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PRACTICES TOWARDS VOLUNTARY COUNSELING AND TESTING FOR HIV/AIDS AMONG YOUTHS AT BUSOTA HEALTH CENTRE III KAMULI DISTRICT. A CROSS-SECTIONAL STUDY.

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Abstract.

Background.

One of the most important intervention strategies adopted by SNAP in the effort to curb the gradual rise in the number of people infected and affected by the epidemic is to encourage people to know their HIV Status and act accordingly. This study examined the Practices towards Voluntary Counseling and Testing for HIV/AIDs among youths at Busota Health Centre III, Kamuli District.

Methodology

A descriptive cross-sectional study design was used, and data was collected from a sample of 60 respondents**.** The respondents were selected by using a purposive sampling method as a sampling technique and a semi-structured questionnaire with open and closed-ended questions written in English as a data collection tool. Data was analyzed manually using tally sheets and entered into the computer using the Microsoft Excel computer program illustrated using graphs and figures for quantitative data.

Result

Most (43.3%) respondents reported that they were Anglican, (40%) of the respondents had attained primary level of education. Up to (60%) of the respondents reported that they had ever taken HIV/AIDS testing service before (86%) of these had taken the test voluntarily, (55.5%) of the respondents had done the test from a primary health facility and (55.6%) reported that they had tested for HIV/AIDS in the last 12 months. The majority of the respondents (40%) had only one sexual partner with whom they had done testing and counseling.

Conclusion.

The overall practices of youth towards HIV/AIDS counseling and testing were fair. This was in view that the majority of the respondents had ever taken HIV/AIDS testing services before voluntarily.

Recommendations.

The Ministry of Health should put in place more HIV testing centers to make HIV testing more easily accessible by literally everyone, anywhere.

Keywords: *HIV/AIDS, Voluntary Counseling and Testing (VCT), Busota Health Centre III, Kamuli District.*
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Background.

Human Immunodeficiency Virus (HIV) has remained the largest human pandemic. Since the discovery of the disease, there has been a gradual global spread of the infection, with the greater burden of the disease being found in Sub-Saharan Africa. The World Health Organization (WHO) global prevalence report among adults in 2022 showed an increase in the number of individuals living with HIV, an estimated 39.0 million people were living with HIV at the end of 2022, two-thirds (25.6 million) of whom are in the WHO African Region and 1.3 million acquired HIV (WHO, 2022).

In 2022, there were an estimated 1.9 million adolescent girls and young women (aged 15-24 years) living with HIV compared with 1.2 million adolescent boys and young men (aged 15- 24 years). Globally, 46% of all new HIV infections were among women and girls (all ages) in 2022. Worldwide, between 2000 and 2002, HIV infections among adolescent girls and young women fell by 55%, and the rate of that decade has accelerated over the past decade. The number of adolescent girls and young women (aged 15-24 years) who acquired HIV in 2022, however, was nearly five times higher than the 2025 target of 50000. (UNAIDS

2023).

The overall pooled prevalence estimate of HIV testing uptake among sexually active men was 33.0%. There was a variation in the prevalence across countries, ranging from 7% in Guinea to 77% in Cameroon. Central Africa had the highest HIV testing prevalence among unmarried men at 47%, while West Africa had the lowest HIV testing prevalence at 11%. Results further showed that young men aged 15-19 were less likely to test for HIV, and young men who spent 8 years and above in school had higher odds of engaging in the use of HCT (Musonda, 2023).

Access points to prevention, treatment, and control of Human Immunodeficiency Virus (HIV) infection is HIV Counseling and Testing (HCT), which is the process whereby an individual or a couple undergoes counseling to enable them to make informed choices about being tested for HIV (Bibiana et al., 2018). HIV/AIDS currently has neither a cure nor a reliable vaccine (Holland & Nicholls, 2020). The HIV epidemic is classified as a low epidemic with adults (15-49 years), with an HIV prevalence of less than 0.3% according to the 2016 estimates and projections. The Ministry of Health has taken the initiative to establish the Sudan National AIDS Program (SNAP), which has the responsibility of coordinating the HIV/AIDS response in the country. One of the most important intervention strategies adopted by SNAP in the effort to curb the gradual rise in the number of people infected and affected by the epidemic is to encourage people to know their HIV Status and act accordingly. This strategy, known as voluntary counseling and Testing (VCT) services, was established in Sudan in early 2004 (Abusalih et al.,2021).

