

**FACTORS INFLUENCING UPTAKE OF VOLUNTARY COUNSELING  
AND HIV TESTING SERVICES IN MWENSE DISTRICT, ZAMBIA**

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## **KEY WORDS**

Acquired immunodeficiency syndrome

Voluntary counseling and testing for HIV

Disclosure

Attitudes and knowledge

Perceptions

Awareness

Confidentiality

Barriers

Knowledge

Stigma

Zambia



## **ABSTRACT**

**Introduction:** For more than two decades now, the acquired immune deficiency syndrome (AIDS) and its etiological agent, the human immunodeficiency virus (HIV), has been a growing challenge that affects all segments of the global population. Voluntary HIV counseling and testing (VCT) is one of the many prevention and control strategies adopted globally and by the Government of the Republic of Zambia. VCT is the process by which an individual undergoes counseling to enable him/her to make an informed choice about being tested for the human immunodeficiency virus (HIV). This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. VCT is a key component of both HIV prevention and care programs.

Although VCT is increasingly available in Zambia through public health facilities, VCT only or stand-alone sites and mobile counseling and testing services, there is still great reluctance among many people to be tested.

**Aim:** This study explored factors affecting the utilization of VCT services in Mwense District, Zambia.

**Methodology:** An explorative, qualitative study was conducted. Data was collected through focus group discussions with community members, and key informant interviews with lay counselors and health care workers. Thematic analysis of transcribed data was done to elucidate knowledge and awareness of HIV/AIDS and VCT services, factors facilitating uptake and barriers to utilization of VCT services and suggestions for improving VCT uptake.



**Results:** The study found that HIV/AIDS was recognized as a major problem in the communities and that participants were aware of the availability and benefits of HIV counseling and testing services. The main reasons for seeking an HIV test included facilitating sexual behavior change to avoid infection, re-infection or infecting others with HIV. Facilitators to uptake of VCT services include accessing information on HIV/AIDS and other care and support services such as prevention of mother to child interventions, peer and social support systems, home-based care and early treatment with antiretroviral therapy if one is HIV positive. Community members indicated that VCT was an entry point to reaching out to the family and community for on-going counseling, which would lead to reduction in HIV/AIDS stigma and discrimination.

Several barriers to VCT were identified by the participants. At individual level, barriers included: the fear of the ramifications of a positive test; fear of HIV/AIDS stigma and discrimination; doubt about the existence of HIV and AIDS; and fear of loss of control of life circumstances and destiny. Health facility level barriers included concerns about confidentiality of HIV-test results, familiarity with service providers, lack of promotional activities of the VCT services, shortage of testing logistics and commodities, and human resource shortages both in terms of numbers and confidence to promote VCT services. Community levels barriers included cultural beliefs and customs, gender imbalances, religious beliefs and stigma.

**Conclusions:** There is urgent need for community sensitization about VCT and its benefits in HIV/AIDS control. Community outreach interventions and establishing strong post testing services may be useful to reduce stigma and thus enhance the uptake of VCT services.

## **DECLARATION**

I declare that *factors influencing uptake of voluntary counseling and HIV testing services in Mwense district, Zambia*, is my own work, that is has not been submitted for any degree or examination in any university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Date: 21<sup>st</sup> February 2012



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Finally, I wish to thank my Almighty Father in Heaven and the Lord Jesus Christ for being with me and granting me grace, guidance and strength throughout my studies.

## **LIST OF ABBREVIATIONS**

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral therapy
CBO	Community-Based Organization
FGD	Focus Group Discussions
FNDP	Fifth National Development Plan
GRZ	Government of the Republic of Zambia
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NAC	National HIV/AIDS Council
NASF	National HIV and AIDS Strategic Framework
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SNDP	Sixth National Development Plan
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
VCT	Voluntary Counseling and HIV Testing
WHO	World Health Organization
ZDHS	Zambia Demographic Health Survey

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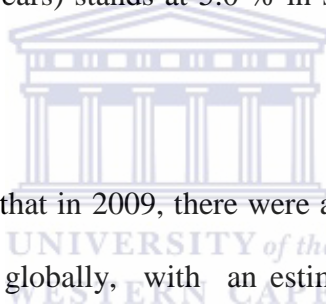
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# **CHAPTER 1: INTRODUCTION**

## **1.1 BACKGROUND: OVERVIEW OF THE HIV/AIDS PANDEMIC**

For more than two decades now, the acquired immune deficiency syndrome (AIDS) and its etiological agent, the human immunodeficiency virus (HIV) has been a growing challenge that affects all segments of the global population. UNAIDS report on the global AIDS epidemic 2010 (UNAIDS, 2010) estimates that 34 million people were living with HIV worldwide at the end of 2010, with about 22.5 million residing in sub-Saharan Africa, representing 68% of the global HIV burden. Women and girls comprise 60% of Africans living with HIV (UNAIDS, 2010). HIV prevalence in adults (15–49 years) stands at 5.0 % in sub-Saharan Africa compared to the global rate of 0.8 %.



The UNAIDS report further states that in 2009, there were an estimated 2.6 million people who became newly infected with HIV globally, with an estimated 1.8 million people from sub-Saharan Africa. Of the global total of 1.8 million adult and child HIV related deaths in 2009, 1.3 million occurred in sub-Saharan Africa. Additionally, of the 16.6 million children globally who lost one or both parents to an AIDS-related illness, 14.8 million reside in Africa.

## **1.2. HIV PREVALENCE IN ZAMBIA**

Zambia had the first AIDS case reported in 1984 (Bayley, 1984). According to the 2007 Zambia Demographic and Health Survey (ZDHS) (Central Statistical Office [CSO], 2009), 14.3% of Zambian adults age 15-49 years are HIV positive. This represents a slight decrease from 15.6% prevalence observed in the 2001-02 ZDHS. In the 2007 survey, 16.1% of women and 12.3% of men were HIV-positive compared to the 2001-02 survey where 17.8% of women and 12.6% of



men were HIV positive. According to the ZDHS (CSO, 2009), 1,100,000 people in Zambia are living with HIV, and about 56,000 deaths due to AIDS. The epidemic is estimated to have left at least 600 000 children orphaned. HIV/AIDS morbidity and mortality also result in an estimated 50% of general hospital admissions and more than 70% of specialized medical hospital admissions. HIV prevalence is twice as high in urban areas as in rural areas (20% versus 10%). Further, more than half of HIV-positive women (55%) and almost three quarters of HIV-positive men (72%) do not know that they are infected.

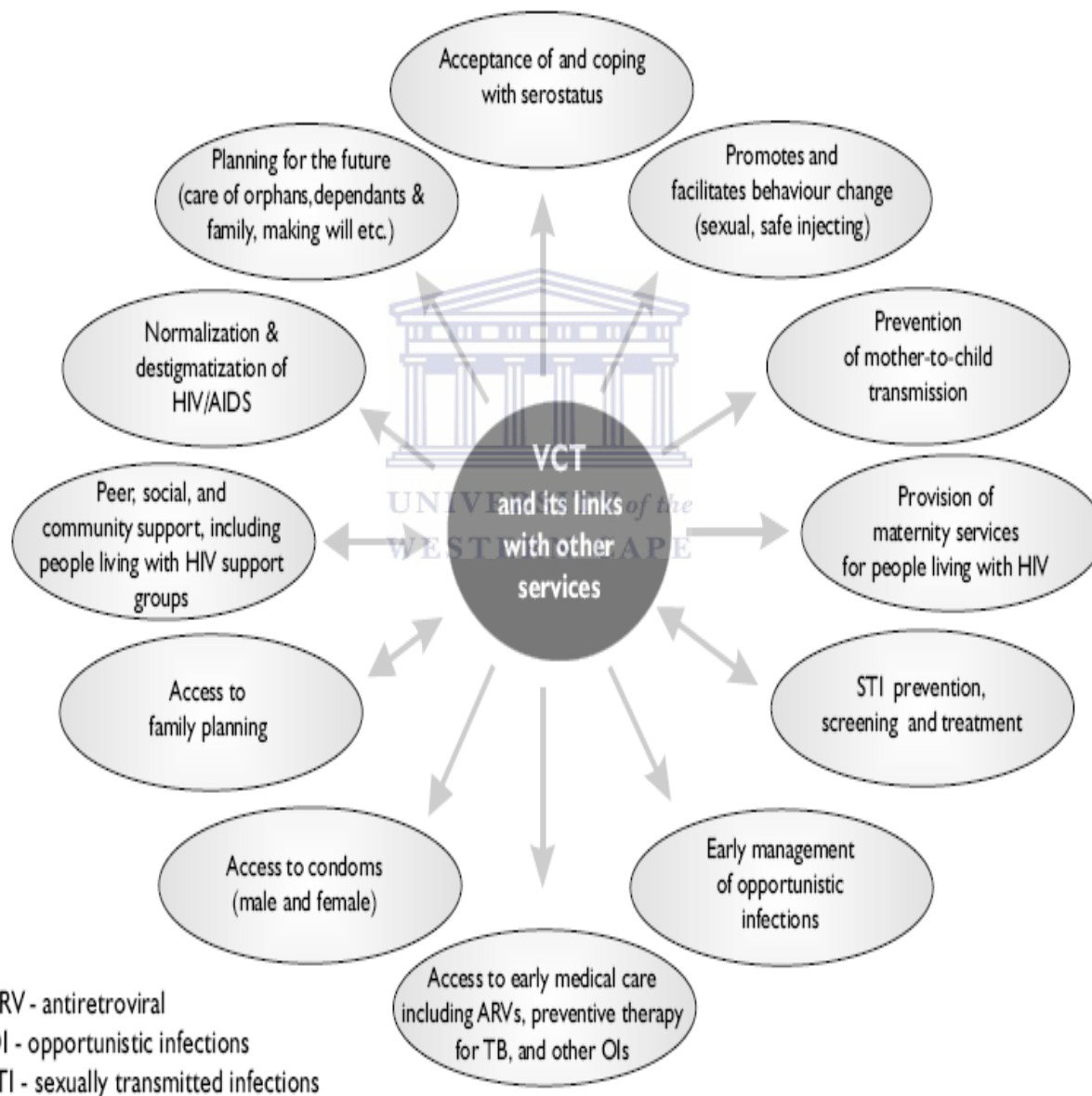
The major mode of HIV transmission in Zambia is through heterosexual intercourse, which accounts for 78% of the country's HIV infections (CSO, 2009). This mode of transmission is exacerbated by high-risk sexual practices, poor socio-economic status of women and high prevalence of STIs. Mother-to-child transmission during pregnancy, at birth or while breastfeeding account for 20% of infections. The ZDHS estimated that less than 1% is transmitted through contaminated blood and blood products, use of needles and sharp instruments, and sex between men.

### **1.3. VOLUNTARY HIV COUNSELING AND TESTING**

Voluntary HIV Counseling and Testing (VCT) is a major component of HIV prevention and care programs in many countries. HIV counseling and testing is a direct, personalized and person-centred intervention, tailored to prevent transmission and obtain referral to additional medical care, preventive, psychosocial and other needed services in order to remain healthy (CDC, 1994). VCT has been posited as beneficial as it presupposes the right to: know one's HIV status; link with further and ongoing information, supportive counseling, treatment, care and support systems; initiate and sustain behavioral changes that reduce risk of becoming infected and to assist HIV positive individuals in avoiding infecting others and efforts to raise public awareness

about HIV/AIDS and reduce stigma and discrimination (CDC, 1994; WHO, 2004). VCT is also a critical component of preventive strategies to reduce transmission of HIV/AIDS from mother to child. The following figure demonstrates the importance of VCT as a strategy in the management of HIV/AIDS.

**Figure 1: VCT as an entry point to prevention and care services**



Source: Voluntary Counseling and Testing (VCT): UNAIDS Technical Update May 2000

VCT is a central component of the Zambian government's strategy to prevent the spread of HIV and to provide care and support to those living with HIV/AIDS (MoH, 2005). The National Government's commitment to expanding access to VCT for people across the country creates a policy framework for increased uptake of VCT services in Zambia. According to the National HIV and AIDS Strategic Framework 2006 – 2010 (National AIDS Council [NAC], 2006), one of the strategic objectives under “the intensifying prevention theme” is “to improve access to and use of Confidential Counseling and Testing” (p.5). This is also reflected in the Sixth National Development Plan 2011-2015 under the objective “to reduce the rate of new infections every year (HIV incidence)”, where the strategy reads “expanding and scaling-up access to and use of VCT services” (GRZ, 2011, p.29).

According to the National HIV/AIDS/STI/TB Council (NAC, 2010), there were 1500 VCT sites in Zambia as of June 2010. Most of these sites are public health facilities and a few stand-alone managed by private and non-governmental organizations. In Zambia, like most African countries, HIV testing centers are used primarily to confirm diagnosis of HIV/AIDS in symptomatic persons referred to the center by clinicians (Coovadia, 2000; van de Perre, 2000).

However, despite of the critical role of VCT services in HIV/AIDS care and prevention and a growing number of studies that attest to the value of VCT in largely healthy populations, counseling services have been slow to gain acceptance in many countries (UNAIDS, 1999). Estimates based on surveys in 12 high-burden countries in sub-Saharan Africa indicate that a median of just 12% of men and 10% of women in the general population have been tested for HIV and received their results (WHO, 2007).

## 1.4 PROBLEM STATEMENT

The Demographic and Health Survey 2007, revealed that adult HIV prevalence rate to be at 14% (CSO, 2009). Among women aged 15-49 years, the HIV prevalence rate is 16%, while among men aged 15-49 years the HIV prevalence rate is 12%. It also reported that 9% of men and 14% of women (12% of all adults) have ever been tested. Additionally, 69% of women and 64% of men want to be tested but have not done so. Given the high percentage of Zambian adults who would like to be tested, it is certainly possible to increase coverage and maximize the benefits obtained from knowing one's status. It is, therefore, important to find out what people know about VCT and what the perceived barriers to utilizing VCT services in the rural areas are, as most of the studies have been done in urban areas.

## 1.5 OUTLINE OF THESIS

This thesis comprises of five chapters:

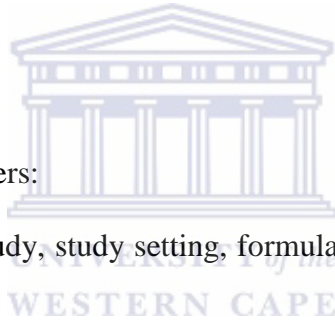
**Chapter 1:** Introduction to the study, study setting, formulation of the problem, purpose of the study.

**Chapter 2:** Literature Review.

**Chapter 3:** Methodology: Aims, objectives, definition of terms, study design, sampling, data collection and data analysis procedures, ethical considerations and limitations of the study.

**Chapter 4:** Results and Discussion.

**Chapter 5:** Conclusions and Recommendations.



## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

The previous chapter provided an orientation to this study by discussing the introduction to the study, study setting, formulation of the problem, purpose of the study, and the outline of the research study. This chapter covers the literature review related to this study, which is centered on the following areas: VCT its elements, options and importance and factors that affect the uptake and utilization and finally barriers to utilization of VCT.

### **2.2 VOLUNTARY HIV COUNSELING AND TESTING**

VCT is the process of providing counseling to an individual to enable him or her to make an informed choice about being tested for HIV (UNAIDS, 2001). This decision must be entirely the choice of the individual, and he or she must be assured that the process will be confidential.

According to UNAIDS (2001), VCT provides the opportunity for individuals to know their HIV status and help them cope with a positive or a negative test result. It serves as the gateway for both HIV prevention and for early access to treatment, care and support. United Nations Population Fund (2002) posits that knowing one's status provides for the choice whether positive and negative test results. A negative test result can serve as a strong motivating factor to remain negative, while VCT services can link people who test HIV positive to options for treatment, to care and support and allows for adoption of preventive measures.

## 2.3 PRINCIPLES OF VOLUNTARY HIV COUNSELING AND TESTING

WHO (2003) recommends that the following guiding principles be observed in the provision of all HIV testing and counseling services:

- a. Testing and Counseling must be scaled up: offering HIV testing and counseling should become standard practice wherever they are likely to enhance the health and well-being of the individual. The objective is to enable the greatest possible number of people to benefit from the ever-improving treatment, care and prevention options and realize their right to the highest attainable standard of health care.
- b. HIV testing should be voluntary: mandatory HIV testing is neither effective for public health purposes nor ethical, because it denies individual choice and violates principles such as the right to health, including the right to privacy and the ethical duties to obtain informed consent and maintain confidentiality. All those offered the test should receive sufficient information and should be helped to an adequate understanding of the testing process and possible consequences of being tested.
- c. Post-test support and services are crucial: the result of HIV testing should always be offered to the person being tested. It is the person's decision to share this result with others. Along with the result, appropriate post-test information, counseling or referral should be offered according to the result.
- d. Confidentiality must be protected: all medical records, whether or not they involve HIV-related information, should be managed in accordance with appropriate standards of confidentiality. Only health-care professionals with a direct role in the management of patients or clients should have access to such records or the information they contain, and only on a "need to know" basis.

## 2.4 VCT SERVICE DELIVERY MODELS

Family Health International (FHI, 2005) presents different VCT models which include:

- (i) Stand- alone: Stand-alone sites, also known as freestanding sites, are generally operated by non-governmental organizations (NGOs) and are not associated with medical institutions. Usually counseling and testing is the only service these sites offer, and the staff is dedicated full-time to providing counseling and testing.
- (ii) Integrated: In the integrated model, counseling and testing is provided alongside other services such as general in- and out-patient, tuberculosis (TB), antenatal, and sexually transmitted infection (STI) care.
- (iii) Quasi-integrated: In quasi-integrated sites, an NGO provides counseling and testing in a public sector health facility; both the NGO and the facility contribute to managing the services. This model capitalizes on the strengths of both stand-alone and integrated models and its success greatly depends upon the quality of the partnership.
- (iv) Private sector: This model, a variant of integrated counseling and testing, reaches people in higher income brackets who are less likely to use public-sector services. Private medical practitioners offer CT in their offices.
- (v) Mobile: Mobile counseling and testing takes the services into the community either out of a van or from designated places in the community. In some cases, bicycles and motorcycles are used. Under this model, a team of providers sets up a temporary site where they offer services to the general population, to defined groups such as a church congregation, attendees at cultural and sports events, employees of a company, or to hard-to-reach groups such as injection drug users, sex workers, truck drivers, street boys or those with no fixed address.

(vi) Home based: It is similar to the mobile model in that CT is offered within the home to family members, including children where appropriate. For this reason, it is sometimes referred to as the family-based model.

FHI (2005) posits that in most cases, a combination of models is appropriate to maximize coverage and improve the accessibility and acceptability of CT services. One testing model may serve as an HIV prevention tool for the general population, while another may help prevent mother-to-child transmission of HIV (PMTCT), and yet another may provide an entry point to clinical care for those living with HIV/AIDS. Expanding the number of models help more people to know their HIV status and benefit from prevention, care and treatment services.

