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Responses to VCT for HIV among young people in Kampala, Uganda

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Attitudes to voluntary counselling and testing (VCT) for HIV among young men and women in a slum area of Kampala, Uganda, were studied through 22 individual semi-structured interviews and 5 focus group discussions. Attitudes to VCT ranged from having no problem with the procedure to being very reluctant. Despite fear of stigma, the participants perceived 'positive living' after HIV testing as realistic. VCT was regarded as an important step to avoid HIV infection, but informants expressed the need for the service to be more accessible in terms of cost, time and quality of pre- and post-test counselling. We argue that counselling without HIV testing should be available for those who are reluctant to test. Poverty and gender power imbalances appeared to limit youths' possibility of making rational decisions about sexual behaviour and accessing VCT. The importance of considering the context in which such issues are being negotiated and decided is highlighted.

Keywords: Africa, attitudes, counselling services, focus group discussions, health service delivery, HIV testing, interviews, psychosocial aspects, sex differentials, youth services

Introduction

The HIV epidemic in Uganda reached its peak in the late 1980s; thereafter HIV prevalence turned sharply downward (Ministry of Health [MoH] Uganda, 2003a). This achievement was attributed to the ABC approach: abstain, be faithful and use condoms. Voluntary counselling and testing (VCT) for HIV is also regarded as an important intervention for the prevention of HIV infection (Uganda AIDS Commission, 2004). The documented openness about HIV in Uganda (Parkhurst, 2002; Dyer, 2003) has made information available to many people through a multi-sector approach. The government, NGOs and the mass media have all contributed to the positive achievements as regards reduced HIV prevalence in Uganda. VCT for HIV, especially encouraging people to know their HIV status, was initiated by the Ministry of Health and implemented by the AIDS Information Centre (AIC) in 1990 (Neema, Musisi & Kibombo, 2004). In 1994 it became possible to take a client's blood sample and give back an HIV test result the same day, whereas previously clients had waited two weeks or more to receive the result.

The HIV epidemic especially affects youths. Young people aged 10 to 24 years constitute about 33% of the Ugandan population (Neema *et al.*, 2004). Approximately 50% of all HIV-infected people in Uganda are youths, and the vast majority of those are females (Neema *et al.*, 2004). Young women are especially vulnerable to sexually transmitted infections (STIs), including HIV, because their genital tract is immature and more susceptible to infection

and because they constitute a group less likely to access healthcare (Futterman, 2004).

Studies in Uganda and South Africa have indicated that acceptance of VCT is relatively low and there are many obstacles for an individual to obtain his or her HIV test result (Nyblade, Menken, Wawer, Sewankambo, Serwadda, Makumbi, Lutalo & Gray, 2001; Nuwaha, Kabatesi, Muganwa & Whalen, 2002; Matovu, Gray, Makumbi, Wawer, Serwadda, Kigozi, Sewankambo & Nalugoda, 2005). Groups at higher risk of exposure to HIV, such as youths, are often underrepresented among VCT recipients, and a population-based study in a rural district of Uganda has shown that adolescents of both sexes have the lowest VCT participation rates (Nyblade *et al.*, 2001). Only 15% of participants in a study of STI prevalence among adolescents in Kampala had ever been tested for HIV (Råssjö, Kambugu, Tumwesigye, Tenywa & Darj, 2006). There is a lack of qualitative information about young people's attitudes to VCT for HIV in East Africa, although such studies would be beneficial for programme development (Amuyunzu-Myamongo, Biddlecom, Ouedraogo & Woog, 2005). Among the questions that need in-depth elaboration are: What are the obstacles and cues for accessing VCT services for young people living in a society with a high prevalence of HIV infection? And, are the motives for accessing VCT different for females and males? This study was designed to explore and describe attitudes to VCT for HIV among young women and men in a slum area of Kampala, the capital of Uganda.

