RESEARCH SUMMARY

Attracting Youth to Voluntary Counseling and Testing Services in Uganda

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A peer counselor is counseling a female youth client at the Naguru Teenage Information and Health Center.

HIV voluntary counseling and testing (VCT) is a valuable way to identify people who need HIV care and has been shown to lead to the adoption of safer sexual behaviors among some groups of adults (Voluntary HIV Counseling and Testing Efficacy Study Group 2000). Little is known, however, about the use of VCT by youth, a group that comprises more than half of those newly infected with HIV. An exploratory study conducted in Nairobi, Kenya, and Kampala and Masaka in Uganda revealed that youth want information, confidentiality, low-cost HIV testing, and friendly, professional counseling (Horizons 2001). Two facilities in Kampala, Uganda, the AIDS Information Center (AIC) and Naguru Teenage Information and Health Center (NTIHC), responded to these needs by implementing new youth-oriented strategies to increase VCT utilization and satisfaction with services among young people.

Description of the Interventions

AIC, a stand alone VCT site, has delivered HIV testing since 1990. Although AIC served youth as well as adults who came in for services, it did not target youth specifically. In 2001, AIC established a youth corner behind the regular adult clinic with a separate gate so youth could enter in privacy. Staff at AIC developed a counseling training manual to train counselors to deliver youth-friendly VCT services. AIC also reduced the HIV testing fee from 4,000 (US$2.27) to 1,000 (US$0.58) Ugandan shillings for youth.

Open since 1995, NTIHC is a drop-in center that offers free reproductive health services to youth, including diagnosis and treatment of STIs, family planning, pregnancy testing and counseling, and antenatal and postnatal care. In 2002, NTIHC began offering VCT two days per week and expanded its facility to provide waiting and counseling space for youth seeking VCT. AIC provided initial technical and material support to NTIHC,

including training peer counselors to do pre- and post-test counseling, orienting laboratory staff, implementing a client monitoring system, and supplying testing kits.

AIC developed a three-day training course for counselors at both sites on how to counsel youth within the context of VCT. Specific issues addressed by the training included mental and emotional development in adolescence, how to discuss puberty with youth, and pressures in the environment that affect youth decision-making.

The clinics initiated activities to inform young people about the new services through the media. Both clinics collaborated with the Straight Talk Foundation in designing promotional posters and brochures, and in writing articles for the popular and widely distributed youth magazine, "Straight Talk." In addition, radio programs for youth managed by both NTIHC and the Straight Talk Foundation featured discussions of the need and value of VCT and also explained the procedures that youth would encounter when they went to the clinics for testing.

Horizons conducts global operations research to improve HIV/AIDS prevention, care, and support programs. Horizons is implemented by the Population Council in partnership with the International Center for Research on Women (ICRW), the Program for Appropriate Technology in Health (PATH), the International HIV/AIDS Alliance, Tulane University, Family Health International, and Johns Hopkins University.

Methods

This summary presents findings from exit interviews conducted with youth 14 to 21 years old leaving services at AIC and NTIHC. The exit interview data from AIC are from interviews with youth conducted prior to the implementation of the youth corner (February to May 2001) and after the intervention was well established (May to August 2003). The exit interview data presented from NTIHC were collected after VCT services were well under way at the youth drop-in center (May to August 2003). The summary also draws on in-depth interviews with exit interview participants and on focus groups conducted with tested and untested youth.

Researchers adapted items from UNAIDS' *Tools for Evaluating HIV Voluntary Counseling and Testing* to measure satisfaction by youth with services. Researchers also conducted in-depth interviews with counselors to learn their views of the job and the new youth-focused services. In addition, expert VCT counselors from other facilities observed and rated counseling sessions with individuals, couples, and groups. Table 1

Table 1 Sample sizes by research method used for analysis

	Pre-youth VCT services			Post-introduction of youth VCT services		
	Males	Females	Total	Males	Females	Total
Youth exit interviews						
AIC	79	290	369	155	245	400
NTIHC	—*	—	—	146	254	400
Youth in-depth interviews						
AIC	10	10	20	10	10	20
NTIHC	—	—	—	5	5	10
Provider interviews						
AIC	4	14	18	3	13	16
NTIHC	—	—	—	3	1	4
Counseling session observations	**Individual**	**Couple**	**Group**	**Individual**	**Couple**	**Group**
AIC	12	13	35	40	4	22
NTIHC	—	—	—	21	1	34

*NTIHC did not offer VCT before the baseline survey.

presents the data collected by facility before and after youth VCT services were introduced.

Characteristics of the Exit Interview Samples

After the introduction of VCT services, about 85 percent of youth were 18 to 21 years old, and more females than males came for services. Seventy-seven percent of youth lived in Kampala and 90 percent were unmarried. The clinics served somewhat different populations regarding schooling: AIC attracted more out-of-school youth (56 percent) than did NTIHC (44 percent).

