PROVIDING INTEGRATED VOLUNTRY COUNSELLING AND TESTING (VCT) SERVICES IN UGANDA

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ABSTRACT

The aim of the study was to explore the nature and utilisation of voluntary counselling and testing (VCT) service delivery to the Kasenyi fish landing site in the Wakiso district, Uganda. A qualitative, descriptive and explorative study was conducted and data were collected by conducting semi-structured interviews with seven purposively selected VCT counsellors from two hospitals serving the study area. VCT counsellors, mostly trained in medical sciences and in counselling, also provided other services at their hospitals within an integrated service delivery model. VCT services were offered at the hospitals or through mobile outreaches within target communities, including home-based VCT services. Different forms of counselling included individual, group, family and couples counselling. Although counsellors were well trained and qualified to offer VCT and related services, they faced challenges such as staff shortages and limited institutional support, which affected VCT service delivery and utilisation. Recommendations include increasing VCT staff, recruiting community volunteer counsellors, strengthening institutional support to VCT counsellors and sensitising communities about VCT services.

KEYWORDS Counselling of couples, discordant couples, HIV counselling, outreach VCT services, integrated health services, Uganda, VCT counselling

INTRODUCTION

Voluntary Counselling and testing (VCT) is internationally recognised as an effective and important strategy for both HIV/AIDS prevention and care (De Cock, Bunnell, Mermin, 2006: 441). VCT is a cost-effective intervention in averting HIV infections (Thielman, Chu, Ostermann, Itemba, Mgonja, Mtweve, Bartlett, Shao, Crump 2006:119). VCT is

a core intervention within the comprehensive strategy of the Ministry of Health of Uganda (MoH 2005:2) to address HIV/AIDS.

VCT is a confidential dialogue between a person and a care provider (MoH 2005:22) enabling the person to make an informed decision to use VCT services to receive the test results. In Brazil, truckers strongly recommended VCT services to their peers because it helped to know one's HIV status and to access information, free condoms and medications (Juan, Chinaglia, Lippman, Pulerwitz, Ogura & Mello 2006:5).

Within each hospital department VCT services are provided, which can be offered with other services, by the same staff. According to Uganda's MOH (2005:8), the most common method of making VCT services available is through existing public health systems integrated into general health care. Asiimwe, Kibombo and Matsiko (2005:3) report that integrated VCT service delivery is common in Uganda.

AIM AND OBJECTIVES

This study aimed to explore, describe and explain the models of VCT service delivery and VCT uptake. The objectives were to identify the different VCT delivery models and factors that influenced VCT service utilisation among the fishing communities, as perceived by the VCT counsellors.

RESEARCH METHODOLOGY

This qualitative study collected and analysed data from VCT counsellors at two hospitals in Wakiso District, Uganda, which provide VCT services. The researcher took a naturalistic approach to gain knowledge of how the two hospitals delivered VCT services to their target populations (Polit & Beck 2008:13-15).

Sampling procedures

VCT counsellors were selected as the study population because they counsel, sometimes test and give clients their HIV results. Seven VCT counsellors (four at one and three at the other study site) comprised the sample. Participants needed to have worked as counsellors for at least two years, and willing to be interviewed.

Data collection

Semi-structured interviews were conducted to collect data. Items included questions about the background of the participants, their training, conducting pre- and post-test counselling sessions, and challenges to ensure clients' privacy and confidentiality.

Data analysis

Data analysis was determined by both the research objectives (deductive method) and multiple readings and interpretations of the raw data (inductive method). Transcripts

were entered into a word processing computer software program which facilitated data searching, sorting and copying into separate files.

Trustworthiness

Trustworthiness of the study was achieved through three main ways, namely; dependability, confirmability and credibility (Rolfe 2006:305). Dependability, including activities that increase the probability that credible findings will be produced, was ensured through recording sessions dealing with the interpretation of data and keeping track of how coding evolved. Confirmability, relating to the objectivity or neutrality of the data, was ensured through field notes and interviewing transcripts kept by the researcher and research assistant. At the conclusion of each interview, the researcher reconfirmed the main points with the participant. Credibility, relating to confidence about the truth of the data, was achieved through vigorous training of the research assistant.

