AN ASSESSMENT OF THE QUALITY OF HIV COUNSELING AND TESTING SERVICE DELIVERY IN PRIVATE HEALTH UNITS IN KAMPALA DISTRICT; A CASE STUDY OF MAKINDYE DIVISION

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RESEARCH REPORT SUBMITTED TO THE COLLEGE OF HUMANITIES AND SOCIAL SCIENCES AS PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE BACHELOR'S DEGREE OF SOCIAL WORK AND SOCIAL ADMINISTRATION OF KAMPALA INTERNATIONAL UNIVERSITY

MAY, 2018
DECLARATION

I, KAZIBWE MICHEAL, declare that this is my own original work and has never been presented to any institution for any award of bachelor degree.

Signature .................................. Date ........................................

26/05/18
APPROVAL

This piece of work has been under my supervision and ready for submission for examination

Signature ...........................................

Mr. ACHODA DENNIS

Date....................................................

27.05.18
DEDICATION
I do dedicate this piece of work to my family members for the support they rendered to me throughout my education.
ACKNOWLEDGEMENT

My ultimate acknowledgement are un to Almighty God, for the divine love, care and wisdom he gave me to successfully go through the field of academics and education struggles in the process of pursuing my bachelors degree of social work and social administration.

I am grateful to all the lecturers of Kampala International University more so those in the department of social work who without their support I would not have accomplished my dissertation. With great and deep pleasure I wish to extend my sincere thanks to my parents for their continued financial and moral support throughout my education.

I extend my appreciation to my supervisor Mr. Achoda Dennis for his parental guidance and support during the course of the development of this research report. I do acknowledge the other lecturers for the support accorded to me.

And fellow colleagues who have helped in the process of pursuing this degree, I appreciate your devotion, hard work and keen interest in your respective areas of work and for giving me the useful information and guidance which I believe will enhance my career develop merit and work capacity may God bless you all abundantly.
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<table>
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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
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<td>HCT</td>
<td>HIV Counseling and Testing</td>
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<td>PICT</td>
<td>Provider-Initiated Counseling and Testing</td>
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<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>ART</td>
<td>Antiretroviral</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immune Virus/Acquired Immunodeficiency Syndrome</td>
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<td>PFT</td>
<td>Private for Profit</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organizations</td>
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<td>PNFT</td>
<td>Public and Private Not for Profit</td>
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<td>MOH</td>
<td>Ministry Of Health</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>MAP</td>
<td>Multi-Country AIDS Project</td>
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<td>UDHS</td>
<td>Uganda Demographic Health Survey</td>
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<td>SPSS</td>
<td>Statistical Package for Social Scientists.</td>
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ABSTRACT
The topic of the study was an assessment of the quality of HIV counseling and testing service delivery in private health units. The study had the following objectives to determine the level of adherence to counseling and testing guidelines by HCT, nature of health facility infrastructure factors that affect quality of HCT service delivery and to identify possible ways to improve the quality of HCT services in the private health units in Kampala.

The study used the Morgan formula for determining the sample size out of the total population of which 85 were selected as a representative sample for the purpose of this study. These guided the study and determined the data that the researcher collected from the field through interviews and questionnaires.

The study used an exploratory research design to explore into issues concerning the practice of desertification and rural development in Makindye division, simple random sampling was used to select a representative sample from the study population where a sample size of 80 respondents were selected for the study.

Data was collected from both primary and secondary sources using documentation, interviews and questionnaires, collected data was analyzed qualitatively using thematic analysis to generate relate data into tables that helped the researcher in discussing the findings.

The findings indicated that there are HIV counseling and testing services in Makindye division, the quality of the services is still wanting and geographical scope is still a challenge however, the service providers are determined to keep improving its quality.
CHAPTER ONE
BACKGROUND TO THE STUDY

1.0 Introduction
This chapter contains the background, definition of key terms, purpose of the study, research objectives, research questions, scope of the study, and significance of the study

1.1 Background of the Study
Globally, South Africa has the highest number of people living with HIV in the world. Despite this, many South Africans do not know their HIV status and uptake of voluntary counseling and testing (VCT) has been suboptimal. In clinical settings there are many missed opportunities for HIV diagnosis as most patients are not routinely offered HIV counseling and testing (HCT). Provider-initiated counseling and testing (PICT) has been introduced to ensure that HCT becomes the standard of care in all consultations with health providers. PICT promotes universal access to prevention, care and treatment services for all clients by increasing the utilization and acceptance of HCT services.

This article outlines the rationale for PICT as well as providing an overview of the implementation protocol that will equip health care providers with the knowledge required to integrate HCT into routine medical care.

In African view Since the first antibody tests for human immunodeficiency virus (HIV) infection became available, public health organizations and human rights activists have debated the best approach to HIV testing and counseling (HTC). (Bayer R, Edington C 2009). At a time when there was no effective treatment and HIV-infected individuals faced widespread discrimination and stigmatization, (Bayer R, Edington C 2009) many argued that HTC was inappropriate because it provided little benefit to the individual. Conversely, others believed that testing was the key to promoting a change in behavior. These two concerns framed early debates about HCT.

Initially, there was general support for a cautious response to HTC and HIV infection, although this was considered “exceptional” compared with responses to other infectious diseases. For example, in 1987, the World Health Organization (WHO) emphasized caution in extending routine HIV testing beyond blood donors. (Bayer R, Edington C 2009). At that time, standards
for HTC, which were based on an international consensus reached by WHO and other stakeholders, emphasized voluntarism and gave rise to the adoption of voluntary counseling and testing. (Bayer R, Edington C 2009) This approach consisted of three primary components: counseling before and after an HIV test, which included an individualized risk-reduction plan based on the test results; informed written consent; and confidentiality. (Bayer R, Edington C 2009)

As evidence emerged that antiretroviral therapy (ART) could significantly reduce mother-to-child HIV transmission and “alter the clinical course” of HIV infection, the HTC debate changed. (Bayer R, Edington C 2009) Clinicians and public health professionals now argued that an exceptional approach to HTC was no longer appropriate. The view was that HTC should be standard clinical practice in settings where patients present with symptoms of an HIV infection and where ART is available.

Nationally, HIV counseling and testing (HCT) remains a very important intervention in HIV/AIDS control as it is the entry point into prevention, care, treatment and support services (Kipitu U., 2005). In Africa Uganda has achieved the most success in the fight against HIV/AIDS and has shown the greatest commitment to promoting HIV counseling and testing. HIV counseling and testing (HCT) in Uganda started in 1990s with voluntary counseling and testing as the model of implementation. New innovations in HCT have evolved and currently the ministry of health is rolling out provider initiated HCT in hospitals.

