

Voluntary Counselling and Testing (VCT) in South Africa: Analysis of Calls to the National AIDS Helpline

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Voluntary counselling and testing (VCT) is a central component of the South African government's strategy to prevent the spread of HIV and to provide care and support to those living with HIV/AIDS. Government commitment to expanding access to VCT for people across the country creates a policy framework for increased uptake of VCT services in South Africa. The scope of the challenge in scaling up VCT – both in terms of human resources and physical infrastructure, and in raising awareness and changing attitudes – is considerable. Understanding popular attitudes to VCT – including misconceptions and fears about the process – is important if communication and advocacy campaigns are to be effective in encouraging people to test. This report draws upon findings from focus group sessions with counsellors at the South African National AIDS Helpline to highlight the informational needs about VCT reflected in calls to the Helpline. On the basis of these findings, the paper makes recommendations for enhancing VCT-related communications.

Voluntary Counselling and Testing (VCT) is regarded as a priority area in strategies to prevent the spread of HIV and to provide care, support and treatment to people already living with HIV (UNAIDS 2001; WHO 2003). By allowing people to learn their HIV status and be counselled about its implications, VCT may help to curb the further spread of HIV (Weinhardt *et al* 1999; UNAIDS 2001). VCT also represents a mechanism for referral into care, treatment and support systems. These include treatment for opportunistic infections, prevention of mother-to-child transmission (PMTCT), post-exposure prophylaxis (PEP), access to anti-retroviral treatment (ARV), as well as longer-term counselling and support for positive living (UNAIDS 2001).

VCT may also play a role in promoting greater social acceptance of the HIV/AIDS epidemic. Some have argued that widespread uptake of VCT within communities can help to normalise HIV/AIDS, to reduce AIDS-related stigma, and to raise awareness of the epidemic (De Kock and Johnson 1998; UNAIDS 2001).

Guidelines on HIV testing recommend that VCT be widely accessible on a voluntary and confidential basis. VCT services should include pre-test counselling to explain the purpose and possible implications of the test, informed consent on the part of the client, and

post-test counselling to discuss the test results (UNAIDS 1997). VCT is recommended as the 'standard of care' in any instance where a patient shows signs or symptoms of HIV/AIDS, and in routine medical contexts such as antenatal care and the treatment of sexually transmitted infections (STIs) (WHO 2003).

Voluntary Counselling and Testing in South Africa

VCT has been available in South Africa since the early 1990s – notably through city-based AIDS Training, Information and Counselling Centres (ATICCs), various NGOs, private sector services, and in some clinics and hospitals. In 2000, the process of expanding VCT within public sector health care was initiated as part of the national strategic plan on HIV/AIDS and STIs.

The *South African National Voluntary Counselling and Testing (VCT) HIV Prevention and Care Strategy* sets as its goal universal access to VCT services for 15-49 year

The Communicating AIDS Needs Project (CAN) was established in 2003 to draw together lessons learned in African contexts with a particular focus on individual and community level responses to the epidemic. The first year of the project is funded by DFID and USAID/Johns Hopkins University Center for Communications Programs. The views expressed in this report are not necessarily endorsed by the project funders.

olds (DOH 2003b). The strategy seeks to move beyond existing 'integrated' medical sites that offer VCT, such as primary health clinics, STI clinics, and family planning clinics, to establish a greater number of non-medical integrated or stand-alone sites that cater for particular target groups, such as youth, rural inhabitants, and working men (DOH 2003b).

A series of guidelines, protocols and policies outline specific aspects of the South African VCT strategy. The government's *National Policy on Testing for HIV* guides the administration of HIV testing in both public and private facilities in South Africa. It provides guidelines on the circumstances under which HIV tests may be conducted with a client's informed consent, the instances in which informed consent is not required, and specific circumstances in which HIV testing may not be undertaken. It also provides definitions of pre- and post-test counselling and informed consent, and sets forth standards for how these should be undertaken (DOH 1999).

