THE ATTITUDE OF PEOPLE TO WARDS COUNSELING AND TESTING SITUATION: A CASE STUDY OF KIMAANYA-KYABAKUZA-MASAKA DISTRICT

BY

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SEPTEMBER, 2011

DECLARATION

I do hereby declare that this research proposal presented is my own work and it has never been presented to any academic institution for any academic qualification.

ABERI AGNES

SIGNATURE.....

DATE:16/9/2011.....

DEDICATION

To my beloved my brothers, sisters and friends

APPROVAL

This is to confirm that the researcher's work has been done under my supervision and subsequently approved by me.

SUPERVISOR

DR. LAAKI SAMSON

SIGNATURE.....

DATE.....

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ACRONYMS

HIV/AIDS.....Human immune Virus

VCT.....Voluntary Counselling and Testing

UNAIDS.....United Nations AIDS

ARV.....Antiretroviral

UDHS.....Uganda Demographic Health Survey

AIC.....Aids Information Center

NGOs.....Non-governmental Orgnisations

WHO.....World Health Organisations

FGDs.....Focus Group Discussions

LIST OF FIGURES

TABLE OF CONTENT

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter presents an over view of the proposal, the background of the study, problem statement, purpose and objectives of the study, research questions, scope of the study and its significances to the government or policy makers and implementers the local communities and the researcher

1.1 Background

The study focuses on the views of the people in the Kimaanya-Kyabakuza Sub-county Masaka District of Uganda regarding access to and use of the Voluntary Counseling and Testing Services(VCT), which is increasingly used as a strategy for reversing the HIV/AIDS pandemic. Improved health care and nutrition in Uganda have resulted in an increase of the numbers of children reaching adolescence. According to the Uganda population and housing census 2003 done by the Uganda Bureau of Statistics (UBOS) the current population of Uganda is over 20 million people, of which over 7 million are between 10-24 years or almost thirty two percent (32%) of the total population. HIV/AIDS pose as a challenge to their lives; however, voluntary counseling and testing (VCT) acts as an entry point for providing comprehensive HIV/AIDS services. AIDS poses one of the most serious threats to people with HIV/AIDS in poor countries. Globally, more than half of the new HIV cases occur among young women and men of 15-24 years (UNAIDS, 2000; UAC, 2000). According to the Uganda Demographic Health Survey (UDHS, 2002), it is estimated that the HIV prevalence rate among youths (15-24 years) is 3.70-5.56% among females, and 1.59- 2.38% among males in Uganda. This compares with the sub-Saharan rates of 6.41-11.39% for females and 3.13- 5.56% for males (UNAIDS, 2002). The females' aged 15- 19 years are six times more likely to be infected than males in this age group. Early marriage and earlier onset of sexual activity for females, as well as sexual relations with older men are cited as factors predisposing young women to infection (UDHS, 2002). Studies have shown that social, cultural, and biological factors contribute to the vulnerability of girls to HIV/AIDS (Ayiga et al., 1999;

Gumusiriza et al., 1996; UNAIDS, 2000). Available data in Uganda indicate that among youths of 15-24 years, the prevalence rates have declined from 11% among males and 29% in females in 1992 to 2.5% and 12.1% respectively in 1999 (UDHS, 2002). And the general prevalence is down from 18% in 1992 to 6.5% in 2001. This decline is as a result of the open policy the Uganda government adopted in 1986 to fight HIV/AIDS. Messages of prevention were spread and people became aware of the causes of the disease. It is currently estimated that knowledge about HIV/AIDS in Uganda is almost universal (UDHS, 2002). Voluntary counseling and testing, initiated as early as 1987 when the Immune Suppressive Syndrome clinic was founded at Mulago Hospital in Kampala, had within months hundreds of clients registered for HIV counseling and testing.

1.2 Statement problem

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

The AIDS Information Centre (AIC) in Uganda was the first Non Governmental Organization (NGO) to start a VCT clinic in 1990 and in its first 11 months of operation,

it served over 9,000 clients and above its target of 5,000 (AIC, 2003). The Uganda Demographic Health Survey (2002) indicates that over 70% of Ugandans are eager to know their HIV status. However, the percentage for those who actually volunteer for the test is still small: eight percent (8%) men and twelve percent (12%) women.

These are mostly people with some secondary education and those living in urban areas. Married men also access the services in greater numbers compared to the unmarried. A baseline study by Baggaley and Boswell (2001) in two countries of East Africa, Uganda and Kenya showed that most of the young people who had taken a HIV test, said that they would adopt safer sexual behaviors such as abstinence, practicing monogamy, using condoms and reducing the number of sexual partners. This suggests providing comprehensive HIV/AIDS services. AIDS poses one of the most serious threats to young people in poor countries. Globally, more than half of the new HIV cases occur among young women and men of 15-24 years (UNAIDS, 2000; UAC, 2000). According to the Uganda Demographic Health Survey (UDHS, 2002), it is estimated that the HIV prevalence rate among youths (15-24 years) is 3.70-5.56% among females, and 1.59- 2.38% among males in Uganda. This compares with the sub-Saharan rates of 6.41-11.39% for females and 3.13- 5.56% for males (UNAIDS, 2002). The females' aged 15- 19 years are six times more likely to be infected than males in this age group. Early marriage and earlier onset of sexual activity for females, as well as sexual relations with older men are cited as factors predisposing young women to infection (UDHS, 2002). Studies have shown that social, cultural, and biological factors contribute to the vulnerability of girls to HIV/AIDS (Ayiga et al., 1999; that VCT can be an important strategy in controlling and

reversing the HIV pandemic.

1.3 Objective of the study

The main objective of this study was to assess people's attitude towards VCT and testing situation in Kimaanya-Kyabakuza Sub-county, Masaka District.

1.3.1 Specific objectives

i. To determine people's attitude towards VCT situation in Kimaanya-Kyabakuza Sub-county, Masaka District.

ii. To identify practical ways of improving accessibility of VCT to the people as a measure of controlling the spread of HIV/AIDS, using participatory action research.

iii. To identify the collaboration between researchers and practitioners as well as communities.

1.3.2 Research questions or hypotheses

i. What is people's attitude towards VCT situation in Kimaanya Kyabakuza Sub-county Masaka District.

ii. What practical ways of improving accessibility of VCT to the people as a measure of controlling the spread of HIV/AIDS, using participatory action research.

iii. What is the collaboration between researchers and practitioners as well as communities.

