KNOWLEDGE LEVELS OF VOLUNTARY COUNSELLING AND TESTING FOR HUMAN IMMUNODEFICIENCY VIRUS AMONGST TAXI DRIVERS IN KAMPALA, UGANDA

BY

Dr. Assisi-Franklin B. Kizito

Registration number 0312394F

DEGREE FOR WHICH REGISTERED: MASTER OF PUBLIC HEALTH

UGANDAN SUPERVISOR: PROF. ELLY KATABIRA, FRCP

WITS SUPERVISOR: PROF. SHAN NAIDOO, MBBCh, DTM&H,.DPH,DHSM,DOH,MMed

A RESEARCH REPORT SUBMITTED TO THE FACULTY OF HEALTH SCIENCES, UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH

Kampala, 2005

DECLARATION

I DR. ASSISI – FRANKLIN BAFIRAWALA KIZITO do hereby solemnly declare that this piece of work is as a result of my own efforts and has never been presented by any body or appeared any where for any qualification, certification or publication.

Signature ……..

……..day of ……..., 2006

DEDICATION

I dedicate this manuscript to my parents whose efforts and sacrifice have enabled me to achieve and to produce this work.

ACKNOWLEDGEMENTS

I acknowledge every one who in one way or the other contributed to the accomplishment of this report. However, special thanks go to the following people; the Executive Director of TASO Dr. Alex Coutinho who secured the scholarship that enabled me pursue the postgraduate studies at the Witwatersrand University, South Africa; my supervisors both Professor Shan Naidoo (external) and Professor Elly Katabira (internal) who guided me during the development of the protocol as well as the encouragement, the support and the patience they accorded me during the process of compiling this report. Special love goes to my wife and the children who missed me for nine months while I was doing my course work in South Africa; the entire TASO senior management team that endorsed my studies; the funding agency that provided the tuition plus the upkeep fees; UTODA and the Taxi Drivers who contributed to the information that has been used to compile this report. I cannot forget all my classmates in the MPH 2003 class at the Witwatersrand University who encouraged me to develop the protocol; my friends and the professional colleagues who contributed constructive ideas during my research and all those who might have been inconvenienced to pardon me. I am indeed indebted to the references consulted in compiling this manuscript.

Lastly all these were possible because, I was given the will, the health and the determination by the Lord Almighty.

Dr. Assisi-Franklin B. Kizito

P. O. Box 10443

Kampala.

Uganda.

E-mail address: afbkizito2002@yahoo.co.uk

Mobile Telephone: 077 2 58 76 20

TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF TABLES

ABBREVIATONS/ACRONYMS

AIC	AIDS Information Centre
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ELISA	Enzyme Linked Immuno-Sorbent Assay
GP	Glycoprotein
HIV	Human Immunodeficiency Virus
IFA	Immuno-Florescence Assay
Km	Kilometre
NGO	Non Government Organization
PCR	Polymerase Chain Reaction
PI	Principal Investigator
RIPA	Radio Immuno-Precipitation Assay
STD	Sexually Transmitted Disease
TASO	The AIDS Support Organization
UTODA	Uganda Transport Operators and Drivers' Association
VCT	Voluntary Counselling and Testing

SUMMARY

Introduction:

Human Immunodeficiency Virus (HIV) was first isolated from human blood in 1983 at the Pasteur Institute, Paris. Currently there is no cure for HIV and control efforts emphasize prevention. One of the components of the Global Strategy put forward to preventing HIV transmission is HIV Voluntary Counselling and Testing (VCT) (Ginwalla, Grant, & Day:2002). Taxi drivers are part of the Ugandan population at special risk of acquiring this virus. It was therefore necessary to carry out a study in this group of people to assess how much they knew about HIV/VCT services.

Study Objectives

To establish the level of knowledge amongst the taxi drivers about the availability and accessibility of HIV VCT services in Kampala.

To identify factors that influence the taxi drivers in Kampala, Uganda to access the HIV VCT services.

Methods and materials

A cross-sectional descriptive study design was used to carry out the study amongst 400 taxi drivers who consented to participate and operated within and around the city of Kampala during 2004. A structured questionnaire to record variables that included, age, sex, marital status, level of education, level of knowledge of VCT, factors that enhance VCT uptake, factors that inhibit VCT uptake, history of having ever had VCT, and knowledge of spouse or sexual partner's HIV serostatus, was used.

Data was entered into EPI-INFO 6 computer program and descriptive and analytic investigation using proportion or percentages to compare the level of knowledge generated was used.

Findings/Results

A total of 399 taxi drivers with 52.8% of them aged between 26 – 35 years participated in the study. 68.8% lived within 6 km of the city centre. All were married and 78.8% had one spouse. 0.75% were lady drivers.

55% of the participants had attained secondary school level of education. 69% of the taxi drivers knew that HIV/AIDS was the commonest health problem in the country and 57.4% of the participants mentioned HIV testing as the only way one would ascertain their serostatus. 94.2% had heard about HIV/VCT mainly from the media and as much as 98.7% of the taxi drivers knew a place where such services could be got. 82.2% confirmed that these places were accessible and 85.9% said that the services were not expensive. However, 57.3% of the participants preferred getting these services where they were known in order to get genuine results and subsequent support. The 26% who opposed this idea sighted confidentiality as the main obstacle.

Despite the knowledge level about HIV/VCT amongst the participants, 68.3% of the communal taxi drivers were willing to go for the service and only 16.1% had actually taken the test. Out of the 399 participants 59.6% felt that they could share their serostatus with their spouses.

Conclusion

The taxi drivers are knowledgeable about HIV/VCT services and these findings lie within the overall range of knowledge of the population in urban Uganda.

The HIV/VCT services are accessible and affordable to the taxi drivers but the fear to receive the unexpected results and the consequences of having positive results hinder the taxi drivers from seeking the VCT services.

The majority of taxi drivers preferred to go to HIV/VCT service points where they were known. This factor could have contributed to the small number of taxi drivers that had taken the test. Probably few suitable service points to go to, that had been identified by these taxi drivers.

Recommendations

The government and other organizations that provide care in the field of HIV should organize sensitization seminars for taxi drivers to address issues aimed at allaying their anxiety or fear to receive positive results.

Also, there is a need to intensify counselling services for the taxi drivers by establishing counselling centres close to the two taxi parks in the City.

HIV/VCT service centres should be integrated with other health services so that people who seek either of the services can gain from both. This will encourage more taxi drivers to come to these centres.

OPERATIONAL DEFINITIONS

Human Immunodeficiency Virus:

This is a virus that destroys the human immune system thus leading to AIDS. HIV type 1 has a cylindrical core surrounded by a bi-layered lipid envelope acquired as the new virion buds from its host cell. Implanted into this envelope are viral glycoproteins (Gp 41 and 120) carrying receptor sites for the CD4 antigen expressed on the surface of host cells. Only cells bearing this antigen are susceptible to infection. This is the main virus causing heterosexual transmission in Uganda.

Acquired Immunodeficiency Syndrome (AIDS)

This is the illness characterised by one or more indicator diseases namely Kaposi's sarcoma, cryptococcal meningitis, oesophageal candidiasis, herpes zoster in patients below 50 years and oral thrush in patients below 50 years.

Counselling:

This is an interpersonal communication through which a person is helped to assess his current situation, explore his feelings and be able to come up with a constructive option in dealing with the illness.

Pre-test counselling:

This is counselling offered before taking an HIV-antibody test.

Post-test Counselling:

This is counselling done when the test results are ready and are about to be given to the patient and includes counselling immediately after the test results are given.

Human Immunodeficiency Virus testing:

Serological tests for detecting HIV-1 and 2 antibodies in whole blood, serum or plasma. These include a). Rapid screening tests, b). Enzyme-Linked Immuno-

Sorbent Assay (ELISA) test, c). Confirmatory tests e.g. Western blot, Radio Immuno-Precipitation Assay (RIPA) or Indirect Immuno-Florescence Assay (IFA) Detecting HIV RNA/DNA by use of the Polymerase Chain Reaction (PCR) technique can also be done. However this is a very expensive test.

Voluntary Counselling and Testing (VCT):

Counselling and testing sought voluntarily from doctors, clinics, or health maintenance organisations or as done through any other organisation in which HIV antibody tests are done and people obtain results by their own choice primarily to determine infection status.

Taxi Driver:

This is a person who drives a public transport vehicle for the purpose of ferrying passengers from one point to another in return for money.

Uganda:

This is an East African Country bordered by Tanzania in the South, Rwanda in the South-West, Democratic Republic of the Congo on the West, Sudan in the North and Kenya to the East. The capital city is Kampala with a population of 1.5 million people.

Positive Living:

Refers to one who has HIV to be able to cope with the current state by avoiding re-infection, having good nutrition, seeking medical care appropriately, getting enough rest and exercise, continuing with his/her day to day duties as long as possible and use of a condom to stop spread of infection to others or adopt abstinence.

Opportunistic Infection:

Infections that would not manifest in a person with a normal immune system but emerge as a result of lowered immune system's ability of the body to fight them off.

Slim disease:

This is a name given to the HIV/AIDS condition in Uganda because of the severity of wasting that manifest with it as a result of chronic diarrhoea and other weight-losing opportunistic infections such as tuberculosis.

Sexually active:

Refers to individuals who are active sexually i.e. they are responding to physiological sexual desire or demands of the body through sex with other people.

CHAPTER 1

1.0 INTRODUCTION AND BACKGROUD

1.1 Introduction and Background Information

Human Immunodeficiency Virus (HIV) type 1 (HIV-1) was first isolated from the human peripheral blood in 1983, at the Pasteur Institute, Paris, as a lymphadenopathy associated virus (Sauhami & Maxiham: 1994). The evidence that it was responsible for the Acquired Immunodeficiency syndrome (AIDS) appeared in 1984 (Sauhami & Maxiham: 1994) and was also designated the Human T. lymphocytic Virus type III (Marcus, Chatton 1986:87). HIV has a lipid envelope, and is about 100 nm in diameter. There are many minor variations between HIVs but only two major variants, namely HIV-1 and HIV-2 have been identified as being responsible for the Acquired Immune Deficiency Syndrome (AIDS). HIV-2 was first found in West Africa in 1986 and exists both as single infection and as a co-infection with HIV-1 and is less virulent (Sauhami &.Maxiham: 1994).

The main action of the virus is to cause depletion of the T_4-helper or inducer lymphocytes as well as infecting other cells of the immune system of the human body with resultant profound immune-suppression (Sauhami & Maxiham: 1994). The profound immune suppression leads to various opportunistic infections, such as candidiasis, Pneumocytis Carinii pneumonia, cryptococcal meningitis, wasting syndrome and other disease indicative of immune suppression. This forms the Acquired Immunodeficiency Syndrome, which if not treated eventually culminates in death.

Prior to the identification of HIV-1, as the causative agent of AIDS, a diagnosis of AIDS was made solely on clinical grounds (Kurt, Martin & Braunward: 1996) by using the World Health Organization Clinical Staging system (Katabira, Kamya & Mubiru: 2000). The system is based on clinical presentation and how active a patient is on a daily basis.

The establishment of HIV as the causative agent of AIDS and related syndromes early in 1984 was followed by the rapid development of sensitive screening tests for HIV infection and by 1985 blood in USA was being screened for antibodies to HIV (Phillips, & Coates: 1995). The infection is diagnosed by serological tests that demonstrate the presence of antibodies to HIV and or the direct detection of HIV or one of its components. These include Enzyme-Linked Immuno-Sorbent Assay (ELISA), and the Western blot, which is more sensitive to the specific antibodies. In either way a gold standard test – the Polymerase Chain Reaction (PCR) has gained acceptance in many areas of microbiology for use to detect the virus itself (Phillips, & Coates: 1995).

Currently there is no cure for this virus but it can be prevented and treated. The primary prevention aims at stopping the infection from occurring in the first place. This is achieved through health promotion messages and programmes to market and encourage the use of condoms, being faithful to one partner, and abstinence. The secondary prevention is aimed at promoting health care seeking behaviour so that those who are infected recognize this, regardless of symptoms, and as a result come forward for HIV counselling and testing plus care if required.

CHAPTER 2

2.0 LITERATURE REVIEW

In National household level of health and family planning surveys in Kenya, Tanzania and Zimbabwe it was shown that around 60% of adults want to know their HIV status while 15% or less had access to VCT (UNAIDS: 2000). A Ugandan study in the rural community in Western Uganda through a focus group discussion approach, showed an acceptance level of 74 % for VCT (Kipp, Kabagambe & Konde-Lule: 2002). Another study again in rural Uganda found an acceptable level of 48% in men and 41% in women for VCT (Nyblade, Gray & Makumbi: 2000). This difference was attributed to the subordinate role the women played in a household depending on the men for any financial transaction to take place, like paying for the VCT services. In this same study it was also found that those people who had some income were more likely to go for the HIV-VCT services than those who had none. A study in a rural area in Tanzania involved households and demonstrated that the acceptance level of HIV-VCT was 55% (Killewo, Kwesigabo & Comoro, 1998).

