VCT: VOLUNTARY COUNSELLING AND TESTING OR VERITABLE COMMUNICATION TRAGEDY?

Communitas
ISSN 1023-0556
2008 13:115 - 133

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ABSTRACT

This article examines the communication factors and the prevailing socio-cultural context which underlies the lack of VCT uptake amongst male construction workers in South Africa. The article is based on focus group discussions carried out with a group of African construction workers in Howick, KwaZulu-Natal. Lack of understanding of the term "VCT", lack of information on topics such as antiretroviral therapy and rapid-testing facilities, and lack of constructive interpersonal verbal communication on the topic were found to impact on VCT uptake. Socio-cultural factors such as high levels of stigma and discrimination of HIV positive persons, norms surrounding childcare, as well as notions of masculinity contributed to lack of VCT uptake amongst males. It was also noted that the perceived susceptibility of the males was high as a result of misunderstandings and irrational fears of the means of transmission of the HI virus. Suggested means of improving communication on VCT include re-branding VCT for certain populations, capitalising on the trust placed in radio, and implementing peer-led education programmes to promote dialogical discussion.

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INTRODUCTION

The effects of HIV/Aids have been seen to be highly problematic worldwide. Sub-Saharan Africa has been identified as the region most adversely affected by HIV/Aids, with an estimated 24.5 million HIV positive people at the end of 2005 (Fredriksson & Kanabus 2006). The level of HIV prevalence in South Africa, currently estimated to be at 10.8 percent of the population, is a pressing issue which clearly demands an aggressive strategy to curb it (Shisana *et al*. 2005). One of the most effective ways, proven to assist in this process, is through "Voluntary Counselling and Testing" (VCT) for HIV, teamed with the provision of antiretroviral therapy (Thom 2005).

VCT has become more desirable for use since the advent of rapid-testing (Fredrikkson & Kanabus 2006). Results are available in between five and thirty minutes, allowing for both pre-test and post-test counselling, which accompanies the test, to be carried out in one visit (Cichocki 2006). Depending on the results of the test, personally tailored advice, referrals and avenues for support are offered to the patient (Thom 2005). These include advice on the consistent use of condoms and where necessary, tests for CD4 counts, contacts for support groups, and as of 2003, in South Africa, access to free antiretroviral therapy (Swanepoel 2005). Access to VCT is thus seen to be important, as it has been shown that counselling, being aware of one's status and receiving advice can positively impact on increasing health-promoting behaviour (Nogogo 2005).

Pooled European research has shown that antiretroviral therapy decreases one's risk of dying within ten years of contracting HIV by 64% (Mocroft *et al*. 2000, in Kippax 2006). However, these medications are not without side effects, often visible, amongst them "lipodystrophy" – the redistribution of body fat from the limbs and face to the abdomen (Fallon 2003).

VCT uptake in South Africa

Despite being successful in countries such as Uganda, Brazil and Kenya (Thom 2005), VCT uptake in South Africa has been surprisingly low. The availability of antiretroviral treatment in the public health sector was hoped to assist in diminishing the stigma surrounding HIV/Aids (by presenting it as a manageable, chronic illness) and thus increasing VCT uptake (IRIN Plus News 2006a). However, research carried out by the Human Sciences Research Council in South Africa in 2005 indicated that VCT uptake is estimated to be at a level of 30.3% of the population (Shisana *et al*. 2005).

Within this one-third of the South African population, other researchers have estimated that the ratio of male to female testees is 21% to 79% (IRIN Plus News 2006b). This ties in with research which details the phenomenon of women attending public health clinics significantly more frequently than men, due to the demands of childcare (Tollman *et al*. 1999, in Pronyk *et al*. 2002).

Other patterns could be seen to be indicative of various underlying factors. These include structural, socio-cultural and communication factors. This study aims to uncover these factors and identify ways in which more culturally relevant and thus effective communication on the topic of VCT, especially targeting males, can be designed and implemented.

LITERATURE REVIEW

Communication, both interpersonal and impersonal, has been identified as being an important barrier to accessing the VCT service in South Africa (Policy Project 2003a). Whilst in countries such as Uganda, HIV/Aids communication has focused on morality and personal responsibility, in South Africa different needs have been identified as being important. These are identified by Simelea (2002, in Cullinan 2002) as being the challenging of stigma, discrimination and denial surrounding the disease. These identified foci are underscored by research which has shown that amongst other factors, fear of rejection and violence, as a direct result of stigma and discrimination, are barriers to accessing VCT services (Riasa 2005).