1.4 Scope of the study

The study focused on people's attitude towards VCT situation in Kimaanya-Kyabakuza Sub-county Masaka District.

a)Time scope:

The research was carried out for the period covering from the year 2011. This time period was chosen because the consistent decline in its performance started around this time.

b) Content scope:

Content scope was based on people's attitude towards VCT and testing situation

c) Geographical Scope:

This research will be carried out in Kimanyanya-Kyabakuza in Masaka District, which is made up of other three sub-counties, namely Kakuuto, Kasasa and Kifamba.

1.5 Significance of the Study

i. Policy makers such as government can use the findings of this research to come up with good policies on people's attitude towards VCT situation.
ii. The selected case study: help it to come up with a system that is accessible and flexible and also improve on the one in existence.
iii. This study shall be used as a requirement for the award of a diploma in Guidance and Counseling of Kampala International University.
iv. Future researchers shall use the findings got from this research as future references as they do their research in the topic and also related topics.

CHAPTER TWO

LITERAURE REVIEW

2.0 Introduction

This chapter presents the literature that the researcher got from related concepts on tourism done by other researchers, books and theories concerning Voluntary Counseling and Testing.

2.1 Definition of major terms

2.1.1 Voluntary counseling and testing has been defined as "a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour." (World Health Organization [WHO], 1994).

2.1.2 Pre-test counselling

HIV counseling is often given in connection with a voluntary HIV test. Such counseling helps to prepare the client for the HIV test, explains the implications of knowing that one is or is not infected with HIV, and facilitates discussion about ways to cope with knowing one's HIV status. Patient D, Neil MO (2004)

2.1.3 Post-test counseling

Baggaley R, Boswell. D (2001) Post-test counseling helps the client understand and cope with the HIV test result. Here, the counselor prepares the client for the result, gives the result and then provides the client with any further information required, if necessary referring the person to other services. The two usually discuss ways to reduce the risk of infection or transmission. HIV test results should always be given with counseling.

2.1.4 (AIDS) Acquired immunodeficiency syndrome

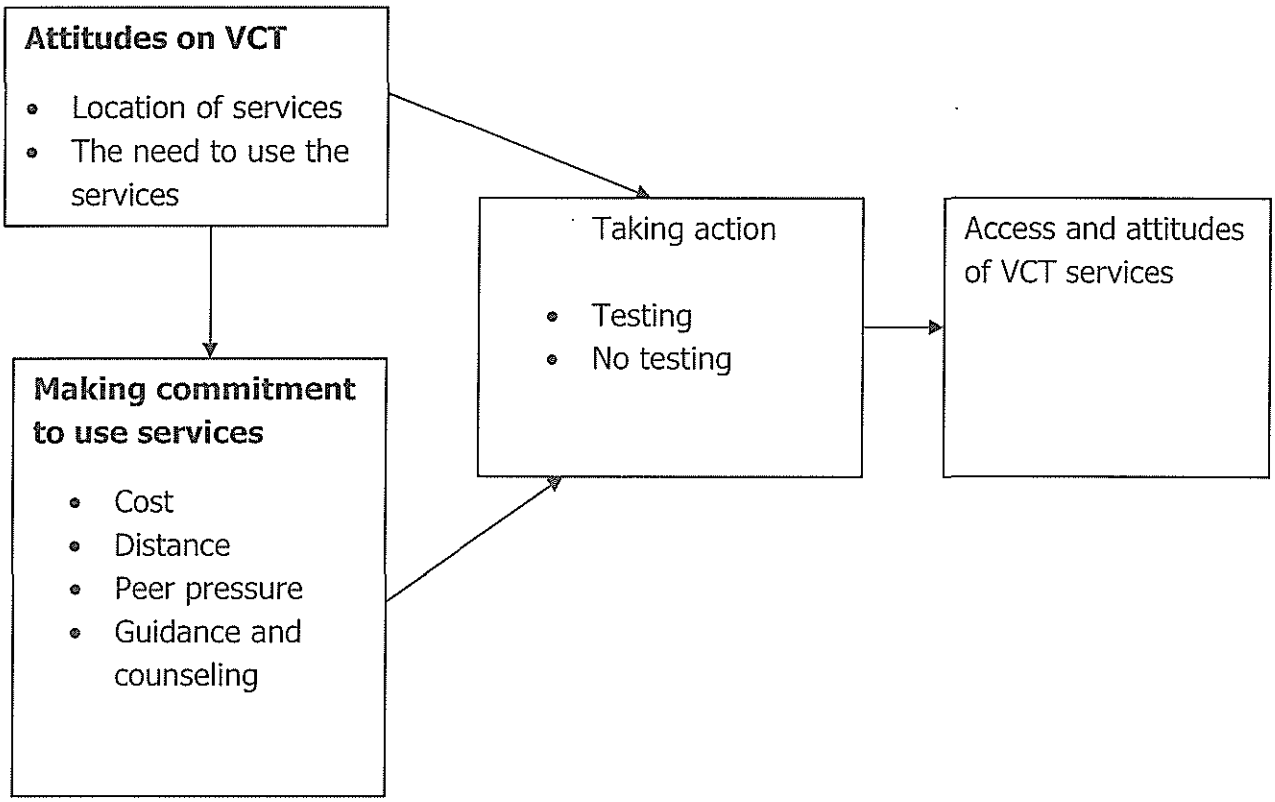
2.1.5 The counseling process

HIV counseling is a confidential dialogue between a client and a counselor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counseling process includes evaluating the personal risk of HIV transmission, and discussing how to prevent infection. It concentrates specifically on emotional and social issues related to possible or actual infection with HIV and to AIDS.

With the consent of the client, counseling can be extended to spouses, sex partners and relatives (family-level counseling, based on the concept of shared confidentiality). HIV counseling has as its objectives both prevention and care. A counselor is a person trained in the skills of the job: listening to the client, asking supportive questions, discussing options, encouraging the client to make his or her own informed decisions, giving practical information and suggesting follow-up.

2.5 Conceptual frame work

Figure 1. Conceptual model on people's attitudes towards voluntary counseling and testing.



Source: Masaka District: Records 2010

2.6 Theoretical frame work of the study

Theory of Fear. Rachman (1992). The theory of fear postulates that fear is acquired through the absorption of threatening information posits that fear could be generated through information which may or may not be threatening but which the recipient perceives as threatening. For instance information about some terminal illnesses could generate the fear of death. The visual display of HIV/AIDS patients in the media is capable of creating fear in the minds of the members of the public. In many cultures in Nigeria HIV/AIDS is perceived as an evil disease and no one would want to be identified with such an evil disease. It is this perceived fear of contracting such an evil disease that discourages many people from taking advantage of screening to know their status.

