

Barriers to Voluntary Counselling and Testing (VCT)

By

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ABSTRACT

It has been estimated that one in five people who are infected with HIV in South Africa know their status. There is widespread concern that the uptake of VCT throughout the country is too low and ways of encouraging people to come forward voluntarily are continually explored. The low VCT uptake by individuals brings the question: *Why do people who know that they are at risk of HIV infection not voluntarily present themselves for counselling, HIV-testing and referral?*

The purpose of this study was to investigate the barriers to voluntary counselling and testing for HIV and AIDS. The overall aim of the study was to examine the relationship between VCT knowledge, perceived social stigma, and VCT uptake. This was a quantitative study. A sample of 30 male and 258 female respondents participated in the study. A questionnaire was used to collect data from respondents. The questionnaire consisted of four sections, namely background information, VCT knowledge scale, attitudes towards VCT and HIV and AIDS scale, and perceived social stigma scale.

It was found that most respondents who had never used VCT services before had low levels of VCT knowledge and negative attitudes towards VCT, HIV, and AIDS. The levels of perceived social stigma were low among the respondents who had never used VCT services before. This showed that individuals who did not know their HIV status believed that their community held less stigmatising beliefs about people living with HIV and AIDS.

The results from this study show that there is a need for a trusting relationship to be developed between the clients and health care workers. This could be done through training health care workers about proper counselling and developing communication skills with the clients. There is also a need for VCT communication campaigns that will give information about what the VCT process entails so that individuals who have not used VCT before would have a clearer understanding of the VCT process. Information about benefits of HIV testing need to be highlighted, in order to persuade those who have not been tested to seriously consider presenting themselves for VCT.

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LIST OF ABBREVIATIONS

AIDS

Acquired Immuno-Deficiency Syndrome

ART

Antiretroviral Therapy

ARV'S

Antiretrovirals

HIV

Human Immuno Virus

HSRC

Human Sciences Research Council

TPA

Theory of Planned Action

TRA

Theory of Reasoned Action

UNAIDS

The Joint United Nations Programme on AIDS

USAID

United state Agency for International Development

VCT

Voluntary Counselling and Testing

CHAPTER 1

MOTIVATION, AIMS AND OVERVIEW

1.1 Introduction

HIV and AIDS affect many people in South Africa. The statistics show that between 11% and 20% of South African adults are HIV positive, 420 000 children have been orphaned by AIDS, and 1500 new infections occur every day (Kalichman & Simbayi, 2003). The South African government has established more than 450 VCT centres with more than 800 counsellors around the country. VCT is a strategy used by the government to prevent the spread of HIV and to provide care and support to those living with HIV and AIDS. By allowing people to learn their HIV status and be counselled about its implications, VCT may help to curb the further spread of HIV (UNAIDS, 2001). Research conducted in developing and developed countries has shown that VCT can reduce high risk sexual practices and decrease rates of sexually transmitted infection.

Although most South Africans are aware that VCT services are available, only one in five people in South Africa who know about VCT have tested for HIV. Among the reasons why South Africans may not seek HIV testing are negative perceptions of testing services. AIDS-related stigmas are another factor that probably influences people's willingness to be tested. Stigmatizing beliefs about AIDS and associated fears of discrimination can influence people's decision to seek or not seek VCT in South Africa (Kalichman & Simbayi, 2003).

VCT-delivery involves: pre-test counselling, HIV-tests, post-test counselling, and referral to appropriate care and support services. There are a number of advantages of early detection of HIV infection (Pelzer, Nzweni & Mohan, 2004). VCT provides an opportunity for counsellors to assist high-risk individuals in assessing their level of risk, develop realistic plans to reduce their risk, and increase safer sex practices. For people who test negative, knowledge of their serostatus should be an impetus for changing their risky sexual behaviour and for regular testing for HIV and STIs. Knowing that one is

sero-negative could also alleviate psychological symptoms such as worry, anxiety, and feelings of hopelessness and despair.

People who test HIV-positive can be referred to active care and support services. This will enable them to make informed decisions about changes in their life-styles so as to protect and boost their immune system as well as to prevent infection of others with HIV. Early treatment of opportunistic infections and utilization of available care and support system can help HIV-positive individuals to live productive and more meaningful lives. HIV-testing is never a goal in itself, but clearly is motivated by prevention and care and support goals. Consequently, the efficacy of VCT programmes is in turn also co-determined by the availability of effective prevention and care and support programmes.

The major health-promoting behaviour promoted by most VCT communication interventions therefore is that one should go for counselling and get tested early for HIV if one has run the risk of being infected with HIV. VCT also helps individuals to prevent infecting others with HIV or re-infecting themselves or others. It also helps individuals to obtain access to the available care and support system if they have been infected with HIV or have progressed to the stage of AIDS.

Research also indicates that despite the low uptake of VCT, a large section of the South African population think that one should know their HIV-serostatus (Pettifor, Rees, Stefenson, Hlongwa-Madikizela, MacPhail, Vermaak, & Kleinschmidt, 2004; Shisana & Simbayi, 2003; Van Dyk & Van Dyk, 2003). The question that immediately comes to mind is: *Why do people who know that they are at risk of HIV infection not voluntarily present themselves for counselling, HIV-testing, and referral?*

1.2 Motivation for the study

The purpose of this study was to investigate the barriers to voluntary counselling and testing for HIV and AIDS. VCT centres are available throughout the country, but only very few South Africans make use of the services. It was hypothesized that stigmas may pose considerable barriers to seeking VCT in South Africa (Van Dyk & Van Dyk, 2003).

The research question for this study was “What are some of the reasons why there is low VCT uptake at a particular clinic in Gauteng province of South Africa?”

The aim of the study was to contribute towards our understanding of the factors that serve as barriers to VCT uptake. The VCT programme relies on initiation by the client; it emphasizes choice and free will. This allows people to delay the decision to test, often until that choice is preempted by factors such as severe illness, pregnancy, or insurance requirements. The researcher has always thought that people who voluntarily present themselves for VCT are brave, especially if they were not prompted by certain factors. After undergoing VCT herself, the researcher asked some of her friends about their feelings on VCT. It was interesting to note that most of them have not undergone VCT, mainly because they felt that they did not perceive themselves as being in danger of contracting the HI virus. They reported that they were in trustworthy relationships and therefore had not seen the need to undergo VCT. Contrary to what her friends reported about themselves, probing further about this subject, the researcher uncovered an underlying fear of knowing their HIV status. It appeared that some of them could not imagine living with HIV, because of the stigma experienced by members of the community who are known to be HIV-positive. Some of her friends mentioned that it was better not to know about their status, because then they would not worry about being sick and having to take ARV's.

1.3 Aims of the study

This study sought to:

- Investigate the role of stigma in a community that pose as barriers to voluntary counselling and testing for HIV.
- Investigate and describe the respondents' levels of knowledge about VCT.
- Investigate and describe the respondents' perception of VCT services.

1.4 Overview of the study

This study consists of five chapters. In chapter 2 relevant literature is reviewed, including psycho-social theories pertaining to barriers to HIV and AIDS voluntary testing and counselling. Chapter 3 provides a detailed description of the methodology employed during the course of the study. It also provides a description of participants, questionnaire and data collection process. In chapter 4, the statistical techniques that were used to analyze the data are described, after which the findings from the study are presented. The thesis concludes with chapter 5, in which the study's findings are discussed and recommendations for future research are made.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

With nearly 5 million people thought to be living with HIV and AIDS and an estimated 1700 new infections occurring everyday, South Africa is a country with one of the highest number of people infected with HIV. The vast majority of the HIV-infected population does not know its HIV status (Mwamburi, Dladla, Qwana & Lurie, 2005).

The process of testing and knowing one's own HIV status has been associated with a reduction in high risk behaviour and has been shown to be effective. However, there are substantial barriers that inhibit the uptake of voluntary counseling and testing (VCT). For many people, the motivation to use VCT is low, because correctly or incorrectly, they do not perceive themselves as being at risk of contracting HIV (Hutchinson & Mahlalela, 2006).

The perceived benefits of VCT may also be low when treatment is not readily available or is unaffordable. Also, stigma surrounding HIV and AIDS and people living with HIV and AIDS serves as an additional barrier affecting the acceptability of testing (Hutchinson & Mahlalela, 2006). In order to deal with the high HIV prevalence in South Africa, VCT programs need to be intensified. VCT is an essential strategy in fighting the HIV and AIDS pandemic.

In this chapter, literature on the role of VCT in curbing HIV will be examined. Also, literature on the challenges and barriers associated with VCT and its delivery will be reviewed. The extent to which a number of Psycho-social theories could account for decisions regarding VCT uptake will be examined. In particular, the review focuses on the extent to which the following theories: Health belief model, Theory of reasoned action and Theory of planned action, could account for low VCT uptake among South Africans. Finally the VCT campaigns in South Africa will be discussed

2.2 The Benefits of Voluntary Counselling and Testing (VCT)

Voluntary Counselling and Testing (VCT) is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential (UNAIDS, 2003).

VCT entails volunteering for a blood test to establish whether there are antibodies of HIV in one's blood or whether the virus can be detected. The procedure includes receiving brief pre- and post-test counselling from trained professionals. Pre-test counselling is intended to prepare the person for the test and its possible outcome, and post test counselling involves supportive counselling, prevention strategies, medical advice, and care (USAID, 2002).

Furthermore, the goals of pre- and post-test counselling are to identify and clarify people's concerns and their risk of contracting HIV, and to check whether the individual understands how HIV is transmitted and how transmission can be prevented. VCT also helps clients understand the antibody test, to make more informed decisions by weighing up the pros and cons of having the test, to consider what might be their greatest concern if they were either HIV-positive or HIV negative, to access information about the personal, medical, social, psychological and legal implications of being diagnosed either HIV-positive or HIV-negative, and to prepare for difficulties they may face in the future (Richter, Griesel, Durrheim, Solomon & Van Rooyen, 1999).