## **2.5 BENEFITS OF VCT**

### **2.5.1 VCT as a gateway to HIV Prevention**

VCT is regarded as a priority area in strategies to prevent the spread of HIV and to provide care, support and treatment to PLWHAs (UNAIDS, 2001; WHO 2003). By allowing people to become aware of their HIV status and be counseled about its implications, VCT may help to curb the further spread of HIV and presents a mechanism for referral into care, treatment and support systems (UNAIDS, 2001; Weinhardt *et al.*, 1999). These include early treatment for opportunistic infections such as tuberculosis (Godfrey-Faussett *et al.*, 1995; Mwinga *et al.*, 1998), post-exposure prophylaxis (PEP), palliative care, access to anti-retroviral treatment (ART) and adherence counseling, as well as longer-term counseling and support for positive living (Baggaley *et al.*, 1998; Greene *et al.*, 2000; UNAIDS, 2001).

VCT also encourages changes in sexual behavior following testing through partner notification and referral for other services, such as contraception, which can help couples (both seropositive



and sero-negative) make informed decisions about family planning methods and having children (Lutalo *et al.*, 2000; Pugh *et al.*, 1998; Temmerman *et al.*, 1995). In Rakai, Uganda, 13% of positive women and 12% of negative women used female-controlled family planning following VCT (Lutalo *et al.*, 2000).

### **2.5.2 VCT as a gateway to interventions to prevent mother-to-child transmission of HIV**

In developing countries, affordable and feasible methods to significantly reduce mother-to-child transmission (MTCT) of HIV and advice on modifying infant feeding practices for seropositive women are available (Chopra *et al.*, 2000; Painter, 2001; Sangiwa *et al.*, 2000; Van de Perre, 1999). These can reduce HIV transmission from mother-to-child to 10% or less. Studies have also shown that pregnant women who test HIV positive and receive short courses of zidovudine or nevirapine, reduce their risk of transmitting HIV to their babies (McIntyre and Gray, 2002). Pregnant women who are aware of their sero-positive status can, therefore, prevent transmission to their infants.

Concerns about the safety of children and mothers and the test results may influence male involvement and behavior change; thus preventing HIV transmission among sero-discordant couples (Matovu *et al.*, 2002). In a small study from Uganda, women attending VCT associated with MTCT sero-negative mothers chose abstinence or condom use until their partners accepted VCT (Matovu *et al.*, 2002).

### **2.5.3 VCT as a gateway to on-going social support and emotional or psychological care**

People who test seropositive may experience a range of emotional problems ranging from denial and anger to despair and suicidal ideation (Baggaley *et al.*, 1998; Keogh *et al.*, 1994; Vollmer and Valadez, 1999). Knowing the HIV status allows seropositive people and their families to benefit from social support services at an earlier stage, hence cope more easily with the psychological sequelae of testing seropositive and prevent the development of serious or long-term, intractable problems (Baggaley *et al.*, 1998; Keogh *et al.*, 1994; Lie and Biswalo, 1996; TASO, 1994; Vollmer and Valadez, 1999). This may include opportunities to join support groups, networks of people living with HIV/AIDS and other social networks. Studies from the United Republic of Tanzania and Uganda have also shown that counseling can enable people to gain social and emotional support and cope better (Lie and Biswalo, 1996; TASO, 1994).

### **2.5.4 VCT as a gateway to legal and future planning**

One of the benefits of VCT is that it can help people with HIV to make plans for their future and the future of their dependents (UNAIDS, 2000a). This may include making a legally binding Will of estate to secure provision for the needs of the family. Research conducted in Uganda has shown that as a result of counseling, HIV seropositive individuals have been able to make financial and survival plans for their families (Kaleeba *et al.*, 1997, TASO, 1994). This may have entailed making changes in their work life, which include getting a second job, working overtime and saving.

### **2.5.4 VCT as a gateway to promoting normalization of HIV**

Overcoming the stigma associated with HIV is the biggest challenge to its prevention and care (UNAIDS, 2000a). It has been proposed that wider access to VCT and a larger number of

people's greater awareness of their HIV status within a community are important elements in challenging stigma (Lambouray, 1998). Countries where VCT is well established, such as Uganda, have a less stigmatizing attitude to HIV. However, for it to be effective in challenging stigma, HIV testing has to be a voluntary process associated with counseling that helps people understand and accept their status (UNAIDS, 1999; 2000a). It has been argued that if VCT were offered routinely, and more people would accept VCT as an important component of medical care, it would promote "normalization" of HIV (De Cock *et al.*, 1998; Godfrey-Faussett *et al.*, 1998). De Cock states that the excessive caution around HIV testing has had the detrimental effect of preventing people with HIV from accessing care. It also has contributed to the stigma and secrecy associated with testing.

## **2.6 UPTAKE AND UTILIZATION OF VCT SERVICES**

The global coverage of HIV testing and counseling remains unsatisfactorily low despite many acclaimed benefits and efforts to promote its acceptance. Surveys in heavily affected countries have shown that knowledge of HIV status is limited (Mabunda, 2001; Obermeyer and Osborn, 2006). Recently completed demographic and health surveys in the 12 high-burden countries of sub-Saharan Africa (Botswana, Cameroon, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Nigeria, Democratic Republic of Congo, United Republic of Tanzania and Uganda), showed that the median percentages of men and women who had been tested for HIV and had received their results were 12% and 10%, respectively (UNAIDS/ WHO/UNICEF, 2007).

In Lesotho, where adult HIV prevalence is 23%, only 12% of women and 9% of men had ever been tested for HIV and received their results, In Nigeria it was reported that 6% of women and 14% of men had ever been tested for HIV and received their results. A similar survey in Ethiopia

revealed that 4% of women and 5% of men had ever been tested for HIV and received their results. In South Africa, 31% of women and 26% of men had previously been tested for HIV.

Statistics from more developed countries show that about 20% to 30% of seropositive individuals are unaware that they are HIV positive (CDC, 2004). This means that most people living with HIV get testing and counseling only when they already have advanced clinical disease. The aforementioned statistics and verifiable benefits of VCT and related pronouncements considered, the question that requires answering relates to barriers to the utilization of VCT.

## **2.7 BARRIERS TO UTILIZATION OF VCT SERVICES**

Contributing factors to the low motivation for the uptake or demand for VCT services in sub-Saharan Africa range from personal or societal factors to factors associated with delivery of the service.



### **2.7.1 Personal Factors**

HIV testing might have far-reaching implications and consequences for the person being tested. These personal factors discussed below include survival and poverty, knowledge and practice about VCT, perception of personal risk, perceived benefits of VCT, fear of HIV positive result and safety and accuracy of HIV test

#### **2.7.1.1 *Survival and Poverty***

In most African countries, poverty influences individual health behavior patterns (Abdulraheem, 2007). With 75% of Zambians living in abject poverty (ZDHS, 2009) and numerous socioeconomic burdens are a daily concern whether they are HIV-positive or negative is of little consequences for them (Alder & Qulo, 1999). It might just mean the realization that they will not be able to support themselves or their families, when they become sick. Often they would rather

not know. Thus, messages to promote safe behavior are often inappropriate and ineffective (Alder & Qulo, 1999).

#### 2.7.1.2 *Knowledge about VCT*

Knowledge plays a pivotal role in accessing, utilizing and accepting the health services (Esnor, 2004). The study in a rural South African village revealed that knowledge of the availability of VCT services did not influence HIV testing behavior (Mabunda, 2006). In another related study conducted in Ghana, only 24.6% of respondents knew of the existence of VCT and HIV rapid kits (Baiden *et al.*, 2007).

#### 2.7.1.3 *Perception of Personal Risk*

Studies have revealed that perception of personal risk for HIV infection was a major motivation for people to test (De Graft-Johnson *et al.*, 2005; Maman *et al.*, 2001). For many people, the motivation to use VCT is low because (correctly or incorrectly) they do not perceive themselves as being at risk for HIV (Killewo *et al.*, 1998; Simpson *et al.*, 1998). Furthermore, studies conducted in areas of low HIV prevalence such as urban Mali, found a widespread disbelief in the existence of the AIDS virus or improper risk perception (Castle, 2003). Pronouncements made by key influential personalities, like former South African President Thabo Mbeki who questioned the causal link between HIV and AIDS, are known internationally, and resulted in many people on the African continent questioning the existence of the illness (Castle & Konaté, 2000; Cohen, 2000; Horton, 2000).

#### 2.7.1.4 *Perceived Benefits of VCT*

A common barrier to VCT is the lack of perceived benefit to knowing your HIV status, especially when seropositive (Baggaley *et al.*, 1995). Studies indicate that the perceived benefits of VCT may also be low when treatment is not readily available or is unaffordable, as has been

the case in much of the afflicted areas of Africa (Baggaley *et al.*, 1996; Voluntary HIV-1 Counseling and Testing Efficacy Study Group, 2000; Mabunda, 2006). According to van Dyk and van Dyk (2003), people see no point in knowing their HIV status when there would be no follow up support services or treatment of proven efficacy.

#### 2.7.1.5 *Fear of HIV Test Results*

The goal of VCT is often defeated when people do not come back for test results after receiving initial pre-test counseling (Solomon, 2004). According to WHO (2005), the fear of having to face being HIV-positive contributes to people not coming forward voluntarily for testing. Consequently, testing often only takes place when the person starts showing signs of being ill. This factor inhibits the VCT objectives of promoting prevention and healthy lifestyles. Most people, particularly those who consider themselves high risk may feel justified to fear HIV testing because to them, a positive result may be considered a death sentence, as most people still regard HIV/AIDS as an automatic death sentence (van Dyk and van Dyk, 2003). This makes them to believe that it is not advisable for them to know their HIV status.

#### 2.7.1.6 *Safety and Accuracy of Testing*

An understanding of the nature of the test, duration of waiting for the results and the actual interpretation of the results have been reported as raising questions on the reliability and accuracy of the results. This has been worsened by the shift to rapid tests, which enables availability of results within minutes. In South Africa, callers to the National AIDS Helpline (Birdsall *et al.*, 2004) expressed concern about the accuracy and reliability of HIV testing, particularly rapid tests that were administered through oral swabs or finger pricks. Counselors were of the opinion that this category of question probably constituted the most common VCT-related call:

People have been told [in the past] that in an HIV test they have to draw blood from you and then you have to wait something like two weeks. Therefore, they call and say, ‘But now I went there and they just give me the results within 30 minutes. Can I trust these results?’ ... Most people do not think that test is reliable enough for counselors to tell them they are HIV-negative. So there are those [questions] of trust towards VCT. It’s like, before we used to go away and you’d say come back after seven days. So now with just thirty minutes – ‘No, it might not be accurate’ (Birdsall *et al.*, 2004, p.5).

Another issue hinges on understanding and interpreting the HIV test results. Counselors to the National AIDS Helpline in South Africa reported that callers who had accessed VCT had questions about the test results. According to counselors, callers did not always understand the meaning of their test results or were sometimes given written results without any explanation. It was not uncommon for callers to say that they were told that they were ‘reactive’, without being given an interpretation of what this meant, nor being given post-test counseling.

## **2.7.2 Health Service Related Factors**

Service delivery factors perceived as barriers impact on how the process of VCT takes place. These include promotion of VCT services at health facility; quality, accessibility and availability of VCT services; confidentiality and attitude of health workers; type of service provider; and human resources management for health.

### **2.7.2.1 Promotion of VCT at Health Facility**

Studies have revealed that few health workers have had VCT themselves, and they may be skeptical about the wisdom of HIV testing for their clients, especially where high HIV prevalence makes the odds high that a positive test result will be the outcome (Solomon *et al.*,

2004). This may lead to reluctance by health workers to promote VCT. Additionally, primary care health workers often work under difficult circumstances with low pay and poorly supplied and equipped clinics (Bassett, 2002). They may have low morale, not have treatment options to offer and talking about the risk of AIDS raises personal unresolved fears and concerns.

#### 2.7.2.2 *Quality, Accessibility and Availability of VCT Services*

A major problem related to effective VCT service delivery is apparent inconsistencies between strategic objectives and service delivery realities (Solomon *et al.*, 2004). Solomon and colleagues argue that VCT objectives cannot be met in reality due to inadequate resources such as testing kits, finances, infrastructure or even basic medication. Modiba *et al.* (2001) have shown that there are common negative experiences of care in general clinics which include victimization of HIV positive users, negative treatment from health providers, poor confidentiality, overcrowding, long waiting times, limited hours of service and shortage of drugs.

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). Studies in India (Abraham *et al.*, 1998), South Africa (Viljoen *et al.*, 1998) and the Democratic Republic of Congo (Denolf *et al.*, 2000) have documented the shortcomings of available VCT services, which include poor quality of interactions between clients and counselors, particularly perceived lack of confidentiality (Coovadia, 2000). In Kinshasa (DRC), counselors noted that in clinical settings pre-test counseling was not often done and results were often not relayed to the client (Denolf *et al.*, 2000). Medical staff were themselves reported as having an “unhelpful attitude” to VCT such as reluctance to give positive results to clients.



### 2.7.2.3 *Confidentiality and Attitudes of Health Workers*

Van Dyk and van Dyk (2003) posit that although people generally believe that it is a good idea to know their HIV status, it is evident that a lack of trust in the public health care system is a huge stumbling block. Adults and young people often do not seek VCT because they fear being seen at a testing site or having health care personnel tell others that they have come to be tested. Grant *et al.*, (2001) found that breaking confidentiality and privacy happens almost every day in Uganda where health care workers disclose the HIV status of clients without their consent.

A qualitative study investigating VCT uptake by pregnant women in South West Uganda revealed that pregnant women were anxious about taking up VCT, due to the fear for confidentiality and fear that maternity staff might refuse to assist them when the time come to deliver if their HIV-positive status were known (Pool *et al.*, 2001). A study in Zambia found that three times as many people accepted testing at the non-clinic locations compared to the clinic (UNAIDS, 2001).

### 2.7.2.4 *Type of Service Provider*

According to Solomon *et al.* (2004), VCT provision has brought about tension between the medical and the non-medical professionals. Because the HIV test is a medical test, it has been assumed that only a trained medical person can do it. As a result, most VCT is done in medical rather than non-medical settings. On the other hand, HIV counseling is a non-medical service often performed by lay and non-professional people that takes place in a medical setting, which is occupied by professional doctors and nurses. In some countries with critical staff shortages, a tiered approach which relies on lay or peer counselors backed up by professional counselors to handle most VCT service has been successfully used (Bassett, 2002; Sanjana, 2008). This approach has the potential to reduce the demand for full-time professional counselors.

Baiden *et al.* (2007) found that 98.7% of respondents in Ghana approved of the use of lay counselors to promote community-based VCT, although there was apprehension about giving them HIV rapid test kits. Accessibility and socio-cultural familiarity were the main reasons advanced in favor of the use of lay counselors. Varying views emerged on whether the lay counselor should be a native of the community or not. Fear of breaches in confidentiality if the counselor happened to be a native emerged as a concern. Bassett (2002) raises the issue of acceptability and preference in terms of service providers as community perceive the health care workers and the lay counselors differently, including the level of confidence placed on them.

In studies in Zambia, Uganda and South Africa, community- and home-based services have been well accepted and apprehensions about breaches in confidentiality were not actualized (Fylkesnes and Siziya, 2004; Matovu *et al.*, 2002; Wolff *et al.*, 2005).

#### 2.7.2.5 *Human Resource Management for Health*

According to Kombe *et al.* (2004), human resources are the cornerstone of a health system. Without skilled health workforce, the Zambian public sector health system cannot deliver adequate and appropriate care to its population. Most facilities operate with less than half of the normal staff establishment which entails that staff cannot perform their duties effectively (Kombe *et al.*, 2004). In many VCT sites health care providers are required to do counseling work in addition to their designated medical duties. The added workload and lack of financial compensation leaves service providers, who are not adequately and regularly supervised, feeling frustrated and despondent (Solomon *et al.*, 2004).

There is recognition in the literature that often the VCT system does not take into account the fact that counselors bring their own issues into any counseling situation (Coovadia, 2000). These

may arise from being personally affected by the epidemic and/or finding their jobs increasingly stressful as they feel themselves to be helpless in the face of the growing HIV epidemic.

### **2.7.3 Community-related Factors**

Adeokun (2006) posits that the complexity of the HIV/AIDS epidemic stems from its links with all aspects of society and culture. This implies that social and cultural factors affect not only viral transmission, but also the success of prevention strategies and the compassion with which people living with the virus are treated.

#### *2.7.3.1 Cultural Beliefs*

People's beliefs about disease causation ultimately influence their health-care-seeking behavior and efforts to protect themselves from infection (Adeokun, 2006). In some African countries there is wide-spread belief that the origins of ailments are not as simple as modern medicine posits (Caldwell, Orubuloye and Caldwell, 1992). The authors argue that the combination of different systems of philosophical or religious beliefs or practices which are inherent in African religions and customs—the beliefs that events are multi-causal and that the timing of death is predestined—resulted in an initial under-reaction to AIDS. This resulted in a fatalistic attitude, which in some instances caused some people to remain in denial about the epidemic.

Orubuloye and Oguntimehin (1999) demonstrated that this indifference to the prospect of death produces a high risk-taking sexual culture among men and little behavior change in response to HIV prevention interventions. The reluctance to talk about sex within marriages and between generations also has delayed the public health response to a sexually transmitted epidemic. Many Nigerians, for example, believe that fertility-associated diseases are in a special category, treatable by indigenous practitioners. Wasting, a dominant feature of AIDS, also is perceived to

be linked to witchcraft. The alien image of AIDS adds to its stigma and encourages the perception of AIDS as retribution for those who engage in immoral activities.

### 2.7.3.2 *Discrimination and Stigma*

Stigma has been expressed as a complex social process resulting from the interactions between social and economic factors in the environment (Ogden and Nyblade, 2005). It creates unfavorable attitudes, beliefs and policies directed toward people perceived to have HIV/AIDS as well as toward their families, close associates, social groups and communities (Brimlow, Cook and Seaton, 2003).

Goffman (1963) defined stigma as an "attribute that is deeply discrediting" that reduces the bearer "from a whole and usual person to a tainted, discounted one." (p.3). Goffman described three types of stigma that individuals face: stigmas related to various physical deformities; flaws in individual character such as weak-will or dishonesty; and stigma associated with a social group, race, or religion. Diseases associated with stigma share common attributes: often the person with the disease is seen as responsible for having the illness, the disease is both progressive and incurable, the disease is not well understood by the public, and the symptoms cannot be concealed (Goffman, 1963; Herek and Capitano, 1999; Seaton, 2003).