At the individual level, motivation to take up HIV-VCT may differ from individual to individual as well as the circumstances under which the test is being performed. This study of the taxi drivers will try and address some of these issues through a questionnaire on a one to one basis.

Uganda's efforts to control and respond to the AIDS epidemic have been greatly enhanced by strong political leadership and will at every level. There have been

commendable efforts to mobilize and unify the response by the establishment of the multi-sectoral Uganda AIDS Commission, the AIDS Control Programme and District AIDS coordinating committees. There is a growing body of evidence that all these activities and interventions have resulted in substantial levels of behaviour changes including reduction in the number of sexual partners, reduction in casual sexual partners, adaptation of condom use and delaying the onset of sexual activities in young people (Opio, Assimwe-Okiror, & Musinguzi: 1996).

In spite of these accomplishments, myths regarding condom ineffectiveness, alleged cures and other modes of transmission persist and have not been adequately addressed by the national authorities. HIV counselling and testing services are not yet available in many parts of the country. The sexually active Ugandans still present with sexually transmitted diseases (STD) at the STD Clinic in Mulago, (Major Hospital) which indicates that people still indulge in unsafe sex. STD is considered a prerequisite for HIV infection. It is estimated that ten million young people (aged 15 – 24) are living with HIV in Sub Saharan Africa (UNAIDS: 2002).

Each year extensive resources – both financial and human, are used to try to achieve the goal of prevention of HIV transmission. Interventions vary from mass media campaigns to working on a one to one basis (McOwan, Gilleece & Chisiett: 2002). The AIDS epidemic continues to expand rapidly in the general heterosexual populations of the developing countries and particularly in sub-Sahara Africa despite preventive measures advocated by the individual countries.

Voluntary HIV counselling and testing is a key component of the public health strategies for reducing transmission of HIV in developed countries but this strategy has not been considered to be important in developing countries (Muller, Sarangbin & Ruxrungthan 1995). In a study in the mines in South Africa, VCT was reluctantly taken up because of the fear of job loss, death and stigmatization (Ginwalla, Grant & Day: 2002). In Uganda the employers have learned to support all those employees who might be having HIV/AIDS. The employees are encouraged to work until they are too weak to carry on working. This is one of the policies in The AIDS Support Organization. However, significant clinical manifestations of HIV/AIDS appear when one is in stage 3 or 4 according to the WHO staging system of the HIV disease, and by such a time massive transmission of HIV has already occurred if the individual never took an early HIV test.

In Uganda VCT is offered by several health institutions but the quality of services differ. VCT needs a qualified person trained in HIV counselling to conduct pre- and post-test counselling. The quality of counselling and sharing information between the counsellor and the subject is quite crucial if the VCT is to be of any benefit. Lack of timely HIV testing leads to missed prevention opportunities and poor prevention counselling may be related to further disease spread (Moseu, Wenger & Shapiro 1998). The test itself should be of high sensitivity and high specificity so as to minimize false results, which might jeopardize the purpose of the strategy.

Improvements in testing and counselling procedures, the availability of treatment for early HIV infection and subsequent support provided has increased the level of acceptance for VCT in the developed world. Health professions commonly use the pre-and post-test counselling outcomes of those tested to develop ongoing

strategies to reduce risks of future HIV transmission. There is some data suggesting that counselling and testing lead to reduction in risk behaviour in those who test positive although any effect on those who test negative and those who have never tested is less clear (McOwan, Gilleece & Chisiett: 2002). While in a study among Hispanic men living in South Florida, it was found that testing history and future testing intentions were related to socio-demographic factors, health care access, sexual risk behaviour and perceptions of risk of HIV (Fernandez, Perrino & Royal: 2002)

Uganda is one of those countries, which has launched massive campaigns to increase VCT awareness in the population. McOwan et al (2002) however states that such campaigns in Scotland resulted in an increase of people going for HIV testing, but these changes appeared to be largely confined to those at low risk of infection. This kind of trend definitely reduces the cost-effectiveness of the intervention. However definite conclusions cannot be made unless studies of this nature i.e.on the use of VCT services by sexually active Ugandan taxi drivers is carried out.

Early diagnosis of HIV infection would help one to seek treatment for opportunistic infections and plan thereafter for ARV drugs when the appropriate time comes. Early HIV testing can help one to remain negative if found negative. For those found positive they could live a positive life with counselling, use of condoms, or by adopting abstinence so that the spread of the infection is contained. This is one of the ways through which the epidemic can be controlled. Life expectancy in Uganda is at 45 years. This is down from 57 years a decade ago and is regarded as mainly due to the HIV/AIDS epidemic. If voluntary counselling and HIV testing was

undertaken by almost all the sexually active people and they then adopted to remain negative or sought medical treatment and undertook preventing measures against re-infection, such a strategy could significantly have a positive impact on the life expectancy in Uganda

What makes people not to go for VCT when such services are available? In a study in Nigeria, 62% of mothers who had sick children in a hospital would consent to HIV testing (Akpede, Lawal & Momoh: 2002). While the other 38% of the mothers in the same study, would not consent to the testing because of the following main reasons: one's perception of good health and lack of exposure to VCT; the despair owing to lack of specific treatment; and the fear of a break-up of families with one of the partners being negative (HIV discordance).

Confidentiality is the basis for implementing a successful HIV voluntary counselling and testing services in a country. HIV prevention strategies raise complex ethical issues related to the disease and confidentiality (Sauka & Lie 2000). The counselling experts in Uganda state: 'Divulging HIV results may depend on the assurance of social support as much as on the effectiveness of counselling received in relation to learning one's test results' (Kaleeba, Kalibbala & Kaseje: 1997). In Uganda such supportive organizations are many including The AIDS Support Organisation (TASO) which provides counselling, social support, medical and nursing care for opportunistic infections as well as Antiretroviral Therapy (ART).

New studies in Africa show dramatic increases in demand for VCT when the services are made accessible, affordable and secure to those who want to know

their HIV status. (UNAIDS: 2000). The studies by Kipp et al indicated that the high level of fear to reveal sero-status is related to fear of spousal abuse, rejection and eventual divorce. However, removing the elements of doubt through VCT benefits both HIV – positive and HIV – negative clients; and has been shown to increase safer sex practices (UNAIDS: 2000). While not for everyone, the evidence indicates that VCT services are an essential component to investment in developing countries as a tool for empowerment, and for overcoming the HIV/AIDS stigma and denial that undermines HIV/AIDS prevention and care.

Sexual and other risk behaviour while travelling were increased particularly by young men and were considered as casual factors in the spread of HIV infection and other sexually transmitted diseases (STDs) (Lee, Bell & Hinojosa: 2002). Their study indicated that the probabilities of having a new sexual partner was more common for a single person and specifically a young male, and their conclusion was that 5% of all travellers were likely to have sexual intercourse when they were away from their home areas. Being a truck driver on Ugandan roads, roadside stops because of the easy availability of refreshments, food, accommodation and sex are risk factors that have been identified to promote the acquisition of HIV infection (Gysels, Pool & Bwanika: 2001). Some of the taxi drivers have been truck drivers before and there are speculations that some of these drivers use drugs (Kirunga: 1997).

While a study done in Western Uganda in a rural community, which involved people in focus group discussions concerning their attitudes, and perceptions towards an HIV counselling and testing programme concluded that extra-marital sexual relationships were widespread. Men attributed extra-marital sexual affairs to the

consumption of alcohol (Kipp, Kabagambe, & Konde-Lule: 2002). Consumption of alcohol may interfere with judgment and decision-making and thus may lead to unsafe sexual behaviour. However, a study in the Netherlands, found no relationship between alcohol use and unsafe sexual activities either among clients or prostitutes (de Graaf, Vanwesenbeeck & van Zessen: 1995).

CHAPTER 3

3.0 STATEMENT OF THE PROBLEM, JUSTIFICATION AND STUDY OBJECTIVES

3.1 Statement of the problem

Sub Saharan Africa is the worst affected region with an estimated 29.4 million people living with HIV/AIDS, and 20 million already dead as a result of HIV (UNAIDS: 2002). The latest figure in Uganda from the sexually transmitted disease and AIDS surveillance reports show a prevalence rate of 8% with a total estimated number of 820,000 people infected with HIV/AIDS and as many as 110,000 Ugandans dead as a result of HIV and related complications (USAID/CDC:2003).

In the absence of a cure the only effective way to reduce the prevalence of HIV is to prevent transmission. VCT is the main tool in the prevention of HIV especially among high risk groups. Taking an early HIV test can help one to make a decision to live positively and prolong life. Changing risk behaviour remains a key health promotion objective of HIV/VCT. Despite all the efforts by Government and NGOs in Uganda to increase accessibility and awareness to HIV/VCT services in the country there is still low service utilization by the general public and there are different perceptions and motivations for the use of HIV/VCT services (Kipp, Kabagambe, & Konde-Lule:2002).

The taxi drivers are part of the Ugandan public who are at particularly high risk of acquiring the infection through the various routes of transmissions. A study therefore is necessary to find out the level of knowledge about HIV/VCT use amongst taxi drivers who operate within the city of Kampala in Uganda.

3.2 Justification for the study

HIV counselling and testing services are the cornerstone in any country for the HIV epidemic preventive strategies. As the HIV-VCT services continue to be available in developing countries, there is a need to find out the level of knowledge about the services amongst the population for whom they are planned. Prior studies have found that people with risky sexual behaviour do not always perceive themselves to be at risk or in need of VCT (Phillips & Coates: 1995). In this particular study of the taxi drivers therefore, the researcher was interested in establishing the factors that enhance and barriers that contribute to the taxi drivers' level of knowledge and use of Voluntary Counselling and Testing services. Taxi drivers were targeted for the following reasons:

Taxi drivers are known to be amongst people who practice risky behaviour as compared to the rest of the population (Kirunga: 1997). Sexual and other risk behaviour while travelling was shown in a very recent study to be increased particularly in young men and taxi drivers (Lee, Bell & Hinojosa: 2002). Also, the phenomenon of trade off sex for support exists amongst people who handle money such as taxi drivers (WHO Editorial: 1991and Pickering, and Okongo: 1997). Taxi drivers are a highly sexually active group (Kirunga:: 2002). Taxi drivers interact with a wide scope of people in all walks of life and their attitudes can impact on many other people. The taxi drivers transport the sick and this should trigger interest in seeking for HIV-VCT services. Taxi drivers are a highly accessible group and can represent the wider informal business sector population in Uganda. In some developing countries such as in Thailand taxi drivers deliver HIV messages to their customers (Troitongyoo: 1991). Taxi drivers are in the age bracket that is highly affected by the HIV infection. It is estimated that ten million young people (aged 15

– 24) are living with HIV in Sub Saharan Africa (UNAIDS: 2002). There is therefore a pressing need to establish taxi drivers' perceptions about VCT services in Kampala.

The findings of the study shall be used to design intervention measures aimed at increasing the awareness about and utilization of HIV/VCT services by taxi drivers in Kampala, Uganda.

3.3 Study Question

'What is the level of knowledge about HIV VCT services amongst the taxi drivers in Kampala, Uganda?'

3.4 Study Objectives

3.4.1 General objective

The aim of the study was to establish the level of knowledge about HIV VCT services amongst taxi drivers in Kampala, Uganda in 2004 in order to develop appropriate interventions in this high risk group.

3.4.2 Specific objectives

1. To establish the level of knowledge amongst the taxi drivers about the availability and accessibility of HIV VCT services in Kampala.

2 To identify underlying factors that influences the taxi drivers in Kampala, Uganda in accessing the HIV VCT services.

CHAPTER 4

4.0 METHODS:

4.1 Study area:

The study was conducted in Kampala district of Uganda where about 1000 taxi drivers operate. There are two major taxi parks in Kampala. The Old and New taxi parks. One can get connected to any destination in the country through these two parks. However, concentration of taxis to the East and South of the city is in the Old taxi park while taxis going to the Western and Northern areas of the country are mainly located in the New taxi park.

4.2 Study design and data collection method:

A cross-sectional descriptive study design employing both qualitative and quantitative data collection methods was used to carry out this study amongst taxi drivers who operated within and about the city of Kampala in 2004.

The data collection tools included a structured questionnaire that was used to record information of the study variables.

Two well-trained interviewers recorded all the variables at a one-to-one interview with the participants. The data collected was collated for analysis.

4.3 Study population:

The study population included all the taxi drivers operating in the two taxi park hubs within the city of Kampala with an estimated total number of taxis up to 1000.

4.4 Study sample:

The study sample size was determined by using the following formula (Kish and Leslie: 1965).