According to De Zoysa, Phillips, Kamenga & O'Reilly (1995) the theoretical foundation on which VCT is built involves mainly the individualistic psychological model of the stages of change. HIV testing and counselling promotes progression across the continuum of the stages of change. For instance, in rural Uganda, the majority of participants in a research study reported that they had already made behavioural changes because of previous AIDS information, but that making further changes to protect themselves was dependent on knowing their HIV serostatus (De Zoysa *et al.*, 1995). The study also found that counselling promotes risk reduction through increasing the perception of risk, self-

efficacy and personal skills, and through reinforcing a sense of responsibility (De Zoysa *et al.*, 1995).

In addition, HIV counselling and testing may have an important social impact through people knowing their serostatus and sharing it with others, thus laying the groundwork for changes in social norms. Research in Uganda also indicated that 90% of all clients had revealed their HIV status to somebody following counselling services. A positive result has also encouraged some people to give personal testimonies in community forums, a consequence that can have a powerful effect on people's attitudes, behaviour and social norms (De Zoysa *et al.*, 1995). VCT therefore plays an essential role at many levels in the community, for couples, families and individuals.

2.3 Principles for VCT delivery

The counselling aspect of VCT can be based on a number of theoretical models. According to Balmer (1991), counsellors in general utilize an eclectic approach. HIV and AIDS counselling approaches derive their assumptions, procedures and operations from heterogeneous sources, including psychoanalyses. Nevertheless, there are general principles for the delivery of VCT services that apply to any context anywhere in the world (Oberzaucher & Baggaley, 2002). These include the following: confidentiality, voluntary counselling and testing.

The principle of confidentiality requires that an HIV test result should only be revealed to the person tested and that everything that is discussed between the counsellor and the client during pre- and post-test counselling is done in confidence. Confidentiality also implies that all medical records pertaining HIV-related information should only be handled by health-care professionals with a direct role in patient management.

In principle it is possible, but practically it poses many challenges because in some cases, confidentiality may have to be breached where there is a clear indication that a third party may be harmed by the actions of the patient. For example, if the patient has been thoroughly counselled on the need for partner notification but fails to consent to partner

counselling and poses a real risk of HIV transmission to an identifiable partner, confidentiality may be at risk of being breached by the health care worker.

Confidentiality seems difficult to maintain because there are certain situations that could lead to people knowing other people's status by default. For example, at a clinic known to the author, there is a special room where only HIV-positive patients are consulted. Therefore, people who regularly visit that clinic know that when a person goes to that room, then the person is HIV positive. There are also baby formulas that are given out for free only to HIV-positive mothers in clinics. Therefore if a mother is seen carrying the baby formula, then people would know that the mother is HIV positive. This is something that is beyond the control of health workers but it affects the issue of confidentiality.

The decision to have an HIV test must be the choice of the individual. Informed consent is linked to voluntarism. Informed consent means that the person has been made aware and understands the implications of the test (Van Dyk & Van Dyk, 2003). Mandatory HIV testing is neither effective to public health purposes nor ethical because it denies an individual choice and it violates principles such as the right to health, including the right to privacy and ethical duties to obtain informed consent. All tested individuals should be given sufficient information and should be helped to understand the processes of testing and possible consequences of testing. There are three crucial elements that need to be obtained in order to achieve proper informed consent, which are:

- Providing pre-test counselling on the purpose of testing and on the treatment and support once the results are known.
- Ensuring understanding
- Respecting the individual's right on whether they want to be tested or not.

Only when these elements are in place can an individual make an informed decision on whether to test or not, based on their current circumstances and values (UNAIDS, 2003). The principle of voluntarism is not always possible to adhere to, because in some instances, the patient is too sick to consent to HIV testing, and the test may be crucial in

order to make a proper diagnosis. Therefore, the issue of ethical conduct is brought into question when a decision is made to test a patient without their consent.

Besides, voluntary testing presents with many challenges, as it relies on the initiation by the client. The majority of people do not test out of their free will, but only when forced by circumstances (e.g. pregnancy, illness, or insurance). This may lead to people testing when they already have AIDS and therefore making antiretroviral therapy ineffective, because an individual may have progressed to AIDS stage.

HIV counselling has been defined as a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV (UNAIDS, 2003). Counselling has both prevention and care as its main objectives. It concentrates on the emotional, social and behavioural issues related to the possible or actual infection with HIV. All clients accessing these services should be offered both pre- and post-test counselling. The pre-test counselling and post-test counselling are both processes which involve explaining what an HI virus is, and also includes giving results.

This process is often met with confusion, as many people do not seem to understand the terms used during counselling. People have complained that counsellors often use technical terms when giving them results. For example, a study in South Africa conducted by Birdsall, Hajjiannis, Nkosi and Parker (2004) indicated that counsellors reported that callers who had accessed VCT sometimes called the Helpline with questions about test results. According to the counsellors, callers do not always understand what their test results mean, or are sometimes given written results without any explanation.

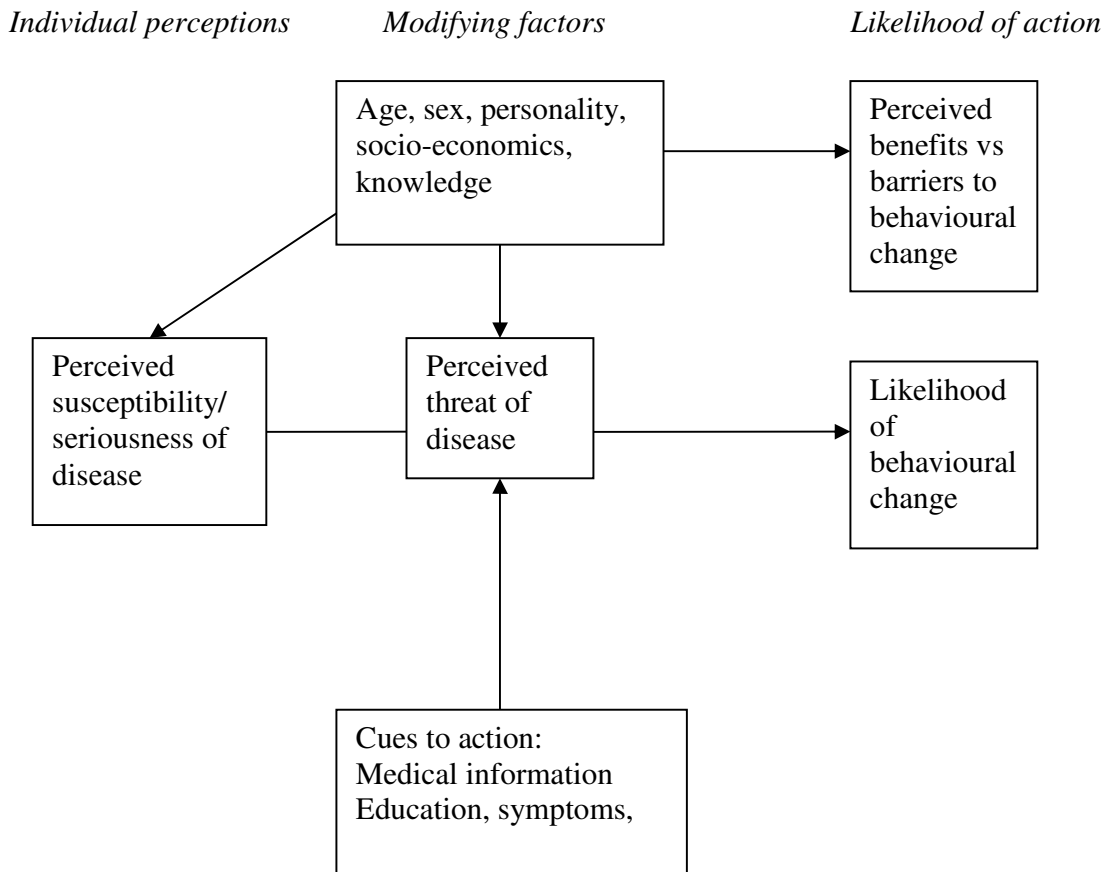
2.4 Psycho-social Theories

The health belief model is useful in understanding and predicting HIV-preventive behaviour. This model focuses on the attitudes and beliefs of individuals. It proposes that an individual will take a health-related action if certain conditions are met. It is based on

the theory that individuals make an analysis of perceived threats and net benefits of their behaviour (Rosenstock, 1974).

The health belief model contains five health belief measures: perceived susceptibility to the health problem (an individual's assessment of risk of getting a health problem), perceived severity of the health problem (the individual's assessment of the seriousness of the condition as well as its consequences), perceived efficacy of practicing preventive behaviour (an individual's self-assessment of the ability to successfully adopt the desired behaviour), perceived barriers to practicing preventive behaviour (the individual's assessment of the influences that facilitate or discourage adopting the promoted behaviour) and perceived benefits (the individual's assessment of adopting the behaviour). In terms of the decision about taking an HIV test, the individual will make an appraisal of the above-mentioned factors as shown in figure 1:

Figure 1: Health belief measures



Source: Glanz, Rimer and Lewis (2002)

Perceived susceptibility

According to the health belief model, the greater the perceived susceptibility to a negative health condition such as being HIV positive, the more likely the person is to engage in protective behaviour. An individual is less likely to consider taking up VCT if he or she views their chances of contracting HIV to be very low or unlikely. According to the health belief model, people will most likely avail themselves for VCT if they perceive themselves as susceptible to contracting HIV. Assessing one's risk of having contracted HIV is a necessary condition in the decision making process of deciding whether or not one should present themselves for VCT.