Mistrust of health professionals, problems relating to accessing health services, as well as a lack of belief in one's ability to cope with the emotional turmoil of testing, have also been identified as reasons behind a lack of VCT uptake in South Africa (Van Dyk & Van Dyk 2003). A study on VCT uptake carried out by Hutchinson and Mahlalela (2006) in the Eastern Cape confirmed many of these factors, as well as identifying misperceptions of risk and a shortage of testing and treatment facilities. The probability of being tested was noted to be linked to psycho-social factors, such as "the absence of stigma" or "knowing someone with HIV/Aids" (Hutchinson & Mahlalela 2006).

Other more general factors which have been identified through studies in the US as being catalysts of the process of deciding to undergo VCT, include marriages, new relationships, the death of a partner, distrust of a partner, illness, weight loss and sexually transmitted diseases (Shuter *et al*. 1997, in Fako 2006).

Socio-cultural factors

Culture and health

Culture is defined by the collective consciousness of community of people, which is seen to be shaped by a "shared history, language and psychology" (Airhihenbuwa *et al*. 2000: 106). The inclusion of a focus on culture has been deemed highly important in determining the success of health communication programmes in collectivist cultures. This is due to the fact that "culture is a central feature in health behaviour and decisions, particularly in the context of behaviours that predispose people to HIV/Aids" (Airhihenbuwa *et al*. 1992, in Airhihenbuwa & Obregon 2000: 6).

Each community can be seen to maintain health, prevent disease, respond to symptoms and treat the ill in a specific, well-established manner (Gilbert *et al*. 1996). "Health–seeking behaviour" follows the realisation of illness and, in many circumstances, includes consulting family members, friends and family (Gilbert *et al*. 1996: 49). The course of action, be it visiting a modern health care practitioner or traditional healer, is often the result of the advice given by the network of persons consulted (Gilbert *et al*. 1996).

Power relations and masculinity

There are many contextual factors, identified by Parker (2004), which contribute to the spread of HIV/Aids. Amongst these, gender power relations are identified as being unequal and weighted towards decision-making by males (Parker 2004). Linked to such issues of power are those of masculinity, which Campbell (2004) identifies as furthering the spread of HIV/Aids. In research conducted by Van Dyk and Van Dyk (2003) it was found that the main reasons behind men not wanting to disclose their HIV positive status were due to fear of losing their sexuality and sex appeal.

It is asserted that VCT programmes should take into account the intricate issues of male sexuality and psychological barriers which are encountered in this process. Couple-focused VCT is recommended as a means by which to empower men to take responsibility for sexual choices, rather than denying their status or refusing to present for VCT (Van Dyk & Van Dyk 2003).

Stigma and discrimination

Stigma is referred to as prejudice and discrimination against people, and the treatment of people in a negative manner.

The stigma often attached to Aids has been identified as a barrier to the humane treatment of people worldwide (Singhal & Rogers 2003). Many studies have shown that people often understand how HIV is transmitted, yet do not have a suitable understanding of the ways in which it is not transmitted (London & Robles 2000, in Dias *et al*. 2006). A large proportion of respondents in a US study were shown to overestimate the risk of infection that casual contact with HIV positive persons poses (MMWR 2000, in Dias *et al*. 2006). It is asserted that this fear of contracting HIV through casual contact increases stigma through an increase in fear that people have of associating themselves with HIV positive persons (Dias *et al*. 2006). Parker and Aggleton (2003, in Dias *et al*. 2006) argue that HIV/Aids campaigns have not addressed this misunderstanding of the ways in which HIV is transmitted, as well as the ways in which it is not.

Strategies to increase VCT uptake

Recommendations of Shisana *et al*. (2005) include the need to refocus the communication strategy by addressing, amongst other factors, gender-related vulnerability, age-related vulnerability and vulnerability as a result of migration and mobility. More specifically, it is suggested that low levels of personal susceptibility be addressed, with specific emphasis placed on the need for persons to present themselves for VCT, as well as to disclose their status to their partners. The risk of contracting HIV/Aids during pregnancy and the suggestion that testing of both partners before planning to conceive should also be highlighted. This would thus incorporate the need for the periodic testing of men and women in stable relationships.