Even those that know their status shy away from counseling because they do not want to be identified with such an evil disease.

In 1990, Catinia et al. (1990) developed a theoretical model of the AIDS Risk Reduction. This model explains some of the interacting factors in limiting and promoting HIV/AIDS spread. This model can be replicated for the VCT services as one of the parameters for HIV/AIDS reduction. The interacting factors thus contribute in one Mway or the other to the spread of HIV/AIDS as shown in Figure 1. It is clear from this model that knowledge on the availability of the services influences the actions taken and making commitment to change. These factors when studied may contribute to the access and increased utilization of the services.

2.7 People's attitudes towards VCT

Lack of skills to negotiate safe sexual behaviour, poor access to contraceptives, and vulnerability to sexual abuse put people at highest risk of HIV infection. These factors, among others, contribute to people's reluctance to use VCT services.

Fear of stigma, marital disharmony, and incurable nature of the disease and cost of treatment. Formal education, female gender and HIV knowledge significantly predicted positive attitude toward VCT for HIV/AIDS among the study population.

People fear that confidentiality might not be maintained in health facilities. Health workers' attitudes towards teenage sexuality are sometimes negative and young people perceive them as intimidating. Communication with parents about sexual issues is rare and often times information comes from peers and is often incorrect. Lack of skills to negotiate safe sexual behaviour, poor access to contraceptives, and vulnerability to sexual abuse put young people at highest risk of HIV infection. These factors, among others, contribute to young people's reluctance to use VCT services.

Reasons indicated for avoiding VCT include "afraid of stigma and discrimination in case of a positive test result" (48%), "fear of the unknown" (34%), "marital disharmony"

(9%), "because it has no cure anyway" (3%), and "the treatment is costly and not readily available" (6%). Only 57.7% of male respondents were willing to have VCT compared to 82.8% of the female respondents. Significant predictors of positive attitude towards VCT include: formal education, knowledge of HIV/AIDS and being female (Table 4). Although older respondents appeared to have positive attitude towards VCT, this difference was not statistically significant.

In many cultures, it is socially unacceptable for young people to be sexually active unless they are married. As a consequence, sexually active young people don't openly talk about their experiences with adults, including health workers. They fear that confidentiality might not be maintained in counseling facilities. Counselors' attitudes towards teenage sexuality are sometimes negative and young people perceive them as intimidating.

Many people do not know where to obtain these services. In 10 of 18 counties surveyed, less than 50% of people aged 15–24 knew where they could go to be tested for HIV" (WHO, 2006). Masaka district doesn't escape this statement of fact. Indeed, despite government and NGOs prevention efforts towards adolescents, their access to information and reproductive health services remains low because of many factors such low schooling, lack of appropriate health care services and other socio-cultural factors.

AIDS related stigmas are another factor that probably influences seeking VCT in Masaka district, Uganda. Stigmatizing beliefs about AIDS and their associated fears of discrimination can influence decisions to seek HIV testing and HIV treatment services.7 8 In a study conducted in the United States, Stall et al9 reported that two out of three men who have sex with men who were unaware of their HIV status indicated that AIDS related stigmas were an important factor in their testing decisions. More recently, Herek et al10 found that 38% of a US national sample of adults stated that they would be very concerned about stigma if they tested HIV positive, and 44% of people who expressed this concern indicated that stigma influences their testing decisions.

2.8 Practical ways of improving accessibility of VCT to the people as a measure of controlling the spread of HIV/AIDS.

Counselling: consistent counselling by all the health care workers in the multidisciplinary adherence team, where each member plays their part and all members jointly give consistent messages to the patient can boost adherence.

Treatment diary: a pill chart or pill chart is kept for each patient and the diary is marked every time the patient misses a dose and the reason for missing. This way the reasons for missing doses can be collated and addressed accordingly.

Pill boxes: these are containers for storing medication with dividers for each day and each dose within the day. This makes it easy for patients to take doses correctly. Pillboxes with electronic reminders are also available. Some pharmacies in the West even distribute pre-loaded pillboxes. A possible disadvantage of the pillbox in developing country settings may be its visibility in situations where patients need to hide medications from others due to confidentiality reasons. Patients who are illiterate or very sick may need help to fill the pillboxes correctly.

The 'buddy' system: The buddy system relies on a friend or family member to help the patient to take medications regularly—reminding the patient to take his medication on time, offering encouragement to keep going, helping to keep hospital appointments, providing support etc.

2.9 Collaboration between researchers and practitioners as well as communities.

Modified DOT: DOT (Directly Observed Therapy) is an intensive program in which patients take their medication under the supervision of adherence staff. In treatment of tuberculosis (TB), DOTS is used, where health workers observe the intake of all medication doses for the entire treatment period of 6–9 months of treatment. TB DOTS

is more regimented and provides tighter monitoring of medication intake. In the case of ART, it is not practical to observe all doses as most Highly active antiretroviral therapy (HAART) regimens have multiple doses and treatment is lifelong. Therefore, only some doses are observed for a fixed period of time (a few months). This is called *Modified DOT* or *Directly Administered Antiretroviral Therapy (DAART).* Modified DOT can be done at health centres, in community-based organizations or even at a patient's home.

In the management of HIV infection, a modified DOT strategy, through frequent patient–provider contact, is used as a behavioural intervention that helps patients:

a. to develop an understanding of the treatment;
b. to develop good treatment taking behaviour;
c. to receive support during the first few weeks of antiretroviral therapy when patients have short term side-effects; and
d. to develop a trusting relationship with providers.

IEC : the use of Information, Education and Communication (IEC) materials in patient education in HIV treatment is another way to promote adherence. The IEC material should be simple, lucid, legible and only address matters that the client needs to know to enhance adherence, and should not be burdened with deep scientific information that can confuse the patient instead of educating him/her, or that the patient does not necessarily need to know to improve his/her adherence.

Telephone reminders: telephone reminders are being tried out in some studies on adherence. There are several limitations to its use: it is labour intensive for staff, patients must have a telephone at all times and cost issues. Internet based *confidential reminders services* are also being used.

Patient tracking: the involvement of community health workers (tracers) to track down patients who fail to attend scheduled clinic meetings or peer education sessions has also been used with some success. This method especially works in cohesive societies where members interact, meet, know each other and are in close touch with each other. This method may not work in cities and such other *'individualistic'* communities, and the success of this method also depends in some measure on the amount of stigma in the community.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the research methodology used by the researcher, which describe research designs, study or target population, sample techniques and sample size. It also includes data collection methods, data analysis and ethical considerations and the limitations to the study.