According to a study conducted by the Human Sciences Research Council (HSRC, 2005), many people who perceive themselves as being at high risk of being infected with HIV were reported to have tested for HIV. Findings from this study indicated that an individual's belief in his or her susceptibility to HIV infection is an important element in deciding whether or not to undertake VCT (HSRC, 2005). Another study done by the Shisana and Simbayi (2002) found that people who did not consider testing felt that they were at low risk.

A low risk perception is linked to the intention to go for VCT. If a person believes that she or he is not at risk of HIV and AIDS, the person will not undergo VCT. On the other hand, a high risk perception is one of the motivators for people to go for VCT (Van Dyk & Van Dyk, 2003).

Despite the high prevalence of HIV and AIDS in South Africa, the uptake of VCT has been low. Only an estimated 18.4%-19% of the population has been tested for HIV and knows their serostatus (Shisana & Simbayi, 2002). This has negative consequences for the public health effort to address the HIV and AIDS epidemic in South Africa: high risk individuals who are not aware of their HIV-status but continue unsafe sex practices are major drivers of new infections. According to a survey conducted by Simbayi, Chauveau & Shisana (2004), only 2% of South Africans had tested for HIV in 2004. In the 2005 survey, one of the reasons given why South Africans do not take the HIV test is that they do not perceive themselves to be at risk of contracting HIV. For example, 66% thought that they were probably or definitely not at risk of contracting HIV. Of note, more than half of those who tested positive thought the same thing (AIDSmap, 2007). Assessing one's risk of having contracted HIV is a necessary condition in the process of deciding whether or not one should go for VCT (Swanepoel, 2003).

In a survey by Pettifor, Rees, Steffenson and Hlongwa-Madikizela (2004), people's subjective assessment of their risk was determined by asking them to rate their chances of acquiring HIV and AIDS on a scale (no risk at all, small risk, moderate risk, great). Optimistic biases clearly operate in this assessment as a number of researchers have

indicated. Pettifor *et al.* (2004) found that in a sample of South African youth, only 14% indicated that they were at a great risk of getting HIV and AIDS, despite the high prevalence of HIV and AIDS in this group and high levels of unsafe sex practices. That these assessments are clearly biased is indicated by the fact that 62% of the youths who tested positive (as part of the survey) thought that their chances of contracting HIV were small, or that they were at no risk at all. A low risk perception is also linked negatively to the intention to go for VCT. If people believe that they are not at risk of HIV and AIDS, it makes no sense to go for VCT. On the other hand, survey data also indicates that a high risk perception is one of the main motivators for people to go for VCT.

Research suggests that HIV and AIDS risk assessment could be a function of any one or more of three kinds of risk assessment: absolute, cumulative and comparative risk assessment (Linville, Fischer & Fischhoff, 1993; Van der Pligt, Otten, Richard & Van der Velde, 1993; Weinstein & Klein, 1995). The assessment of HIV and AIDS risk forms part of a more comprehensive decision-making process in which people assess the threat HIV and AIDS poses for oneself. Such a threat perception is itself a function of both one's assessment of one's susceptibility to HIV and AIDS and one's assessment of the severity of HIV and AIDS. Most South Africans see HIV and AIDS as a severe illness, so that their assessment of their risk of contracting it could have a major impact on whether or not they decide to present themselves for VCT (Swanepoel, 2003).

Absolute risk judgment is an outcome of a process in which one has to assess one's susceptibility to HIV and AIDS on the basis of one's past and present sexual behaviour, one's degree of risk (given one's knowledge of how HIV and AIDS is transmitted, and the fact that one could have been infected by a single unprotected act of penetrative anal or vaginal sex), and the HIV serostatus of one's partner. People could thus have a low risk estimate in terms of an absolute risk-assessment if they have not engaged in unsafe sex practices, or they could have a sense of high risk if they have. As research indicates, those that do go for VCT mostly fall within the latter category (Van der Pligt *et al.*, 1993).

Comparative risk refers to the fact that people also assess their risk relative to the risk they ascribe to others (e.g. their friends or people of their own age group). Unrealistic optimism refers to the fact that people overestimate the risk for HIV and AIDS of comparative others and underestimate their own risk compared to the referent group. This egocentric bias is a function of the fact that people know what risk-reducing behaviour they themselves perform, but not those of the reference group (Van der Pligt *et al.*, 1993).

One of the major factors underlying unrealistic optimism is that people have an illusory sense of being able to control the possibility of HIV-infection. This includes: individuals washing their genitals after sex, having access to condoms should they be needed, and being able to screen one's sexual partner for HIV-infection on the basis of their physical appearance, as well as social, personality, and moral attributes used as points of reference for the screening process. Unrealistic optimism is hypothesized to be moderated by personal experience of the consequences of risk behaviour e.g. for engaging in unsafe sexual behaviour (Swanepoel, 2003).

Cumulative risk assessment refers to assessing one's risk on the basis of accumulation of own risk of acquiring HIV as a consequence of repeated episodes of unsafe sex. The risk of acquiring HIV in a single sexual encounter is in fact quite small and near zero if one's partner is not from a high risk group. But risk accumulates over repeated acts of unsafe sex with HIV-infected partners. However, people have difficulty in judging their own accumulative risk, and they typically underestimate their own accumulative risk for HIV, but overestimate the accumulative risk of others (Van der Pligt *et al.*, 1993).

Perceived severity

The health belief model suggests that people may undertake preventative behaviour such as VCT if they view HIV as a serious and dangerous disease. VCT is the first step towards preventing the contraction and spread of HIV. The low rate of testing has profound consequences for the nation. Studies have shown that ignorance of one's status perpetuates the spread of HIV, thus increasing the AIDS pandemic. Although the rollout of ARV's is finally on track in South Africa, many South Africans who would qualify for

the treatment are not receiving it because they have not been tested for HIV (AIDS map, 2007).

According to USAID (2003) VCT is viewed as an important tool to curbing the spread of HIV. People who do not test for HIV are more likely to continue with high risk behaviour, compared to those who know their HIV status. It has been found that VCT has enabled HIV-positive people to reduce their high risk behaviour, in order to avoid spreading the virus (USAID, 2003).

Perceived benefits

According to the health belief model, people are more likely to undertake VCT if there are considerable benefits in doing so. This suggests that people may undertake VCT if they believe that VCT will help ease anxiety about living a blind life, e.g. not knowing one's status. VCT may be undertaken if individuals recognized that people who undergo VCT are likely to plan better for the future due to knowing their status, whether positive or negative (Baggaley, 2001).

VCT may help to curb the further spread of HIV, and also represents a mechanism for referral into care, treatment, and support systems. Individuals may be likely to undergo VCT if they believe that knowledge of one's HIV status can enable them to seek appropriate emotional support such as counselling (Baggaley, 2001).

According to Van Dyk & Van Dyk (2003), VCT may be viewed as a preventative method to help curb the spread of HIV. How effective individuals think VCT will be in preventing HIV could be a motivating factor for them to test.

VCT may be considered if individuals perceived HIV testing as part of the process that allows infected people access to medical care, and this means that people can live longer if they start treatment early, therefore avoiding HIV-related illnesses. Medical care includes treatment for opportunistic infections, prevention of mother-to-child

transmission, post-exposure prophylaxis, access to anti-retroviral treatment (ARV), as well as longer-term counselling and support for positive-living (UNAIDS, 2001).

According to De Kock & Johnson (1998), recognizing the role that VCT may play in promoting greater social acceptance of those living with HIV and AIDS may influence individuals' decision to undergo VCT. Some have argued that widespread uptake of VCT within communities can help normalize HIV and AIDS, reduce AIDS-related stigma, and raise awareness of the epidemic. Involving the community in VCT and related programs helps to increase participation in VCT and fosters community ownership of the programs (USAID, 2003).

Perceived barriers

There are a number of reasons for the low levels of HIV testing in South Africa, such as high levels of fear of positive results, perceived stigma, misperceptions of risk, and shortages of testing centres, treatment facilities, and access to VCT sites. The health belief model suggests that people may be willing to undertake VCT if guaranteed treatment in the event they test positive, and also if they do not perceive the likelihood of experiencing stigma from people.

A study of mineworkers by Day *et al.* (2003) found that the most common barriers to testing were fear of testing positive for HIV and the ramifications of a positive test result, including stigmatization, disease, and death. According to Swanepoel (2003) common barrier beliefs that reflect people's concern about testing HIV-positive and which generates high levels of fear, relate to having to cope with the intense emotional turmoil after receiving a positive HIV test result.

The person who tests positive will have to deal with the following:

- Coping with the consequences of being HIV-positive;
- Disclosing one's HIV-status;
- Coping with stigma;
- Coping with rejection by significant others in one's life and the community;

- Coping with the possible physical abuse from partner;
- Coping with the mental consequences of the disease (suffering from depression and dementia, self-blame, coping with the threats to one's self-esteem and the loss of a sense of future, coping with constant uncertainty).

In several parts of Africa as well in South Africa, people are reluctant to return to VCT centres to obtain their results. In KwaZulu-Natal, it was found that 305 people tested over two-month period, only 17% returned for their results and were counselled (Richter *et al.*, 1999).

A survey done by Simbayi, Chauveau, & Shisana (2004) found that those who reported that they would consider testing indicated that they would do so if confidentiality was maintained. Often the quality of interactions between clients and counsellors, particularly inappropriate confidential safeguards has limited the acceptability of VCT and reduced the likelihood that people will return for results (Coovadia, 2000).

