason(s) for your answer.....	
54	Do you think having VCT is good or bad?	BAD ..... 0 GOOD ..... 1 DON'T KNOW ..... 8
55	Why do you think so?	ONLY WAY TO KNOW HIV STATUS ..... 1 HELPS TO PLAN FOR THE FUTURE ..... 2 YOU DIE TOO FAST ..... 3 CAN SPREAD HIV ..... 4 OTHER (Specify) ..... 7
56	Has anybody ever given you advice about VCT?	NO ..... 0 YES ..... 1 CANT REMEMBER ..... 8
57	If YES, what was the advice?	BAD SIDE OF VCT ..... 0 IMPORTANCE OF VCT ..... 1 OTHER (Specify) ..... 7
58	If somebody in your community receives an HIV positive result, would you prefer that people in the community know about it?	NO ..... 0 YES ..... 1 DON'T KNOW ..... 8

59	Give reasons for your answer.	SO AS TO DISASSOCIATE FROM HIM/HER ..... 1 SO THAT WE SUPPORT HIM/HER ..... 2 IT REDUCES STIGMA ..... 3 IT INCREASES STIGMA ..... 4 IT ENCOURAGES OTHERS TO TEST ..... 5 IT DISCOURAGES OTHERS TO TEST ..... 6 OTHER (Specify) ..... 7
60	Among the people you interact with, who influences you most when making health related decisions?	NO ONE ..... 0 SEXUAL PARTNER ..... 1 FRIENDS ..... 2 OTHER (Specify) ..... 7

**E: CAMPAIGNS AND VCT AWARENESS**

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES
61	How often do you read printed materials (such as newspapers, magazines, pamphlets etc)?	NOT AT ALL ..... 0 EVERYDAY ..... 1 AT LEAST ONCE A WEEK ..... 2 AT LEAST ONCE A MONTH ..... 3
62	How often do you listen to a radio?	NOT AT ALL ..... 0 EVERY DAY ..... 1 AT LEAST ONCE A WEEK ..... 2 AT LEAST ONCE A MONTH ..... 3
63	How often do you watch television?	NOT AT ALL ..... 0 EVERY DAY ..... 1 AT LEAST ONCE A WEEK ..... 2 AT LEAST ONCE A MONTH ..... 3
64	In the past THREE MONTHS, have you heard or seen any messages about VCT?	NO ..... 0 YES ..... 1 DON'T KNOW ..... 8
65	If yes, what was the message? .....	

**F: OTHER**

66. What would you want your community leaders to do in order to promote VCT in your area?  
 .....

67. What suggestions do have for making VCT more accessible and acceptable?  
 .....

68. What other comments do you have about VCT?  
 .....

69. Do you have any question?

**THANK YOU FOR PARTICIPATING IN THIS STUDY**

## ANNEXURE C

### PHASE II. VCT MANAGERS' INTERVIEW GUIDE

Name of Hospital: .....

Job title of study participant .....

Roles and responsibilities of participant. ....

#### ***VCT services set up***

1. Please describe to me how VCT services are carried out?
2. What are the advantages and challenges of offering VCT at this facility
3. What were the factors that influenced the decision to set up the VCT services here and how accessible is the service?

#### ***Privacy and confidentiality***

4. Please describe to me how privacy and confidentiality are ensured in the VCT service.
5. How would you describe the counselling and waiting space?
6. Have you in the past dealt with any problems arising out of lack of confidentiality? If so, elaborate.

#### ***Linkages***

7. Please describe the referral process within and outside your health facility and any challenges you have had with regard to referrals.

#### ***HIV testing methods***

8. Describe the testing and confirmation of the results process.
9. Please tell me how you ensure quality for HIV tests.
10. Do you receive complaints from or about unsatisfied VCT clients with regard to test results?  
Please explain.

#### ***Cost and sustainability***

11. How is the VCT service financed?
12. If user fees are charged, how much is it and what happens to those who cannot afford, yet they want VCT services?
13. Are there any inducements given to people attending VCT at the site? If yes, elaborate.

#### ***Services for special and vulnerable groups***

14. Please tell me the nature of VCT services for the following vulnerable populations.

- Pregnant women
- Young people
- Children and families
- Sex workers
- Refugees
- Men Having Sex with Men (MSM)
- Intravenous Drug users (IDU)

***VCT service utilisation***

15. Reflecting on this year and last, how would you rate utilization of VCT services?

16. To what extent is the VCT service utilized by fishing communities?

***If outreach VCT (VCT in non-clinical settings) is carried out, then ask the following***

17. How is outreach VCT carried out and where are the services provided?

18. What determines where to take VCT services in outreaches?

19. Are residents of Kasenyi fish landing site reached in these outreaches? And if not, please explain why.

20. What are the advantages of outreach VCT?

21. What are the challenges of offering outreach VCT?

***Advertising and promotion of the VCT service***

22. Please explain how your VCT services are made known to the target population.

***Counsellor training and selection***

23. How are the VCT counsellors recruited or assigned?

24. How do you rate counsellors' performance with regard to VCT service delivery?

***Policy issues:***

25. How would you describe the policies regarding VCT service?

26. Could you identify any restrictions in the policy guidelines on providing VCT services? Please elaborate?



***Recommendations***

27. Given your experience, how do you think VCT can be made more accessible to Kasenyi fish landing site residents?
28. How can VCT utilization be increased generally?

**THANK YOU FOR PARTICIPATING IN THIS STUDY.**

**ANNEXURE D**

**PHASE III. VCT COUNSELLORS' INTERVIEW GUIDE**

Name of Hospital: .....

Job title of study participant .....

Roles and responsibilities of participant. ....