3.1 Research design

The research design used was cross sectional using both qualitative and quantitative methods of research. Qualitative methods of data collection was used because they capture and inform better on those aspects. In addition qualitative methods were used. Quantitative methods of data collection were used to capture aspects, which needed quantification such as bio data and population percentages. More emphasis was given to qualitative data in order to capture the in-depth data.

3.2 Study area.

The study was conducted in Kimaanya-Kyabakuza Sub-county Masaka district, which is located in the central part of Uganda. The area was selected for this study because of its being at the center of HIV/AIDS cases.

3.3 Study population

The study population was comprised of the residents within Kimaanya-Kyabakuza Sub-county the selected area and the district officials.

3.4 Sample size and sample procedure

The sample size was a portion of the population whose results were generalized to the entire population under study. Ideally the whole population was used to get information for research. However, it was not possible to investigate the whole population due to inadequate resources and time. A sample size was therefore deemed necessary. The immediate purpose of a sample was to increase the ability of generating the outcome of the population and to ensure that the sample included all units of interest to the study.

3.5 Methods of data collection

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

In depth interviews

These were held with twenty (20) young people from the community, fourteen (14) of whom were tested and six (6) who were not, four (4) service providers, one (1) hospital medical superintendent, twelve (12) adult women in the community, eight (8) adult men in the community, five (5) district administrators, six (6) political leaders, four (4) religious leaders, three (3) traditional medicine providers and three (3) sub county leaders of Kimaanya-Kyabakuza Sub-county.

The focus group discussions

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

3.6 Data analysis and management

The data was analyzed using thematic and content analysis. All interviews and focus group discussions were transcribed and translated. The transcripts were then be read and coded manually to identify concepts, patterns and themes. The themes were developed in the analysis among which included attitude on VCT services, factors

limiting the use of the available services, and what alternatives to be explored for improving accessibility and utilization of the services by the people. Quotes were recorded verbatim in the text with some editing done without losing the content and ideas of the participants. As part of improving quality, the research assistants were trained in participatory research methods, provided with detailed background to research project, aims/objectives and methodology, pretesting the research instruments, sampling technique and good communication/interviewing technique (using role plays), for the facilitation of the numerous qualitative data collection methods. The research team daily discussed on emerging issues and gaps in order to maximize quality in the data collection exercise.

3. 7 Ethical consideration

A letter of introduction stating the purpose of the research was obtained from the head of department, Kampala International University. In addition, permission was sought from Masaka District Officials and the local authorities of the study area before the collection of data. Confidentiality was assured to the respondents before the interview started. To maintain integrity of the information to be presented in the research report, reference were made to all information collected from already documented texts.

3.8 Limitations of the Study

i. Primary benchmark information was not easy to get from the respondent for reference. However, the researcher maked use of the district documents and staff records.

ii. At the time of this study, it was like opening old wounds. The whole exercise raised emotions; some respondents were rude and they even refused to give any information.

iii. This study was not an easy task. Being the first of its kind, the researcher faced problems of getting relevant literature on the subject.

CHAPTER FOUR

PRESENTATION, INTERPRETATION AND ANALYSIS OF DATA

4.0 Introduction

After data collected the next thing to be done is data presentation, interpretation and analysis. In this chapter the goal is to present the results of the data gathering. Through this chapter analysis of the results of the study can be done. The research output or the gathered data needs to be properly presented

4.1 Discussion

Knowledge on VCT

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

This calls for designing other innovative ways such as painting of big pictures on the walls of big buildings like community halls, dispensaries and shops depicting information on the adverse effects of HIV/AIDS on the youngpeople in particular and the need for VCT services among the young people.

Commitment to action

An interaction of individual, community and institutional factors have been found to be contributing factors to the low use of VCT services by the youths and hence influence the commitment to go for a test or not. This shows the stigma attached to the

structures and the personnel who provide the services. Some of the young people still do not know the advantages of the VCT services. The stress is related to the imminent death or loss of income, the fears, and lack of support because of the costs associated with positive status. All these individual factors point in one way to the fact that there is this kind of stigma attached because as soon as the youths enter the facilities or consultation rooms it is like a condemnation and a belief that has had an exposure to the risk. This kind of environment needs to be adjusted to suite the beneficiaries of the program and their involvement in the designing process.

The quality of services, particularly the time taken to release results which came out as one of the concerns, is a manifestation of the structural arrangements of bureaucratic processes, undermining the provision of VCT services. While advocating for the same day results as an attraction for accessing the services it is still a challenge in this community and hence the need to modify the procedures being folloid. (UNAIDS 2000, Jackson 2002).

Alternative and choices to providing VCT services

The study results have shown that there are number of alternatives and choices which can be explored and strengthened in order to increase on the accessibility to the services. Mobile clinics in market areas are potential alternative sites. The youths found the mobility of these structures to be a source of privacy and provided anonymity as compared to the regular health units or hospitals.

Structural stigmatization could be a limiting factor to accessing (Patient and Neil, 2004; Ayiga et al., 1999). This is because it puts the clients or patients in situation to disclose their conditions by virtue of their presence to such structures and personnel providing the services. The traditional and herbal medicine providers ire found to be potential outlets for the provision of services where the government or NGO had been unable to. Though care must be taken to ensure these providers get the adequate training and a structure put in place for supervision. On the side of modern medicine, there are drug

shops and private clinics again to meet the needs of the people in the area especially treating STI. Qualified personnels provide treatment and care in most of the health facilities. Many youths go to private clinics for services.

The youths seem to feel more comfortable in these establishments and have therefore a potential for counseling, education and mobilization, after which the youths can be given appropriate referrals. These approaches can be explored further through dialogue meetings with the various stakeholders and particularly involving the youth.

The policy guidelines

There is a policy on VCT which provides for guidelines to be folloid. The guidelines however are silent on providing services in a youth friendly manner which needs to be looked at. This will provide a framework for the service providers on what special arrangements could be made
purposely for the youths in the resource limited settings.