It is suggested by Parker (2004) that with regard to the response to HIV/Aids in South Africa, national level (vertical) communication campaigns should serve as a useful backdrop to local, related (participatory) activities. The combination of the use of both is vital for the purpose of increasing general knowledge and awareness.

The participatory communication which is referred to could be seen to be present in the practice of "peer-led education". This is best described as "dialogic interpersonal communication and group learning processes" (Mason *et al.* s.a.: 3). This process allows for alternative behavioural norms and practices to be identified and evaluated in a language with which the participants are comfortable and in relation to certain issues which are most personally relevant (Campbell 2003).

Moving beyond the realm of peer-led education, it is asserted by Mason *et al.* (s.a.: 3) that in order to maximise behaviour change strategies, these should involve individuals, families and communities. Such extended "dialogic interpersonal communication and group learning processes" can be maximised by the use of "micromedia" – carefully and specifically created media for use with small, clearly defined groups of people which promote discussion and learning.

THEORIES OF HEALTH COMMUNICATION AND BEHAVIOUR CHANGE MODELS

This study was guided by three theories, namely Health Belief Model, Social Learning Theory and Diffusion of Innovations Theory. These theories fall into three categories which indicate the level at which they operate, namely the "individual" level, the "interpersonal" level and the "community" level (Glanz & Rimer 1995: 40).

The Health Belief Model is a rational-cognitive model, attributed to Becker (1974), which seeks to explain the reasoning behind the lack of uptake in programmes designed to assist in disease prevention and detection. The main focus falls on understanding the personal perceptions of issues surrounding the programme or disease (Airhihenbuwa & Obregon 2000). This model is comprised of five components (Glanz & Rimer 1995): perceived susceptibility; perceived severity; perceived benefits; perceived barriers; and cues to action. A further component, according to Glanz and Rimer (1995: 19), is that of self-efficacy, which refers to the confidence which a person has in his/her ability to carry out a particular behaviour.

Social Learning Theory, developed by Bandura in 1986, focuses mainly on the way in which modelling of behaviour and vicarious or observational learning has an effect on increasing levels of self-efficacy and individual behaviour change (Slater & Rouner 2002). Particular concepts are included in this theory and highlighted by Glanz and Rimer (1995: 23-24). The first of these is *reciprocal determinism*, which refers to the triadic nature of the theory and the way in which the behaviour of the individual, the environment and the cognitive processes of the individual have the ability to impact on each other in reciprocal manners. *Behavioural capability* refers to the assertion that in order for a person to carry out a specific behaviour, it is necessary that the person is

aware of the specific details surrounding the behaviour and how it can be achieved. The third concept is that of *outcome expectations* and refers to the results that a person anticipates will occur due to following a specific action.

The fourth concept is that of *self-efficacy*. *Observational learning* or "modelling" is also included and refers to the way in which people are able to learn through the experience of others. The process of socialisation is possible through the act of modelling.

The Diffusion of Innovations Theory, devised by Rogers in 1983, focuses on the ways in which "….new ideas, products and social practices spread within a society…" (National Cancer Institute 2001: 226). There are five characteristics of innovations which have been identified as being important: relative advantage; compatibility; complexity; trialability; and observability (Glanz & Rimer 1995: 28). Another important component of the theory includes the communication processes which are involved in the spread of a new idea – in terms of both knowledge and its application (Airhihenbuwa & Obregon 2000). This is viewed as a two-way process in which message receivers are active agents, as opposed to passive receivers (Glanz & Rimer 1995). The two-step flow of communication, which is incorporated in the theory, highlights the way in which opinion leaders are able to mediate messages (Glanz & Rimer 1995).

RESEARCH METHODOLOGY

Content analysis, which refers to the quantitative research technique that objectively and systematically describes the manifest content of communication (Berelson 1952, in Deacon *et al*. 1999), was carried out. Posters and pamphlets from the Howick clinic, as well as television advertisements, radio content and local billboards formed the basis for this analysis.

The main method of primary research carried out was that of focus group discussions, of which two were carried out in isiZulu and seSotho, each with six male participants, all of whom being construction workers in the Howick area.