1. What is your background training?
2. How long have you been working here in this facility as a VCT counsellor?

***Selection***

3. How were you selected to be a counsellor?
4. What is your general view on working as a counsellor?

***Training***

5. Describe the counselling training you received?
6. Please tell me of any follow-up or refresher trainings you have had?

***Support and supervision=***

7. What proportion of your working time is spent on counselling?
8. Please tell me any support supervision you have towards counselling?
9. Do you have any other form of support towards counseling? If so, explain?

***Burnout***

10. How do you feel about your job as a counsellor?
11. Are VCT counsellors respected by the rest of the staff? Explain your answer
12. Counsellors sometimes get stressed because of disturbing stories they may hear from their clients, or certain types of information they are required to pass on to their clients. Do you sometimes experience such a situation and how do you deal with it?
13. As a counsellor, how is your performance measured?

***Pre and post test counselling***

14. If I came over here and I want to have VCT, what steps do I have to go through before I get VCT and receive the results?
15. As clients wait for VCT services, what are the activities to positively occupy them?

16. From previous interviews with Kasenyi fish landing site residents, many complained about long waiting hours, what are your views about this?

***Building interpersonal relationship and gathering information***

17. In what ways do you make your clients feel relaxed in order to open up and sustain a conversation?

***Information giving***

18. What methods do you use while counselling to adequately pass on relevant information to a client?

***Dealing with special circumstances***

19. Do you experience any language barriers during counseling and how do deal with it?

20. Are there any special VCT service arrangements for a certain category of people? Please explain.

***Content based elements***

21. What information do you solicit from clients during pre test counselling?

22. What information do you give out to clients during pre test counselling?

23. Apart from individual counselling, tell me your experience with regard to;

- a. Couple counselling
- b. Group counselling
- c. Family counselling

***Privacy and confidentiality***

24. How do you ensure privacy and confidentiality in VCT services?

25. Have you had any problems arising from privacy or confidentiality?

***General issues***

26. Please describe to me the outreach VCT you carry out *(if it is carried out)*

27. What are the advantages and disadvantages?

28. What ways do you think VCT accessibility and acceptability can be increased for Kasenyi fish landing site?

29. In general, what strategies can be used to increase accessibility and acceptability of VCT?

**THANK YOU FOR PARTICIPATING IN THIS STUDY**

## ANNEXURE E

### UGANDA NATIONAL COUNCIL OF TECHNOLOGY ETHICAL CLEARANCE LETTER



## Uganda National Council For Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Your Ref:.....

HS 345

Our Ref:.....

3/09/07

Date:.....

Mr. Mugisha Emmanuel  
P O Box 22616  
Kampala

Dear Mr. Mugisha,

**RE: RESEARCH PROJECT, "ANALYSIS OF THE EXTENT TO WHICH VOLUNTARY HIV COUNSELLING AND TESTING (VCT) PROVISION MODEL INFLUENCES UTILISATION PATTERNS AMONG FISHING COMMUNITIES IN UGANDA"**

This is to inform you that the Uganda National Council for Science and Technology (UNCST) approved the above research proposal on **August 30, 2007**. The approval will expire on **August 30, 2008**. If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST.

If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST. Any problems of a serious nature related to the execution of your research project should be brought to the attention of the UNCST, and any changes to the research protocol should not be implemented without UNCST's approval except when necessary to eliminate apparent immediate hazards to the research participant(s).

This letter also serves as proof of UNCST approval and as a reminder for you to submit to UNCST timely progress reports and a final report on completion of the research project.

The Resident District Commissioner(s) of Wakiso District in which the study will be conducted is informed by copy of this letter, and is kindly requested to give you the necessary assistance to accomplish the study.

Yours sincerely,

Jane Nabbuto

for: Executive Secretary

**UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY**

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*LOCATION / CORRESPONDENCE*

Plot 3/5/7, Nasser Road  
P.O. Box 6884  
KAMPALA, UGANDA.

*COMMUNICATION*

TEL: (256) 414-250499, (256) 414-705500  
FAX: (256) 414-234579  
E-MAIL: [uncst@starcom.co.ug](mailto:uncst@starcom.co.ug)  
WEBSITE: <http://www.uncst.go.ug>

ANNEXURE F

UNIVERSITY OF SOUTH AFRICA DEPARTMENTAL CLEARANCE LETTER

**UNIVERSITY OF SOUTH AFRICA  
Health Studies Research & Ethics Committee  
(HSREC)  
College of Human Sciences**

**CLEARANCE CERTIFICATE**

Date of meeting: ..... **22 August 2007** ..... Project No: ..... **41709144** .....

Project Title: **Analysis of extent to which voluntary HIV counselling and testing (VCT) provision model influences utilization patterns among fishing communities in Uganda**

Researcher: **E Mugisha**

Supervisor/Promoter: **Dr GH van Rensburg**

Joint Supervisor/Joint Promoter: **Prof E Potgieter**

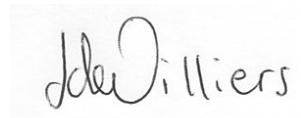
Department: **Health Studies**

Degree: **Doctor of Literature and Philosophy (D Litt et Phil)**

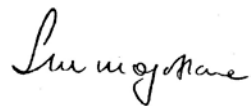
**DECISION OF COMMITTEE**

**Approved**  **Conditionally Approved**

Date: ..... **23 August 2007** .....