Rapid tests are uniformly used in public sector VCT services in South Africa. Guidelines for the administration of rapid HIV tests – *Rapid HIV Tests and Testing* – overview the roles and indications for rapid HIV testing, outline testing protocols for positive and negative results, and recommend the implementation of quality control and quality assurance procedures for the use of rapid test kits (DOH, 2000b).

National guidelines have also been developed on pre- and post-test counselling, group information sessions, couple counselling, and how to establish VCT sites (DOH, 2003b).

Key Issues Surrounding VCT in South Africa

Several key issues must be addressed in expanding VCT services in South Africa, including:

- ❑ Developing and strengthening the human and infrastructural resources required to deliver VCT services;
- ❑ Promoting VCT among target audiences and encouraging large numbers of people to test;
- ❑ Monitoring, evaluating and ensuring quality control of VCT programmes.

A report on public sector VCT services in South Africa, commissioned by the Department of Health and published in 2002 (HST 2002), provided an interim assessment of the government's expansion of VCT in terms of access, infrastructure, organisation of VCT service delivery, quality of VCT services, management systems for VCT services, marketing of VCT, routine data collection, and policy planning and management. Among its findings were:

- ❑ Access to VCT within the public sector is overly reliant on primary health clinics, which may discourage some people from testing;
- ❑ VCT services tend to be provided during standard working hours only, which may deter employed people and students from testing;
- ❑ Some VCT sites face environmental/infrastructural

challenges, such as a lack of privacy, or inadequate storage and waiting space;

- ❑ There is an absence of routine data collection about VCT and a lack of quality control systems around testing;
- ❑ Counsellors work under challenging conditions and appropriate support systems are lacking for them to continue working at a professional level; and
- ❑ The absence of a coherent VCT promotional strategy means that voluntary uptake of VCT is low.

By March 2004, VCT was available at more than 1900 service points in South Africa (National HIV/AIDS and TB Programme, 2004). These sites cater primarily for clients who access VCT in the context of PMTCT or home-based care (DOH 2003b). VCT has also expanded in other sectors including private sector clinics and hospitals, workplaces, and community-based/non-profit organisations.

As in many countries, stigma continues to surround HIV/AIDS in South Africa. People fear learning their status and the implications of a positive result. In a study of 105 South African mineworkers (one-third of whom had undertaken VCT), fear of testing positive for HIV – and of potential consequences such as stigmatisation, disease and death – were identified by respondents as the main barriers to testing (Day *et al* 2003). A non-representative survey on attitudes to VCT among South Africans (van Dyk & van Dyk 2003) found that the idea of VCT in and of itself is largely acceptable, but that people are concerned about the confidentiality of the process and possible rejection by friends, family or medical workers should a positive result become known.

Recent changes in government policy on anti-retroviral treatment may impact on uptake of VCT. In November 2003, the South African Cabinet announced its intention to provide anti-retroviral treatment free of charge through the public health system (Cabinet 2003b). VCT will be the entry point to this programme. Once identified as HIV-positive, individuals will be assessed for the stage of illness, including through a CD4 count, and referred on to medical care. HIV-positive individuals who are symptomatic and/or have a CD4 count of less than 200 will be offered the option of anti-retroviral treatment (Cabinet 2003a).

Methods

The Communicating AIDS Needs Project (CAN) focuses on individual and community-level responses to HIV/AIDS with a view to understanding communication and resource needs at both levels. The project includes a number of in-depth research activities in selected South African communities, as well as reviews of service provision and communications systems. One component of the project is research and analysis of calls to the national AIDS Helpline.

The AIDS Helpline was established by the South African Department of Health in 1992, in partnership with Life Line. The Helpline service was consolidated into a centralised call centre in Johannesburg in 2000.

It is staffed by full-time, trained counsellors and can handle up to 24 incoming calls at a time. Calls are monitored through data capture forms, and also through automated electronic call counting. It provides callers with basic information, counselling, and referral to services in all 11 South African languages and is available 24 hours a day, seven days a week.

