

*Full Length Research Paper*

# The youths' perspective on HIV/AIDS counseling and testing (HCT) in Gulu, Northern Uganda. A Cross-sectional study design

<sup>1</sup>D.L Kitara and <sup>2</sup>C. Ecik

<sup>1</sup>Gulu University, Faculty of Medicine, Department of Surgery P.O Box 166, Gulu, Uganda.  
<sup>2</sup>(Dip. In Clinical and Community medicine)

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**A study conducted by Uganda AIDS Commission (UAC) in seven districts of Uganda indicated that 64% of those who tested for HIV/AIDS did not disclose their sero-status to their sexual partners. During the political turmoil in 80s and 90s in Uganda, there was an estimated HIV prevalence of 29% in the urban areas with high levels of stigma and superstition preventing HIV counseling and testing. According to the chairperson of Uganda parliamentary committee on HIV/AIDS, less than 20% of Ugandans know their HIV status. A cross-sectional study conducted in Gulu district, Pece division among 86 youths between 15 to 35 years. 93% of the respondents understood HIV counseling and testing (HCT) and 97.7% were able to mention 2 or more benefits, 84.9% would encourage others to do it. Only 36% of them had undertaken HCT while only 32.1% having done it more than twice. 90% of the respondents practiced stigmatization as a method of deterring other youths from contracting HIV/AIDS. In conclusion, there is sufficient knowledge, a positive attitude but the practice about HCT is poor (36.1%) among the youths.**

**Keywords:** HIV counseling and testing, youth, Gulu, Northern Uganda

## INTRODUCTION

HIV/AIDS blood testing became available in Uganda at the middle of 1985. It was immediately put in to use all over Uganda in most of the facilities that collected blood for blood transfusion for HIV testing. This was able to point out the most unpredictable source of HIV infection that no one would have suspected (Serwadda et al., 1985). The wide spread acceptance and the use of blood testing for HIV/AIDS helped reduce the spread of the virus. This was achieved through adequate counseling to explain the meaning of a positive test result, provision of psychosocial support to ease the shock of a positive test result and the fact that many people accepted the result and pronounced their positive lives in the public without the fear of stigmatization. This created the biggest impact on the fight against HIV/AIDS in Uganda and its current prevalence which declined from 29% in the 80s to less

than 10% in the year 2000 (UNAIDS, 2010). It should be noted here that when the HIV/AIDS antibody test first became available in the 1985, many of those concerned with combating the spread of the virus opposed the idea of widespread HIV testing. The simple reason was that little could be done for the person who had acquired the HIV infection and that it would not help in the prevention of its spread to other people (UNDP, 2008). They did not consider the powerful message that would come out of the people who would live positively with it. Today, however there are antiretroviral drugs (ARVS) that when administered early can prevent, delay the onset of full blown AIDS and improve the quality and life of the victim. The best HCT program offers pre and post-test counseling, HIV prevention, care, support and treatment (Horizons Program, 2001; Kalichman, 2005).

There is common believe in Uganda that it is possible to be HIV positive without developing AIDS. Those who have HIV positive results will be monitored, supported and counseled to live positively and that has helped them

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\*Corresponding author Email: [klagoro@yahoo.co.uk](mailto:klagoro@yahoo.co.uk)

live longer and currently there are people in Uganda who have lived for over 20 years with HIV/AIDS. HCT is the best and objective way to diagnose HIV infection and prevent the spread of the virus (Kalichman, 2005). The major objective of this study was to find out the knowledge, attitude and practices of youths of Gulu, Pece division, commercial road parish about HIV counseling and testing.

## **METHODS**

### **Population and sample**

We conducted questionnaire guided interviews with the youth of commercial road parish which is one of the parishes in Pece division of Gulu Municipality in northern Uganda. Gulu is a regional city strategically located and endowed with its transport terminals and pivoted role in the vast and profitable distribution of goods in the region. It shares borders with southern Sudan where lucrative cross border trade takes place. It is the regional commercial center and draws a largely rural population; many people were displaced into camps famously known as the internally displaced peoples camps (IDPS) for safety from the 20 year old insurgency. According to the Revised Gulu District Development Plan 2009/2010, Pece division has a population of 36,133 and composed of 4 parishes, 16 villages. One of the parishes is Commercial road parish which was chosen as a study site purposively because of its high population density and large number of youth. This parish was massively affected by this displacement of persons from the neighboring rural communities. A cross-sectional study conducted among the youth 15 to 35 years using a prepared questionnaire designed for data collection. A total sample of 86 respondents was selected, interviewed from different households to complete the numbers for the study. The study variables were controlled by interviewing only respondents, who were residents of the parish, had consented to the interview and of qualifying age.

