SJ Public Health Africa
Vol. 1 No. 4 (2024): APRIL 2024 ISSUE
https://doi.org/10.51168/x9kzhk51
Original Article

A CROSS-SECTIONAL STUDY ON KNOWLEDGE, ATTITUDE, AND PRACTICES TOWARDS VOLUNTARY COUNSELLING AND TESTING FOR HIV AMONG YOUTHS SEEKING HEALTHCARE AT KAJJANSI HEALTH CENTRE IV, WAKISO DISTRICT.

Francis Kimbowa, Cliffe Atukuuma*
Kampala School of Health Sciences P.O.Box 1426, Kampala-Uganda.

ABSTRACT.

Background:
Objective: To assess knowledge, attitude, and practice of Voluntary Counselling and Testing for HIV among youths who sought health care at Kajjansi Health Center IV, Wakiso district.

Methodology:
This study used a descriptive, cross-sectional study design and quantitative methods. The respondents were selected using Simple random sampling. An interview method was used to collect data from the respondents and a researcher administered questionnaires.

Results:
66% of the respondents were male while 34% were female. (50%) were between 25 - 29 years old. All respondents, (100%) were aware of VCT. (95%) defined it as the willingness to go for an HIV test after deciding on one's own. (84%) of the study, participants knew its importance before testing. (80%) got information from health workers, 72% of the respondents reported that, it enabled one to know their HIV status and start treatment if found positive. 60% of respondents had ever attended HIV/VCT services before. In the attitude assessment, 75% were interested in being tested for HIV/AIDS but they had limited information about HIV/VCT services. (67%) would recommend fellow youths for HIV/VCT services. 15% of the youths had never had any HIV/VCT counseling services before. (67%) had tested for HIV at least once

Conclusion:
The study revealed that youths had a high Knowledge of HIV/VCT services. The majority understand VCT as willingly receiving information on HIV/AIDS and getting tested, having a negative attitude towards HIV/VCT services, and having low practice towards HIV/VCT services.

Recommendations:
The government through the Ministry of Health and district health teams should open up more VCT centers in rural areas and equip them, train more health workers and teachers in HIV/VCT services, and organize mobile HIV /VCT health camps in schools and communities to disseminate more information.

Keywords: Voluntary Counselling and Testing, Youths, HIV, Health care
Submitted: 2024-01-12 Accepted: 2024-03-19

*Corresponding author: Francis Kimbowa**
Email: franciskimbowa19@gmail.com
Kampala School of Health Sciences P.O. Box 14263, Kampala-Uganda

BACKGROUND OF THE STUDY.

Voluntary counseling and testing (VCT) refer to the process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for human immunodeficiency virus (HIV). The decision must be entirely the choice of the individual and he or she must be assured that the process was confidential.

Acquired immunodeficiency syndrome (AIDS) is a world pandemic that has claimed many lives without a cure. Since its inception in the 1980s, countries like Ethiopia, South Africa, Malawi, and Zimbabwe have initiated various methods of fighting it and among them, VCT has proved to be the key strategy due to its advantages. Despite its benefits, a larger proportion of young people are hesitant to use its services due to negative beliefs such as limited access to its services, stigma, and a lack of confidentiality in service delivery.

In Africa, especially Sub-Saharan Africa where it is estimated that over 70% of new infections occur every other year due to the diverse effects of HIV/ AIDS, 95% of the population became aware of the existence of VCT services and their effects. Various teachers responded differently towards HIV/AIDS prevention, care, treatment, and support programs. Studies from countries like Ethiopia, South Africa, and Malawi indicated that the knowledge, attitude, and practice of male teachers towards VCT is moderate and its uptake in schools is minimal. The low uptake was found

to be associated with ignorance, fear of being positive, cost of VCT, inadequate number of VCT centers, and stigmatization, (Aarakit. B,2017).

In Uganda, where it is estimated about 1.2 million youth are living with HIV/ AIDS, youths (89%) know of the existence of VCT services but have negative attitudes toward using them with the general uptake of VCT among youths estimated at 50%. It is mostly the women under the Elimination of Mother-to-child Transmission of HIV program (EMTCT) who are accessing VCT services. This kind of attitude has led to limited skills, values, and knowledge about the spread and management of HIV/AIDS in communities in the country.

For effective prevention and management of HIV/ AIDS, the government of Uganda also operationalized the use of VCT as one of the key methods for promoting HIV/ AIDS awareness campaigns among youths in communities around the country. Under this method, hospitals and health centers were given responsibility to conduct the VCT campaign down to schools, and outreaches in the communities to gain access to the youths. It has been carried out to the extent of home-to-home visits, The VCT campaign enhances the ability to reduce one's risk of acquiring or transmitting HIV, access HIV-specific treatment, care, and support, manage learner's health, and plan for the future. VCT is also vital for providing access to emotional support, improving skills to cope with HIV-related anxiety, and increasing motivation to avoid risky behaviors among youths. (MOH, 2016)

In November and December 2019, only 136 youths attended the VCT services. This is an indication that very many youths do not have a positive attitude towards the use of VCT services lowering the rate of HIV/AIDS in schools and communities. However, given the advantages, no studies were conducted on the knowledge, attitude, and practices of the youths towards VCT service in Wakiso District. The present study therefore was conducted to assess the knowledge, attitudes, and practices of the youths who visit the health facility towards voluntary counseling and testing of HIV in Kajjansi Health Center IV Wakiso District.

Broad Objective.

