South Africa: Who Goes to the Public Sector for Voluntary HIV/AIDS Counseling and Testing?

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HIV/AIDS poses a fundamental threat to global health. South Africa is one of the worst-affected countries in the world, with an estimated HIV prevalence of 11.4 percent (Shisana and Simbayi 2002). Studies show that socioeconomic status is the principal determinant of exposure to HIV/AIDS, with poverty and social inequalities leading cofactors in HIV transmission (Farmer 2001; Gilbert and Walker 2002). Reaching disadvantaged groups is therefore crucial for both prevention and awareness campaigns. This chapter examines patterns observed in the socioeconomic status of individuals attending public sector clinics and receiving voluntary counseling and testing (VCT) in three township areas of Cape Town, South Africa.

VCT for HIV/AIDS, combined with pretest and posttest counseling, has been promoted as a key motivating force for safer sexual behavior (Magongo and others 2002; UNAIDS 2002). VCT is a critical component of any national strategy to limit transmission of HIV (Forsythe and others 2002) and is a prerequisite for effective treatment, care, and support services, including programs to reduce mother-to-child transmission, preventive therapy for tuberculosis, and administration of antiretrovirals. The evidence is growing that VCT can bring about behavioral change and can improve the coping strategies of people with HIV, leading to reductions in reported risk behavior (Pronyk and others 2002).

Studies in Uganda (Matovu and others 2002; Nuwaha and others 2002) have explored reasons for obtaining VCT. Factors influencing VCT uptake
included attitudes about the consequences of an HIV-positive result, the influence of a sexual partner, cost, accessibility, awareness, and the perceived risk of HIV infection. The features and quality of a counseling service also influence uptake by different groups. Matovu and others (2002) suggest that clients value confidentiality, regular availability of counseling (rather than “one-off” sessions), the possibility of receiving counseling without testing, presence of nonresident counselors (for greater confidentiality), and counseling outside the health center (at a “neutral site” such as a community center).

Research Questions
This study seeks to ascertain the socioeconomic status of individuals accessing VCT at public sector clinics in South Africa and the reasons for any unusual distribution of uptake. These aspects of VCT use are important to understand because VCT will increasingly be the entry point for a range of support and treatment services for people living with HIV. Any skewing of access to VCT in favor of certain socioeconomic groups will have implications for the equitable delivery of all these other services.

In addition to its public sector health clinics, South Africa has a thriving private sector. There is evidence that people from all socioeconomic groups use the private sector, believing that both the technical quality and the interpersonal quality of care are superior (Schneider and others 1999). In periurban settings such as those where this research was conducted, a network of public sector clinics offers primary care free of charge to the uninsured, who make up more than 80 percent of the South African population. In urban South Africa there is also a competitive market of private general practitioners (Chabikuli and others 2002) and a growing number of commercial clinic chains (Palmer and others 2003). VCT is free of charge in the public sector, and capacity to offer the service is slowly being established throughout Western Cape Province, although it is still rudimentary outside the Greater Cape Town area.

Methods
Three clinics with relatively well established VCT programs in the Greater Cape Town area were selected, in consultation with local health department personnel. :

- *Masiphumelele Clinic* is located in a settlement with a population of about 20,000 that has developed over the past 10 years on the outskirts of Cape Town.
Khayelitsha Site B General Clinic is a big community clinic in Cape Town’s largest township, which has an estimated population of 500,000.

Langa Clinic serves the oldest township community within the Cape Town vicinity (population about 60,000). The clinic has implemented an integrated program to address the dual tuberculosis-HIV epidemic in cooperation with the ProTEST initiative. ProTEST is coordinated by the World Health Organization and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with four Sub-Saharan African countries. The underlying principle of the approach is that early detection prevents ongoing transmission of tuberculosis and slows the progression of the HIV infection. A key feature of the ProTEST initiative is that every patient who comes to a pilot site for tuberculosis services receives counseling about tuberculosis and HIV and is encouraged to take an HIV test (Godfrey-Faussett and others 2002).