A study conducted in a helpline by Birdsall *et al.* (2004) reported calls from people who suspected that they, or a relative, an employee, or an acquaintance, might be HIV positive, but were reluctant to undertake VCT to confirm their status. Among these were individuals who requested information about symptoms of HIV and AIDS in order to understand whether they might be positive. Such callers expressed that they were not prepared to test, but instead hoped to 'self-diagnose' their HIV status with the help of information from counsellors (Birdsall *et al.*, 2004).

There is a relatively low number of men who show up for VCT, mainly because they fear that their HIV-positive status will be disclosed through testing and that stigmatization will follow. Surveys have shown that some men see no value in knowing their HIV status, viewing such knowledge as a burden (Avert, 2007).

Research by Kellerman *et al.* (2002) indicates that people in fact see few advantages of going for VCT, but that they could hold a host of negative beliefs about the consequences

of doing so. The latter relates to the various activities that comprise VCT (i) the consequences of testing HIV-positive, i.e. being a person that has to live with HIV and AIDS and (ii) beliefs about follow-up care and support services

Not wanting to know whether one is HIV-positive or not is a major determinant of why people do not want to go for VCT. However not wanting to know one's HIV status is a consequence of various beliefs that people have about the negative physical, emotional, social, and economic consequences one will have to face up to if one tests HIV-positive and having to live as a person with HIV and AIDS. Besides beliefs about threats to one's life and disruption of one's social support network, people also fear the threats posed by having HIV and AIDS to their self-esteem, values and their sense of future (Swanepoel, 2003).

The Helpline study by Birdsall *et al.* (2004) found that there were concerns by the callers about accuracy and reliability of HIV testing, particularly rapid tests that are administered through oral swabs or finger pricks. The concern about the accuracy of the test is widespread enough that it may dissuade some people from accessing testing.

The study found that callers reported that they have been told in the past that in an HIV test they have to draw blood and then wait for two or more weeks for the results. Therefore getting results in 30 minutes raised concerns about reliability (Birdsall *et al.*, 2004). Although rapid testing technologies decrease the waiting time for test results, concerns about the accuracy of test is often raised. Fears of inaccuracies are often fuelled by newspaper reports of inaccurate tests being done and the immense emotional stress that this has caused to individuals (Birdsall *et al.*, 2004)

Studies have shown that there are problems with the quality of VCT delivery because some counsellors are not adequately trained and may lack medical knowledge about HIV (USAID, 2003). Counsellors described instances in which individuals going for HIV testing were not able to access pre-test counselling in the Helpline study. They noted that

rural residents may be particularly impacted by the lack of counsellors at clinics and health facilities (Birdsall *et al.*, 2004).

One study noted inhibiting factors such as shortages of counsellors, long queues, lack of privacy, and lack of follow-up support following diagnosis (Van Dyk & Van Dyk, 2003). Other researchers have highlighted the level of training and availability of counsellors (Coovadia, 2000). Other studies have highlighted lack of access to testing services with trained counsellors and to treatment for HIV-infected persons (USAID, 2002). Another study indicated that people would test if the counselling was more supportive (Shisana & Simbayi, 2002).

Fear of AIDS-related stigma is one of the major barriers to VCT. Fear of stigma relates to fears of having to disclose one's status, and fears about violation of one's right to confidentiality and privacy. The fear of being stigmatized immediately raises people's concerns about the issue of who has control (and of getting that control) over information about one's stigmatizing condition (Swanepoel, 2003). Stigma surrounding HIV and AIDS and people living with HIV and AIDS serves as an additional barrier, affecting the acceptability of testing (Kipp, Kabagambe & Konde-lule, 2002). Many people fear the psychosocial consequences of testing positive for HIV and AIDS, particularly when it may lead to loss of social status and discrimination (Brown, Macintyre, & Trujillo, 2003; Parker & Aggleton, 2003; UNAIDS, 2003). Testing in itself, regardless of the outcome, was seen by many as risking the loss of social status (Day *et al.*, 2003)

Fear of stigmatization has also deterred individuals from being tested for HIV and from disclosing their status to sexual partners, family, and friends (Herek, Capitanio, & Widaman, 2002). According to Van Dyk & Van Dyk (2003) clients are concerned about the possibility of prejudiced behaviour by health care personnel who are aware of their HIV status. Clients also fear disclosing their HIV-positive status to their sex partners. Attawell & Long (1999) mention that HIV-positive people have been rejected by their family or community, and have experienced discrimination or violence.

A separate study in a black township in Cape Town showed that people who had not been tested had significantly higher levels of AIDS-related stigma and negative attitudes towards testing than individuals who had been tested, even though two-thirds of the people who had not been tested reported having engaged in at least one behavioural risk (Kalichman & Simbayi, 2003).

Many people fear taking VCT, because of the discrimination experienced by some people they know after having tested positive for HIV. There are a number of institutions that discriminate towards HIV-positive people, e.g. there are a number of insurance policies that exclude HIV-positive people.

Beliefs about the physical suffering that HIV and AIDS brings, is not indicated as one of the most important barriers to VCT, but beliefs about threats to one's identity (self-concept) and relationships are dominant.

In this regard, people may not only fear breaches of confidentiality by others, but also their own ability to keep the information a secret. Not going for VCT may well be the best strategy of avoiding being stigmatized in the first place. Van Dyk and Van Dyk (2003) list the following as the main barriers to the uptake of VCT: breaches of confidentiality by health care workers, fear of being discriminated against by health care workers, general lack of trust of the health care system, and the fear of disclosing one's HIV-positive status to sex partners.

According to Attawell & Long (1999) HIV testing can result in human rights violation. It has been found in recent cases where people who had openly disclosed their HIV status became victims of abuse from the community, as in the case of the murder of Gugu Dlamini after declaring her HIV status on World AIDS day (Baleta, 1999; Avert, 2007).

Under these circumstances, people find it difficult to undergo VCT. Studies have shown that fear of a violent reaction by a male partner because of a positive result is a barrier to

both VCT and subsequent disclosure of the result to male partners. A woman's positive result has been found to be associated with partner violence (USAID, 2002).

There are studies that found that marital break-ups are high following VCT (Baggaley, 2001). Women often face more discrimination than men when they are known to be HIV positive. Since antenatal clinics provide a chance for testing, more women know their status and they are therefore branded as HIV spreaders (Avert, 2007). One of the reasons why many people do not test is because of the burden that comes with HIV-positive results. According to Attawell & Long (1999), a positive test result can come as a great shock, and can be very difficult for a person to cope with.

A study conducted in South Africa on mineworkers indicated that there was limited or no knowledge about ARV-treatment among the employees. This suggests that employees would not readily undertake VCT because they do not know of available treatment for HIV and AIDS (Day *et al.*, 2003). In the absence of treatment options, many people do not see the benefits of testing.

Many studies have examined the lack of access and poor quality of VCT services in developing countries, noting that testing has often been done primarily through antenatal services rather than general health services (UNAIDS 2001).

A study by Shisana & Simbayi (2002) found that people would consider testing if the VCT centre was accessible and if the cost and quality of services were acceptable. This suggests that the reasons for undergoing VCT are more closely related to negative perceptions of services and low perceived risk than problems with availability of VCT services. According to Muller and Phanuphak (1993) a well-designed anonymous or confidential VCT service, preferably non-governmental, is most likely to benefit the community.

According to Alonzo & Reynolds (1995) those contemplating VCT ideate about the consequences of going for VCT, and evaluate these consequences as positive or negative

in terms of their own knowledge of HIV and AIDS and their stereotypes of people living with AIDS.

The negative beliefs about being HIV-positive have their origin in a variety of information sources from media portrayals, including HIV and AIDS campaigns, information one gathers from one's informal information networks (peers, family), or from direct experience with people living with HIV and AIDS, that feed people's stereotypes of what it is like to live with HIV and AIDS, (Van der Pligt *et al.*, 1993). The health belief model suggests that protective behaviour such as undertaking VCT is likely to occur when perceived susceptibility, perceived severity, and perceived benefits are high and perceived barriers are low.

Modifying factors

The theory of planned action is based on the assumption that human beings are usually quite rational and make systemic use of information available to them. It suggests that people consider the implications of their actions before they decide to engage or not engage in a given behaviour. This theory specifically focuses on an individual's intention to determine whether behaviour will occur, and intention is based on an attitude towards the behaviour.

According to the theory of reasoned action, a person's intention is a function of two basic determinants, one personal in nature and the other reflecting social influence (subjective norm). The personal factor is the individual's positive or negative evaluation of performing the behaviour. This factor is termed attitude 'toward the behaviour.' It refers to the person's judgment of whether performing the behaviour is good or bad. The normative construct of this theory aims to capture the motivational aspect that behavioural norms have in individual-level decision-making processes on whether or not to engage in behaviour.

According to Ajzen and Fishbein (in press) subjective norms are viewed in this model as being a function of normative beliefs (i.e. beliefs that a specific individual or group has regarding whether one should or should not perform the behaviour in question) and

motivations to comply with this norm (i.e. the degree to which, in general, one wants to do what the referent thinks one should do). The second determinant of intention is the person's perception of the social pressures put on him/her to perform or not perform the behaviour in question (Ajzen & Fishbein, in press).

This theory suggests that an individual would take up VCT after careful considerations about the behaviour. VCT would be viewed as either good or bad, based on one's own judgment as well as on the society's perceived social pressures. According to this theory, it is reasonable to feel positively about performing a behaviour if one believes that its performance will lead to more good than bad outcomes.

It is also reasonable to feel social pressure to not perform a specific action if one believes that people with whom one is motivated to comply believe that one should not perform it. Individuals weigh their personal feelings and perceived social pressure when arriving at and carrying out their intention (Ajzen & Fishbein, in press).