$n= Z^2 \cdot P \cdot Q/D^2$

Where: n = sample size

Z= is the standard normal value corresponding to 95% confidence interval (1.96)

P= is the expected proportion of drivers who have knowledge of VCT (50%). Because the estimate was not known 50% was used since it gives the largest sample size.

Q= is the proportion or power which is equal to 100 - P or 100 – 50 = 50%.

D= is the desired precision of the estimate which is 5%

Therefore: $n= (1.96)^2 \times 50 \times 50 / 5 \times 5 = 384.16$

n= was approximated to a figure of 400

4.5 Sampling method

From the total population of taxis, a systematic sampling method of every 2nd taxi that had registered for operation that day was selected for participation in the study. Those that were selected in subsequent days but had been used before were dropped. The total number of participants selected was 400.

4.6 Measurement variables

Dependent variable: The level of knowledge amongst Taxi drivers.

Independent variables: These included Age, Sex, Education level, marital status, and Religion.

4.7 Inclusion criteria

For one to qualify into the study the following eligibility criteria had to be fulfilled,

a). Must have been a communal taxi driver registered with Uganda Transport Operators and Drivers Association (UTODA).

b). One who had signed the consent form and was willing to be interviewed for at least 20 minutes.

4.8 Quality assurance

4.8.1 Training of the Research Assistants

Two research assistants with medical background were selected and trained for 1 day to impart on them the skills to interview appropriately and in the use of the data collection tools.

4.8.2 Pre- testing of Tools

Data collection tools were pre-tested for one day prior to the collection of data, after which the questionnaire was updated. The questionnaire was pre-tested on 20 taxi drivers (not communal taxi drivers) who drive special hire taxis within Kampala. The aim was to assess the simplicity, the feasibility, the weaknesses and deficits of the questionnaire before its final implementation into the study.

4.9 Data processing methods and data analysis plans

4.9.1 Data management

The principal investigator (PI) closely supervised the research assistants during data collection. The PI also edited the questionnaires in the field and all missing data was collected immediately.

4.9.2 Data analysis

The data recording sheet was developed after piloting it in the special hire taxi drivers. The collated data was entered by a data clerk, and then cross checked by the PI. Analysis was done with the help of a statistician.

Descriptive analysis for the numeric variable namely age and the categorical variables, namely sex, educational level, marital status and residential area was done.

Statistical programs used was EPI-INFO version 6 software (Centre for Disease Control and Prevention, USA and World Health Organization, 1996)

The information collected was expressed in proportions and percentages. The information was then presented in tables, pie charts and bar charts.

4.10. Ethical considerations

4.10.1 Ethical Clearance

The University of the Witwatersrand's Ethical Committee, Makerere University Medical School Ethical Committee, Uganda Science and Technology Research Ethical Committee, the Uganda AIDS Control Programme, City Council of Kampala and The AIDS Support Organization (TASO) gave their respective Ethical Clearances. Wits' ethics clearance protocol number is 03-10-19.

4.10.2 Consent

Informed consent was sought from the participants before the questionnaire was administered. Participants were informed of the voluntary nature of the interview and their right to withdraw freely at anytime from the study if they so wished without any negative consequences. All information was kept confidential and analysis was done on pooled anonymous data.

4.10.3 Confidentiality

The interviews were confined to two rented rooms near the taxi parks and they were one to one interactions and no information was divulged to a third party. No names were used. Serial numbers were allocated to each questionnaire.

4.11 Language

100% of all respondents spoke the local language (Luganda), which the interviewers used in administering the questionnaire. A sample of the questionnaire had been translated into the local language for use during the interviews.

4.12 Dissemination of study results

The findings of the study will be presented to the district authorities through a workshop and to any other forum if given an opportunity. A copy of the report will be given to The Uganda Taxi Operators and Drivers' Association (UTODA).
A copy will also be submitted to The Witwatersrand University School of Public Health and to The Makerere University Institute of Public Health (M.U.I.P.H). The AIDS Support Organization shall also be given a copy of these findings.
Findings of this study will also be presented as articles in different public health journals both locally and internationally where possible.

4.13 Project management

4.13.1 Staffing and work plan

The Uganda Taxi Operators Development Association (UTODA), provided rooms for the two research assistants from where the respondents were interviewed. Each of the respondents received a bottle of soda during the interview session that took approximately 30 minutes each. Each of the research assistants interviewed 10 respondents per day. This was done between 11.00 o'clock and 3.00 o'clock to avoid the peak busy hours of early mornings and evenings.

CHAPTER 5

5.0 RESULTS

There were a total of 400 communal taxi drivers selected for the study but one withdrew his consent during the interview and so the number of participants remained 399. Out of this number three were female drivers. The results of the study are presented below.

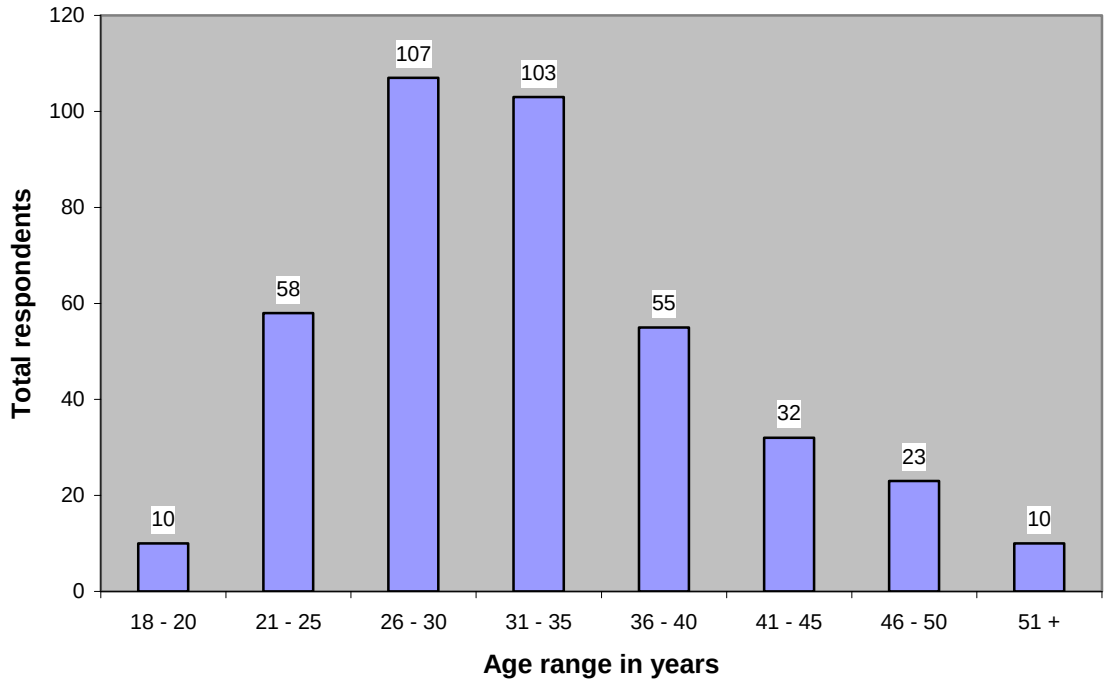
.

5.1 Social demographic characteristics of the respondents

5.1.1 Age of respondents

The following figure shows the age distribution of the respondents in the study.

Figure 1: Age of respondents

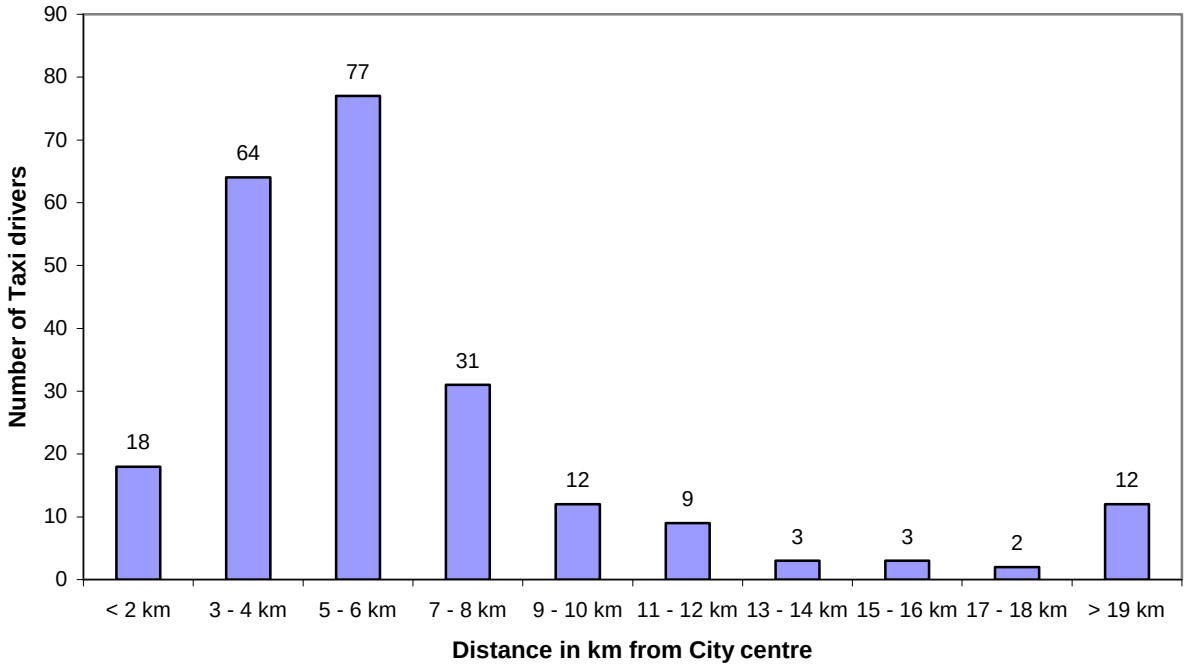


It was noted that most of the respondents (52.8%) were in the age bracket of 21 to 40 years.

5.1.2 Residences of respondents

The following figure, shows the distance in kilometres from the city centre where the respondents reside.

Figure 2: Residences of respondents



The majority of respondents (68.8%) lived within 6 kms of the city centre.

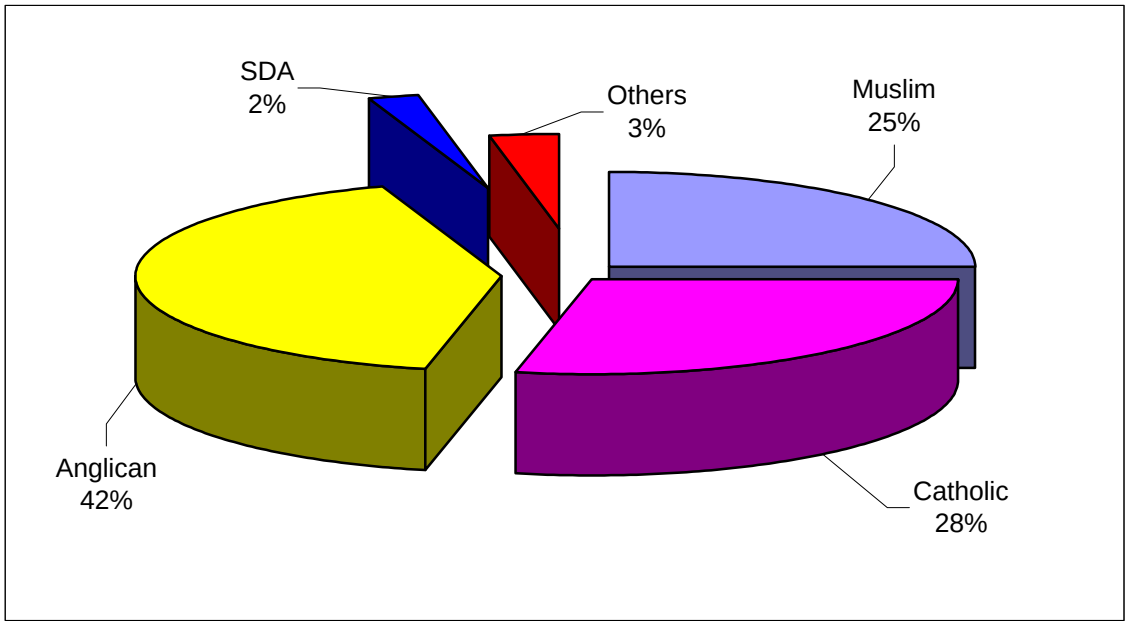
5.1.3 Gender

Among the 399 participants who took part in the study, there were only 3 (0.75%) lady drivers.

5.1.4 Religion of respondents

The following figure shows the religious affiliations of the respondents

Figure 3: Religion of respondents (N=399)



Most of the respondents (42%) were Anglican, 28% Catholics, 25% Muslims, 2% Seventh Day Adventists (SDA) and 3% of other denominations.