The Helpline has received close to seven million calls since May 2001; approximately seven percent of these are 'genuine calls' (currently defined as calls that are more than one minute in duration) where information, referral and counselling is provided. A quantitative analysis of calls to the Helpline between July 2000 and December 2003 found that slightly more than half of genuine calls to the Helpline are for information, but the proportion of counselling calls has been rising over time. Seventy-five percent of callers are under 30. A growing proportion of callers to the Helpline are disclosing their HIV status (Katz 2004).

During the latter half of 2003, a series of focus group discussions was conducted with AIDS Helpline counsellors with a view to assessing call trends and exploring key issues raised by callers. The focus groups were conducted with five to six counsellors at a time and followed standardised protocols. Most counsellors had worked at the AIDS Helpline for two or more years, and were thus able to reflect on a large body of calls to the line. All counsellors had completed relevant counselling training courses and received ongoing supervision, training and debriefing. The duration of the focus group sessions ranged from one and a half to two hours. Sessions were mostly conducted in English, although allowance was made for the use of other languages as the need arose. Facilitators prepared discussion guides prior to each session and discussions were tape-recorded, translated where applicable, and transcribed. All transcriptions were checked for accuracy.

Focus group transcripts were read a number of times by a senior researcher to allow for an understanding of the material and to develop a strategy for coding. The data was then coded and categorised electronically by two researchers using HyperRESEARCH OSX 2.6.

Strengths and limitations

The focus group discussions with Helpline counsellors were conducted as a counterpart to a quantitative analysis of data on calls to the Helpline, the results of which have been published separately (Katz 2004). The qualitative research was intended to highlight key issues and gaps in understanding about HIV/AIDS on the basis of actual cases and examples recounted by Helpline counsellors.

It is important to underscore that the findings of this research are not uniformly generalisable. Whilst calls to the AIDS Helpline are made by callers countrywide, callers are primarily individuals inclined towards information seeking. The issues raised in this report emerged from subjective recall of participating counsellors.

The strength of the approach is that it provides a relatively simple means through which to assess concerns and misunderstandings in relation to HIV/AIDS, drawing on national-level perspectives. The calls allow for analysis of gaps in understanding, which in turn provide useful reflection on potentials for communication campaigns and local and/or service-level communication support. Novel perspectives also emerge through the capacity to develop an understanding of the experience of HIV/AIDS within individual contexts. It is also acknowledged that the AIDS Helpline service plays a valuable role in reducing misunderstanding, and also providing a mechanism to address individual-level concerns and contexts – communication processes that are only matched by face-to-face counselling.

Findings

Analysis of the focus group data revealed that VCT-related calls to the Helpline generally related to one of four main themes, with related sub-themes:

- Reluctance to test for HIV
 - Symptoms of HIV/AIDS (self-diagnosis)
 - Fear of testing and of result
 - Confidentiality of VCT and VCT results
- Safety and accuracy of HIV testing
 - Reliability of rapid test results
 - Safety of HIV testing
- Understanding of HIV test results
 - Inadequate explanation of test results
 - Contradictory or 'changing' results
 - HIV testing during medical care
- Counselling
 - Lack of counselling

Reluctance to Test

Counsellors reported calls to the Helpline from people who suspected that they – or a relative, an employee, or an acquaintance – might be HIV positive, but were reluctant to undertake VCT to confirm their status.