In Uganda, based on the Epi-data country estimates for the financial year 2022, HIV prevalence among the adult population (15- 49 years) has reduced to 5.1% by 2022 from 5.2% in 2021. HIV incidence among adults is at 0.22%, and overall 51,516 new infections were registered in the year 2022. Adolescent girls and young women (15-24) have the highest HIV incidence rate in Uganda at 0.62%. An estimated 1,433,337 people were living with HIV(PLHIV) as of December 2022, of which 1,403,603 (98%) were on ART as of June 2023, and 17,337 AIDS-related deaths occurred (UGANDA AIDS COMMISSION, 2023). This study examined the Practices towards Voluntary Counseling and Testing for HIV/AIDs among youths at Busota Health Centre III, Kamuli District.

Methodology.

Study design.

A descriptive cross-sectional study design was used to collect basically quantitative data. This is simply because it is suitable for the collection of data at one point in time in a dynamic population.

Study area

The study was conducted in the outpatient department at Busota Health Centre III, a zone 1 health Centre managed by the government to deliver services to the general public. The facility was originally a Health Center II and was elevated to a Health Center III in 2018. It's located in Busota ward, Kamuli municipal council, along Kamuli Jinja road. The hospital serves several villages in the Kamuli district, which include Butaama, Butabaala, Butimba, Bwambala, and Bwese, offering services like ART treatment, emergency, OPD, maternity, laboratory, and theatre services and on average receives over 100 people on a daily.

Study population

The study included youth (15-25 years) seeking medical services at the Out-Patient Department at Busota Health Centre III in Kamuli District.

Sample size estimation

The sample was estimated using Burton's formula (1965). The assumption was that the sample was representative; the sampling error was small; the sample was viable in the context of funds available for the research study; systemic bias was controlled in a better way, and results from the sample study were generalized.

S= GR / O

Where;

S=desired sample size, G=number of respondents interviewed per day, R=maximum number of days for data collection, and O=maximum time the interviewer spent on each respondent.

Thus, the sample size was calculated as follows: S= (10x30)/5

S= 60

Therefore, 60 respondents were used as the sample size.

Sampling technique

The sampling technique refers to the criteria used to select respondents in the study. The youth found seeking medical services at OPD ready to consent, following the inclusion and exclusion criteria were selected using a purposive sampling method until the required sample size was obtained.

Selection criteria

Inclusion criteria

The inclusion criteria comprised of youth (15-25 years) who were found seeking medical services at the outpatient department at Busota Health Centre III, Kamuli district, and willing to participate in the study.

Exclusion criteria.
Those youth in the sample who were too weak to participate or continue with the study, including those who wished to discontinue.
Those youth in the sample who the researcher wished to replace and those who would willingly refuse to adhere to the guidelines provided for in this project.

Study variables
Dependent variable
Voluntary Counseling & Testing for HIV/AIDS among youth attending Out-Patient Department services at Busota Health Centre III was the dependent Variable.

Independent variables
Practices towards Voluntary Counseling & Testing for HIV/AIDS were the independent variables.

Data collection methods.
Data was collected using semi-structured questionnaires that were used in English and translated into the local language, Lusoga, and also interviews with those respondents who cannot read and write.

Data collection tools.
Data for the quantitative part of the study was collected using a semi-structured questionnaire with closed and open-ended questions written in the Lusoga language, which is easy to read and understand. This is because it helped the researcher to gain insight into hidden aspects as well as allowing open-ended responses from participants for more in-depth information. It also encourages two-way communication and allows respondents time to open up about sensitive issues.

Data collection procedure.
A letter of introduction from the school was presented to the person in charge of Busota Health Centre III, who later granted permission to the researcher to collect data further helped to introduce the researcher to the individuals attending OPD as our respondents. Upon reaching the respondents, the researcher introduced himself and informed them of the reason for carrying out this research and the benefits that would be gained at the end of the study. However, they were informed that information obtained during the study was to be kept confidential that their names were not to be needed on the questionnaire that it was voluntary, and that they could withdraw at their wish. Following the provision of the questionnaires, participants were provided with verbal explanations on how to answer the questions on each objective. Those who were not able to read and write were interviewed by the researcher or an assistant while recording the questionnaire. The questionnaires were then collected after completion for management and analysis.

Quality control.
Pre-testing of the research tool
The data collection tools were discussed with the research supervisor to ensure accuracy and appropriateness. For consistent and reliable results from the research, the tools were constructed local language that is Lusoga, and appropriate vocabulary for easy understanding for the selected respondents.

Piloting of the study
This was done in the first week before actual data collection in the Out-Patient Department at Busota Health Centre III. This helped the researcher to determine how effective or valid the research was. The relevance, reliability, and suitability of the research tool were assured through pre-testing of the questionnaire on five respondents at OPD at Busota Health Centre III, thereafter the questionnaires were edited to fill in all the missing information, and ambiguous questions removed, training of the research assistants to avoid many errors, and ample time was given to collect data.