The model for VCT delivery is similar in all three clinics. Counseling is provided by lay counselors from local nongovernmental organizations (NGOs). A nurse is responsible for testing and refers patients back to the counselor after informing them of the results.

An interview administered in the waiting room of each clinic was used to assess access to VCT services by various socioeconomic groups. In-depth interviews and focus group discussions with staff, clinic users, and local community groups were conducted to explore barriers to access and attitudes toward VCT.

To establish the socioeconomic status of the respondent, the waiting room questionnaire asked a series of brief, closed-ended questions about gender, race, education, employment status, sanitary and living conditions, and household assets. Many of these latter questions were taken from the South African Demographic and Health Survey (DHS) to allow comparison with that data set during the analysis phase of the study. Some questions about knowledge concerning VCT were also asked.

The waiting room interview was developed in English, translated into Xhosa, and then back-translated to check the quality of the translation. It was administered by a single fieldworker at all three sites. Systematic sampling was used, with every fifth adult (defined as above age 14) approached in the waiting room, as well as in any specific VCT waiting area, and asked to give informed consent to participate in the interviews. Interviews were split into two parts. The first was carried out in this initial phase, and the second was conducted once it had been established whether the person...
being interviewed would have VCT at that visit. For those who did attend VCT, reasons for electing to use the service were explored. For those who did not, more general questions were asked concerning sources of information about VCT and HIV.

Qualitative methods were used for in-depth interviews and for community and staff focus group discussions to explore attitudes toward VCT uptake and provision. Sets of detailed interview guidelines were developed for in-depth interviews as well as for focus group discussions with clinic staff and community groups. These interviews and discussions were conducted in both English and Xhosa by different members of the research team.

Participants in 15 extensive in-depth interviews were chosen in part from a subset of patients and in part randomly from the communities. Community focus group discussions were held with groups that were suggested by community members as representative (a community development group in Masiphumelele, a housing project group in Khayelitsha, and a church group in Langa). A further criterion for inclusion was knowledge about services at the local clinic, but group members did not have to be patients at the facility.

Nature and Sources of Data
The findings reported here are based on four sets of data:

- **Data from the waiting room surveys, described above, on the socioeconomic status of individuals (a) attending clinics and (b) receiving VCT.** In all, 540 waiting room interviews were conducted (50 in Masiphumelele, 270 in Khayelitsha, and 220 in Langa). After data cleaning, the final sample included 525 patients, 208 of whom had attended the clinics for VCT.

- **Data from the South African Demographic and Health Survey (DHS) on socioeconomic status of urban households.** To enable us to comment on any differences in socioeconomic status between those attending the clinic and receiving VCT and those within the catchment area of the clinic, a picture of the broader socioeconomic environment of the area was required. This was obtained by generating an asset index from South Africa’s 1998 DHS. All urban households from the DHS were used to generate an asset index by means of principal component analysis (N = 7,752). Household characteristics and assets included in the generation of the index were the particular household’s main
Findings about the Distribution

Of the 525 people interviewed, 208 were attending the clinics for VCT. The socioeconomic characteristics of three groups were compared:

- a universal sample of the 507 Cape Town and Johannesburg township households in the DHS (the reference population)
- a systematic sample of 525 people attending three clinics for any service
- the 208 individuals (out of the 525) who were attending for VCT

Figure 6.1 illustrates how the 507 sample township households in the metropolitan areas of Johannesburg and Cape Town fit within the socioeconomic quintiles of the sample of all urban households in the South African DHS. Although the number of township households in the top quintile of all South African urban households is low, at 8.1 percent, it is still higher
than would be expected for this type of periurban setting. One explanation lies in the broad range of socioeconomic backgrounds and income levels that make up the top quintile in South Africa, which has a highly unequal income distribution, as reflected by a Gini index of 59.3 (World Bank 2001). Under apartheid, black South Africans were restricted as to where they could live. Townships today therefore include areas of widely varying wealth.

