

Knowledge and Attitudes of Youth in Relation to Provider Initiated Counselling and Testing at the Primary Health Care Services of the Capricorn District, Limpopo Province

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ABSTRACT The aim of the study was to assess the knowledge and determine attitudes of youth about Provider Initiated Human Immunodeficiency Virus counselling and testing) at the Primary Health Care services of the Limpopo Province, South Africa. The target population was the youth between the ages of 16 and 35 years. The sampling method was non-probability and purposive, while data were gathered by using a structured questionnaire. The data analysis was summarised by means of descriptive statistics. Validity and reliability were ensured by undertaking a literature review; developing and pre-testing the questionnaire. Ethical considerations were adhered to. The consent for participation from participants who were between 16 and 17 years was obtained from parents or guardians. Results indicated 90 percent youth demonstrated sufficient knowledge and awareness of the availability and the value of Provider Initiated Human Immunodeficiency Virus counselling and testing services; however 50 percent had negative attitudes on the utilization of the services because they felt compelled as they were not given opportunity for making choices. The establishment of interventions for HIV prevention, namely Youth-friendly HIV Counselling and Testing services and strengthening the quality post-test counselling at Primary Health Care facilities were made.

INTRODUCTION

According to the World Health Organization (2007) more than 33 million people were living with HIV/AIDS with at least 2.7 million new infections being transmitted annually. In South Africa, an estimated 5.7 million people were HIV positive in 2009, the largest number for any country in the world. According to Department of Health (2012) the prevalence rate of HIV amongst Antenatal women in Limpopo province in 2011 was 22.1 percent. Within the infected population, the majority of people living with HIV and AIDS were between 20 to 30 years old. The high incidence of HIV infection prevalence is growing at an alarming rate, with the youth representing more than 50 percent of the total infected population. It is estimated that 1 out of 5 in the 20 to 30 years age group is living with HIV and AIDS, while 85 percent of infections are occurring as a result of heterosexual interaction amongst the general population (Leblanc and Andes 2015). The youth are the most threatened, globally, and are accounting for half of the new cases of HIV infections (Harrison et al. 2010).

In a mid-term review of the National Strategic Plan 2007 - 2011, the Human Sciences Re-

search Council reported that while the HIV epidemic in South Africa appears to have stabilised, a significant number of South Africans do not know their HIV status and testing is still primarily client initiated (Department of Health 2012). Therefore, sensitising community about the epidemic is the greatest hope for turning the tide against AIDS (UNAIDS 2008). HIV testing is an entry point to prevention, as well as treatment, care and support services and the future of the epidemic will be shaped by the actions of the youth. The study on utilization of counselling and testing by Obermeyer and Osborn (2007) pointed that to scale up treatment and prevention, rapid increasing of both the volume of testing and the ability to counsel those who are tested are needed. The client-initiated HIV counselling and testing which is commonly referred to as voluntary counselling and testing (VCT) should be encouraged. This is motivated by an individual's right to know his or her HIV status, and it takes place when an individual seeks counselling and testing at a facility that offers the services (Kharsany et al. 2010). This type of HIV testing and counselling service is offered widely, mainly through facilities integrated in health settings, mobile services and in standalone fa-

cilities that are located away from health care facilities such as community-based settings and night services (Fylkesnes and Siziya 2004; WHO and UNAIDS 2007). Provider-initiated testing in contrast to the client initiated testing is recommended by a health provider to people attending a health facility (Kayigamba et al. 2014; Roura et al. 2013). This approach to testing can be offered with an opt-in or an opt-out approach, the latter being prominent in specialized programmes such as prevention of mother-to-child-transmission programmes (PMTCT). The difference between the two is that with the opt-in approach patients need to affirmatively agree to test before the test is conducted, whereas in opt-out approaches clients actively decline after the pre-test information is offered, if they do not want the test to be performed (Ujiji et al. 2011; WHO and UNAIDS 2007).

With Provider Initiated Human Immunodeficiency Virus counselling and testing (PICT), the health care provider routinely offers and recommends an HIV test to all clients, irrespective of the medical diagnosis (Leblanc and Andes 2015; Becker et al. 2009). The main objectives are to integrate HIV testing into routine medical care, thereby facilitating early diagnosis. When reporting findings on the overview and the practice of PICT, Makhunga-Ramfolo et al. (2011); Njeru et al. (2011) were of the opinion that since PICT, had limited counselling to prepare clients with a minimum of knowledge on how to live with either a HIV negative or a HIV positive status, this can further diminish their confidence in the health providers and the health system, and can drive them away from visiting the PHC facility. This model has been criticised from an ethical and human rights perspective for paving the way to neglect of informed consent (Gruskin et al. 2007; Yeatman 2007) and for reducing the amount of counselling that is accompanied by the HIV test. The manners in which the provider initiated opt-out testing model is being interpreted and implemented WHO/UNAIDS (2007) and Njeru et al. (2011) have serious unintended negative effects. Firstly a reduced focus on counselling in general was found, and limited or no preventive counselling taking place for persons with HIV negative test results was particularly brought up. Secondly the provider-initiated opt-out strategy was perceived to impede the much valued consent process inherent in pre-test counselling (Topp et al. 2011).