The purpose of the study was to assess the knowledge, attitude, and practices regarding Voluntary Counselling and Testing for HIV among youths seeking health care at Kajjansi Health Center IV.

Specific objectives.

- To assess the knowledge regarding Voluntary Counselling and Testing for HIV among youths seeking health care at Kajjansi Health Center IV.
- To establish the attitudes towards Voluntary Counselling and Testing for HIV among youths seeking health care at Kajjansi Health Center IV.
- To identify the practices of youths regarding Voluntary Counselling and Testing for HIV among youths seeking health care at Kajjansi Health Center IV.

METHODOLOGY.

Study design.

A descriptive cross-sectional study design was used to enable the researcher to obtain information about the situation at hand and show the current condition under study in the desired population.

Study site.

This study was conducted at Kajjansi Health Center IV, a public health facility, located in Kajjansi Town Council, Wakiso District in the central region of Uganda about 29 Km south of Kampala city, Ugandan capital. Kajjansi Health Center IV provides primary health care services, and maternal and child health services to the residents of the district, and the neighboring district within the region.

Study population.

The target and Study population comprised of youths within the age range (15 - 35) who reside within Wakiso District.

Sample size determination.

The sample was calculated as follows;

$$N = \frac{z^2pq}{d^2}$$

Where,

N-represents the sample size

d-Represents the precision of the study, a precision of 9.5% was used due to limited resources and study time.

z-Represents standard normal deviation corresponding to a 95% confidence interval which is 1.96

Represents proportional characteristics which have been estimated at 50%.

Represents (1-p) which is (1-0.5) = 0.5.

$$N = \frac{1.96^2 \times 0.5 \times 0.5}{0.095^2}$$

N = 120

Therefore, the sample size for the study was 120 respondents.

Sampling method.

Probability, the simple random sampling method was employed to identify the participants for the study, and it involved the identification of the youths and collection of data from participants who were identified by the use of the sampling method from the outpatient department and inpatient wards at the health facility.

Sampling procedure.

All youths who met the inclusion criteria were requested to randomly pick a pre-prepared note from a box containing

pieces of paper with notes “yes” and “no” once without replacement. Any mother who picks a paper with the “yes” was part of the sample and this was done on every day of data collection until the desired respondents have been sampled.

Study variables

Dependent variable

The dependent variable of this study was voluntary Counselling and testing for HIV.

Independent variables.

The study focused on determining the knowledge, attitude, and practice regarding VCT among youths.

Selection criteria.

Inclusion criteria.

The study included all youths 15 to 35 years, old who lived within the study area and attended OPD or were admitted to IPD at Kajjansi Health Center IV who voluntarily accepted to participate and with sound mind to give informed consent and mothers who were not very sick.

Data collection.

Data collection method.

The study employed a Survey data collection method, where a questionnaire was administered to 120 youths who met the inclusion criteria at the study site and selected through a random selection and was taken in the study once.

Data collection tool.

The researcher used researcher-administered questionnaires for respondents.

Data collection procedure.

The researcher together with the trained research assistant interviewed the respondents using researcher-administered questionnaires to ensure that the data collected was accurate. Both the researcher and the research assistant introduced themselves to the in-charge of the health facility that has been chosen as the study site and to the youths at the OPD and in the wards during days of data collection, where they got access to the respondents and obtain the sample to collect data from on each day.
The exercise of actual data collection always commenced at 08:00 am and ended at 02:00 pm every day from Monday to Friday for the 20 days of data collection. The evening hours were utilized for passing through the research questionnaires to check for completeness.

Quality control.

Pilot study.

A randomly selected sample of 10 youths was used for the pilot study from Wakiso Health Center IV. Here the questionnaires were pre-tested for effectiveness of data collection by interviewing 10 youths. Repetitions, overlapping response options, and other inconsistencies in the tools were identified and corrections were made to ensure that relevant data were collected. The findings of the pilot study were not used in writing the research report.

Training the research assistant.

One Research Assistant was trained as an interviewer and the selection was based on the ability to speak good English and Luganda was trained on how to administer questionnaires during data collection.
The main aim of the training was to achieve appropriate techniques in questioning approaches and proper filling of the questionnaires.

Data analysis and presentation.

Data was analyzed manually and using Microsoft Office Excel then presented using tables, graphs, and pie charts and was also subjected to content analysis where the obtained data having been summarized was analyzed per specific objective and question with responses.

Ethical consideration.

The research proposal after being approved by the Research Committee of Kampala School of Health Sciences and duly signed by the supervisor, the researcher was provided with an introduction letter directed to the Incharge Kajjansi Health Center IV, Wakiso District.
The researcher obtained permission to collect data, from the in charge of Kajjansi Health Center IV. Given that this study is on a sensitive and controversial topic, the principle of informed consent was always upheld through the recruitment process and data collection. The identities of the respondents were not disclosed and their confidentiality was maintained; data from the respondents was stored under lock and key.
The respondent's consent was by signing. Privacy and confidentiality of respondents were ensured by interviewing each respondent alone and using the information for the sole purpose.

https://doi.org/10.51168/x9kzhk51

PRESENTATION OF RESULTS.