**Prof L de Villiers  
RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES**



**Prof SM Mogotlane  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

**PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES**

## ANNEXURE G

### EXPERTS OPINION ON STRATEGIES FOR IMPROVING VCT ACCESSIBILITY AND ACCEPTABILITY

#### DEMOGRAPHIC DATA

Complete the following information with regard to your own data:

<b>Academic qualifications</b>	
<b>Current occupation</b>	

Indicate your field/s of expertise or interest from which you would evaluate the strategies:

<b>Field of expertise or interest</b>	<b>Indicate expertise or interest with X</b>	<b>Comments (Optional)</b>
Academic		
HIV/AIDS specialist		
Community expert		
Counsellor		
Policy		
Other (specify):		

Please disclose any other information that is of importance for the researcher to take note of regarding the evaluation of the strategies:

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#### EVALUATION OF THE STRATEGY

<b>Criteria</b>	<b>Not acceptable or needs major revision</b>	<b>Acceptable with recommended changes</b>	<b>Acceptable as described</b>	<b>Comments</b>
<b>Clarity, simplicity and consistency</b>				
<b>Appropriateness and relevance</b>				
<b>Comprehensiveness</b>				
<b>Adaptability and generalisability</b>				
<b>Practicality and usefulness</b>				
<b>Importance for research, practice and education</b>				
<b>Validity or trustworthiness</b>				
<b>Other (specify):</b>				

**Additional comments:**

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## ANNEXURE H

### AN EXAMPLE OF INTERVIEW WITH A VCT MANAGER UNDER PHASE II

**Date:** 20<sup>th</sup> November 2007

Interview: VCT Manager – Phase II

Sex: Male

Age: 44 years

Duration of work at site: 12 years.

Venue: XXXXXX Hospital

Start time: 11:33 Am

Identifier: Participant 1

**Researcher:** Please tell me briefly about xxxxxxxx Hospital

**Participant:** xxxxxxxx Hospital is a xxxxxxxx Hospital offering both in and out patient services. We collaborate very closely with xxxxxxxx and xxxxxxxx. This is one of the xxxxxxxx hospital in the region

**Researcher:** Here at the hospital, what are you responsible for in terms of VCT services?

**Participant:** I am the xxxxxxxx and I am responsible for the entire technical management of the hospital activities, both curative and preventive. I am in charge of VCT as well, making sure that the service is offered according to the guidelines, that quality is ensured and assured.

**Researcher:** Please describe to me how VCT services are carried out?

**Participant :** In xxxxxxxx, VCT services were started here in xxxxxxxx as a government requirement, although it was at a very small scale because many people had not known about the services and of course there was still high stigma in society with regard to testing. At the same time, it was not well integrated but now, its is well integrated. In fact it was our xxxxxxxx she got interested and pushed hard to get the service started. You remember when we were coming to xxxxxxxx to ask for some push.

**Researcher:** What do you mean by integrating VCT?

**Participant:** By integration I mean that its [VCT] available in almost all departments as a regular services. For example here at xxxxxxxx hospital, we provide VCT through family planning services, under prevention of mother-to-child transmission, under ART programme, under post-rape programme, also available in out-patient

**Researcher:** Can you describe to me how VCT is carried out in these areas you mentioned?

**Participant:** Integrated VCT. Here personnel in different departments are trained on counselling and asking patients or informing them about availability of VCT. This is done mainly to help the patient but it also helps a Doctor make a diagnosis eg someone tells you he has been coughing for three months, of course you suspect TB but at the same time, about 80% of TB patients have HIV. For that reason, you ask for a test to manage the patient better.

b) Then we have VCT provided under PMTCT program.

**Researcher:** What is PMTCT).

**Participant:** You definitely know PMTCT, but this is where a mother is given niverapine just before delivery to prevent infecting the unborn child. Well, when expecting mothers come here for ante natal care, they are told of VCT services and if they do accept, then they are tested and if found positive, then they are further counselled about mother to child transmission. They are urged to deliver at hospital, and once they come for delivery, we already know them and manage them. We then follow them up, advising them on dietary issues, living positive and preventing further infections eg condom use.

**Researcher:** Do they all accept to be tested?

**Participant:** Yes, very many accept the services. They know that once they test [HIV] positive, they will be helped.

**Researcher:** Please tell me about the proportion that does accept.

**Participant:** Approximately 90% accept to be tested and get Niverapine. But we would want to get the 10% as well. We try to ask them to bring their husbands, but you know men, they claim they have no time. We now have a project with xxxxxxxx, xxxxxxxx coordinated by xxxxxxxx, which has increased acceptability.

Then we have VCT under ART program. This is Ante retro viral therapy [*he laughs and says that he now has to avoid all abbreviation as per the rules of the interview*] Our hospital is well accredited to offer ART. Sometimes patients come asking for ARVs and we ask them, Have you tested? And they tell you, 'You know, my wife died' or 'I have HIV symptoms' etc. Even those who test under out patient, they always ask, what if I test positive. For example the counsellors tell me that every time they counsel someone for VCT, before knowing even the results, they are already asking for ART, which means that many come knowing that they are infected and do not come for VCT but for ART.



d) We also have VCT under family planning services, although use of FP service in Uganda is generally low and therefore patients coming for FP are few thus few get VCT. Sometimes when women are informed of VCT, they say 'we want to consult our husbands', and they never come back.

**Researcher:** How about men, when they have come for FP, do many accept VCT services?

**Participant:** Men, ha ha ha, men rarely come for FP. They just tell the women its their concern.

**Researcher:** Please go on with other VCT services available here.

**Participant:** then we have outpatient VCT, where people come specifically for VCT services, we have a VCT centre. We have a collaboration with xxxxxxxx where both xxxxxxxx and xxxxxxxx hospital staff alternate in offering VCT. For example research related VCT happens on xxxxxxxx to xxxxxxxx and then ours, the general one is done on xxxxxxxx.