While Uganda has put in place policies and guidelines to ensure high quality HCT services within the reach of every Ugandan, the quality of HCT in PFP health facilities is not known since most programs and projects target public health facilities and not private for profit (PFP) health facilities. Since the quality of HCT in PFP health facilities is not known most likely a knowledge gap exists in private for profit health facilities. The Ugandan HCT policy indicates that private for profit health units should adhere to the national HIV testing algorithm and have a quality control link with established reference laboratories. The policy also recommends that the facility should have personnel, space for counseling and an HIV testing laboratory. It should offer ongoing care and support for HIV/AIDS patients or should have an established referral system or links with other HIV/AIDS services.
1.2 Statement of the Problem

Knowledge about the quality of HIV counseling and testing (HCT) in private health units is limited. It is not known what quality of HCT is being given to clients who carry out their HIV counseling and testing from private health facilities yet the private sector is increasingly becoming an important source of health care, filling gaps where no or little public health care is available. In Uganda the public seeks up to 90% of health care from the private sector for common ailments and HCT is expected to be performed routinely for all patients aged 13-64 years.

The problem of HCT is that, it makes fear of syringes or needles (if it is a blood rather than saliva or urine test). Fear of rumors spreading if you are seen at the testing site or a health care worker knows your result. Fear of people reacting with stigma and discrimination. And Fear of facing violence, abuse or abandonment from your partner or family members. All this problems need to be solved in order to do HCT effectively.

The Ugandan HCT policy indicates that private health units should adhere to the national HIV testing algorithm and have a quality control link with established reference laboratories. The policy also recommends that the facility should have personnel, space for counseling and an HIV testing laboratory. However it is not also known whether PFP health facilities do follow the policies and guidelines on testing and quality control. It is therefore important to study the quality of HIV counseling and testing service delivery so that gaps are identified and this will lead to important steps in improving HCT service delivery in private health units which will in turn influence client service utilization, behavior change and satisfaction.

1.3 The purpose of the study

The purpose of the study is to assess the quality of HIV counseling and testing service delivery in private health units. It purpose is to determine its adherence, its factors that affect quality of HCT service delivery and how it can be done.

1.4. Objectives of the study

1.4.1 General objective

To assess the quality of HIV counseling and testing in private health units in order to improve HCT services in Kampala district, a case study of Makindye division.
1.4.2 Specific objective
To determine the level of adherence to counseling and testing guidelines by the HCT service providers in private for profit health facilities in Kampala district, a case study of Makindye division.
To establish the health facility infrastructure factors that affect quality of HCT service delivery in private for profit health facilities in Kampala district, a case study of Makindye division.
To identify possible ways of improving the quality of HCT service delivery in private for profit health units in Kampala District, a case study of Makindye division

1.5 Research questions
What are the infrastructural factors affecting the quality of HCT service provision in PFP health units?
What is the quality of counseling and testing being offered to clients who receive HCT services in the PFP health units?
What possible ways can be used to improve the quality of HCT service delivery?

1.6 Scope of the study
1.6.1 Content scope
The content of the study was to assess the level of adherence to counseling and testing and health infrastructure factors affecting the quality of HCT

1.6.2 Geographical scope
The study was conducted in selected private health units in Makindye division, Kampala District.

1.6.3 Time scope
The study covered a period of three months, that is from March to May 2018

1.7 Significance of the study
The research provided reference material for upcoming researchers by adding to the on existing literature in related studies.
The study helped the researcher to improve and build on the research skills.
The study would help the government to reduce on the spread of the virus

1.8 Conceptual frame work
The diagram above shows the conceptual framework between the two variables that is independent and dependent variables and the independent variable is HIV counseling and testing whereas service delivery remains the dependent variable which depends on basically how HCT is conducted. When HCT is properly managed then it automatically improves the service delivery hence becoming beneficial.

1.9 Definition of the key terms

Client: Refers to a person to whom HIV counseling and testing (HCT) professional services are rendered.
Confidentiality: This refers to health workers not disclosing an individual's HIV status to any other person without specific permission from them/ client.

**HIV counseling and testing (HCT):** Process of one getting to know their HIV status through a blood test on them.

**Private for profit health units:** Health facilities owned by individuals, groups where by clients have to pay for the services being offered and they make profits out of them.

**Private not for profit health units:** Health units in Kampala district that are faith based and offer services at a subsided rate and do not aim at making profit.

**Public health units:** Health units in Kampala district that are government owned and most of the services are free.

**Quality HIV testing and counseling:** HIV counseling and testing services that are in line with national HCT policy guidelines.

**Quality Assurance:** This refers to set minimum HCT standards for good care in areas such as provider performance, infrastructure, and client satisfaction.

**Technical competence:** Refers to the ability of the HCT service provider to deliver HCT services according to the national HCT policy guidelines (standards).
CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction
This chapter looks at the literature review from other scholars and authors in different locations as seen below

2.1 Factors affecting HIV/AIDS testing and counseling

Time management
In Uganda a study showed that waiting times will be an important component of overall VCT quality. Long waiting times, particularly while waiting for a HIV test result, deterred clients from learning their HIV status (Wagalwa S, 2003). In the same study the NGO sector recorded the shortest waiting time (15 minutes) while clients in the mission sector waited the longest (42.5 minutes). There will be no significant differences between sectors in the median amount of time spent by clients in their pre-test or post-test counseling sessions, or in waiting for a HIV test result (Wagalwa S, 2003). There will be relatively low wait times for HIV test results after testing, and post-test counseling sessions will be substantially shorter than pre-test counseling sessions.

Clients’ perception of VCT services in Uganda reported that female counselors will be preferred compared to male counselors and the average time will be 1 hour and 7 minutes.

In South Africa, a study on VCT in the public sector found that counselors spent an average of 25 minutes on pre testing and 20 minutes in post testing and counseling. The absence of doctors and mismanagement of time for post-test counseling will be the main reasons why women did not receive test results in Burkina study (Liku, et al, 2003).

Provider adherence to standards
A study done in Kenya assessed the implication of quality assurance of VCT in by observing client-provider interaction in 20 VCT centers. The study found that overall VCT providers did a good job on counseling about HIV transmission and prevention. However counseling about condom use to prevent STIs and unwanted pregnancy has been less common and condom distribution is low (Evans C NE, 2009). Another study showed that nurses will be generally positive about PITC, but expressed the need for more training and managerial support. Health system constraints (lack of staff, lack of space) meant that nurses did not always have time to
provide adequate counseling (Agha S MD, 2007). Nurses will be particularly stressed by breaking bad news and handling ethical dilemmas (Mungherera M VA, 1997).

Mungherera (1997) found that Hospital-based health workers missed important opportunities for AIDS prevention education with their patients, 26% of health workers had never referred patients for HIV counseling and 31% had never advised patients suspected of HIV infection to be tested. Frequent explanations for not providing AIDS prevention education included time constraints and/or lack of related knowledge or skills. However the Tanzanian study showed that 60% of counselors did not meet standards of preventive counseling skills, while most counselors reported good counseling practice on self assessment.