The percentage of people falling into the lowest wealth quintile is also lower than might be expected. Whereas the township areas in the two metropolitan areas under investigation are of key importance for the study of social and economic transformation and relative deprivation in South Africa, they do not represent the economically worst off metropolitan neighborhoods in the country. A number of urban localities in other parts of South Africa are significantly more deprived. As can be expected, most of the township population falls into the middle three wealth quintiles, with a peak at 28.8 percent in the central quintile.

A first finding, therefore, is that the area in which the study was conducted is not worse off overall than the South African urban population in terms of relative distribution of household assets. A comparison that took

![Figure 6.1. Township Asset Scores Compared with Urban Demographic and Health Survey (DHS) Wealth Quintiles, South Africa](image)

Source: Demographic and Health Survey (DHS), South Africa, 1998.
into account both urban and rural households would reflect the fact that township households are, on average, considerably better off than households in rural areas (Booysen 2002).

The systematic sample of patients from three township clinics around Cape Town reveals a clear pattern when analyzed in terms of asset scores. Figure 6.2 assigns the patient sample to South African urban wealth quintiles. The upper two wealth quintiles were underrepresented among both the patients visiting the clinics for general health services and those coming to the clinics for VCT. Only 1.9 percent of patients who came for general services and 1.0 percent of those who received VCT fell into the top quintile; 8.8 and 7.2 percent, respectively, belonged to the second-highest quintile. Within both subsamples the second-lowest quintile was best represented, with 38.5 percent of general patients and 38.9 percent of VCT users.

The most obvious differences between those attending these clinics for general services and those receiving VCT emerge in the lowest and central

Figure 6.2. Patient Asset Scores Compared with Urban Wealth Quintiles, South Africa

<table>
<thead>
<tr>
<th>Wealth quintile, urban population</th>
<th>General services</th>
<th>VCT services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (lowest)</td>
<td>26.2</td>
<td>1.9</td>
</tr>
<tr>
<td>2 (low)</td>
<td>35.6</td>
<td>1.0</td>
</tr>
<tr>
<td>3 (medium)</td>
<td>38.5</td>
<td>8.8</td>
</tr>
<tr>
<td>4 (high)</td>
<td>38.9</td>
<td>7.2</td>
</tr>
<tr>
<td>5 (highest)</td>
<td>24.6</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Sources: Waiting room interviews; Demographic and Health Survey (DHS), South Africa (1998).
Note: VCT, voluntary counseling and testing.
quintiles. Nearly a quarter of general patients fell into the medium wealth quintile (24.6 percent), while the percentage of VCT users from this category was substantially lower (17.3 percent). There is a corresponding discrepancy at the lower end of the wealth scale: 26.2 percent of general patients came from the lowest wealth quintile, whereas more than a third of VCT users (35.6 percent) belonged to this socioeconomic group. There is a significant relationship between township households’ socioeconomic status and public sector VCT uptake (chi-square for trend, 6.713; \( p = 0.00957 \)). This result requires further investigation, given such pronounced differences among socioeconomic groups in utilization patterns of general and VCT services.

The service utilization pattern becomes more intriguing when viewed within the socioeconomic spectrum of the township environment. For the purpose of this analysis, the factor scores generated for each asset on the basis of the urban DHS sample were used to define the wealth quintiles for this subsample of township households from the DHS.

**Figure 6.3.** Patient Asset Scores Compared with Township Wealth Quintiles, South Africa

*Sources: Waiting room interviews; Demographic and Health Survey (DHS), South Africa, 1998. Note: VCT, voluntary counseling and testing.*
Health service utilization across the wealth quintiles generated at the township level reveals a pattern in which public service utilization decreases with increasing wealth (figure 6.3). This is true for both general health services and VCT services offered at the township clinics, but the pattern is more pronounced for VCT services (chi-square for trend, 4.802; \( p = 0.02843 \)). For general clinic utilization and uptake of VCT, representation of service users from both top quintiles is low: 4.4 percent of general patients and 4.8 percent of VCT patients fall into the top quintile, while 9.8 percent and 9.6 percent, respectively, can be assigned to the second-highest quintile. Between service categories, notable differences emerge in the socioeconomic structure of patients from the lower three wealth categories. The most remarkable result is that more than half of the VCT patients, 54.8 percent, falls into the lowest township wealth quintile. These results are unexpected because the services offered are targeted at the whole socioeconomic spectrum of public sector users.