Such arrangements may include the arrangements in the locations, facilities, the nature and type of service providers and the necessary structures to be put in place. The recommended work load for a counselor and the qualifications are limiting in them because a limited number of clients will be served on a clinic day and hence limited service utilization. Where group counseling is done a big number can be served on a particular clinic day if clearly done ill. The use of peer youth educators can also be adopted by providing basic youth counseling services. This can be done by integrating the peer educators into the mainstream HIV/AIDS activities, which
is an area that is lacking in the policy document.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter is dedicated to the summarization of the results presented in the previous chapter, as ill as the conclusions that can be derived from the gathered and collated data. Recommendations for actions as ill as further studies are also included in this chapter.

5.1 Summary of findings

Knowledge on VCT services

In analyzing the data for this study, i found that most young people have knowledge and information on VCT services available. This is an indication of the amount of publicity of VCT, as a key informant shared: 'People are being sensitized every day about the advantages of VCT services and their availability.

The VCT ser-vices ire brought nearer (health centers) but before, people used to suffer a lot in the villages" (Key informant district administrator) In all the focus group discussions, the youths- male and females- in rural- urban described the prints media and the radios as their main source of information on VCT services:

"I have heard about VCT services through radios, (FGDs)". Others, especially mothers had heard about VCT services when they attended the health centers for other health issues as shared by a married youth:

"I have heard about VCT and i have been checked at the Health Centre. I got our results" (FGD Married Youth).

The students youths preferred the messages on radios and straight talk, a newspaper pullout on sexuality especially among the youth; an indication that the interaction and communication betien the youths and service providers could be problematic. The

services are provided in the government facilities, the key services provided being testing, and counseling. The youths ire given information on behavioral change such as reducing the number of sexual partners, avoiding drinking alcohol, and seeking further counseling. Additional health education about prevention of mother to child HIV transmission and treatment of sexually transmitted diseases for those who need the services was provided.

Commitment to take actions on going for a test

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

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

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

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

"The boys (male youth) rarely seek the VCT services because they tend to be busy and lack patience. At times one has to spend almost a whole day at the VCT due to many patients" (Ki, Service provider).

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

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

The youths in this study, however are willing to know their health/blood status, whether negative or positive, so as to plan accordingly. They also want to have access to free drugs and plan for a career as illustrated by this story nshared by Jane regarding her process of accessing and utilizing the VCT services (name has been changed to provide anonymity). Jane wanted to know her health status so she could begin medication if found positive. Jane wanted VCT services in this area because she had hope for a job to work as a teacher in the tailoring class. Because the distance to the VCT was not too long, she could walk in case she had no money for transport. Jane was sensitized through a friend who was a member of the Drama group and had used the services already. She had developed some fear although counseled but later gained strength when going for results. Jane got her results after waiting for some four hours because of the large number of clients. Jane learnt to take care by use of condoms especially when tempted to having sex. She stopped taking alcohol because it influenced her so much into sex. Jane started planning seriously for her future. She wanted to start business in Kimaanya-Kyabakuza Sub-county, Masaka District after getting capital. She found the environment at the VCT centre friendly and excellent especially on theside of counselors.

Fears after testing

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

'I had no fear at all [testing] because of my past movements. I enjoyed life so much at Kimaanya-Kyabakuza Sub-county, Masaka District because I was a driver of pick up – Datsun. In fact, it is for my mother and she also contributed much on my acquiring aids because may be if she had not given me a car, I wouldn't be positive by now" (In depth Interview with
Young PHA).

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

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

Community factors

Transport costs: I found transport cost to be a barrier in accessing VCT services. In most cases the high transport costs is due to the long distance to the service centers

and this was mentioned as a constraint mainly for the female youths as shared by a political leader:

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

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

Institutional factors

Quality of services: Quality of services determines how much the youths will access and utilize the VCT services. In this study i found that although the majority of the health workers are trained, they are few compared to the demand. This is especially the case in outreach centers where the youths said that their morale was loired from the long waiting, "on reaching there, one has to wait for so long, no drink available so people lose morale" (FGD female youth Kimaanya-Kyabakuza Sub-county, Masaka District). The youths said that they found the quality of counseling to be good, with confidentiality assured when filling in forms with the counselor.

The counselors ire described as friendly to the patients but the constraints mentioned included lack of peer educators, long waiting hours to access the services, givingvarying

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

"Some youths are very mobile: today in Uganda and two ieks reside in Tanzania. So it would be better if they give us a day in a month when they can test us. They could tell us two ieks before the actual day of testing in order to organize ourselves" (FGD Female Youth Kimaanya-Kyabakuza Sub-county, Masaka District).

Another constraint towards quality services described was the time taken to release results. The government health facilities take a short time to release results after testing but in some non governmental projects it was revealed that it takes 2 – 3 ieks.

The counselors in the government health facilities ire older and offered youth friendly services and provided an environment conducive to the youths. In other non-governmental facilities there was no clear information on how the youths are accessing VCT services despite the indication that the services are being provided. The service providers, however, re-ported that, there are sometimes delay in supply of reagents, medicine which interrupts the services both with government and NGOs.

Cost of services: Cost of services largely influences the provision of ser-vices. In this study, i found that the services ire not free and the cost ranged from 2500/ (1.5 US dollars) to 5,000 (2.5 Us Dollars) as shared by a male participant: "Currently, people get VCT services from Kimaanya-Kyabakuza Sub-county H/C, where they pay 5,000/= for transport and this is very expensive to the majority" (FGD Males Kimaanya-Kyabakuza

Sub-county, Masaka District). Other related costs such as being asked to bring one's own stationary was reported during the FGDS, 'When filling in the clients forms i are told to buy exercise books where medicine is recorded" (FGD PHA Kimaanya-Kyabakuza Health center). This discussion revealed that such services ire too costly to the youths who in most cases have no source of income.

In the study, i found that there was a referral system of clients from the loir health units to hospitals for further services as needed. However, the clients ire referred to the hospitals at their own transport expenses making it even more costly. Clients ire mostly referred to a district hospital (Kimaanya-Kyabakuza Sub-county, Masaka District) and at the Health Centre Level IV (Lyantonde). Sometimes they are referred to NGOs like World Vision about their concerns for economic support. The reasons why clients are referred include when reagents are unavailable at the health cen-ter, preference to particular counselors and lack of drugs particularly the STI drugs in the loir health units. Interestingly, among the facilities visited by the study team there was no Post-Test support services, and Kimaanya-Kyabakuza Sub-county, Masaka District a historical site for AIDS, had practically no services specifically targeting HIV/AIDS control as shared by a female participant, "The last time i received an outreach was on World AIDS Day of 1999, where people participated so much" (FGD Female Youths, Kasenero).