### **Questionnaire administration**

Questionnaires were administered by the interviewers at the respondents' residence to collect the data required. Informed verbal and written consents were obtained from the respondents before the interview and they had to freely agree to join the study and provide the required information. The questionnaire was pilot tested among the youth of Layibi division, Cereleno parish in Gulu, and was designed to collect the background demographic data and the detailed information on HIV counseling and testing (HCT). After the test, it was improved to help the

youth recall the HCT events and space added to consider other relevant information. The tested questionnaires were then administered to the respondents to obtain the accurate information needed. In order to avoid an unnecessary semantic misunderstanding, the questionnaire was written in simple English and translated into Luo, the main regional language by the investigators in conjunction with a trained interviewer and interpreter. The respondents were asked open-ended questions to describe their knowledge, attitude and practices on HCT and also made to restate their information before entry in to the questionnaire. HIV counseling and testing (HCT) was defined as the process by which an individual, couple, or family receives HIV testing and counseling on HIV prevention, treatment, care, and support. Extra spaces were used as qualifying remarks which aided considerably in giving answers to specific questions and providing additional information which assisted the researchers. During the data collection process, confidentiality, respect, privacy and high moral principles were observed. The sampling technique was purposive for the Commercial road parish and to the villages and households. In the households the youth were consecutively sampled for the interviews based on the village, informed consent and age. A maximum of 2 youth were sampled per household. Overall 60 households were selected and samples of 86 youth were obtained. Ethical clearance and approval of the study was obtained from the research committee and the administration of Gulu regional referral Hospital. The data obtained were put in descriptive form and analyzed in percentages and fractions (See figures and Tables).

## **RESULTS**

### **Knowledge of respondents about HCT**

Ninety three percent of the respondents understood what HCT was while 7% had no knowledge. HIV counseling and testing (HCT) was defined as a process by which an individual, couple, or family receives HIV testing and counseling on HIV prevention, treatment, care, and support.

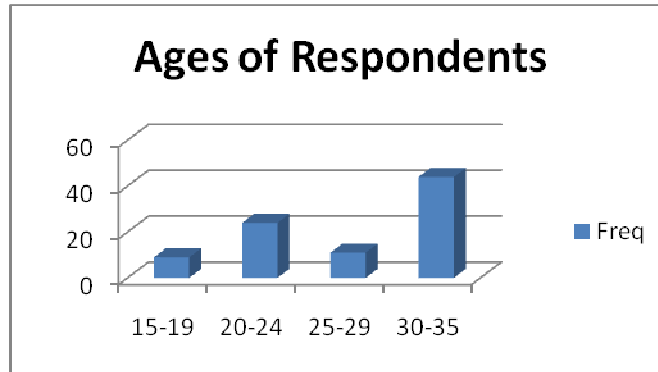
### **Sources of HCT information for respondents**

41.3% received HCT information from health workers, 12.6% from friends, 26.9% from FM Radios and 19.2 % from others e.g. newspapers, posters, public functions and schools.

### **Knowledge of respondents on the benefits of HCT**

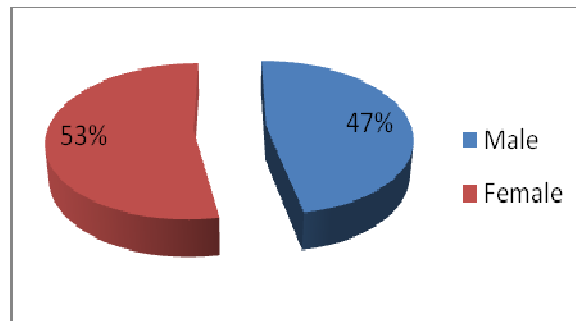
97.7% respondents mentioned more than 2 benefits of HCT while 2.3% could not mention any but recognized