Key Findings

Youth were highly satisfied with the new youth-oriented services.

Exit interview data from AIC indicate that overall satisfaction with VCT services was generally high before the intervention (79 percent), yet increased after provider training and implementation of the youth corner (95 percent). There were also increases in the proportion of youth clients at AIC who indicated that the counselor took important steps as part of the VCT process, such as praising the client for having the courage to come for services, clarifying information, correcting misconceptions, repeating important information, and responding to their concerns and worries (Table 2).

Ninety-three percent of NTIHC clients participating in exit interviews after the introduction of youth VCT said they were satisfied with the services they had received. Moreover, almost all of the youth clients indicated that their counselor exhibited good counseling skills as part of the counseling process (Table 2). Steps that counselors did not take as consistently with youth clients at both sites were making referrals for treatment, further counseling, or care services.

Youth were asked to name three things they liked best about the services, and post-introduction of youth VCT services, the greatest number at both sites mentioned "friendly provider." A large majority also mentioned warm reception and provider professionalism. Although less than a third of respondents at both sites mentioned confidentiality, this figure had actually doubled at AIC from pre- to post-introduction of youth VCT (15 to 30 percent). Major improvements at AIC were also detected with regard to warm reception, provider professionalism, and information given on HIV/STIs (Table 3).

> *"I was so worried because I had lost a lot of weight but I stopped worrying when I came to this place. The reception was so good. It was like life goes on and these people are very caring."*
>
> Male youth at AIC

Table 2 Actions taken by counselor as reported by youth clients (%)

Results from exit interviews	AIC		NTIHC
	Pre-youth VCT (n = 369)	Post-introduction of youth VCT (n = 400)	Post-introduction of youth VCT (n = 400)
Praised client for courage in coming for service	89	99	99
Clarified information with client	74	98	97
Corrected misconceptions	81	97	98
Repeated information	92	100	100
Responded to concerns and worries	95	98	99

Table 3 Aspects of service that youth liked best (%)

Results from exit interviews	AIC		NTIHC
	Pre-youth VCT (n = 369)	Post-introduction of youth VCT (n = 400)	Post-introduction of youth VCT (n = 400)
Friendly provider	80	91	85
Information about HIV/STIs	31	69	50
Confidentiality of results	15	30	28
Provider professionalism	32	74	86
Warm reception on arrival	33	87	88

Clinics could not handle all the young clients who came.

After counselors from both facilities received training in youth-friendly services, the youth corner at AIC began operation and NTIHC started offering VCT as a new type of service. To serve more youth, NTIHC placed several large tents in the garden behind the clinic to allow for more waiting and counseling space. Media promotion of VCT services by Straight Talk and a local FM station, Radio Simba, followed. These activities led to an influx of young people seeking VCT services at the two facilities.

While the counselors reported that the training was beneficial to their efforts to advise young clients, they could not cope with the large numbers of young people who came to the clinics seeking services. To avoid disappointing youth, AIC booked only the number of youth they could handle each day and scheduled future appointments for the remaining youth. At NTIHC, the trained peer counselors determined that they could only counsel 20 young people each day and so they served only the first 20 to come for VCT services each morning. To reduce counselor stress, NTIHC offered services only two days a week. Eventually, the media outreach activities had to be discontinued to reduce the demand created by their promotional messages.

Risk exposure was the main reason clients got tested.

In the exit interviews and focus groups with tested youth, participants gave a number of reasons why they decided to come for VCT. One was that testing is part of preparation for marriage; another was to protect a relationship in which a partner asked them to test. According to a male focus group participant who got tested at AIC, "You may propose to a girl and she gives a condition that for any relationship you have to take an HIV test first." A few felt that they needed to know their HIV status in order to plan their future or because their job, education, or insurance required that they be tested.

However, after the promotion and introduction of youth VCT services, the vast majority of exit interview respondents at AIC (81 percent) and NTIHC (86 percent) got tested because they believed they had been exposed to HIV. Specific reasons for getting tested mentioned in focus groups included having unprotected sex, having worrisome symptoms, caring for someone with an open wound, and having parents who were sick or dead due to HIV infection. For AIC, this represents a huge change in their client profile, because only 7 percent of respondents prior to the introduction of youth VCT services mentioned risk exposure as the main reason for testing.

More females than males used the VCT services at AIC and NTIHC.

At AIC, females younger than 21 years old constituted 20 percent of total clients compared to 10 percent for males (January 2001 to April 2003 service statistics). NTIHC saw equal numbers of males and females during the first two months of VCT services. However, this pattern changed from the third month onward, with increasingly more female than male youth seeking VCT at the facility.