In Burkina a study showed that the quality of pre-test counseling has been very poor as 42% did not understand the process (Liku J, et al, 2003). Other studies have shown that counselors have been competent and confidential; a community health survey on HIV/AIDS-related knowledge, attitudes and practices of health care workers in Tamatave (Madagascar) showed that 61% of the health-workers reported never having advised patients to be tested while only 10% mentioned correct counseling precautions (Kipp WK and G. Konde Lule, 2002) and in most cases health workers are the most favored service provider of HIV CT services. Health care workers from two states in southern Nigeria showed a fair level of knowledge with doctors scoring the highest while laboratory workers scored lowest (Obiajulu A, 2010). There has been a significant gender difference in the level of knowledge but the data suggested that knowledge did not differ by hospital settings. There has been generally negative feelings and views about the care of HIV/AIDS patients among the professionals, these views being worst at the community health centers and best at the government hospital. The greatest source of information for the majority of professionals has been health talks/seminars.

In the Zambian study to assess ‘who goes where and why for HIV counseling and testing’, it was observed that counselor have questions with enough detail”; the 8 NGO sector had the highest rates, although the private sector also performed well on this indicator. Counselors also provided clear explanation of the HIV test result,” the private sector performed the best; the vast majority of clients across all sectors felt they received a clear explanation of their HIV test result (Wagalwa SM J, 2003). According to Obiajulu Anthony (2010), of the University of Limpopo South Africa in his MED thesis found that, very high level of knowledge, is a moderately supportive attitude and a moderately high level of practice of VCT amongst health care
providers. He observed that divorced/separated respondents to this study had more supportive attitude towards VCT than their single colleagues. Age had been found to have a very weak but positive correlation to attitude score. There has been no significant difference in knowledge and attitude scores between those who practiced VCT and those who did not. And he concluded that health professionals understand the importance of VCT as an HIV preventive behavior but there remains some VCT knowledge, attitude and practice concerns together with other determinants of VCT behavior that needs to be addressed

In a cross-sectional survey carried out by UNAIDS, twenty-two nurse counselors and six community volunteers were interviewed. Twenty-four counseling sessions were observed and 24 client exit interviews conducted. Although nine of the 22 nurse counselors had only in-service rather than formal training for HIV counseling whereas all community volunteers had been formally trained, nurse counselors demonstrated better interpersonal skills than did community volunteers. Both clients and counselors identified fear of a positive result as a major barrier to HIV testing. Clients also raised concerns about confidentiality. The study identified areas where training needs to be strengthened and suggested ways of improving the services

**Infrastructure**

In 3 districts of rural Uganda the quality of was assessed basing on the existing infrastructures, trained staff, and quality of equipment and good clinical skills of provider. The quality of care for all public and private not for profit (PNFP) facilities were found to be good or satisfactory. Most private for profit (PFP) units were also found to have satisfactory quality of care but some few, especially clinics or drug shops that were manned by persons, who had no fully training, had unsatisfactory quality of care (Patouillard et al,2007) and (Mandelli ALK,2005). This is because many of them had shortage of space, lacked the basic diagnostic equipments like thermometer or blood pressure machine and failed the clinical competence tests. The assessment tool scored the informal units very low because none of them had basic equipment.

In Uganda a research to assess the private for profit (PFP) HIV care in Uganda found that although nearly 60%of the PFPs surveyed offered voluntary counseling for HIV and distributed condoms, only 29% had facilities for HIV testing. The quality of services in these facilities had not been assessed, and little will be known about the quality of HIV care in PFPs. Service quality had been thought to likely vary from one PFP to another, depending on available resources invested. It was also thought that PFPs might be missing out on support available from the
Government and its partners, since PFPs are not integrated with the public health system. In the Zambian study there are very few significant differences between sectors in the physical environment for VCT. The only significant difference between sectors relate to the mean percentage of VCT rooms with lancets: the mission sector had the highest percentage (86 percent) and the public sector with the lowest (41 percent). The private sector had the highest number of rooms available for VCT, with an average of 2 VCT rooms. Other studies on assessing quality care of VCT concluded that quality of care could be improved by: increasing accessibility; expanding the buildings to promote privacy and maintain confidentiality; reducing cost for test; increasing awareness and reducing stigma (MOH, Zambia 2006).

The Horizon project in Kenya and Uganda found a wide range of configurations of testing and counseling offered. Some facilities provided only testing and no counseling. Other facilities provided only counseling, but will be sending clients to another venue for testing. The researcher concluded that periodic satisfaction studies are very important tools for evaluating services delivery (Horizon, 2001).

Monitoring the quality of counseling remains a challenge for most VCT program; good quality of services is not only reflected by client attendance, but it is also important to ensure effective strategies that facilitate changes in adoption. In many low and middle income countries, the private sector is increasingly becoming an important source of health care, filling gaps where no or little public health care is available. Uganda has 4,639 health facilities of which 2,154 (46%) are privately owned. Government has accredited 36 private for profit to provide care and treatment to people with HIV/AIDS. The conclusion of the review is that research is needed to examine both clients’ and counselor’s expectations, experiences and satisfaction with HIV test counseling. Like many other countries Uganda is at the stage of promoting and even formalizing linkages between public and private health care systems with the aim of improving access to health care. However, knowledge on the private sector providers in terms of HIV/AIDS is limited and this makes it difficult to include them in health care planning (Adelekan et al, 1995, 7) and (Bongoni MMS, 2003).

**Client satisfaction**

Patient's satisfaction is a major indicator of the quality care and quality of service can be assessed by mapping out patient satisfaction with care providers. Furthermore, clients’ views on delivering VCT services in South Africa concluded that 63% of clients reported to be satisfied
with counseling session. Clients felt that those providing counseling should work full time on counseling and need to be trained in counseling. However, qualitative studies on public interest towards VCT in Malawi and Uganda reported that community members valued VCT; counselors gave them enough time to ask questions and others said counselor are competent and confidential. Some studies showed that clients preferred that counselors do not come from the same community. The Malawi Demographic and Health Survey in 2004 showed that people from the urban areas are more likely to report HIV testing than those from the rural areas, similarly those with higher primary school education levels and those in higher wealth quartiles are more likely to test for HIV than those in the lower wealth quintiles. In 2007 WHO/UNAIDS issued new HIV testing guidelines recommending 'provider initiated HIV testing and counseling' (PITC) (WHO, 2007). Key concerns was whether/how informed consent, privacy and confidentiality would be upheld in overstretched health care settings, and whether appropriate post-test counseling, treatment and support could be provided (Mungherera et al, 1997).