Methods

Study setting

The study was conducted in January 2004, in Kisenyi, a slum area of Kampala. Kisenyi has a youth centre called Muvubuka Agunjuse Reproductive Health and Service Provision Centre. The area surrounding the clinic is a densely populated slum, with market places, bars, and small industries, particularly for metal recycling. It has a substantial immigrant population, such as Somalis and Ethiopians, and intermarriages are common. Many youths have come from villages to live with relatives or to look for employment; very few live with both parents. The Ministry of Health of Buganda Kingdom runs the Muvubuka Agunjuse centre, where services are provided to young people aged 10–24 years, to improve their reproductive health standards. Medical treatment, counselling and contraception advice are offered by a nurse/midwife and a social worker. At the centre, peer communicators organise youth clubs offering a variety of activities, such as music, games, drama and discussion groups. Youths from the Muvubuka Agunjuse centre are referred to the AIDS Information Centre (AIC), also in Kisenyi, for VCT for HIV, where clients are offered pre- and post-test counselling. The AIC has a special 'youth corner' with specially trained youth counsellors and a low service fee (less than US\$1). However, the youth corner has only two counselling rooms (where only two counsellors can work at the same time) although the number of youth clients can reach 30 in a day; this means long waiting hours for clients.

Life for a young person in Kisenyi is characterised by tending to personal and family responsibilities. Most young people struggle to receive an education or to find work; many have been sent away from their rural homes because their parents could not afford to pay school fees. These young people tend to hold the belief that education is a way out of poverty. Some already have children of their own to support.

Many young people in Kisenyi have had personal experience with HIV or AIDS through friends and family members. They receive information on HIV and AIDS from friends, teachers and the media. Many read *Straight Talk*, a newspaper supplement with information about sexual and reproductive health matters for young people, or they listen to *Capital Doctor*, a radio programme to which young people may call in or write with questions about bodily changes, sexuality, menstruation and pregnancy.

Study procedures

After individual interviews and focus group discussions (FGDs) were conducted, the data were analysed according to qualitative content analysis (see Graneheim & Lundman, 2004).

Individual interviews

Individual, semi-structured interviews were conducted with 11 females (15–22 years old) and 11 males (16–21 years old). Two young Ugandans with university education and experience in conducting interviews for research assisted the first author. One was a male social worker at the youth

centre, the other was a female appointed for the research project. The research assistants purposefully sampled youths willing to reveal their feelings about HIV testing. Females and males, both in and out of school, were invited to participate. Participants were initially recruited among visitors to the youth centre. Four of the 11 females were interviewed in their homes, to make them feel more at ease with the interview situation; this enabled the inclusion of girls who otherwise would not have been able to participate, as they could not spend much time away from home. One or two persons per day were approached, and before signing a consent form they were given oral and written information about the purpose of the study, stating that their participation would be voluntary and confidential.

Participants decided whether they wanted to be interviewed in English, the official language, or in Luganda, the most common local language. Eleven interviews were conducted in English and seven in Luganda; in four interviews the language shifted between English and Luganda. If English was chosen, the first author conducted the interview with the assistance of one of the two bi-lingual Ugandan research assistants (this allowed the use of Luganda if it seemed too difficult to discuss an issue in English). If Luganda was chosen, the research assistants conducted the interview, which was translated into English and transcribed immediately afterwards. A pre-tested question guide was used, and probing followed up the participants' answers. The tape-recorded interviews started with questions about the informant's social background, living conditions and experience of STIs. Data on interview language and informant demographics are presented in Table 1.

Each individual interview lasted between 20 and 45 minutes. The focus was on the following questions: 1) Have you ever been tested for HIV? If 'yes,' tell us as much as you can about that experience. 2) Tell us as much as you feel comfortable with, about how you made up your mind to go for VCT or else to abstain from VCT. 3) Finally, what is most important in your life at present, and what do you hope to be doing in the next five to ten years?