In short you can define VCT by venue ie static versus mobile or by requisition ie client initiated or health provider initiated.

**Researcher:** What are the advantages and challenges of offering VCT on site at this facility

**Participant:** The biggest problem, we have in xxxxxxxx is limited health manpower, and if one can do all jobs, become a jack of all trades, it is great. That means that as one offers VCT, then he/she can take up other tasks. If there are no people for VCT, then the counsellor, who is a Nurse will be doing other jobs, eg vaccinating mothers and children, deliveries and other general healthcare services. The problem is when one is doing VCT and an emergency case comes up elsewhere. They have to attend to the emergency first. Again, clients wanting to rush the process, wanting to spend as little time there as possible.

**Researcher:** What do you do if a Nurse is counselling and an emergency comes up, what happens?

**Participant:** Let me ask you, since you are a health worker, if you are a nurse in a hospital and you have a VCT client and all of a sudden they bring in a woman in labour or even an accident victim, whom do you attend to first?

Definitely you will deal first with the emergency and come back later to VCT, but a [VCT] client may not understand that. You know this is a hospital and we deal with all cases and only refer those we cant handle. Other issues with static VCT is transport problems, many

patients come from far and funds are limited. Finally, they keep postponing until they get money for transport.

**Researcher:** You talked of referring some cases, please tell me about your referral systems and the challenges.

**Participant:** First, we have internal referral ie interdepartmental eg Girls who come in having been raped, we refer them xxxxxxxx for support and testing. Then we have external referral, those that we refer for either sophisticated tests or care eg the mentally ill, we refer those to xxxxxxxx, and some children we refer to xxxxxxxx

**Researcher:** Do you follow up to see if a referral has happened?

**Participant:** My friend, very limited staff and lack of funds are the major problems, how do you follow up. You just hope that someone goes to where you have directed him to be helped. I am sure they go unless some one just wants to die.

**Researcher:** Now that we have talked at length on Static VCT services, now tell me about the mobile VCT services that you carry out.

**Participant:** First, mobile VCT is where you literally take the services to the people. You have a field team, which decides when they will go and where. They plan this with the local leaders and administration to provide transport etc.

**Researcher:** Who forms the field team?

**Participant:** This is formed of at least nurse/counsellor and a driver, but we insist that one of the counsellors should be a nurse to offer healthcare if needed or even counsel the community on other health matters. There are different forms of mobile [VCT]; e.g., home-based, door-to-door. But here we only do the community outreach, where a community is organised and called to one place. This is where a community is organised and called to one place fro VCT. Here we normally do out reaches with xxxxxxxx since its also their volunteer recruitment avenue. But they must go together with hospital staff.

**Researcher:** How do they decide where to go?

**Participant:** Generally, xxxxxxxx has certain communities they recruit from eg xxxxxxxx etc, they organise with the local leaders and tell them we want to bring to you VCT on such and such a day, please mobilise people and get a convenient place. They keep visiting community after community, getting new participants.

**Researcher** Are some fishing communities involved in the mobile VCT?

**Participant:** Yes, very much so, I told you of xxxxxxxx fish landing site, there is another called xxxxxxxx etc.

**Researcher** How about Kasenyi fish landing site?

**Participant:** xxxxxxxx mainly covers Kasenyi, although a few of them come here for static VCT.

**Researcher:** Please tell me the advantages and challenges of providing this form of VCT?

**Participant:** Well, with mobile VCT, you tend to catch many people, in one place and for them they do not incur any costs. But my friend, The costs to the hospital are high. You need transport, you need to send your personnel there a full day, and provide lunch. In fact if it were not xxxxxxxx I think we would do it once a month. You need transport, you need to send your personnel there a full day, you need to provide lunch etc. Its not cheap really. Of course other problems like finding an appropriate venue, rain. But if money was to be available, this would be a very good form of VCT.

**Researcher:** You talked of money, how is VCT services funded?

**Participant:** VCT here is integrated into other services, there are no funds strictly for VCT but each department is supposed to ear mark a few funds for VCT. Of course the funds come from Government. But we have also been helped by xxxxxxxx and xxxxxxxx. Eg xxxxxxxx does our quality assurance at no charge, which is an important service. As you know gov't user fees and so VCT patients do not pay any money. We also get VCT inputs in kind such as test kits

**Researcher** Do you give any inducements to people attending VCT at the site? If so, please elaborate.

**Participant:** Ha ha my friend, an inducement in government facility, you must be dreaming. We can't because we do not have the funds. Even if we had the funds, we would rather allocate them to another department for example, you should look at our maternity wing, its in shambles. In fact you should look for funds to assist us.

**Researcher** Please describe to me your HIV testing methods and how you ensure quality

**Participant:** We follow government guidelines in HIV testing. First a screening test, which then must be confirmed if positive and finally a tie breaker if all are positive. So we use Determine then to Stat-pak and finally to Uni-Gold as the tier breaker *[At this moment, he asked a counsellors to bring him a copy of the guidelines with the testing algorithm]*

With regard to quality, we take samples to xxxxxxxx, we use approved kits, etc. We use well-trained and qualified laboratory staff. And as mentioned,.

**Researcher:** What proportions are normally involved at each stage:

**Participant.** We get about 15-20% testing positive on the first test, then about 10% on the second test and about 5-10% testing positive on the 3<sup>rd</sup>.