Overall, the findings show that socioeconomic groups are not evenly represented in clinic attendance, and this pattern is even more exaggerated when it comes to VCT use. The least well off quintiles among the township population take up the services more than the others.

The waiting room survey gathered a wide range of data about people’s knowledge concerning VCT and the motives for VCT uptake. Of the multiple reasons people gave for having a test, the leading ones were tuberculosis (explicitly mentioned by 30.0 percent of patients) and sexually transmitted diseases (explicitly mentioned by 28.0 percent). In both cases, nearly all the patients had been referred by a health worker. People also mentioned a range of general symptoms of illness—“because I am very sick,” coughing, chest problems, loss of appetite, and similar complaints. Most of the younger age groups came for testing as a consequence of sexually transmitted diseases or because they simply wanted to know their status. In the older groups, tuberculosis was the key reason for testing.

Clinic health workers clearly play an important role in conveying information about HIV prevention services available at the clinic. Of the clients interviewed, 95 percent had received information from clinic health workers. The role of information transmitted via radio and television is also apparent; the impact of televised information had even reached beyond those living in households with television sets. Posters at clinics in the study setting reached more patients (63.7 percent of the sample) than did campaigns that used brochures and leaflets (14.8 percent of the sample). Community health workers had reached 42.8 percent of the people interviewed at the clinics.
Findings about Reasons for the Distribution

The quantitative analysis presented above suggests that certain groups within the community are more likely to access public sector clinics and VCT. To complement these findings and to explore reasons that may explain them, focus group discussions and in-depth interviews were analyzed.

Any discussion about voluntary counseling and testing is dominated by fears surrounding HIV/AIDS. The fear of an incurable disease is paired with the perceived risk of expulsion from the family or rejection by a partner. Lack of access to treatment was also given as a reason not to test:

[If I tested positive,] . . . I would just feel like I am already dead because there is no cure for this. (woman, Khayelitsha)

What makes people not come [to VCT services] is their background. Sometimes you get that their family do not accept a positive person. They see her as if she is someone who was misbehaving outside and then got positive. One is afraid to tell her husband because she is worried that the husband will divorce her. A mother who is not working is afraid of being left with the children to feed . . . Some people think when you touch them you going to make them positive. (woman, Langa)

Positive people are not welcome in the family. (woman, Langa)

People have a fear of knowing. They also say "Why must we test if the government does not treat us?" (woman, Langa)

In staff focus groups, counselors observed that these general fears lead many people to delay attending VCT unless they experience symptoms that might be AIDS related.

A big impediment people face in their communities is the stigma that leads people to shun anything related to HIV/AIDS. Resistance to outreach programs by counselors was voiced:

If [the clinic counselors] would go outside to the community, it would be worse. People do not want that counselors be seen who come to their door. It is better if the counselors stay there, so they can counsel those who go to the clinic. (woman, Khayelitsha)

We also don’t want [the counselors] really to come to our places. (man, Khayelitsha)

HIV/AIDS workshop is not very good because that name is scary. (man, Khayelitsha)
For the same reasons, people criticize the lack of anonymity in the clinics:

We are a small community. If you are seen [in the waiting area for VCT], there is some question mark above you. So people don’t want to be seen there. They don’t want to go local. HIV is often portrayed as misbehavior. (woman, Langa)

There’s a problem with the clinic: the room where counseling takes place. Everyone in the waiting room can see it and from the public entrance. If you go in there everybody knows what you are there for. There’s the stigma. (woman, Langa)