Focus group discussions

Five FGDs, three with females and two with males, were conducted, and a total of 20 females (13–19 years old) and 21 males (12–24 years old) participated; the FGD size ranged from 6 to 12. The males were divided into a younger and older group. Local council leaders, who were informed about the purpose of the study, helped to recruit participants and suggested the place and time for the FGDs. All youths who attended were allowed to participate, and it was explained that participation in the discussion was voluntary; thus, the purpose of the study and the importance of confidentiality were stressed before the discussions started. The first author led the discussions as the group moderator. The two research assistants translated between Luganda and English when needed. Topics were presented in English and translated into Luganda, and the discussions followed in either English or Luganda. If the language gravitated to Luganda, one of the research assistants translated a summary of the discussion to the moderator. The tape-recorded FGDs were translated into English and

Table 1: Interview and demographic data for individual interviews with Ugandan youths

	Females (n = 11)	Males (n = 11)
Interviewed in English	7	4
Interviewed in Luganda	3	4
Interviewed in English and Luganda	1	3
Age range (years)	15–22	16–21
Education level	Primary 7 to university	Never attended school to Senior 6
In school/out of school	5/6	4/7
In a sexual relationship	8	2
Never had sex	2	1

transcribed immediately afterwards. The moderator ensured that all group members had the opportunity to speak, although some needed more encouragement than others, and sometimes the discussions were disrupted by noise from outside. One FGD was held at the clinic and the other four in a community centre.

Each FGD lasted for approximately one hour. The participants were asked to talk about what they knew about HIV or AIDS and the difference between being HIV-positive and having AIDS. They were also asked to discuss the implications of HIV testing for an individual and why some people abstain from HIV testing.

Data analysis

All interviews and FGDs were tape-recorded and transcribed verbatim and translated into English before the analysis. The texts from interviews and FGDs were analysed by the first author as one set of data. This analysis was conducted in four steps. First, the whole text was read several times and the meaning units were identified: a meaning unit being a part of the text, a sentence or several paragraphs where attitudes to VCT are revealed. Second, all meaning units were condensed to shorten the text but keep the message; these condensed meaning units were discussed with the Ugandan research assistants in order to avoid cultural or other misconceptions. Third, the condensed meaning units were categorised according to similarities and differences in content. Finally, data were divided gender-wise and the condensed meaning units were compared for differences between genders (see Graneheim & Lundman, 2004).

Ethical clearance

The study was approved by the Ugandan National Council for Science and Technology, the Uganda Ministry of Health, Buganda Kingdom, and the Research Ethics Committee of Uppsala University, Sweden.

Findings

The youths' generalised attitudes to VCT for HIV are listed in Box 1 and further described below.

'I am willing to test whether my risk of being HIV-positive is high or low, and I know what to do with the result'

The perception of the personal risk of being HIV-positive

Box 1: Informants' attitudes to VCT for HIV

'I am willing to test whether my risk of being HIV-positive is high or low, and I know what to do with the result.'
 'I would test, if testing were accessible.'
 'I will not test because I don't trust the method.'
 'I will not test because I fear the pain.'
 'I will not test because I fear being neglected.'
 'I will not test because the knowledge of HIV would cause worries and even shorten my life.'
 'There is no need for me to test because I know I am safe.'

was often mentioned by the participants and appeared to affect their attitudes to VCT in various ways. An awareness of high risk could be a reason for going for HIV testing:

'I have had unprotected sex with someone in the village when we went for the burial ceremony. It was really knocking on my head that you never know, you may have got HIV or gonorrhoea as I did last time. That's why I have come back for this HIV testing, so that I can know my life status very nicely' (Male, age 19, interview).

Likewise, a perception of low risk could be a motive for testing:

'It's like I just wanted to be sure of my status, whether positive or negative. But what I know is I'm negative' (Female, age 18, interview).

The attitude that there was no problem connected to the decision to test for HIV was also found among youths who were uncertain about their HIV status. Some informants experienced symptoms that they thought were signs of STIs or HIV infection. Genital itchiness was a common symptom among both males and females and it was generally considered the result of an STI. General skin problems, which are very common in this setting, were also believed to be signs of HIV infection and thus a reason to test:

'I was worried about myself...I'm not so sure [if it is HIV] but I see some rash here on my hand. That's why I have come here...I realised I've got these [indicating some ringworm on her right arm]. That's why I have decided to come' (Female, age 18, interview).