5.1.5 Marital status

The following table indicates the marital status of the respondents

Table 1: Marital status

NUMBER OF SPOUSES	FREQUENCY	PERCENTAGE	CUMULATIVE
1	252	78.75	78.75
2	62	19.38	98.13
3	4	1.25	99.38
4	2	0.63	100

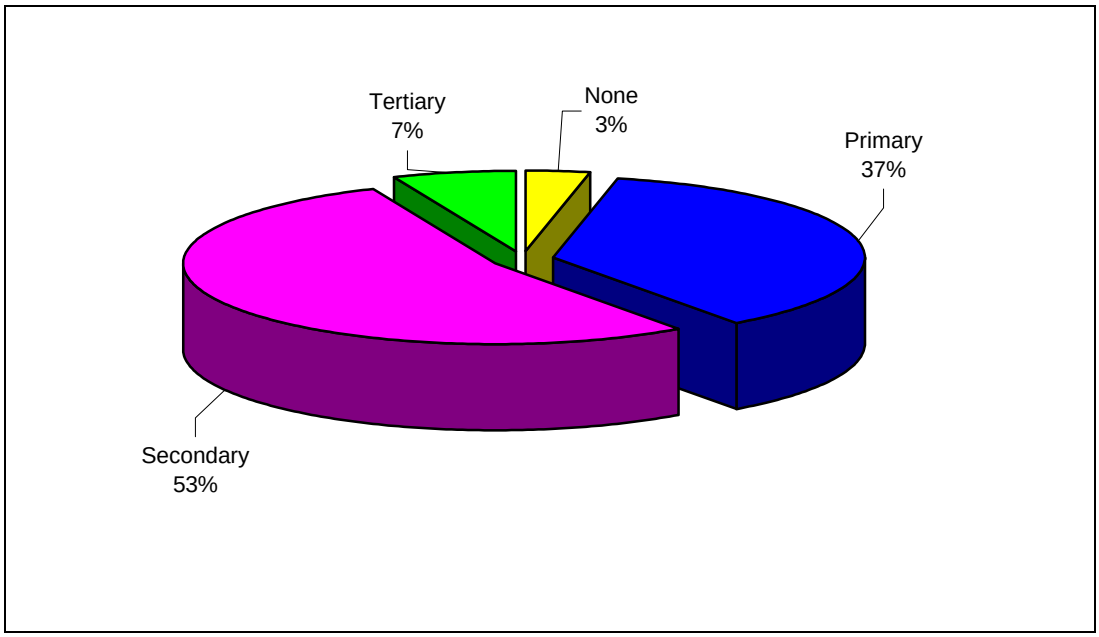
All the respondents were married.

5.1.6: Level of Education

The following figure shows the distribution of respondents by level of education

Figure 4: Level of education of respondents

.



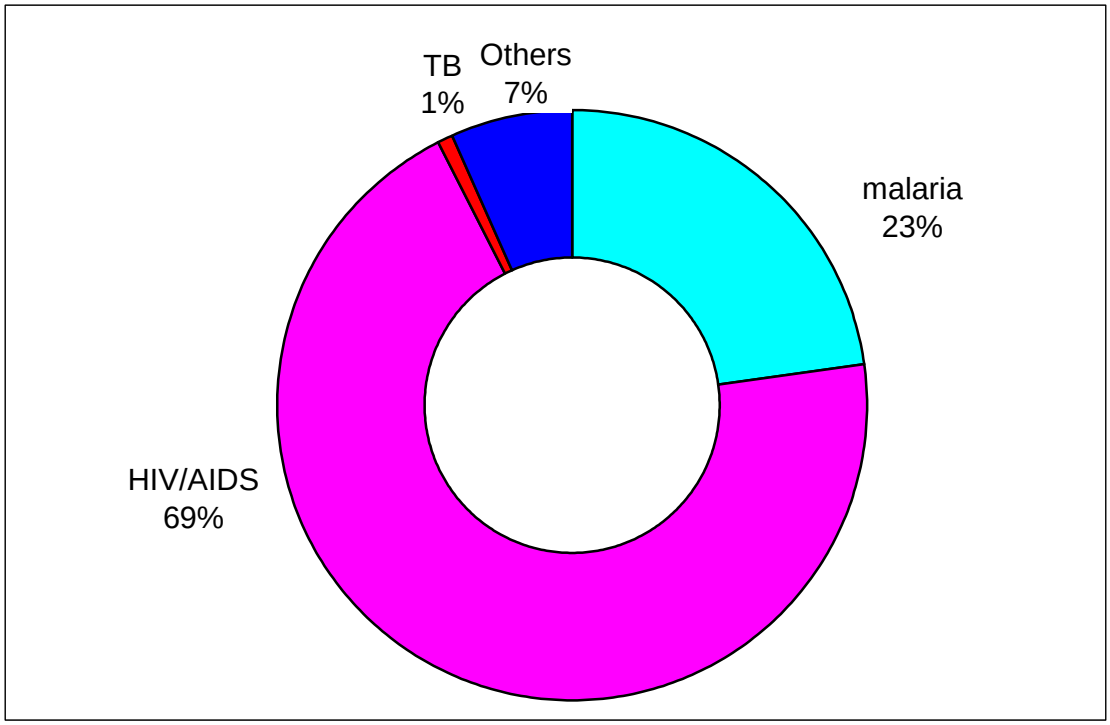
The majority of the Taxi drivers (53%) had attained secondary school level of education**.** A small number (7%) had attained tertiary education while 3% had never gone to school at all.

5.2 Knowledge about HIV and VCT

5.2.1: The current commonest health problem

The taxi drivers interviewed were asked as to what they thought was the commonest health problem/s faced by Uganda. The figure below illustrates this.

Figure 5: The current commonest health problem

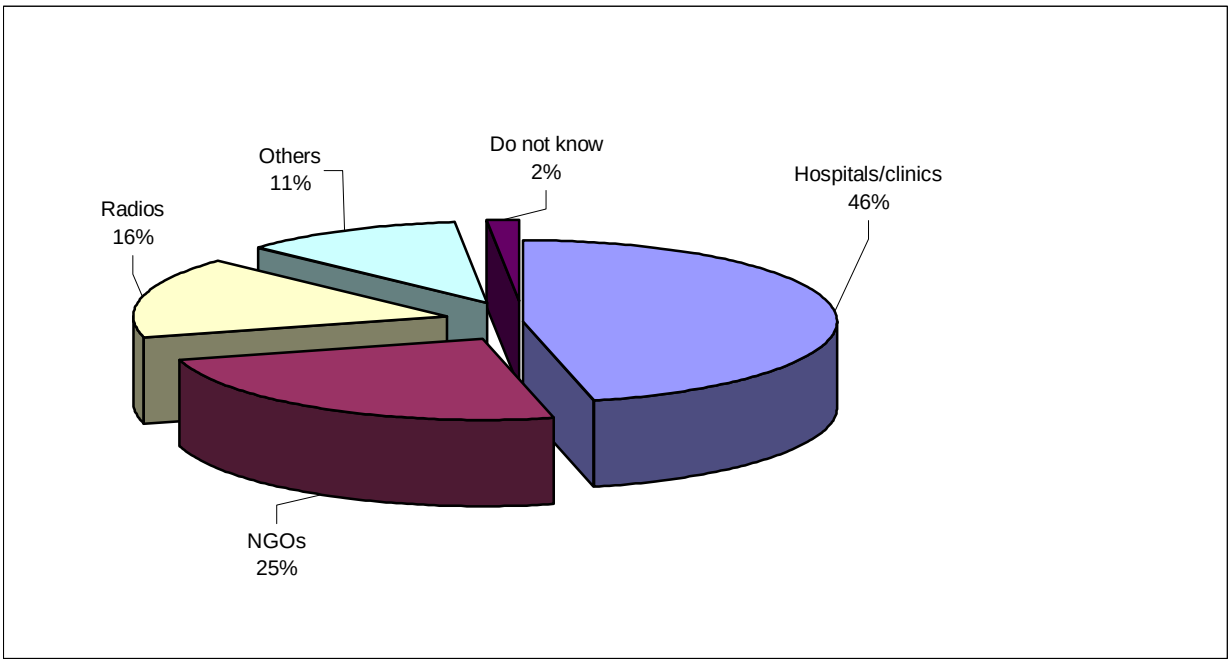


Most of the respondents (69%) thought that HIV/AIDS was the commonest health problem in the country. However, 23% thought it was malaria and 1% mentioned TB. The remaining 7% mentioned other conditions.

5.2.2 The source of information about HIV/AIDS

The taxi drivers interviewed described their sources of information about HIV/AIDS as illustrated in Figure 6 below.

Figure 6: Source of information about HIV/AIDS

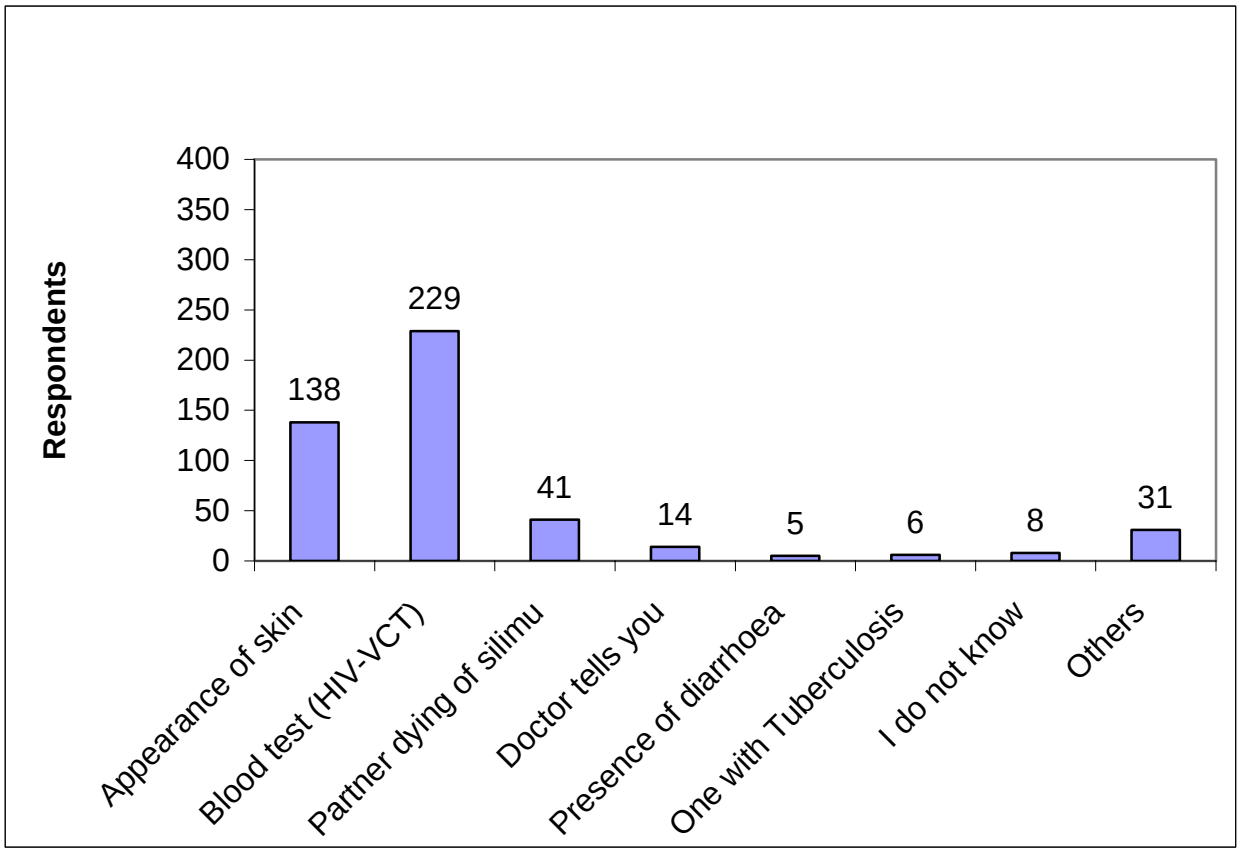


Most of the respondents (46.4%) reported having got information about HIV/AIDS from health institutions, while 25% got it from NGOs. 16% got it from radios, 11% from other sources. The remaining 2% had no idea.

5.2.3 Knowledge of how one would know s/he has HIV/AIDS

Asked how one would know whether one has HIV/AIDS the taxi drivers interviewed responded as illustrated below.

Figure 7: Knowledge of how one would know s/he has HIV/AIDS



Most of the respondents (229) knew that a blood test would provide information on one's serostatus. Another important finding was in relation to appearance of skin of the infected person. A few suggested that the death of a partner from Slim would indicate infection in the other partner.

5.2.4 Knowledge about what HIV/VCT is.

Table 2 describes the proportion of taxi drivers interviewed who knew about HIV/VCT services.