According to this theory, if it was a norm that every member of the society who is sexually active should undergo VCT, then not going for VCT will be seen as non-compliant with social group norms. Then as a result, a person would be viewed in a negative light for non-compliance.

The central factor in the theory of planned behaviour is the individual's intention to perform a given behaviour. Intentions are assumed to capture the motivational factors that influence a behaviour. As a general rule, the stronger the intention to engage in a specific behaviour, the more likely it is that the behaviour will be carried out. However, a behavioural intention can find expression in behaviour only if the behaviour in question is under volitional control (Ajzen, 2002).

A study by Nelson Mandela/HSRC (2000) found that testing was positively associated with education, household resources, knowledge that HIV causes AIDS, discussion with partners about HIV prevention, and condom use at last intercourse (among those testing positive), but negatively associated with race, the number of sexual partners, and living in

rural areas. No links were made in the study to the availability of VCT services or to the quality of available VCT services.

Self-efficacy

Perceived ability to perform certain behaviour may influence whether the behaviour occurs. Self-efficacy pertains to people's subjective assessment of their ability to present themselves for VCT, irrespective of the negative consequences they perceive as deriving from it (Swanepoel, 2003).

According to the theory of planned behaviour, perceived behavioural control refers to the perceived ease or difficulty of performing the behaviour, and it is assumed to reflect past experience as well as anticipated impediments and obstacles. This is also referred to as self-efficacy. Self-efficacy involves concerns about the ability to perform the desired behaviour. Self-efficacy is believed to be one of the most important characteristic that determines behaviour change (Ajzen & Fishbein, in press). Self-efficacy can be increased in several ways, such as providing clear instructions, providing an opportunity for skills development or training, and modelling the desired behaviour. As a general rule, the more favourable the attitude and subjective norm with respect to a behaviour, and the greater the perceived behaviour control, the stronger the individual's intention to perform the behaviour under consideration (Ajzen & Fishbein, in press).

This model makes the prediction that once people have formed an intention to go for VCT, doing so could be mediated by two variables: beliefs and concerns about one's skills in performing the behaviour and consideration of the possible environmental barriers to performing the behaviour (Swanepoel, 2003). The skills required from the potential testees to present themselves for VCT is also one variable that plays a role in uptake of VCT. Testing for HIV requires no technical skills from a potential testee, as this is performed by health care providers. However, going through the pre- and post-test counselling session does require some personal skills (Swanepoel, 2003).

These mainly show up in fears people have about handling the interaction with counsellors. For example, people fear having to discuss and disclose their sexual behaviour to counsellors, experiencing and coping with self-blame for engaging in unsafe sex behaviour, coping with unfriendly, unsympathetic counsellors, coping with the pressure to consent to HIV-testing, and not being able to control breaches of confidentiality, especially with regard to the fact that one has been for VCT or of disclosing one's HIV results to others (Myers, Worthington, Haubrich, Ryder & Calzavara, 2003). Effectively coping with the client-counsellor power dynamics therefore requires a range of skills, often those that are the focus of life skills education programmes (Kelly & Parker, 2000).

Cues to action

There are many campaigns in South Africa that are directed at spreading a message about HIV prevention and VCT (Avert, 2007). These campaigns include Lovelife, Khomanani which are geared towards promoting awareness. These campaigns used mass media to get across HIV prevention messages that particularly emphasized HIV testing.

These campaigns may have probably saved many people's lives but the actual difference that they have made in reducing the number of new infections is difficult to measure. The prevailing high rate of HIV in South Africa suggests that either the message is not getting through to many people or people are receiving the message but they are not acting upon it (Avert, 2007).

2.5 Conclusion

VCT is a key element in identifying those who are infected with HIV in order to benefit in therapeutic interventions that may both prolong their own lives and also save other people's lives. Although VCT is one of the important strategies for curbing the spread of HIV, it still presents with a number of factors that deter many people from testing. It was indicated that VCT has a number of benefits, but these benefits may be outweighed by the barriers. A number of factors that influence VCT uptake seem to affect the level of VCT acceptance. These factors need to be explored further in order to understand

people's perceptions and attitudes relating to HIV testing. Hence this study sought to find barriers that impede on VCT uptake.

The psychosocial theories have suggested the following to be barriers to VCT uptake:

- Lack of role models who undertake VCT.
- Lack of readiness and intention to undertake VCT.
- Perceived difficulties in undertaking VCT.
- Inability to perceive rewards or benefits from VCT.
- Perceived inability to undertake VCT.
- Perceived negative outcomes of VCT.
- Negative information regarding VCT.
- Fear of stigmatization.

It was also found that, with regard to the uptake of VCT, the intention to go for VCT is the strongest predictor of whether people will indeed present themselves for VCT. The intention to go for VCT, in turn is a function of three sets of beliefs: beliefs about the outcomes of going for VCT and their evaluation as being either positive or negative (attitudinal beliefs), beliefs about whether salient others think one should go for VCT, and one's willingness to comply with this behavioural norm (normative beliefs), and people's subjective assessment of whether they think that they will be able to go for VCT, despite any barriers that may impede them from doing so (efficacy beliefs)

In conclusion, campaigns that are directed at making HIV testing a normal routine and reducing HIV and AIDS related stigmas need to be intensified in order to increase VCT uptake while reducing the number of new infections in South Africa.

CHAPTER 3

METHODOLOGY

3.1 Introduction

In this chapter the research design and methodology that was used during the course of the study are described. First, a brief description of the research site is provided. This is followed by a detailed description of the research design for the study. Finally a description of the method used in this study will be provided as well as that of the participants, questionnaire, and data collection process.

3.2 Research site

The study was conducted at a community clinic which is located in Vosloorus in the Ekurhuleni Metropolitan Municipality. The clinic is managed by a senior nursing sister and has six female staff and one male. The clinic deals with the following health issues: primary health care, baby wellness, communicable diseases, VCT, prenatal care and Antiretroviral Therapy (ART). VCT services are provided early in the morning so that the patients will be able to receive their results on the same day. VCT is done by the same nurses all the time in order to maintain confidentiality.

This clinic is in the neighbourhood of “bond” houses and therefore people who live closest to the clinic are the so called “working middle class” who are likely to afford medical insurance. However, most of the people who attend the clinic live in an informal settlement that is located approximately 15 km away. Most of the people who attend the clinic are females aged between 15 – 55 years. The women who make up the majority of people who attend the clinic go to the clinic for primary health care and baby wellness programmes. Several women who attend the clinic are single, unemployed and seems not well educated.

3.3 Research design

This was a **quantitative** study in which questionnaire data were collected and used to test specific hypotheses. The overall aim of the study was to examine the relationship between VCT knowledge, perceived social stigma and VCT uptake. The following six hypotheses were tested:

- Individuals who perceive themselves as less able to keep secrets and more likely to disclose their status would be less likely to go for VCT
- Individuals who perceive health workers to be capable of maintaining confidentiality would be more likely to take up VCT
- High levels of knowledge about VCT were expected to be associated with high levels of VCT uptake.
- Individuals with negative attitudes towards HIV and AIDS would be less likely to take up VCT.
- Individuals who perceive their sexual behaviour as safe are less likely to take up VCT.
- High levels of perceived social stigma were expected to be associated with low levels of VCT uptake

3.4 Method

3.4.1. Participants

A sample of 30 male and 258 female respondents participated in the study. The difference in number of males and females who participated in the study was expected because primarily, the clinic was attended by females who took their babies for the baby wellness program. As a result, cross gender comparisons were not warranted. Most of the respondents (49.3%) were Zulu, 23.3% were Sotho, 11.5% were Xhosa, 4.9% were Tsonga and another 4.9% were Tswana. Less than 1% of respondents were Venda (.7%), Swati (.7%) or English (.3%).

Most of the respondents (43.4%) had high school education, 39.2% had tertiary school education, while 17.4% had primary school education. Sixty seven percent of the respondents were single while 28.8 % were married. The percentages of divorced and widowed respondents were 2.8% and 1.4% respectively. Most of the respondents (37.2%) were members of the apostolic church, 28.1% were Zionists, 22.6% were Catholic and 12.2% were Protestants.

3.4.2. Questionnaire

A self report questionnaire was used in this study (see Appendix B). The questionnaire contained yes/no questions as well as questions which required the respondent to indicate his/her level of agreement with the statements provided.

The questionnaire was made up of four sections. Section A consisted of demographic questions. This section contained questions on the respondent's gender, home language, age, highest educational level, marital status and religious affiliation.