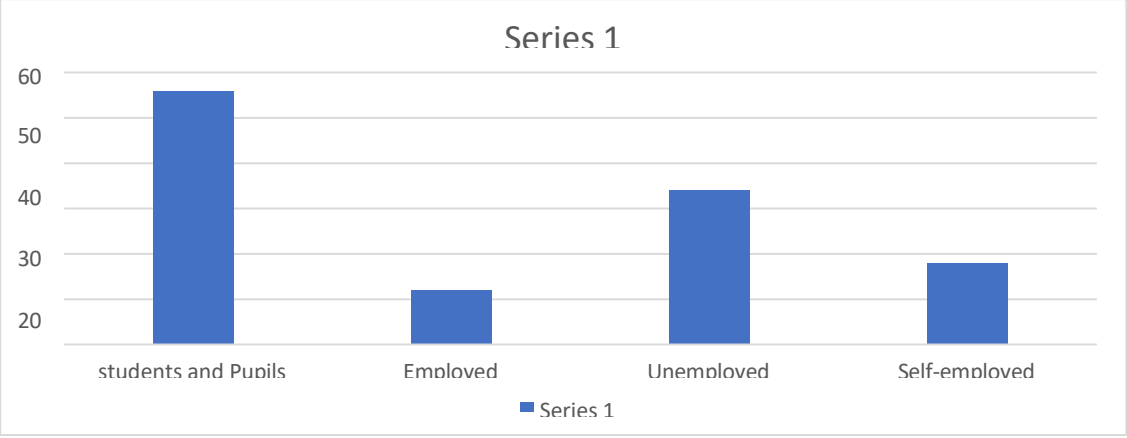
Socio-demographic characteristics of respondents.

Table 1: Showing socio-demographic data of the respondents.

Variable	Frequency (n=120)	Percentage (100%)
Gender		
Male	66	55
Female	54	45
Age of respondents		
15-19	32	26.6
20-24	60	50
25-29	20	16.7
31-35	8	6.7
Area of Residence		
Rural	72	60
Urban	48	40
Marital status		
Single	76	63.4
Married	42	35.0
Separated	02	1.6
Widowed	00	00
Religion		
Christian	102	85
Muslim	18	15

In Table 1, there were more male respondents, 66(55%) than female respondents, 54(45%). 32(26.6%) of the respondents were within the 15-19 years age range, 60(50%) were in the age range of 20-24 years, 20(16.7%) were in the range of 24-29 years, 8(6.7%) were in the 31-35years age group. The greater group lived in the rural areas 72(60%) with the minority 48(40%) living in the urban areas. Majority of respondents, 102 (85%) were Christians, with 18(15%) Muslims. More than half of the respondents 76(63.4%) were single, 42(35%) were married, with 2(1.6%) separated from their partners and none was widowed.

Figure 1; Showing Occupation of Respondents.



56(46.7%) of the respondents comprised of students and pupils, 34(28.3%) were unemployed, 12(10%) were employed and 18(15%) were self-employed as shown in the figure 1.

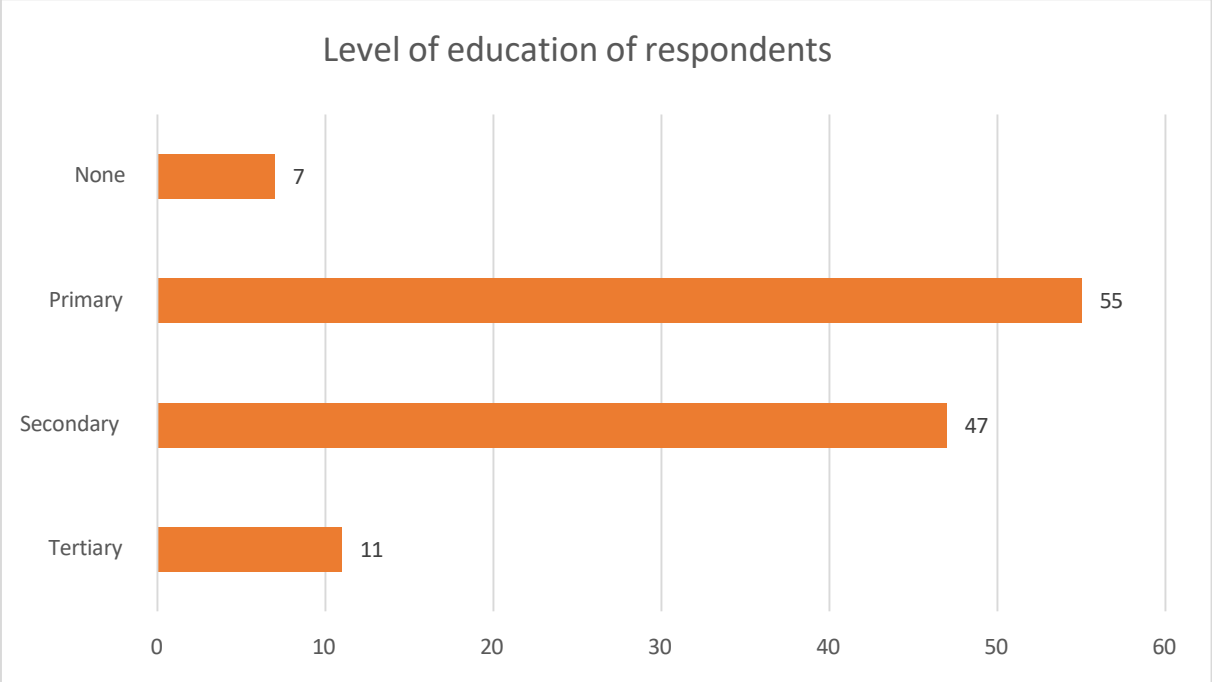


Figure 2; Showing Level of education of respondents.