**Researcher** have you had any bad experiences with people getting their test results.

**Participant** experiences?*[first takes time and thinks while saying no]* We generally do not have problems with test results. With HIV, one must be very very careful. Even though there is treatment, its still a major problem, so one has to be very sure of results. But of course always first reaction about HIV is ... this is wrong result. I remember one incident. In fact at one time a client came to my office crying, telling me that my staff had given her the wrong result: that she was positive. I followed up the case and also ended up counselling her because I am a trained counsellor, asking her to come back after three months for a repeat test

**Researcher** How about privacy and confidentiality, how do you ensure them.

**Participant:** First and foremost, one of the core courses in counsellor training is privacy and confidentiality. Then all the staff here are also cautious about confidentiality. We have designated places for counselling, not just under the shade, where one cant eavesdrop, although we have space problems here. By the way, some people think when Dr So-and-So or Nurse X counsels me and gives me positive results, he or she will inform my community. I am assuring you that here we deal with so many people as a hospital and you cannot keep track of who tested positive or negative, and cannot even remember him even if you met him. We now have a good waiting place where even VCT clients watch TV as they wait.....to reduce stress.

**Researcher.** Have you ever had any case of breach of confidentiality.

**Participant:.** No no, we have never.

**Researcher** Now tell me about your counsellors, how were they selected, trained and how are they supervised?

**Participant:** VCT found us here, by the time VCT was introduced, we already had the Nurses and those were the ones who were trained to offer VCT. Earlier, it was only xxxxxxxx offering VCT training but later xxxxxxxx came in. And then many of the counsellors have undergone refresher training, which further reinforces VCT principles.

Besides, VCT field is changing first and counsellors must be up to date. Initially those who were very much interested are the ones who received VCT counselling training like our administrator, but later when we started rotating them, we realised that all needed basic training. Almost all have received counselling skills. Even those who are not involved in day today implementation eg myself I also had to be trained as a counsellor. I told you of how my counselling skills helped me one time, I also, when seeing patient advise them and counsel them for testing.

**Researcher:** And how do you monitor or rate counsellors' performance?

**Participant:** We definitely use the government t system of annual evaluations and appraisals.

**Researcher** Any special support to counsellors.

**Participant:** Not really, we treat counselling as any other duty at the hospital.

**Researcher:** Do you have any special VCT services for special populations?

**Participant:** No, we don't, everyone who comes at the hospital is treated in the same way. May be a few cases like those who are raped, we have a xxxxxxxx, and then say those who are pregnant are handled under PMTCT. So I wouldn't say we have special consideration for anyone.

**Researcher** How about such groups as young people,

**Participant:** No

**Researcher:** How about sex workers

**Participant:** No, besides we wouldn't know who is a sex worker and who is not

**Researcher:** How about children:

**Participant:** No, all counsellors are trained to handle children, although sometimes we refer them to xxxxxxxx.

**Researcher** Men having sex with men?

**Participant:** Ha, we don't have this group here. If they are there, we don't know them.

**Researcher** How about refugees

**Participant:** No, we don't have them

**Researcher:** You have been making reference to policy; let me ask you about policy now. How would you describe the policies regarding VCT service?

**Participant:** Yes, we have policy guidelines that we follow. However, VCT and HIV are ever changing and so perhaps we need a new policy every month. The current policy was approved in the late 1990's and there have been several reviews, with issues like such as access, confidentiality, informed consent and counselling. However, VCT and HIV are ever changing and so perhaps we need a new policy every month. Donors come in with their own practices etc.

**Researcher:** Please tell me about Advertising, promotion and utilisation of VCT services

**Participant:** Well, what I can say is that VCT no longer needs advertising. Almost everyone knows that every hospital in Uganda is supposed to provide VCTs services. Its now part of the routine. Besides, even if we wanted to, where would we get the money from? By the way, even without advertising, the numbers for VCT are ever swelling. But also government has generally advertised about VCT, radios, TV, even the media [Newspapers]

**Researcher** For example comparing last year (2006) and this year 2007, in term of VCT service use, how do they compare?

**Participant:** My friend, this year has seen the largest increase in VCT use ever, For example, about more than 15,000 people have accessed VCT service this year (2007) compared to about 8,000 people last year (2006).

**Researcher** Do you have any reason why this was so?

**Participant:** This could be due to increased availability of ART, reducing stigma, increased awareness about HIV/AIDS. People are now aware that when you test early, there are advantages

**Researcher** Advantages such as?

**Participant:** Accessing treatment early enough

**Researcher:** Looks like many people are aware about VCT services and why they need to use them. Please tell me who mainly uses VCT services here in xxxxxxxx hospital

**Participant:** I would say almost everyone around xxxxxxxx. Even some people come from as far as Kampala. Sometimes people do not want to test where they are known.

**Researcher** Why is that so?

**Participant:** Stigma, Of course stigma still exists in Uganda.

**Researcher** Finally, given your experience here, how do you think VCT can be made more accessible generally and then to Kasenyi fish landing site residents in particular.

**Participant:** Bottom line, more finances. There is need for more funding for health services and they must hire additional staff because it's the main constraint we have. Demand for VCT services has gone up but staff and facilities are static. By the way, even though integration is good, it increases workload tremendously.

**Researcher** Given that the government says there is no money, how else would you deal with these issues?

**Participant:** I do not believe that government has no money, there is a lot of money. The only issues are prioritisation of health. In fact a place like Kasenyi, put more health units there and you will solve a lot of problems including poverty. Of course if one is sick, he cannot go for fishing. In fact these fishing villages will remain pockets of HIV transmission unless they are tackled. We can also revitalise the village health teams, I think it is a good concept.

**Researcher;** Do you have any other question or comments

**Participant:** Not really but to thank you for picking up these issues and we hope the report will be availed to the government.