HIV and AIDS have generated fear, anxiety, and prejudice against people living with HIV/AIDS (Baggaley *et al.*, 1998). Being HIV positive also creates widespread stigma and discrimination in a population, and can adversely affect both people's willingness to be tested for HIV and adherence to antiretroviral therapy. Societal attitude towards HIV can have a strong impact on individual choices, and if people known to have HIV face discrimination and stigma, VCT is unlikely to be a popular intervention (Baggaley *et al.*, 1998, UNAIDS, 2002b).

Several factors have been identified that determine stigmatizing reactions towards people living with HIV/AIDS (PLWHA) (Dijker and Koomen, 2003; Herek, 1999; Herek and Capitanio, 1998; Pryor *et al.*, 1999; Weiner *et al.*, 1988). First, perceived contagiousness of the disease is related to feelings of fear and stigmatization. Second, perceived seriousness of the disease is related to stigmatization. Third, perceived responsibility for becoming HIV infected is associated with stigmatization of PLWHA. And fourth, negative reaction towards PLHA often symbolizes negative attitudes towards groups associated with HIV/AIDS, such as men having sex with men, commercial sex workers, and drug users.

HIV/AIDS-related stigma and discrimination have been recognized as one of the main obstacles to the prevention and treatment of HIV and AIDS (Kalichman and Simbayi, 2004). Studies conducted by the International Centers for Research on Women (ICRW, 2005) found that HIV/AIDS-related stigma takes various forms in different communities, which may be physical, social, verbal or institutional. It undermines public health efforts to combat the epidemic (Malcolm *et al.*, 1998; UNAIDS, 2000a) and serves as an additional barrier, affecting the acceptability of testing (Kipp *et al.*, 2002). Stein and Nyamathi (2000) posit that HIV/AIDS-related stigma and discrimination affects establishment and membership to social support groups and networks and is the single greatest challenge to slowing the spread of the disease.

### 2.7.3.3 *Power Relations and Gender Inequalities*

Power relations and gender inequalities in communities and households pose a barrier to VCT service utilization (Maman *et al.*, 2001). Research has shown that women in Tanzania lack the personal control to make decisions about health services in general, a situation that extends to testing for HIV (Maman *et al.*, 2001). Fear of male partner reaction, especially physical or verbal abuse, breaking up of marriages, being neglected, or disowned by their families, loss of

security, shelter, food and relationship, and even murder have been found to be a major deterrent to HIV testing and result notification among the women (Maman *et al.*, 2002; Pool *et al.*, 2001; Temerman *et al.*, 1994; van Dyk and van Dyk, 2003; UNAIDS, 1999).

## **2.8 SUMMARY**

This chapter has covered a broad review of literature on factors affecting uptake of Voluntary Counseling and HIV Testing. It is clear that, although there are many possible benefits of knowing one's HIV status, Voluntary Counseling and HIV Testing uptake rate is low in developing countries. The literature has also suggested that barriers to the utilization of VCT services include personal factors (survival and poverty, knowledge and practice about VCT, perception of personal risk, perceived benefits of VCT, fear of HIV positive result and safety and accuracy of HIV test), health facility level factors (lack of promotion of VCT services at health facility; quality, accessibility and availability of VCT services; confidentiality and attitude of health workers; type of service provider; and human resources management for health) and community-related Factors which include cultural beliefs, stigma and discrimination and gender inequalities. Whilst there was limited information in the literature on Zambian literature, I have drawn on literature from comparable developing countries in Africa and Asia.

## **CHAPTER 3: METHODOLOGY**

### **3.1 INTRODUCTION**

This chapter presents the methodology of this study. According to Burns and Grove (1995), research methodology “refers to the strategy of the study, from identification to final data collection”. The chapter contains the following: aims and objectives, study design, study population, sampling procedure, data collection tools, data processing and analysis, validity and reliability of the designed instruments, data management, generalizability, and ethical considerations .

### **3.2 AIMS AND OBJECTIVES**

#### **3.2.1 Aims of the study**

The aim of the study was to explore factors that affect utilization of VCT services in Mwense district, Zambia.

#### **3.2.2 Objectives**

The objectives of the study were:

- i. To explore the existing knowledge of VCT services;
- ii. To explore the community’s motivation for seeking VCT care;
- iii. To explore factors that influence the utilization of VCT services;
- iv. To describe the perceived barriers to utilizing the VCT services; and
- v. To explore community’s suggestions for improving VCT services.

### **3.3 STUDY DESIGN**

An explorative, qualitative study design was utilized. According to Welman and Kruger (1999), qualitative research is multi-method in focus, involving an interpretative, naturalistic approach to its subject matter. The study was conducted in community settings of Mwense district, using the local language and terminologies. This enabled the participants to relate to the issues of VCT and HIV/AIDS and gave responses reflecting the realities of what was obtaining in their communities. This is in line with Creswell (2007), who states that the key words and central aspects of qualitative research are process and meaning arrived at through human interaction within the social context.

Qualitative study methods were chosen because of their usefulness in exploration of people's knowledge, views and experiences (Kitzinger, 1994) and because they provide the researchers with opportunity to study social interactions in a natural setting as recommended by Hollander (2004). The current qualitative study revealed patterns of perceptions that underlie communities' otherwise quantifiable knowledge and practices about HIV voluntary counseling and testing. Sensitive topics such as sexuality were also easily discussed in qualitative methods because once the "ice is broken" by one participant, others started to open up (Kitzinger, 1994). The researcher used open-ended questions in both individual interviews and focus group discussions, which allowed the participants to express themselves in their own vocabulary.

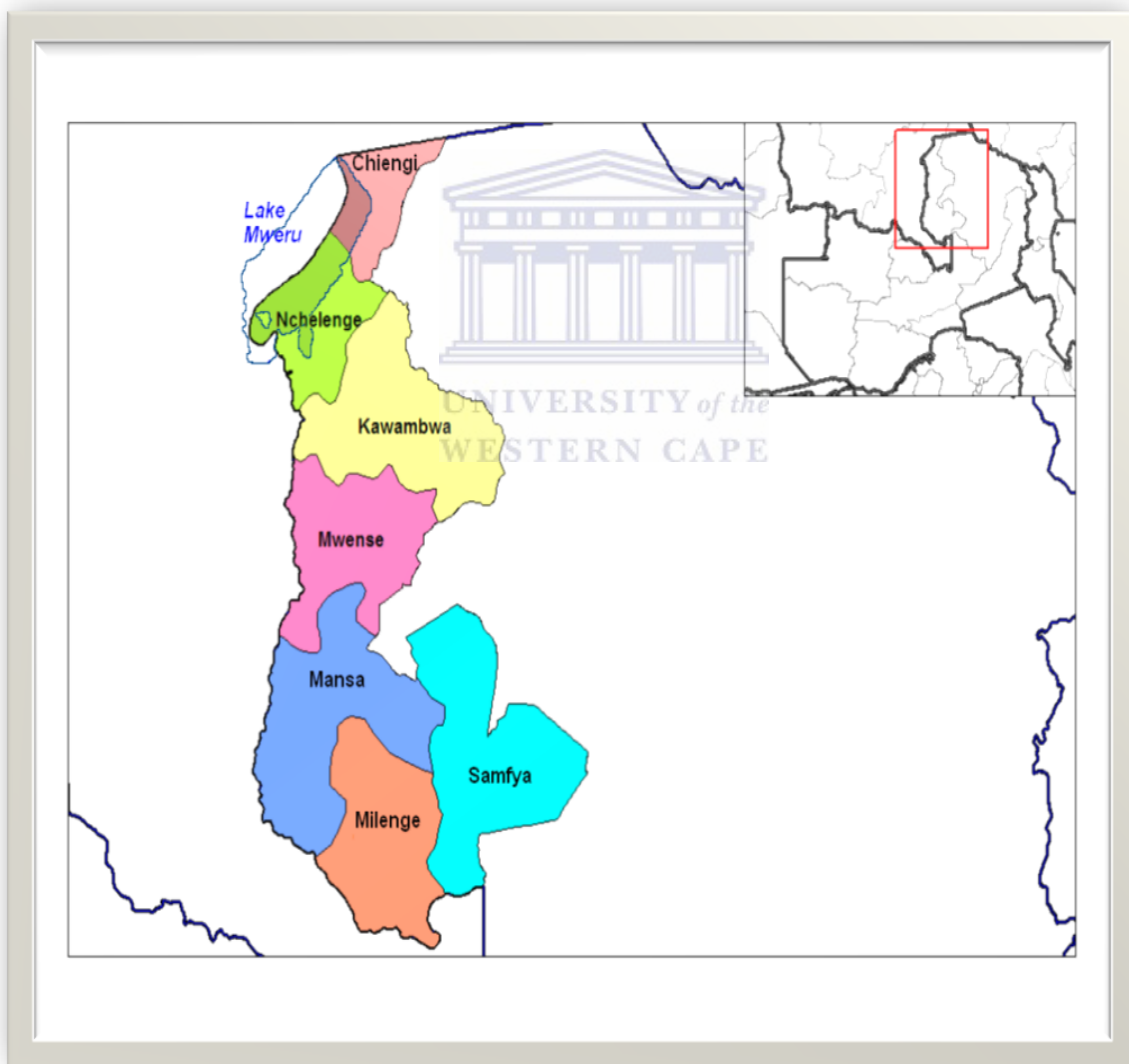
### **3.4 DESCRIPTION OF THE STUDY SETTING AND POPULATION**

The study was conducted in Mwense district in the Luapula Province of Zambia. Mwense is a rural district with an approximate population of 120, 690 inhabitants (CSO, 2001). There is one hospital which acts as a referral centre for 24 rural health centres.



The primary target population of this study was adult men and women and youths residing in Mwense District, and living within 3-5 km from the three rural health centres, Kashiba, Musangu and Mwense stage II. Population density and VCT statistics at the facility were used as the main criteria of selecting the sites to conduct the study. Health care providers from the three rural health centres providing VCT formed the secondary study population with key informants drawn from government ministries, non-governmental, Faith based and community based organizations.

**Figure 2: Map of Luapula Province**



Source: [http://en.wikipedia.org/wiki/Luapula\\_Province](http://en.wikipedia.org/wiki/Luapula_Province)

The inclusion criteria for selecting primary study population were:

- Residents of the facility catchment area;
- The minimum age should be 18 years with no upper age limit;
- HIV status not requirement for inclusion;
- Speak local language (Bemba or English).

### 3.5 SAMPLING PROCEDURE

Two sampling methods were used in this study. Convenience sampling was used to select participants for focus group discussions meeting the inclusion criteria.

Purposive sampling was used to select of key informants and health care workers based on their experience and knowledge of HIV/AIDS and VCT activities.

**Table 1: Focus Group Discussion Participants**

Study areas/group	Adults			Youths
	Mixed	Male	Female	Mixed
Kashiba Catchment area	12	-	-	13
Musangu Catchment area	0	11	8	10
Mwense Catchment area	10	0	0	12
Community Lay Counselors	9	0	0	0
Health Care Workers	5	0	0	0

### 3.6 DATA COLLECTION

Information was collected through focus group discussions and individual semi-structured interviews. A research team consisting of the principal investigator and two research assistants (note taker and recorder) conducted the study. Two day orientation in qualitative research was

conducted for the two research assistants (one male and one female), who already had previous experience and knowledge in using this approach to data collection. An interview schedule was designed in English and key technical words translated to the local language, Ushi/Bemba. Topics covered were general awareness of HIV in the community, VCT service availability, motivation to utilization of VCT and factors affecting utilization.

### **3.6.1 Key Informant Interviews**

Key informants refer to people in the community with specialized knowledge about a subject or practice and considered the major sources of information due to the fact that they are based within the setting under investigation (Chopra and Coveney, 2003; Sankar *et al.*, 2006). Six (6) key informants were interviewed, who included two members of Mwense Home-based Care, a traditional leader, the District AIDS Coordinator, Coordinator of Network of people living with HIV/AIDS (NZP+) and four health care workers.

The key informant interviews took place at the participants' work places at times convenient for them after prior arrangements. A brief explanation of the aim of the study and confidentiality related issues kicked off the interview. Each interview lasted about one hour. During the interview, data was documented by taking hand written notes and audio-tape recording.

### **3.6.2 Focus group discussions**

The focus group discussion (FGD) is a rapid assessment, semi-structured data gathering method in which a purposively selected set of participants gather to discuss issues and concerns based on a list of key themes drawn up by the researcher/facilitator (Kumar, 1987). It is a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (Kreuger, 1994). Its purpose is to obtain in-depth information on

concepts, perceptions and ideas of a group about a particular topic or need by interviewing a group of people directly affected by the issue (Kreuger, 1994).

Focus group discussion guide composed of predetermined topics including awareness of VCT services provided in the area, perceptions of the importance of VCT, factors that influence people to and hinder them from seeking VCT, and suggestions for increasing VCT uptake.

Nine (9) focus groups discussions (FGDs) were held, seven with community members, one with lay counselors and one with health care workers. The number participants in the FGDs ranged from 9-12, with the age ranging from 18-65 years. Each FGD began with a welcome, brief introduction of the research project and setting of the ground rules, which included confidentiality of the information provided. Each participant was given an opportunity to speak until the information was saturated and no new ideas were emerging. One research assistant was a moderator while the other was recording key emerging responses on the flip chart. The researcher was taking notes, observing the group interaction and atmosphere and operating the tape recorder. The discussions were held in vernacular language. FGDs allowed respondents to react and build on responses of other group members. This process resulted in data that would otherwise remain uncovered.

### **3.7 DATA PROCESSING AND ANALYSIS**

According to Glesne and Peshkin (1992) “data analysis involves organizing what you have seen, heard, and read so that you can make sense of what you have learnt” (p.127). From working with the data, the process involves the creation of explanations, the development of theories and linking the stories you have with others (Glesne and Peshkin, 1992). It is a process through

which qualitative findings are built from original raw data (Patton, 1990). The goal was to create descriptive, multi-dimensional categories that formed a preliminary framework for analysis.

In-depth interviews and FGDs were transcribed verbatim to allow for easy analysis of the texts and to ensure that no information was lost prior to starting data analysis. The first step of the analysis process involved multiple reading of the transcripts to identify perceptions, feelings, attitudes and understanding of the concept under study, VCT. Content that was identified to be important for this study's investigation was consolidated into categories that were identified as being used most commonly by the participants or as holding particular meaning for answering the research question.

Themes, categories and sub-categories were grouped and concepts generated under which data was labeled, sorted and compared. Re-examinations of categories identified were then done to determine how they were linked in order to get more explanations and recurring themes or patterns, using a process recommended by Straus and Corbin (1990). Words, phrases or events that appeared to be similar were grouped into the same categories. The categorization (or coding) stopped when no new themes emerged from the data. Themes were then categorized in accordance to interview questions but not exclusively due to their tendency to overlap.

### **3.8 RIGOR**

Rigor or study quality is of utmost importance when conducting qualitative research to ensure that results and interpretations are valid and reliable.

***Credibility:*** Credibility refers to process of demonstrating that inquiry was conducted in a manner that ensures the accuracy of how subjects were identified and described (Marshall and Rossman, 1995). Credibility was achieved through a detailed description of the research setting

and methodology. The researcher adhered strictly to the selection criteria and only eligible participants were interviewed. The interview process was explained to participants and field notes were recorded and the interviews were transcribed verbatim. The researcher interviewed participants to the point at which there was information saturation. Credibility was also enhanced by using different data collection methods, (triangulation), namely in-depth interviews and focus group discussions. The researcher used information from participants and his own observations to interpret data. Data was also stored on the tape recorder for further analysis.

***Transferability:*** refers to the extent to which the findings can be applied to other contexts or with other participants (Mouton, 2001; Polit and Hungler, 1995). According to Marshall and Rossman (1995), transferability allows the researcher to generalize the results about the particular sample to the population from which the sample was drawn. Creswell (2003) states that like the issue of generalizability, the uniqueness of a study within a specific context mitigates against getting exactly the same results if replicated in another context.

The study was limited to one district and its findings may not necessarily apply to all districts in Zambia due to variations in socio-economic and cultural dynamics across the country.

***Dependability:*** refers to the degree to which the reader can be convinced that the findings did indeed occur as the researcher says they did (Lincoln and Guba 1985). The researcher used direct quotations from discussions and interviews to ensure the veracity of the results. The researcher also fed back to the respondents after data analysis, checking that they agreed with what was recorded in the findings of the study. The feedback sessions confirmed that the information presented in the study was in line with what was discussed in the interviews and focus groups.

**Confirmability:** refers to the extent to which the data confirm the general findings and not simply the products of the researcher's bias (Lincoln and Guba, 1985). This was achieved by comparing the findings and interpretations to the wider literature and by giving feedback of the findings at the end of the interview to the participants and checking whether they agreed with them. This is the strategy which Creswell (2003) calls member checking - where the informant serves as a check throughout the analysis process. An ongoing dialogue regarding the researcher's interpretations of the informant's reality and meanings ensured the truth value of the data.

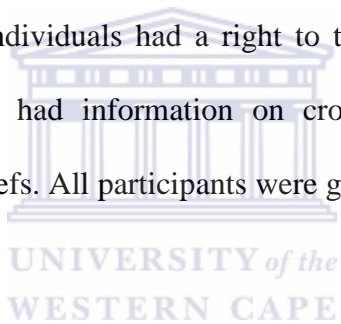
**Researcher's reflexivity:** The researcher is aware of his long interest in this area of VCT as having worked in this sector for more than 10 years. He is of the view that VCT is a form of community and individual empowerment which may lead to wellbeing, increase awareness of and participation in health promoting and risk reduction behavior, access to information and continuum of care and control of one's destiny. For this to be attained, it needs to be supported by government policy and district level implementation. To address the potential for professional bias the researcher ensured rigor through explicit and systematic design, collection, analysis and interpretation of data (Bowling, 1997).

### **3.9 ETHICAL CONSIDERATIONS**

Ethical approval for the study was obtained from the University of the Western Cape (UWC) Ethical Committee and the research protocol and consent forms were approved. Written permission to conduct the study was sought from the Ministry of Health, through the Provincial Health director and the District Health Director, upon submission of the relevant documents.

Understanding the sensitive nature of the HIV problem, the researcher ensured confidentiality and anonymity by not divulging names of the participants in the report and safely stored field notes and tapes. The aim of the study was explained to all the potential participants. Permission to include them in the study was sought and written consent was obtained. The participants were informed that they were free to withdraw at any time without giving reasons. A decision not to participate was strictly respected and women assured that non-participation would not affect their health care in any way.

Ground rules covered issues of confidentiality of the discussion, recording of the discussion and that all individual opinions were important and should be respected. It was emphasized that participation was voluntary and individuals had a right to terminate their participation at any time. In addition, the researcher had information on cross-cultural studies and knew the community's local culture and beliefs. All participants were given ZMK5000.00 each as token of appreciation for their participation.



