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Barriers and facilitators associated with HIV testing uptake in South African health facilities offering HIV Counselling and Testing

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ABSTRACT

Background: The scale-up of HIV Counselling and Testing (HCT) in South Africa to 4500 public health facilities and the service's provision in mobile and non-medical sites was aimed at increasing HCT uptake. However, some people still have never had an HIV test.
Objective: An HCT survey was carried out to ascertain barriers and facilitators for HIV testing in South Africa.
Methods: A cross-sectional survey of 67 HCT-offering health facilities in 8 South African provinces was undertaken. Individuals (n = 489) who had not tested for HIV on the day of the site visit were interviewed on awareness of HCT services, HIV testing history and barriers to HIV testing. Frequencies were run to describe the sample characteristics, barriers and facilitators to HIV testing. Bivariate and multivariate logistic regression was used to identify the association between never tested for HIV with socio-demographics, awareness of HCT services and type of HCT facilities.
Results: In all 18.1% participants never had an HIV test. Major barriers to HCT uptake comprise being scared of finding out one's HIV test result or what people may say, shyness or embarrassment, avoidance of divulging personal information to health workers and fear of death. In multivariate analysis the age group 55 years and older, and not being recommended to have an HIV test were associated with never had an HIV test. Potential facilitators for HIV testing include community or household HIV testing, providing incentives for those who test for HIV, mandatory HIV testing and disclosure of HIV status by those who test HIV positive.
Conclusion: The benefits of HCT which include the reduction of HIV transmission, the availability of HIV care and treatment needs to be emphasized to enhance HCT uptake.

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Health workers also need to recommend HCT to all individuals attending health facilities offering this service.

1. Introduction

HIV Counselling and Testing (HCT) facilitates early diagnosis for HIV positive persons which helps reduce the risk of further transmission, provides access to care and treatment, while motivating people who test HIV negative to maintain their negative status (Day et al. 2003:665; Peltzer, Matseke, Mzolo, & Majaja, 2009:2; Subramanian, Gupte, Mathai, Boopathi, & Dorairaj, 2008:26). This suggests that HCT is vital for both knowledge of one's HIV status and HIV prevention. However, there are still people who have no knowledge of their HIV status. For instance, in sub-Saharan Africa, the region hardest hit by the epidemic, the median of people who knew their HIV status was reported to be below 40% in 2007–2009 (World Health Organization [WHO], The Joint United Nations Programme on HIV/AIDS [UNAIDS], United Nations International Children's Education Fund [UNICEF] 2010). In South Africa specifically, the percentage of people who reported to have ever had an HIV test and hence are aware of their HIV status was 65.5% in 2012 (Shisana et al. 2014), 50.8% in 2008, from 21.4% in 2002 and 30.5% in 2005 (Shisana et al. 2008:49). These findings are similar to a study assessing HIV testing attitudes in a black township in Cape Town, 2003 which found that about 53% of the study participants had never been tested for HIV (Kalichman & Simbayi, 2003:444). Although there has been an increase in the uptake of HIV testing, a significant number have not been tested yet.

Traditionally, low HIV testing rates were associated with the reliance on Voluntary Counselling and Testing (VCT) which is initiated by the client, as the sole approach to HIV testing (Jürgens, 2006:9). In 2006 the World Health Organization and The Joint United Nations Program on HIV/AIDS developed a draft guidance on Provider-Initiated HIV Testing and Counseling (PITC) to increase the opportunities for HIV diagnosis, thereby reducing the barriers associated with HIV testing (Leon, Naidoo, Mathews, Lewin, & Lombard, 2010:2; WHO, UNAIDS 2007:14). The PITC approach recommends routine HIV testing and counselling to clients who attend health services regardless of their presenting illness (WHO, UNAIDS 2007:15). It is against this backdrop that in its *National Strategic Plan for HIV & AIDS and STIs, 2007–2011*, the South African government made the fight against HIV/AIDS one of its top priorities by setting up two primary goals: the reduction of new infections by 50% and the reduction of the impact of HIV and AIDS by expanding access to comprehensive treatment, care and support to 80% for infected individuals by 2011 (National Department of Health South Africa [DoHSA] 2007:10). To achieve these goals, HCT services offering PITC were scaled up to more than 4500 public health facilities as well as mobile services and non-medical sites (NDOH, 2007:8). This was followed by the launch of a national HCT campaign in 2010 which targeted 15 million South Africans to test for HIV by June 2011 (UNAIDS 2010:65).

A number of studies conducted in health clinics and hospitals between 2006 and 2010 worldwide have investigated the impact and acceptability HIV testing and counselling in relation to the routine offer of HIV testing (Bassett, Giddy, Nkera, & Wang, 2007:2; Bokhour, Solomon, Knapp, Asch, & Gifford, 2009:1109; Creek et al. 2007:103; Jürgens, 2006:6; Leon et al. 2010:2; Nakanjako et al. 2007:754; Wanyenze et al. 2008:303). Overall, routine HIV testing was perceived to be acceptable and helped to increase testing rates, thus enabling awareness of HIV status for patients who had never tested. For instance, in a Ugandan study in two hospitals, of the 98% participants who accepted testing, a 28% HIV prevalence was found in patients who had never had an HIV test previously (Wanyenze et al. 2008:304). These findings were consistent with another Ugandan study where 95% participants accepted testing and about half had an HIV diagnosis (Nakanjako et al. 2007: 756). In terms of HIV diagnosis of previously undiagnosed patients, these findings were consistent with two South African studies, one of which identified an HIV prevalence of 40% overall while the other study had a 32.7% HIV prevalence of which 64.9% had never had an HIV test before (Bassett et al. 2007:5; Leon et al. 2010:5). In terms of the increase in testing rates, however, both studies had lower HIV testing acceptance rates compared to the two Ugandan studies, one had a 76% testing rate which was lower than their targeted rate and the second study only achieved a 48.6% HIV testing rate of the eligible participants (Bassett et al. 2007:4; Leon et al. 2010:5). It is evident from these studies that although HIV testing uptake has improved over the years, barriers to testing may still exist.

Previous studies have reported various factors associated with the lack of HIV testing including (1) personal factors, (2) health system factors, and (3) sociodemographic factors. *Personal barriers* to HIV testing may include lack of knowledge of testing sites (Choi, Lui, Guo, Han, & Mandel, 2006:40), low perceived risk of infection (Deblonde et al. 2010:423; MacKellar et al. 2011:422; Peralta, Deeds, Hipszer, & Ghalib, 2007:403), fear of testing HIV positive, discrimination, stigma and rejection (Daftary, Padayatchi, & Padilla, 2007:574; De Wit & Adam, 2008:21; MacKellar et al. 2011:421; Musheke et al. 2013:11; Spielberg et al. 2003:322). The fear of discordance has also been a deterrent to HIV testing as a potential indicator of infidelity, thus providing a strain in relationships, particularly marriage (Angotti et al. 2009:2266; Larsson et al. 2010:6; Larsson et al. 2012:73). Other studies reported that men are decision-makers with regards to HIV testing and women have to obtain permission before seeking HIV testing from their spouses (Daftary et al., 2007:574; Råssjö, Darj, Konde-Lule, & Olsson, 2007:219; Theuring et al. 2009: 96). Furthermore,