Choices and alternatives for providing VCT services to the youths

In this study, i found some alternatives that could be used to make VCT accessible to the youth other than the mainstream health facility. These alternatives included establishing of mobile clinics in market places and the use of traditional and complementary medicine providers.

These alternatives sites ire found to offer the youth more anonymity and privacy compared to health care facilities and hospitals.

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

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

Use of traditional and complementary medicine providers: Some young people and Community members mentioned the services of the traditional and complementary medicine providers as widely used especially in areas where health facilities are non-existent.

The interviews with traditional healers in the area also confirmed they provide such services to the youths.

These ire seen to have potential in providing care and support to clients as shared by a key informant:

'I are here. People of all ages come to us with different problems and i solve them, i counsel them, i give them advice. I even go to schools to talk about HIV/AIDS. I even approached the District Director of Health Services asking his support. If wint with a per-son from his office, I can be listened to better.

The policy guidelines for voluntary counseling and testing 2003 gives the process of providing VCT services and the various institutional arrangements to be put in place. Under the circumstances under which HIV testing in the Uganda should be made, it spells out that only people who have attained the legal age of 1 8 years should consent for VCT and thus qualify to be tested. However, it provides for legal minors to be tested because of the early exposure to sex by the age of 14. On the type and location of VCT services it provides for a free standing site like market place that is not physically located in an existing healthy facility. The policy states that under such circumstances a strong referral system should be in place to support this kind of arrangement. In human resources for VCT the policy provides that a trained counselor should not see more than 6 clients a day and it should a trained counselor to provide the services. The person to perform the test should have the rank of a medical laboratory technician or a person with a diploma trained as a medical personnel. The policy recommends that VCT services being preventive they should be provided free of charge.

5.2 Conclusions

In conclusion this study has demonstrated that there is adequate knowledge on the availability of VCT services in the community though still the traditional methods of disseminating and providing information to the youths are still being used. An interaction of individual, community and institutional factors ire found still to be limiting the youths" access and utilization of the VCT services and hence have an influence on the commitment to take action to test or not. These factors have the possibility of adding on the overall costs of providing the services to the youths, which in most cases reduces the utilization levels. Mobile clinics and outreaches seem to be more acceptable to the young in case VCT service is to be provided to them rather than the structural

arrangements in health facilities and project sites. Traditional and complementary medicine providers have an advantage of reducing on the transport costs by clients to distant service centers which in most cases have been stigmatized by the young people. The policy on VCT is still silent on providing youth friendly VCT services; thus provides a stabling block to the service providers and hence limiting access to VCT services among the youths.

This study has shown that there is a need to start a dialogue with the various stakeholders in providing VCT services to the youths, policy makers especially in regard to changing the strategy of provision and disseminating the information on VCT. The youths value anonymity and confidentiality which seem to lack in the regular health units and hospitals. There is also a need to cut cost and provide free medicine for those who test positive. The policy revision should be made to incorporate issues providing VCT services in a youth friendly manner in order to improve on access.

The needs assessment results show that the feasibility of establishing the COVCT project is high. This is because there ire no VCT services in the nearby health units thus the project will contribute in filling this gap. Available district statistics show that from 2000- 2003 less than 1% of the total population had tested for HIV, indicating low utilisation of HIV testing services in the district. This is attributed to low coverage, facility based constraints, long distance, lack of understanding the importance and benefits of VCT service, and lack of care and support services.

The available VCT services are largely provided in static units with limited outreach activities. Even where the services are provided, they are faced with several problems, namely shortage of skilled counsellors, lack of counselling rooms, which do not ensure confidentiality and inadequate supply of HIV testing kits. In addition, outreach services are severely constrained by lack of facilitation in terms of fuel and allowances.

Despite the above constraints, the willingness to participate in the project was high in both communities and they both had the potential to contribute to and manage the COVCT services. This is based on the assessment of existing collective social initiatives such as support groups and savings associations where community members' participation, contribution and sustainability ire very high. However, this potential is affected by low household incomes and savings, limited access and availability of productive resources, gender constraints, and inadequate management and entrepreneur skills. This raises the need for the project design to incorporate innovative ways of strengthening the communities' ability to take lead in 'marketing' the service, contribute to, utilise, manage and enjoy the benefits from the COVCT.

5.3 Recommendations

In light of the above, i propose the following recommendations that should be incorporated in the design and implementation of the COVCT project in order to ensure community ownership and active participation.

1. A comprehensive Information, Education and Communication Strategy (IEC) The IEC strategy should emphasise the benefits of VCT services for the individual, household and community. The strategy activities should focus on prevention, stigma reduction, care and support, Political commitment and support to the project as these are crucial for the project activities to take off.

2. Strengthen communities' ability to contribute and utilize the COVCT services

The recommended intervention that will strengthen communities' ability to contribute and utilize the COVCT services is the promotion of Village Savings and Loans Associations (VS&LA) approach (for details of the methodology, see appendix II). This approach will help members of the community to strengthen their saving capacity, which is currently very low. The VS&LA approach uses the group solidarity model, which mobilizes community members into self-selected groups, trains them on how to manage

their groups savings and credit operations. The group members are then facilitated to pool their money into a fund from which group members can borrow and pay back with interest, thus allowing the fund to grow. VS&LAs have almost no operating costs, and unlike banks and most micro finance institutions (MFIs) they have no drainage of funds from the group, all the savings and interest paid by the members remain within the group. This model has been tested and found to improve the living conditions of the poor in different parts of Uganda and elsewhere in Africa (see ib www.vsla.net). These VS&LAs will be used as platform for dissemination of knowledge and information about VCT services as ill as offering psychosocial support since the groups meet regularly.

This model should be supplemented by training of the community to improve their entrepreneur skills. The training should address some of the underlying causes that contribute to increased vulnerability to HIV/AIDS.

3. Apply a combination of approaches in the delivery of the COVCT services

AIC should focus on building the capacities of the following community structures to enable them deliver some of the COVCT services.

i. Facilitate and build capacity of local councils, religious leaders, TBAs and Traditional healers to become mobilisers, counsellors, and educators as ill as monitors of project activities.
ii. Build the capacity of the existing community support structure such as *Muno mukabi*, *Nigina* and others (*for details, see table 4 in section 2.2.1 of the report)* to provide the neccessary care and support.
iii. Build the capacity of the existing health structures in terms of skills, equipment and space to enable them provide comprehensive prevention, care and support services. More emphasis should also be put on establishing post test clubs at community levels.
iv. Establish a strong referral system that links the community with other health services.

v. Establish strong partnerships with some local CBOs/NGOs that are found in the sub-counties. The partnership approach will increase outreach in terms of scale (numbers) and provide quality services. However, AIC should carry out detailed assessment of potential partners (CBOs and Local government structures) to establish their capacity and partnership needs. This partnership should be clearly defined through a memorandum of understanding (MOU) that details the partnership objectives, obligations, accountability and reporting mechanisms, expected outputs and contribution of each stakeholder in terms of resources.