ETHICAL CONSIDERATIONS

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; wellbeing; anonymity; justice, and confidentiality (UNCST 2007:4).

RESULTS

All participants were women because all VCT counsellors were women. All participants, except one, had background training in medical sciences and four had worked at the hospitals for more than five years. The youngest participant was 28 while the oldest was 54. The rest of the results are presented according to themes that emerged during the data analysis.

Theme 1: Aptness of VCT counsellors

This theme examined how qualified the participants were to offer counselling services, their ability and willingness to offer the services at their respective sites, producing two sub-themes.

Selection of VCT counsellors

VCT services were introduced into the hospitals in early 2003 and the existing staff members were selected to offer counselling services. All the participants' selection as counsellors was based on the fact that they interacted with patients and had opportunities to counsel clients. The VCT counsellors did not apply to do counselling, but happened to be working in the departments when and where VCT services were introduced. One of the participants re-affirmed this by stating: *"... now that HIV/AIDS services have been integrated into many of the existing services, it is inevitable to avoid counselling"*.

The counsellors provided VCT services as well as other health services, although this could result in work overload. According to Asiimwe et al (2005:2), VCT services are provided by trained counsellors who are mostly nurses also providing other services within their hospitals.

Counsellor training

All except one of the participants had background training in the medical sciences, but all underwent formal counselling training. Training included HIV/AIDS, family planning, sexually transmitted infections (STIs) and tuberculosis (TB) as well as communication and counselling skills and trainee supervision.

Follow-up training, or refresher training, emerged in this sub-theme. At both hospitals, the participants indicated that whenever there was a new VCT project, refresher training was offered as an internal activity. Some participants had attended five refresher training sessions. Externally, the MoH frequently conducted counsellor workshops usually lasting three days, as explained by one participant: "*When the Ministry [MoH] 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, in that all counsellors should regularly update their knowledge through refresher and in-service training (MoH 2005:8).

Theme 2: Modes of counselling

The mode of offering VCT at the hospitals was identified as a second major theme. The participants compared different modes of counselling available at both hospitals.

Individual counselling

At both research sites, the most common approach to VCT counselling was individual counselling. Individuals go through pre- and post-test counselling just as individuals, as stated: *"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 is also referred to as one-on-one counselling. Ideally every individual, who accesses VCT services, should have a one-on-one session, especially during post-test counselling. The MoH (2005:11) emphasises that post-test sessions should be conducted confidentially regardless of the setting and whether the result is negative or positive, and that everyone being tested should have the opportunity for individual post-test counselling.

Group counselling

At both hospitals, pre-test counseling was sometimes offered to a group. However, individuals received their results separately, unless they asked to receive them together as in the case of couples or family VCT. Although group counseling 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 at all, while others want to dominate the discussion. 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 for dealing with group dynamics, the participants indicated that when there were many clients, groups were formed according to gender or estimated ages to minimise negative group dynamics. Group counselling may sometimes provide a favourable environment for accepting HIV testing. In India (Gupta, Lhewa, Viswanath, Jacob, Parameshwari, Radhakrishnan, Seidel, Frenkel, Samule & Melvin 2007:193) 215 mothers attending antenatal services were offered group counselling. Most (210; 97.6%) accepted HIV testing, which could be attributed to the value of group assimilation, which might otherwise have declined.

Couples counselling

The data indicated that clients were increasingly being tested 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 most HIV transmissions occurred through sexual encounters. The participants indicated that at least one or two couples received VCT every week, many of whom received concordant HIV negative or positive results, although discordant results sometimes occurred.

The major challenge in couple counselling concerned cases of discordant results. One participant added: *"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."*

Couple counselling is considered a positive move towards VCT as potential HIV infections are averted. A study in Uganda revealed that most couples get married without knowing their HIV status (Bunnell, Nassozi, Marum, Mubangizi, Malamba, Dillon, Kalule, Bahizi, Musoke & Mermin 2005:1006). In Nigeria, Uneke, Alo and Ogbu (2007:119) found that HIV infections were averted when HIV serology tests revealed HIV discordance among couples intending to get married.

The most demoralising event for participants was when (after efforts to counsel discordant couples on the need for protected sex) such couples decided that there was no need for using protection. According to the AIDS Information Centre (AIC), most challenges related to people believing that they were already infected, and considered themselves to be immune from further infections, and seeing no reason for practising preventive behaviours (Bunnell et al., 2005:1005).