2.2 Key Elements of Quality for HIV Counseling
The client must make the decision him/herself to receive VCT services, and consent must always be obtained and documented before testing occurs. Additionally, confidentiality must be maintained throughout the process. Counseling should be adapted to the client’s needs, and approaches may include individual and couple sessions. Pre-test counseling should be centered on the client’s: personal history and risk of exposure to HIV, understanding of HIV/AIDS and experience in dealing with crisis situations, previous attempts at reducing risk, understanding of the HIV test and decision whether to take it.

The counselor should discuss with the client: basic facts about HIV/AIDS prevention, treatment, the meaning of the HIV test, a personal risk assessment, the client’s readiness and intentions after learning his/her status, ways to cope with an HIV-positive result, ways of staying uninfected if the test results are negative, family planning (FP) methods, potential support from friends and family, consent; and any other concerns the client might have. The counselor should be able to explain the procedures (including wait time) and offer educational materials about VCT and HIV in the waiting rooms.

The results should be given in the same day, in a private setting, and the client may request to have a supportive person accompany him/her. Clients who test negative should be encouraged to return within three months to ensure that they are truly uninfected. Regardless of the result, the
client should be counseled on leading a healthy lifestyle and developing a personalized risk-reduction plan. HIV-positive clients should be referred to appropriate treatment services. Other referrals (regardless of the result) include medical, social, legal, economical, spiritual, and psychological support. If a client requests only testing, the counselor should explain that VCT services are a package and should encourage the client to come when s/he has enough time to undergo both procedures. A client may request only counseling services, and should not be pressured or coerced into being tested.

2.3 Key Elements of Quality for HCT Infrastructure
Does the HCT room have good lighting, adequate space, and well-ventilated?
Does the HCT room provide privacy and confidentiality for the client?
Is there water available for hand-washing in the VCT room?
Availability of information, education and communication (IEC) materials on HIV/AIDS
Availability of a waiting area with chairs/benches for VCT clients
Availability of furniture, supplies and test kits including: Screening test, confirmation test, and tie-breaker test,
Gloves, Alcohol/methylated spirit, Cotton, Lancets, and Safety box for disposal of needles/lancets
At least 1 desk, 3 chairs, and a 1 lockable cabinet

2.4 Barriers to HCT
A number of qualitative and quantitative studies have examined barriers to accessing HCT, accepting HCT, and/or receiving one’s test results. Table 1 presents a comprehensive overview of these findings. While participants’ responses are many and diverse, certain themes become quickly apparent. These include: lack of knowledge, misconceptions, low risk perception, fear, and lack of motivation/time, fatalism, economic barriers, structural/service barriers, gender barriers, and readiness barriers.

Several studies found that lack of perceived risk of HIV infection was a major reason for not receiving a test. The best estimates of perceived HIV risk come from the 2004-2005 UHSBS. An estimated 21% of women and 23% of men perceive themselves to be at high risk of getting infected with the HIV, another 36% of women and 35% men perceive their risk as moderate,
18% of women 17% of men perceive low risk, and 12% of women and 13% of men think they have no chance at all of getting HIV (Uganda Ministry of Health & ORC Macro 2006).

In an assessment of the Multi-county AIDS Project (MAP), the Uganda AIDS Control Project investigated reasons why 33% of men 36% of women in their sample felt they were at high risk of HIV infection, as well as the reasons why the remaining portion of the sample felt they were at low or no risk (Mukaire et al. 2004). The most commonly mentioned reason for both men (39%) and women (60%) who perceived themselves to be at high HIV risk was not trusting their partner. Other reasons for high levels of perceived HIV risk included having many partners (33% for men, 16% for women), having no steady partner (20% for men, 22% for women), not using condoms (16% for men and 11% for women), because most people are infected (12% for men and 8% for women), and not being married (5% for men and 4% for women).

Among those who thought themselves to be at low or no risk of HIV infection, 97% of men and 32% of women said it was because they were faithful, and another 41% of men and 23% of women said it was because they were married. However, a faithful and/or married individual only knows if he or she is faithful, not necessarily whether or not his or her partner is equally monogamous. Thus, this conviction that being faithful reduces HIV risk is incomplete without taking into account the fidelity of one’s partner. Much smaller percentages of men and women said they were at low risk due to condom use (11% of men, 4% of women) or abstinence (4% of men, 10% of women) – arguably the two more reliable ways to reduce HIV risk.

Fear of knowing one’s status, as well as the resulting consequences, also came out strongly as a behavioral inhibitor in multiple studies. Respondents were not only concerned about the health implications of receiving an HIV positive test result, but also about the reactions of their partners (separation, loss of income, physical abuse), family members (blame, neglect), and the community at large (gossip, discrimination), suggesting that, as much progress as has been made around stigma in Uganda, there is still a need to address this issue.

Although not easily addressed through social and behavior change interventions, financial barriers and distances to testing sites were other important limiting factors. Certain apathy also seems to exist around HCT. Three studies found that respondents were unconcerned about their status or couldn’t be bothered to go for counseling and testing. HCT was not a priority.
Despite the relatively high levels of HCT knowledge reported in the 2006 UDHS, general unfamiliarity with HCT and a more specific lack of awareness about where to go for HCT still came out as barriers in these studies. For some, the thought of going for HCT had simply never occurred to them. Further, Mukaire et al. (2004) and Wolff et al. (2005) isolated myths and misconceptions pertaining to HCT, particularly prominent in rural communities. It will be important to correct these misunderstandings and provide reassurance about the confidentiality and validity of the process.
CHAPTER THREE

METHODOLOGY

3.0 Introduction
This chapter presents methods and procedures that the researcher used when assessing the findings of the study. And it also presents the important information (data) and specific fields of the survey carried out in national medical stores.

3.1 Research Design
A cross sectional study design was used to assess the quality of HCT in private health units. Quantitative methods of data collection were used to collect the data through structured questionnaires to answer the research questions. A facility assessment tool was used to inspect the infrastructure.

3.2 Survey population
The study participants comprise of 85 out of the 100 HCT counselors and laboratory personnel from private health units that carry out HCT. In the counseling unit and the laboratory section only one counselor and one laboratory personnel was selected from each health facility. The counselor and laboratory personnel who were at the facility at the time of the interview were the ones interviewed and all these carry out HCT services. The health facility factors that affect HCT were established in this study.

3.3 Sampling methods
The researcher used purposive sampling to select the samples from the population. Simple random sampling was used, on the biasness of purposive sampling. Numbers were allocated, written on small pieces of paper, shuffled and randomly picked by respondents until all the required respondents were over.

3.4 Sample Size
The sample size was determined using Krejcie and Morgan (1970) tables (attached below). A total sample of 85 was selected out of the total population of 100 Private health units.
3.5 Sampling Procedure

Using simple random sampling, staff members who were ready to provide information were selected. Simple random sampling technique was applied because each individual in the population was given equal chance of being selected.