4. Mainstream gender issues into project activities

The project should involve both men and women as key stakeholders in deciding how the services are organised (timing, frequency, and siting) at the community level and specifically target men through sensitisation in order to increase their appreciation of the importance of VCT including couple dialogue on issues concerning VCT. In addition, the project should establish links and identify mechanisms for collaboration with other HIV/AIDS service providers to share information on effective responses to gender related HIV/AIDS issues as ill as creating a referral and networking system to allows monitoring of the coverage and quality of COVCT delivery process.

5. Implement the project in two phases

It was initially envisaged that implementation of the COVCT project would start soon after the needs assessment exercise. However, given the findings and recommendations
above, i strongly propose that AIC should revisit the project implementation plan and implementation be done in two phases as explained below.

6. Inception phase: approximately 6 months

In consultation with relevant stakeholders, AIC should:

i. Develop a project framework that details the project goal, objectives, expected results,
interventions and specific activities, implementation strategy including monitoring and
evaluation plan, staffing and project budgets.

ii. Establish a project implementation and management structure. The structure should include among others, a full time staff that will coordinate and manage the project. This particular staff should have expertise in community development work as ill as VCT.

Invest time and resources in promoting dialogue with the district and the community on the project framework and definition of roles and responsibilities of the different stakeholders. This is will create a shared understanding, appreciation and commitment to the implementation of the project.

Identify potential partners (CBOs, informal groups and resource persons) that will implement the project together with the community.

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APPENDIX I
INDIVIDUAL QUESTIONNAIRE
INTERVIEW GUIDE FOR THE KEY INFORMANTS
THE ATTITUDES OF PEOPLE TOWARDS COUNSELING AND TESTING
SITUATION: THE CASE OF MASAKA DISTRICT

1. Gender

Male ☐ Female ☐

2. Marital status

Single ☐
Married ☐
Separated ☐
Other specify ☐

3. Age of the respondents

20-25 ☐
26-30 ☐
31-35 ☐
36-40 ☐
41-50 ☐
50 ☐

4. Highest level of qualification (*Please tick one)*

Less than bachelor ☐
Bachelor ☐
Graduate ☐

Any other specify.....

5. Relation to Head of household

Head ☐

Spouse ☐

Accountant ☐

Any other specify.....

SECTION I: PEOPLE'S ATTIDUES TO WARDS VOLUNTARY COUNSELLING AND TESTING

6. Is there a member in this family who has never attended to voluntary counseling and testing? Who is this?

.....

.....

7. Are there relatives to this family who had/have attended voluntary Counseling and testing?

.....

.....

8. How has voluntary counseling and testing affected them?

Financial Burden.

.....

.....

Extra responsibilities of taking on siblings

.....

Time Consumption

.....

.....

SECTION II: VOLUNTARY COUNSELING AND TESTING ON FINANCIAL CONDITION

9. Has the voluntary counseling and testing affected the economic situation of the people in this area? If yes, how?

.....

.....

10. Has any additional member(s) had to take up earning responsibility? Who?

.....

.....

11. Has the family had to take financial help from other sources? If yes, which are these?

.....

.....

12. If not, do you anticipate financial need in the immediate future? Whom do you expect to contact for it? Is assistance expected/required from an external agency (like NGO, Government)?

.....

.....

13. Where do you and members of this household normally seek treatment when sick? (Health centre, Hospital, Traditional practitioners, self-medication)

.....

.....

14. What means of transport do you use to this source?

.....

.....

15. What problems are involved in travelling to this (i.e. in terms of transport costs) source?

.....

.....

16. Are there some services that you have to pay now that you did not pay for before? Which ones?.....

.....

17. How would you rate the fee you pay for counseling(fair, expensive)

.....

.....

18. If you can't pay for the services, can you have access to the services at the counseling centre?

.....

.....

19. Who is responsible for the counseling needs of family members?

.....

.....

20. Who decides where family members should seek for counseling services?

.....

.....

21. Did you ever have to sell property or give goods to pay for counseling expenses? If so, what kind?

.....

.....

22. Do you (and your family) usually use the services whenever you fell like using them?

.....

.....

23. How much do you pay each time that you use them?

.....

.....

24. How much money did your family spend on health care during the last 3 months? Is this affordable?

.....

.....

APPENDIX II
INTERVIEW GUIDE FOR THE KEY INFORMANTS
THE ATTITUDES OF PEOPLE TOWARDS COUNSELING AND TESTING
SITUATION: THE CASE OF MASAKA DISTRICT

Designation: .....

Sex : .....

1. How is voluntary Counseling and testing introduced and how are they implemented?

.....

.....

2. Are there some services that are offered free of charge? If so, which ones?

.....

.....

3. Who decides between paying services and free services?

.....

.....

4. Do you think there have been improved services since the implementation of voluntary Counseling and testing? Explain.

.....

.....

5. Do people seem happy about the quality of voluntary Counseling and testing services? Explain.

.....

.....

6. What are the advantages and disadvantages of voluntary Counseling and testing?

.....

.....

7. How big is the voluntary counseling and testing issue in this community?

.....

.....

8. Have you had any of your family members/relatives counseled or tested? Who is this?

.....

.....

9. What has been the impact of voluntary Counseling and testing on you/your family?

.....

.....

10. Do community members who need voluntary Counseling and testing and their families pay for counseling services? If no, what are the exemption mechanisms?

.....

.....

11. What is the policy for people who seek for voluntary counseling and testing but cannot pay?

.....

.....

13. What other problems do you think people who do not attend voluntary counseling and testing face?

.....

.....

14. How do they cope with voluntary counseling and testing?.....

.....

15. What is community role in supporting voluntary counseling and testing?

.....