**Researcher:** Thank you so much for your time and information provided.

## ANNEXURE I

### AN EXAMPLE OF INTERVIEW WITH A VCT COUNSELLOR UNDER PHASE III

**Date:** 27<sup>th</sup> November 2007

Interview: VCT Counsellor – Phase III

Sex: Female

Age: 47 years

Job: Nurse/Midwife

Duration of work at site: 16 years.

Venue: XXXXX Hospital

Start time: 10:15 Am

Identifier: Participant 3

**Researcher:** Tell me about HIV counselling and testing generally.

**Participant:** Yes, counselling and testing. I like doing it. It's a job of helping others. I like helping people who are in need. I mean those coming for testing [testing for HIV]. Even people coming for other [piece of] advice. Its actually an enriching job

**Researcher:** Tell me how you got involved in VCT

**Participant:** You see, as I told you, I have been working here for about 16 years but when I started working here, at that time, HIV and counselling and testing were only found in a few hospitals or clinics in the country. Haha, at that time.... where would you get counselling, if you were lucky to get a test [HIV test] they would just draw blood, tell you to come after a month and when you come, they tell, you, you are dead. Go and eat everything of yours. But now all this changed.

**Researcher:** Please tell me how the situation has changed?

**Participant:** Now you have to get pre counselling and after counselling [post test counselling]. Anyway, in the late 1990s, when even when TASO [The AIDS Support Organisation] came in, then the science of counselling started, where they emphasis positive living. So then, the hospitals were asked to also offer counselling. There were several trainings and the government supplied the testing kits. This mean that by the time VCT came, we were already working here, so I can say VCT found us here.



**Researcher:** It looks like VCT found you here, did you have to do more training for VCT?

**Participant:** Yes, true, as I mentioned, VCT found us here.... We were already offering other health services but then it was a requirement to have training as well in order to offer VCT service. I was asked to go for training at AIC [Aids Information centre]. This training wasn't like that one of the early 1990s, where people would train for a whole six months. This one of mine was a one week course followed by practical sessions. In the trainings, we covered issues like communication. I had never thought of the science of communication. Then highlights on other areas for HIV patients eg family planning, TB control etc. But there was this whole area of preparing patients for testing, and then giving them their results, how to control their stress and anxiety and ensure they are okay.

**Researcher:** Any further training ever since?

**Participant:** Oh yes, the refresher courses, we always have these refresher trainings. Every now and then the government or even some NGOs organise VCT courses and invite us to attend. But as you know our biggest problem here is few staff, so all of you cannot go at once. Some miss out, but wait for another chance.

**Researcher:** As you do the counselling, do you receive further support for example from the trainers or the administration?

**Participant:** Well, after the AIC training they were supposed to keep monitoring us for some time, but they came only a few times, because I think of money [lack of funds] for transport etc. And the hospital also is poor and cannot keep paying. Other support from administration.... I think I can say its allowing us to go for refresher courses. But they also keep bring us videos which we show to clients, we also have internet where we can check for new information. With counselling, you need to be updated and have all the new information on your finger tips otherwise a patient [VCT client] can challenge you. But you see counselling has become a routine, so it has become like any other service within the hospital.

**Researcher:** How is VCT organised here at the hospital eg your self do you only offer VCT?

**Participant:** My dear, I am a trained Nurse and my main role is handling sick patients, so I have to do that as I do VCT as well. eeh, you want me to forget my skills. What happens is that we alternate counselling and offering other services at the hospital. So like me I do VCT on Tuesdays and Thursday while the other days I am on the wards. But I like it that way, because with this, then you are not stressed by one job. By the way counselling can be stressing sometimes.

**Researcher:** How stressing can VCT be and how do you deal with it.

**Participant:** You don't know how counselling can be stressing, ho ho ho, you see, sometimes you get people, especially women, and they want to tell all their problems right from the time they were born, in the process they remind you of your own problems, they take a lot of time, yet there are other patients etc. Eeh, it can be a tough job. But now with a lot of awareness, at least not so many surprises.

**Researcher;** Please tell me how you deal with such situations of those who tell you long bad stories

**Participant:** Of course I have to listen but then I try to bring them to finish the story. Sometimes you say, okay, I have heard that, its so unfortunate, lets talk about HIV testing, then you ask a direct question for example have you ever tested etc.

**Researcher:** Please tell me, typically what a VCT client goes through when he/she comes for testing, how is the process like and how long does it take?

**Participant:** Okay, let us assume a patient [client] has never been here and is coming for the first time. So the receptionist welcomes them, and directs them to the waiting area. But before that she [receptionist] asks for reason why they are here, once she ascertains that its for VCT, then she registers them and gives them a number. She informs one of the counsellors on duty who then calls the patient, by the number, not by name. When they are few, then we give individual counselling but if they are say more than five, we give group counselling before the test. So after the pre-test sessions, we then send them to the lab, they have a blood draw and then they go back and wait in the waiting area. In act as they

wait, we have videos we show and some pamphlets, so they are kept busy there. When the results are ready, say after 20 minutes, we then call in one by one, unless they have come as a couple or as a family. Some family members agree that they share their results, especially those intending to marry or parents who bring in their daughters.

But I tell you, giving results is not easy. The patient becomes so uneasy, they become so suspicious. We have to go through some of the information again eg what does an HIV negative or positive [result] mean, But all they ask, is tell me, how am I, am I dead or not. But we try to calm them. When you finally give the results, you discuss the options eg if he is negative [HIV negative], emphasise prevention and repeating the test in 3 months, if he is positive, then you go into advise on treatment . you then refer him to the ART clinic where he is assessed further, even for tuberculosis and other OIs [Opportunistic Infections].