3.6 Data collection instruments

3.6.1 Questionnaire

Questionnaires were chosen because of their ability to reduce any bias and the collection of authentic data important for data analysis. The researcher used both closed ended and open-ended questionnaires. However one of the limitations to this study was that since the study was self-administered; the researcher noticed inconsistencies in answering and returning of the questionnaires. The researcher further noticed (during the editing process) that most respondents expressed high levels of bias according to their departments. These factors tremendously reduced the actual sample size used for analysis to 72.

3.6.2 Interview Guide

Structured questions and open ended statements were used by the researcher in trying to interview the respondents. However the researcher noticed that considerable difficulty in contacting these respondents since most of them were busy people than workers of the hospitals. The researcher further noticed that some respondents were not sincere, since they feared for their positions. However the researcher had earlier assured them of absolute confidentiality.

3.7 Source of data

Both primary and secondary data were used. Primary data was collected by the use of questionnaires and secondary data were got from reports, journals, and internet.

3.7 Data processing, analysis and presentation

Quantitative data were collected by the questionnaire which was first coded. In the coding process, a coding sheet was constructed. A number then assigned to each answer in the questionnaire with a corresponding number on the coding sheet. Then the same questionnaire was constructed on the computer using excel. Frequency tables, and graphs were worked out basing on the data entered into excel. In these frequency tables, graphs and analysis was done...
with a corresponding percentage. However statistical packages for social sciences (SPSS) were used to determine the relationship between the two variables.

3.8 Data Analysis
The frequency and percentage distribution was used to determine the demographic characteristics of the respondents.

The mean and standard deviations was applied for the levels of working capital management, and managerial performance. An item analysis to illustrate the strengths and weaknesses based on the indicators in terms of mean and rank. From these strengths and weaknesses, the recommendations were derived.

3.9 Ethical Considerations
To ensure confidentiality of the information provided by the respondents and to ascertain the practice of ethics in this study, the following activities were implemented by the researcher:

Sought permission to adopt the standardized questionnaire through a written communication to the author

Solicited permission through a written request to the concerned officials of the selected firms in the study

3.10 Limitations of the Study
Extraneous variables which were beyond the researcher's control, such as respondents' honesty, personal biases and uncontrolled setting of the study

Instrumentation: The research instruments on profitability are not standardized. Therefore a validity and reliability test was done to produce a credible measurement of the research variables.

Testing: The use of research assistants brought inconsistency in the administration of the questionnaires in terms of time of administration, understanding of the items in the questionnaires and explanations given to the respondents. This was minimized by the orientation of the research assistants and briefing them on the procedures to be followed in data collection.

Attrition/Mortality: Not all questionnaires were returned completely answered nor even retrieved back due to circumstances on the part of the respondents such as travels sickness, hospitalization and refusal/withdrawal to participate. The researcher reserved more respondents
by exceeding the minimum sample size. The respondents were reminded not to leave any item in
the questionnaires unanswered and were closely followed up as to the date of retrieval.
CHAPTER FOUR

DATA PRESENTATION, INTERPRETATION AND ANALYSIS

4.0 Introduction

This chapter presents findings from the study about the assess, level of adherence to counseling and testing and health infrastructure factors affecting the quality of HCT. The study determined the level of adherence to counseling and testing guidelines by the HCT service providers in private health facilities in Kampala district. It also established the health facility infrastructure factors that affect quality of HCT service delivery in private for profit health facilities in Kampala district and identified the possible ways of improving the quality of HCT service delivery in private health units in Kampala District.

4.1 Demographic characteristics of Respondents

The study put into account the sex of the respondents and their academic qualification which were considered relevant to this study. Table 4.1 presents the background information of respondents.

Table 1 Sex Distributions of Respondents

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>45</td>
<td>64</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Primary Data, May, 2018

Table 1 above is about the sex distributions of the respondents. It is evident from this gender frequency distribution table that the majority of respondents were males at 64% while 36% were females. This tentatively implies that the health facilities employed more male employees than female employees.
Table 2: Respondents by position held

<table>
<thead>
<tr>
<th>Position Held</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselors</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Laboratory personnel</td>
<td>55</td>
<td>79</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Primary Data, May, 2018

Table 2: shows respondents by various positions they held in their respective companies. Out of the 70 total numbers of respondents, 79% were laboratory personnel and 21% were counselors. This implies that there are many laboratory respondents compared to counselors since they do not contribute much.

Table 3: Respondents by terms of service

<table>
<thead>
<tr>
<th>Experience</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>39</td>
<td>55</td>
</tr>
<tr>
<td>Fixed Term</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Temporary</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Primary Data, May, 2018

Results in Table 3 revealed that most of the respondents 55% were in the permanent category. 29% and 16% were in the fixed term and temporary categories respectively. The study noted from the above results that majority of staff in these private hospitals in Kampala district were regular employees on pay roll. This may seem that these are their desire to operate effectively and this needed regular staff on duty.
Table 4 Respondents by work experience permanent basis.

<table>
<thead>
<tr>
<th>Period Worked</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a year</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>1-2 years</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td>2-5 years</td>
<td>29</td>
<td>41</td>
</tr>
<tr>
<td>5-10 years</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>10 years and above</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Primary Data, May, 2018

Table 4: shows the respondent’s work experience in the company. The results indicate that, the majority were in the category of 2-5 years represented by 41% of the total respondents. 13% were in the category of 5=10 years, and 14.1% and 17% in 1 year and below. 1-2 years categories respectively. Only 14.1% were in 10 years and above category. This may be true because most of the respondents were fresh graduates whose work experience was short. It was realized that most of the respondents had worked for not more than 10 years. However, since majority was on permanent job basis, they had relevant information needed for this study as individuals who had stayed in one place.

Table 5: Respondents by Levels of Education

<table>
<thead>
<tr>
<th>Educational Levels</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diploma</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>55</td>
<td>79</td>
</tr>
<tr>
<td>Post Graduate Degree</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Source: Primary Data, May, 2018
Results in Table 5 revealed that the majority of the respondents 79% had University Bachelor's degrees. The study noted that this was very important those hospitals should employ and retain competent and qualified staff because most of their activities are medical in nature and requires the use of knowledge, skills and abilities.

4.2 The findings on the level of adherence to counseling and testing

A considerable proportion of the information on the levels and demographic determinants of testing comes from studies of specific groups at risk. In low-HIV-prevalence countries of the Northern Hemisphere, attention has been directed primarily at men who have sex with men, as well as migrants and intravenous drug users. In Africa, most studies come from programs for pregnant women and high-risk groups such as mine workers, truck drivers, and sex workers.