Table 2: Proportion of respondents who have heard bout HIV/VCT (N=397)

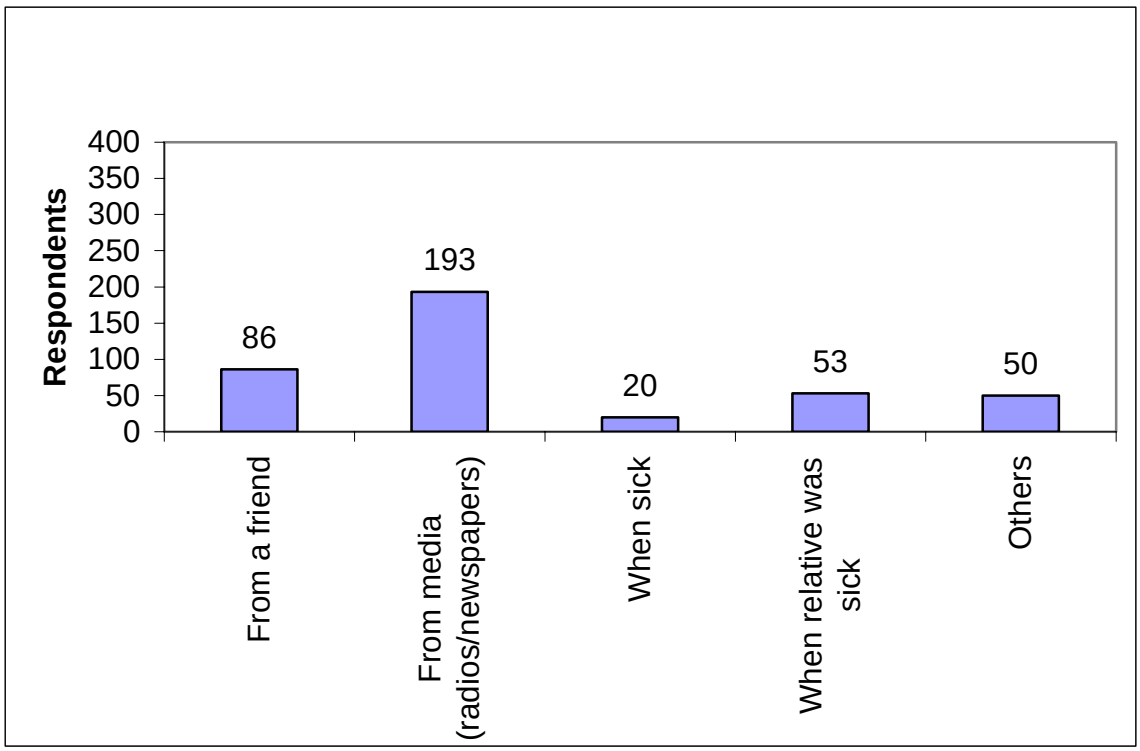
RESPONSE	FREQUENCY	PERCENTAGES
Yes	374	94.20%
No	18	4.50%
I do not know	5	1.30%

The majority of the respondents (94.2%) had heard about HIV/VCT. The rest of the respondents (4.5%) denied having heard about it while 1.3% were not sure.

5.2.5 How the taxi drivers got to know about HIV/VCT

Figure 8 illustrates how taxi drivers that were interviewed got to to know about HIV/VCT services

Figure 8: How the taxi drivers got to know about HIV/VCT



Most of the respondents (48.4%) got to know about HIV/VCT from the media (radios and the newspapers). While 86 of the respondents learnt about it from friends. Others when they were sick themselves or having a relative sick.

5.2.6 Service delivery points known by the respondents

When the taxi drivers were asked whether they knew any HIV/VCT service point their answers are reflected in the table below.

Table 3: Service delivery points known by the respondents

SERVICE DELIVERY POINT	FREQUENCY	PERCENTAGE OF RESPONDENTS
HOSPITAL	188	47.1%
AIC(KISENYI)	133	33.3%
PRIVATE CLINIC	73	18.3%
I DO NOT KNOW	5	1.3%

The majority of the respondents (98.7%) knew at least one place where such services could be got. The remaining 1.3% denied having any knowledge about them.

5.2.7 Accessibility and affordability

The majority (82.2%) confirmed that these places (i.e. where VCT was offered) were accessible. The cost of services was regarded as not expensive by 85.9% of the respondents.

5.2.8 Type of Services offered at these points

The respondents when asked to mentioned some of the services offered at the points they had mentioned, their answers included those in table 4.

Table 4: Type of Services offered at these points

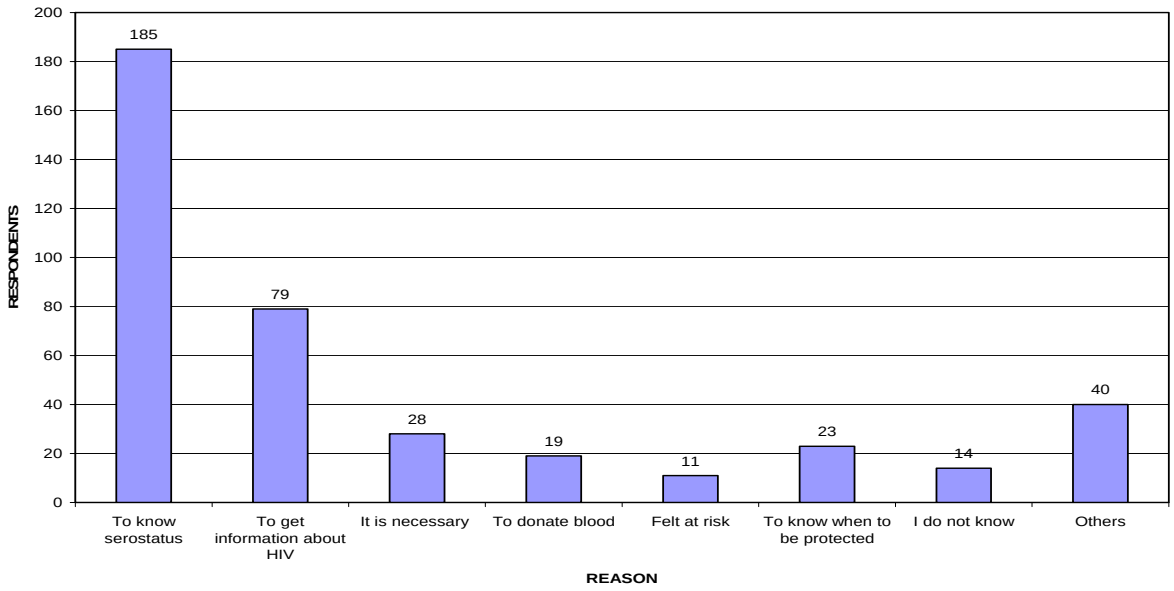
TYPE OF SERVICE	FREQUENCY	PERCENTAGE OF RESPONDENTS
HIV TEST	204	51.1%
TREATMENT	72	18.1%
COUNSELLING	65	16.3%
FOOD SUPPORT	58	14.5%
TOTAL	399	100%

The majority the respondents (51.1%) mentioned checking blood for HIV as one of the services offered at these points. The other services mentioned included treatment (18.1%), counselling (16.3%), and food distribution (14.5%).

5.2.9 Reasons for going to these service delivery points

When asked why one should go to these service delivery points the taxi drivers gave the reasons in figure 9

Figure 9: Reasons for going to these service delivery points



185 respondents preferred to go for HIV VCT at the service points in order to know their sero-status. Other reasons given were to get information about HIV, to donate blood and to get assistance when one felt he/she was at risk of having got HIV.

5.3.0 Reasons for getting a test where one's identity was known

225 of the taxi drivers (56.4%) preferred getting the test at a place where they were known and gave some of the reasons as indicated in table 5 below..

Table 5: Reasons for getting a test where one's identity was known

REASON	FREQUENCY	PERCENTAGE
To get genuine results	117	52%
Easy to get support	98	43.6%
To act as a model	10	4.4%
Total	225	100%

5.3.1 Reasons for not willing to take a test where one is known

102 of the respondents (26.0%) wanted to take the VCT test where they were unknown and gave the reasons below. The remaining 17.6% of the taxi drivers were undecided, as shown in table 6 below.

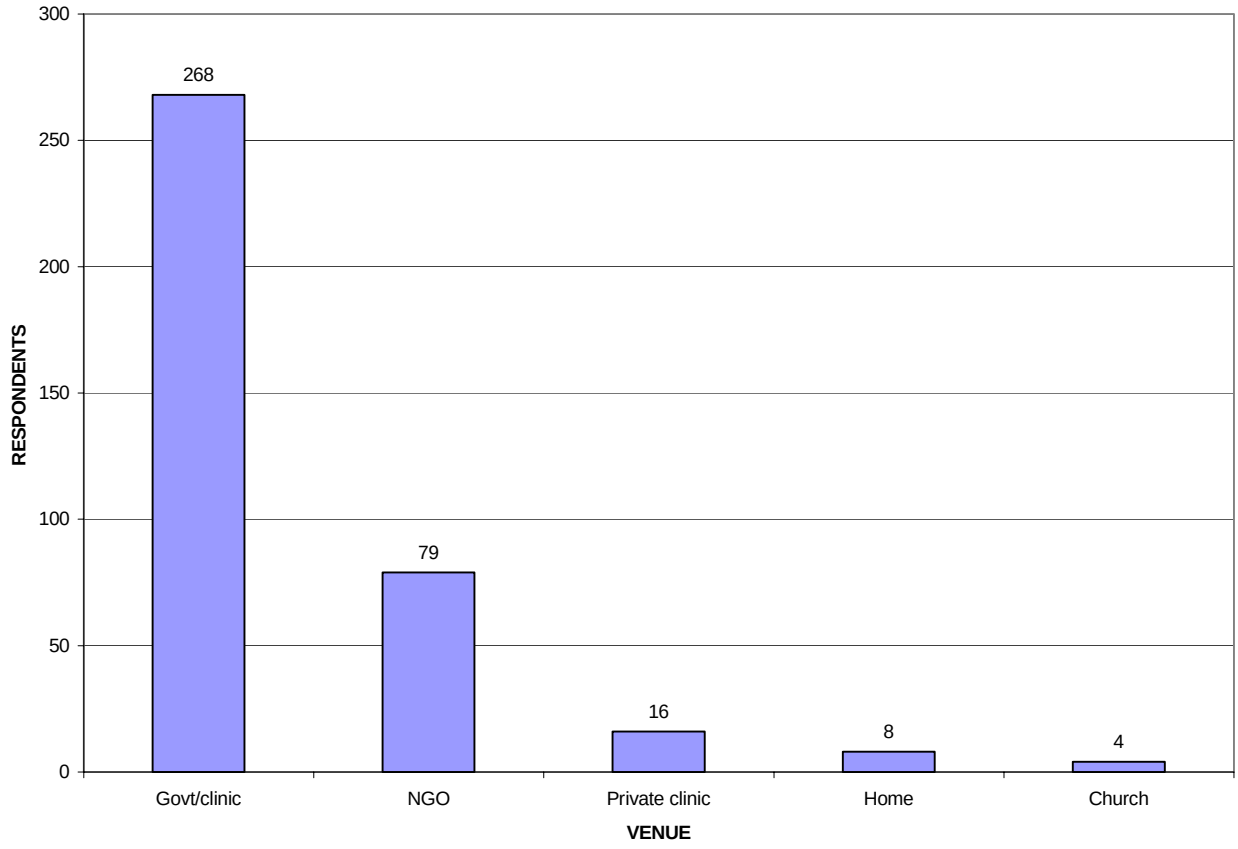
Table 6: Reasons for not willing to take a test where one was known

REASON	FREQUENCY	PERCENTAGE
Confidentiality	60	58.8%
To avoid stigma and discrimination	42	41.2%
Total	102	100%

5.3.2 Service delivery points preferred/suggested by respondents

As illustrated in Figure 10 below the majority (67.2%) of the respondents suggested that the services should be offered in Government Health facilities. However, the rest suggested NGO, private clinics and homes.