### **3.10 LIMITATIONS OF THE STUDY**

Our study has a number of limitations. Firstly, the sample size of this study is small, so the results may not be generalizable to the population seeking VCT services in Mwense district. By covering a limited number of areas, the study reflects perceptions, attitudes and opinions of people in the research sites and cannot reflect situations in other parts of the province nor country as a whole. Secondly, as bias and error are endemic in any scientific study, voluntary participation in the FGDs may have introduced some selection bias. Errors are likely to arise from the fact that the study touches on sensitive issues such as sexuality, safe sexual behaviors, health seeking behavior in the context of high levels of HIV/AIDS and other related diseases.



Additionally, group dynamics could have influenced the responses during FGDs as no one would have given responses outside what might have been considered normal and correct. Also, there may be a possibility of respondents giving socially desirable responses. According to Catania *et al.* (1990), gathering information on sexual and HIV/AIDS matters is subject to "measurement error" and "participation bias".

Furthermore, as we did not observe the actual counseling sessions to assess time spent per client or the content and conduct of counseling session, our attempt to assess the quality of services provided is limited.

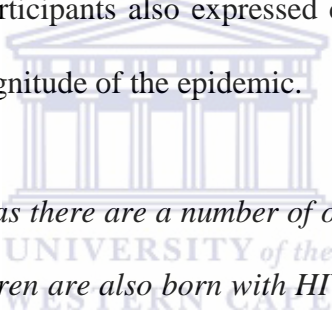


## CHAPTER 4: RESULTS AND DISCUSSION

This chapter presents the results of the study and discussions on their implications. The main themes discussed in this chapter are awareness of HIV and AIDS and VCT services in the community, facilitators and barriers to VCT uptake and suggestions for the improvement of VCT uptake.

### 4.1 AWARENESS OF HIV/AIDS IN THE COMMUNITY

HIV/AIDS was recognized as a major public health problem by all focus group participants. This is manifested through the deaths of breadwinners and other family members including an ever increasing number of orphans. Participants also expressed concerns about being vulnerable to HIV as a clear indication of the magnitude of the epidemic.



*“HIV and AIDS is a problem as there are a number of orphans, meaning their parents died of HIV/AIDS. Some of the children are also born with HIV and are ill, and others do not live long. We also have a growing number of widows and widowers in our communities.”*

(Female Adult, Kashiba)

*“It is a problem as it is everybody’s problem. There are people who are sick in our communities. Actually every one of us gathered here has had an experience with HIV/AIDS, lost relatives, looking after patients and orphans and is daily challenge with the fear and anxiety of who the next person will be.”* (Female Adult, Musangu)

Participants identified the following as intertwined factors that contribute to the spread of HIV in their communities: poverty, multiple and concurrent sexual partners, cultural and traditional

practices such as sexual cleansing after the death of a spouse, alcohol consumption and low status of women.

### *Poverty*

Study participants identified the inability by community members to meet the daily necessities of life as contributing to the spread of HIV/AIDS. They reasoned that poverty drives people into the underground activities which exposed them to the risk of contracting HIV/AIDS, such as engaging in unsafe sexual practices, including prostitution and cross-generational sex.

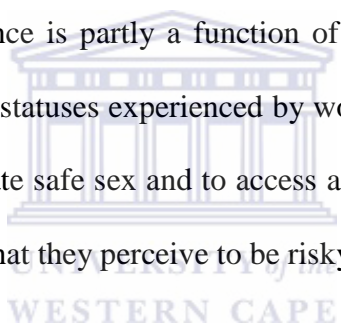
*“There is high poverty in the community which has resulted in some women, married and single, getting involved in sexual relations in order to raise money to survive on. Some parents even encourage their daughters to raise money for the family this way.”* (Female Adult, Musangu)

*“People may know the dangers of HIV/AIDS, but because of the poverty people experience in our society, it forces them, to take certain risk behaviors knowingly. You may find that someone died of HIV/AIDS, with clear visible symptoms and signs, but when this man comes for a partner, he finds one and when news goes around of the partner status, he/she says it is ok, since we all are going to die one day. This is due to poverty and lack of economic and social empowerment especially among women, thus affects the self-perception and self-esteem, hence vulnerability.”* (Key Informant, Mwense)

*“Adults are going out with young ladies and vice versa. There is cross-generational sex and cross-generational spread of HIV. This is mostly as a result of poverty due to limited livelihood options. The older generation seems to have money and possibly HIV*

*and lure the younger boys and girls to having sex with them, so the virus is spread. The young boys and girls going out with older women and men, also have relationship within their age group. You can see how HIV now cuts across age groups.”* (Key Informant)

In a study which aimed at investigating sexual practices in two communities of Mansa District in Zambia by Kalinda and Tembo (2010), participants in the focus group discussions mentioned that the poor economic conditions and high levels of unemployment contributed to the increase in the number of young girls and women involving themselves in transactional sex and marital infidelity. Shelton *et al.*, (2005) posit that the poor, especially women, were vulnerable to sexual exploitation because HIV prevalence is partly a function of survival. They argue that the low socio-economic and socio-cultural statuses experienced by women translate into commercial sex work, violence, inability to negotiate safe sex and to access adequate information and less likely that they will leave a relationship that they perceive to be risky.



#### *Multiple sexual partners*

Some study participants held the view that individuals who had multiple sexual partners had increased risk of contracting HIV as each new and concurrent sexual relationships introduced another pathway for HIV transmission. This was exacerbated by low or no condom use in the community.

*“HIV is spread through extra and multiple sexual relations as both single and married people are going round having mostly unprotected sex as condom use is not popular, although available at the Clinic and shops. Men especially are having many sexual partners, which makes it easy to acquire or spread HIV”* (Female Adult, Mwense)

Our findings are consistent with those by Kalinda and Tembo (2010) where participants in the FGDs asserted that having multiple sexual partners was considered an acceptable traditional part of the community life. The study participants further alluded to the fact that young men engaged in high-risk sexual behavior because that was the way the community expected them behave. These findings are in line with those by Nshindano and Maharaj (2008) from a qualitative study conducted among University students in the capital city of Zambia, Lusaka. The respondents in the study stated that multiple partnerships were relatively widespread among young people and that the majority of young men grow up believing that their identity as a man was defined by their sexual prowess.

Additionally, the Zambia Demographic and Health Survey 2007 (CSO, 2009), showed that a much larger proportion of men than women reported having more than one sexual partner. 14% of men reported having two or more partners in the 12 months preceding the survey compared with only 1 % of women. Among respondents who had sexual intercourse in the 12 months preceding the survey, 20% of men and 2 % of women had two or more partners. The average number of lifetime sexual partners for men age 40-49 was eight, compared with only two partners for women in the same age group.

Green (2003) argues that considering that most HIV infection is transmitted through sexual intercourse, were it not for multiple sexual partnerships, HIV would probably not reach global epidemic levels. Multiple sexual partnerships are, therefore, regarded as indicative of high-risk sexual behavior because they substantially increase the risk of HIV transmission through sexual networks.

### *Traditional Practices*

Cleansing after the death of a spouse is a common traditional rite performed in Mwense district. Participants mentioned that although there were different ways cleansing, the sexual one was preferred, which also exposed both the cleanser and the cleansed to HIV - in the event of either of them being HIV infected.

*“Sexual ritual cleansing is also contributing to the spread of HIV/AIDS. This is done when one loses a partner and in order to cleanse the ghost of the deceased, relative to a deceased has to have sex with the widow/widower. Condoms are not used as there is a strong belief that the traditional method. This is not the only known method of cleansing, but it seems most preferred.”* (Female Youth, Kashiba).

This custom of sexual ritual cleansing is documented as one of the most deep - rooted and widespread among Zambia's 73 ethnic groups (Malungo, 1999). Our findings are consistent with by Kalinda and Tembo (2010) where participants in the FGDs mentioned that it was necessary on the death of either spouse for the survivor to have sexual intercourse with a relative of the dead partner. Participants argued that if this act was omitted, intercourse with any other person was believed or held to be rendered dangerous by the “anger” of the spirit of the dead person. Some men were afraid to marry a widow who had not been through the rite. The ritual is performed to “cleanse” the surviving partner of the spirit of the dead spouse, by having sexual intercourse with the surviving partner in a ceremony closely monitored by other relatives (Malungo, 1999).

A study among the Tonga tribe of Maamba by Nasilele, (1997), revealed that the belief in sexual intercourse as a way of cleansing was so strong among the village communities that they could not even accept the use of a condom as they believed that the condom would not permit the “blood to meet” and, therefore, the ritual would have been incomplete.

### *Ignorance about HIV/AIDS*

Study participants indicated that ignorance or lack of sufficient information and knowledge about HIV/AIDS by community members was perceived as a contributing factor to the spread of the HIV infection. This is because people may engage in risk behaviors unknowingly.

*“It is also clear that not all the people have sufficient information on HIV/AIDS. As a result they are more likely to put themselves at risk of contracting HIV due this ignorance.”* (Male Youth, Kashiba)

In the study undertaken to provide a comprehensive look at risk and protective factors for behaviors that put Zambian adolescents at risk for HIV/AIDS and that might be targeted in future interventions, Magnani *et al.* (2002) found a strong and consistent link between the level of knowledge of HIV and sexual activity. The study revealed that having knowledge of HIV/AIDS was protective against ever having had sex for both male and females. Among males, it was also protective in reducing the number of partners over a lifetime, reducing the likelihood of having had more than one partner in the last three months, and of increasing the likelihood of using a condom at last sex. The study concluded that people with higher level of HIV/AIDS knowledge appeared to be more likely to abstain from high-risk sexual activity and to consistently use a condom. A lack of education and knowledge about HIV and its prevention causes higher growth rates, as people are without the information necessary to prevent its spread.

### *Alcohol consumption*

Participants in the FGDs argued that people who consumed alcohol to excess were more likely than others to engage in sexual risk-taking behaviors such as having multiple partners, casual partners or unprotected sex, which placed them at risk for contracting HIV. This is because under the influence of alcohol the person's judgment is impaired and can easily be involved in these risk behaviors.

*“Beer drinking is one such contributing factor as people fail to use their senses and control themselves when drunk. When one is drunk there is no mission impossible fear is all gone and usually the need for protection or condom use is not there, spreading or contracting HIV.”* (Male Adult, Musangu)

There is evidence to support a relationship between alcohol use and increased risk of infection of HIV and other sexually transmitted diseases. In a qualitative study conducted in South Africa's Gauteng province by Morojele *et al.*, (2006), participants indicated that alcohol consumption increased people's sexual arousal and courage while decreasing their inhibitions to disclose their sexual desires. Some of the male participants admitted that alcohol encouraged them to propose sex to women. Furthermore, participants mentioned that alcohol numbed their feelings in both a physical way (e.g. they would have unprotected sex in order for them to fulfill their sexual desire or “to feel more”), as well as in a mental way (e.g. eventual dangers and consequences of their risky sexual acts would be forgotten or ignored). The study demonstrated that alcohol consumption is strongly linked with sexual abuse and risky sexual behavior, including unprotected sex and having multiple sexual partners.

Kalichman and colleagues (2007) have identified cognitive outcomes expected from alcohol consumption as critical aspects that affect risky sexual behavior. The factors include: social



facilitating expectancies, behavioral disinhibiting effect, sexual enhancement expectations and sexual context of drinking. Social facilitating expectancies refer to the expectation that alcohol consumption would ease conversation and increase friendliness. This expectation is closely related to the general behavioral disinhibiting effect – acting out and doing things one would not ordinarily do. Sexual enhancement expectations refer to expectations that alcohol will increase sexual desires and sexual pleasure. In practical terms, these are expectations that alcohol would increase sexual desire or libido and enhance experience of a sexual intercourse.

### *Gender inequality*

Participants expressed concern that in patriarchal societies like Mwense district, women had few rights within sexual relationships and the family. Often men made the majority of decisions, such as whom they will marry and whether they will have more than one sexual partner. This power imbalance made it difficult for women to protect themselves from getting infected with HIV.

*“Tradition has also contributed to women not having power and rights in a marriage relation. The man can marry as many women as he wants and he may also have other outside sexual affairs, while the wife is fully aware but can do nothing. The woman cannot even decide or request the husband to use a condom despite knowing that she is at risk. Women lack empowerment and this makes them at risk of contributing HIV.”* (Male, Adult, Mwense)

Cultural expectations and practices were found to contribute to women’s vulnerability to HIV/AIDS. According to UNAIDS, (2000), gender issues are increasingly being recognized as having critical influences on the HIV epidemic in Southern Africa. The gender dimension is therefore vital to understanding how HIV is spread: the concept facilitates an analysis of how men’s and women’s roles increase vulnerability to the disease (Shisana, 1999).

A recent study among HIV positive Zambian women found that women's role in sexual decision-making remained limited and was influenced by poverty; many of them did not know the sero-status of their partner and the partner's status was not associated with sexual behavior (Jones *et al.*, 2005). The study concluded that much sexual risk-taking by girls and young women was marked by unequal gender relations, and unequal access to resources, assets, income opportunities and social power.

Rao Gupta (2000) argues that the gender power imbalance, which is found to a varying extent in all societies, translates into a power imbalance in sexual interactions which increases vulnerability to HIV. For women social norms defining their acceptable behavior, characteristics and responsibilities, economic dependency, and violence make them vulnerable, whereas ideals of masculinity associated with risk taking and sexual conquest also create vulnerability in men. Economically vulnerable women are therefore highly dependent on men's financial contributions and are thus less likely to succeed in negotiating protection and less likely to leave relationships that they perceive to be risky (Whiteside *et al.*, 2003).

#### *Condoms and anti-retroviral (ARV) drugs*

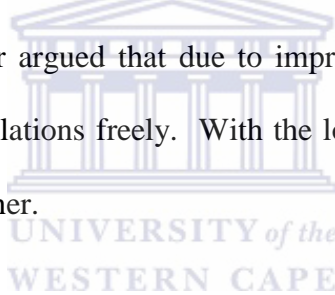
The availability of condoms and anti-retroviral (ARV) drugs was also "blamed" as contributors to the spread of HIV/AIDS, although with mixed views. Study participants insinuated that consistent use of condoms was not sustainable and the possibilities of condoms bursting were high. As a result, protection from HIV infection using condoms was unreliable and not guaranteed.

*"These things called 'Vima condoms' (derogatory expression) have contributed to the spread of HIV. Why do I say so? People may start using condoms when they are not very*

*familiar with each other. As they get used to each other and do not see any signs of illness, they stop using them. We know that these condoms also burst in the act and hence increasing the risk of passing and getting HIV, you know.” (Male Adult, Kashiba)*

However, the above statement on condoms seems to contradict the general expressed view by most participants that condom use is generally very low, even when readily available and free of cost at health centres and/or at the shops at a reasonable price.

The majority of the participants, especially the men, argued that the availability of ARVs has made persons infected with HIV and those suffering from AIDS regain their health, showing no signs or symptoms of being ill. This has made distinguishing between people infected and those not infected difficult. They further argued that due to improved health status, infected people were marrying or having sexual relations freely. With the low condom use, the possibilities of spreading HIV were becoming higher.



*“The other problem is that most of the people on ARVs are looking healthy and fat, they do not reveal their HIV status and are ‘sleeping’ round. Instead of behaving themselves, they are out there and infecting others. Some of these people may be doing it deliberately as they do not want to die alone – eeeeh, somebody gave them the virus and also want to share it with other. These ARVs have their own good and bad side.” (Female Adult, Kashiba)*

Roura *et al.* (2009) argue that although the availability of effective treatment has transformed HIV into a manageable condition which is contributing to a reduction of self-stigma and is stimulating VCT uptake, this is counter balanced by the emergence of new sources of stigma associated with ART provision. Their study in rural Tanzania revealed that there was a general

perception among community leaders that as ART users regained their health they increasingly engaged in sexual relations and “spread the disease”. Fears were exacerbated because HIV patients were perceived to be very mobile and difficult to identify physically.

In all the FGDs and in some in-depth interviews with key informants, it was reported that some community members still perceived HIV/AIDS as an “old health condition” which had been in existence for many years and caused by either witchcraft or/and evil spirits. This belief resulted in some people seeking traditional medication and divination as the first choice treatment option, even when tested HIV positive at the health centre.

*“Some people still doubt the nature and origin of HIV/AIDS and whether it is a new and different disease from the ones which have been afflicting the community, which were treatable by traditional healers.”* (Male youth, Musangu)

*“Others believe that if you slept with a woman who aborted or was not cleansed after the death of the husband, one will be haunted by his ghost or evil spirit and will make them sick, with similar symptoms like those of an AIDS patient. When they are sick, they rush to witch doctors, who will confirm their fears and believe that they have an evil spirit.”* (Female Adult, Musangu)

Some participants, however, mentioned that the denial of the existence of HIV and linking it to witchcraft and/or evil spirits was a deliberate and calculated ploy, because being bewitched and/or possessed with evil spirits were more acceptable and less stigmatized in the community than HIV/AIDS.

*“Everyone knows the dangers of HIV/AIDS as there is no cure. Some people believe they are bewitched or possessed by evil spirits. Some do this genuinely, while others do not want to face the facts and their situation, so they hide in witchcraft.”* (Traditional leader, Kashiba)

*“I feel the denial of existence of HIV is deliberate, especially for those who are sick and know their past. To avoid a being called names, they hide in evil spirits as the cause of their sickness. Even educated people from cities, when they are sick and brought for treatment in the village, they also claim to have been bewitched or possessed by evil spirits.”* (Female Adult, Mwense)

Our findings are consistent with the findings by Roura *et al.* (2008) where it was observed that collective denial of the existence of AIDS prevailed in Tanzania. The cultural belief that “we just bewitch each other” was reported to exist among community members in their study setting.

#### **4.2 AWARENESS OF THE AVAILABILITY OF VCT SERVICES**

Participants were aware that HIV counseling and testing services were provided at the three health centres. Some minor confusion, however, existed concerning the days and times when VCT services were offered. This could be indicative of the irregularity of use of service by participants.

*“The clinic provides general counseling and testing which includes pre and posttest counseling every Monday and Wednesday in the afternoon, with a monthly average attendance of 30 clients. This is provided mostly by two lay counselors who work three days in a work and are supervised by a health care worker at times, when the work load is light.”* (Nurse, Mwense Clinic)

*“VCT is offered at our clinic by community counsellors and nurses. I am not sure if it is every day or certain days of the week. Community counsellors don’t work every day, because they are part time.” (Male Adult, Kashiba)*

A mixture of health care workers and lay counselors provided counseling and testing services at the three clinics. Both groups had received a two-week training in counseling and testing according to the Ministry of Health national VCT training protocol. However, the study participants observed that lay counselors were the main providers of VCT services at the health facilities.