Area of study

The Howick Clinic is a municipal clinic situated in the KwaZulu-Natal Midlands. The clinic serves the surrounding population through the provision of primary health care. Amongst the many services offered is voluntary couselling and testing. Patients who are identified as being HIV positive and requiring ART are referred to the nearby Communicable Diseases Clinic (Van Niekerk 2006). As a result of this clinic being non-governmentally run, patients presenting at this clinic are referred to the government-run Grey's Hospital in Pietermaritzburg, a distance of approximately 30 km from Howick (Cheek 2006).

Other organisations – such as New Start Voluntary Counselling and Testing Centre – are also in existence, and work in conjunction with the Department of Health. This organisation, based in Cape Town, Durban and Johannesburg (New Start Voluntary

Counselling and Testing Centre 2006), makes use of mobile VCT, where members of the organisation travel to certain areas and offer VCT in rural areas, places of employment, at colleges and at universities (Mtshali 2006). During these mobile VCT events, the usual testing fee is waived in an attempt to attract higher levels of uptake. Couple's VCT is a concept promoted by New Start, where a price discount is offered to those testing as a couple. This option has not yet proven very popular, although it is noted that different communities produce different patterns in testing practices, both with regard to VCT for couples, as well as the male to female ratio of testees (Mtshali 2006).

FINDINGS AND DISCUSSION

General health tests

Health tests for diseases which were identified by both Group 1 (isiZulu speakers) and Group 2 (seSotho speakers) included cancer, asthma, arthritis, blood pressure and HIV/Aids. Differing points of view existed with regard to the importance of these tests, but the majority of the views were in line with the assertion by one group member that health checks are important as they allow one to know one's health status with regard to illnesses, thus allowing one the opportunity to access treatment early. Such attitudes could be seen to be indicative of the findings of the research of Day *et al*. (2003), where a lack of belief in the value of health tests was not seen to be the main factor preventing uptake of VCT, but rather social barriers, such as stigma.

Very critical views of clinics, including a general mistrust of staff, a preference for doctors in private practice and the perception that "….things don't go well if I go to the clinic" (Sotho male B) were aired. One member in Group 2 asserted that white doctors were attempting to reduce the numbers of black people, that medicines offered at clinics generally did not tend to alleviate problems and that traditional herbs had to be used as well as prescribed medication. Such comments and practices were seen to be in line with the assertion that most Africans tend to believe that traditional healers are more skilled at treating ailments than modern doctors, despite such modern doctors often being visited (Green 1994, in IRIN Plus News 2001).

Awareness and understanding of HIV/Aids

None of the 12 men in the discussions indicated that they had heard of the term "VCT", although one member of Group 1 later stated that he had, but did not know what was being referred to.

In order to facilitate further discussion, a brief explanation of the term, indicating the inclusion of HIV testing, was given.

Group 2 members did not offer any suggestions as to how long the process of VCT was believed to take, whilst a member of Group 1 indicated that one has to return for the result of the test after a few weeks. The misperceptions surrounding the time taken for VCT indicated that the availability of rapid-testing did not appear to be well known. This is an important factor, as the results of research carried out with mineworkers by

Day *et al*. (2003) indicated that the implementation of same-day testing services had increased willingness to undergo testing in a group of 105 males by a significant 25%.

A lack of awareness of the intricacies of these services could impact on the *outcome expectations* and *behavioural capability* components of the Social Learning Theory (Glanz & Rimer 1995), thereby negatively impacting on the *self-efficacy* of the person with regard to presenting for VCT. With regard to the Diffusion of Innovations Theory (Glanz & Rimer 1995), the understanding of the *complexity* of the VCT service could also be negatively affected, potentially decreasing one's inclination to test.

Reasons offered for people choosing to undergo VCT included feeling unwell, being persuaded by family members to test, as well as by female partners who had undergone testing during pregnancy. This insistence by family members for testing to take place, could be seen to be indicative the collectivist culture prevalent in Africa (Airhihenbuwa & Obregon 2000). Later in the discussion, the point of view was raised that "people should stop seeking VCT when they are too ill, but HIV testing should become a habit" (Zulu male A). Statements such as these could be seen to link to the possibility of "opt-out" testing for HIV/Aids, where routine testing for HIV/Aids is carried out as a component of normal medical treatment, unless expressly refused by the patient (IRIN Plus news 2006c), being viewed favourably amongst some sectors of South African society.