Closely linked to the issue of stigma is people’s fear that their interaction with nurses and counselors is not confidential. Community members may travel to a clinic in a different part of town to have an HIV test. Some interviewees in the communities stated that they preferred to go to a private general practitioner for testing for reasons of confidentiality:

If my counselor is my neighbor, I think that maybe she can tell people about me and my status. Therefore I decide to go and do the test in Salt River and not here in Langa, you understand? (woman, Langa)

Sometimes people they go to another clinic. We fear each other. (woman, Langa)

We don’t have any confidentiality here . . . for confidentiality we go to Wynberg. (woman, Khayelitsha)

False Bay is not safe anymore because the health workers do go there and come back and tell, so the only place I see is Fishhoek clinic, and Wynberg. People prefer going to places far away from here. (woman, Masiphumelele)

Breaches of confidentiality reported in the communities may not actually reflect reality. Rumors about what happens at the clinics echo people’s fears:

There is a particular chair in the clinic that people know if you are seen sitting in it, you know that is for people who tested positive. (woman, Masiphumelele)

Overall problems having to do with waiting times and with rudeness and favoritism on the part of health workers were similar to those raised about primary care services generally in South Africa (Edgington, Sekatane, and Goldstein 2002). In a number of cases, lack of trust toward health workers is clearly expressed, although this often appears to be based on expecta-
tions of what would happen or on the experience of others rather than on individuals’ own experience:

I don’t trust anyone. Because I just hear from the TV that they treat some people with needles that have been used by an HIV person. (woman, Khayelitsha)

The people at the clinic do not have a nice way of dealing with the issues in a sensitive way . . . [tells a story about someone else] . . . the health worker visited the house and shouted at her. (woman, Masiphumelele)

I don’t know if this test is voluntary. (woman, Khayelitsha)

These health workers do not make people confident because they turn around the folders and check the status of the people. (woman, Masiphumelele)

The level of distrust seems to be more an expression of uneasiness and anxiety associated with HIV/AIDS than a reflection of actual negative experiences with clinic staff and VCT services. People interviewed who revealed their HIV-positive status generally described a different experience than was expected by other respondents, and they reported kindness, support, and confidentiality on the part of the clinic staff:

They treat them [those with HIV] good and advise us how to behave. (woman, Langa)

The staff here care very much. (HIV-positive woman, Langa)

Issues surrounding information and the type of promotion of public VCT services were also discussed in the focus groups. Several participants mentioned radio, leaflets at the clinic, and LoveLife, a media campaign promoting reproductive health:

The billboards are good but they must not be put on the freeway where you cannot see them. (woman, Langa)

What about those who cannot read? They are people like us. How are they going to get this information? (woman, Khayelitsha)

The most marginalized parts of the townships—that is, informal settlements or squatter camps—were spoken of as those least likely to access services. Their residents were seen as high-risk groups for HIV but as more inclined to call on traditional healers. Reasons mentioned for the lack of interaction between squatters and public primary health services were eco-
nomic (people spend their time looking for money and food), cultural, and related to language and education.

They in the informal there, they suffer. (woman, Khayelitsha)

[HIV awareness should] include people from the rural areas, who cannot read and also include our culture, the culture of the African people. According to our culture the elders are not allowed to talk with their children about sex. (man, Khayelitsha)

Limitations

As highlighted in the previous section, carrying out research on issues associated with HIV/AIDS is a highly sensitive task. Both the reluctance of people to be interviewed in depth and limitations on what they were willing to talk about in interviews hindered data collection. Because of the difficulties of recruiting people for interviews or focus groups, qualitative data are not drawn from a wide, community-based sample but from specific groups, and these groups’ views may differ systematically from those of other members of the community.

The second set of limitations concerns the use of the South African DHS for the comparison data. The approach had two drawbacks. Because the DHS was conducted in 1998, the data are relatively old, and asset ownership patterns within townships in South Africa may have changed. The only clear development in asset ownership affecting households across the board, however, seems to relate to the possession of telephones as a result of the spread of mobile phones. The second weakness of the DHS data is the extent to which the asset ownership questions used in the DHS are appropriate for South African urban and periurban settings. Given the relatively high prevalence of many “basic” assets, a refined set of questions would probably have yielded superior results. Future work could benefit from a focus on more appropriate wealth indexes for specific settings.

