to VCT despite 13 years of community-based awareness campaigns in a peri-urban township in northern Limpopo

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To the Editor: An estimated 5.7 million people in South Africa live with HIV/AIDS. In 2008, it was estimated that 12.5% of the Limpopo population aged 15 - 49 was HIV-positive, while the national HIV prevalence estimate was 18.8%.2

Over the past 8 years, the South African government has supported prevention campaigns, expanded voluntary counselling and testing (VCT) sites, and increased the access to antiretroviral therapy (ART) to decrease the burden of the epidemic.3 4 VCT was offered at 87% of primary health care facilities in Limpopo Province in 2003.5 By 2007, 42% of the people in need of ART in South Africa had commenced it.4 Despite VCT’s benefits and the increased number of testing sites, many South Africans remain untested for HIV for various reasons.

In Bela-Bela, the HIV/AIDS Prevention Group (HAPG) has been active since 1996, providing VCT and care and support to people with HIV/AIDS. Its activities include prevention campaigns, free VCT and ART, home-based care and orphan care. Each year, 39.4 - 42.2% of the HAPG VCT attendees test HIV-positive. In 2005, 254 HIV/AIDS prevention activities were organised, reaching 15 570 participants (73% women).

We studied motivations for, and barriers to, VCT uptake among black South Africans living in Bela-Bela, a peri-urban town with a population of 55 844 and an unemployment rate of 21%.6

Methods

Eight gender-mixed focus group discussions (FGDs) totalling 86 people, of whom 58% were women, were conducted in 2005. Participants ranged in age from 15 to 35 years (median 21 years). Four FGDs comprised people who had undertaken VCT; participants of the other 4 had not experienced VCT. The questions, for tested participants, focused on HIV/AIDS-related knowledge, experience with VCT, motivations for and barriers to VCT uptake, facilitating factors to go for VCT, and the effects of VCT. Non-tested participants were asked about knowledge related to HIV/AIDS and VCT, and barriers and facilitating factors for VCT uptake. FGDs were tape-recorded and transcribed verbatim. The analysis was supported by QSR N6 software (QSR International Pty Ltd, Melbourne, Australia). Data were coded and analysed by 2 researchers. A coding book was progressively structured, based on the research questions and emerging themes. Qualitative matrices were built to identify major trends in the data. The results were shared with the HAPG director, and ensuing discussions provided additional information to contextualise and update the findings.

Results

We studied motivations for, and barriers to, VCT uptake among black South Africans living in Bela-Bela, a peri-urban town with a population of 55 844 and an unemployment rate of 21%.6

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by information campaigns. Another possibility is that people attending the campaigns were unable to adequately transfer knowledge gained from the group level, where it is given, to applying it to themselves. This lack of ‘internalisation’ hinders communicating about HIV/AIDS and VCT, in partner relationships and in the community. The request for more information could be an excuse to transfer individual responsibilities to the HAPG, thus justifying not having to change behaviours or undertake VCT. People may also need behavioural and life skills to be motivated to undertake VCT.

Although South Africa has experienced political and public debate about the existence of HIV/AIDS, we found that the disease is recognised as a major threat in Bela-Bela. However, despite HIV/AIDS and VCT information campaigns, these interventions seem unable to effectively address the barriers to VCT. In 2005, the lack of internalisation of knowledge detracted from the uptake of VCT. To enhance social communication about HIV/AIDS and to increase the effects of prevention campaigns and the spill-over effects of VCT in the community, we recommended that factual information should be complemented by providing communication, behavioural and life skills.

Four years later, with increased access to ART, has the situation changed, and is the need for the targeted information and communication skills reported in 2005 still present? Recent discussions with people from HAPG indicate that the content and focus of awareness and information campaigns has not changed. However, since 2009, there have been monthly door-to-door campaigns and weekly road campaigns whereby staff members address people from street corners, providing them with information regarding VCT and HIV/AIDS-related services, including ART. The Department of Health’s shift towards provider-initiated counselling and testing of pregnant women has also increased VCT among this group in Bela-Bela.

Despite these changes, more information is still requested. Increased access to ART seems not to be a sufficiently large incentive to undertake HIV testing nor to decrease discrimination.

The need to open the discussion and communication about HIV/AIDS, VCT and sexuality at partner, family, community and national levels is essential in any action to decrease fear and stigmatisation, to increase VCT uptake to maximise its secondary preventive effects and as an entry point for ART, and to seriously decrease the burden of the disease.

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