Sources of information

Some participants indicated that sources of information on HIV testing included elderly persons at home, one's place of work, hospital and the radio. In one focus group it was indicated that VCT had been mentioned on the television series *Soul City*, but it was not understood exactly what was being referred to. The fact that this series was identified as an information source, highlights the *observational learning* component of Social Learning Theory (Glanz & Rimer 1995: 23) and the effects that watching others carrying out a certain task can have on the knowledge of the person observing. It can also be seen to link to the *observability* component of the Diffusion of Innovations Theory (Glanz & Rimer 1995: 28), which allows the person a better understanding of the service. However, it should be noted that in both cases, this observational learning and observability components were not fully realised due to the actual process of VCT not being depicted.

It was interesting that most of the sources involved mainly verbal communication. In Group 1, Ukhozi FM, an isiZulu radio station, was specifically identified as a source information on HIV testing. The frequency with which HIV/Aids-related messages are broadcast on radio was highlighted by Group 2 members. This is in line with information obtained from the programme manager of Ukhozi FM, who indicated that a strong focus was placed on empowerment and the provision of knowledge building information (Msane 2006). It was claimed that HIV/Aids content was included in programmes in one or another manner, ranging from phone-in discussions to promotions, interviews and advertisements an average of five or six times per day (Msane 2006).

Whilst television and radio were noted to be regarded highly in terms of credibility, points of view regarding the need for "live" persons allowing for two-way communication were also raised. Such comments could be seen to indicate desire for the dialogical nature of interpersonal communication, as well as the opportunity to engage with opinion leaders, a component of Diffusion of Innovations Theory (Glanz & Rimer 1995).

With regard to the amount of discussion which occurs on the topic of HIV/Aids and VCT, it was indicated that whilst discussion on the topic of HIV/Aids was common, especially amongst men, the VCT experience itself was not commonly discussed, except in the event of a negative test result. This was identified as being as a result of fearing stigmatisation and abandonment. This lack of discussion on the topic of the VCT process could impact on the *trialability*, a component of Diffusion of Innovations Theory (Glanz & Rimer 1995), of the service, whereby a lack of exposure to knowing what the process entails and thus a lack of ability to contemplate undergoing VCT could prevent uptake.

The fact that interpersonal communication on the topic of HIV/Aids exists, ties into the assertion that oral communication is viewed as highly valuable in traditional societies, despite often being overlooked (Airhihenbuwa & Obregon 1996). It also disproves the assertion by Lau and Muula (2004) that HIV/Aids is often considered a taboo subject, resulting in hindering diagnoses, treatment and prevention. Perhaps one could assert that it is not the fact that HIV/Aids is a taboo subject that causes these hindrances, but rather the lack of direction in talking openly about such topics in a non-judgmental, guided and constructive manner.

Perceptions of severity

HIV/Aids was perceived to be a great problem amongst members of both groups, with examples given of the experiences of attending funerals weekly and seeing others in the community suffering and dying from Aids-related illnesses. It was highlighted that persons with HIV/Aids often became very dark in complexion, lost weight and became too weak to walk unaided. It was also stated that overweight women were deemed to be HIV positive, but perceived to be on antiretroviral treatment, known to cause weight gain.

This could be seen to link to the *observational learning* component of Social Learning Theory, (Glanz & Rimer 1995) in the sense that persons who were noted to be HIV positive were able to be identified by certain "markers" (Singhal & Rogers 2003). It was interesting to note the way in which the perceptions of HIV positive persons have changed, and this could be noted as an indication of the way in which the HIV/Aids pandemic has rapidly changed (Parker 2004). Such perceptions could be seen to increase the amount of stigma and discrimination, even with those uninfected with HIV/Aids, due to the markers of the disease having shifted. Factors such as these should be addressed in health communication.

When asked which group of people were believed to be most affected by HIV/Aids, Group 1 indicated that the youth, adults and infants were most at risk. Group 2 members indicated that females were most at risk as a result of being sex workers and being generally promiscuous. Women were identified by both groups as being those who most often undergo VCT. The reasons behind this included "because the diseases starts with them" (Sotho male C, Group 2), and "because they care for their children, and they often go to clinics for prevention" (Zulu male B, Group 1).