The majority of respondents attained formal education, where55 (45.8%) had attained a primary level of education, 47(39.2%) had a secondary level, 7(5.8%) reported not having had any formal education, and the minority, 11(9.2%) had tertiary level of education as shown in figure 2.

Knowledge regarding HIV voluntary counseling and testing.

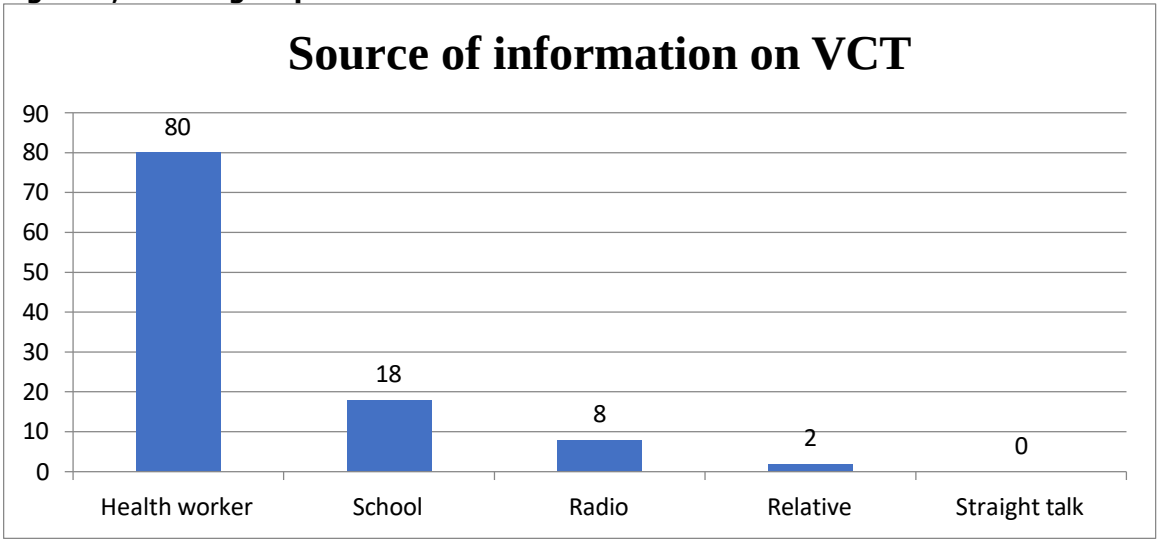
The researcher assessed knowledge regarding HIV VCT amongst the respondents using a set of questions as discussed in the findings.

Table 2; Showing Respondents' knowledge regarding HIV/AIDS.

Variable	Frequency (n=120)	Percentage (100%)
Awareness of HIV?		
Aware	120	100
Not Aware	00	00
How is HIV transmitted from one person to another?		
Having sexual intercourse with an infected person	120	100
Sharing sharp objects	00	00
Mother passing it to the baby	00	00
How can one identify if a person is infected with HIV?		
Taking an HIV test	108	90
Doctor's examination	12	10
I don't know	00	00

Of all respondents, 120(100%) were aware of HIV and mentioned having sexual intercourse with a person who is infected with HIV as the best-known mode of HIV/AIDS transmission from one person to another. The majority of the respondents, 108(90%) were aware that Taking an HIV test is the only way to find out if one has the germs (virus) that causes AIDS as compared to the 12(10%) who reported a doctor's examination of a patient as a way to identify the virus. (Table 2)

Figure 3; Showing respondents' source of information on VCT.



In Figure 3, the majority of the respondents, 80(74.1%) reported having learned of VCT from health workers, 18(16.6%) from their schools, 8(7.4%) learned from radio, and the least 2(1.9%) reported to have learned of VCT from their relatives.

Table 3: Showing respondent's response to HIV testing.

Variable	Frequency (n=120)	Percentage (100%)
Definition of HIV Voluntary Counselling and Testing		
Testing for HIV when someone forces you to do so.	6	5
Going for an HIV test after deciding on your own without being forced by anyone.	114	95
Where can someone access VCT services?		
Health facility	108	90
Health outreach centers	7	5.8
Schools	5	4.2
Awareness of the Benefits of having an HIV test		
Aware	120	100
Not aware	00	00
Benefits of VCT		
People who test positive for HIV can get treatment	72	60
Helps to plan for the future	18	15
Preventing the spread from a positive person to a negative	16	13.3
Referral of positive persons to support groups	4	3.3
Increasing community awareness of HIV	8	6.7
Reducing stigma among people	2	1.7

The majority of the respondents, 114(95%) knew that HIV Voluntary Counseling and Testing refers to going for an HIV test after deciding on your own without being forced by anyone with only 6(5%) who said VCT is testing for HIV when someone forces you to do so but not your own decision. 108(90%) respondents said one can access VCT services at a health facility, 7(5.8%) said at health outreaches with only 5(4.2%) said the VCT services can be accessed at Schools.

All respondents knew the benefits of having an HIV test, as more than half 72(60%) responded that people who test positive can get treatment, 18(15%) said it allows one to plan for the future, 16(13.3%) said it avails for effective prevention of spread from those who are positive to the

negative, 4(3.3%) said it also enables positive living through referral to social groups like (TASO) and peer support groups, 6.7% said it increases community awareness about HIV and 1.7% responded that it reduces stigma among HIV/AIDS people. (Table 3)

Attitudes towards the uptake of HIV voluntary counseling and testing.