**Researcher:** What kind of information do you give in the pre test and post test

**Participant:** Lots of information on HIV, transmission and prevention. We also try to assess their risk and knowledge on key issues related to HIV, their lifestyle, what they do etc. We discuss the meaning of each result, and importance of testing. At the post test, we repeat the same information, but then add on information as per the outcome of the results. A lot of time is taken for those who test positive especially, because they need support. We have to ensure they don't transmit more HIV to others. You know some of them say since I am already infected I can have sex with everyone without a condom, which is dangerous. So we make them understand. In fact what I have seen, many of the patients come here thinking they are infected, They tell you oh my girlfriend died of AIDS, my wife or husband is cheating on me [having extra marital affairs], oh, I got a skin rash, or I coughed for a month etc. But then many turn out negative.

**Researcher:** Do you feel the time given to clients is enough, short or long?

**Participant:** Yes, surely, the time given to each client is enough. We need to give enough education to the client, prepare him for his results, and so the time is very appropriate, it's not too much time, but just enough. But as I mentioned earlier, some want to talk endlessly, so they think time is very short. And others want to get results as quickly as

possible, they do not see the value of counselling especially at the start, so those ones things oh... we have to spend too too much time.

**Researcher:** How good or bad are the different forms of counselling eg couple counselling, group counselling, individual counselling etc

**Participant:** Hmm, this depends on an individual counsellor, but let me tell you what I personally feel

**a) Individual counselling,** its good and I think everyone if possible should get this but because there is limited staff. Sometimes it is difficult to counsel just one individuals especially if he is too quite.

**b) Group counselling,** is not bad. You know it's a like what you researchers call a focus group discussion. They talk to each other and for you guide them, but there are stubborn ones who do not want to give their friend a chance.

**c) Couple counselling,** hahaha, this one is trickily. It's a good form of counselling because you have both husband and wife there, but sometimes they begin quarrelling in front of you, and you have to sort them out. You can't defend one or the other, you try to counsel them. Oh my, the worst time in couple counselling is when couples receive discordant results! You first deal with one partner blaming and potential of violence, especially if a woman is the one who is HIV positive, then go on to explaining the reasons, some of which are too scientific for the clients to understand. You can even spend two hours just explaining. Sometime back I had to invite in my fellow counsellor to help out. After all this, then you have to convince them to return, but many never return.

**Researcher:** When you have such challenges, do you get some form of supervision support, or emotional support.

**Participant:** Hahaha, [laughs] support, the only thing the supervisor is asking you, especially when you have a project, is how many have you tested this week, how many were negative and how many positive,. They don't ask what problems you had. Its tough.

**Researcher:** Now lets us talk of VCT outside the counselling room, please tell me whether you offer VCT only here at the hospital or you go out to offer VCT in the field.

**Participant:** On yes, the mobile VCT, yes, we actually go out to the surrounding communities and set up and then offer VCT. We normally go to markets or even at some of the lower small health units and offer VCT.

**Researcher:** Please tell me the strengths and challenges for this form of VCT services.

**Participant:** Mobile VCT is good for the community. In fact, with mobile VCT, you feel happy as a counsellor seeing as many people as possible receiving VCT. You know there are many people out there who had never heard of VCT and so we talk to them. Some of them do not have transport to come here at the hospital so we find them. But the problem is that field work is tough in itself. You have to have good transport and sometimes our vehicle breaks down. Or you go there and few come or even many come and you have to see how to deal with the situation, rain also is bad, even the hot sun is not good. Some places we are given to work from do not provide confidentiality and others keep peeping. Actually, mobile VCT can be challenging sometimes. For example, you go to a place and the best place you can get for VCT is a school or church without doors and windows. And as you give results, you see some other people trying to peep in, to see if he [VCT client] is crying or smiling. If he is crying, then they say, Hey, that one is positive and if they see he is smiling, they know he is negative. So we have those issues of where exactly you test from, the venue.

**Researcher:** How deal with situations when clients come too many?

**Participant:** We explain to them and then we give them coupons to come to the hospital and when they do come, we do not make them wait, we counsel and test them immediately. In fact we have a seriously manpower problem and if you were to help us, you would convince the government to give us more staff. We are really overworked, we are few, and the clients are many. We have complained to our bosses but now we have given up, may be you can help us through your research. In fact I should be leaving now, my boss is about to ask me [she looks at her watch]

**Researcher:** As we finalise, what would you advise the government to deal with manpower problems, given that there is, limited funds

**Participant:** The government has a lot of money but they are just refusing to give to us. Let me ask you, a Doctor, how much does he earn, and how about your MP who even stopped at senior six, how much does he earn? Who is more important, of course a health worker. Let me not shout on this, but we need help.

But also these volunteers, may be tat could help, they hire and train volunteers who can actually counsel patients before they come here, and that was we shall save time. You sometimes get some people who are real green [uninformed] about HIV testing and you have to start from the basics.

**Researcher:** Lastly, counselling as a whole, what challenges and what possible solutions?

**Participant:** Limited staff is the problem, and this is because the government does not want to commit more money.

**Researcher:** Apart from staffing and funds, any other?

**Participant:** Yes, we need good transport for field work, good vehicles that won't get stack on the poor roads.

**Researcher:** Thank you for your time and the information you have given us.

**Participant:** Thank you and I wish you the best. Please make sure you inform those people at the Ministry of Health to put more efforts in funding and staffing.

## ANNEXURE J

### AN EXAMPLE OF FIELD NOTES

FIELD NOTES – Thursday 26<sup>th</sup> November 2007 (First interview with VCT counsellors).