Data analysis and presentation.
Data processing commenced soon after the field activity and was done in the following ways, all responses from the data collection tools were compiled and summarized using pens and pieces of paper, and the data obtained was coded inform of words, numbers, and tables for presentation. Data editing was done by checking the quality like accuracy, completeness, and consistency, and then using computer Microsoft Excel Word package in the form of bar graphs, frequency distribution tables, and pie charts with narrative following.

Data management.
After checking for completeness and accuracy, a filled questionnaire was kept under lock and key and those with mistakes were corrected before respondents could leave the session and thereafter were kept for privacy and confidentiality.

Ethical approval.
An introductory letter was obtained from the school and approved by the principal which in turn was used to get permission from the in-charge of Busota Health Centre III who later introduced the researcher to the attendees of the Out-Patient Department (OPD) who were our respondents. Access to study data was limited to the researcher and only two research assistants. A written consent was obtained

from the respondents for their approval to be part of the study. Participants were assured of confidentiality and anonymity.

Informed consent

To obtain informed consent, the research was open to the respondents about the purpose the study as purely for academic use, and requested participants' consent. This involved signing a consent form to prove that the participants had agreed to engage in the study without coercion.

Results.

Demographic data

Table 1: Shows the distribution of respondents according to demographic data (N=60).

Variables	Categories	Frequency	Percentages
Sex	Male	24	40
	Females	36	60
Total		**60**	**100**
Age (in years)	15-18	15	25
	19-21	15	25
	22-25	30	50
Total		**60**	**100**
Level of education	Primary level	24	40
	Secondary	16	26.7
	Institution/University	08	13.3
	No formal education	12	20
Total		**60**	**100**
Marital status	Single	38	63.3
	Married	08	13.3
	Divorced	11	18.3
	Widowed	03	05.1
Total		**60**	**100**

Able 1: revealed that the majority (60%) of the respondents were females whereas the minority (40%) of the respondents were male by sex, the study findings revealed that most (50%) of the respondents were in the age bracket of (22-25) years, whereas the least (20%) were in the age bracket (15-18) years. Regarding the study findings regarding the educational level, most (40%) of the respondents had attained a primary level of education, whereas the least (13.3%) had attained the University level. In addition to that, the study findings also revealed that the biggest percentage (63.3%) of respondents were single and the least (3.3%) percentage was divorced. The results also showed that most (43.3%) respondents were Anglican, followed by Catholics and Muslims (23.3%), and SDAs (10.1%) by religion.

Practices Towards Voluntary Counselling and Testing For HIV/AIDs among Youth

Table 2: Shows distribution of respondents according to whether they had ever gone for AIDS testing service (N=60)

Response	Frequency(f)	Percentage (%)
Has ever tested for HIV before	36	60
Never tested for HIV before	24	40
Total	**60**	**100**

Table 2, more than half of the respondents (60%) had ever gone for an HIV/AIDS testing service before whereas the least (40%) had never gone for an HIV/AIDS testing service before.

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Table 3: Shows the distribution of respondents who had ever gone for VCT according to whether they received the HIV/AIDS tests voluntarily (N=36).

Response	Frequency (f)	Percentage (%)
Voluntarily	31	86
Required	5	14
Total	**36**	**100**

From Table 3, the majority (86%) had taken the test voluntarily whereas the remaining (14%) had taken the test when just required by someone.

Table 4: Shows the distribution of respondents of respondents who had ever gone for VCT according to where they had received the tests from (N=36).

Response	Frequency(f)	Percentage (%)
Primary Health Care Center	20	55.6
HCT facility	10	27.8
Health camp	3	8.3
Home (self-testing)	3	8.3
Total	**36**	**100**

Table 4; shows that more than half of the respondents (55.6%) had received the VCT service from primary health care centers, whereas the least (8.3%) number of the respondents had done the HIV testing at Health camps and by self-testing at home.

Figure 1: Shows distribution of respondents showing when they last went for VCT (N=60).

