

Review of Factors Associated With the Acceptance of HIV Voluntary Counseling in Africa

Kudakwashe Sithole

Zimbabwe Open University, Faculty of Commerce and Law, Department of Management and Business Studies, Harare, ZIMBABWE

Abstract: This article reviews factors associated with the acceptability of HIV VCT in Southern Africa. A literature search was conducted to establish social and individual factors which affect HIV VCT and found perceived vulnerability, attitudes and perceived benefits as important determinants of the acceptability of HIV Voluntary Counselling and Testing in Africa.

Keywords: HIV, Voluntary Counselling and Testing, Southern Africa, Determinants.

I. INTRODUCTION

The low uptake of HIV Voluntary Counseling and Testing (VCT), an effective HIV prevention intervention, has hindered global attempts to prevent new HIV infections, as well as limiting the scale-up of HIV care and treatment for the estimated 38 million infected persons (UNAIDS 2008). According to UNAIDS and WHO (2007), an estimated 80% of HIV-infected individuals worldwide are not aware of their HIV status. In Zimbabwe according ZDHS 2005-2006, 6.6% of women and 6.6% of men aged between the ages of 15-49, had been tested and received their results in the 12 months prior to the survey (CSO, 2007). No data was available for most at risk populations such as truck drivers and sex workers. The country set targets to increase the numbers of adults knowing their status to 20% in 2007 and 85% in 2010 in line with the Millennium Development Goals (MDGs). Such efforts however may not produce required results due to lack of literature on factors that affect HIV Voluntary Counselling and Testing to guide programme implementation among specific high-risk population groups such as truck drivers and sex workers.

II. METHODOLOGY

Data was gathered from books and journal articles. Studies, which were not empirical by the relevant data was basically excluded in the review process. The formulation of the review question was identified the focus and boundaries, and shapes all aspects of the review process, such as inclusion and exclusion criteria, the search strategy, extent of the literature reviewed, the quality appraisal, and synthesis of evidence. The review question was: What are the factors associated with the acceptability of HIV Voluntary Counselling and Testing in Southern Africa? The search strategy was comprehensive and articles were collected from Google and Google Scholar. This study included only empirical evidence from various experimental or observational research, which included qualitative and quantitative research. However, this study did not include unpublished work. Selected articles were significant, reliable, acceptable, and empirically valid.

III. RESULTS AND DISCUSSION

Literature identified attitudes towards VCT, perceived vulnerability and perceived benefits as factors affecting HIV VCT in Southern Africa.

Attitudes towards VCT:

Studies that have focused on people's attitudes to VCT, in general, attempt to provide some measure of the acceptability of VCT in some population as an indicator of the demand for VCT services in that population. Such studies have shown high acceptance of VCT programmes, and HIV prevention services in general across a number of countries, including Ivory Coast, Kenya, Tanzania, Malawi, Zambia and Zimbabwe (Cartoux et al., & The Ghent International Working Group on Mother-To-Child Transmission of HIV, 1998; Cartoux et al., 1998; Kiarie et al., 1999; Kipp et al., 2001; Pool, Nyanzi and Whitworth, 2001; Wilkinson and Wilkenson, 2001).

However, the value of using acceptability as a measure of the demand for VCT services is somewhat questionable. A high level of acceptance at the level of attitudes, and a stated desirability for a service is not always equal to the intention to use it. Likewise, a stated intention to test is not equivalent to, but only a precondition for, undergoing the process of VCT. This is shown not only in the fact that there are low levels of HIV testing in areas where there is high acceptability and demand for VCT services, but also in the fact that even those who do come for testing and counselling do not always return for their results, showing that willingness to test does not always equal willingness to know. This point is well demonstrated by Fylkesnes, et al., (1999). These researchers explored the uptake of VCT in a general population sample of selected urban and rural areas of Zambia. Of those stating that they wanted testing only 9.4% actually came forward to be tested. Furthermore less than half of those who did get tested returned for their test results. These authors found that although self-perceived risk and high-risk behaviours were positively associated with initial (in principal) willingness to test, they were not associated with the *actual* use of VCT services, demonstrating that the use of VCT services may be predicated on far more complicated factors than attitudes towards these services.