**a) A running account of what happened.**

- Together with the research assistant, we left Kampala for XXXXXX hospital at about 8:30am.
- Our mission: To interview counsellors in XXXXXX hospital, for phase III. Appointments had been made the previous week
- Arrived at the XXXXXX hospital at 9:22, but found the health workers were in a meeting, I guess a staff meeting.
- Waited for about 15 minutes and the Medical Superintendent (MS) comes out of the meeting (he himself had been earlier interviewed, and so he knew us very well.
- He welcomed us and we reminded him we were here to interview the counsellors, to which he quickly remember and said, “oh yes, that’s fine, but added that he hopes they will have the time, being a Monday. He mentions that the hospital is busy at the moment.
- 9:42am. He tells us to go with him to the see the counsellors. This will be our first interview with the counsellors.
- The MS leads us to the counselling room and we meet one of the counsellors. She was reviewing something like a report, and she welcomed us. The MS introduced us “these are your visitors today” and she replied that no problem. Then before the MS leaves, he asked her about the patient who had been mentally disturbed, to which she replies that they have managed to control him.
- Then MS leaves, wishing us success and directing the counsellors that when we are done, she can take us to other counsellors. To which she agrees.
- 9:47am. We again introduce ourselves, what we are doing and the purpose. I then ask her if she can give us about 45 minutes of her time, to which she agrees. Just as I was finishing, her fellow nurse passes by and asks her how she felt about ..... some issue that they had discussed in the meeting. The counsellor (our target counsellor) replies that she too is not happy, but quickly adds that she is now going to have a meeting with us and we shall also talk to her later.

- As they are talking with the Nurse, I go for my documents, ie the interview guide and the consent form. My colleague the research assistant also reaches out for his folder and papers and pens.
- 9:50am. We begin the interview. I read out the consent form, verbatim while she carefully listens. She asks me whether we have a tape a recorder and say no, and she sighs with some kind of relief. I ask her whether she hates tape recorders and she replies in the affirmative, that she hates them. I again inform her that we are writing down each and everything but non of her names will be linked to the information she gives. I asked her to feel relaxed.
- The first questions relates to herself social demographic issues, to which she replies without any hesitation, and then we go to the entire interview.
- The interview goes on well without any disruption, except at end when she reminds her that patients are waiting. The research assistant was busy taking notes, and sometimes she would ask him if he has recorded all that is said.
- Towards the end of the interview, she tells us, pointing through the window that those people coming in are VCT clients, coming for testing. She looks at her watch, and murmurs some words in the local language, which basically mean that time has run out. We prepare to wind up the interview.
- Before the interview ends, we apologise for the time taken, but I ask her if I can summarise key issues she has told us. She agrees and I ask my research assistant to summarise. He goes through the key issues, and as we do that, she basically does not disagree with the record but gives us more information or clarifications, which the research assistant add in.
- At 10:42am the interview ends and we thank her and stand up to leave. She then stands up as well, and while we are saying bye, she asks us we want to have VCT as well. We thank her for asking and we tell her we shall come back for that. She insists that the only way we can know what goes on with VCT is having VCT services ourselves, but we assure her we shall return for VCT another day.
- Before leaving, we ask her if she can help us and direct us to another counsellor, she responds in the affirmative. She says that she is taking us to the lady who had come in at the start, that she is also a counsellor.
- She then leads us to another room, but we find the person not in the office. She picks her phone and begins searching for a number to call her. I then volunteer my phone to call her. She calls the number, but its busy. She tells us to wait a bit and assures us she will be coming. We thank her again and she leaves while we stay at the door waiting for the second interviewees.
- **b) Personal reactions and interpretation.**



- **The participant:** She was very friendly. She is dressed in her Nurse uniform (White dress and black belt) with white heeled shoes. She occasionally smiles, but at some points she laughs at some of the statements or questions asked. Uses a lot of you know, you see. She also uses a lot of abbreviations, which we keep asking her what they mean in full, but she seems to get upset when we ask even the “obvious” eg ART. But I explain to her that for purposes of the interviews, we assume that we do not know anything and we want to learn from her. She seemed very truthfully in whatever she says. At some point, she lowers her voice to indicate to us that this is secret information. She felt more comfortable without using a tape recorder, but was very okay with hand-writing all that she said.
- **Set up of the venue:** It’s a counselling room as we are told. And it looks like she was waiting for clients to come. She is seated behind a small desk and then for us we are seated on two chairs across the small desk facing her directly. On the desk is big black covered book, written on top “VCT patient register”.
- **Environment:** Its generally a quiet place. Very clean environment. All papers and books in the office are well arranged.
- **Interference:** Not much interference during the interview. Only towards the end of the interview, when some one knocks at the door. It’s a lady, who is telling her that some people outside want to see her.

**c), Methodology related issues.**

- During the interview, I tried as much as possible to listen to what she was saying, and tried as much as possible to keep the conversation in the same line, often asking for clarifications. As she talked, I kept eye contact, but at the same time noting down some of the key issues.
- I kept a record of some of the common key terms mentioned; things that would help enrich the research assistant notes. Some of these issues are helped in identifying the emerging theme, “buzz” words (meaning units), In this particular interview, some of the word coming out included – onsite integrated VCT, outreaches (often used interchangeable with mobile VCT), home based VCT, refresher courses, patient/clients, modes of counselling such individuals, couple counselling, family VCT. Problems, challenges and benefits of each are mentioned. Staff limitations keep coming up as well as limited resources, transport problems etc.

**Notes taking:** The role of the researcher assistant was basically to take notes from the interviews, writing almost everything said by the interviewer and the interviewee, often using abbreviations ie following every question and every response. At a few instances, the note taker would ask for “pardon” to clearly write the verbal expressions.