Among these were individuals who requested information about 'symptoms' of HIV/AIDS in order to understand whether they might be positive. Such callers expressed that they were not prepared to test, and instead hoped to 'self-diagnose' their HIV status with the help of information from counsellors:

Normally the question that comes is that of symptoms. People ask about symptoms: 'I had this, I'm losing weight, I'm having hair loss, and a rash'... It is important for the counsellor to explain [that] it's not about symptoms – it might be what the symptoms are from. ... Losing weight doesn't mean that you are HIV positive. It might mean a lot of things and it's all about testing. It's important that they go for a test in order to see or to find out whether they are HIV positive.¹

Most of the people want to know about symptoms. They'll say, 'We want to know what these are the

symptoms of.' ... Even if they didn't go for testing, they want to know, you know? But usually what we do is tell them about the symptoms, but tell them that it doesn't confirm that you may be HIV positive...²

Counsellors expressed the need to be cautious with these types of calls – to speak only in general terms about common symptoms of advanced AIDS, but to consistently recommend to callers that they access testing. They noted that some callers are confused about the difference between HIV and AIDS – for example, the fact that an HIV-positive individual can lead a healthy, 'symptom-free' life for years before advancing to AIDS, while unknowingly transmitting HIV to others.

Counsellors reported receiving calls from specific categories of people, such as grandparents caring for young children, or employers of domestic workers. In these cases, the callers expressed suspicion about the possibility of HIV infection, but were reluctant to confront the possibility directly by facilitating an HIV test:

Older people or grandparents are worried, because maybe a mother and a father passed away and they didn't know what was wrong with the person. So they are worried that the child may be HIV-positive, but they are not ready to tackle the issue and they are not ready to take the child for a test.³

Fear of stigma and discrimination – and of disease itself – emerge in discussions with counsellors as factors which make individuals reluctant to test for HIV. However, at the same time, callers also express an awareness and understanding of the importance of testing:

A lot of callers phone in, they want to get tested, they want to know their status. But they fear how their families or friends will react, as well as fearing being HIV-positive itself.⁴

Counsellors described examples of callers raising questions about the confidentiality of VCT. This included concerns about both the process of being tested and the possibility of a positive result being disclosed to others. Counsellors noted instances when young people in particular would voice concerns about the confidentiality of VCT, fearful that their parents could find out that they had sought testing. According to counsellors, concerns about confidentiality were also raised by callers who were worried that VCT staff from their own community would not respect their right to confidentiality and would disclose their test results to others.

Sometimes they want to know if they have done an HIV test, whether it is confidential. Is there confidentiality there? Are they going to take their name and maybe give it to their parents?⁵

The other thing I've noticed – it's a sense of confidentiality amongst those guys working at VCT. Taking into consideration that the very

same members of that location have to use such a resource. But with regard to issues of prejudice and discrimination, the very same counsellors gossip about the status of their clients. That in itself serves as an obstacle for people not to effectively use VCT centres.⁶

Ya, even youth – you find out that maybe he or she wants to do an HIV test, but for the fact that maybe an aunt is working at the clinic. Maybe he or she is afraid to test because maybe she will tell the parents: 'So and so was at the clinic and she has tested positive.' So you find out that it's difficult for youth to go and get tested, because of their relatives in the hospitals.⁷

Safety and Accuracy of Testing

Callers to the Helpline express concern about the accuracy and reliability of HIV testing, particularly rapid tests that are administered through oral swabs or finger pricks. Counsellors 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. So 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 don't think that test is reliable enough for counsellors to tell them they are HIV-negative. So there are those [questions] of trust towards VCT.⁸

Some calls that we have [about HIV tests] are about how accurate it is. That's the first question they ask about 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'.⁹

Counsellors expressed the view that concern about the reliability of rapid tests was widespread enough that it may dissuade some people from accessing testing. It was noted that when callers expressed scepticism about the tests, counsellors provided more information about how rapid tests work and encouraged confidence in the reliability of the technology:

A number of people calling do not actually trust this VCT test that is being done – the rapid test. They believe it is not accurate. The person will maybe say, 'How accurate is this rapid test?' I think that this actually can make people not to go to VCT sites.