Table 4; shows Respondents' Attitudes towards uptake of HIV Voluntary Counselling and Testing.

Variable	Strongly agree		Agree		Disagree		Strongly disagree		Total	
	F	P	F	P	F	P	F	P	F	P
My friends would treat me badly if I were tested for HIV	09	7.5	82	68.3	18	15	11	9.2	120	100
I would not get tested because I would be asked questions that are too personal	18	15	72	60	18	15	12	10	120	100
I would be embarrassed if my friends found out I had decided to have an HIV test	22	18.3	84	70	9	7.5	05	4.2	120	100
I am afraid that if I go for a test the people in the community will discriminate against me if they found out that I am HIV positive	04	3.3	90	75	20	16.7	06	5	120	100
I do not have time to get an HIV test.	10	8.3	70	58.3	34	28.4	06	5	120	100
I don't want to know my HIV status as I will always think about it and it will depress me	17	14.2	60	50	23	19.1	20	16.7	120	100
There is no use in going for an HIV test because if you test positive there is no Cure	24	20	72	60	20	16.7	04	3.3	120	100
I could easily discuss HIV antibody testing with my family	00	00	18	15	92	76.7	10	8.3	120	100
I am afraid that if my partner finds out that I am HIV positive he/she will leave me	22	18.3	80	66.7	16	13.3	02	1.7	120	100
My partner will think I am cheating if I decide to go for an HIV test	18	15	70	58.4	16	13.3	16	13.3	120	100
It is not necessary to go for an HIV test if you know that you are faithful to your partner	30	25	60	50	30	24	00	00	120	100
It would bother me if someone I know sees me going to get an HIV test from the health center	08	6.7	72	60	30	25	10	8.3	120	100
I am concerned that the doctors might say I am positive whereas I am HIV negative	05	4.2	49	40.8	55	45.8	11	9.2	120	100

KEY. F= FREQUENCY
P= PERCENTAGE

According to Table 4, the majority of the respondents, 82(68.3%) agreed that their friends would treat them badly if they were tested for HIV with only 24.2% disagreeing. More than half of the respondents, 72(60%) agreed they would not get tested because of fear of being asked questions that are too personal as compared to 25% who disagreed with it. A majority, 84(70%) agreed to be embarrassed if their friends found out they had decided to have an HIV test as compared to11.7% who disagreed. 90(75%) agreed to be afraid that if they tested, people would discriminate against them in case of a positive test result as compared to 21.5% who disagreed.

70(58.3%) responded by agreeing to not having time to take a test more than the 40.4% who disagreed. Half of the respondents‟ population agreed to not wanting to know their status for fear of always thinking about the results and depression as compared to the 35.8% who disagreed. 60% agreed that there is no use in going for a test because even if one tests positive, there is no cure with only 20% disagreeing. The majority, over 80% disagreed with discussing HIV antibody testing with their family, with only 18(15%) agreeing. 80(66.7%) were afraid that if their partner finds out that they were HIV positive he/she would leave them and 58.4% said their partner would think they are cheating if they decided to go for an HIV test. Half of the respondents, 60(50%) agreed that going for an HIV test is not necessary if you know that you are faithful to your partner with only 33.3% disagreeing.

More than half, 66.7% said being tested by someone who knew them would bother them as compared to 33.3% who disagreed. 55% agreed that doctors would say they are positive whereas they were HIV negative with only 45% disagreeing.

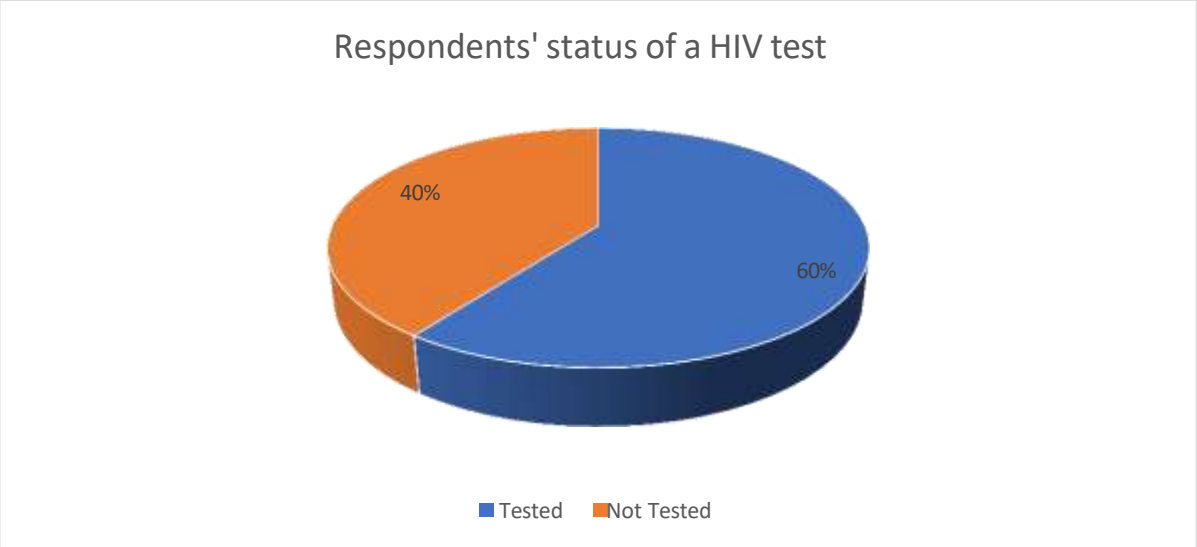
Practice of HIV voluntary counseling and testing.