Testing for HIV was also mentioned as a way of proving that one is free from HIV infection before marriage and before pregnancy:

'I want to have a baby, so my boyfriend said I must first go for a test. So I'm also coming for it because of that' (Female, age 18, interview).

Those deciding to test claimed that a negative as well as a positive test result would help them to change their behaviour. They would either abstain from sex or reduce their number of sexual partners in order to avoid spreading the infection to others, and, if necessary, they would seek medical care.

Interviewer: *If you go for HIV testing and the result comes out negative — what will you do?*

Informant (girl, age 16): *If the result comes out negative I will also tell my boyfriend to go for HIV testing and if we are both negative we go.*

Interviewer: *Where?*

Informant: *We go live. Without a condom.*

Interviewer: *What will you do if the result is positive?*

Informant: *Then, there I go to hospital and get medicine and also stop having sex.*

'I would test, if testing were accessible'

Informants claimed that before a young person decided to go for HIV testing, s/he needed to have information about where to go and what s/he can expect to happen at the testing site. The cost, the waiting time and what to do if the test result was positive were also concerns for the youths:

Moderator: *So, what is preventing you from going for the test?*

Boy: *Actually, nothing else apart from I don't know where I can be tested from, I don't know the amount [cost] of testing, and actually I need more information.*

Girls in the FGDs mentioned that lack of money and time were equally important obstacles to using VCT. In-school youths had difficulty leaving school for HIV testing; many were in boarding schools and could leave only during vacation. For employed youths, it was a problem to leave work during office hours, when the testing sites were open:

'Some of us are too busy. Therefore, we don't have time to go for counselling. Sometimes you feel that maybe it is too costly in terms of time. It takes a lot of time. Then, in the end of day with some few money, you know, every time you work for money. Any time you may lose a job. Therefore, some people we are too busy to go for such services' (Male, FGD).

Although the AIC is located near the youth centre, some of the participants did not know where they could go for testing:

'I ever thought about testing, but I don't know where they test from and I don't have the money' (Female, FGD).

'I will not test because I don't trust the method'

Participants expressed a lack of trust in the results being reliable and claimed that the HIV test result could be different depending on the testing site, as they knew that this had happened to others. The young men in one FGD seemed unaware of the possibility that an HIV test can be negative if it is taken during the window period before antibodies appear:

'For example I might test from your clinic and they tell me that I'm OK and when I go somewhere else, like

Kyanamuka, and they tell me that I'm dead. So that reason is also serious.'

One group of females discussed the possibility that people abstained from testing because of fear that infected needles were used by some health workers:

'They might think that the instruments they use for blood sampling were used on an infected person and in the process they might also end up getting the virus.'

'I will not test because I fear the pain'

The fear of pain connected to blood collection was sometimes the only reason given for abstaining from HIV testing:

Informant (girl, age 16): *I don't fear to tell me that I'm HIV-positive.*

Interviewer: *Then what do you fear?*

Informant: *I fear so much the injection they use for blood sampling.*

Interviewer: *That it will hurt?*

Informant: *Yes.*

'I will not test because I fear being neglected'

Participants explained that friends with HIV infection had reacted very negatively to the diagnosis: they had isolated themselves from others and feared mistreatment. Fear of rejection from friends and family or fear of being mistreated were also mentioned as a reason why they themselves would not go for HIV testing:

'You know some may fear the results like being — let me say, being segregated from others. That thing really hurts. Me, I think, if I'm the one, I cannot go if I can get to know that I'm positive. I don't feel good when I'm with others so I feel neglected' (Female, FGD).

Another concern was whether they as a young person could cope with the knowledge of being HIV-positive, or whether it would be better to wait and test when they were adult and ready to marry. Many of the youths already had problems with insufficient money for school fees and other necessities and parents might not find it worthwhile to pay school fees for someone who was HIV-positive. One situation where lack of support was especially traumatic was after sexual violence:

'Some of us don't engage in sexual relationships, but there are some cases like me — my uncle came at home, he raped me. So now I don't know if I have AIDS or not [starts crying].... I want to know where I can get support. If I test positive, where can I get support? Because they will stop paying school fees for me if I'm positive' (Female, FGD).