A more appropriate measure of the extent to which VCT is actually deemed desirable in any given population, may be the extent to which participants who undergo VCT return for their test results. Certainly, if counselling accompanies testing, then this is because it is generally acknowledged that only after a process of counselling are individuals in a position to make informed decisions regarding whether or not they want to undergo testing. Thus, in measuring the extent to which people make this informed decision, one should have a better indicator of the actual willingness to test in a population.

Studies that have used return rates as an indicator, have on the whole found low rates of return for test results (Ladner et al., 1996; Sahly et al., 1999; Kipp et al., 2001). For example, in a study conducted in Ethiopia less than half (43.5%) of those who came for VCT returned for post-test counselling and their results (Sahly et al., 1999). Similarly, a study conducted in Nairobi found that only 35% of women choose to return for their results (Temmerman et al., 1995). Other studies show less extreme, but still significant dropout rates (Ladner et al, 1996; Cartoux, et al., 1998; Sahly et al, 1999; Kiarie et al., 2000; Kipp et al, 2001). This issue may, at first sight, appear to have lost much of its urgency with the advent of rapid testing. It has been demonstrated that uptake rates, i.e. the proportion of those returning for post-test counselling and receiving their results) can be improved significantly by simply shortening the period of time between pre and post-test counselling (Fylkesnes et al, 1999). However, findings regarding return rates are still very important, in so far as they indicate that people who request their blood to be taken often change their mind if given the opportunity to do so. This should clearly be taken into account in the refinement of counselling procedures applicable to rapid testing protocols to ensure that those receiving testing really do want to know their HIV status.

It seems likely that high-drop out rates can be attributed to counselling procedure as much as to individual or group variables. In other words, it is possible that the approach to, and method of, pre-test counselling used, is a determining factor of the extent to which individuals, especially high-risk individuals, return for their results. For example, in a London Health District, where high-risk patients were individually counselled for between 20 and 40 minutes, all of those who decided to undergo testing returned to receive their results (Bor, Miller & Salt, 1991). By comparison, in many of the African studies under review, pre-test counselling was performed through group pre-test, followed by individual post-test counselling. It is clear that those who are part of this group pre-test session (e.g. women at ante-natal clinics) may feel pressured to "consent" to testing and it is therefore unsurprising that many of these people fail to return for their results.

This pressure to “consent” for testing may be especially true of VCT efficacy trials and other research studies where participants may be tested not to know their status but for a myriad of other factors. For example, in the efficacy study in rural Uganda where there were extremely high drop out rates for post-test counselling, 74% of participants said that they underwent HIV testing not because they wanted to know their results, but because they wanted to be part of another research study (Kipp et al, 2001). Similarly, in a study of informed consent in VCT research, Abdool-Karim et al. (1998) found that although women participating were assured that their participation was voluntary, and indeed, participants themselves stated that they ‘wanted to know’ their HIV status, 88% also maintained that they felt compelled to participate in the research. Of these, 28% stated that they agreed to the test in order not to compromise the care they had come to the hospital for in the first place. This subtle coercive element - which may operate in any research conducted at public health care setting or where health care professionals are held in high regard - has already been noted by other researchers. It is well documented that patients relinquish autonomy to professional medical authority in medical settings and it is therefore not surprising that informed consent sought under such circumstances may be less than voluntary. In such contexts, not returning for test results may be the only polite way for many women to decline testing.