*“Health care workers and community volunteers provide VCT at the health facilities. Due to human resource crises in our health facilities, the health care workers handle mostly curative cases and VCT is taken care of by the lay counselors, since this is the main and only activity on a day to day basis. The health care worker supervises them, although remotely.” (Key Informant Mwense)*

*“We have community members providing counseling and are very committed as there is a big shortage of trained nurses and clinical officers. Most counseling is actually done by our brothers and sisters, community counselors as they call themselves.”(Female Adult, Mwense)*

*“If you were to go through the CT registers, you will find that most of the counseling and testing is done by lay counselors.” (Female Lay Counselor)*

The above sentiments are supported in the study conducted in Zambia by Sanjana *et al.* (2009), which revealed that 70.5% of clients interviewed at the health facilities received counseling and

testing from a lay counselor rather than a health care worker. The study showed that lay counselors provided counseling and testing services of quality and relieved the workload of overstretched health care workers. Since lay counselors were trained specifically and uniquely in VCT, this degree of specialization allowed them to focus exclusively on service provision of consistent quality, while allowing health care workers to concentrate on other aspects of clinical care.

Despite the key role played by lay counselors in VCT service provision, participants reported that community members would prefer being attended to by HCWs instead of Lay Counselors. The reasons forwarded were that HCWs were professionally trained and considered “self-contained” - meaning they possessed adequate knowledge and information which would enable them attend the other health needs of the clients beyond HIV/AIDS. Due to this perceived professionalism, the HCWs were also seen as capable of upholding confidentiality since they handled various complicated health conditions.

*“As for me, I would go for trained health care workers as they have more knowledge and information and our discussion may go beyond HIV/AIDS depending on the results. They are self-contained as they have knowledge of different health conditions and are not limited to HIV/AIDS.”* (Female Adult, Kashiba)

*“Health care worker are perceived by the community as a professionally trained, who can attend to them comprehensively and uphold confidentiality. Community has confidence in them due to their level of qualification. Lay counselors, on the other hand, are seen as having limited knowledge on health and may end up referring patients to nurses or clinical officer.”* (Key Informant, Mwense)

*“People generally have confidence in the people in uniforms. Some of these lay counselors we know them, live with them and may have crossed paths, they may have a vengeful heart and hence broadcast the news of the client’s HIV status to others in the community.”* (Male Adult, Musangu).

On the contrary, lay counselors considered themselves to be the first choice VCT providers by the community. Being part of the community, the lay counselors felt they were familiar with people’s needs as they knew their culture and language. This made interactions with the community easier and VCT clients as the lay counselors would be less judgmental and able to uphold confidentiality. Since some lay counselors are living with HIV, it is easier for them to share real life experiences with the clients, hence building the confidence in them.

*“Most of the people are comfortable being tested and counseled by lay counselors because they are free to express themselves. They can use the local language and feel that lay counselors will not be judgmental as they may not have had any previous encounters with them on medical grounds, e.g. STI clinic.”* (Male Lay Counselor)

*“People love lay counselors more than the health personnel. There was something in the radio about disclosure of the HIV status of clients in our district and this was linked to some health personnel. From that time people feel that the health care providers are not able to maintain confidentiality and people shun them.”* (Female Lay Counselor)

*“People feel safer with the lay counselors because they stay with them in the community, they understand their problems and situations better and are more likely to be sympathetic and considered as equals.”* (Female Lay Counselor)



*“Since we are at the same level with the community they are able to express themselves fully and freely without leaving any information.”* (Male Lay Counselor)

*“Some clients even go back if the lay counselors are not available at the clinic as they feel they will not be attended to freely and with respect by the health care workers as they feel inadequate time will be given to them by health care workers due to other demands.”*  
(Female Lay Counselor)

*“Some lay counselors who are HIV positive also give their testimonies during counseling sessions, which gives the people confidence that it is possible to live with the HIV positive status and creates confidence in the process and outcome.”* (Male Lay Counselor)

*“I think the uniform is a sign of authority and formal interaction, which may be intimidating. Since lay counselors do not have any uniform there is no barrier in interaction and communication-people are free to discuss with them.”* (Female Lay Counselor)

The above sentiments were also supported by community members in very few instances.

*“The lay counselors may be easy to understand you as they know you and understand your culture, your language and can advise you accordingly.”* (Male Adult, Musangu)

The reasons forwarded by the lay counselors as being preferred as VCT service providers are consistent with the findings from the study conducted in Zambia among lay counselors placed in the health facilities to provide counseling and testing by Sanjana and colleagues (2009). The study revealed that some lay counselors spoke of their influence in lessening stigma as well as

representing community as role models. The study further indicated that lay counselors had a deep sense of commitment to their role in the health facility and viewed themselves as professionals providing a critical service.

It is, however, interesting to note that some of the reasons forwarded by Lay Counselors for considering themselves as preferred service providers were, in fact, viewed as barriers to utilization of VCT services by the community members. This will be highlighted in the section dealing with barriers to utilization of VCT services.

Although no community member had publicly disclosed their HIV status, study participants, however, expressed their fears and concerns on how the community and family members would react if someone did so.

*“I am sure they would be gossiped by the community. Association with them would be limited as they would be considered sick and with bad behavior. Some families would even disown them, as they would be considered as having brought shame and disgrace, a sign that the family or parents failed to instill correct morals in the person. This is so because people think that whoever is HIV positive was involved with many sexual partners or unfaithful. The family or community would abandon them as they consider HIV as a self – inflicted disease, blaming the person and allowing him/her to face the consequences.”* (Female Adult, Kashiba)

Van Dyk (2001) asserts that disclosure can have negative consequences such as rejection, and the conviction that people are judgmental. Cases of violence, breaking up of marriages, being neglected or disowned by their families, loss of economic support, blame, abandonment, physical and emotional abuse, discrimination, disruption of family relationships, loss of security, shelter,

food and relationship, and even murder have been reported as real consequences of people disclosing their positive HIV status to their sex partners (van Dyk and van Dyk, 2003).

### **4.3 FACILITATORS TO UPTAKE OF VCT SERVICES**

The recurrent themes regarding facilitators to uptake of VCT services are clustered around health, social and cultural, personal, employment requirement, peer pressure and role models.

#### **4.3.1 Health Reasons**

Chronic illness and pregnancy were the main reported health reasons for seeking VCT services.

##### *Chronic illness*

Chronic illness dominated the discussions regarding the reason for getting tested. The driving force to seeking VCT was to get to the root cause of the chronic illness with a view of getting the appropriate medical treatment, support and care.

*“Sickness is the major reason for seeking VCT services. One may have persistent sickness and as part of the investigations, HIV test is usually suggested. This is important so that the right medicine is given for the correct condition identified.”* (Male Adult, Mwense)

*“What made me go for VCT was due to persistent headache and malaria, which worried me so much. I wanted to be sure about what was causing ill health, so I decided to go for VCT and declared that whatever the result let it be as long as I am able to know my health status.”*

(Female Adult, Kashiba)

##### *Pregnancy*

Participants reported that pregnant women were offered VCT services at the clinic in order to prevent the transmission of HIV from the mother to the child. There was, however, confusion on

whether VCT offered to pregnant women was compulsory/mandatory or optional. Those who understood it to be compulsory were of the view that it would discourage mothers from going for antenatal clinic (ANC), and hence deny them the needed services. Others understood it as a service routinely offered to which one might decide to be tested or not.

*“Pregnant women are given the opportunity to be tested when they go for antenatal clinic in order to safeguard their health and that of the unborn baby. Men may also get tested through this approach as the health workers usually request women to go with their husbands or partners for ante-natal. Those who go alone are either sent back or attended to last.”* (Female Adult, Mwense)

#### **4.3.2 Social and Cultural Reasons**

Male and female participants identified marriage and sexual cleansing after the death of a spouse as main traditional practices facilitating VCT service utilization by the community.

##### *Pre-marriage VCT*

Participants reported that some families, faith-based organizations and church groups demanded that couples be tested for HIV prior to marriage. Most participants were in favor of VCT before marriage as they believed it would enable the couple to make decisions about getting married, having children and overall planning their future. The general perception was that about two out of ten couples intending to get married would go for VCT. However, since most couples would have already indulged in unprotected sexual activities long before marriage, participants wondered the effectiveness and significance of pre-marital VCT in HIV prevention.

*“For some of us who are not married, it would be important to go for testing when we find a marriage partner so that we know how to live in our marriage – whether, in the first place,*

*you even go ahead and get married. I have heard of people who have married even when one was found HIV positive – it is an individual choice, with its own results. The tricky part, however, is that most couples would already have had unprotected sex long before marriage.”* (Male youth, Mwense)

### *Pre-Sexual Cleansing*

Participants mentioned that sexual ritual cleansing was still being promoted and even favored in the community. This is done to cleanse the evil spirit of the deceased spouse on the remaining partners through sexual intercourse. In order to minimize the possibility of infection, some families insist on VCT prior to sexual cleansing.

*“Ritual cleansing is still a custom which is with us and will continue being there because of what is believed would happen if not performed - people want to be cleansed of the ghost of the dead. Although there are different methods of cleansing, sexual cleansing seems to be favored and believed to be effective. So before cleansing, it is important the cleanser and the cleansed to know their status. Although there is always controversy surrounding this issue as some feel subjecting a traditional rite to VCT destroys its meaning and importance.”*

(Female Adult, Kashiba)

### **4.3.3 Personal reasons**

Personal reasons for seeking HIV testing include concerns about one’s past lifestyle and the acquisition of information on the benefits of knowing one’s HIV status.

### *Concerns about Past Lifestyle*

Participants reported that one's past lifestyle, which might have exposed them to HIV, may motivate them to seek VCT in order to clear their mind. This could be with or without any sign of sickness.

*“Past history, even when one may not show any signs or may not be ill, may trouble the person in this time of HIV/AIDS. In order to be at peace with oneself, one may be forced to go for VCT. This is more so, if the person did not use any protection such as condoms during their sexual experiences or heard about the death of the previous sexual partner.”*

(Male adult, Kashiba)

### *Acquisition of information about VCT*

Participants mentioned that people may willingly go for VCT following the acquisition of information or knowledge on HIV/AIDS or seeing people affected by AIDS, even without past risk exposure history. This enables a person make the necessary behavioral and lifestyle changes.

*“What makes some people go VCT is the gaining of knowledge about the services and the benefits one can get from knowing their status became a powerful motivation tool as knowledge is power, as the English say.”* (Male Adult, Kashiba)

*“Others just for interest's sake to know about their health status upon being sensitized about HIV/AIDS and the availability of testing services. These are, however, few and should have the confidence that they never involved themselves in any activity that could have made them get the virus.”* (Female Adult, Kashiba)

#### 4.3.4 Employment Requirement

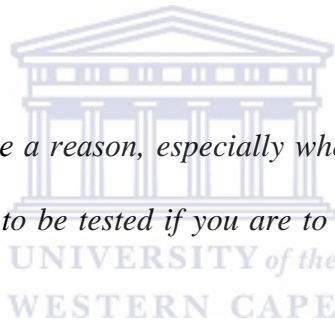
Although not experienced by the community members, participants reported hearing that some organizations or companies demanded an HIV test as a prerequisite for employment.

*“Some companies may require that the HIV status of their would-be employees is known. So as a requirement for a job, one may go for VCT.”* (Male Adult, Mwense)

#### 4.3.5 Peer Pressure

Although not commonly presented, youths at Mwense Boma alluded to the fact that peer pressure may compel others to conform to group norms, which may include testing for HIV as cited below:

*“Peer pressure could also be a reason, especially when you have friends who have been tested, who may compel you to be tested if you are to remain part of them.”* (Male Youth, Mwense)



#### 4.3.6 Role Models

Having role models such as influential community and government leaders testing for HIV, whether or not their test result is made public, was also seen as facilitating community members to go for VCT.

*“When important community members such as traditional leaders lead by example to go for testing, it also encourages others and challenges them (both young and old) to go for VCT. It is important to have role models in the community.”* (Female Adult, Kashiba)

The reasons for seeking VCT presented above are similar to the ones found by Yoder and Matinga (2004), in the study in Malawi where VCT clients were asked what brought them into the VCT centre. The reasons they gave presented in the order of the frequency they were mentioned were:

- Fear of having been exposed to HIV by one's own actions
- Fear of having been exposed to HIV by the actions of one's spouse or partner(s)
- Feeling sick
- Family events (e.g., marriage, pregnancy, reunion, new partner)
- Job circumstances (e.g., new job, scholarship, application requirement).

The study conducted by Jereni and Muula (2008) in Malawi, revealed that at least one third of the study participants reported that they presented for counseling and testing because of recent information on HIV and AIDS. Obarzaucher and Baggaley (2002) cites peer influence as a major contributing factor in increasing VCT uptake in youth centres in Zambia, while Boswell and Baggley (2002) posit that the declaration of role models or valued members of the community that have been tested is important in promoting acceptability of VCT, reducing stigma and increasing the uptake of HIV testing.

#### **4.4 BENEFITS OF UTILIZING VCT SERVICES**

The benefits of knowing one's HIV status as identified by the participants ranged from enhancing future individual and household planning, behavioral changes, accessing other health promoting and disease preventing services such as ART, membership to social support groups, home based care and other accompanying services.



#### **4.4.1 Helps Understand and Accept the HIV Situation**

Participants mentioned that VCT helped people to understand and accept the HIV situation based on factual information given as well as receiving an HIV test.

*“VCT can help free your mind and lead a life with full knowledge of your health status and what action to take. In being counseled and test, you find peace with yourself, with your family, and with God. It also improves your perception of life and living.”* (Female Adult, Musangu)

*“Counseling encourages a person to look at life and life situation differently. Those who are counseled receive and accept their status easily and readily and are able to cope with their situation.”* (Male Adult, Kashiba)

#### **4.4.2 Understanding the underlying cause of ill health**

Participants felt that the causes of chronic or persistent illness could be diagnosed through VCT through either self-referral or diagnostic counseling and testing.

*“It helps you get to the root cause of your poor health, especially if you have been chronically ill. At VCT, you are given the appropriate advice or treatment. It also makes you have defense, especially if people had already judged you as having HIV/AIDS and the results show to the contrary.”* (Female Adult, Musangu)

#### **4.4.3 Serves as a means of creating awareness**

Study participants expressed that VCT involved sharing of information on HIV and other related issues with the client. This could go beyond the person seeking VCT to family members and community at large in creating awareness.

*“At VCT, there are good lessons on how to live with whatever status and your fears are relieved when you talk to someone who gives you hope and courage. You never walk alone after VCT as you can be linked to support groups. Home based care group and can even receive pastoral counseling.”* (Female Youth, Mwense)

*“VCT is considered as an educational opportunity where a trained counselor gives you the relevant information on HIV/AIDS, health and life related information. It is also important in that as you learn, you also pass on the information to the household members so that they too can learn how to prevent themselves from catching HIV. So it goes beyond the person seeking the service to a larger community and family.”* (Male Adult, Kashiba)

#### **4.4.4 Promoting behavioral modifications or changes**

Participants mentioned that VCT provided an opportunity to modify behavior aimed at reducing the risk of HIV transmission and self-care, irrespective of the test result.

*“Previously, people used to cleansed sexually easily and most people looked forward to that. But since VCT was introduced in the community, people don’t make a mistake to be cleansed without testing. The community by and large knows or have an idea when one has died of HIV/AIDS as the symptoms/Signs are generally known VCT is helping in the community.”* (Key informant, Mwense)

*“When one is tested, transmission may be reduced as the person will be more responsible and take care of themselves as everyone wants to live longer. The knowledge acquired during the counseling and the HIV results obtained can also motivate the person to*

*change their behavior so as to reduce the chances of them being infected too.” (Male Lay Counselor)*

*“If people know their status they will be motivated to prevent HIV/AIDS and care for themselves. No one found HIV negative would risk changing their status as they would guard it jealously.” (Key informant, Mwense)*

#### **4.4.5 Plan for the future**

Participants held the view that VCT provided one with the opportunity to plan for the future, especially if the HIV test results were positive.

*“VCT helps in planning how to take care of the children if you know you are HIV positive. Planning for the well-being of children is important because even here in the villages, the greedy and ugly head of property grabbing has surfaced. VCT would help you by knowing your status, write a will which will protect the children or husband or wife. You don't leave them poor and at the mercy of the hungry wolves.” (Female Adult, Kashiba)*

*“VCT is important because it helps one plan to plan for the future of the children and the family. It also helps in the disclosure of the HIV status to the one giving support and care.” (Male Lay Counselor)*

#### **4.4.6 Provides a means of accessing available HIV care and support services**

Participants were of the view that VCT facilitated access to support services, including further counseling, home based care and antiretroviral therapy (ART).

*“Knowing the status enables one to have access to treatment such as ARVs. It also helps connect or be linked to home based care and support groups and social safety nets such as those provided by the ministry of community development and social welfare. I have also seen that those who know their status are considered vulnerable and benefit from agricultural inputs like the fertilizer support program.”* (Male Lay Counselor)

*“Where they are strong support group and Home based care programs, people are motivated to go for VCT as they know there will be ongoing support and care if found positive.”* (Key informant, Mwense)

#### **4.4.7 Prevention of mother to child transmission**

The need to protect the unborn baby from HIV infection came out prominently among the adult participants during the FGDs, perhaps an indication of the value placed on children in the rural setting.

*“Counseling and testing is good in relation to PMTCT whereby the mother will know her status and how to take care of the self, what treatment to take and where to deliver. The status of the mother will also determine what care to take to the unborn baby. Treatment is also given to the mother and the baby at the appropriate times.”* (Female Lay Counselor)

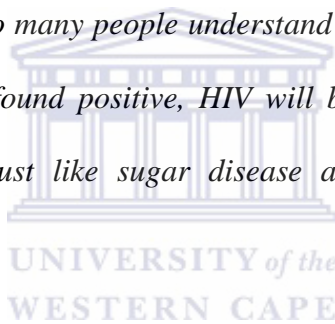
*“PMTCT has also encouraged couple counseling and testing as some facilities have made it a rule that mothers come with their partners and has reduced deaths of mothers and children.”* (Male Adult, Mwense)

#### 4.4.8 Normalization of HIV and Stigma reduction.

Participants mentioned that VCT enabled the HIV message to reach the individual, family and community, which might motivate more people to be tested, accept HIV/AIDS and live normally with the disease, and with less stigmatization of people infected.

*“VCT encourages dialogue in the family, which may spill over to the community. This may enable communities and families understand HIV and take the needed care, prevention and support measures.”* (Key informant, Mwense)

*“VCT enables people to come out in the open and disclose their status, hence destigmatizing HIV. When so many people understand what HIV is and what services can be rendered when one is found positive, HIV will be considered as a normal disease which can be managed just like sugar disease and other related illnesses.”* (Key Informant, Mwense)



In a community where witchcraft and sorcery are considered rife, VCT was seen as an adjudicator.