'I will not test because the knowledge of HIV would cause worries and even shorten my life'

A prominent attitude was that HIV testing should be avoided because the knowledge of being HIV-positive could be destructive. Thus, some felt young people should abstain from HIV testing, unless they were certain they were negative. Informants claimed that knowledge of being HIV-positive would cause a person to think s/he was about to die every time s/he had a headache:

'Like me, it is not money, not anything else.... But me,

I cannot go for testing because I want to die not knowing what has killed me. But when you get to know the truth you start worrying, thinking a lot. But at least you die not knowing that it is HIV.... At least you get to know that you are dying of AIDS, but not knowing earlier. You understand? When you know earlier, you die quickly' (Male, FGD).

'There is no need for me to test because I know I am safe'

Finally, participants who perceived themselves at no risk of having HIV infection argued that this was a good reason to abstain from testing:

'I don't want it because I know I have never engaged in any risks which can expose me to contract HIV. So I can't see the reason for it' (Male, age 16, interview).

Gender differences

Most of the attitudes to VCT described above were shared among both females and males. In only a few aspects were differences between the genders apparent. Males emphasised that a negative HIV test would help them with future planning:

'You know, counsellor, when you test it gives you confidence and hope in whatever you are doing. When you test negative it will give you courage to work so hard and to make sure that you leave some things aside so that you can be a very good citizen' (Male, age 19, interview).

Females rarely admitted that they perceived themselves to be at risk for HIV infection through sexual transmission: they just wanted to know their status, and friends had often influenced them in their decision to test:

Interviewer: *But what gave you the idea [to test]?*
Informant (female, age 18): *Me, I don't know. My friends told me, too — You should go testing. Having an HIV test is not bad. Just get your status, whatever — That's how I made up my mind.'*

This contrasted to boys who tended to reveal more about previous sexual experiences and their perceived risk of HIV infection:

'I have a doubt about myself since I have engaged in unprotected sex with someone whom I was not trusting' (Male, age 18, interview).

Distrust in the testing methods was only expressed by males, whereas the fear of pain as a reason for abstention was only mentioned by females:

'One of the reasons why young people don't want to go for testing is the testing machines they use. Someone may be tested from Mbarara, and they tell him or her that you don't have, you are safe. And when he comes in Kampala, for example, you go to AIC, you test for the second time and they tell you that you have. How come? Those are some of the reasons why they don't go. Because they get confused: you have — you don't have. What advice are you giving to them?' (Male, FGD).

'I fear, because I have heard many people saying that testing is painful and I don't know how it pains. And I have not yet got the chance to test. I am always at school' (Female, FGD).

Discussion

Challenges to the data collection

In this study, both individual interviews and FGDs were used for data collection. The individual interview offered a situation where opinions and experiences could be revealed privately to the researchers. However, a previous study with young females in a similar setting indicated that an individual interview with a focus on the person interviewed can be embarrassing to some, especially girls, and thus it may restrain their ability to speak freely (see Råssjö & Darj, 2002). During data collection in the present study, young females were reluctant to speak in the individual interview situation, even when interviewed by a young adult female interviewer in their own language and in their own home. In contrast, group interaction in the FGDs appeared to encourage girls to speak. Since dominant participants can create bias and cause less articulate people to withhold their opinions (Robinson, 1999), both methods were used in order to obtain reliable and comprehensive data.

Another challenge was the use of two languages, English and Luganda. Luganda was not the mother tongue for all participants and they were not all fluent in English; therefore, either language was used, according to the preference of the participant. This may have affected the phrasing of the questions and answers and the presentation of the quotes. Thus, in order to reduce misunderstandings, cultural or linguistic, the meanings were discussed with the bilingual research assistants throughout the process of data analysis.

Interviewing someone of the opposite gender could possibly cause embarrassment. However, in this study the first author, who is a woman, found that interviewing male participants was less difficult compared to interviewing females. The young boys did not appear embarrassed to talk about sexual matters. This may have been due to the wide age span between the interviewer and interviewee, or to the fact that the interviewer came from a different culture.