Section B consisted of statements relating to VCT knowledge. These questions required a yes or no response. Eight statements were used to obtain the data. Examples of the statements that were included in this section were as follows: *'I know about voluntary counseling and testing (VCT) services in my area,' 'I understand the process of VCT.'*

Section C consisted of twenty statements relating to attitudes towards HIV and AIDS and VCT. This section was developed by the researcher to measure the respondents' attitudes towards HIV and AIDS and perceptions of VCT services. This section required the respondents to rate from 1 to 4 how strongly they disagreed or agreed with each statement. The first concept that this section measured was respondents' attitudes towards HIV and AIDS. Twelve statements were used to obtain the data. Examples of the statements that were included in this section are: *'I think everyone should test for HIV,' 'I have fears about getting an HIV test,' 'I think HIV and AIDS is a serious and dangerous disease,' and 'Getting an HIV test is a difficult task.'* The second concept that this section measured was confidentiality. The following three statements were

presented: *'I think HIV test results are completely confidential,' 'I would trust a health care worker with my test results,' and 'I would test for HIV if my results were completely confidential.'* The third concept that was measured was "fear of self disclosure." The following two statements were used to obtain the data: *'If I would test HIV positive, I would not tell anyone,' 'When I go for an HIV test, and I would take someone with me.'* The last concept that was measured in this section was perceived safe sexual behaviour. The following three statements were used to obtain the data: *'I take measures to protect myself from HIV,' 'If I test HIV positive I will do this,' and 'I would change my sexual behaviour.'*

Section D consisted of twelve statements relating to perceived social stigma. The questions were used to assess the respondents' thoughts about how people who live in their community perceived people with HIV and AIDS. Two concepts were measured in this section. The first concept related to perceived interaction with HIV-positive people. This section required the respondents to rate from 1 to 4 how strongly they disagreed or agreed with each statement. Five statements were used to obtain the data. Examples of the statements that were used in this section are: *'Most people would not like to sit next to someone with HIV in a public or private transport,' 'Most people would not like someone with HIV living next door,' and 'Most people feel uncomfortable around people with HIV.'* The second concept related to perceived judgment about HIV-positive people. Seven statements were used to obtain the data. Examples of the statements were as follows: *'Most people think that getting HIV is a punishment for bad behaviour,' 'Most people think less of someone because they have HIV,' and 'Most people feel that, if you have HIV, it is your own fault.'*

3.4.3. Data collection process

The respondents were approached and invited to take part in the study after they had reported at the clinic reception. The researcher informed the respondents, the study was voluntary. During initial contact with the respondents, the researcher introduced herself and briefly explained the purpose of the study. The researcher explained to the respondents that the research was not being conducted by the clinic, but by the researcher

as part of her studies at the University of Pretoria. In order to maintain confidentiality, the respondents were informed that the data collected during the study would only be accessed by the authorized research team from the University of Pretoria.

The respondents who were interested in taking part in the study were given a consent form to read and sign, followed by a questionnaire to fill in. The respondents were given instructions on how to fill in the questionnaire. In order to maintain anonymity, the questionnaires handed to the respondents did not require their names to be filled in, and no other personally identifying information was collected from the respondents. The questionnaire took about ten minutes to complete. The researcher remained close by while the respondents were filling in the questionnaires, in case they required assistance. The process of data collection took place over a period of three weeks.

CHAPTER 4

DATA ANALYSIS AND RESULTS

4.1. Introduction

In this study, the raw data was coded and captured in Excel before being imported for analysis into SPSS for Windows (version 15). Data cleaning involved running frequencies on all variables in order to ensure that only those codes assigned to particular variables appeared in the data files and to check for missing values.

It will be recalled that the purpose of the study was to establish the extent to which perceived social stigma, knowledge levels, and confidentiality issues act as barriers to VCT uptake at a community clinic. Specifically the following hypotheses were tested:

- Individuals who perceive themselves as less able to keep secrets and more likely to disclose their status were expected to be less likely to go for VCT.
- Individuals who perceive health workers to be capable of maintaining confidentiality were expected to be more likely to take up VCT.
- High levels of knowledge about VCT were expected to be associated with high levels of VCT uptake.
- Individuals with negative attitudes towards HIV and AIDS were expected to be less likely to take up VCT.
- Individuals who perceived their sexual behaviour as safe were less likely to take up VCT.
- High levels of perceived social stigma were expected to be associated with low levels of VCT uptake.

Chi-square test statistics were applied to the contingency tables, in order to establish the significance of different proportions.

4.2. The Impact of Fear of Self-Disclosure on VCT Uptake

Data on the fear of self disclosure was obtained using two questions. The first question explored whether or not the respondents would disclose their status if they tested HIV positive. The second question related to whether or not the respondents would take someone with them when going for an HIV test.

Table 4.1 Proportions of respondents who either agreed or disagreed with each of the questions on the impact of fear of self-disclosure on VCT uptake

	I have used VCT services before		Chi Square	
	Yes	No		
If I were to test HIV positive, I would not tell anyone	disagree	57.7% (n=127)	42.3% (n=93)	$\chi^2=0.826, p=0.221$ N=288 n/s
	agree	51.5% (n=35)	48.5% (n=33)	
When I go for an HIV test I would take someone with me	disagree	57.7% (n=94)	42.3% (n=69)	$\chi^2=0.307, p=0.332$ N=288 n/s
	agree	54.4% (n=68)	45.6% (n=57)	

The differences in proportions on the two questions that related to the impact of fear of self-disclosure on VCT uptake were not statistically significant ($p > 0.05$).

4.3. The Relationship between Perceived Confidentiality among Health Workers and VCT Uptake

Three questions were used to obtain data on the perceived confidentiality among health care workers and VCT uptake. The first question explored whether or not the respondents thought that HIV results were completely confidential. This was followed by a question that related to whether or not the respondents would trust the health care workers with their results. The last question related to whether or not the respondents would test for HIV if their results were completely confidential.

Table 4.2 Proportions of respondents who either agreed or disagreed with each of the questions that related to confidentiality as a function of VCT uptake

		I have used VCT services before		Chi Square
		Yes	No	
I think HIV results are completely confidential	disagree	42.9% (n=21)	57.1%(n=28)	$\chi =4.304, p=0.028^*$ N=288
	agree	59.0% (n=141)	41.0% (n=98)	
I would trust a health care worker with my test results	disagree	48.4% (n=30)	51.6% (n=32)	$\chi =1.985, p=0.103$ N=288 n/s
	agree	58.4% (n=132)	41.6% (n=94)	
I would test for HIV if my results will be completely confidential	disagree	56.6% (n=30)	43.4% (n=23)	$\chi =.003, p=0.5$ N=288 n/s
	agree	56.2% (n=132)	43.8% (n=103)	

Table 4.2 indicated that only one out of the three questions that related to confidentiality and VCT uptake showed significant differences in the proportions. The results showed that while 59% of respondents who had used VCT services agreed that HIV test results are completely confidential at the clinic, only 41% of those who had not taken up VCT said that the results of VCT tests at the clinic are completely confidential. This difference was statistically significant ($\chi =4.304, p=0.028$). No significant differences were observed with respect to the other two questions ($p > 0.05$)

4.4 The relationship between levels of VCT knowledge and VCT uptake

The relationship between levels of VCT knowledge and VCT uptake was obtained using three questions. The first question related to whether or not the respondents knew about VCT services in their area. The next question enquired if the respondents understood the process of VCT. The last question explored whether or not they knew that if they tested HIV positive, they would get medication that could prolong their lives.

Table 4.3 Proportions of respondents who either agreed or disagreed with each of the questions that related to VCT knowledge and VCT uptake

		I have used VCT services before		Chi Square
		Yes	No	
I know about VCT services in my area	disagree	9.0 (n=6)	91.0% (n=61)	$\chi^2=79.360, p=0.00^*$
	agree	70.6% (n=156)	29.4% (n=65)	N=288
I understand the process of VCT	disagree	16.1% (n=14)	83.9% (n=73)	$\chi^2=81.688, p=0.00^*$
	agree	73.6% (n=148)	26.4% (n=53)	N=288
I know that if I test HIV positive, I can get medication that can prolong my life	disagree	60.0% (n=12)	40.0% (n=8)	$\chi^2=0.123, p=0.457$
	agree	56.0% (n=150)	44.0% (n=118)	N=288 n/s

Table 4.3 shows that two of the three questions showed differences in proportions that were highly significant. The results indicated that 91.0% of the respondents who had not used VCT services before reported that they did not know about VCT services in their area. However, a mere 9% of the individuals who had used VCT services did not know about VCT services in the area. This difference in proportions was statistically significant ($\chi^2=79.360, p=0.001$).

Also, the results indicated that (83.9%) of the respondents who had not used the VCT services before did not understand the VCT process. However, only 16% of the people who had used VCT services said that they did not understand the VCT process. This difference was statistically significant ($\chi^2=81.688, p=0.001$). No significant differences were observed with respect to the other question, which related to knowledge about availability of medication if one tests positive for HIV ($p>0.05$).

4.5 The impact of individuals' attitudes towards HIV/AIDS on VCT uptake

Data on the impact of individuals' attitudes towards HIV/AIDS on VCT uptake was obtained using ten questions. The first question explored whether or not the respondents thought everyone should test for HIV. The second question related to whether or not the respondents had fears about getting an HIV test. This was followed by a question on whether the respondents thought HIV and AIDS was a serious and dangerous disease. The next question related to whether or not the respondents thought that they were at great risk of being infected with HIV.

The fifth question related to whether or not the respondents thought knowing one's own HIV status was beneficial. The following question related to whether or not the respondents thought getting an HIV test was a difficult task. The seventh question related to whether or not the respondents would test for HIV, if antiretroviral therapy (ART) was made more easily accessible. This was followed by a question relating to whether or not the respondents thought that they would be able to follow advice on antiretroviral therapy (ART) if they tested HIV positive. The ninth question explored whether or not someone important to the respondent thought that he/she should have an HIV test. The final question assessed whether or not the respondents thought that they had a low chance of contracting HIV. Table 4.6 shows how negative attitudes towards HIV and AIDS impact on VCT uptake.