In focus groups, youth gave various reasons for the gender disparity. Some thought that females would be more motivated to get tested because they are more vulnerable to HIV infection due to rape or intercourse with older men, or because they are enticed or forced into sex at younger ages than males. Others thought that in general, females are more likely to have a single partner and therefore a good chance of testing negative. In contrast, most young men have multiple partners and have a good reason to fear testing because of the likelihood of a positive result.

In general, both male and female youth felt that females are more concerned about their lives and future and therefore, they are more likely to seek and respond to health information than males. Respondents also noted that more females than males are getting married in their late teens and early twenties and thus are likely to seek VCT before marriage. Almost all believed that it would be the female who would want the HIV test before marriage and that she would have to persuade or even push the man to get tested.

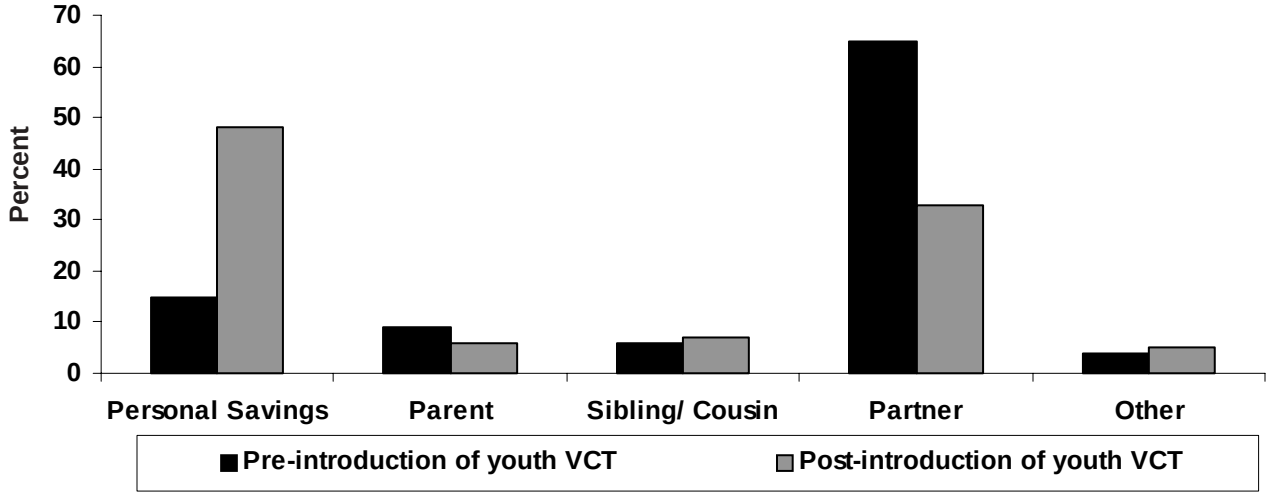
After the intervention, AIC attracted more young women who paid for the service themselves rather than relying on a partner to pay for VCT.

Youth at AIC were asked where they got the money for the HIV test. Personal savings was the main source for males prior to the introduction of the youth corner (80 percent) and post-introduction (88 percent). However, for females who tested at AIC prior to the introduction of the youth services, most (65 percent) had partners who paid for the test. At the post-introduction measure, the proportion of females whose partners paid for the HIV test dropped to 33 percent, and the percentage who paid for their own test increased from 15 to 48 percent (Figure 1). This may be attributed to the reduction in HIV testing fees. Thus many more females could afford to pay for VCT themselves. Only 3 percent of females at post-introduction felt the HIV test fee was high, compared to 20 percent at pre-introduction.

The intervention at AIC increased the proportion of young women who came to test unaccompanied.

AIC females were twice as likely as their male counterparts to be accompanied for testing prior to the promotion and introduction of the youth corner (69 vs. 35 percent). Although females were more likely than males to be accompanied by someone at post-introduction, the proportion dropped substantially for females (49 percent), while that of males changed little (34 percent). The lowered cost of testing might have enabled more females to test independently of partners.

Figure 1 Where do you get the money for the test? (Females only at AIC)



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A counseling room at the AIDS Information Center Youth Corner in Kampala. In 2001, AIC established a youth corner behind the regular adult clinic with a separate gate so youth could enter in privacy.

Accompanied youth said that they had someone with them because they wanted emotional and financial support, advice, and someone with whom they could share the experience. To explore whether accompanied youth had been pressured to come for testing, researchers interviewed 67 people who accompanied youth clients at AIC and NTIHC after the introduction of youth VCT services. Seventy-one percent of the people interviewed reported that they had been tested, and most of them had encouraged the young person they had accompanied to come for testing. More than a fourth of respondents (27 percent) said they had accompanied a partner, and these were all males. From these interviews and focus groups with youth, there seemed to be little outside pressure to test.