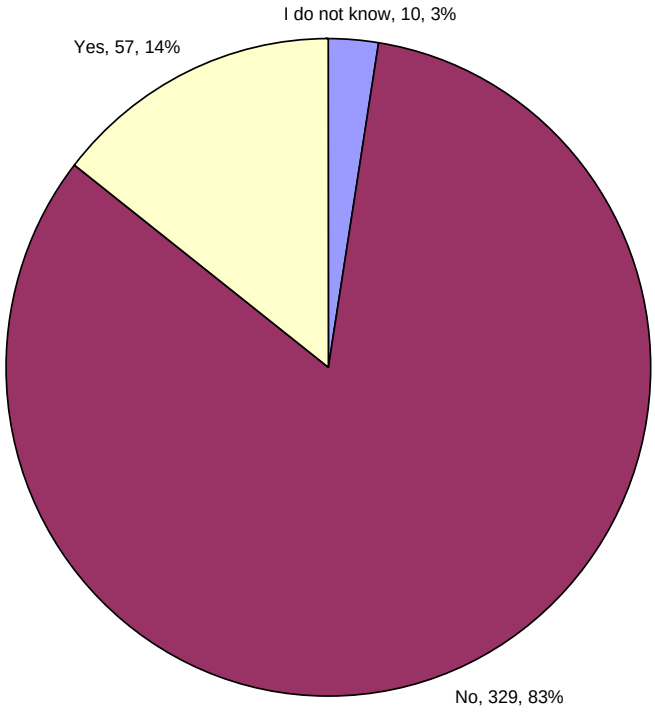
Figure 10: Service delivery points preferred/suggested by respondents



5.3.3 Opinion about public disclosure of one's sero status

Figure 11 illustrates that the majority of the Taxi drivers (329 = 83.1%) objected to the identity of people with HIV infection being announced in public. However, 14% felt that it should be done as a measure of controlling HIV in the country.

Figure 11: Opinion about public disclosure of one's sero status



5.3.4 Reasons against announcing people with positive results publicly

Table 7 contains the reasons given by those who do not support public disclosure of one's serostatus. The majority (76.2%) gave these reasons below against announcing people with positive results publicly.

Table 7: Reasons against announcing people with positive results publicly

REASON	FREQUENCY	PERCENTAGE
To avoid stigmatization and neglect	54	17.8%
To avoid discrimination	96	31.6%
It was not their own wish	38	12.5%
To prevent suicide	18	5.9%
To avoid worries	28	9.2%
It is not good	45	14.8%
It will deter people from going for HIV/VCT	25	8.2%
Total	304	100%

N= 399

5.3.5 Reasons given for wishing to announce them publicly

Table 8 below contains those reasons that are given by the respondents who support the idea of announcing all those with HIV infection publicly. 63.2% think that it could prevent spread of the infection while 33.7% think that it would deter adultery in the society.

Table 8: Reasons given for wishing to announce them publicly

REASON	FREQUENCY	PERCENTAGE
Prevention of spreading the infection	60	63.2%
It deters adultery in the society	32	33.7%
They are not the first to get the infection	03	3.1%
Total	95	100%

N= 399

5.3.6 Frequency of taking the HIV/VCT services

The majority (32.9%) of the Taxi drivers suggested that one should go for the test after every 3 to 6 months depending on the behaviour of the individual, while 28.3% suggested every year, 6.0% felt it should be every after unprotected sex (see Table 9 below).

Table 9: Frequency of taking the HIV/VCT services

SUGGESTED PERIOD	FREQUENCY	PERCENTAGE
After sex without a condom	24	6.0%
Every year	113	28.3%
Whenever one felt unwell	17	4.3%).
As many times as possible	46	11.5%).
Between 3months and 6 months	131	32.9%).

5.3.7 Would you like to go for the HIV/VCT?

The majority (68.3%) were willing to go for the test but only 16.1% had actually taken the test. However 14.6% declined going for a test (see Table 10 below)

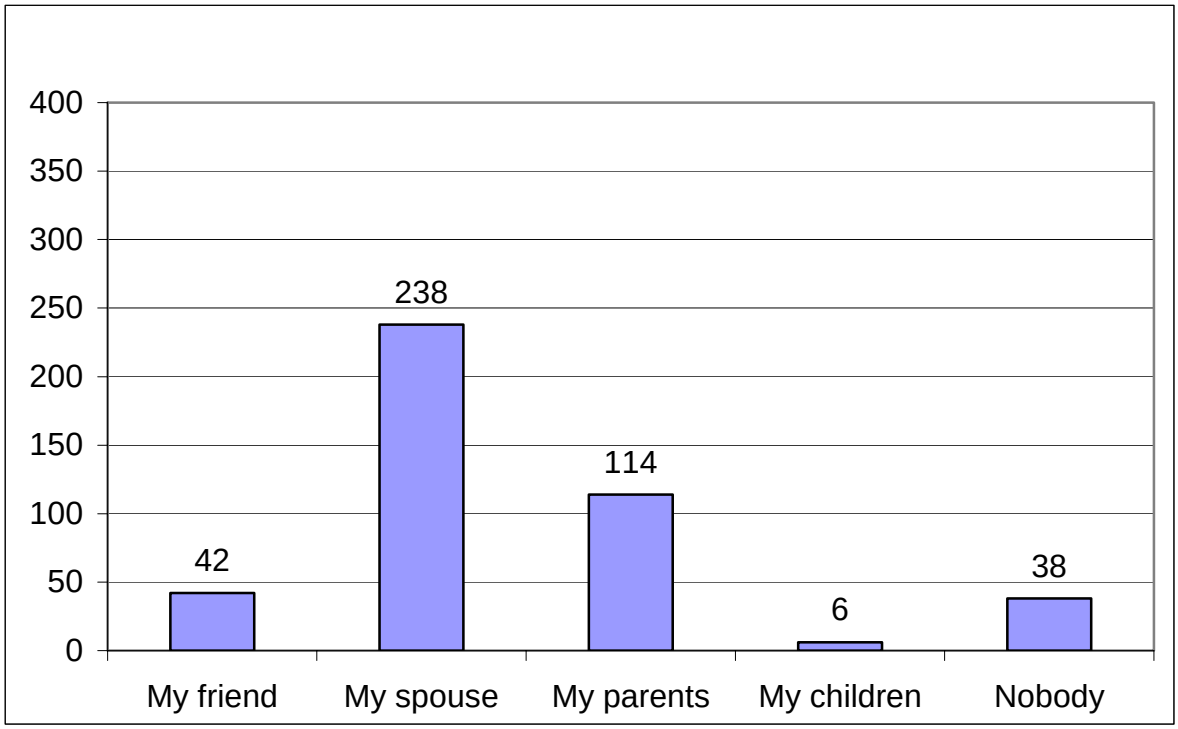
Table 10: Would you like to go for the HIV/VCT?

Response	Frequency	Percentage
I do not know	4	1.0%
I have taken the test	64	16.1%
No	58	14.6%
Yes	271	68.3%
Total	397	100.0%

5.3.8 To whom the participants would disclose their sero-status

Figure 12 indicates that most of the respondents (238 = 59.6%) felt that they should disclose their HIV status to their spouses and yet 28.6% preferred their parents. Some people gave more than one answer.

Figure 12: To whom the participants would disclose their sero-status

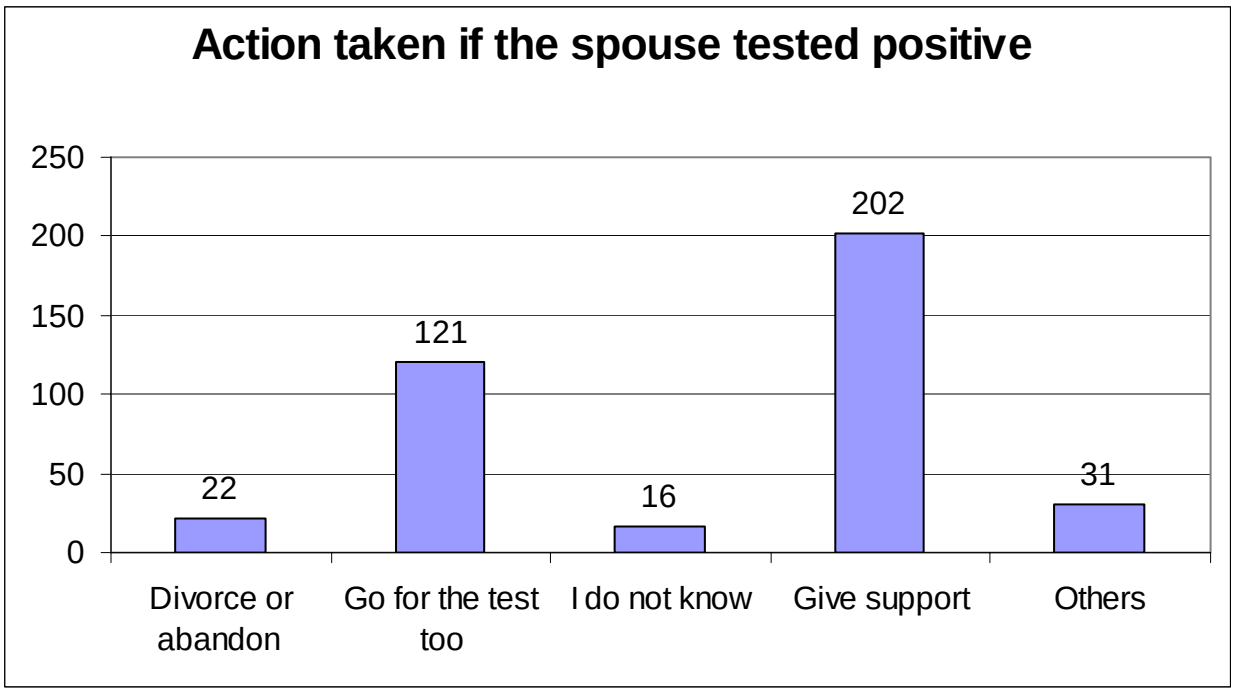


N= 399

5.3.9 What the participants would do if the spouse tested positive

The majority (202) said that they would support their spouses while 30.9% would go for the test to confirm their sero-status. A small number (5.6%) felt that divorce would be the solution (see Figure 13 below).

Figure 13: What the participants would do if the spouse tested positive

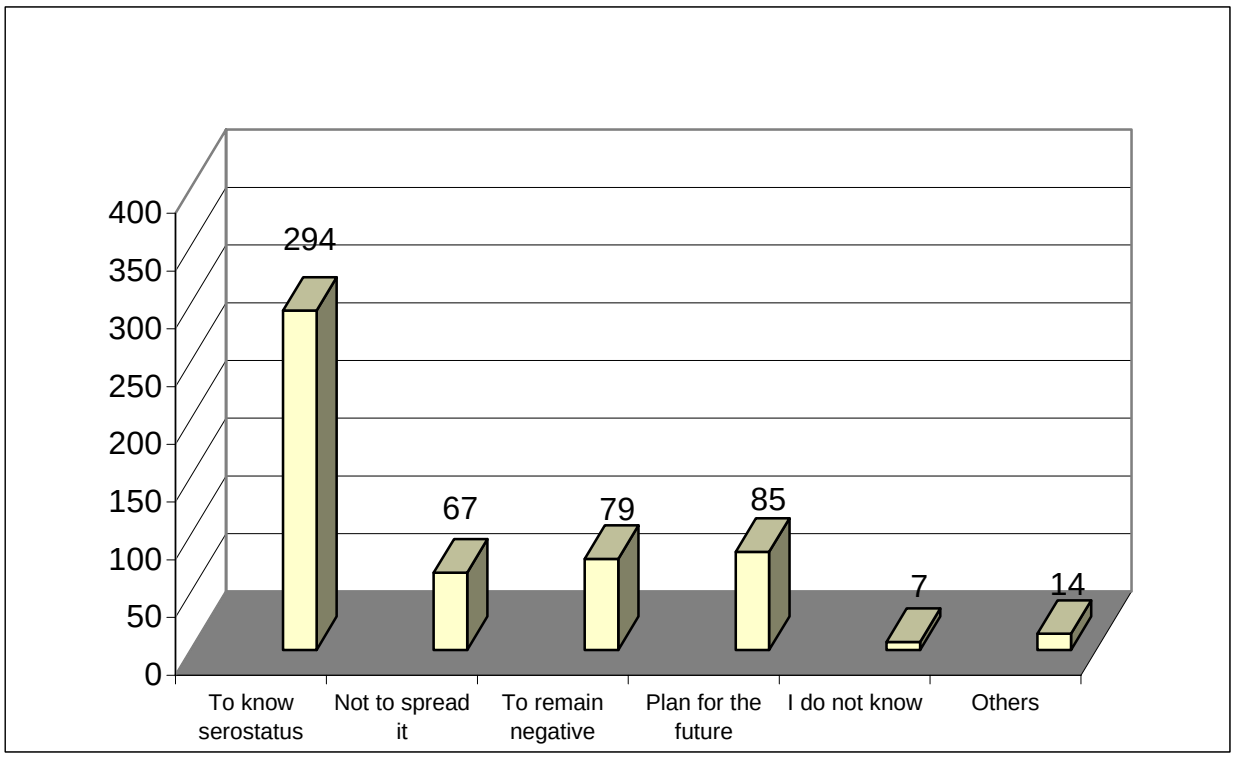


N= 392

5.4.0 Benefits of HIV/VCT

Figure 14 indicates that the respondents (73.7%) gave 'to know one's sero status' as the most important benefit of HIV VCT. Other benefits mentioned included, plan for the future (85), to remain negative (79) and not to spread the infection (67).