Table 5; Showing Respondents' awareness and visit to a VCT site.

Variable	Frequency (N=120)	Percentage (100%)
Do you know of any place where HIV VCT services can be? Accessed		
Yes	102	85
No	18	15
If "Yes", How did you know about the place? (N=102)		
The health worker told me	18	17.6
A Friend told me	62	60.8
I heard on the radio	22	21.6
How far is the nearest health facility with VCT from your residence?		
<1km	14	11.7
1-5km	58	48.3
>5km	30	25
I don't know	18	15
Have you ever visited that VCT site?		
Yes	90	75
No	12	10
Not applicable	18	15

Table 5 shows that the majority of the respondents, 102(85%) had known of a VCT site, while 18(15%) did not know of any. Of the 102, 62(60.8%) were told about the site by a friend, 18(17.6%) by a health worker, and 22(21.6%) heard about the site from a radio. Close to half of the respondents, 58(48.2%) reported walking between 1-5km to access a health facility with VCT services, 30(25%) reported more than 5km, 14(11.7%) less than 1km with th3 18(15%) in the category that did not know of any HIV VCT site, who also had not visited any VCT site coupled with 12(10%) who knew of a site but hadn't visited it as compared to 90(75%) who knew and had visited the nearest VCT site.

Figure 4; Showing the state of an HIV test among Respondents.



More than half, 72(60%) of the respondents have ever had an HIV test as compared to the 48(40%) who reported to have never been tested for HIV before.

Table 6; Showing reasons for not having gotten an HIV test by the 40% of respondents.

Variable	Frequency (n=120)	Percentage (n=100%)
Reason for not having taken an HIV test before		
Fear of stigma/consequences of a positive test result	08	6.7
Never thought about it	03	2.5
Don't think am at a risk	08	6.7
Don't know where to get it	08	6.7
I am afraid to know my status	06	5
I don't think there is any benefit to getting tested	10	8.3
Do not like needles	02	1.7
Do not trust if results are confidential	03	2.5
Not applicable	72	60

On assessing for reasons as to why 48(40%) had not taken any HIV test before, 3(2.5%) had never thought about it as well as not trust the confidentiality of the results with a similar percentage, 8(6.7%) reported not thinking if they were at any risk, same percentage for fear of stigma/consequences of a positive result as well as not knowing where to get the test from,10(8.3%) doubted if there is any advantage to getting tested, 6(5%) reported being afraid to know their status with only 2(1.7%)who reported not liking needles. (Table 6)

https://doi.org/10.51168/x9kzhk51

Table 7; Showing Practice of VCT among Respondents.

Variable	Frequency (N=72)	Percentage (100%)
If you have ever tested for HIV, did you pay for the services offered at any VCT site? (N=72)		
No	72	100
Did you take the test voluntarily?		
Yes	32	44.4
No	40	55.6
If not voluntary, what was the reason for the test? (n=40)		
Antenatal care	16	40
Employer related testing	6	15
Tested because a doctor/ nurse suggested it	18	45
When was your most recent HIV test?		
Within past 12months	30	41.7
Between 1-2 years	34	47.2
Between 3-4 years	8	11.1
Did you find out your test result?		
Yes	72	100
Where did you take the most recent test from?		
The clinic I usually get treated from	26	36.1
Private General practitioner	10	13.9
Antenatal clinic	16	22.2
This hospital	00	00
Health facilities in another region	8	11.1
At home with a home test kit	12	16.7
Do you have a partner /spouse?		
Yes	72	100
Have you ever taken any HIV tests together with your spouse?		
Yes	18	25
No	54	75
Do the services offered at VCT centers encourage youth involvement? (N=120)		
Yes	102	85
I don't know	18	15
Why do you think the services are youth-friendly? (n=102)		
No cost	72	70.6
Privacy provided	8	7.8
Counselors are approachable	10	9.8
The result is kept confidential	12	11.8

According to table 7,
Of the 72(60%) of the total study population who had taken an HIV test before, all of them reported not having paid for any of the VCT services and found out the result of the test they took. Out of them, 40(55.6%) did not take the test voluntarily as 16(40%) took it at ANC, 18(45%) tested because a doctor/nurse suggested it and 6(15%) tested as their employer requested; as compared to the 32(44.4%) who voluntarily took the test for HIV. Out of the 72(60%), 34(47.2%) had their most recent test 1 to 2 years ago, 30(41.7%) took it within the past 12 months and the least, 8(11.1%) took their most recent test over 2 years ago.
26(36.1%) of those who have ever taken a test before took their last test from a clinic that they usually use for minor health problems, 8(11.1%) from a clinic or hospital in another region, 10(13.9%) from a private General Practitioner, 16(22.2%) during Antenatal Clinic,12(16.7%) took it at home with a home test kit and none tested from the site of this study. All the 72 respondents reported having sexual partners and the majority, 54(75%) have never taken an HIV test with their partner with only 18(25%) who have ever had a test as a couple.
The majority of the respondents 102(85%) of the total respondent believed that the services offered at VCT centers encourage youth involvement, with only 18(15%) who had no idea since they had never heard of any VCT center. Of the 102 respondents, more than half, 72(70.6%) reported the free services to be one key factor making the services youth-friendly, 12(11.8%) said, the results are kept confidential, 10(9.8%) reported the approachability of the counselors and the provision of privacy according to 8(7.8%) of the respondents is one reason making the services youth friendly.