These findings reinforce the concern of Fylkesnes et al., (1999) that the use of rapid testing in contexts such as STI clinics, antenatal clinics and TB clinics - where VCT is routinely offered to all clients - needs to be further examined. The promotion of VCT to all clients is very different to a situation where VCT service is simply made available to those who may request it. While the anxiety attendant upon waiting for results is significantly reduced with the advent of rapid testing, the client is given only limited time to reflect on the pre-test and to make a considered decision about whether they really wish to proceed with the testing procedure (Beardsell and Coyle, 1996). Clearly, rapid testing highlights the difficulties inherent in achieving genuine and well-considered informed consent. The implications for counsellors as well as clients must be considered if many of those who might well have chosen not to return for their results, are in fact not truly willing to entertain a positive result, yet will now be receiving it.

Finally, some reflections on the research reviewed in this section. Firstly, it is worth noting that, although there are exceptions to the rule (e.g. Killewo et al., 1998; Pronyk et al., 2001), the vast majority of studies under review regarding the acceptability of VCT services were conducted at antenatal clinics. This is not surprising given that VCT has been implemented most extensively in this context where the imperative of preventing mother-to-child transmission (MTCT) is paramount. As a result, however, substantially less information is available regarding men’s attitudes to VCT or regarding attitudes to VCT in other community facilities or contexts such as PHC clinics, where the advantages of VCT for the prevention of MTCT do not predominate. The importance of researching men’s attitudes to VCT is reinforced by the fact that numerous studies also concur that women are less likely to present for VCT at general public testing facilities than men (Pronyk et al., 2001).

Secondly, in reviewing the large amount of research that has focused on the acceptability of VCT, the question must be asked of why it is that so much time and resource has been devoted to researching what is by definition not an invasive public health intervention but rather a voluntary and individual choice. Clearly, Abdool-Karim et al., (1998) have identified a key issue when they look at whether VCT is genuinely ‘voluntary’, especially in medical settings in which it is routinely advised.

Perceived Vulnerability:

Many studies have shown that the one variable most significantly associated with failure to return for post-test counselling and results is the perceived probability of a positive HIV test result (Wilson et al., 1996). This is despite a widely held view that an awareness of risk is one of the primary motivators for individuals to get tested in the first place (Maman et al., 2001). For example, Cartoux et al., (1998) show that HIV-infected women in Burkina Faso, West Africa, were three times less likely to return for results than uninfected women. Similarly, Temmerman et al., (1995) show that only 35% of women with a positive test result at an ante-natal clinic in Ethiopia requested their results (Ladner et al, 1996, and Kiarie et al., 1999) report similar findings). This suggests that those who are willing to receive a test result are doing so because they have reason to believe that it will be negative. For this reason, Manson (1990), as cited in Beardsell, (1994) argues: “people who are unlikely to be infected are the ones who take the test, in droves”.

Certainly, there has been a great deal of resistance to VCT in African settings on the grounds that confidentiality procedures may not be trusted, and that stigmatisation and discrimination results from disclosure. In addition, it has been acknowledged that knowledge of sero-status increases anxiety without major treatment benefits in low-income countries

where antiretroviral therapy is not universally available (Ladner et al., 1996; Van Rooyen & Wood, 1998; Kipp et al., 2001). Such concerns may well outweigh the advantages of receiving a test result; especially for those who have reason to believe their result may be positive (cf. section 3.3.2 for the impact of VCT on coping).

However, findings regarding the extent to which HIV-positive as opposed to HIV-negative people volunteer for VCT are not wholly conclusive. In Northern Uganda, differentials in attitudes towards HIV tests showed that ethnicity, marital status and gender, but not HIV status, were some of the determinants of willingness to be tested (Ayiga et al., 1999). Likewise, In Ethiopia, (Sahly et al., 1999) factors affecting post-test attendance did not include HIV status and results were requested equally often by sero-positive and sero-negative women; however these authors did suggest that this population may not have recognised themselves to be at risk.