It is also our duty to tell people, to give them trust in the instrument, [to explain] that instruments have been discovered that really measure what [they're] intended to. And try to [explain] that it is very rare that you get a positive when it is negative. And go further to explain to them that should it be positive, they would always suggest a second test, a

confirmatory test. Then some of them you can see, "Oh, oh well, if it's like that, I will go." ¹⁰

Counsellors described calls in which questions about the reliability of rapid testing were linked with misunderstandings about the meaning of 'negative' and 'preliminary positive' results (explored in more detail below):

Maybe somebody wants to go, but he once heard that somebody tested positive on a VCT and negative at the laboratory. So which one is reliable? How reliable is it? Because there are lots and lots of callers with that kind of question.¹¹

Counsellors reported receiving some calls from people asking about the HIV testing process, seeking clarity on whether the procedure was done correctly and questioning whether the test needed to be repeated as a safeguard:

The first question of course is accuracy: 'Is it the correct way? Like where they drew blood here in my finger. Should I go for another test?' With VCT they always ask if they should go for another test, just in case.¹²

Counsellors also reported some instances where callers were concerned that the process of being tested could put them at risk for contracting HIV.

Understanding Test Results

Counsellors reported that callers who have accessed VCT sometimes call the Helpline with questions about the test results. According to counsellors, callers do not always understand what their test results mean or are sometimes given written results without any explanation. It is 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 counselling.

Counsellors underscored that it is not within their mandate to interpret HIV test results for callers. In instances when callers phone for clarification of their status, the counsellors direct them back to the testing site and encourage them to speak with the counsellors or nurses there.

The following interchange between Helpline counsellors highlights several interlinked points related to understanding test results:

They go to the clinic, they are given things – [for example], this woman got the results, she went to fetch her test results, they gave her the results and she didn't understand. Then I had to return her to the clinic and that's where they found the problem. After the nurse issued her with the results, she didn't expect her to come back. That's the problem they are facing when they go back to their testing sites sometimes – it's actually from the testing sites. Unless the person was given the results by a counsellor or something.

Facilitator: So what is it that they don't understand in terms of their results?

Maybe the person's results are written down – they normally write 'non-reactive' or 'reactive.' And then even if it's non-reactive, the person will say: 'I have the results, it's non-reactive and I don't understand what this means.' And we are not allowed to say, 'No, it's negative or it's reactive - it's positive.' So you normally send [them] back to where they tested to get the explanations.

I think it [is connected] with the fact that our public clinics are not empowered enough in terms of counsellors. The results are being given by nurses and they do everything according to the book and from a medical point of view...

They don't have time...

They tell you that, okay, you are HIV-positive and these are your results. Sometimes that person didn't understand what it actually meant when this person said I'm HIV positive. When the person studies the booklet, there's a lot of information in there and they start calling and say, 'But it says this and this,' and the person will expect you to explain.¹³

Counsellors also report questions that reflect confusion about the meaning of test results – particularly about the need to undergo a confirmatory test following a preliminary positive result. They noted that callers sometimes express confusion about contradictory results from rapid and lab-based tests:

There are incidents when a person does VCT, tests positive, then again goes to the hospital. Then they take the sample to the laboratory, then it tests positive. Or maybe first time negative, next time it's positive, so there are more stories of that...

Facilitator: And is it based on facts in many instances, or is it based on just rumours?

No, in most cases it's people who went for VCT, then tested positive, then after sometime they go to the hospital and they test negative at a laboratory.¹⁴

Counsellors also recounted examples when callers expressed confusion or misunderstood the importance of the three-month 'window' period following possible exposure to HIV in which antibodies may not yet appear in a diagnostic test. In other words, people testing negative through rapid testing do not necessarily understand the limitations of this result.