In 2007, WHO made recommendations to introduce provider-initiated counselling and testing (PICT) in addition to client-initiated counselling and testing, also known as VCT, as an effective public health intervention to increase access to HIV counselling and testing (HCT) and reduce missed opportunities for testing (Njeru et al. 2011). Another aim of PICT was to bring about positive behaviour change, encouraging individuals and communities to take responsibility for their health by knowing their HIV status (Department of Health 2010).

Considering the extent of youths' susceptibility to HIV infection, the low uptake presents missed opportunities and efforts should be made to understand the factors that motivate them to seek VCT (Njeru et al. 2011). According to UNAIDS (2003), an increasing number of youth within the age group of 15 to 25 years have continued to be infected with HIV and AIDS. Also, the Department of Health (2003) reported that the youth are more vulnerable to sexual infections because of their age. This assertion was supported by UNICEF UNAIDS and WHO (2007) that the youth are the most sexually active individuals. These attitudes have created a lot of problems for the youth and have led to the spread of HIV amongst them. The attitude and behaviour of the youth to PICT are therefore factors that need to be addressed (UNAIDS 2003). This study was aimed at assessing the knowledge and to determine attitudes of the youth about Provider Initiated Counselling and Testing at the Primary Health care services of the Capricorn district, Limpopo Province.

METHODOLOGY

Research Design

The study was conducted at the Mankweng catchment area in the Polokwane Municipality, which is under the Capricorn District of the Limpopo province. The catchment area consist of four PHC facilities namely; the Makanye, Mankweng, Nobody and Phuti Clinics. These clinics have been chosen since they are offering PICT services. A cross-sectional descriptive research design was used for this study. The study was descriptive in that the researcher collected detailed descriptive information concerning the knowledge on the availability of services and attitudes of the youth towards PICT, and the

situations and events that influenced the knowledge and attitudes of youths towards PICT.

Population and Sampling

The study population comprised members of all youths; both males and females aged 16 and 35 years; who were visiting health care facilities for general consultation and who agreed to participate in the study. Probability, systematic sampling was used to select every third youth to participate in the study. Two hundred (200) participants were sampled while visiting the health facility for consultation, during period, December 2011 to March 2012.

Data Collection Methods

Ethical clearance was obtained from the University of Venda Ethical Committee. The permission to access health facilities was obtained from the Department of Health and Social Development Research Committee in the Limpopo Province, and the local area manager of the Primary Health Care facilities. The principles of informed consent, principles of beneficence and right to privacy were observed, the consent for participants who were aged between 16 and 17 years were obtained from parents or guardians. Four research assistants were trained and supervised by researchers during data collection at four PHC facilities. Data were collected by administering structured questionnaires which included closed and open-ended questions. The questionnaires were written in English and those participants who did not understand English were assisted by research assistants to complete. A total of 200 structured questionnaires were administered voluntarily to participants, and a 100 percent response rate was obtained from participants. Some of participants chose not to complete certain sections of the questionnaire or certain items of specific sections due to the personal nature of the particular questions.

Descriptive statistics was used to analyse data, this enabled researchers to organise the data in ways that provided meaning and facilitated insight. Data were grouped into smaller categories, coded and presented in percentages. To ensure validity, both face and content validity were applied to avoid bias and to ensure that the instrument is measuring the content that it desires to measure. A panel of experts

was used to evaluate and document the content validity of new instruments. They also examined the relevance of each item (Polit and Beck 2008). The instrument was pre-tested by administering the questionnaire to 20 participants and their findings were not included in the main study.

RESULTS

The findings were presented according to the participants' demographic data (Table 1); information about knowledge of the youth in relation to PICT; and the attitudes of the youth to PICT.

Table 1: Participants' Demographic details (n=200)

<i>Variables</i>	<i>Number</i>	<i>%</i>
<i>Gender</i>		
Male	50	25
Female	150	75
<i>Age</i>		
16-20	61	30.5
21-25	139	69.5
26-35	0	0
<i>Education Level</i>		
Secondary education	138	69.2
Tertiary education	62	30.8
<i>Marital Status</i>		
Single	156	78
Married	44	22
<i>Employment Status</i>		
Unemployed	86	43
Employed	94	47
Scholars	20	10
<i>Location</i>		
Rural	166	83
Semi-rural	34	17

Knowledge about Provider Initiated HIV Counselling and Testing Services

Most respondents (93.5%) had heard of PICT, 74 percent received information about PICT from the clinic while 19.5 percent from the media. When asked about availability of PICT services, approximately 85.5 percent indicated that everyone could decide to take part in HCT at the clinic. Most (90.5%) participants were aware of facilities that were offering PICT in the Capricorn District while 97.2 percent mentioned the correct facilities, namely, the 24hr community health centres and 8hr clinics. They further indicated that services are free and that counselling is compulsory but testing is voluntary. 97.5 per-

cent knew that PICT was a free service, while 97.5 percent of them knew exactly where to get tested. Most, 84.0 percent of the respondents knew that PICT was a confidential service and 63.5 percent knew that sensitisation to HIV counselling and testing of people was of paramount importance to healthy sexual practices.