The statistical evidence on HIV testing is growing, thanks both to national surveys and surveys among particular populations. It shows that coverage is low everywhere, including in many high-prevalence countries. Despite the wealth of statistics, however, comparative analyses have been limited. Few analyses have investigated differentials in utilization to derive general patterns, such as the association of education, income, or gender with behavior regarding testing. Most studies tend to focus on measuring the statistical associations among variables that are detached from their social context. These explanatory frameworks, often inspired from psychology, have tended to be individualistic and to assume a rational and unidirectional connection between ideas and behaviors-an assumption that is not always tenable. A few studies have used micro level ethnographic or qualitative methods, but they tend to be limited to small samples whose representativeness is unknown. As has been observed for research on sexual behavior and HIV, few studies have overcome the barriers between disciplinary boundaries and integrated qualitative and quantitative approaches.

The diversity of policies regarding testing and counseling underscores the multiplicity of approaches to testing and what it means in different contexts. For example, in Botswana since 2004, prenatal care programs began to implement opt-out testing and counseling; this resulted in higher rates of testing, raising questions about the ethical aspects of scale-up. In Uganda, where the Ministry of Health has revised its policy guidelines, several models for providing testing and counseling coexist: the routine offer of testing at health facilities, home-based voluntary
counseling and testing whereby individuals are offered testing and given results in their home, and traditional freestanding voluntary counseling and testing centers.

Debates about policies reflect the shifting context of testing as a result of the availability of treatment. They also serve to illustrate the difficulty of reconciling the protection of the privacy of HIV-positive individuals with concerns for the safety of others who may be endangered if information is withheld. The possibility of allowing health workers to disclose patients’ status to their partners has been discussed in African countries, where it is referred to as “beneficial disclosure.

4.3 The factors influencing acceptance of VCT for HIV are considered under attitudinal beliefs, social influence, self-efficacy, awareness, and risk of infection with HIV.

Attitudinal beliefs

In the FGDs it was said that positive consequences of VCT would encourage testing such as: encouraging of positive living like eating a good diet, stopping smoking, drinking and “generally caring about your health”; planning for one’s future as in making decisions about marriage and having children. Planning treatment if one has the means was also echoed as a benefit. Other positive consequences mentioned were gaining confidence in life with what one does, and practicing safer sex or abstinence. It was said that if one was found negative there is greater likelihood of adopting safer sexual practices or abstinence so as to jealously guard one’s negative status. A common echo was “you would be foolish to infect yourself after knowing that you are negative”. It was also said that some people after testing become goodwill ambassadors in encouraging others to test and also protect themselves and others against infection.

On the other hand it was said that anticipated consequences of being found positive would discourage HIV testing. Among the negative consequences mentioned were: loss of hope leading to destructive behavior, early death through worries, and sometimes suicide. “It may be better not to know your status and you live longer” was a common expression. It was also mentioned in all FGDs that once people are found positive they may decide not to “die alone” and may deliberately spread the HIV. Other negative consequences of VCT mentioned included stigma from society and rejection from friends, relatives, and sexual partners. In the individual
interviews, people were asked the advantages and disadvantages of undertaking VCT. (Table 2.) Women were more likely to mention rejection whereas men were more likely to mention suicide.

**Attitudinal beliefs concerning Voluntary Counseling and Testing for HIV**

**Social influence**

It was said that the decision to undertake VCT is mainly a personal individual decision. However, the decision was also said to be influenced by other people ("important others"), such as spouses, sexual partners, prospective marriage partners, relatives, friends, health workers/counselors, religious leaders, political leaders and those that have undergone VCT in the past. In the individual interviews the people were asked the most likely source of influence on decision of VCT.

It appears that about three quarters of the people said that they would influence the decision to undergo HIV test by themselves. It was interesting that sex never appeared to have influence on this decision ($\chi^2 = 0.49$, 1 degree of freedom and P-level = 0.39).

**Self-efficacy, barriers and supports**

Among the problems mentioned with VCT were that testing centre's were too far especially if coupled with poor means of communication/transport as in rural areas. The services were also said to be expensive and out of reach of many people especially the youth and women. Poor perceived quality of care was also articulated as a barrier in form of time taken to give the results (many people preferred one day result), long waiting time before VCT, confidentiality and secrecy in handling of the results. The issue of sensitivity and specificity of the results were also mentioned anticipating the danger and consequences of labeling one HIV positive where as not.

When FGDs participants were asked about what can be done to increase the number of people undertaking VCT, the mentioned responses were: bring services nearer to the people; provide free services, and offer help (especially with anti-retroviral drugs) to those found to be HIV positive. A common expression was “*what is the use of VCT if one cannot manage the very expensive AIDS drugs*”
In the individual interviews people were asked what could be done to make more people undergo VCT.

Supports and barriers towards Voluntary Counseling and Testing for HIV other two issues emerged from the FGDs and individual interviews that were considered very important and are therefore described separately. These issues were labeled Awareness and Risk of HIV infection.

**Awareness**

In the FGDs it was said that lack of awareness on the need for VCT reduces the number of people undertaking VCT. It was reportedly said that among the strategies for HIV control the government had never encouraged people to undertake VCT. "...May be they fear the consequences of testing", otherwise. Why haven't I heard a lot of campaign for testing on Radio," was one expression in one of the FGDs. In improving the percentage of people who would undertake VCT people suggested increased mobilizations, and campaigns through the famous FM radio stations, and through seminars/workshops.

**4.4 The findings on the possible ways of improving the quality of HCT service**

Protect confidentiality of clients who are recommended or receive HIV CTR services. Information regarding a client's use of HIV CTR services should remain private (i.e., confidential). Personal information should not be divulged to others in ways inconsistent with the client's original consent.

Obtain informed consent before HIV testing. HIV testing should be voluntary and free of coercion. Informed consent before HIV testing is essential. Information regarding consent may be presented orally or in writing and should use language the client can understand. Accepting or refusing testing must not have detrimental consequences to the quality of care offered. Documentation of informed consent should be in writing, preferably with the client's signature. State or local laws and regulations governing HIV testing should be followed. Information regarding consent may be presented separately from or combined with other consent procedures for health services (e.g., as part of a package of tests or care for certain conditions). However, if consent for HIV testing is combined with consent for other tests or procedures, the inclusion of HIV testing should be specifically discussed with the client. For a discussion of HIV
testing in pregnant women, consult the guidelines for HIV screening of pregnant women (see Revised Recommendations for HIV Screening of Pregnant Women).

Provide clients the option of anonymous HIV testing. Anonymous testing (i.e., consented voluntary testing conducted without a client's identifying information being linked to testing or medical records, including the request for testing or test results) has been used widely and effectively. Anonymous testing can benefit the health of individual persons and the public by prompting earlier entry into medical care (60). Persons who would otherwise not be tested might seek anonymous HIV testing and learn their HIV status. Consistent with public health best practices, states in which anonymous testing is not available should reconsider their policy. When the client has no clear preference regarding testing type, confidential testing (i.e., information documented in client's record) should be recommended to promote receipt of test results and linkage to follow-up counseling and referral for needed services. Clients opting for anonymous testing should be informed that the provider cannot link the client's test result to the client by name. Therefore, if the client does not return for test results, the provider will not be able to contact the client with those results.