Family counselling

Family VCT is normally carried out when children and youths are tested for HIV as 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.

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 Uganda, it is becoming increasingly difficult for the caretakers, often grandmothers, to take care of orphans and therefore some children are abandoned (Mugambe, 2006:2).

VCT for special populations

Besides mothers who are offered VCT under PMTCT programmes, other categories of VCT clients include disabled people, rape victims, and youths. One hospital had established a centre for rape victims, where they received specialised counselling and were tested for HIV and STIs. Special treatment refers to giving clients priority for VCT services or even special attention. In their programme, Homsy, Kalamya, Obonyo, Ojwang, Mugumya, Opio and Mermin (2006:153) explain that discordant couples deserve particular attention and additional time to address their concerns regarding sexual and reproductive health issues and to reinforce HIV prevention messages and condom use.

Mobile outreach VCT

Mobile VCT or outreach VCT, identified as a sub-theme, were offered at both research sites. Advantages of outreach VCT included that many clients were reached. According to a participant: *"With mobile VCT, you feel happy as a counsellor seeing as many people as possible receiving VCT"*.

The challenges of mobile VCT included the high demand for VCT in certain communities, where everyone who appeared expected to be served. As counsellors, they were sometimes 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"*. The participants explained 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.

Confidentiality and privacy were other challenges in mobile VCT services. Participants mentioned that that sometimes privacy and hence confidentiality might be compromised in mobile VCT, especially where large numbers came for VCT services or when using a venue with limited facilities. Njagi and Maharaj (2006:120) report that some of the respondents observed that the VCT services were not confidential, particularly when making an appointment, and lack of privacy especially in the waiting rooms, which could have contributed to low service utilisation.

Theme 3: Institutional challenges

The third major theme alluded to the fact that offering VCT services were sometimes influenced by the environment in which they operated, posing challenges. Three sub themes were further identified.

Counsellor support and supervision

The participants indicated that counsellor support took different forms, such as weekly meetings where previous work and challenges were reviewed, staff retreats, and attending counselling-related workshops and seminars. At one research site, weekly meetings were uncommon, 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 clients. 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.

Counsellor support and supervision are essential to avoid burnout, a common occurrence among VCT counsellors, affecting the quality of VCT services (Held & Brann 2007:213; Harrington & Harringan, 2006:109). In their study, Rohleder and Swartz (2005:404) found that some counsellors felt that senior staff members lacked appreciation for counsellors' work and did not understand clients' needs.

Institutional pressures

The participants indicated that when counselling was done as a project, there was more emphasis on numbers than on the quality of counselling. A common question in project VCT services were, "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. One participant 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. This resulted in a competition: *"If your team tested fewer patients, you would feel demoralised, as if you are competing"*.

Pressure from the organisation to offer VCT in a way contrary to a counsellor's preference has been observed. In a study by Rohleder and Swartz (2005:403), counsellors complained about conflict with the nursing managers, who were concerned about the number of people who needed to be tested, indicating that the counsellors often rushed to finish off counselling sessions. Overloading counsellors and prioritising certain health services over VCT services occurred commonly at hospitals in Uganda. According to Asiimwe et al. (2005:7), this was what commonly happened with the integration of services without providing additional staff members.

Theme 4: Factors likely to affect client satisfaction

The fourth theme related to counselling-related factors likely to affect the accessibility and acceptability of VCT services.

Information sharing during VCT sessions

The participants described different techniques to retrieve useful information from clients. A relaxed environment was created 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 behaviours.

Some participants pointed out that there were "stubborn" clients who refused to divulge useful information. They were given general counselling and were not counselled about their specific problems and needs. According a participant: *"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"*. The type and nature of information passed on to clients included 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 correct condom use.

Waiting time

The time clients spent at VCT sites emerged as a sub-theme. The entire process of VCT services might take 60-90 minutes. The participants had mixed reactions on whether the waiting time was too long. 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"*.

Some 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 and other health services especially medical emergencies, clients sometimes had to wait 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 integration of services without necessarily having additional staff frequently means long waiting times. Asiimwe et al. (2005:7) found staff shortages due to integration of VCT services in Uganda.