### The ages



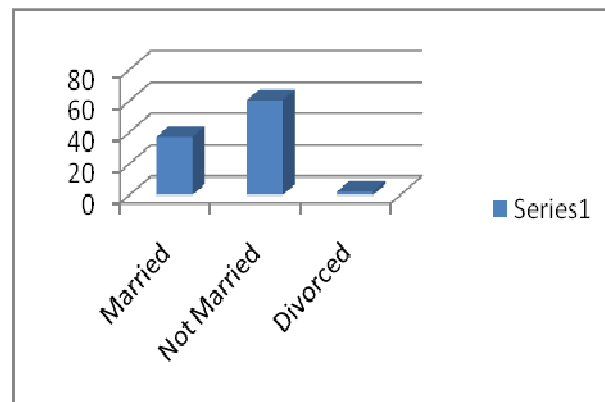
**Figure 1.** The ages ranged from 15 to 35 with a mean of 31 years and the peak of 31-35 years.

### The sex of respondents



**Figure 2.** Female to male ratio of 1.1:1 (53%:47%).

### Marital status of respondents

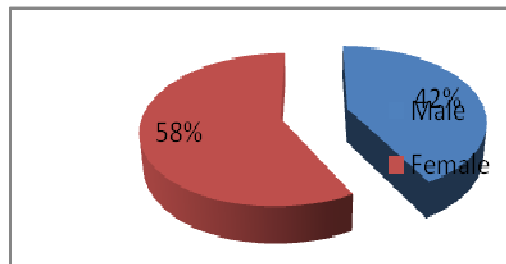


**Figure 3.** 37.2% of the youths were married, 60.5% were not married and 2.3% were divorced/or separated.

**Table 1.** Number of sexual partners of the respondents

No. of partners	Freq	Percentage
one	19	22.1
Two	28	32.5
> three	39	45.4
Total	86	100.0

Nineteen respondents (22.1%) had a single sexual partner, 32.5% had two sexual partners and 45.4% had more than three sexual partners.



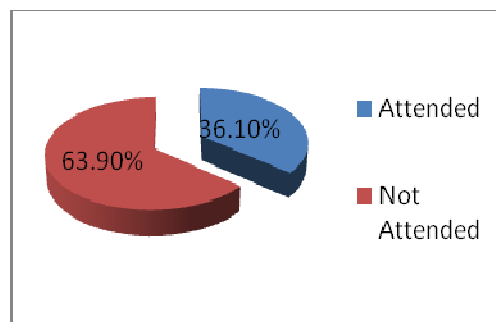
**Figure 4:**The respondents with a single sexual partner

Fifty eight percent of the females had a single sexual partner compared to 42% in males.

**Table 2:** Respondents' opinion on who should be recommended for HCT

Persons	Freq	Percentage
Students	34	39.5
Barmaids	33	38.4
Married	10	11.6
Others	9	10.4
Total	86	100

Thirty four (39.5%) respondents recommended HCT services to the students, 38.4% barmaids, and 11.6% married couples and 10.4% to others.



**Figure 5:** Attendance of HCT by respondents

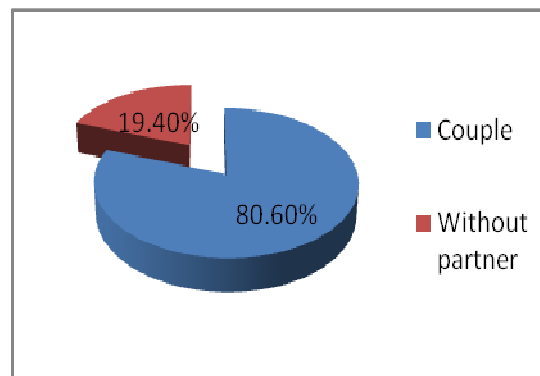
Only 36.1% of the respondents had attended HCT while 63.9% had not and were not planning to do soon.

**Distribution of HCT attendance by Sex:** 70.9% of the respondents were females while 29.1% males.

**Table 3:** The number of HCT sessions attended

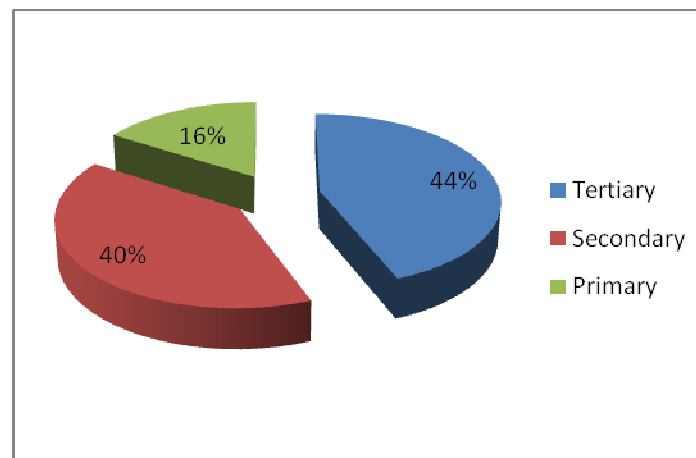
No. of times	Freq	Percentage
Once	3	9.7
Twice	18	58.1
> two times	10	32.3
Total	31	100.0