What is clear, however, is that the assumption that perceptions of personal risk or perceived vulnerability will motivate individuals to be tested is an erroneous one. Two studies specifically investigated this question and found that previous high-risk behaviour was not significantly associated with the decision to test (Sahly et al., 1999; Machekano et al., 1998). In fact, males who reported recent casual partners tended to be more reluctant to learn their test results. This could be attributed to the psychological factors of denial and avoidance coping (i.e. not wanting to know) on the part of those who know they are at high risk of being infected (Wilson et al., 1996).

Other research findings show that the relation between perceived risk, actual risk and HIV test results is an exceptionally complicated one. For example, Wilson et al. (1996,) have shown that self-reported previous risk is not significantly associated with increased likelihood of infection. They found that perceptions of susceptibility might not be related to actual risk levels as measured by STI tests. Furthermore, Muller et al. (1992) in a comparison of HIV-positive and HIV-negative individuals found that previous risk, measured in terms of reported lifetime numbers of previous partners and reported number of casual sexual contacts in the previous 6 months, did not appear to substantially differentiate HIV-positive from HIV-negative individuals. This is an interesting finding, in so far as it suggests that the behavioural measures of risk commonly used by researchers may not be highly predictive of infection.

Additional Factors in the Demand for VCT:

Apart from a perception of risk, another salient factor that appears to influence the individual's decision to be tested is the perceived benefits of testing. A number of studies have focused on this question by looking at who comes for VCT and, more importantly, why they do so (Muller et al., 1993; Gibney et al., 2000; Maman et al., 2001). An ability to plan for the future is perhaps the main perceived benefit of testing, either because it allows couples to proceed with unprotected sexual intercourse, marriage and pregnancy or because it allows individuals to prolong and modify their lives in the face of HIV infection (Gibney et al., 1999; Maman et al., 2001).

Other researchers have focused their attention on profiling the socio-demographic characteristics of who comes for VCT in an attempt to identify variables associated with the demand for VCT (e.g. education, age, gender, marital status, etc.). These studies have, by and large, provided a number of inconsistent findings (Brimmer et al., 1996; Ayiga et al., 1999; Marum et al., 2000) with the result that while these studies do provide a demographic and behavioural profile of VCT clients in a specific area at a specific time, they tell us nothing about the nature of the decision-making process involved in being tested for HIV. Beardsell and Coyle, (1996) therefore argue that most quantitative studies regarding VCT users have merely succeeded in identifying a variety of socio-demographic factors that are statistically associated with their dependent variables, but have not shed real light on the question of who uses VCT and why.

One of the studies under review did attempt to address this question (who comes for VCT?) from another perspective, i.e. that of the research participants themselves (Kipp et al., 2001). Respondents were asked to identify their own reasons for returning or not returning for a result. However, the full decision-making process was not explored and participants are generally simply asked to provide a reason for non-attendance. In fact, reasons offered by participants would have been better labelled 'excuses' than 'reasons'. Such responses included being sick, visited relatives, or forgetting (Kipp et al., 2001).

Maman et al. (2001) point out that gender inequality is a significant factor affecting the uptake of VCT in women. Fear of a partner's reaction and partner's negative attitudes towards testing will act to limit the number of women who choose to be tested. Thus, it would appear that unequal power relations that limit women's control over their risk of infection in the first place also limit testing behaviour. There also appear to be important differences in the factors that motivate men and

women to ask for a test. For example, it would appear that while men tended to be tested to confirm that they are negative, women are more likely to have a perception of personal susceptibility and therefore will engage in testing to find out if they are positive (Maman et al., 2001).

IV. CONCLUSION

This review has explored literature on HIV Voluntary Counselling and Testing in Africa. The factors associated with HIV Voluntary Counselling and Testing in Africa vary from social to psychological. Among the social factors include demographics such as age, gender, gender inequality and psychological variables include perception of HIV risk and vulnerability, attitudes, knowledge and sexual practices. It becomes important that efforts aiming at scaling HIV Voluntary Counselling and Testing in Africa need to focus on psycho-social variables and recognise that a one-size approach does not fit all.

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