With few exceptions, the young men in this study wishing to test for HIV perceived themselves to be at risk of infection through sexual intercourse, whereas the young women rarely perceived themselves to be at risk of being HIV infected. This may reflect that young men take more health risks or that they are more open about the issue. Women may be unable to assess their own health risk as it is related to the risk of their partner (Stringer, Sinkala, Kumwenda, Chapman, Mwale, Vermund, Goldberg & Stringer, 2004). Another possible interpretation is that there was a selection bias: women who suspected that they were HIV-positive might have been reluctant to volunteer to participate in an interview or FGD. The individual's HIV status was unknown to most of the participants and was not asked for among those who had been tested. It is possible that this caused another selection bias: HIV-positive individuals may have been reluctant to participate, and thus a sample of the attitudes of those who have experienced receiving an HIV-positive test result may be missing.

Reflections on the findings

This qualitative investigation on VCT among youth in Kisenyi in Kampala demonstrated that young people there

have a generally positive attitude towards VCT for HIV, although they face many obstacles to access those services. Knowledge of one's own serostatus was claimed to encourage positive living and future planning, and this was a motive for accessing VCT among some of the youth: the positive-living concept was considered desirable. HIV testing has become a standard ingredient in the preparations for marriage in Uganda (Råssjö & Darj, 2002) and it has potential for prevention of mother-to-child transmission of HIV. The concept of positive living has become important in counselling for HIV testing. The emphasis with this concept is on accessible methods of staying healthy, not on accessing antiretroviral drugs (ARVs). At the time of the study, free ARVs were not widely available in Uganda, a situation that has since changed (MoH, 2003b).

Many youth described that they personally intended to abstain from sex after HIV testing, or that a negative test would help them stay faithful to one partner, or else they would use condoms. However, factors such as poverty, the urge to have sex, and peer pressure were mentioned as reasons why intentions to practice safer sex sometimes failed. The poverty experienced by many of the adolescents presented difficulties in affording their basic needs, and thus sex in exchange for material goods was a possibility. A qualitative study in Ghana, Burkina Faso, Malawi and Uganda indicated that the habit of giving and receiving money and gifts in exchange for sex is common (Amuyumunzu-Myamungo *et al.*, 2005). This happens within the 'sugar-daddy' relationship, where the male partner is considerably older, and also between partners of the same age (Hulton, Cullen & Khalokho, 2000). Many Ugandan adolescents consider this exchange to be normal in a sexual relationship (Nyanzi, Pool & Kinsman, 2001; Neema *et al.*, 2004). The age difference in a partnership has been used as a proxy for power relations (Neema *et al.*, 2004), as most female teenagers have partners that are considerably older. In a sample of teenage girls in Kisenyi, 48% had a partner who was at least five years older and 14% had a partner who was more than 10 years older (Råssjö *et al.*, 2006). Multiple partners are common among Ugandan adolescent males (Uganda Bureau of Statistics, 2001) and sexual experiences and multiple partners are highly valued among adolescent boys attending FGDs in rural Uganda (Nyanzi *et al.*, 2001). Another factor preventing especially females from avoiding risks is sexual violence. Sexual coercion and sexual violence are common in Uganda (Koenig, Lutalo, Zhao, Nalugoda, Kiwanuka, Wabwire-Mangen, Kigozi, Sewankambo, Wagman, Serwadda, Wawer & Gray, 2004; Neema *et al.*, 2004); a recent study determined that 21% of teenage girls in Kisenyi reported being forced to have sex (Råssjö *et al.*, 2006). Imbalance in gender power relations in terms of economy, age difference and use of violence, appear to influence especially young women's ability to decide if, when, and under what conditions they have sex, and consequently this affects their risk of exposure to HIV.