Youth heard about VCT from the media and friends.

The media campaign, carried out in collaboration with the Straight Talk Foundation and Radio Simba, succeeded in reaching many youth. After the introduction of youth VCT, radio was the major source of information for NTIHC respondents (88 percent) and AIC respondents (74 percent). About half of youth learned about youth VCT services from *Straight Talk* magazine (AIC: 47 percent; NTIHC: 59 percent). Some youth reported hearing about VCT from peers and partners, who influenced them to seek services. In some cases, groups of friends went to get tested together.

"If your friends have all tested you are influenced also to go for VCT services due to peer pressure or testimonies…and you decide to go for a test."

Female youth, NTIHC

Anxiety about handling positive results prevents some youth from testing.

In the focus groups with youth who had not had an HIV test, the most common reason for not testing was the fear that they could not handle the situation if they tested positive for HIV. Youth said that a positive test result might easily lead to negative social and psychological consequences. They mentioned that fear of stigma and discrimination from the community might force an HIV-positive person to move to a place where they were not known, or could result in the loss of relationships or the end of marriages.

Negative psychological outcomes of positive results were considered common, and even

inevitable. HIV-positive people were thought to be unable to concentrate at school and work, and to be depressed because they could not hope to have a family or to make future plans. Such people might commit suicide or adopt a lifestyle filled with risky behaviors like drinking and having many sexual partners. Others feared that the increased stress caused by learning that one was HIV-positive would exacerbate the disease.

A few youth who had had many sexual partners, or had had a partner who was either ailing from or had died of AIDS, did not see the need for testing because they strongly believed that they were already HIV-positive. Others who had never had sexual intercourse or unprotected sex did not see the need for testing; they felt they were safe.

Lack of information and misinformation are also barriers to youth use of VCT services. Some youth did not know about HIV testing and others feared counselor criticism. They thought that counselors would reprimand them for having exposed themselves to risk of infection. Other youth did not trust test results and feared that they may not be accurate. Many untested youth feared stigma if they entered a VCT facility, no matter what their results were.

Youth satisfaction with peer counselors was high, although they faced particular challenges in their counseling roles.

To serve youth, NTIHC trained young people to counsel their peers before and after HIV testing. In contrast to NTIHC, AIC relied on professional adult counselors. However, both professional and peer counselors received the same training in pre- and post-HIV test counseling and in working with adolescent clients. Findings show that at post-introduction, overall satisfaction with professional counselors and youth peer counselors was high. In addition, similarly high proportions of youth from both clinics reported that professional and peer counselors took important steps to make the counseling experience a successful one (Table 4).

The peer counselors faced special difficulties that did not affect the professional counselors. For example, some peer counselors reported that clients occasionally questioned their authority and expertise. In addition, young counselors were more likely to feel isolated in their work and less likely to feel confident about their skills. Youth counselors also had to think about getting a permanent job.

Table 4 Satisfaction with professional and peer counselors by youth clients at post-introduction of youth VCT services (%)

	Asssessment of professional counselors at AIC (n = 400)	Assessment of peer counselors at NTIHC (n = 400)
Overall satisfaction	97	93
Encouraged client to speak	100	100
Listened attentively	100	100
Nonjudgmental	100	100
Praised client for coming	99	99
Clarified information with client	98	97
Corrected misconceptions	97	98
Repeated information	100	100
Responded to concerns and worries	98	99
Used words client understood	99	96
Used a kind, warm tone	100	100

Results Utilization and Dissemination

The AIC and NTIHC clinics are both continuing to provide youth with VCT counseling and testing. In addition, two more AIC testing centers outside of Kampala are adding youth-friendly corners and specially trained youth counselors, and other AIC clinics will eventually add special youth services.

In October 2003, staff from AIC and NTIHC joined the researchers from Makerere University in hosting a meeting in Kampala that drew over a hundred participants to discuss the study's findings. Participants concurred that increased utilization of VCT was a valuable way to prevent HIV infection and to identify youth who need care, and attendees from other health programs agreed to set up a referral network for counselors to use for referring HIV-positive youth.

Program Implications

Many youth in Uganda would like to undergo VCT, and offering special youth services and publicizing their existence increased VCT utilization. Based on the findings, special training of providers improved services, lowered fees and adding a test location enabled more youth to test, and media outreach through radio and magazines informed many young people about VCT.

Unfortunately, the services were not able to serve all the young people who wanted to be tested and, without increased capacity, the clinics will have difficulty handling all the youth attracted to their new, youth-friendly services. Therefore, it is important that VCT centers that set out to attract youth anticipate increasing demand and plan accordingly.

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