Table 4.4 Proportions of respondents who either agreed or disagreed with each of the questions that related to attitudes towards HIV/AIDS on VCT uptake

		I have used VCT services before		Chi square
		yes	no	
I think everyone should test for HIV	disagree	52.0% (n=13)	48.0% (n=12)	$\chi^2=0.201, p=0.40$ N=288 n/s
	agree	56.7% (n=149)	43.3% (n=114)	
I have fears about getting an HIV test	disagree	65.1% (n=99)	34.9% (n=53)	$\chi^2=10.318, p=0.001^*$ N=288
	agree	46.3% (n=63)	53.7% (n=73)	
I think HIV/AIDS is a serious and dangerous disease	disagree	71.2% (n=47)	28.8% (n=19)	$\chi^2=7.789, p=0.004^*$ N=288
	agree	51.8% (n=115)	48.2% (n=107)	
I think I am at great risk of being infected with HIV	disagree	57.8% (n=67)	42.2% (n=49)	$\chi^2=0.180, p=0.381$ N=288 n/s
	agree	55.2% (n=95)	44.8% (n=77)	
Knowing my status is beneficial	disagree	44.4% (n=8)	55.6% (n=10)	$\chi^2=1.087, p=0.212$ N=288 n/s
	agree	57.0% (n=154)	43.0% (n=116)	
Getting an HIV test is a difficult task	disagree	62.3% (n=81)	37.7% (n=49)	$\chi^2=3.533, p=0.039^*$ N=288
	agree	51.3% (n=81)	48.7% (n=77)	
If antiretroviral therapy (ART) would be easily available, I would test for HIV	disagree	51.9% (n=27)	48.1% (n=25)	$\chi^2=0.483, p=0.023^*$ N=288
	agree	57.2% (n=135)	42.8% (n=101)	
If I test positive, I would be able to follow advice on antiretroviral therapy (ART)	disagree	68.8% (n=11)	31.3% (n=5)	$\chi^2=1.076, p=0.220$ N=288 n/s
	agree	55.5% (n=151)	43.8% (n=121)	
Someone very important to me thinks I should have an HIV test	disagree	62.1% (n=90)	37.9% (n=55)	$\chi^2=4.018, p=0.030^*$ N=288
	agree	50.3% (n=72)	49.7% (n=71)	
I think I have a low chance of contracting HIV	disagree	58.2% (n=78)	41.8% (n=56)	$\chi^2=0.391, p=0.307$ N=288 n/s
	agree	54.5% (n=84)	45.5% (n=70)	

Table 4.4 indicated that five out of the ten questions that related to attitudes towards HIV and AIDS on VCT uptake showed significant differences in proportions. The results indicated that more than half of the respondents (53.7%) who had not used VCT services before had fears of getting an HIV test. Less than half of the respondents (46.3%) who had used VCT services before had fears of getting an HIV test. The differences in proportions were significant ($\chi=10.318$, $p=0.001$). More than half of the respondents who had used VCT services (51.8%) agreed that HIV and AIDS is a serious and dangerous disease while less than half of the respondents (48.2%) who had not used VCT services were of the same view. This difference in proportions was statistically significant ($\chi=7.789$, $p=0.004$).

Results also indicated that 48.7% of respondents who had not used VCT services before thought that getting an HIV test was a difficult task. On the other hand, 62.3% of the respondents who had used VCT services before did not think that getting an HIV test was a difficult task. The differences in proportions were significant ($\chi=3.533$, $p=0.039$). The results further showed that 42.8% of the respondents who had not used VCT services before would test for HIV if antiretroviral therapy was easily available. On the other hand, 57.2% of the respondents who had used VCT services before reported that they would test for HIV if antiretroviral therapy (ART) was easily accessible. The differences in proportions were significant ($\chi=0.483$, $p=0.023$).

The results also indicated that, while an almost equal number of respondents who had used VCT services and those who had not used VCT services agreed that someone important to them thought that they should have an HIV test, far fewer respondents who had not used VCT services (37%) disagreed, compared to 62.1% who disagreed among those who had used VCT services. The differences in proportions were significant ($\chi=4.018$, $p=0.03$). No significant differences were observed with respect to the other five questions ($p>0.05$).

4.6. The relationship between perceived safe sexual behaviour and VCT uptake

Three questions were used to obtain data on the relationship between perceived safe sexual behaviour and VCT uptake. The first question explored whether or not respondents took measures to protect themselves from HIV. The next question explored whether or not the respondents would change their sexual behaviour if they tested HIV positive. The final question enquired whether or not the respondents thought it was difficult to protect them from HIV infection.

Table 4.5 Proportions of respondents who either agreed or disagreed with each of the questions that related to perceived safe sexual behaviour and VCT uptake

		I have used VCT services before		Chi Square
		Yes	No	
I take measures to protect myself from HIV	disagree	60.5% (n=23)	39.5% (n=10)	$\chi^2=0.325, p=0.348$ N=288 n/s
	agree	55.6% (n=139)	44.4% (n=11)	
If I test HIV positive, I would change my sexual behaviour	disagree	48.1% (n=13)	51.9% (n=14)	$\chi^2=0.795, p=0.245$ N=288 n/s
	agree	57.1% (n=149)	42.9% (n=112)	
It is difficult to protect myself from HIV infection	disagree	59.2% (n=122)	40.8% (n=84)	$\chi^2=2.599, p=.070$ N=288 n/s
	agree	48.8% (n=40)	51.2% (n=42)	

Results on Table 4.5 indicated that all the three questions that related to perceived safe sexual behaviour and VCT uptake showed no significant differences ($p > 0.05$).

4.7. The Impact of Perceived Social Stigma on VCT Uptake

Data on perceived social stigma was obtained using twelve questions. The first question explored the respondents' perception of their community with respect to whether or not they thought that getting HIV is a punishment for bad behaviour. This was followed by a question relating to what they thought people in their community felt about sitting next to someone with HIV in public or private transport. The third question related to what

respondents' perceptions were with regard to whether or not they thought most people in their community thought less of people because they have HIV.

The fourth question explored what the respondents' perceptions were with regard to whether or not their community thought that having HIV was ones' own fault. The following question related to the respondents' perception of their community with regard to whether or not they would like someone with HIV to live next door. In the next question, the respondents' perception of their community relating to the aspect of fear of being around someone who is HIV positive was explored. This was followed by a question relating to whether or not their community would drink from the same tap if someone with HIV had just drunk from it.

The next question explored the respondents' perception of their community with regard to whether or not they believed that people with HIV deserve it. This was followed by the question that explored the respondents' perception of their community with regard to whether or not they believed that people with HIV should feel ashamed of themselves. The next question explored respondents' perception of their community's feelings about being comfortable around people with HIV. The final question related to the respondents' perception of their community with regard to whether or not they would reject the friendship of someone with HIV.

The questions that constituted the perceived social stigma scale can be grouped into two categories of constructs. The first construct measured respondents' perceived judgements about being HIV positive while the second construct measured perceived social stigma in relation to interaction with HIV-positive individuals. Table 4.1 shows the proportions of respondents who either agreed or disagreed with each of the perceived social stigma questions that related to the respondents' perceived judgement about HIV-positive people as a function of VCT uptake.

Table 4.6. Proportions of respondents who either agreed or disagreed with each of the perceived social stigma questions that related to the respondents' perceived judgment about HIV-positive people as a function of VCT uptake.

		I have used VCT services before		Chi square
		yes	no	
Most people think that getting HIV is a punishment for bad behaviour	disagree	41.1% (n=46)	58.9% (n=66)	$\chi^2=17.15, p=0.00^*$ N=288
	agree	65.9% (n=116)	34.1% (n=60)	
Most people think less of someone because they have HIV	disagree	43.0% (n=37)	57.0% (n=49)	$\chi^2=8.717, p=0.002^*$ N=288
	agree	61.9% (n=125)	38.1% (n=77)	
Most people feel that if you have HIV it is your own fault	disagree	41.9% (n=36)	58.1% (n=50)	$\chi^2=10.317, p=0.00^*$ N=288
	agree	62.4% (n=126)	37.6% (n=76)	
Most people believe that if you have HIV you must have done something wrong to deserve it	disagree	46.3% (n=38)	53.7% (n=44)	$\chi^2=4.574, p=0.02^*$ N=288
	agree	60.2% (n=124)	39.8% (n=82)	
Most people believe that people with HIV should be ashamed of themselves	disagree	49.0% (n=47)	51.0% (n=49)	$\chi^2=3.111, p=0.05^*$ N=288
	agree	59.9 (n=115)	40.1% (n=77)	

Surprisingly, results on the perceived social stigma scale indicated that respondents who had not utilized VCT services perceived less stigma in their communities than those who had used VCT services before. Results in table 4.6 showed that all the five questions that related to respondents' perceived judgment about HIV-positive people as a function of VCT uptake showed differences in proportions that were highly significant in the opposite direction.

It is indicated in table 4.6 that 34.1% of the respondents who had not used VCT services before thought that most people think that getting HIV is a punishment for a bad behaviour. On the other hand, 65.9% of the respondents who had used VCT services were

of same view. The differences in proportions for this question were highly significant ($\chi=17.15$, $p=0.001$).

Thirty eight percent of the respondents who had not used VCT services before believed that most people in their community thought less of someone because they have HIV. On the other hand, 61.9% of the respondents who had used VCT services believed the same. The differences in proportions for this question were significant ($\chi=17.15$, $p=0.001$). Less than half (37.6%) of the respondents who had not used VCT services before thought that most people in their community felt that if one has HIV, it is their own fault. A high number of the respondents (62.4%) who had used VCT services before thought the same. The differences in proportions for this question were significant ($\chi=10.317$, $p=0.001$). Next, the results showed that 39.8% of the respondents who had not used VCT services before thought that their community believed that if one had HIV one must have done something wrong to deserve it. On the other hand, 60.2% of the respondents who had used VCT services thought the same. The differences in proportions for this question were significant ($\chi=4.574$, $p=0.02$).

Finally, 40% of the respondents who had not used VCT services thought that most people in their community believed that people with HIV should be ashamed of themselves. On the other hand 59.9% of the respondents that had used VCT services before thought the same. The differences in proportions for this question were statistically significant ($\chi=3.111$, $p=0.05$).

Table 4.7 Proportions of respondents who either agreed or disagreed with each of the perceived social stigma questions in relation to interaction with HIV-positive individuals.