The study design was highly focused and reveals a number of areas requiring further exploration. The study examined only relatively well resourced township clinics in the public sector. It thus highlights the need to know more about what is happening in more rural areas and about where else people might be going for VCT. Furthermore, our facility-based study design did not allow us to comment on the rate of uptake or of exclusion from the service in the community as a whole. Larger, more comprehensive (and hence more expensive) research designs would be required to shed light on these important questions.
Implications

The population of townships in Western Cape Province is relatively affluent compared with the rest of the South African population covered by the DHS. Public sector users in those townships are from the poorest quintiles, and public sector users of VCT are even more concentrated in those quintiles. Reasons for this are suggested by the qualitative findings, which consistently reflect a perception that public sector VCT is deficient in confidentiality—a key quality dimension for this service.

Health policy makers face a number of dilemmas related to access to services. The first is whether services reach the right population and in sufficient quantity. Related to this is the question of whether services are perceived to be of adequate quality and accessibility. Findings from this study suggest that VCT in public sector clinics reaches poor groups but that this may be happening as a result of negative attitudes toward the service rather than positive ones.

It is unlikely that the relatively wealthier groups choose not to obtain VCT at all; studies from other countries show that uptake of VCT is positively associated with socioeconomic status and education (Kowalczyk and others 2002). But we do not know where individuals who do not use the public sector for VCT are going. Evidence abounds that many urban South Africans go to the private sector for general primary health care services and that where conditions of greater sensitivity are involved, this is likely to be a very high percentage. For instance, more than 50 percent of patients with sexually transmitted infections use the services of private general practitioners (Rispel and others 1995; Wilkinson and others 1998). We can therefore hypothesize that some groups, especially wealthier ones, go to the private sector and that others may travel out of the area to obtain VCT in more anonymous settings in the public sector.

In light of high private sector utilization throughout the world, the perception of public sector health services as being of poor quality is a problem of increasing concern for those who can afford no alternative. It undermines many areas of health service delivery in the public sector and causes impoverishment of vulnerable households that pay for private services instead of using the public sector. Although the findings of this study suggest a progressive incidence of uptake of VCT, a more positive finding would have been an even distribution of VCT use across all socioeconomic quintiles, including the poorer groups.

VCT recipients who choose not to use the public sector incur costs of travel and time or private sector fees to access a service of tremendous pub-
lic health importance that is available free of charge. Measures to address this situation could include improving the perceived confidentiality of services at public clinics through physical modifications such as changes in waiting areas and room allocations and by training health workers and helping to cultivate trust in health workers at the clinics. The physical environment at the clinics must be designed in a way that ensures confidentiality, and health workers and counselors must place higher value on patients’ privacy. To be sure, the reputation of services, rather than their actual shortcomings, may keep many people away. The problem may be one of suspicion and perception as much as of real breaches of confidentiality. This points toward a need to address people’s perceptions, as well as features of the service. If many people are using the private sector and are likely to continue doing so in the near future, the possibility of a voucher system for VCT could be explored if the private sector could offer good-quality counseling and testing that is more acceptable to clients and can be monitored for quality.

Finally, the study findings suggest a clear agenda for future research in this area. It is important to begin to understand the extent of exclusion from VCT in various service settings and areas. Research at the community level into uptake of VCT and choice of provider (and the associated costs) would be one next step toward advancing knowledge in this area. It should be coupled with more in-depth qualitative work aimed at understanding the key barriers to access to VCT by different vulnerable groups.

Notes

1. VCT as part of antenatal care was explicitly excluded because it is part of a broader service. Moreover, the uptake of services within a package focusing on the prevention of mother-to-child transmission is based on a different set of motivations.

2. Johannesburg townships in the DHS, similar to those in Greater Cape Town periurban areas, were included to increase the sample size of reference households.

References