Provide information regarding the HIV test to all who are recommended the test and to all who receive the test, regardless of whether prevention counseling is provided. The information should include a description of ways in which HIV is transmitted, the importance of obtaining test results, and the meaning of HIV test results.

Adhere to local, state, and federal regulations and policies that govern provision of HIV services. Laws at the local, state, and federal levels might address aspects of HIV services or regulate how services are provided to particular persons (e.g., minors). In addition, policies, local ordinances, funding source requirements, and planning processes could also affect a provider's decisions regarding which services to provide and how to provide them.

Provide services that are responsive to client and community needs and priorities. Providers should work to remove barriers to accessing services and tailor services to individual and community needs. To ensure that clients find services accessible and acceptable, services can be offered in nontraditional settings (i.e., community-based or outreach settings); hours of operation
can be expanded or altered; unnecessary delays can be eliminated (e.g., integrating counseling and testing for STDs/HIV with counseling and testing for hepatitis); test results can be obtained more easily (e.g., with rapid testing or by telephone in certain situations); and less-invasive specimen collection can be used (e.g., oral fluid, urine, or finger-stick blood).

Provide services that are appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level. These factors could affect how the client seeks, accepts, and understands HIV services. Providers should consider these factors when designing and providing HIV services to increase the likelihood of return for test results and acceptance of counseling and referral services.

Ensure high-quality services. To ensure ongoing, high-quality services that serve client and community needs, providers should develop and implement written protocols for CTR and written quality assurance and evaluation procedures. Many state and local health departments have substantial expertise in providing and monitoring the quality of HIV CTR services and can be a resource to private providers or community-based or outreach settings initiating these services.
CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction
This chapter presents the summary, conclusion and recommendations of the findings.

The summary focuses on the findings in relation to objectives of the study that it intends to achieve. The summary is followed by the conclusion, which is also based on the findings of the study and lastly the recommendations.

5.1 Summary of the Findings
The results of this study have clearly demonstrated that the quality of HIV counseling and testing is way below the recommended standards (HCT guidelines & policies): there were few HCT service providers who had ever undergone in service training in HCT.

There was minimal supportive supervision from MOH/District or partners. Facilities lacked standard operating procedures (SOPs) & guidelines for guidance and there were few qualified HCT service providers especially in the area of counseling. Privacy was also present in a few of the facilities.

These results are comparable to other studies that showed the quality of service delivery in private health facilities to be low when compared to public and PNFP facilities (Obiajulu A, 2010) and (Yoder P MS, Matinga P, 2004). There were few qualified counselors (19/102) yet the policy recommends that HCT should be carried out by qualified personnel (MOH, Uganda 2005). This could have compromised on the quality of counseling and testing in that the clinicians and nurses could not commit enough time to HCT as they had their core duties in the health facilities. This is evidenced by the waiting time which was either too long or too short.

Privacy was adequate in only 76% of the counseling rooms and all health workers practiced some form of confidentiality such as information remaining between client and health worker (84%), using lockable cupboards (10%), computer pass word (2%) or all the above (4%). The policy recommends 100% privacy and confidentiality and if there is any gap in privacy then the quality is compromised (MOH, Uganda 2005).
Written consent was obtained by only 15.7% of health workers and the rest obtained verbal consent. The guidelines recommend written/documentated consent for privacy purposes however written consent contributes to continued stigma and discrimination.

Some policy makers think HIV test should be like any other test where one does not need a written consent.

Only 86% of health workers referred their positive clients for chronic care and only 2% started their clients on cotrimoxazole. This is the main aim of HIV counseling and testing; linking positive clients to care. If all health workers are not linking their positive clients to chronic care then the quality of HCT is being compromised. This also shows a gap in knowledge and skills in HCT service providers.

Results demonstrated that health facilities are not receiving supportive supervision, a few have trained in HIV counseling and testing and even few guidelines have been availed to these health facilities. This is putting the level of adherence to guidelines low which is highly compromising on the quality of HIV counseling and testing. The policy states that HCT services shall be standardized nationwide and shall be authorized, supervised, supported and regulated by MOH.

On self assessment 67% described quality of HCT in their facilities to be good. This can be explained by the fact that there were some qualified counselors and laboratory personnel and in addition 73% had undergone in service training in HCT.

Other studies have also shown that on self assessment HCT service providers reported good counseling practice (Evans C NE, 2009). However this need to be proved further by interviewing clients, in the same study clients rated them poor as they did not meet standards for preventive counseling (Evans C NE, 2009).

**Health facility infrastructure**

HIV counseling and testing guidelines were present in only 25% of the health facilities. And standard operating procedures were present in only 39% health facilities. Both these materials are important for HCT service provider use as they provide guidance as they carry out HCT. Lack of the policies, guidelines and standard operation procedures compromised greatly on the quality of HCT as they did not have any reference to make to in case they needed to do so.

Waiting area was present in almost all the health facilities and this was the same waiting area for clients with other conditions. This was excellent quality as it reduced stigma and discrimination. However Information, Education and communication materials were present in only 11% health
facilities. Waiting areas should have HCT IEC materials for all patients to read and get more information on HIV; this was lacking in almost all the facilities.

The policy stipulates that MOH registers should be used in all the health facilities. MOH has also gone ahead to harmonize with partners so that the information collected is relevant and can be incorporated in the health management information system of the MOH. But in private health facilities assessed the MOH registers were present in only 13% of the health facilities. Meaning that HCT data is not being reported to the ministry of health and so is not being reported in national statistics leading to under reporting of HCT data.

For purposes of infection control, the laboratory should have adequate space, adequate storage facilities, and safe ways of waste disposal and should also have post exposure prophylaxis. All these were present in some facilities and absent in many of the health facilities and lead to the quality of HCT to be below standards.

5.2 Conclusion

The quality of HIV counseling and testing in private for profit health facilities in Kampala district is far below the standards. This is evidenced by the fact that there was little or no in service training in HCT, minimal supportive supervision from MOH/District and partners, Facilities lacked standard operating procedures (SOPs) & guidelines for guidance, few qualified HCT service providers especially in the area of counseling and privacy was only present in a few of the facilities.