31 (36%) respondents attended HCT, 3 (9.7%) visited HCT once, 18 (58.1%) visited HCT twice and 10 (32.2%) attended more than twice.



**Figure 6:** Respondents attending HCT as a Couple

Thirty one couples attended HCT, 80.6% attended HCT without their partners while 19.4% attended with partners. Among those who did not attend HCT with their partners, 68.0% discussed their test results with their partners while 32% of those who tested as a couple did not disclose their status to their partner.



**Figure 7:** Respondents' level of Education

The study revealed that 44% of respondents had attained tertiary education, 40% secondary education and 16% primary level education.

the danger of contracting HIV/AIDS if one did not know his/her HIV status.

### **Respondents' attitude to open discussion on HCT result**

88.4% of respondents agreed that it was proper to discuss HCT result openly with colleagues, friends and public. They reported that they would feel free to talk about it with a health worker, or a friend who keeps secrets, a wife or a girl-friend. However, those who said it was not proper to discuss it openly said they would only consider discussing it with a health worker otherwise they would prefer to keep the information to themselves because of fear of stigmatization.

### **Attitude of respondents towards access to HCT**

84.9% respondents had positive attitude towards those who attended HCT while 12.8% were not bothered and 2.3% could only sympathize with them.

## **DISCUSSION**

### **The Age**

The majority (51.1%) of respondents were in the age range 31-35 years. Uganda is one of the most successful countries in Africa in reducing the prevalence of HIV/AIDS significantly from 18% (1992) to 6.4% (2005) over the last two decades. The 2004/05 Ministry of Health National HIV Sero and Behavioural Survey (NHSBS) established that for both sexes, HIV prevalence is highest among those aged 30-34 and lowest in the 15-19 years age category. This represents an upward shift in age of highest prevalence over the last two decades. In addition, women have higher prevalence of HIV across all age categories and regions of the country (7.3% of women have HIV compared to 5.2% of men aged 15-59 years) (UNDP, 2008)

### **The sex**

Most respondents were females (53.5%). This reflects the normal population distribution of the people of Uganda although in this particular study, the researchers noted that they more often found female youth at home and the likelihood for them being interviewed were increased. Due to existing societal gender inequalities, women are often economically, culturally and socially

disadvantaged as compared to the men. Women lack equal access to treatment, financial support and education on HIV/AIDS. Cultural standards for female versus male sexual behaviours differ. It is often believed that promiscuous woman deserve to become infected, while promiscuous men are merely proving their manhood. Gender power dynamics assert themselves in sexual partnership (Wambayi, 2010).

### **The level of Education**

Most respondents (83.7%) had attained a post primary education while 16.3% primary level. This high level of knowledge of respondents (93.1%) to HCT was more likely to have been due to their good educational standard. Their sources of information were from health workers (41.3%), radios (26.9%), friends (12.6%) and other such as newspapers (19.2%). The few who could not define HIV counseling and testing were mainly those who had attained primary education only. However those who had no knowledge on HCT were still able to mention at least one of its benefits and the most mentioned was HIV status. There is a good media coverage (several radio stations in the area) in which health workers regularly disseminate information about HCT to the youth. It is true therefore that education plays a major role in understanding and awareness of the environment. Education is a tool that reduce stigma from communities in order to reduce the escalation of HIV/AIDS. Ignorance is always a barrier to advancing any knowledge. Studies have shown that when people have been prepared through the right education, they will be more willing to get tested, to seek treatment and to change their behaviours. They will be less affected by stigma, shame and guilt and will be able to contribute to an equally tolerant society (Kalichman and Simbayi, 2005).