Figure 14: Benefits of HIV/VCT



5.4.1 Messages by the respondents to the public.

The taxi drivers interviewed described the messages below in Table 11 as the most important as regards HIV prevention.

Table 11: Messages by the respondents to the public.

Messages	Frequency	Percentage
People should test for HIV in order to know their sero-status	106	26.5
Be faithful and stop adultery	195	48.9
Use condoms	88	22.1
Assorted messages	10	2.5

N = 399

CHAPTER 6

6.0 DISCUSSION

6.1 Factors that influence the taxi drivers in Kampala, Uganda in accessing the HIV VCT services.

6.1.1 Accessibility and affordability

It is clear that affordability and accessibility are important factors in the delivery of services. The VCT services have been reported to be accessible and affordable by most respondents. This is a very significant indicator as these services are more likely to be utilized by this group of people. New studies in Africa show dramatic increases in demand for VCT when the services are made accessible, affordable and secure to those who want to know their HIV sero-status (UNAIDS: 2000).

6.1.2 Types of services offered

The availability of different types of services at a service centre has an influence on the decision of the client to come to that centre. Divulging HIV results may depend on the assurance of social support, treatment and as much as on the effectiveness of the counselling received in relation to learning one's test results (Kaleeba, Kalibala, et al: 1997). In Kampala, most of the HIV VCT centres offer more than one type of service. This is therefore anticipated to encourage more people to seek for services at these points. Given that the majority (82.2%) of the taxi drivers reported that these service centres are accessible, they would be encouraged to go for the HIV/VCT services, supportive counselling and other support services at once. People may go to these delivery centres for a different service not necessarily HIV testing but end up getting information on the need of taking an HIV

test. In this way many of the taxi drivers who are always busy would opt to go to such centres where a variety of services are provided at the same point.

6.1.3 Type of service delivery point.

HIV/VCT services can be offered at government health unit, NGO health unit, private clinics, homes, or any other institutions. The majority (67.2%) of taxi drivers prefer getting this service from the government health units. This is mainly because the government health units in Uganda offer free health services including HIV/VCT. The taxi drivers being among the low income earners prefer to go to such points. In a study by Nyblade et al (2000) it was found that people who had some income were more likely to go for the HIV-VCT services than those who had none.

6.1.4 Being known at a place where services are provided

Where services are provided free of charge, there is always an influx of service seekers and this contributes to long queues of people waiting for the services. Some people therefore would prefer to go to institutions where they can easily be identified by friends and receive the services promptly. Some patients think that people who do not know them might give them sub standard treatment and therefore the taxi drivers express the need to go to the service points where they are sure they will get the best treatment provided by known health workers. With the HIV/VCT services, every one seems to want to get unbiased results. This is one of the reasons why 57.3% of the Taxi drivers preferred getting their HIV test results from the place where they are known. They also think that they can get the necessary support from service providers known to them.

6.1.5 Public disclosure of one's serostatus

HIV carries a lot of stigma. People regard it as a condition associated with adultery and prostitution and these are not acceptable norms in the society. People who would go for the HIV test sometimes postpone the idea because they think the government might decide to pronounce their identities in public. In a study in South Africa VCT was reluctantly taken because of fear of job loss and stigmatization (Ginwalla, Grant et al: 2002). The majority (83.1%) of taxi drivers do not support the idea of public serostatus disclosure while the rest think that public serostatus disclosure could be used as a means to prevent further spread of the infection. Sauka et al (2000) say that confidentiality is a basis for implementing HIV/VCT in any country.

6.1.6 Wanting to know the serostatus

Many people including taxi drivers do not have any signs or symptoms related to HIV infection although they might be already infected. With increasing demands for one to know his or her serostatus, people are bound to find out where such services are offered. There is a natural drive for an increasing number of people seeking for the HIV/VCT services wherever they can be offered and this is confirmed by this study.

6.2 The level of knowledge about HIV VCT services amongst taxi drivers

6.2.1 Current commonest health problem

HIV was mentioned by 69% of the taxi drivers as being the current commonest health problem in the country. It has no cure and the number is increasing through unprotected sexual relationships. The infection does not carry any specific signs in a person who is asymptomatic. The undisciplined patients, who have been started

on ARVs drugs, will continue to spread through unprotected sex. There is no home or family that hasn't lost a relative or friend because of HIV infection The latest figure from the National HIV sero surveillance report in Uganda, shows a prevalence rate of 8% with a total estimated number of 820,000 people infected with HIV and as much as 110,000 Ugandan dead from it (USAID/CDC: 2003). Since the taxi drivers are part of this community, they are bound to know the commonest health problem in the country. They meet many people, transport people to hospital and assist with transport for funerals.

6.2.2 Source of information about HIV/AIDS

Information about health issues is disseminated to the public at places where health services are provided. NGOs like TASO, with health related programmes also play a role in the information dissemination. The majority (46%) of the taxi drivers mentioned the hospitals and clinics as being the source of the information about HIV/AIDS. Public Health services spend a huge amount of resources on education about HIV/AIDS in Uganda. This often happens at health service points. The service points include antenatal care, under five, outpatients, inpatients and outreaches to the communities and at such points HIV/VCT services are also provided. In order for one to know his/her serostatus, an HIV test has to be done.

6.2.3 Knowledge of how one would know s/he has HIV/AIDS

HIV testing is important in those who are still asymptomatic but with time as one starts to develop AIDS related symptoms one can be diagnosed on clinical grounds of signs and symptoms (Isselbacher, Martin, Braunward: 1996). The majority (229 = 67%) of the taxi drivers mentioned HIV/VCT service as the best way that would provide information about one's serostatus.

6.2.4 Motivation for seeking HIV/VCT service

Deciding to take a test has a lot of bearing on individuals and what the test is planned for. The result one gets has to be of value to make a decision in one's life. Only 64 (16.1%) of the taxi drivers had taken the test while the majority had not because of fear of the outcome. People who are willing to take the test are either sick, have low risk behaviour or have an activity that requires of them to take the test (McOwan, Gilleece, et al: 2002).

6.3 Study limitations

The following were some of the limitations of the study

6.3.1. Information bias

The drivers who completed the interview earlier might have pre-empted the content of the questionnaire to those who had not been interviewed thus influencing the answers to the questionnaire. The participants were requested not to divulge the questions to those who had not taken the interview and this might have minimized this bias.

6.3.2. Respondent bias - the respondent might have decided to give false information. This was handled by assuring them of confidential handling of all the information that they were to provide. The questionnaire did not bear any name apart from the serial number.

6.3.3. Recall bias – this was also minimized by the simplicity of the questionnaire whereby daily issues were asked, however, where there was a problem; probing skills were used to get the information needed.

6.3.4. Selection bias – the taxi drivers in Kampala were more advantaged to getting current information and thus more enlightened than others in various parts of the country. However, this is the population that we had targeted to study.

CHAPTER 7

7.0 CONCLUSIONS

It has been established that most of the taxi drivers are in the age bracket in which the HIV scourge is dominant, and know that HIV/AIDS is the commonest health problem in the country. The majority of the taxi drivers dwell within the suburbs of the city. This has a bearing to their knowledge level of HIV/VCT. Information spreads much faster within the city and it is discussed in communal taxis by friends and the more informed city commuters.

The majority of the taxi drivers know that the blood test provides the information about one's serostatus. They also know some of the places where HIV/VCT services are provided. The HIV/VCT services are accessible to and affordable by the taxi drivers but the fear to receive the unexpected results and the consequences of having positive results hinders the taxi drivers from seeking the VCT services.

The majority preferred to go to service points where they were known and this could have hindered their access to the services if they never identified suitable service points to go to.

All the taxi drivers who were interviewed are married. Their knowledge about HIV/VCT services lie within the overall range of knowledge of the population in urban Uganda.

The majority of taxi drivers do not support public disclosure of identity of people with HIV because it leads to stigma, discrimination, stress and neglect. This created fear among many taxi drivers and could deter them going for HIV/VCT services.

CHAPTER 8

8.0 RECOMMENDATIONS

HIV/VCT service points should be established in the city for these taxi drivers to access these services easier and comfortably. Programmes such as peer counselling amongst taxi drivers that fit into this age bracket to handle HIV issue should be planned and supported by both government and NGOs such as TASO. Taxi drivers should be trained in HIV preventive strategies and be utilized to deliver HIV/AIDS related information by use of radio cassettes and other Iinformation Education and Communication materials. The taxi drivers should be used to distribute these to the commuters.

The government and other organizations that provide care services in the field of HIV such as TASO should organize sensitization seminars for taxi drivers. Issues aimed at allaying their anxiety of fearing to receive positive results should then be addressed.

There is the need to intensify counselling services for the taxi drivers by establishing counselling centres close to the two taxi parks. Support services for the people who test positive should be well spelt out at such VCT service points so that those who need these services access them accordingly. TASO provides such services as counselling, opportunistic infection management, provision of ARVs, social support that include food, school fees and income generating activities but the service points are far from these two taxi parks. TASO will be urged to take up this challenge!

Since all taxi drivers are likely to be married, they should be encouraged to access HIV/VCT as well as PMTCT services in order to curb HIV infection in their new borns as well as prepare the adults for ART.

HIV/VCT service centres should be integrated with other health services so that people who seek either of the services can gain from both. This will encourage more taxi drivers to come to these centres. More centres such as the Naguru health centre and AIDS Information Centre (AIC) that have specialized clinics to handle special categories of people should be duplicated in other health institutions within the city to motivate taxi drivers access HIV/VCT services at such special points..

Public disclosure should be discouraged in order to encourage more people in seeking for the VCT services without fear. Individuals should be encouraged to disclose their serostatus themselves. However, sensitization about the HIV spread or re-infection should be intensified. One of the core activities of TASO is to counsel people infected with HIV and its services are offered in 11 centres spread out countrywide.

CHAPTER 9

9.0 ANNEXES

9.1 Annexure 1

Letter of Introduction and requesting permission from the City Council

The Chief Executive Officer

The City Council of Kampala

(TASO)

Kampala

Uganda.

The AIDS Support Organization

P. O. box 10443,

Kampala, Uganda.

24th January 2004

Dear Sir/Madam,

Ref: A request to conduct a study into the level of knowledge about Voluntary Counselling and Testing amongst taxi drivers in Kampala by Dr. A.B. Kizito

Dr. Kizito is a postgraduate student in the Master of Public Health Programme at the Witwatersrand University, S. Africa. He would like to carry out a study in the taxi drivers concerning their level of knowledge about Voluntary Counselling and Testing. He would like to carry out this study between March and May 2004 in order to present his findings by July 2004.

The Uganda Science and Technology Research Ethical Committee and the Ministry of Health have approved the research proposal. The protocol and other relevant documents concerning the study are available for review.

Your assistance will be of great help to him in the accomplishment of the study.

Yours sincerely,

The Chief Executive Officer

The AIDS Support Organization

9. 2 Annexure 2

Letter granting Permission

The City Council of Kampala
City Taxi Operators Department
Kampala.
Uganda
4th July 2004

To: Dr. Assisi-Franklin B. Kizito
P. O. Box 10443
Kampala, Uganda
Dear Sir/Madam,

Ref.: A Study to involve taxi drivers in establishing their level of knowledge about Voluntary Counselling and Testing.

The City Council of Kampala – City Taxi Operators Department, has accepted your request to carry out the study. The department will expect you to submit the final copy of your report at the completion of the study.
The department will inform the people concerned about you and the study. UTODA will provide you with two rooms, one in the new park and another in the old park in which to conduct your interviews. For any assistance please don't hesitate to contact us.
Yours sincerely,

Chairman
The City Taxi Operators
City Council of Kampala
Uganda.

9. 3 Annexure 3

Information sheet

TASO (U) LTD.

P.O. Box 10443

Kampala, Uganda

Contact Person: Dr. AFB Kizito

Tel. 077587620

Dear volunteer,

We are from TASO and are trying to carry out a study to find out the level of knowledge in taxi drivers as regards to the HIV/AIDS (“Slim Disease”) and the related test taken to ascertain the serostatus in order to implement preventive mechanism. You are part of the general population that is sexually active in the normal sense of sexuality and health. We would appreciate if you could accept to be interviewed for about 20 minutes using an anonymous questionnaire. There will be no names or use of any of your identification documents. Confidentiality will be observed by having the interview conducted in a private room and only two people – you and the interviewer – will be present. The information you will volunteer will be kept secret and be used specifically to improve the VCT services and thus prevention of HIV/AIDS transmission in this country. The study has been cleared by, The Uganda Science and Technology Research Ethical Committee and the Ministry of Health.

It is your right to decide whether or not you volunteer to take part in this study. You have the right to withdraw from the study at any time without giving any reason. There is no monetary or any kind of reward that will be offered for participating in the study.