*“It is important to go for VCT as it sometimes acts as a referee when there are conflicts or accusations as to the cause of illness. When one family is accused of having bewitched the other and usually there is hatred, acrimony VCT and the test results resolve the issue. VCT therefore becomes the great judge who settles all like Jesus of the Bible.”* (Male Adult, Kashiba)

The need for VCT is increasingly compelling as HIV infection rates continue to rise and countries recognize the need for their citizens to know their sero-status as an important

prevention and intervention tool. In the prevention aspect, VCT helps people to learn about how HIV is transmitted, practice safer sex, get HIV test and, depending on the result, take steps to avoid becoming infected or infecting others.

Within the care and support programs, HIV test results and follow up counseling mean people can benefit from care and support services. These services may include: medical care (including ARV therapy, treatment of OIs, prevention of OIs and HIV-associated infections and screening for HIV-associated infections and tumors); family planning (including counseling about reproductive choices and PMTCT); emotional care (including individual, couple and family support); counseling for positive living (nutrition, pastoral care, ongoing counseling, disclosure issues and identification of safety network); social support and improved coping and planning for the future and legal advice. (UNAIDS, 2001). Moreover, VCT services have been shown to contribute to an increase in safe behavior at the individual level, and are likely also to reduce the ignorance, fear and stigma associated with HIV infection in the population at large (UNAIDS, 2001).

#### **4.5 BARRIERS TO UTILIZATION OF VCT SERVICES**

Uptake of VCT has been disappointingly low due to a number of factors that hinge on personal level information, attitudes and beliefs, health facility service provision structures and systems and community level social norms and other contextual factors.

##### **4.5.1 Personal Factors**

The emerging personal factors that influence VCT utilization include fear of an HIV positive result, lack of knowledge about HIV/AIDS and VCT services, perception of risk to HIV infection, lack of support and knowledge of HIV/AIDS.

#### 4.5.1.1 *Fear of HIV positive results*

Although reasons cited for getting an HIV test include knowing one's status in order to take necessary precautions, for most people, it is an anxiety provoking process. Participants expressed that becoming aware that one is HIV positive was akin to knowing that they would soon die from the disease itself and/or from the treatment, as well as the reaction they would receive from their families and wider community. There was also the fear of coping with the HIV-positive result and the uncertain future.

*“What is stopping people from coming for VCT is the fear that if they come out positive, what would people think of them? Others have died of depression and other would not want to continue living. They would rather die than living with the thought and knowledge of having HIV. People would rather not know or link their illness with HIV.”* (Male Youth, Kashiba)

Indeed, this was a mantra that flowed through all group discussions.

*“No one wants to live their life with the worry that death is near. Although all of us will die, but knowing one's HIV status makes you smell death every day. Even with ARVs, people are still dying. So the fear of living a life as a dead person is what is stopping people from being tested.”* (Male Adult, Musangu)

*“If you are tested and know you are HIV positive, it means your future plans are destroyed and you feel you have lost your future. We go to school to do something for ourselves, our families and even community. Having to redo all your life plans due to a positive HIV result is not easy and can be depressing and frustrating.”* (Male youth, Musangu)

Our findings are consistent with those of Day and colleagues (2003) in their study among mine workers in South Africa, who found that fear of test results and the potential consequences, particularly stigmatization, disease and death, were the main barriers to utilizing VCT services.

The study by van Dyk and van Dyk (2003) in South Africa revealed that an overwhelming majority of the participants believed that it was not advisable for them to know their HIV status as it would cause depression and early death. This is because, according to Manirankunda *et al.* (2009), HIV/AIDS evokes feelings of fear, mainly owing to its severe personal and social consequences on both the health and emotional wellbeing. Van Dyk (2001) posits that the anticipation of dying carries the same emotional stress as the reality itself. This, therefore, means that an HIV positive person who worries a lot about dying may actually die prematurely due to stress related factors.

Botha (2005) posits that people with a positive HIV status feel that they no longer have control over their future plans and want to resign their goals to fate and chance. Josephson (2000) also maintains that having a HIV positive status “places much of one’s life under the sign of uncertainty”, meaning that there is uncertainty both concerning the time when infection took place and about one’s prognosis. This uncertainty seems to cause discouragement concerning future plans and tends to externalize the locus of control (Josephson; 2000).

#### 4.5.1.2 *Lack of Knowledge about availability of VCT services*

Participants expressed that some community members were not aware of the availability of VCT services, while others may not know how the services are provided ,especially the quantity of blood needed for an HIV test to be conducted. As result, the services are not fully utilized.

*“Lack of knowledge on the availability of the services, the cost of the service and even the benefit of knowing one’s status may hinder someone from using VCT service. Others think*



*the service is at a cost and with poverty, one would rather buy food than going for VCT, especially when not sick.” (Female Adult, Mwense)*

*“What is preventing others to go for VCT is that they don’t know how blood for HIV test is obtained and the quality of the blood drawn. They believe that a large quantity of blood is required, which makes people fear as they think that the quantity of blood in the body will reduce or that the service providers would use their blood for other purposes, Satanism has become a big issue and some of the service providers are believed to be practicing it.”*

*(Adult Female, Musangu)*

A study in Zambia by Ndubani (2001) acknowledged that knowledge and awareness about VCT is still low. Rural populations are less likely to be aware of VCT, based on the inadequacy or absence of VCT-related promotional activities. In a study conducted by Nuwaha and colleagues (2010) in Bushenyi district of Uganda, participants in the FGDs mentioned that lack of awareness on the need for VCT reduced the number of people undertaking VCT.

#### *4.5.1.4 Lack of knowledge/understanding about HIV/AIDS*

Participants mentioned that some community members did not have sufficient knowledge and understanding about HIV, its causes and modes of transmission and the prevention and treatment options.

*“Some people in the community may not have sufficient knowledge and information about HIV/AIDS and may not even know that VCT services are available at the clinic and the benefits in knowing their status. So lack of knowledge can also prevent people from using VCT services. Ignorance and illiteracy are high in these villages.” (Male Adult, Mwense)*

*“There are still others who are ignorant of the dangers of HIV although they may know that the disease exists. This is worsened by the circulating views as to the cause of illness, where some people still believe that evil spirit are the cause, so why should one go to the clinic for , if he believes he is bewitched or possessed with evil spirit?.” (Female Youth, Kashiba)*

*“There are some who believe that HIV/AIDS is not a new and different disease from that of olden days. So there is no purpose of going for VCT as illnesses were attended to without VCT in the past. These people go for traditional and not modern medicine.” (Female Adult, Kashiba)*

Participants also observed the mystery surrounding HIV/AIDS which leads people make what seem irrational behaviors or actions. It was reported that people deliberately ignored the HIV/AIDS and VCT messages as they feared it would confuse them or compel them to go for VCT, while not prepared to face the ramification of a positive test. Vermund and Wilson (2002) point out the no acknowledging the risk for HIV in a population with high HIV prevalence rates could be a coping strategy.

#### *4.5.1.5 Perception of risk to HIV infection*

Participants in the FGDs mentioned that people who did not consider themselves as having engaged in risk behaviours which were known to contribute to the spread of HIV in the community, such as having multiple sexual partners, being unfaithful or promiscuous, engaging in prostitution and having unprotected sex, did not perceive themselves as personally at risk.

*“If you are personally sure that you have not done anything that puts you at risk of getting the virus and your health is perfect, there would be no reason of going for VCT. So if you*

*know your past and you have all the necessary information regarding HIV/AIDS, you can make you self-assessment.” (Male Youth, Musangu)*

Others were of the view that people who perceive themselves to be at high risk may also not be motivated to go for VCT as the results were already known/expected. Subsequently they did not feel the need to take an HIV test.

*“People comfort and assure themselves that if it has not been confirmed by an HIV test, their illness or condition might as well be anything. It seems the knowledge of one being positive through a test is more devastating than self-diagnosis, which might not be HIV related. I think it is the sure pronouncement of death that the HIV test brings that people don’t want to go for testing.” (Female Adult, Mwense)*

Our findings are consistent with those of Njagi and Maharaj (2006) in a study conducted among college students in Kwazulu-Natal. Respondents in this study did not utilize VCT services because they felt not at risk of contracting HIV mainly because they were not currently sexually active, consistently used condom or never had sex. Nuwaha and colleagues (2010), in their study in Uganda also reported that participants in the FGDs mentioned that people at low risk of HIV infection were less likely to consider HIV testing and that people who considered themselves at increased risk of HIV infection were more likely to undertake an HIV test.

#### *4.5.1.6 Lack of perceived benefit*

The decision to have an HIV test may depend on anticipated benefits, especially if the individual expects a positive test. In the FGDs, most participants were of the view that few community members would want to know their HIV status if there was no benefit from knowing it.

*“People are not interested to be tested as there is no cure. As a result they reason that there is no benefit to being tested as there is no cure.”* (Male Youth, Kashiba)

*“People may not see any benefit of testing as they know that there is no cure of HIV/AIDS. ARVs are believed to have side effects and may not be easily accessible, as only 4 of the 26 health facilities in the district offer ART services.”* (Health Care Worker)

The study conducted in South Africa by Meiberg and colleagues (2008) supports the hypothesis that VCT services are likely to be under-utilized if perceived threats outweigh perceived benefits. This is because where there is no perceived benefit, either in the immediate or future, unless one is already sick, for most the opportunity to learn one’s status does not appear to be sufficient incentive to go to the clinic and pay the cost. This position is augmented by Van Dyk and Van Dyk (2003) who assert that people who believe that they could do nothing about AIDS, might become affected with feelings of fatalism and depression, should they know their HIV positive status. As a consequence, people with these perceptions do not seem to be inclined to voluntarily report for VCT-uptake. In a study of mineworkers in South Africa, Day *et al.* (2003) found that in the absence of treatment options, many people did not see the benefits of testing, while testing itself, regardless of the outcome, was seen by many as putting a person at risk of loss of social status.

Participants expressed that the availability of free ARVs at ART sites had to some extent motivated people to seek VCT services. In 2003, the Government of the Republic of Zambia launched its national policy of providing free and universal access to ARVs, which was expanded in 2005 to include all ART, related services.

*“For most of the people who come for VCT, the next question they ask, especially those who come out positive is ‘when will I start taking the medicine?’. This shows that the knowledge of the availability of ARVs has also motivated people to go for VCT, as they know that something to improve their lives and chances of survival exists.” (Male Lay Counselor)*

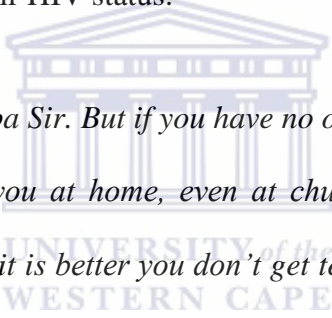
*“ARVs have motivated people to go for VCT as they know that they can be given some treatment, although not a cure, that can prolong their lives. Previously people who tested HIV positive were only counseled and encouraged to take a balanced diet. Additionally, I don’t know if ARVs are provided at our local clinic. If not, unless someone is really sick and has the resources to go to Mwenze Boma (about 20km) to get the ARVs, the person may not be encouraged to be tested, when he cannot access the ARVs due to distance and cost of transport.” (Male Adult, Musangu)*

The fact that ARVs are freely available in public health facility in Mwenze district and valued for their life-prolonging effects was on the overall perceived as an incentive for HIV testing. However, the knowledge that ARVs are not a cure and the belief that they have grave side effects, which may kill the patient faster than AIDS itself, may somehow affect the acceptability and utilization of ARVs. Additionally, Mwenze district only has four ART sites which are scattered across and not easily accessible by those needing them due to distance and transport costs. This might be a barrier to utilization of VCT services as people may not see any benefits of testing if they cannot access life-prolonging drugs. This issue of ARVs and its potential effect on VCT utilization may require further research as this study did not explore the subject matter to greater detail.

Sherr *et al.* (2007) argued that the advent and expansion of ART may drastically affect motivation and cause a shift in normative attitude since personal gain and treatment access were likely to have a dramatic effect on uptake of VCT. This is, however, subject to the distance to the ART centres, the cost of accessing the drugs, especially transport cost and the perceived benefits of ART. Additionally, where anticipated stigma prevails, provision of antiretroviral drugs alone is unlikely to have sufficient impact on VCT uptake.

#### 4.5.1.7 *Lack of support*

The operational efficiency of the service provider's referral and support systems has an impact on the attractiveness of VCT. Participants reported lack of support as a contributing factor towards their fear of finding out their HIV status.



*“Being tested is one thing, ba Sir. But if you have no one to look after you because people don't want to relate with you at home, even at church and you don't have access to treatment and proper food, it is better you don't get tested. One thing I have seen is that people will welcome you even when you are sick as long as there is no confirmation that the sickness is AIDS.”* (Male Adult, Kashiba)

*“Others feel they will not be supported by families, friends, and church and may lose face and relationships if they are tested and are positive. So even if they are sick and clearly HIV/AIDS, it seems comforting and acceptable to link it to witchcraft or spiritism as thus is generally considered as one of the causes of illness, whatever its manifestation.”*  
(Female Youth, Kashiba)

Low perceived social support services and lack of proper follow-up and support after VCT have been shown to be significant predictors of emotional stress among HIV positive individuals

(Koopman *et al.*, 2000; Van Dyk, 2002b). Sherbourne (1988) asserts that the mere perception that adequate support is available can serve to buffer situational stress as much as support itself. This means that the mere knowledge that support is at hand in case one needs it can lessen psychological stress particularly when diagnosed as HIV positive.

#### 4.5.1.7 *Knowledge and insight about HIV/AIDS*

Knowledge about HIV/AIDS can serve as a barrier to VCT utilization. Participants mentioned that due to the high knowledge levels concerning HIV/AIDS in the community, people were able to diagnose themselves (correctly or incorrectly) according to the different stages of the HIV/AIDS progression. This became a deterrent for them going for HIV testing.

*“People in the community are now able to know what are the signs and symptoms of HIV/AIDS. As a result of this, they are able to tell how their health is doing and don’t see any need to go for testing when they can diagnose themselves. This may be a correct or wrong diagnosis as some other diseases may show similar symptoms.”* (Key Informant, Mwense)

Our findings are contrary to those of Sherr and colleagues (2007) in a study conducted in Zimbabwe, where they found that education, including knowledge about HIV was the main determinants of VCT use rather than personal sexual risk behavior.

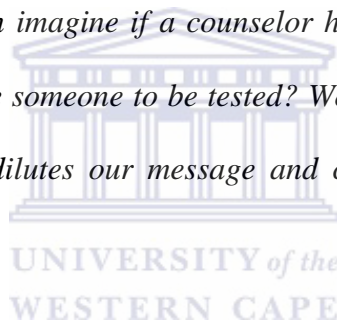
#### 4.5.2 **Health System Factors**

The emerging health system factors that influence VCT utilization include lack of VCT promotional activities, lack of confidentiality, shortages in HIV testing logistics and staffing, distance to service points and familiarity with service providers. These factors are discussed in detail below.

#### 4.5.2.1 *Lack of VCT Promotional Activities*

For community members to utilize a particular health service, its availability must be made known to them by the service providers or their agents. Participants expressed concern that demand generation for VCT services was weak or non-existent. This was partly attributed to the lack of confidence by the counselors to promote the services. Respondents also felt that past campaigns had concentrated too much on putting up banners and posters and not enough on face-to-face communications and peer education which were considered far more effective in getting the health messages across.

*“It is also lack of confidence in the counselors themselves to promote VCT as some of them have not being tested. You can imagine if a counselor himself refuses to be tested, how do you expect him/her to convince someone to be tested? We have the information, but have no courage to be tested, which dilutes our message and conviction for testing.”* (Male Lay Counselor)



The study by Bassett (2002) supports the above sentiments that few health workers have had VCT themselves, and they may be skeptical about the wisdom of HIV testing for their clients, especially where high HIV prevalence makes the odds high that a positive test result will result. As a result, the enthusiasm to promote VCT services at the facilities and at different service points may be limited.

#### 4.5.2.2 *Lack of confidentiality*

Confidentiality is an important factor that may hinder utilization of VCT services. Before taking the HIV test people want to be assured of confidentiality. Participants expressed that lack of confidentiality among service providers, whether health care workers or community lay



counselors would result in community members not accessing and utilizing the services as they feared that their HIV status would be made known to all, with the resultant ramifications.

*“Failure to keep secrets by VCT counselors on the HIV status of the client discourages people, as no one wants to have their status known by the whole village. When information goes around that the clinic staff are not keeping secrets, no one would be willing to come for VCT.”* (Female Adult, Musangu)

*“There is also a general fear that if people go for VCT at the clinic, the counsellor will tell the results to the community members. No one wants to have their status known as it has a lot of life changing implications. So it is the fear of lack of “secrecy” among counsellors that is discouraging people.”* (Male Adult, Kashiba)

Our findings concur with those of Maman *et al.* (2001) in a study conducted in Tanzania, which revealed that individuals who were aware of the possible breach of confidentiality may choose not to undergo voluntary HIV testing. This fear of a breach of confidentiality is closely linked with the fear of rejection by the people near to them. The importance of confidentiality in the context of HIV/AIDS must be considered in a society where there is stigma attached to people who have HIV/AIDS. Stigma and confidentiality are closely linked and the greater the stigma of a condition, the greater the need for confidentiality.

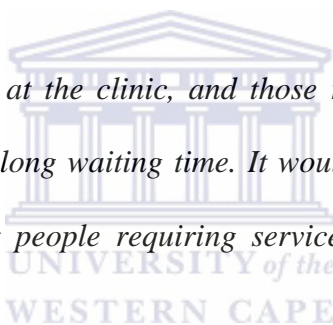
#### 4.5.2.3 *Shortage of HIV test kits and staff*

Availability of HIV commodities (test kits and reagents) and personnel are important for any service provision. Participants reported shortages of HIV test kits and personnel as a barrier to access and utilization of VCT services.

*“Sometimes there are no test kits for conducting HIV at the clinic and people are told to come back the next time. Others do not come back as the desire to be tested would have gone, friends could have discouraged them and many other reasons. Sometime also the staff may not be there to do the test, as most of clinics in these rural areas are poorly staffed.”* (Female Youth, Mwense)

*“Some people would have volunteered to go for counseling and testing, their blood drawn, but only to be told that the machine is not working, they get discouraged and may disseminate the same message to the community that the machine is not working. This will stop people going for counseling and testing.”* (Male Adult, Kashiba)

*“Insufficient human resources at the clinic, and those requiring service are many, others give up due to frustration and long waiting time. It would do a lot if the number of service providers is increased so that people requiring services should be attended to quickly.”* (Male Adult, Musangu)



Our findings concur with the ones by Boswell and Baggaley (2002), which identified lack of personnel and heavy client load as logistical barriers to VCT uptake. In our study however, reliability of HIV testing and consequently test results were not identified as hindrances to accessing VCT services; which is contrary to the findings of Nuwaha and colleagues (2002) in Uganda and Birdsall *et al.* (2004) in South Africa.