The first of these views could be seen to be in line with the findings of studies conducted worldwide, which identified women as being blamed by men for "bringing Aids into the family" (Fleischman 2005, in De Bruyn 2005: 10).

Group 2 members were asked for their perceptions on VCT for couples and it was indicated that this was thought to be a beneficial practice. This was indicated by a group member who claimed that when presenting for testing without one's partner, enquiries were made as to the whereabouts of the partner. When asked whether VCT for couples was thought to take place commonly, it was claimed that it is often the case. The VCT counsellor at the Howick Clinic, however, indicated that couples presenting for VCT were uncommon (Xulu 2006). The fact that recent Department of Health Khomanani and LoveLife television advertisements were noted to focus on encouraging testing by couples, especially before planning a family, indicated a positive move towards pursuing this topic within communication.

Perceptions of susceptibility

Both groups indicated that persons within their community were at risk of contracting HIV/Aids. This was noted in the comment "people in my community are at risk as much as people in the cities" (Sotho male B, Group 2). With regard to information on the transmission of HIV/Aids, Group 1 indicated that HIV/Aids was spread by unprotected sexual activity, contact with infected blood and from mother to infant.

Personal susceptibility was not directly included in the discussions due to the sensitive nature of the topic. However, to a degree this was able to be gauged by responses to the questions relating to communal susceptibility. Interestingly, the comments made by the group members throughout the conversation highlighted the fact that a great deal of personal susceptibility existed. High levels of perceived susceptibility, based on irrational fears of being infected by HIV/Aids as a result of having talked to, touched or worked with an HIV positive individual were noted. This could be seen to disprove the popular assertion surrounding HIV/Aids that perceived severity of the disease is often higher than perceived personal susceptibility to the disease (Govender & Petersen 2004), resulting in a misappraisal of risk and thus a lack of behaviour change. The findings of this paper could be seen to indicate that in some cases, the levels of perceived susceptibility may in fact be equal to or greater than levels of perceived severity of the disease, as a result of irrational fears.

It is exactly these irrational fears which could have incapacitated persons and prevented the accessing of such services, increasing stigmatisation of and discrimination against HIV positive persons.

This is seen by the response which was recorded when the focus group members were asked whether HIV positive people were seen to be different from ordinary people. This was answered in the negative, with the fear of being infected highlighted as the only reason for avoiding such persons.

Perceived barriers to VCT uptake

The first reason for people not undergoing VCT which was identified by both groups as that of fear, both of a positive result and of being judged by others. HIV positive persons were believed to be ill-treated and made to sit apart from others, including family members, for fear of transmitting the virus. Some group members avoided verbal and casual contact with HIV positive persons for fear of being infected. It was also detailed by one member that he felt uneasy having to work with the same construction tools as those who were possibly HIV positive. It was indicated that if a person suspected of being HIV positive was to bleed on such tools, he would refuse to use these. He also indicated that he would not venture too close to the open coffin of a person whom he suspected of having died as a result of HIV/Aids, for fear of being infected.

It was highlighted that very few families were willing to care for those who became ill and that often such people were completely abandoned by the family. There appeared to be fear of rejection, abandonment, dependency and a lack of care at one's home. This linked to the research findings of Hutchinson and Mahlalela (2006) where the availability of home-based palliative care was identified as being an important factor, and was noted to improve the likelihood of testing amongst males.

Besides stigma and discrimination, other barriers which were seen to prevent men from presenting for VCT included a lack of access to clinics due to hours of employment and sheer stubbornness. This stubbornness, as well as the fear of dependency, could be seen to be linked to the assertion by Campbell (2004) that traditional notions of the constitution of masculinity could be seen to negatively impact on the prevention of HIV/Aids.

Asked what factors were felt to motivate people to undergo VCT, both groups mentioned having a friend who had undergone VCT. Additionally, Group 1 members mentioned a fear of dying (fear appeared to play both an encouraging and inhibitory role), often brought on by watching someone else dying; suggestions by friends; a distrust of one's sexual partners; having access to a clinic away from one's community; and television and radio. Such factors could be seen to link to the *cues to action*, a component of Social Learning Theory (Glanz & Rimer 1995).

The fact that members in both groups indicated that having a friend who had undergone the process of VCT would be an encouragement, tied in with research carried out by

Haupt *et al*. (2004). Two-thirds of the 300 construction workers included in their survey claimed to have approached fellow workers on their own accord to discuss HIV/Aids and issues that were not understood. Haupt *et al*. (2004) asserted that such findings indicated that use of peer-educators in such settings appeared to be a vital tool in transmitting relevant information.