Giving test results

According to the participants, 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. The most common reactions were anger and blaming either self or the sex partner. One participant 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. 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".

Various reactions to HIV testing have been reported. According to Roberts, Grusky and Swanson (2008:15), counsellors reported that due to the stressful nature of the HIV testing situation, clients sometimes behave in very unusual ways.

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: *"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".*

Admassu and Fitaw (2006:26) report that anticipation of a positive result commonly comes along with negative consequences such as depression and anxiety and possibly stigma. According to Sahay, Phadke, Brahme, Paralikar, Joshi, Sane, Risbud, Mate and Mehendale (2007:44) among the 65 HIV infected individuals, the likelihood of anxiety, depression and distress was 55.4%, 49.2% and 49.2% respectively.

Privacy and confidentiality

The participants indicated that clients sometimes did not give their actual names during the testing process, and sometimes they forgot the names they had given. Clients who were tested under false names sometimes gave their real names after they had 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 about his name and contact information, and so we had to fill in another form".*

The participants at both sites indicated that they had encountered accusations of breach of confidentiality. Some articipants admitted that they often received requests from third parties, asking to know the HIV test results of certain clients. If a wife tested for HIV and a husband asked the test results, the wife might tell him to find out from the clinic where the test had been done. When some clients were told the results, they still wanted to prove that their spouse received a negative or positive result and therefore might confront 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".

Clients accused health workers, and particularly VCT counsellors, of breaches of confidentiality. Choi, Lui, Guo, Han and Mandel (2006:37) reported that 47% of their respondents experienced fears of breach of confidentiality about their test results as barriers to HIV testing. Njagi and Maharaj (2006:120) emphasised that unless clients could be assured of privacy and confidentiality, the use of VCT services might remain lower than expected.

Counsellor burnout

Counsellors experienced forms of burnout related to VCT counselling. Almost all the participants admitted to having had emotional stress with some clients who told them about their life experiences, especially those who tested positive. Held and Brann (2007:213) found several stressors such as clients who divulged more or less information than needed, the need to keep confidentiality and not to share experiences and remaining empathetic.

CONCLUSIONS

VCT services were provided in hospitals alongside other existing health services under an integrated model. Counsellors normally have background training in medical sciences; and they were already offering health services long before VCT services were introduced in the same hospitals. They offered VCT services both onsite and offsite.

VCT service could be described by the number or relationships of clients receiving VCT at the same time. VCT was offered on an individual basis, and to couples, families and groups. When being counselled for HIV testing, clients were mostly counselled as individuals during pre- and post-test counselling. However, some other clients were offered pre-testing in a group or they were given both pre-testing and post-testing as couples. Although challenging, VCT counsellors found couples' VCT counselling to be more rewarding than the counselling of individuals.

Although the integration of VCT services with related services had benefits for clients, it strained other services, because increased funding and staffing were not supplied. The few available counsellors also had to offer a wide range of other health services, affecting the quality of VCT services.

Other challenges faced by VCT counsellors included dealing with clients' anxiety shortly before receiving HIV test results, dealing with discordant couples, more especially when the infected partner was a female and also when faced with indeterminate results. Other challenges included large numbers of individuals requiring VCT services, especially during mobile VCT services, having to turn some away and lastly institutional pressure to focus on quantity rather than quality of VCT.

LIMITATIONS

This study was limited to VCT service delivery and utilisation in and around Kasenyi fish landing site, in Wakiso district, Uganda. Only two health units provided VCT services at the targeted site, which limited comparison of the data across health facilities. The research results comprise only data obtained during semi-structured interviews. Observations of the service providers' actions during VCT services might have provided different data. No interviews were conducted with clients who used VCT services.

RECOMMENDATIONS

There is a need for increasing the quality, accessibility and acceptability of the VCT services. Community volunteers could be trained to provide pre-test counselling. Institutional support to VCT counselling should be strengthened. VCT counsellors should be given adequate supervision and support through which challenges could be identified and addressed. There is a need to build community awareness and sensitisation about VCT services. This would entail equipping potential clients with adequate information before they access VCT services. This is expected to reduce the amount of time spent in counselling rooms and reduce anxiety on the clients' side.

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