#### 4.5.2.4 *Distance to VCT centres*

Participants reported that distances to the VCT centres, coupled with poor means of communication/transport as is the case in rural areas of Mwense district discouraged community members from utilizing VCT services.

*“Distance to the VCT clinics stops people as there is only one clinic here providing services and the catchments area is wide, about 15 km wide. So you have to be sick to come to the clinic that is why, maybe, most of people utilizing the service are on medical reason.”*

(Female Adult, Kashiba)

*“Although testing facilities are available, the catchment area is too big and the people, especially when not sick, would find it difficult to walk long distances for VCT. Furthermore, even when tested, the next question would be how to get ARVs as not all VCT sites are providing ART.”* (Key Informant, Mwense)

Our study findings are consistent with those of Morin *et al.* (2006) and Simwaka *et al.* (2007) which suggested that structural barriers such as distance is a prohibitive factor for accessing testing services and that more accessible VCT sites were better utilized than less accessible ones, particularly in rural areas. In a cluster-randomized trial of uptake of workplace HIV counseling and testing in Zimbabwe, Corbett and colleagues (2006) found that people who had on-site VCT services available to them took up the option of HIV testing than people who had off-site VCT services available to them. This shows that accessibility of VCT site has an effect on the practice and acceptability of VCT and efforts at scaling up VCT services must be encouraged.

It must be noted that participants in this study lived within 3km distance from the health centre. As such, there was no transport cost incurred. However, utilization of VCT was low at the three health centres. Contrary to findings of the study conducted in Uganda by Nuwaha *et al.* (2002), where participants reported that the VCT services were expensive and out of reach of many people especially the youth and women, the participant in the study did not identify it so.

#### 4.5.2.5 *Familiarity with the service providers*

Taking an HIV test in communities where individuals live is perceived to be problematic in that there is bound to be someone they know who also knows them who is either a patient (at a hospital) or a member of staff. Participants expressed that community members would not seek VCT if they were familiar with the service providers regardless of whether they were community Lay Counselors or health care workers. The fear is related to confidentiality, stigma and labeling.

*“Counselors at the clinic are community members, who are known by everyone. As a result, the community would not be comfortable as they believed or suspected that their HIV status would be made know to everybody. This brings a problem to using VCT at the clinic. It would have been good to have people from other communities to provide VCT services. People shy away.”* (Female Adult, Kashiba)

*“If the service provider is familiar person or family friend, the client would not have the courage to face them, also not knowing whether or not he/she will keep the secret as some people at times access services without notifying the family members of their intention.”*

(Male Youth, Mwense)

Our findings are echoed in a study conducted by Bwambale *et al.* (2008) in Malawi where fear of meeting familiar people in HIV testing clinics made men to prefer being tested in distant clinics. There appeared to be reluctance to use services in which local community members were employed for fear that the confidentiality of their status would be compromised. Angotti (2009) emphasized that familiar service providers may not keep the test results secret, particularly in tightly knit communities where counsellors are deeply embedded in the local social networks.

Matovu and colleagues (2005) suggest that non-resident counselors (for greater confidentiality), was a feature of a counseling service that influence uptake VCT services by different groups.

### 4.5.3 Community level Factors

Individuals live in communities where values, belief systems and attitudes shape that perception of health and illness. Community level factors that influenced utilization of VCT services included traditional beliefs on the nature and causes of HIV/AIDS, gender inequality, stigma and discrimination and religious beliefs.

#### 4.5.3.1 *Traditional beliefs about HIV/AIDS*

Participants reported that misunderstanding and some community beliefs about the nature and causes of HIV were affecting utilization of VCT services. It was reported that a section of the community still believes that HIV/AIDS was not a different disease from those which existed in days of old and caused by witchcraft or evil spirits.

*“There are circulating and deeply held views as to the cause of illness, where some people still believe that evil spirits are the cause. So why should one go to the clinic for VCT, if he believes he was bewitched or possessed with evil spirit?”* (Female Adult, Kashiba)

Roura and colleagues (2008) in their study in Tanzania reported that some community members including leaders referred to a disease from the past (“Kondela”), which looked like AIDS. This disease was caused by witches, and could be cured by Traditional Healers specialized in “divination”. This belief was seen as a disincentive to seek modern treatment, including VCT.

#### 4.5.3.2 *Gender Inequality*

Gender directly shapes attitudes towards health seeking behavior including testing for HIV. In Mwense district, patriarchal structures dominate and relationships are characterized by gender

inequality. Participants mentioned that men had the final say in decision making, including whether or not to go for VCT. As a result, women have to seek permission from their male partners for them to access VCT. Additionally, it was reported that if a woman underwent testing without her partner's consent, she risked being blamed as the source of infection. This has implication in the utilization of VCT services as women would not utilize the services without the consent of the men.

*“Men are decision makers and determine whether or not to go for VCT. Since most women are dependent on men in most areas of life in our rural setting, women would not go for VCT for fear of the consequences once the men come to know about it. This often leads to marital breakdowns, violence and abandonment.”* (Key Informant, Mwense).

*“Women may be aware of the many services provided and may even notify the husband, but if the husband does not allow her to be tested, the woman may die with all her knowledge and not take action or may do it privately with serious consequences if the man comes to know about it.”* (Male Youth, Kashiba)

Some female participants argued that since women consented to being tested at ANC, this in itself was seen as decision making to some degree. However, they were quick to mention that for women who tested without the consent of their spouses, disclosure of test results, especially HIV positive result, was a challenge.

*“Women are involved in decision making as they are the ones who usually frequent clinics. During ANC, they are informed of the testing and some of them accept the testing. This is part of the decision making. They are also encouraged to come with their husbands and the family is tested through the woman who decided to be tested first.”* (Female Adult, Kashiba).

Men also believed that once their female sexual partners or spouse tested for HIV, they did not need to seek VCT because their results would be the same as those of their partners.

*“Some husbands use their wives to be tested first as they fear to face the test results. When the wife tests negative, they also take it that they are safe. However, when she tests positive, she is blamed as having caused or brought about the virus.”* (Female Lay Counselor)

The findings of this study concur with those of Iliyasu and colleagues (2006) that showed that gender inequality contributed to delays in women learning their HIV status and increased the risk of discrimination and violence following disclosure of HIV positive status. They argued that women who feared that being tested may elicit a violent response from their partner remained reluctant to know their HIV status or to encourage others to do so.

The research conducted in Tanzania by Maman and colleagues (2001) revealed that male and female informants frequently referred to the need for women to “seek permission” from partners prior to testing. Most women in their study thought about testing for at least a month prior to actually seeking services. This indicated that many women lack autonomy to make decisions about HIV testing. This finding is supported by Bawah (2002) who posits that men played an influential role in most household decision making in many countries of sub-Saharan countries and that the social structure in most of these countries was patriarchal, which tended to transfer conjugal power to men. Bwambale *et al.* (2006) further allude to the fact that men’s superiority had a negative influence on the VCT seeking behavior as men’s decisions in most cases are unchallenged.

#### 4.5.3.3 *Stigma and Discrimination*

A recurrent theme in the study centered on the role of stigma in impeding the utilization of testing. Fear of society's response if the HIV-positive status should be known was considered a powerful disincentive to testing. The participants mentioned that it was commonly held by the community that only those crossing the sexual norms like womanizers, prostitutes and unfaithful or promiscuous were affected by HIV/AIDS. People would, therefore, prefer not to know their own HIV status in order to avoid the anticipated negative social and psychological consequences. The act of testing alone was anticipated to instigate gossip.

*“Stigma in the community is still high and people living with HIV/AIDS are still looked down upon, sometimes discriminated, isolated and not easily accommodated. They are blamed as having brought this disease due to their carelessness. So people would rather not know their status or attributed it to witchcraft (which seems one of the accepted causes of illness) than be tested and be a subject of gossip and community talk.”* (Male Adult, Musangu)

*“People, even your friends start looking at you differently; your interactions change and feel reduced to a lower human being.”* (Female Adult, Musangu)

The participants further mentioned that knowing that one was HIV positive would discourage them from engaging in any developmental activities, as there would be no perceived long term benefit due to the impending death. They lamented that the community might deny people with HIV/AIDS certain rights such as holding political position, participation in social gathering and fundraising ventures, or membership in livelihood enhancing groups such farmers' cooperatives. This is, however, contrary to the earlier view that considered knowing one's HIV positive as an eligibility criteria to accessing some social services or livelihood improvement and empowerment ventures.



*“The fear of rejection is also a factor as when people are known to be positive they may not have access to social gathering, fundraising ventures and their participation is not considered as they could be a problem to the group once they start falling ill and ultimately die.”* (Female Lay Counselor)

Although it was reported in the study that many people fear the psycho-social consequences of testing positive for HIV, particularly when it leads to loss of social status, to discrimination, to domestic violence or even abandonment as a result of testing positive for HIV, participants had few experiences of such happenings. There seem to be a gap between what the perceived fears are and what is happening in reality. Cases of marital breakdowns and family conflicts were reported as happening, although to a small scale.

HIV-related stigma and discrimination are recognized as key barriers both to the delivery of quality service by health providers and to their utilization by community members and health providers themselves. A study by Kalichman and Simbayi (2004) among inhabitants of a black township in South Africa suggested that AIDS-related stigma was one of the most important barriers for HIV testing. Additional research by UNAIDS (2000) found that stigma and discrimination associated with HIV/AIDS have powerful psychological consequences for how people with HIV/AIDS come to see themselves, leading in some cases to depression, lack of self-worth and despair.

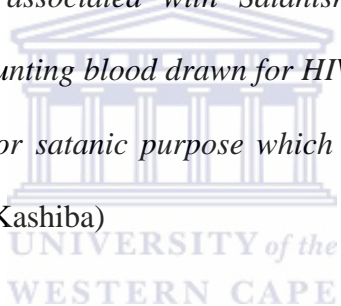
Mhloyi (1992) posits that the fear of stigma following a positive HIV test may result in an individual under-utilizing health and social services, with the fear of social ostracism preventing HIV-positive individuals from disclosing their sero-status or accessing services. Any model proposed for promoting VCT must, of essence, incorporate strategies for reducing stigma.

#### 4.5.3.4 *Religious beliefs*

Religion shapes everyday beliefs and activities. Participants felt that community members belonging to a certain religious group, which does not allow extraction and transfusion of blood, would be deterred from accessing and utilizing VCT services.

*“Some churches do not allow the drawing of blood from the person and believe that conducting VCT requires drawing of blood. This stops their members from drawing blood. There is also a misunderstanding or lack of knowledge on the amount of blood required to do an HIV test.”* (Key Informant, Mwense)

*“Additionally, blood is also associated with Satanism, and when people don't have knowledge regarding the amounting blood drawn for HIV test, they will be reluctant as they fear the blood will be used for satanic purpose which may affect their health, wealth or relationships.”* (Male Youth, Kashiba)



Zou and colleagues (2009) assert that religious activities, communities, and beliefs frame the daily behaviors and attitudes of many people living in countries with high rates of HIV/AIDS.

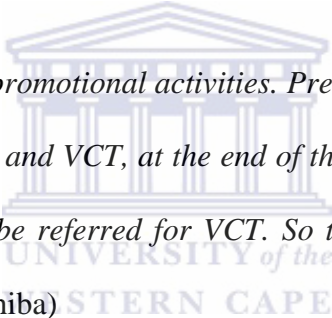
On the community level, religious organizations are influential social networks that have the power to support or stigmatize people living with HIV/AIDS (PLWHA), promote or impede HIV education, and endorse or reject medical treatment of HIV. Some churches require or heavily encourage couples to be tested for HIV before getting married. Religious beliefs significantly shape individuals' outlooks on living with HIV. Faith practices and beliefs can provide a sense of peace and hope, and can also help people to prepare for and accept death. People often turn to religion to make sense of and come to terms with being HIV-infected (Zou *et al.*, 2009).

## 4.6 SUGGESTIONS FOR IMPROVING UPTAKE OF VCT SERVICES

Participants gave suggestions on how to improve VCT uptake. The suggestions evolved around awareness creation, broadening service delivery options, upholding confidentiality and logistical management at facility level; involvement of influential stakeholders and providing symbolism for testing.

### 4.6.1 Public or Community awareness creation

Participants were of the view that low utilization of VCT services was due to lack of information on the availability of service. Different ways of reaching the community with the VCT messages must be used.



*“The clinic should also do promotional activities. Previously they used to show videos on health issues including HIV and VCT, at the end of there would be discussions and those willing to be tested would be referred for VCT. So these video shows must be brought back.” (Female Youth, Kashiba)*

*“Information on the availability of services must be given as people can only use the services if they are aware of their availability. As a result people will only access VCT when they are sick and referred by the nurses to VCT room. Posting large posters to promote services may be a good way of creating awareness.” (Key informant, Mwense)*

*“My observation is that IEC materials are in English and the literacy level in our community is low. If these materials are translated in Bemba, most people would read them, know the dangers of HIV/AIDS and the VCT services which are provided and possibly motivated to using them.” (Female Youth, Kashiba)*

*“The community leaders must be sensitized as they have a lot of influence in our community. These should in turn reach out to their members and sensitize them on HIV/AIDS and VCT services. Additionally, sensitizing community through drama groups and peer educators who go out and reach out to so many people must also be used.”*

(Female Adult, Musangu)

#### **4.6.2 Ensuring confidentiality**

In order to increase the number of people accessing VCT services, participants suggested that service providers should improve in maintaining confidentiality.

*“Confidentiality must be maintained as we have heard counselors spreading the news of the HIV status of the clients. I think those counselors not keeping secrets must not continue being counselors as they will discourage people from coming for VCT services.”* (Male Youth, Kashiba)

#### **4.6.3 Availability of testing logistics**

Participants suggested that testing logistics including counseling space, test kits and reagents should be available all the times as inconsistent supply discouraged people from seeking VCT services.

*“The clinic must make sure that the all the needed requirements for conducting the tests are available at all times. This includes the attitude of counselors towards clients must improve by treating them with respect. Otherwise, the number of people coming for VCT will not increase.”* (Male Adult, Mwense)

*“We can increase VCT/CT if we have additional space for conducting the service.”*

(Health Care Worker, Mwense Clinic)

#### **4.6.4 Mobile/outreach services**

Since all the potential users of VCT cannot access services due to distance and other structural reasons, participants suggested the regularization of mobile VCT and ART services as well as strengthening home-based care programs so as to broaden the entry points. Activities that reach out to the community have greater potential of creating awareness and provide follow-up support which may be seen as an impetus for seeking VCT services.

*“The non-availability of ART services at the local clinic may also be considered a barrier as people may not see the need of being tested if they cannot access treatment due to distance and cost. So if ART clinic was introduced at the clinic or mobile ART services introduced, some people would desire to be tested.”* (Female Adult, Musangu)

*It was suggested by the District Health Office that Mobile CT services would be provided to those living in faraway places, but this has not been done, denying those people services, allowing others to die even when their lives would have helped. Can we revive mobile CT services please?”* (Female adult, Kashiba)

*“Home based care programs are also a way of reaching out to people as there have so many clients on their registers. Home visitations should be used as an opportunity to reach out to the family members and even neighbors. For one to accept being on HBC has also accepted the implications that neighbors will know, so HBC provides seize the opportunity to counsel the significant others or promote VCT services and refer them to the centre where these services are being provided.”* (Key Informant)

#### 4.6.5 Peer education

The youths suggested intensified use of peer education as this would effect changes in knowledge, attitudes, beliefs, and behaviors on HIV/AIDS and VCT and also create change at the group or societal level by modifying norms and stimulating collective action that may contribute to changes in policies and programs.

*“Peer education will be another way for reaching us especially to the youths, some of them may feel this illness is for adult only. Where this is well organized, it has reached a good number of youths, who are our hope for an HIV free generation. It has help change people’s view of HIV/AIDS, and enables communities to jointly identify risk behaviors and take action needed to fight HIV/AIDS.”* (Female Youth, Mwense)

#### 4.6.6 Establishing anti-AIDS and Sports Clubs

Participants recognized the value of anti-AIDS clubs in schools and sports in the community as a way of enhancing sensitization and encouraging people of different age groups to go for VCT.

*“Sports can be used as a point of sensitization as it attracts all classes of people, not the outreaches which may have a self-selected group. We have organized games dubbed “fight against AIDS” and have had drama groups perform/sensitize people during half time. It has always been a crowd puller.”* (Male Lay Counselor, Mwense)

*“We have also formed anti-aids clubs in the schools and even communities where issues of HIV/AIDS are discussed. I know of a group where one of the requirements to be a member is to have an HIV test. This has encouraged people who desire to belong to the group to be tested.”* (Male Youth, Mwense)

#### 4.6.7 Having Role models

Youth suggested that having role models in the community would encourage them to go for VCT.

*“Having youths as model who know their status and would encourage other to go for VCT and talk about the benefit of VCT. Youth HIV/AIDS ambassadors would make a difference as they would speak on behalf of the youths and be a role model.”* (Female Adult, Kashiba).

*“We need to have people who can come out in the open as role model to promote VCT, going for testing and sharing their results, especially those in key position, traditional leaders”. This would challenge everyone that it is possible to go for VCT and does not make one less human.”* (Male Youth, Musangu)

#### 4.6.8 Cultural beliefs

Participants suggested that the diverse cultural beliefs and practices which may promote HIV/AIDS and discourage people from seeking health care, including VCT, must be addressed and debunked.

*“There is need to deal with the traditional myths and hiding under witchcraft when the actual cause is known. We need to educate the people to know that HIV/AIDS is there and not to pretend and hide under evil spirits.”* (Male Adult, Musangu)

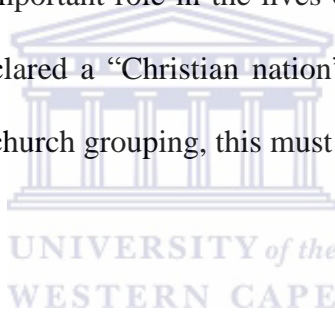
*“Tradition rulers must enforce certain rules of conduct especially with regard to ritual cleansing, insisting that anyone who wants to be cleansed in their villages should undergo VCT. These are our fathers and no one dares going against their rules.”*

*Additionally they can also reach out to the traditional healers and instruct them what to do according to the prevention and safety guidelines. They need to protect their subject otherwise they won't have anyone to rule.” (Female Adult, Musangu)*

*“It is important to reach the older generation who are disputing that HIV/AIDS is not a different disease from those of yester years, who end up giving people false hope. They need to be targeted and brought to change their perception which is doing more harm than good.” (Female Adult, Kashiba)*

#### **4.6.9 Church involvement**

Religion plays a tremendously important role in the lives of many people in Zambia more so that the country is officially declared a “Christian nation”. Participants suggested that since almost each person belongs to a church grouping, this must be used as means to reaching out to them on VCT.