Perceived benefits of VCT

At the end of the discussion, all members in both groups felt that VCT was a beneficial process to undergo. With regard to the perceived benefits obtained from VCT by HIV positive persons, only one member of Group 2 indicated that he felt that HIV positive persons could not be helped in any way.

Benefits which were identified by others included knowing one's status, receiving care and emotional support, receiving medication, receiving condoms and letters for social grants were mentioned in both groups. These could be seen to form the *relative advantage* component of Diffusion of Innovations Theory (Glanz & Rimer 1995: 23).

When asked whether those who were found to be HIV negative benefited from the process, Group 2 members first indicated that such persons were unable to helped in any way. Following probing by the facilitator, HIV negative persons were described as only being able to help themselves by being honest with their partner. Group one members indicated that HIV negative persons and their families benefited psychologically from VCT by obtaining relief. It was interesting to note that mention was not made of further prevention which could be offered to such persons. This could perhaps be seen to be indicative of the assertion that VCT is an effective means of "secondary prevention", but does not appear to offer an effective primary prevention strategy to HIV negative individuals (Weinhardt *et al*. 1999, in Van Dyk & Van Dyk 2003: 119).

When asked about antiretroviral therapy, Group 1 members indicated that they had heard of Nevirapine. Group 2 members indicated that they had not, but this was noted to be as a result of a lack of understanding of the word. Zulu male C (Group 1) indicated that the reason behind taking such tablets was "to lower HIV in their bodies so that HIV will not make them die faster". An opposing view was heard when it was stated that "they finish off people who are very sick" (Sotho male A, Group 2). Overall, it was also claimed that although side effects occured as a result of the medication, they did not cause death and were deemed to be helpful. Misperceptions were seen to exist with regard to the cost of antiretroviral therapy, which could possibly impact on levels of VCT uptake.

RECOMMENDATIONS

Based on the findings of this paper, certain changes with regard to communication strategies targeting HIV/Aids and VCT are recommended. These are discussed below.

The trust placed in radio should be capitalised on by maintaining and increasing the level of HIV/Aids content in ethnic languages, especially content in the form of

discussions with phone-in options that allow for a degree of two-way conversation. The inclusion in these discussions of HIV positive persons who are well-known in certain communities and who are able to openly refer to issues would improve the success of such programmes. Such issues would include discussion on the actual process of VCT, the personal effects of HIV/Aids and stigma, and the fact that a great deal of discrimination and fear is unnecessary due to HIV not spread by touch.

It is recommended that communication on the topic of how HIV/Aids is transmitted and, more importantly, not transmitted be given higher importance, as this appears to contribute to increased levels of irrational fear regarding infection and thus increased stigma and discrimination against those whoe are HIV positive. One possible means of addressing these issues would be to create a short, ongoing educational and informative television programme which is broadcast after 20:00. This could provide an SMS facility, whereby questions could be asked and answers could be researched and given.

Peer-led education campaigns to promote dialogue, perhaps with targeted micro-media, should also be considered. The way in which Group 2 engaged keenly in the focus group discussion could be seen to indicate a need to discuss such issues in an open but constructive manner. Such peer-led education campaigns could be implemented among colleagues at places of work, or within small communities at communal meeting places and persons educated in this way would be encouraged to share knowledge and the micro-media with other peers and family members, thus increasing constructive discussion on the topic of HIV/Aids and VCT, and allowing for diffusion of knowledge, increased community participation and thus community mobilisation.

It is advised that the availability of rapid testing and same-day results be publicised, as this was not known by the group members and, as previously mentioned, research has shown that the availability of rapid-testing has been proved to be a very important factor in determining VCT uptake amongst males. Entertainment-education television programmes should include depictions of persons undergoing the various stages in the VCT process: pre-test counselling, rapid-testing, post-test counselling and benefits such as support groups and antiretroviral therapy.

Focus should also be placed on the argument that people should not wait until they are ill to find out their HIV status, but should rather take the initiative to test early and often for HIV/Aids. A communication campaign which focuses on disclosure, particularly amongst men, thus increasing acceptability of the disease, would also prove beneficial.