VCT for HIV is not accessible for young people without an income, even when the fee is low as at the AIC youth corner in Kisenyi. During and for a couple of weeks after the

study, VCT for HIV was paid for by the research project and many participants took the opportunity to use the service. This illustrated that cost is an important obstacle for youths, with time being another limiting factor. Long waiting hours at HIV testing centres, due to the large number of young people in relation to the few counsellors available, is another barrier and makes it impossible for many working youths and those attending school to access the service.

Young people's motives for using VCT were different from the motives described in a study on acceptability of VCT for HIV among adults in a rural area of Uganda, and reflect shorter sexual experience among the youth (Nuwaha *et al.*, 2002). In that study of adults, the death of a sexual partner or having symptoms of AIDS illness were revealed as the most common motives for HIV testing. These factors were not referred to by the participants in our study. However, the Nuwaha *et al.* (2002) study results have many similarities to the current findings: for example, that HIV testing is a way of proving that one is healthy, and testing is necessary before you can get married and have children.

One important obstacle to HIV testing described by the youths was that the knowledge of a seropositive status can cause worries to such an extent that it would shorten one's life. Another common obstacle was the fear of stigmatisation. Both these reasons for abstaining from HIV testing have been described in other studies, for example among adults in South Africa (Van Dyk, 2003). Stigma was reflected by the mentioning of different ways of hiding the fact that someone has an HIV-related illness, and the data provides an example of what has been called internalised stigma (Gilmore & Somerville, 1994; Parker & Aggleton, 2002): this is when fear of HIV/AIDS-related stigma and discrimination is so strong that the individual tends to isolate her/himself from others. Conflicting results have been reported in previous studies in urban and rural Uganda; some did not identify stigma towards people with HIV or AIDS (Nuwaha, Faxelid, Neema & Hojer, 1999), whereas others reported a high degree of residual stigma, as in a rural setting in Uganda, where relevant education and outreach services have been available for years (Wolff, Nyanzi, Katongole, Ssesanga, Ruberantwari & Whitworth, 2005). Furthermore, the Uganda HIV/AIDS Sero-Behavioural Survey 2004–2005 revealed that more than 30% of the respondents believed that a female teacher who is HIV-infected, but not sick, should not be allowed to continue teaching, and that women are generally less likely to express acceptance towards HIV-infected people (MoH, 2005).

The youths in this study formed their attitudes to VCT in a sexual context where cultural and religious norms and values co-exist with 'modern' western lifestyle temptations and media influences. The tension between the traditional ideal of female chastity and the modern image of sexual freedom forces girls to balance between avoiding being seen as 'loose' but still not appear as 'unsophisticated' virgins (Nyanzi *et al.*, 2001). Our data reveals that youths' decisions on sexuality, HIV, and VCT were made in a context where the individual power to decide was often limited, due to economic constraints and imbalances in gender power relations. This questions the appropriateness of the frequently used behavioural theory models, such as

the Health Belief Model (see Rosenstock, Strecher & Becker, 1988; Zak-Place & Stern, 2004), for describing and explaining in this context individual differences in preventive health behaviour related to sexuality. Briefly, such models assume that preventive behaviour is the result of an individual's rational decision-making, based on perceived severity of disease, benefits from the action, and barriers to action. Our study did not examine the relationship between perception of threat and attitudes to HIV testing; nevertheless, the results indicate that the youth's decisions to go for VCT seldom appeared to be based solely on rational reasoning. We agree with other researchers (e.g. Hulton *et al.*, 2000; Zak-Place & Stern, 2004) in the criticism of the indiscriminate use of such models, and argue that gender power relations, as well as economic and socio-cultural aspects in a specific context, also have to be considered when trying to understand and explain sexual behaviour and related issues such as VCT.

Conclusions

The youths in this study believed that knowledge about HIV status, counselling, and support could help them to stay free from infection or to live positively. VCT services need to be organised in a way that is accessible to the individuals most vulnerable to exposure to HIV — the youth — in terms of cost, time and quality of pre- and post-test counselling. School-based VCT sites could help those in school to gain access to this service. Counselling without testing for those who feel that they are not ready for taking an HIV test should also be available at places where young people most commonly go, for example youth clubs, churches and community centres.

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