*“Some churches have very active HIV/AIDS activities, some as basic as sensitizing people on the need to know their status, others use their members who are HIV positive to give their testimony as a way of encouraging people.” (Female Adult, Mwense).*

*“Zambia is a Christian nation and everybody who is a church goer is a potential VCT user in waiting. The church leadership should have a deliberate program to promote health including VCT.” (Key Informant, Mwense).*

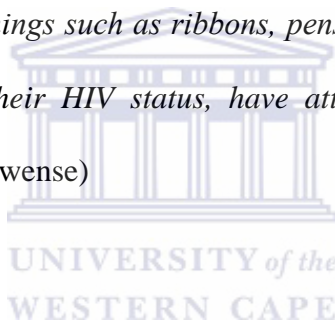


#### 4.6.10 Provide Symbolism for VCT

The youths suggested that giving a symbolism for testing such as a ribbon, T-shirt and the like may encourage their fellow youths to access VCT services as they will have something to show to their friends and community.

*“The clinic and other organizations conducting VCT should “Give T-Shirts with VCT messages to people who test regardless of status. The T-shirts will arouse interest in people who will inquire about the services and given information, which would enable them to go for VCT services as they would also get a T-Shirt.” (Male Youth, Kashiba)*

*“Organizations that give things such as ribbons, pens, caps and T-shirts to persons who are tested regardless of their HIV status, have attracted a lot of people, especially youths.” (Female Youth, Mwense)*



#### 4.7 SUMMARY

This chapter presented, described and discussed the qualitative findings from focus group discussions and key informant interviews on the factors that affect utilization of VCT services. The findings are supported are supported by literature on the subject matter.

The facilitators to uptake of VCT services identified include accessing information on HIV/AIDS and other care and support services such as prevention of mother to child interventions, peer social support systems, home base care and early treatment with antiretroviral therapy if one is HIV positive. Community member indicated that VCT was an entry point to reaching out to the family and community for on-going counseling, leading to reduction in HIV/AIDS stigma and discrimination.

Several barriers to VCT were identified by the participants. At individual level, barriers included: the fear of the ramifications of a positive test; fear of HIV/AIDS stigma and discrimination; doubt about the existence of HIV and AIDS; and fear of loss of control of life circumstances and destiny. Health facility level barriers included concerns about confidentiality of HIV-test results, familiarity with service providers, lack of promotional activities of the VCT services, shortage of testing logistics and commodities, and human resource shortages both in terms of numbers and confidence to promote VCT services. Community levels barriers included cultural beliefs and customs, gender imbalances, religious beliefs and stigma.



## **CHAPTER 5: CONCLUSION AND RECOMMENDATIONS**

### **5.1 SUMMARY OF FINDINGS**

The study set out to explore factors affecting utilization of VCT services in three public health facilities of Mwense district, Luapula province in Zambia. The study revealed that community members were aware of HIV/AIDS and identified the risk factors contributing to the spread of HIV in their communities. Participants cited poverty, multiple sexual partnerships, tradition customs such as sexual ritual cleansing, lack of knowledge of one's HIV status, lack of women empowerment, cross-generational and pre- and extra-marital sexual relations and beer drinking as some of the major contributing factors to the spread of HIV/AIDS in their communities.

The study found that counseling and testing services are provided in the three study sites using community lay counselors and health care workers, mainly in an integrated fashion. Rapid tests are used which enables having the results within 30 minutes or within the same day. Waiting time was therefore not reported as a barrier to utilization of VCT services.

Community members were aware of the VCT services available at the health centre within their catchment area and beyond. The benefits of knowing one's HIV status as cited by the participants ranged from enhancing future individual and household planning, behavioral changes, accessing other health promoting and disease preventing services such as ART, membership to social support groups, home based care and other accompanying services.

Although participants were aware of the availability of VCT services and the benefits of knowing one's status clearly elaborated, VCT use as self-reported was low. This study highlighted the multiple influences on the utilization of VCT that have been identified in the

literature review and confirmed by the results of the study. The major barriers to access and utilization of VCT services included fear of an HIV positive test and its ramifications of stigma, rejection, labeling, isolation, uncertain future, sickness and ultimately death. Lack of confidentiality, perceived lack of benefit and distance to VCT centres were also some of the reasons forwarded. Knowing one's HIV status was seen as the most important reason for VCT as such knowledge would help reduce HIV risk behavior.

A variety of VCT promotional and sensitization activities were reported as being carried out at the health centre and community levels, although this does not seem to impact the service uptake which is still low.

## **5.2 RECOMMENDATIONS**

The recommendations of the study are based on various issues that emerged from the study findings and suggestions made by participants during FGDs and the key informants interviewed.

### **5.2.1 Public Education on VCT**

Public education, which highlights the benefits of testing and counters the widespread misconception that HIV is a “death sentence”, must be promoted at different levels using the appropriate media. It is only when people are aware and knowledgeable about VCT can they change their behavior and attitudes in relation to HIV/AIDS.

### **5.2.2 Number and Variety of VCT Service Outlets**

The health facilities must broaden entry points of access to VCT services using out-patient, in-patient, family planning, STI and TB clinics and, youth friendly centres. A family centred approach involving all family members must also be promoted.

### **5.2.3 Improve Confidentiality**

Fear of a breach of confidentiality by VCT service providers was reported to be one of the main barriers to VCT-uptake. VCT services should, therefore, always preserve and safeguard the individual interests of clients and needs for confidentiality at all service points. Health facilities must create procedure for dealing with HIV or AIDS -related information, which should be incorporated into the procedures used for handling medical information and other confidential matters. This should be augmented by capacity building training for staff handling HIV -related information and ensure the training is regularly updated to reflect changes in the law.

### **5.2.4 Stigma Reduction strategies**

Fear of stigmatization and discrimination is an important barrier to HIV testing and has negative consequences for AIDS prevention and treatment. Since HIV/AIDS-related stigma acts at both the societal and at the individual level, there is need to address stigma to promote adequate, accessible and acceptable HIV/AIDS programs and services. Tackling HIV/AIDS related stigma should involve tackling perceptions and values towards sexuality and HIV/AIDS.

Public health laws, social marketing, anti-stigma campaigns, community mobilizations and the use of mass media are needed to change societal beliefs about people living with AIDS (Kalichman and Simbayi, 2003).

### **5.2.5 Male involvement**

Since men are key decision makers in households in Mwense district, their involvement in VCT promotional activities and discussions should be enhanced in order to demystify HIV and increase men's knowledge of VCT. Additionally, health promotion messages need to be designed in such a way that they move away from the clinic settings where men's presence is

rare. This will encourage men to share the burden of HIV status and will reduce stigma and discrimination.

### **5.2.6 Youth Friendly centres**

Youths are often particularly vulnerable to HIV infection. Youth friendly centres must be created and for VCT to be effective for young people, it must take into account the emotional and social contexts of young people's lives, such as the strong influence of peer pressure (*e.g.* to take drugs or alcohol) and development of sexual and social identities. In order to address this, youth-focused "user-friendly" VCT services, offered in non-threatening, safe, easily accessible environments.

### **5.2.7 Peer to peer communication**

Peer-to-peer communication is an important factor regarding HIV issues. Peer education, which typically involves using the members of a given group to effect change among other members of the same group, is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviors. However, peer education may also effect change at the group or societal level, by modifying norms and stimulating collective action that leads to changes in programs and policies. Therefore, peer-to peer communication might be stimulated, in order to increase positive peer-to-peer communication about VCT services

### **5.2.8 VCT and ART outreach/Mobile services**

Distance to VCT service sites was identified as one of the barriers to accessing and utilizing VCT services. Outreach or mobile VCT and ART services should, therefore, be regularized to distant communities within the health centre's catchment areas.

### **5.2.9 Role models or HIV/AIDS Champions or Ambassadors**

By involving role models who have been tested and by showing examples of how society supports PLWAs, society's attitude towards VCT might improve and, consequently, people might become more inclined to seek HIV.

### **5.2.10 Linkage to support systems**

VCT should not be provided as an end in itself, but as part of a continuum of services and support, ranging from advocacy and community mobilization to reduce stigma and discrimination around HIV/AIDS, behaviour change strategies to prevent HIV/STI infections and re-infections and psychosocial support – care and medical treatment including treatment of opportunist infections and ART where it exists. Concerted effort must be made to ensure the range of services and support systems either through direct provision or by referral and linkage with other programs providing these aspects. This way, the advantage of VCT-uptake should become more evident to the community and, as a consequence, lead to a more positive view on VCT uptake.

### **5.2.11 Gender Sensitive HIV/AIDS Programming**

Women are particularly vulnerable to HIV infection, access and utilization of services restricted by their male counterparts and may risk rejection, violence, abandonment, or loss of home and children if their HIV status becomes known. The need for protection and support of vulnerable women must be considered when developing VCT services.

### 5.3 CONCLUSIONS

Voluntary testing and counseling for HIV has been promoted as an important tool for preventing the further spread of HIV through behavior change and as an entry point for care, treatment and support of individuals who are infected. The study identified both facilitators to the uptake as well as critical barriers to utilizing VCT services. The facilitators to the uptake of VCT services are clustered around themes of health, social and cultural, personal, employment requirement, peer pressure and role models. The barriers were classified under the following themes: individual, health service and community factors. Efforts to improve access and utilization of VCT require a comprehensive approach involving the family, community, health care providers and policy makers, and focusing on addressing personal, environmental and structural constraints.





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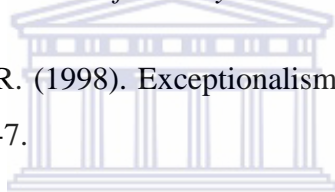
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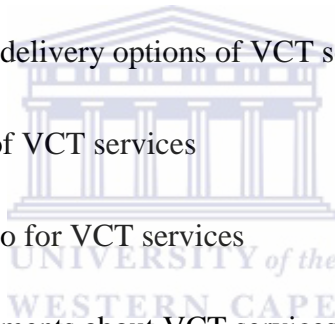
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## **APPENDICES**

### **Appendix I: FGD Guide with Community Members**

*(Utilization of HIV Voluntary Counseling and testing Services Study)*

1. Knowledge of HIV/AIDS and perception of personal and community risk
2. Attitude towards persons living with HIV/AIDS
3. Knowledge of and attitude towards VCT for HIV/AIDS
4. Decision making options and considerations for VCT – Gender dimension, disclosure, etc.
5. Knowledge/awareness of other delivery options of VCT services
6. Factors mitigating against use of VCT services
7. Ways of motivating people to go for VCT services
8. Any other suggestions and comments about VCT services improvement.



## Appendix II: Health Care Workers and Lay Counselors interview Guide

### *(Utilization of HIV Voluntary Counseling and testing Services Study)*

1. Do you provide VCT services at this facility? (Probe on days, time, space, service providers, service uptake/ statistics);
2. Reasons for clients utilizing the services;
3. What promotional efforts is the facility doing for access, utilization and acceptability of VCT services ( both at the health facility and in the community);
4. What do you think are the factors mitigating against/preventing people from using of VCT services at the health facility?
5. How can increase uptake of VCT services (explore ways of motivating people to go for VCT services);
6. Any other suggestions and comments about VCT services improvement



## Appendix III: Key Informant Interview Guide

*(Utilization of HIV Voluntary Counseling and testing Services Study)*

Name of interviewer _____
Position of informant _____
Business/Organization _____
Start time _____ Finish time _____ Total time _____
Interviewer self-check (Print name) _____

### General

Get some details of the respondent such as the length of position, level of involvement in community issues, length of stay in community etc.

### Perceived HIV/AIDS risks and knowledge

1. In general do you think that HIV/AIDS poses a major health threat in this area?
2. What sector of the society is more at risk of HIV/AIDS infections? *(probe for young versus old, male versus female, employed versus unemployed, school going versus out of school youths, commercial sex workers etc.)*
3. Do people in general know about the dangers of HIV/AIDS? *(probe for the perceived risks among the different groups as mentioned above)*
4. How would you rate the HIV/AIDS awareness in this area? *(probe for source of information for various groups, including media )*

### Attitude and Practices

1. Are there people who still do not believe in the existence of HIV/AIDS? *(probe for the reasons why and the category of these people, cultural believe)*
2. What are some of the major factors contributing to the spread of HIV/AIDS in this area? *(probe for list, and how each can be overcome)*
3. Do people generally know that there is no cure for AIDS, what about traditional doctors? *(ask for traditional doctors . with the promise of a cure)*

4. Would you say there is stigmatization and discrimination against individuals who are known to be HIV positive?
5. Has anybody in this area ever declared their HIV positive status?
6. *(if yes)* How were they perceived after the declaration?

### **Voluntary Counseling and Testing (VCT)**

7. Are there any voluntary counseling and testing centers in this area? *(please explain what VCT is and get the respondent to reflect on the existence of such services and get info on who runs these centres)*
8. *(if there are any VCT services)* Do people make use of these services?
9. *(if they do not make use of the service )* What do think are the reasons for people not using VCT services? *(Probe for information on stigma, confidentiality and cultural and any other social believes, locations)*
10. What could be done to overcome these obstacles to the use of VCT? *(probe education, information and any other incentives)*
11. *(if no services exist)* If there were any VCTs, would people go for these services? *(probe for the incentives to induce people to use these services, e.g. medicines, home based support and other incentives)*
12. Do the local clinics provide counseling and testing for HIV/AIDS? *(probe for whether they do only testing or a combination of testing and counseling and probe for pre- and post-counseling)*
13. Would you say that people would prefer to be tested for HIV/AIDS in a hospital setting or in a community VCT center? *(probe for confidentiality of hospital settings versus VCT centers such as the New Start Centre)*
14. Would you say that people would prefer to be counseled and tested by the lay counselors or the health care workers? *(probe for reasons of preference)*

### **Conclusion**

1. What barriers or constraints do you think prevent or discourage people from using VCT services? *(probe the responses given)*
2. What can be done to increase VCT uptake in the district/province? *(probe the responses given)*

3. Who should be involved in order to increase VCT uptake in the district/province? (*probe the responses given*)
4. As a last question, what are your views with regard to VCT?

Thank you for your cooperation



## Appendix 1V: Participant Information Sheet



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### School of Public Health

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Tel: 021- 959 2809, Fax: 021- 959 2872

#### PARTICIPANT INFORMATION SHEET

Dear participant,

Thank you for your time and willingness to hear about this research. What follows is an explanation of the research project and how you may be involved. The research is being conducted as a mini-thesis as a requirement for the partial fulfillment for degree of Masters in Public Health which I am pursuing with the University of the Western Cape, South Africa. Any clarification that you might need on the subject matter, kindly do not hesitate to contact me and/or my supervisor on the details provided at the end of this memo.

#### **Title of Research**

Scaling up VCT services: Exploring factors affecting utilization of Voluntary Counseling and Testing (VCT) services in Mwense District of Zambia.

#### **Purpose of the study**

This study seeks to explore community's knowledge about VCT and what the perceived barriers to utilizing the VCT services are. It is hoped that with your participation, a better understanding will be gained that will help identify strategies to improve availability and accessibility of VCT services so that people may utilize them. This information would enable policy makers and service providers find ways of addressing the factors that affect or limit utilization of VCT services. Improved utilization of VCT services would contribute towards decrease in the rate of HIV infections among the Zambians, in particular, Mwense Residents.

## **Description of the study and your involvement**

The study will include focus group discussions with community members and individual interviews with key people involved in HIV/AIDS activities, Health Care workers and Community Lay Counselors. Questions on access and utilization of VCT services will guide the discussion and /or the interview that I will have with you.

## **Confidentiality**

Information obtained from you and your personal details (Name, address, etc.), including the signed consent form which I will need from you should you agree to participate in this study, will be kept confidential and secured at all times. All the documents will be destroyed upon completion of the research study.

## **Voluntary participation and withdrawal**

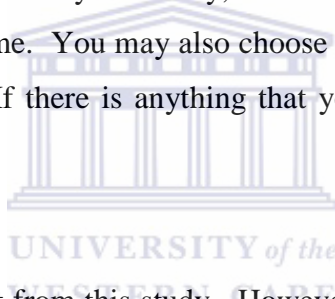
Your participation in this study is entirely voluntary, without any coercion. If you choose to participate, you may stop at any time. You may also choose not to answer specific questions that you are asked in the study. If there is anything that you would prefer not to discuss, kindly indicate so.

## **Benefits and costs**

You may not get any direct benefit from this study. However, the information generated by and solicited from the participants in the study may help develop strategies to increase access and utilization of VCT services and the subsequent benefits of knowing one's HIV status as it serves as a gateway for care, prevention and treatment. There are no costs for participating in this study other than the time you will spend in the group discussion and/or interview.

## **Informed Consent**

Your signed consent to participate in this research study is required before I proceed to interview you. I have attached the consent form with this information sheet so that you will be able to review the consent form and then decide whether or not to participate in this study.





## Questions

Should you have further questions or clarifications, I can be reached on the following:

Charlton Sulwe

Student Number:

Cell: 260-977883393

Email: [csulwe@ZPCT.org](mailto:csulwe@ZPCT.org) or [carltonsulwe@yahoo.com](mailto:carltonsulwe@yahoo.com)

Telephone at work:

Fax Number

I am accountable to Dr Brian van Wyk, my supervisor at UWC. His contact details are

C/o the School of Public Health

Tel. 021 959 2173

Email: [bvanwyk@uwc.ac.za](mailto:bvanwyk@uwc.ac.za)



## Appendix V: Informed Consent Form



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### School of Public Health

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### INFORMED CONSENT

**Title of Research:** Utilization of Voluntary Counseling and Testing (VCT) services in Mwense District of Zambia.

As was mentioned in the Participant Information Sheet: your participation in this study is voluntary and non-coercive. Refusal to participate or withdrawal from the study will not result in penalty nor any loss of benefits to which you are otherwise entitled.

If you choose to participate, you may stop at any time. You may also choose not to answer certain questions that are asked in this study if you feel uncomfortable to or for whatever reasons. If there is anything that you would rather prefer not to discuss, please feel free to say so.

If you choose to participate in this research study, your signed consent is required before I proceed to interview you.

The information collected in this interview will be kept strictly confidential

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I have read the information about this research study on the participant Information Sheet, or it has been read to me. I have had the opportunity to ask questions about it and have received answers to my satisfaction.

I consent voluntarily to be a participant in the study and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature is proof of my willingness to participate in this research study.

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Participant name (printed)

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Participant Signature

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Consent Date

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Researcher Conducting Informed Consent (Printed)

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Signature of Researcher

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Date