DISCUSSIONS

Social demographic characteristics.

The study results on the social demographic data about age reveal that the majority of the respondents (50%), were between 25 - 29 years, while the minority (6.7) were 31 years and above. The majority of the respondents were between 25 - 30 years an indication that they were in their active reproductive stage and prone to acquiring HIV/AIDS. In addition, on the respondents' marital status most (63.4%) were single, while the least number (1.6%) were divorced. Furthermore, on the education level less than half (45.8%) of the respondents ended in primary level, while the minority (9.2%) went to tertiary institutions. Results indicate that more educated youths are not embracing the HIV VCT services because they fear knowing their HIV status. About the places of residence, the majority of the respondents (60%) were residing in rural areas compared to (40%) who were urban-based. The majority of the respondents lived in rural areas because the study was carried mostly rural in a semi-urban setting that receives patients from the surrounding sub-counties in the district. Concerning the tribe of respondents, most of the participants, (60%) were Baganda while the least (5.8%) were of other tribes. This indicates that the study was conducted in the Bunyoro region where the majority of the people are Baganda Furthermore, the findings also established that 85% of the respondents were Christians while 15% of the respondents were Muslims. This implies that there is a need for religious leaders to get involved in disseminating information about HIV/VCT services.

Knowledge of youths on voluntary counseling and testing for HIV at Kajjansi Health Center iv.

Study findings on the awareness of respondents on HIV/VCT services, all (100%) agreed to be aware. Furthermore, of those who understood VCT/HIV services (95%) defined it as the willingness to go for an HIV test after deciding on one‟s own while (5%) testing for HIV when someone else forces one to take the test. This implies that most of the respondents had gotten information about HIV/VCT through the media, health workers, and other means. This is further supported by Aarakit. B (2017) where it was stated that awareness of I-IIV/VCT services improves the likelihood of testing as a high population (84%) of their study participants knew its importance before testing. In addition, where respondents got information about HIV/VCT services, the majority (80%) got information from health workers while the minority (2%) got information from their relatives. This implies that the health workers were doing much to disseminate information about HIV /VCT services, especially to the rural communities. About the importance of HIV/VCT services, 72% of the respondents suggested that it enables them to know their HIV status and start treatment if found positive, 16% said it allows them to prevent the spread of HIV/AIDS while the minority (2%) to get more information about HIV/AIDS and reduce stigma among people in the communities. This implies that the need to know their HIV status and if positive, start early treatment was the main reason as to why many teachers accessed HIVNCT services.

The attitude of youths towards voluntary counseling and testing for HIV at Kajjansi Health Center iv.

According to study findings on whether respondents had ever attended HIVNCT services before, 60% said yes while 40% no. Further still, the highest number of respondents (66.6%) attended HIV VCT services because they wanted to be tested while the lowest number of respondents (33.4%) escorted a friend. This implies that there is still a gap in information dispensation about HIV/VCT services since some individuals were not vigilant enough to inquire about their HIV status. Regarding whether respondents had ever recommended others for HIV /VCT services, 57% said yes while no. This indicates that the prior and post-HIV/AIDS counseling equipped the 33 respondents with good knowledge about HIV/VCT services which they wanted colleagues also to share. About the above, those who

recommend others for HIV NCT services, most respondents (41%) wanted them to know their HIV status, 35% to know the methods of preventing HIV/AIDS while the least (24%) to know HIV/VCT services that were carried out at the Health center. This indicates that they lacked enough information about HIVNCT services at the health center of which they wanted them to be aware. This was in line with a study by the Centre for Disease Management (2014) which suggested that enough information about HIV/VCT services should be disseminated to people to increase their awareness of the services offered. According to the response of those who recommended fellow youths for HIV/VCT services, the highest number (67%) had a negative response while the lowest (33%) had a positive response. In addition, regarding the reasons for the negative response, 50% indicated that they fear stigma, 35% feared positive test results and 15% feared disclosing their test results to unwanted persons by the health worker. This implies that the public still has a negative response toward HIV/VCT services which has led to the prevalence of HIV/AIDS. In relation, a study by Aarakit. B (2017) on knowledge and attitude of youth on HIV/VCT services reported that 50.5% of respondents were unlikely to test at home visit HIV/VCT services because they feared that it would be conducted by unprofessional health workers who would disclose their test results.

Practices of youths on voluntary counseling and testing for HIV at Kajjansi Health Center iv.

Study findings on whether teachers have ever had any HIV/VCT counseling services before, all (100%) said yes Aarakit. B,2017. This could be due to the increased number of HIV/VCT services in health centers and learning institutions in Uganda. Similarly, a study by Aarakit. B(2017) pointed out that the increase in HIV/VCT service centers increased the number of its young clients from 43% to 69.3% in Latin America. However, 15%% of the youths had never had any HIV/VCT counseling services before. Furthermore, on the number of times the youths attended HIV/VCT services, the majority (67%) said once, while the minority (33%) said more than once. This implies that the majority who attended once and tested HIV negative believed they were safe and saw no need for more testing even when they were encouraged by the health workers to test more than once. 35 When asked if they have attended HIV/VCT services with a sexual partner, the majority (55.5%) replied no while the minority (44.5%) said yes.