		I have used VCT services before		Chi square
		yes	no	
Most people would not like to sit next to someone with HIV in a public or private transport	disagree	49.1% (n=55)	50.9% (n=57)	$\chi^2=3.800, p=0.00^*$ N=288
	agree	60.8% (n=107)	39.2% (n=69)	
Most people would not like someone with HIV living next door	disagree	48.4% (n=59)	51.6% (n=63)	$\chi^2=5.353, p=0.01^*$ N=288
	agree	62.0% (n=103)	38.0% (n=63)	
Most people feel afraid to be around people with HIV	disagree	51.6% (n=48)	48.4% (n=45)	$\chi^2=1.200, p=0.16$ N=288 n/s
	agree	58.5% (n=114)	41.5% (n=81)	
Most people would not employ someone with HIV	disagree	51.1% (n=47)	48.9% (n=45)	$\chi^2=1.464, p=0.14$ N=288 n/s
	agree	58.7% (n=115)	41.3% (n=45)	
Most people would not drink from a tap if a person with HIV had just drunk from it	disagree	49.5% (n=47)	50.5% (n=48)	$\chi^2=2.645, p=0.06$ N=288 n/s
	agree	59.6% (n=115)	40.4% (n=78)	
Most people feel uncomfortable around people with HIV	disagree	48.8% (n=39)	51.3% (n=41)	$\chi^2=2.532, p=0.07$ N=288 n/s
	agree	59.1% (n=123)	40.9% (n=85)	
Most people would reject the friendship of someone with HIV	disagree	47.6% (n=39)	52.4% (n=43)	$\chi^2=3.517, p=0.04^*$ N=288
	agree	59.7 (n=123)	40.3% (n=83)	

Results in table 4.7 indicated that three out of the seven questions that related to perceived social stigma in relation to interaction with HIV-positive individuals showed differences in proportions that were statistically significant. The results indicated that 39.2% of the respondents who had not used VCT services before thought that most

people in their community would not like to sit next to someone with HIV in public or private transport. On the other hand 60.8% of respondents who had used VCT service were of the same view. The differences in proportions for this question were significant ($\chi=3.800$, $p=0.001$).

Thirty eight percent of the respondents who had not used VCT services before did not think that most people in their community would not like someone with HIV living next door to them. On the other hand 62% of the respondents who had used VCT services were of the same view. The differences in proportions for this question were significant ($\chi=5.353$, $p=0.01$). Finally the results showed that 52.4% of the respondents who had not used VCT services before did not think that most people in their community would reject the friendship of someone with HIV. On the other hand (47.6%) of the respondents who had used VCT services before thought the same thing. The differences in proportions for this question were significant ($\chi=3.517$, $p=0.04$). No significant differences were observed with respect to the other four questions ($p>0.05$).

4.8 Summary of Findings

Across all sub-scales, not all questions showed significant differences. It was found that VCT uptake was impacted on by some aspects of individuals' levels of VCT knowledge. Many respondents who had used VCT services had more knowledge about VCT than the respondents who had not used VCT services. Respondents who had not used VCT services before had negative attitudes towards HIV and AIDS. Finally, respondents who had not used VCT services believed that their community held less stigmatizing beliefs about people with HIV and AIDS than those who had used VCT services.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter, the findings of the study are discussed with reference to the literature reviewed in chapter 2. Also, the conclusions and policy recommendations arising from the study are presented. The chapter concludes with a discussion of the conceptual and methodological limitations of the study. In the latter section of the chapter, areas in need of further investigation are discussed.

5.2 Discussion

VCT uptake was highly impacted on by issues pertaining to perceived confidentiality. The majority of respondents who had not used VCT services before believed that HIV results were not confidential. Although the data did not provide a definitive link between VCT uptake and fear of breaches of confidentiality, the latter could lead to low levels of VCT uptake. In a study done by Van Dyk and Van Dyk (2003), it was found that clients were not against VCT, but they had serious doubts and anxieties about confidentiality of HIV test results. Also, Philips, Coates, Eversley and Catania (1995) found that participants (especially women in stable relationships, black people, young people and those with a lower income), were only willing to be tested if no one else could have access to their results.

VCT uptake was highly impacted on by levels of knowledge about VCT sites in the respondents' community. Most respondents who had not used VCT services did not know about VCT services available in their area. Possibly, many individuals do not present themselves for VCT because they simply do not know where VCT services can be accessed.

It was also found that most respondents who had not used VCT services before did not understand the process of VCT. One possible explanation of why individuals who had not undergone VCT do not understand the VCT process could be that the media only speak

about VCT uptake but does not report about the whole process that VCT entails, i.e. the Khomanani campaign used mass media, e.g. radio and celebrity endorsement, to get the HIV prevention message across, that particularly emphasized HIV testing. It seems that the only way individuals would know about what VCT process entails is to present themselves for VCT.

These findings were expected, because it is less likely that VCT would be utilized by individuals who do not understand what the VCT process entails. The observed results were therefore consistent with the hypothesis that high levels of VCT knowledge were expected to be associated with higher levels of VCT uptake.

VCT uptake is affected by fears that individuals have about getting tested. It was found in a study on mineworkers by Day et al. (2003) that the most common barriers to testing were fear of testing positive for HIV and the ramifications of a positive test result including stigmatization, disease, and death. VCT may be followed by negative consequences, such as marital break-up, abuse, psychological distress, stress, and depression (Baggaley, 2001).

According to the Theory of Planned Action, self-efficacy plays an important role in determining whether or not an individual will be able to deal with negative outcomes that may follow VCT uptake. Respondents' perception of the seriousness of HIV and AIDS also impacted on VCT uptake. According to the Health Belief model, individuals who perceive HIV as a serious disease are more likely to undergo VCT. In this study, it was found that most respondents who had not used VCT services did not perceive HIV and AIDS to be a serious disease. A possible explanation for this could be that individuals who had not undergone VCT may be in denial about HIV and its existence. The results seem to suggest that self-efficacy may have played a role in the decision not to undergo VCT, because the respondents who had not used VCT services before believed that getting an HIV test was a difficult task.

According to Swanepoel (2003), part of the formation of the intention to go for VCT entails a process whereby people make subjective assessments of VCT and its possible negative consequences. Individuals assess what their chances are of being subjected to these negative consequences. Individuals also assess what skills or measures would be needed to redress the negative consequences.

VCT uptake did not seem to be impacted on by the availability of antiretroviral therapy, since less than half of the respondents who had not used VCT services before would test if antiretroviral therapy were easily available. This could be a result of individuals thinking that anti-retroviral therapy cannot cure HIV. Also, opinions of a “significant other” did not seem to influence VCT uptake, because almost an equal number of respondents who had used VCT services before, and those that had not used VCT services before, reported that someone important to them thought that they should have an HIV test. One possible explanation of this could be that a decision to undergo VCT depends solely on an individual and influences from other people do not impact heavily on whether or not to undergo VCT.

These results suggest that respondents who had not used VCT services before held more negative attitudes towards HIV and AIDS compared to those that had used VCT services. These results were expected, as it was hypothesized that individuals with negative attitudes towards HIV and AIDS would be less likely to undergo VCT.

The results of the perceived social stigma were surprising, because a higher proportion of respondents who had used VCT services believed that their community held more stigmatizing beliefs. On the other hand, respondents who had not used VCT services before perceived their community to be less judgemental and open to interacting with HIV-positive people.

It seems individuals who are not aware of their own HIV status may be more likely to be idealistic because they may not have experienced stigma from the society unlike those who have tested and were responding from their own experiences.

The difference in the expected outcomes and observed outcomes could be attributed to the fact that the data was collected from a clinic and most of the respondents who participated in the study had been already tested and may have experienced stigmas from their community compared to those who have not used VCT services before. Possibly, different outcomes may have been observed if the data were collected from the community and not at the clinic.

5.3 Conclusions

This study has shown that there are a number of existing barriers to VCT uptake. Fears of breeches of confidentiality by health care workers, lack of knowledge about VCT sites and also lack of understanding of the VCT process appear to have emerged as the most significant contributors to low VCT uptake. Fears of undergoing HIV testing as well as perceiving HIV testing as a difficult task were also found to be potential barriers to VCT uptake. It was found in this study that individuals who have not used VCT services before believed that their community held significantly less stigmatizing beliefs about people living with HIV and AIDS.

5.4 Limitations of the study

This study was conducted at a clinic and the sampling technique that was used was convenience sampling. The use of this sampling technique means that the results cannot be generalized to the South African population. The study was conducted at a clinic which is mostly attended by females, as a result most of the data was from the female respondents and data from the male respondents was very limited.

5.5 Recommendations

The results from this study show that there is a need for a trusting relationship to be developed between the clients and health care workers. This could be done through training health care workers about proper counselling and developing communication skills with the clients. There is also a need for VCT communication campaigns that will give information about what the VCT process entails so that individuals who have not

used VCT before would have a clearer understanding of the VCT process. Information about benefits of HIV testing need to be highlighted, in order to persuade those who have not been tested to seriously consider presenting themselves for VCT.

This study had surprising results which related to perceived social stigma. It is recommended that further research be conducted in order to investigate the differences in the observed outcomes and expected outcomes in relation to perceived social stigma. A similar study could be done using two other different scales of stigma which are the personal stigma scale and enacted stigma scale. The personal stigma scale refers to individuals' own attitude towards HIV and the experience of self blame and how they expect others to react towards them on being aware of the diagnosis (UNAIDS, 2002). The enacted stigma scale relates to the actual experienced stigma and discriminatory behaviour towards HIV-positive people or people affected by HIV (UNAIDS, 2002). The use of the personal stigma scale and enacted stigma scale could yield different results from the perceived social stigma because respondents would be responding to their own experiences rather than to what they perceive other people to believe.

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