Counsellors described some calls in which the callers were not sure whether or not they had been tested for HIV while undergoing some form of medical treatment. A counsellor cited an example of a woman who called following care at an antenatal clinic:

[Pregnant women] go to antenatal clinics and they sometimes think that it's a must that you do an HIV test. Some pregnant [women] don't ask their health

workers to do an HIV test. Sometimes when you are pregnant they'll take blood ... to check some other things and when they get their results and are told 'Everything is okay,' then they think they are not HIV-positive. And they say, 'No, no no. They did check.' And when you go deeper and ask, 'What did they check? Did they say HIV test?' 'No, but they took my blood and they said I'm okay.' Then you have to educate them.¹⁵

In this instance, the caller believed she had tested HIV-negative as part of standard antenatal care, when in fact she had not been tested for HIV at all. If the caller was in fact HIV-positive, she could be putting her partner and unborn child at risk of infection. In these situations, Helpline counsellors are able to dispel confusion and underscore the importance of specifically requesting an HIV test.

Access to Counselling

Counsellors described instances in which individuals going for HIV testing were not able to access pre-test counselling. They noted that rural residents may be particularly impacted by the lack of counsellors at clinics and health facilities.

It is a little bit difficult for areas like rural areas. You find that there is no counselling in the clinics – nothing at all – you become shocked. How are you going to refer such callers, moreover in rural areas?... You find that in urban areas there are counsellors in all the clinics, probably, but not necessarily in rural areas. The problem is in rural areas.¹⁶

In certain cases where someone has sought testing but no pre-test counselling is available, the Helpline counsellors themselves have done pre-test counselling for callers. Counsellors expressed that this is not an ideal situation:

Some callers complain that if they go to get VCT, they don't get pre-test counselling. The nurses will tell them, 'We are under-staffed. There is nobody who can give you pre-counselling – the only thing we can do is give you testing only.' So they'll phone us, 'Please can you give me pre-counselling?' They can't go on if they don't get pre-counselling.

Facilitator: So they expect pre-test counselling through the line?

We actually do both pre-test and post-test counselling. Whereas it's better to do this counselling at your local place where you are going to do the test, because it lays a foundation for a first test. Now they are being counselled by different people at different [stages]. So we have to do it, we can't say no.¹⁷

Counsellors spoke about callers' lower satisfaction with the testing experiences in cases when counselling is absent:

Normally with the VCT sites, I think they do

pre- and post-test counselling. The people that are normally complaining are [the ones] tested directly at the clinics. The clinics that do not have the [special] VCT clinics – or maybe it's the doctors – they don't explain that. But if they go to the VCT site, then obviously they do pre- and post-test counselling. There are counsellors.¹⁸

Discussion

VCT-related calls to the Helpline were clustered into several main areas: reluctance to access VCT; concerns about the safety and accuracy of HIV tests; confusion about the meaning of test results; and obstacles to accessing counselling services as part of testing.

It appears from the focus group discussions that a number of information gaps exist amongst callers in relation to VCT. Many of these gaps can readily be addressed through communication campaigns as well as local level communication and VCT practices.

One of the main VCT-related concerns raised by callers to the Helpline is the safety and accuracy of rapid tests for HIV. According to counsellors, callers expressed scepticism that rapid tests can produce accurate results in as little as 20 minutes. This is related to the previous promotion of ELISA testing, which is a far longer process.

This lack of trust seems to be exacerbated by a sense among some callers that the rapid tests can produce 'contradictory' results – i.e. that initial positive tests are later shown to be negative through laboratory confirmations, or even that negative results later turn out to be positive – although this second concern may be the product of hearsay. The scepticism expressed by callers about the testing technology suggests that there is a need to include information on safety, reliability and accuracy of the rapid tests in communication programming.

Confusion expressed by callers about the meaning of 'preliminary positive' and 'negative' test results should also be addressed in communication campaigns. Information on testing protocols, derived from the national guidelines for rapid testing, could be useful in this regard. For example, the guidelines recommend that following a positive result a confirmatory test be done using a different testing method; they also specify procedures in the event of a confirmatory test coming back negative. Clear, accessible communication products explaining rapid test protocols could help to dispel misconceptions about the testing process and encourage more people to access VCT.

Another element that emerged from the focus group data is the centrality of counselling to the VCT process. Three interlinked issues can be noted here.