Please sign the attached consent form that will show that you have accepted to participate in the study. You are free to ask for any clarification on the study from my colleagues and me Dr. A.F.Kizito, directly or use the following office Tel. 041 567 637 or 077 587 620 or come to our office at Mulago.

Date ……. Interviewer …….

9. 4 Annexure 4

Consent form

Statement by the Participant concerning participation in the research.

I have been informed about the objectives of the proposed study and have been allowed to get clarifications by asking questions. There has been enough time to think about the study. I have not been pressured or lured into the study by the interviewer or other participants. The decision to participate in the study is entirely mine. I am free to withdraw my consent anytime.
I also understand that the study has been sanctioned by the City Council and the Taxi Operators department and that confidentiality, respect and privacy are guaranteed during the study.

Name of Participant: ……
Date ……. Signature/Thumbprint …….

Name of Researcher: ……..
Date ……. Signature ……

Name of Witness ……
Date ……. Signature ……..

INFORMATION SHEET (ANNEXURE 3)

This was written in a local language, used by the majority of the taxi drivers and interpreted so that each participant understood and willingly used it to consent.
CONSENT FORM (ANNEXURE 4)
This was written in a local language used by the majority of the taxi drivers and included a name of a witness who was present when the driver gave the consent.

9.5. Annexure 5

The questionnaire was completed by the researcher assistants.

Questionnaire for the Study of level of knowledge about VCT amongst taxi drivers in the city of Kampala, Uganda.

Participant Study Number: ☐ ☐ ☐

Tick all answers of respondent (let her/him to respond to the question).

Demographic information:

1. Age: ☐☐

2. Sex: Male ☐ Female ☐

3. Religion: Muslim ☐ Catholic ☐ Anglican ☐ SDA ☐ Others ☐

4. Place of residence: Distance in kilometres ☐ ☐ ☐

Specify village/location ----------

5. Level of Education: None ☐ Primary ☐ Secondary ☐ Tertiary ☐

(specify level) ----------

6. Marital Status: Single ☐ Married ☐ Divorced ☐ Widower ☐

7. If married: Number of spouses 1 ☐ 2 ☐ 3 ☐ 4 ☐ others ☐

8. If not married: Number of sexual Partners: None ☐ 1 ☐ 2 ☐ 3 ☐ others ☐

9. Do you have children? Yes ☐ No ☐ I don't know ☐

10. Number of years as a driver: ☐☐

Knowledge

11. What do you think is the current health problems in the community?

1. "Slim" ☐ 2. Malaria ☐ 3. T.B ☐ 4. Diarrhoea ☐

5. Any other (specify) …….

12. Where do people get information about "Slim"

1. Hospital/clinics ☐

2. Non-government organizations ☐

3. Radios ☐

4. Any other avenue (mentioned) ☐

13. How can one know that he/she is having "Slim"?

The appearance (wasting and the skin manifestations) ☐

To test the blood ☐

If the partner died of "Slim" ☐

I do not know ☐

The doctors will tell you ☐

When one has Diarrhoea ☐

When one has TB ☐

Others (specify)……. ☐

14. Have you heard about Voluntary Testing and Counselling is?

1. Yes ☐ 2. No ☐ 3. I don't know ☐

15. If yes, how did you come to know about Voluntary Testing and Counselling?

From a friend ☐

From the media/radio/newspaper ☐

When I was sick ☐

When a relative was sick ☐

Others ☐

16. Can you name the places where this service is offered?

1. Hospitals ☐ 2. Private clinics ☐ 3. AIC (Kisenyi) ☐

4. I do not know ☐

17. How accessible are these places you have mentioned?

1. Very accessible ☐ 2. Accessible ☐ 3. Not accessible ☐

4. I don't know ☐

18. How expensive is the test at these places mentioned above?

1. Very expensive. ☐ 2. Expensive. ☐ 3. Not Expensive ☐

4. I don't know ☐

19. What activities do take place at such places?

1. Checking on the blood for the HIV ☐ 2. Counselling ☐ 3. I don't know ☐

20. Which of the activities mentioned would you choose to undergo?

1. Counselling only ☐ 2. Counselling and Testing ☐ 3. I don't know ☐

4. Reason why you choose that ……. ☐

21. Would you like to take the test at a place where you are known?

1. Yes ☐ 2. No ☐ 3. I don't know ☐

4. Reason for the answer above …… ☐

22. What would be the best place where HIV-VCT services be offered?

1. Home ☐ 2. Hospital/clinic (government) ☐ 3. Church ☐

4. Private clinics ☐ 5. Non-government organizations ☐

23. Should people with positive results be announced publicly in order to warn the public?

1. Yes ☐ 2. No ☐ 3. I don't know ☐

4. Reason for the answer ……☐

24. How often should this test be taken?

After sex without a condom ☐

Every year ☐

Whenever you feel unwell ☐

As many times as possible ☐

Any other answer (specify) ……. ☐

25. How should confidentiality about the counselling and testing be maintained?

Use counsellors who are not know to you ☐

Mature people should provide the service ☐

Use private rooms for the services ☐

Any other (specify) …….. ☐

26. If you went for the test, whom would you like to counsel you?

1. Male counsellor ☐ 2. Female counsellor ☐ 3. I don't mind either ☐

27. What should one do after taking the test?

If positive

…….

…….

If negative

……..

…….

28. Would you like to take this test?

1. Yes ☐ 2. No ☐ 3. I do not know ☐

4. I have already taken it ☐

If the answer is 1, then go to question 31 and continue

If the answer is 2, then go to question 29 and skip to 31 and continue

If the answer is 3, then go to question 29 and skip 30 and continue

If the answer is 4, then go to question 30 and continue

29. If the answer is No, Can you give reasons why you do not want to take the test?

---

30. You said you took the test, why did you take the test?

---

31. If you took (or already taken) the test, whom, would you reveal the results to?

My friend(s) ☐

My spouse(s) ☐

My parent(s) (mother), (father) ☐

My child(ren) ☐

Nobody ☐

32. If your spouse/sexual partner took the test and then told you that she/he was positive, what would you do?

Divorce/abandon her ☐

Support her ☐

Go for the test too ☐

I don't know ☐

Others (specify)…… ☐

33. What are the benefits of voluntary counselling and testing?

To know whether one is infected or not ☐

If negative to remain negative by use of safe sex ☐

If positive not to spread it to others ☐

To plan for the future (will making, plan for the children) ☐

People who are positive become role models in the community ☐

I don't know ☐

Any other mentioned (specify) …… ☐

34. What are the disadvantages of HIV-VCT?

Those who know are positive can further spread the infection ☐

Suicidal tendencies will increase ☐

Mental illness will increase ☐

☐

Break-up of marriages and families

Discrimination, stigmatization and rejection in public places ☐

35. What suggestions can you make to stem the spread of “Slim” in Uganda?

_____

_____

_____

_____

Thank you for your participation.

NOTE: This questionnaire will be administered in the local language, which is Luganda.

CHAPTER 10

10.0 REFERENCES-

Akpede, G. O., R. S. Lawal, and S. O. Momoh: 2002. Perception of Voluntary Screening for Paediatric HIV and response to post-test counselling by Nigerian parents: AIDS Care, Vol. 14, No. 5. pp. 683 – 697.

de Graaf, R., I. Vanwesenbeeck, G. van Zessen, C. J. Straver and J. H. Visser: 1995. Alcohol and drug use in heterosexual and homosexual prostitutions, and its relation to protection behaviour: AIDS Care, vol. 7 No. 1, pp. 35 – 47.

Editorial: 1991. Men's responsibility and partnership in the prevention of AIDS. AIDS Health Promotion: Exchange, Number 4,. World Health Organization, Global Programme on AIDS

Fernández, M. I., T. Perrino, S. Royal, D. Ghany, and G. S. Bowen: 2002. To test or not test: are Hispanic men at highest risk for HIV by getting tested? AIDS Care Vol. 14, No. 3, pp. 375 – 384.

Ginwalla, . S. K., A. D. grant, J. H. Day, T. W. Dlova, S. Macintyre, R. Baggaley, et al: 2002. Use of UNAIDS tools to evaluate HIV voluntary Counselling and Testing Services for mineworkers in S. Africa: AIDS Care, Vol. 14, No. 5, pages 707 – 726.

Gysels, M., R. Pool, and Bwanika: 2001. Truck drivers, middlemen and commercial sex workers: AIDS and the mediation of sex in South West Uganda: AIDS Care, Vol. 13, no. 3. pp. 373 – 385.

Kaleeba, N., S. Kalibala, M. Kaseje, P. Ssebbanja, S. Anderson, E. Katabira et al: 1997. Participatory evaluation of Counselling, medical and social services of The AIDS Support organization (TASO), Uganda: AIDS Care Vol. 9. No. 1, pp. 13 – 26.

Katabira Elly, Moses R. Kamya, Francis X. Mubiru and Nathan N. Bakyaita: 2000. *HIV Infection: Diagnostic and Treatment Strategies for Health Workers,* Second Edition, pp. 4 – 5.

Killewo, J. Z. J., G. Kwesigabo, C. Comoro, J. Lugalla, F.S. Mahalu, G. Biberfeld, et al: 1998. Acceptability of Voluntary HIV testing with counselling in a rural village in Kagera, Tanzania: AIDS Care Vol. 10, No. 4, pp. 431 – 439.

Kirunga C. T, Ntozi, and James P.M.: 1997; Socio-economic determinants of HIV serostatus: a study of Rakai District, Uganda.(eprints.anu.edu.au/archive/00000483/00/Kirunga1.pdf).

Kipp, W., G. Kabagambe, and J. Konde-Lule: 2002. HIV counselling and testing in rural Uganda: Communities' altitudes and perceptions towards an HIV counselling and testing programmes: AIDS Care, Vol. 14, No. 5, pp. 699 – 706.

Kish and Leslie: 1965. Survey Sampling. John Wiley and sons, NY

Kurt J. Isselbacher, Joseph B. Martin, Eugene Braunward, Anthony S. Fauci, Jean D. Wilson, and Denis L. Kasper: 1996. *Harrison's Principles of Internal Medicine,* Vol. 2 – International Edition, pp.1584 – 1585

Lee, D., D.C. Bell and M. Hinojosa: 2002. Drug use, travel and HIV risk: AIDS Care vol. 14 No. 4.

Marcus A. Krupp, Milton J. Chatton, Lawrence M. Tierney JR. et al: 1986. *Current Medical diagnosis and treatment*: Lange Medical Publications, pp. 87.

McOwan, A., Y. Gilleece, L. Chislett, and S. Mandalia: 2002. Can targeted HIV testing Campaigns alter health – seeking behaviour? AIDS Care,Vol. 14 No. 3, pp. 385 – 390.

Moseu, D.M., N.S. Wenger, M. F. Shapiro, R.M. Andersen, and W. E. Cunningham: 1998. Is access to medical care associated with receipt of HIV testing and counselling?: AIDS Care Vol. 10 No. 5, pages 617 – 628.

Müller, O., S. Sarangbin, K. Ruxrungthan, W. Sittitrai, and Phanuphak: 1995. Sexual risk behaviour reduction associated with voluntary HIV counselling and testing in HIV infected patients in Thailand: AIDS Care Vol. 7. No. 2 pp 567 – 572.

Nyblade, L., R. Gray, F. Makumbi, T. Lutalo, J. Menken, N. Ssewankambo, et al: 2000 HIV risk characteristics and participation in Voluntary Counselling and testing in rural Rakai District, Uganda

Opio, . A. A., G. Asiimwe-Okiror, J. Musinguzi, and E. Madraa: 1996. A review of AIDS Prevention and control activities in Uganda.

Phillips, K. A., and T. J. Coates: 1995. HIV Counselling and Testing research and policy issue: AIDS Care Vol. 7 No. 2,.

Pickering, H., M. Okongo, B. Nnalusiba, K. Bwanika and J. Whitworth: 1997. Sexual Networks in Uganda: Casual and Commercial sex in a trading town. AIDS Care, Vol. 9 Number 2, pages 199 – 207.

Sauhami, R. L., and J. Maxham: 1994. *Textbook of Clinical Medicine*, Livingstone , 2nd Edition, pp.243, and 3rd Edition pp. 367.

Sauka, M., and G. T. Lie: 2000. Confidentiality and disclosure of HIV infection: HIV – positive persons' experience with HIV testing and coping with HIV infection in Latvia.

Tavatchi Traitongyoo: 1991. Thailand: taxi drivers deliver the message. AIDS Health Promotion: Exchange, Number 4 World Health Organization, Global Programme on AIDS

UNAIDS: 2002. Fact sheet : HIV in Sub Saharan Africa.

UNAIDS: 2000. Fact Sheet : Voluntary HIV/AIDS Counselling and Testing. Many Africans do want to know:

USAID/CDC: 2003. Global AIDS Programme Fact Sheet: HIV/AIDS situation in Uganda.