### **Marital status**

Most respondents (60.5%) were not married, 37.2% were married and 2.3% were either divorced/ or separated. Most of these youth did not have the resources to complete their marriages and even to live on their own. Most youth live with their parents and did not have a specific source of income other than running some small family businesses. In many sub-Saharan African countries, a large proportion of HIV transmission occurs within married relationships or similar unions (Becker and Gray, 2008). Counseling and testing is particularly important for pregnant couples, but male partner involvement in antenatal clinics (ANCs) is usually low. Studies from Nairobi and Lusaka indicated that only 5%-9% of women came with their partners for voluntary

counseling and testing (VCT) in antenatal clinics, despite community outreach (Farquhar et al., 2004), (Semrau et al., 2005).

### **The sexual activity**

Most respondents (77.9%) had two or more sexual partners while only 22.1% had a single partner in the last five years. Many youth feel that they are invincible and that nothing bad will happen to them, many more still believe that HIV does not cause AIDS (Wambayi, 2010). This could explain why only 36.1% of the respondents had ever attended HCT while the remainder had never tested and/or thought of undertaking HCT. This correlates with the findings and explanation from AIDs-sexual behaviour and intravenous drug use (Charles F. Turner, 1988) that individuals who are more concerned about their health may be more likely to seek testing and counseling for HIV or undergo diagnostic evaluation more frequently than those who are less concerned about their health. On the other hand individuals who knew or suspected they were infected would be less likely to seek HCT. Multiple concurrent partnerships, in which consistent condom use tends to be low, combined with low levels of male circumcision, are the key drivers of HIV/AIDS in southern Africa. It said HIV transmission was more likely to occur within longer-term multiple concurrent sexual partnerships, as people were less likely to consistently use condoms within these more regular relationships (Mohapeloa, 2006). Only 19 respondents, (22.1%) had a single sexual partner in the last five years, and 11 (57.9%) were females while 8 (42.1%) were males. At any given time, a significant percentage of men are engaging in multiple sexual partnerships with women -- a situation that may facilitate the spread of sexually transmitted infections, including HIV/AIDS (Childs and Williams, 2007). This can be explained in terms of cultural orientation in this region in which women were always expected to have a single sexual partner while males had the liberty to have as many as possible (polygamous community) and secondly most times the females were confined to the homes to carry out domestic activities while the males had access to other sexual partners. Furthermore, most females got married early and often with early pregnancy with resultant preoccupation in the caring for their children at home.

### **Recommendation of respondents on who should attend HCT**

The majority of the respondents (77.9%) recommended students, barmaids (11.6%), married couples (10.4%). The youth reported that students were very active sexually and that the students have sex with barmaids

who mainly engage in commercial sexual activity. The youth think the students and barmaids were more at risk of contracting HIV/AIDS and therefore the need for the HCT to help and support them overcome their sexual desires. For many years, many societies have associated HIV/AIDS with homosexuality, injection drug use, promiscuity and prostitution. As a consequence the disease has been perceived by religious groups as punishment for the moral failings, thus inflicting guilt on those infected or affected (Wambayi, 2010).

### **Attitudes of respondents to HCT**

Most respondents (88.4%) had positive attitude to HCT. They approved and encouraged others to attend it. However, a few had negative attitude to HCT but were only able to mention one reason why they did not approve it. The simple answer was, "even if you tested and were found HIV positive, what would you do other wait to die". Counseling and testing programs involving raising community awareness, pre- and post-test counseling, psychosocial support, and referral to relevant services. HIV counseling helps people to cope with personal stress and make decisions related to HIV (Baggaley et al.; 2001). It enables an individual or a couple to evaluate their risks of contracting or transmitting HIV and helps them avoid it. Counseling helps people to deal with the stigma and discrimination associated with HIV. The very act of being tested, for example, may have negative consequences in communities where HIV-positive people are stigmatized (Baggaley et al.; 2001). Most respondents (88.3%) were willing to discuss HCT openly with anybody while the rest believed it was improper to discuss it openly except with health workers due to fear of stigmatization. Stigma impedes the fight against HIV/AIDS. It causes reluctance to disclosure, thus promoting secrecy, finally arguably abetting transmission. It drives the epidemic underground. Health seeking is minimized and preventative measures left unused. No open discussions about HIV/AIDS take place when stigma prevails in a community. Pervasive stigma also prevents identification of AIDS orphans and promotes the oppression of women (Wambayi, 2010).