5.3 Recommendations

From the results of this study the following recommendations if put in place will contribute to the improvement in the quality of HIV counseling and testing in private for profit health facilities;

- In service trainings for all the HCT service providers in HIV Counseling and Testing
- Private for profit health facilities should be included in the support supervision schedule for MOH, DHO’s office and partners.
- Guidelines, policies, IEC materials and standard operating procedures should be availed to private health facilities.
- HCT tools such as registers, referral forms, and consent forms should also be availed to private health facilities.
5.4 Areas for Further research

- Further research need to be carried out on the impact of empowerment on the Uganda education sector.
- The effects of empowerment on the development of nation
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Dr Rebecca Kivumbi Mayanja, HIV counseling and testing service delivery 2012
Questionnaire
This study is purely for academic purpose and all information shall be kept confidential.
Assessment of the quality of HIV counseling and testing service delivery in private health units in Kampala districts
Please help us improve our program by answering some questions about the HIV counseling and testing services you offer in this health facility. We are interested in your honest answers, whether they are positive or negative. Please answer all of the questions.

Social Demographics
1. Name of Health Facility__________________________________________________________
2. Position of service provider
   - Trained Counselor [ ]
   - Nurse [ ]
   - Clinician [ ]
   - Other (please specify)...........................................................
3. Gender of service provider
   - Male [ ]
   - Female [ ]
4. For how long have you worked as a counselor in the area of HCT?
   - Less than 1 year [ ]
   - 1-2 yrs [ ]
   - Greater than 2 years [ ]

Adherence to Counseling and testing standards
5. How many days in a week do you offer HCT?
   - 1 day......................
   - 2-5 days..................
   - 7 days..................
6. How many staffs are conducting HIV counseling in this health facility? [ ]
7. On average, how many clients do you counsel in a week? [ ]
8. When clients come for HCT what steps do you take as a counselor (looking for pre & post counseling)?

........................................................................................................................................

36
9. How do you obtain consent from the clients?
   1. Verbally [ ]
   2. Written [ ]
   3. Others (Specify) ………………………

12. How do you ensure clients’ information/confidentiality?
   1. Use of lockable cardboards [ ]
   2. Computer with password [ ]
   3. Information shared remains between clients and counselor [ ]
   4. All the above [ ]

13. When do clients receive their results?
   Same day [ ]
   Not same day [ ]

14. On average how long does it take for a client to receive their results from the time of entry into the health unit?
   Less than 30 min [ ]
   30-45min [ ]
   Greater than 1 hour [ ]
   Other (Specify) ………………..

15. Do you offer post-test counseling?
   Yes [ ]
   No [ ]

16. If yes to the above question, to whom do you offer post-test counseling?
   1. All who test [ ]
   2. Only the positive [ ]

17. What happens during post-test counseling?

18. When a client tests positive what is the next step?
   Refer [ ]
   Start client on Septrin [ ]
   Don’t refer [ ]
19. Where would you refer a patient who test positive for HIV?
   - Specialized HIV clinic
   - Don’t refer
   - No specific clinic

20. Do you have referral forms you use in this facility?
   - Yes
   - No

21. Have you ever had any training in offering HCT services?
   - Yes
   - No

22. If yes who trained you?
   - MOH
   - DHT
   - Other partners

23. If no would you like to receive training in HCT?
   - Yes
   - No

24. Have you ever received refresher training on HCT in the past 1 year?
   - Yes
   - No

25. Do you receive support supervision? Yes
   - No

26. If yes to the above question, from where?
   1. MOH
   2. District
   3. Others (specify)

27. If yes to the above question, how often are you supervised?
   1. Every three months
   2. Every six months
   3. Once a year
   Never

28. Do you have any guidelines you follow when conducting HIV counseling?
   - Yes
   - No
29. If yes to the above question, which guidelines?
1. MOH policies and guidelines on HCT [ ]
2. WHO guidelines [ ]
3. Others (Specify)..........................

30. Over all, how do you rate the quality of HIV counseling in this facility?
Very good [ ]
Good [ ]
Fair [ ]
Poor [ ]
Very poor [ ]

31. In your opinion what factors influence/affect the quality of HCT services provided in this facility?

..................................................................................................................................................................................................................................................................................
Lab personnel questionnaire
Assessment of the quality of HIV counseling and testing service delivery in private for profit health units in Kampala districts;
Please help us improve our program by answering some questions about the HIV counseling and testing services you offer in this health facility. We are interested in your honest answers, whether they are positive or negative. Please answer all of the questions.

Social Demographics
1. Name of Health Facility_______________________________________________
2. Position of service provider
   Laboratory personnel [ ]
   Nurse [ ]
   Clinician [ ]
   Other (please specify).................................
3. Gender of service provider
   Male [ ]
   Female [ ]

Adherence to HCT standards
4. Do you have any HIV testing guidelines? Yes [ ] No [ ]
5. If yes which guidelines do you have?
   MOH
   WHO
   Others (specify)
6. How do you test for HIV in this facility?
   Rapid tests [ ]
   Elisa [ ]
   PCR [ ]
   Others [ ]
7. Have you ever been trained in HIV rapid testing? Yes [ ] No [ ]
8. Please outline how you carry out an HIV test after you have withdrawn blood from the client
9. Which type of test kits do you have and use in this lab
   Determine [ ]
   Startpak [ ]
   Uningold [ ]

10. Have the staffs conducting HIV testing been trained to do so? Yes [ ] No ( )

11. On average how many tests does this lab carry out in a week? [ ]

12. Do you prepare DBS for the infants below 18 months? Yes [ ] No [ ]

13. How is your waste management done in the lab?
   1. Waste bins [ ]
   2. Biohazard bags [ ]
   3. Biohazard bags then into waste bins [ ]
   4. Others (Specify).............

14. Are the following standard documents available at the health facility?
   Lab Register [ ]
   Lab Request Forms [ ]
   HCT register [ ]

15. Are the Standard operating procedures (SOPs) available and in use in health facility?
   1. No SOPs [ ]
   2. SOPs available but not in use [ ]
   3. SOP available and in use [ ]

16. Do you test QC samples for HIV testing?
   Yes [ ]
   No [ ]

17. Does the health facility have enough test kits in stock?
   No test kits at all (stocked out) [ ]
   Not enough test kits in stock (kits will last days) [ ]
   Enough test kits in stock (kits will last month's/ Weeks) [ ]
18. Are the laboratory log book and HCT register updated daily?
Yes [ ]
No [ ]

19. Are you provided with protective gear?
Yes [ ]
No [ ]

20. Overall, how would you rate the quality of HIV testing in this facility in the last one year?
Very good [ ]
Good [ ]
Fair [ ]
Poor [ ]
Very poor [ ]
## Appendix II: Time frame of work plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic search and approval</td>
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<tr>
<td>Proposal Writing</td>
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<td>Data collection</td>
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<tr>
<td>• Data analysis</td>
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<tr>
<td>• Report submission</td>
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<tr>
<td>• Graduation</td>
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### Appendix III: Budget for the research study

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<td>Pens</td>
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<td>Full papers</td>
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<tr>
<td>Typing of the proposal</td>
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<tr>
<td>Printing of the proposal</td>
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<td>Binding the proposal</td>
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<td><strong>Total</strong></td>
<td><strong>118,500</strong></td>
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