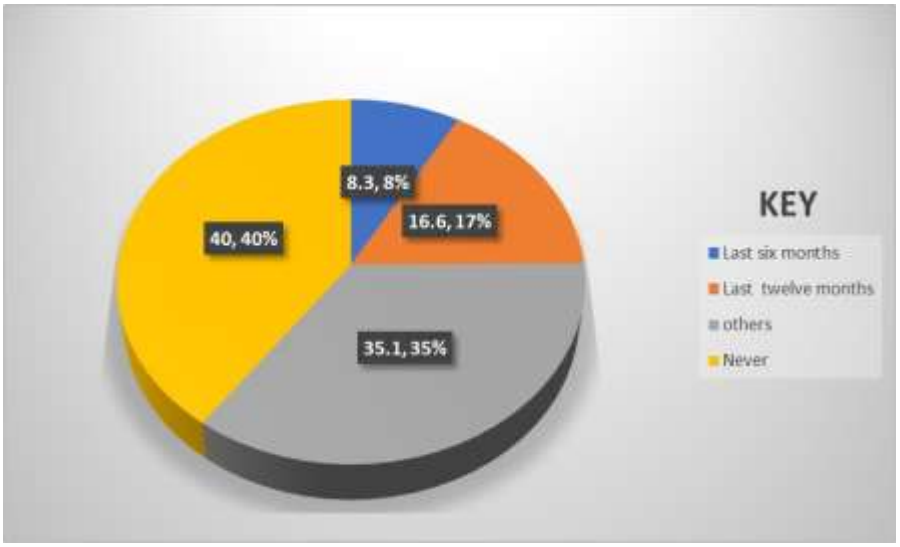

Figure 1: shows that, the majority of the respondents that had tested (35%) reported to have tested for HIV/AIDS in the last six months whereas the least had tested for HIV/AIDS more than a year back. Then those (40%) of the respondents had never tested before.

Table 5: Shows the distribution of respondents depending on how many sexual partners they had (N=60).

Response	Frequency (f)	Percentage (%)
One	24	40
Two	15	25
More than two	6	10
I don't have	15	25
Total	**60**	**100**

Table 5: shows that most of the respondents (40%) had only one sexual partner whereas the least (10%) of the respondents had more than two respondents.

Discussion of results.

Practices toward voluntary counseling and testing for HIV/AIDS among the youth

Results from the study revealed that more than half of the respondents (60%) had taken HIV/AIDS testing services before. This is because of the age group of the respondents being youth and hence sexually active, this causes the need for one to have tested for HIV to know about their status since they are sexually active and hence more prone to get infected. This is not in line with the study by Alem Asaye (2020), where results showed that more than one-third (37.8%) of the respondents had been tested for HIV/AIDS before. The study also showed that most (86%) of the respondents revealed that they had taken the HIV/AIDS test voluntarily. This could be due to the nature and lifestyle of the respondents. This is in line with the study carried out by Emmanuel Mensah (2022), where the study revealed that (70.11% of) those who were tested for HIV did so voluntarily.

The study further revealed that among those who had ever taken an HIV test, more than half the respondents (55.6%) had done the test from a Primary health facility. This is because these are the most common places where all health services are provided. However, this is not in line with the study conducted by Ogunyemi (2020), where results revealed that (34.5%) of the respondents reported that the main places of access to HCT service were primary health centers. The study also showed that more than half (55.5%) of the respondents who had ever tested had done the test beyond the last 12 months. This could be because the respondents had less knowledge about how often one and when one should go for the test depending on other factors. However, this is not in agreement with the study by Ssekankya (2021), where results showed that (78.3%) of the respondents had done the test and received results in the last 12 months.

Conclusion.

Regarding the overall practices of youth towards HIV/AIDS counseling and testing were fair. This was in view that (60%) of the respondents had ever taken HIV/AIDS testing services before and (86%) of these had taken the test voluntarily. (55.5%) of the respondents had done the test from the primary health facility, (55.6%) of the respondents had tested more than the last 12 months.

Recommendation.

That the Ministry of Health should put in place more HIV testing centers to make HIV testing more easily accessible by literally everyone and anywhere.

Acknowledgment

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I salute all the institutions and individuals that I may have omitted. Thank you all.

List of abbreviations.

AIDS: Acquired Immunodeficiency Disease Syndrome
ANC: Antenatal Care

ART: Antiretroviral Therapy
DPHA: Diploma in Pharmacy
FMoH: Federal Ministry of Health
HCT: HIV Counseling and Testing
HIV: Human Immunodeficiency Virus
MoH: Ministry of Health
MPP: Minimum Prevention Package Intervention
NARHS: National AIDs and Reproductive Health Survey
OPD: Out Patient Department
SNAP: Sudan National AIDS Program
UAHEB: Uganda Allied Health Examination Board
UNAIDs: United Nations Agency for International Development
VCT: Voluntary HIV Counseling and
Testing VCT: Voluntary Counseling & Testing
WHO: World Health Organization

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There is no source of funding.

Conflict of interest.
The authors declare no conflict of interest.

Availability of data.
Data used in this study is available upon request from the corresponding author.

Authors contribution.
EII designed the study, conducted data collection, cleaned and analyzed data, and drafted the manuscript SN supervised all stages of the study from conceptualization of the topic to manuscript writing.

Authors biography.
Emmanuel Isaac Ibanda is a student of diploma in pharmacy at Kampala School of Health Sciences.
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