Furthermore, it was found that 36.1% of the respondents had attended HCT while the majority (63.9%) had not. This was because of the attitude of respondents where 77.9% had two or more sexual partners and most of them said they used condoms so there was no need testing them because they felt they were protected by the condoms against any sexually transmitted diseases. In a survey of males and females ages 14 to 21 years, about 90 percent of 210 Ugandans and 75 percent of 122 Kenyans who said they had not received VCT services reported that they wanted to be tested. However, in these and other studies, some young

people feared testing. Some worried that their test results would be positive. Others were concerned that their test results would not remain confidential, that they might lose their partners, and that the services would be costly or be provided in inconvenient locations (Horizon Program, 2001). Of the 31 respondents who attended HCT, 22 (70.9%) were females and 9 (29.1%) males. Females were more willing to undertake HCT than males in Uganda (UNAIDS 2010). The majority of the respondents who had a single sexual partner in the last 5 years were female. The female cared much about their individual health compared to males and more so during the antenatal visits they get tested for HIV as part of the procedural requirements unless any specific objection is raised. Secondly, most women in the region tended to have a better attitude towards HCT than their male counterpart. In a Ugandan study of 369 young people ages 14 to 21 years who had sought VCT, young women who decided to get tested tended to do so if they were about to be married, enjoyed their partners' support, and knew their partners were willing to pay for the service. Nearly two of every three girls said their partners encouraged them to be tested. In contrast, boys were more likely to decide on their own to be tested and to pay for testing themselves. A third of boys said their decision to seek VCT testing was influenced by partners; a third, by friends; and another third, by no one (Juma et al., 2002).

The study showed that only 32.2% of respondents had HCT more than twice. These respondents were only testing after having been engaged in a risky sexual act like being involved in unprotected sexual activity. The reason for the testing was to know their HIV status at that time with no further attempt to attend the next session as required by the HCT testing procedures. Counseling young people, in general, requires special skills. And counseling youth about HIV testing is even more challenging. It is important to be nonjudgmental, establish rapport, and instill hope in young people, particularly those testing positive. "Counselors have to be trained to handle young people's needs, which differ from those of adults," says Namwebya. "Young people who are HIV positive still have their dreams and many years ahead. What will happen to their dreams? How long can they sustain behavior change? We should be able to help them cope."

Most respondents (80.6%) attended HCT without their partners while 19.4% attended as couples. Most of these youth had multiple sexual partners and always declined to attend HCT in fear of being identified and/or stigmatized. Therefore some had to sneak to attend HCT alone. Choosing who to go with for HCT was always a problem. Finally it was also found out that youths mainly engaged in casual sexual relationships for reasons of pleasure and peer influence and that at the end of the act, the relationship would end.

Of the youths who attended HCT without partners, 68%

disclosed their sero-status to partners while 32% did not. Those who disclosed their status to partners were mainly HIV negative and therefore encouraged their partners to go for it as well. Many people live in denial, or fail to disclose their HIV/AIDS status in order to protect their families from social condemnation (Wambayi 2010). Reasons for nondisclosure were obtained from 20 participants. Commonly cited reasons for nondisclosure included need for privacy, fear of rejection, and fear of physical abuse (Menziés et al., 2009). In these expanded efforts to provide HCT services to young people, key programmatic challenges are confidentiality, parental consent, adequate counseling, and ongoing support. Unless VCT is strictly confidential, young people (especially women) run the risk--as do adults--of being stigmatized, suffering violence, and being disowned by family members or partners (Menziés et al., 2009). One of the key challenges for programs is deciding whether to involve a youth's parents in the VCT process, gaining approval for testing and reporting of results. Ideally, each country would determine informed consent procedures for using VCT. In Kenya, national VCT guidelines issued in 2001 advise that "mature minors" do not need parental consent. "Mature minors" include those individuals younger than 18 years who are "married, pregnant, parents, engaged in behavior that puts them at risk, or are child sex workers." (Nairobi: NASCOP, 2001)

## CONCLUSION

There is adequate knowledge on most aspects of HCT by the youth. There is good attitude but poor practice to HCT.

## RECOMMENDATIONS

The Ministry of health in Uganda should strengthen the monitoring of HCT services in all the health facilities and design a focused program to target the youths. Since HIV/AIDS is a social problem, its prevention can only be achieved through persuasion of the youth towards behaviour change. More emphasis should be laid on the psychosocial support to overcome the stigma of HIV/AIDS.

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