The majority of the respondents had never tested with their sexual partner because they feared the negative reactions of their partners in case found HIV positive. In support, a study by Machekano,(2014) established that only 17% of the adults who tested for HIV brought in their wives for HIV testing while the majority (83%) declined due to the fear of negative consequences including sexual denial for the positive test results. In addition, on the measures respondents use to prevent HIV/AIDS, the majority (53%) suggested being faithful to their sexual partner, and the minority (3%) of the youths majorly suggested circumcision. The results indicate that religious leaders have been involved in the fight against HIV/AIDS by encouraging the religious norm of faithfulness among sexual partners. In support, UDHS (2016), UBOS and ICF (2017) suggest that 92% of male teachers knew that limiting sexual intercourse to one faithful and uninfected partner reduces the chances of getting HIV/ AIDS Further still, the availability of private rooms at school for HIV/AIDS counseling, all (100%) said yes. This indicates that there was confidentiality among health workers not releasing the test results to unwanted persons. Still, this could be the reason why some respondents tested more than once. In suppo1i, Aarakit . B (2017) revealed that the lack of private rooms for HIV/VCT services increases stigma, discrimination, and anxieties about confidentiality which scare away clients from the services.

CONCLUSION.

The study revealed that youths had a higher Knowledge of HIV/VCT services. The majority understand VCT as willingly receiving information on HIV/AIDS and getting tested. The higher knowledge among teachers was due to a wider information flow about HIVVCT services disseminated by the health workers to the public and its extension to learning institutions. On attitudes of the youths towards HIVVCT services, the study revealed that the youths had a negative attitude towards HIV/VCT services. The few attended the services because they wanted to be tested for HIV/ AIDS and know their HIV status so that they could start treatment early to improve their health in case tested positive.

On establishing the practices of the youths towards HIV/VCT services, the study revealed that the youths had low practice towards HIV/VCT services. It was further established that some youths had tested for HIV at least once. The study also established the factors that determine the male teacher's unwillingness to test for HIV/ AIDS which included; fear of stigma, fear of positive test results, fear of stigma, not trusting confidentiality of test results as well as of unethical health workers disclosing the test results.

RECOMMENDATIONS.

The government through the Ministry of Health should open up more VCT centers, especially in rural areas, and equip them with the necessary equipment to improve people's access to HIV/VCT services in the communities and as well establish some centers in educational institutions to bring the service near to the youths in schools.

The District Health officers in collaboration with local leaders should work hand in hand with the stakeholders in the education sector to train more health workers and teachers in HIV/VCT services to be able to handle the increasing HIV cases in learning institutions.

The district health leadership should work in collaboration with the health workers in the lower-level health facilities to organize mobile HIV /VCT health comps in schools and

communities to disseminate more information.

ACKNOWLEDGEMENT.

I would like to thank the almighty God for his loving grace upon my life before and during my education.
I extend my heartfelt gratitude to my parents, and siblings for all the unwavering financial and kind support towards my academic journey not forgetting my supervisor Mr. Atukuuma Cliffe for his continued guidance in the formation of this research work
I also would like to thank the administration of Kampala of Health Sciences for all the times of guidance and for showing me direction towards my goals during the time of undertaking my studies at the institute.
May the Good Lord bless you all.

LIST OF ACRONYMS/ABBREVIATIONS.

DEO: District Education Officer
HIV: Human Immunodeficiency Virus
VCT: Voluntary Counselling and Testing
VHT: Village Health Team
AIDS: Acquired Immunodeficiency Syndrome
MOES: Ministry of education and sports
MOH: Ministry of Health
NGO: Non-Government Organization
WHO: World Health Organization
UDHS: Uganda Demographic Health Survey

SOURCE OF FUNDING.

The study had no funding

CONFLICT OF INTEREST.

The author declares no competing interests.

REFERENCES.

1. Centre for Disease Management teachers, (2014) Cost-effectiveness of voluntary HIV- 1 counseling and testing in reducing sexual transmission of HIV-1 in Iran. Lancet. 2000,356(9224):113-121.10.1016/S0140-6736(00)02447-8.View Article Pub Med Google Sclzolar
2. Doherty T, Tabana H, Jackson D, Naik R, Zembe W, Lombard C, 2013. Effect of home-based HIV counseling and testing intervention in rural South Africa: cluster randomized trial.
3. Machekano R, McFarland W, Mbizvo MT, Bassett MT, Katzenstein D, Latif AS: Impact of HIV counseling and testing on HIV seroconversion and reported STD incidence among male teachers factory workers in Harare, Zimbabwe. Cent Afr J Med. 2014, 44 (4): 98- 102.PubMedGoogle Scholar
4. MOH. (2016) The HIV prevalence in the general population of Uganda. Relief web nt/Uganda/HIV prevalence. Viewed 4th /06/2017
5. Aarakit Betty (2017). Knowledge, attitude, and practices of male teachers towards human immune virus/voluntary counseling and testing in schools in Nakalama sub-county, iganga
6. Uganda Bureau of Statistics (UBOS) and ICF. 2017. Uganda Demographic and Health Survey 2016: Key Indicators Report. Kampala, Uganda: UBOS, and Rockville, Maryland, USA: UBOS and ICF.

Publisher details.

SJC PUBLISHERS COMPANY LIMITED

Category: Non-Government & Non-profit Organisation
Contact: +256775434261(WhatsApp)
Email: admin@sjpublisher.org, info@sjpublisher.org or studentsjournal2020@gmail.com
Website: https://sjpublisher.org
Location: Wisdom Centre Annex, P.O. BOX. 113407 Wakiso, Uganda, East Africa.