First, the focus group discussions suggest that pre- and post-test counselling services are not universally available to people who wish to learn their HIV status. It appears that HIV testing can be accessed in many – though not all – areas of the country at clinics and medical facilities, but that the services of trained VCT

counsellors are not universally available or, where available, are sometimes inadequate.

Calls reflecting confusion about the meaning of HIV test results point to an absence of proper post-test counselling. In some instances clients are handed written test results, without any explanation, and later struggle to understand terms such as 'reactive' or 'non-reactive'; in other cases it appears that clients leave clinics or testing facilities not understanding the meaning of their test result. When calling the Helpline for clarification, they are re-directed to the testing centre and told to speak with the counsellors or nurses there. This points to a certain degree of discontinuity in advice, support and care being received by some individuals who seek VCT services.

Second, concerns raised in Helpline calls underscore the importance of consistency, accountability and quality control in VCT counselling regimes. Counsellors must be provided with high levels of training and support if they are to perform in their difficult roles at a consistently high level. In South Africa, counsellors in some sites operate within constrained physical environments with inadequate resources and large workloads (HST 2002). Calls to the Helpline suggest that there are cases in which individuals seeking to test are 'brushed off' by frontline staff who are overstretched and unable or unwilling to provide pre- and post-test counselling.

Third, there are concerns about the confidentiality of the VCT process. Calls to the Helpline suggest that people are not opposed to the notion of VCT *per se*, but are hesitant to learn their status out of fear that someone will see them at the clinic or that a worker at the clinic might gossip with friends, neighbours and relatives. This echoes the findings of a recent (non-representative) survey in South Africa about attitudes to VCT that found high levels of mistrust towards health care workers. In the study, respondents indicated that they would be more likely to undertake VCT if they could do so in a location where they would be sure that no one knew them (van Dyk & van Dyk 2003).

These concerns about confidentiality are closely linked to the stigma that continues to surround HIV/AIDS. People who fear discrimination at work or in the community, or rejection by family or friends, may be dissuaded from learning their HIV status. The role of communication campaigns here would be to emphasise stigma reduction, whilst at the same time promoting the right to confidentiality within VCT processes.

Recommendations

This research has identified a number of communication needs that should be addressed as part of the expansion of VCT services in South Africa.

There is a need for VCT communication campaigns to include specific information about:

- The reliability and accuracy of rapid HIV tests;
- The right to privacy and confidentiality in accessing VCT;

- Overview of VCT processes (counselling, informed consent, testing protocols); and
- VCT as the pathway to treatment, care and support. Communications materials on VCT should be developed in multiple languages and be accessible to their audiences. Products should be relevant to their contexts of intended use and should be disseminated in co-ordination with both government structures and NGOs.

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Footnotes

- 1 52037 CAN HL FGD 2 Sept.txt
- 2 14305 CAN HL FGD 5 Sept.txt
- 3 3564 CAN HL FGD 31 Oct.txt
- 4 13632 CAN HL FGD 5 Sept.txt

- 5 71119 CAN HL FGD 2 Sept. txt
- 6 39230 CAN HL FGD 9 Sept.txt
- 7 39001 CAN HL FGD 30 Sept.txt
- 8 15083 CAN HL FGD 5 Sept.txt
- 9 67752 CAN HL FGD 2 Sept.txt
- 10 37393 CAN HL FGD 9 Sept.txt
- 11 15886 CAN HL FGD 5 Sept.txt
- 12 69653 CAN HL FGD 2 Sept.txt
- 13 6669 CAN HL FGD 22 Oct.txt
- 14 15886 CAN HL FGD 5 Sept.txt
- 15 67752 CAN HL FGD 2 Sept.txt
- 16 25229 CAN HL FGD 30 Sept.txt
- 17 38405 CAN HL FGD 9 Sept.txt
- 18 8575 CAN HL FGD 22 Oct.txt