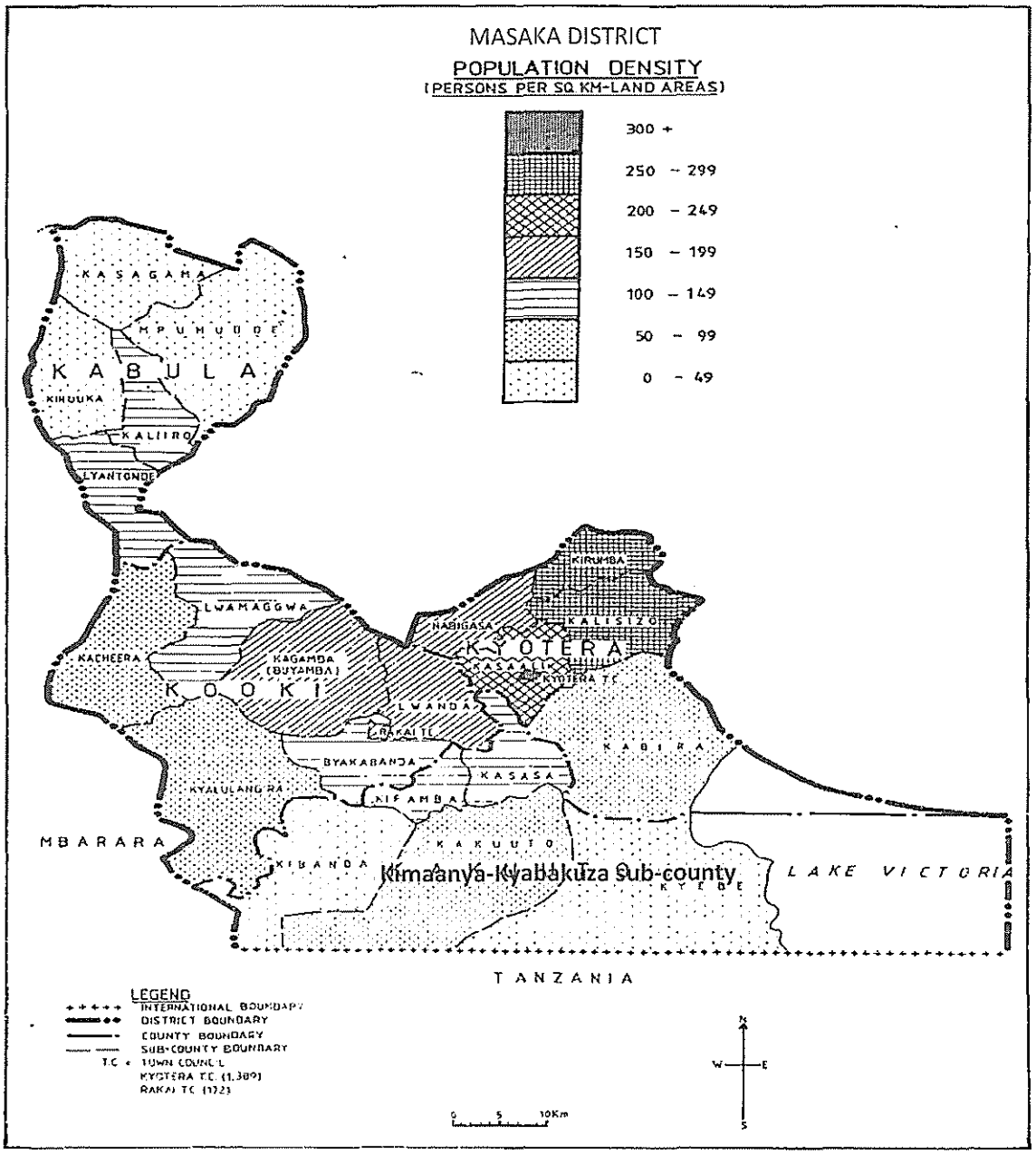
.....

APPENDIX III
MASAKA DISTRICT PROFILE

Area coverage	4989sqkm
Distance from National Capital	190km
Number of Counties	4
Number of Sub-counties	23
Parishes	120
Villages	850
Population	464,600 (2000)
Population density	102-141 people per sqkm
Annual growth rates	3.04%
Urban population	3.8%
Rural population/subsistence farmers	77.4%
Female Headed households	31.7%
Orphans who have lost one parent	17.9%
Estimated number of orphans	65,000
Estimated number of CHHs	300-600
Children under 5	20%
Children between 12-19	17.3%
Male to female ratio	49%:51%
Infant mortality rates	119/1000(1991)
Under five mortality rate	137/1000
Maternal Mortality	600/100,000

Total fertility rate per woman	7.7%
Illiteracy rates	57.9% (female 30.2%/male29.7%
Doctor to population level	1:31958
Population living under the National Subsistence line (5$ per week)	70%
Safe water coverage	33% (1994)
Safe Latrine coverage	68%
Life expectancy	Females 50/Males 45.3 years

APPENDIX IV
THE MAP OF MASAKA DIST RICT SHOWING AREA OF STUDY



APPENDIX V

PROPOSED TIME FRAME/WORK PLAN

TIME FRAME FOR RESEARCH AND REPORT WRITING	
ACTIVITY	**DURATION**
Proposal writing	One week
Data collection	Four weeks
Data editing and coding	Two weeks
Data analysis and presentation	Two weeks
Report writing and compiling	Two weeks
TOTAL TIME PERIOD	**ELEVEN WEEKS**

APPENDIX VI

PROPOSED BUDGET FOR PROPOSAL AND REPORT WRITING

ITEM	QUANTITY	RATE	TOTAL COST
Ream of paper	2	1000/=	150,00/=
Pens	5	100/=	1500/=
Proposal Typing and Printing	2 copies	-	30,000/=
Transport	-	-	60,000/=
Research Assistants	2	4000/=	30,000/=
Dissertation typing, printing and binding	4	5000/=	20,000/=
Miscellaneous	-	5000/=	20,000/=
TOTAL	**Uganda Shillings (Ug shs)**		**176,500/=**

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College of Open Education and Distance Learning

Office of the HOD – Guidance and Counseling

15th September, 2011

To Whom It May Concern:

Dear Sir/Madam,

Introduction Letter for Research

I have the pleasure to introduce **ABERI AGNES (DGC/20010/82/DU)** to you. He is a student of **Diploma in Guidance and Counseling** at Kampala International University. She is carrying out his research on "**The Attitudes Of People Towards Counselling And Testing Situation:The Case Study Of Masaka District.** She is at the data collection stage and your Institution / Organization has been identified as his area of study. It will therefore be appreciated if you can give the best assistance to him for a dependable research work.

The university will be counting on your kind cooperation.

Thank you

Mr. Derrick Ssekajugo
HOD – Guidance and Counseling (CODL)