Awareness of antiretroviral therapy should be promoted, as should clear statements regarding the benefits and the potential side effects of undergoing ART, which should be clearly identified and explained. It should also be highlighted that these are available free of charge at government hospitals, but that various tests have to be carried out to determine whether the person is at the correct stage of the disease to begin treatment.

Whilst “VCT” may be a suitable English phrase to use when referring to the process surrounding HIV testing, it is suggested that ethnic language communication should not make use of this acronym as it is not understood by those who are non-English

speaking. It is felt that it would be more beneficial to simply refer to HIV testing in the way in which it is referred to by the ethnic language speakers, for example "Ukuhlolela isifo sengculazi" in isiZulu and "Liteko tsa koatsi ea bosolla hlapi" in seSotho. It should be noted, however, that these descriptions refer only to the HIV testing itself, thus care must be taken to include the fact that counselling is included in the process, as well as the fact that it is a voluntary process, both of which appear to be fairly common knowledge but which should not be overlooked.

It is asserted that the focus which has been placed on VCT for couples be increased and that males are increasingly depicted in advertisements as being affected by HIV/Aids, and conscientised as to their role in the spread and prevention of HIV/Aids. The process of testing should be depicted as being manly, normal and expected, in an attempt to shift perceptions surrounding the constitution of masculinity.

Communication campaigns targeted at health care workers, which highlight the fears, understanding and beliefs of patients, especially male patients, including tips on how to best deal with male patients, could do well to improve service received by allowing for a more holistic approach to the treatment of the patient.

An increase in the availability of mobile VCT is also recommended, with mobile units visiting communities on weekends, in communal areas which are accessible and visible. This would hopefully increase the perception of the acceptability of VCT and allow for males (and females) to have access to the service which they may not have during working hours.

Further research into the possibility of opt-out testing being introduced in South Africa is recommended, as this could prove helpful in allowing for the disease to be seen as normalised and seen as manageable and chronic, as opposed to shameful and deadly.

CONCLUSION

This article has attempted to answer three questions with regard to which communication factors are seen to prevent the uptake of VCT, how these are linked to wider social and cultural factors and what changes could be made to current communication strategies to increase VCT uptake, in particular amongst African males.

Factors identified in literature and previous studies as being associated with a lack of VCT uptake, including interpersonal and impersonal communication (Policy Project 2003a), as well as fear of rejection, violence and stigma (Riasa 2005). A mistrust of health professionals, problems relating to accessing health services, a lack of belief in one's ability to cope with the emotional demands of testing (Van Dyk & Van Dyk 2003). Misperceptions surrounding risk and a shortage of testing and treatment facilities (Hutchinson & Mahlalela 2006) were also noted.

The article has identified and supported many of the above-mentioned factors which function as barriers to VCT uptake. Barriers associated specifically with males which this article has identified, included low levels of clinic access due to long working hours and not having the need to visit the clinic regularly in the way that females do, as well

as male stubbornness. Factors impacting more generally on VCT uptake levels included a lack of understanding of the term "VCT"; a lack of awareness of the availability of rapid-testing for HIV/Aids; a lack of opportunity to discuss HIV/Aids and VCT in a supportive and constructive environment; the minority belief that antiretroviral therapy can be harmful, as well as expensive to purchase; the fairly common belief that females are to blame for the spread of HIV/Aids; and the belief that casual contact with an HIV positive person places one at great risk of contracting the virus.

Further research in this field could include focusing on the perceptions surrounding peer-led education, identifying the best locations for this to take place and the best means of identifying suitable opinion leaders for training. Perceptions surrounding opt-out testing could also be investigated, determining the views of persons with regard to the potential acceptability aspect of such testing and how the introduction of this in South Africa could impact on levels of stigma and discrimination.

In conclusion, it is suggested that the communication factors which have been identified as impacting on and preventing the uptake of VCT be addressed as a matter of urgency. Without attention, an avoidable worsening of the HIV/Aids pandemic could emerge, as a result of this "veritable communication tragedy".

Endnotes

[1] The author would like to thank Johns Hopkins Higher Education South Africa, which via their Bloomberg School for Public Health, Centre for Communication Programmes, made available the resources to undertake this study. I am indebted to Keyan G. Tomaselli, Abraham Mulwo and Lynn Dalrymple for helping to prepare the article.

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