Most of the participants, 90.0 percent were knowledgeable about facts and intervention that could be done to assist HIV infected individuals to stay healthy and to live longer. From the participants, 95.5 percent indicated that it was necessary for young people to know their HIV status. Seventy seven percent (77.0%) of the participants were aware of the fact that PICT could prevent HIV transmission, while 96.5 percent indicated that knowing one's HIV status was necessary.

Attitudes towards Provider Initiated Counselling Testing

Most participants had positive attitude towards PICT. Out of these participants, 86.0 percent had been tested for HIV, while some were tested twice or more. Among those participants who had tested for HIV, 47.6 percent tested on their own initiative. Then, 76.0 percent were willing to be tested as part of the PICT programme. Ninety two percent (92.0%) of participants were certain that knowing their HIV status was beneficial to them, their partners and to other people. Seventy two percent (72%) of the participants indicated that the approach is good they would not be stigmatised due to their visits to PICT centres, because is the service given to all who visited the facility. Whereas, the 50 percent of participants had negative attitudes towards PITC, they felt compelled to be counselled and tested, because they visited the health facility, not for that service. They felt their rights were not taken into consideration.

When conducting a study on human rights and PICT, Gruskin et al. (2007) were of the opinion that the manner in which the new provider initiated opt-out HIV testing model is being implemented was found to have resulted in high neglect of pre- and post-test counselling. This could hamper the inherent preventive potential in HIV testing contexts.

DISCUSSION

The prevalence rate of HIV in Capricorn district is 25.3 percent, which is second amongst

the 5 district (Department of Health 2012). This prevalence rate underscored the utilization of HCT as effective preventive and treatment program tailored for young people. PITC is when HIV Testing and Counseling is offered to patients accessing health services, regardless of the reason for their visit. To meet the severely unmet need for HIV counselling and testing, South Africa has moved towards encouraging healthcare providers to routinely offer HIV testing and counselling to all those accessing public healthcare services, and especially those accessing services considered key to HIV prevention and treatment such as antenatal care (ANC), family planning (FP), and services for sexually transmitted infections (STIs) and tuberculosis (TB) (Becker et al. 2009; Leon et al. 2013). This descriptive study documented knowledge and attitudes of youth related to PICT services at the Primary Health Care level, in order to recommend interventions for HIV prevention, namely establishment of Youth-friendly HCT services and strengthening the quality post-test counselling at Primary Health Care facilities. It was evident from the study findings that most of the youth had knowledge about PICT for HIV at the PHC services of the Capricorn District, Limpopo Province. From the findings of the study 93.5 percent of the participants indicated that they were aware about the availability and the utilization of PICT for HIV in the Capricorn district. The total percentage of the participants who received information about HIV counselling and testing from the media was 69.5 percent. The study findings confirmed that youth in the rural areas had access to media. This was also supported by Abiy (2006) and Mwandira (2008) as they indicate that several studies done amongst adolescents also mentioned television and radio as the primary sources of information for adolescents. It was concluded that participants were familiar about the availability of the PICT programme and its procedures.

In a study to determine the knowledge, beliefs and attitudes towards VCT for HIV and factors which influence these factors in New Zealand by Adekeye (2009) five main factors were identified as barriers to VCT. These factors were stigma; the association of HIV and AIDS with death; the lack of in-depth knowledge about HIV and AIDS; religion; and confidentiality. Participants were not against VCT but now because it was PICT, they were afraid of what would happen to

them if they tested HIV positive. In the study by Gerida (2007) participants lacked knowledge about HIV treatment and associated HIV positive diagnosis with death and the end of their dreams. Contrary to the findings of the current study, 90.0 percent of participants were knowledgeable about facts and intervention of PITC (Kayigamba et al. 2014). That PITC is free, confidential and only counselling is compulsory but testing is voluntary. It was further evident that participants knew which facilities were offering HIV counselling and testing in the Capricorn District. It confirmed that if the youth needed to be counselled and be tested for HIV they knew where they could go to access these services.

PICT for HIV has a number of benefits, including the facilitation of positive behaviour change, hence it is considered a major HIV and AIDS prevention strategy (Van Dyk 2007; Kayigamba et al. 2014). Whereas in the study on overview of PICT by Gerida (2007) were of the opinion that knowing one's HIV status can have benefits to the individual, the provider and the community. For HIV-negative people, knowing their status empowers them to protect themselves from becoming infected with HIV. It provides them with information on how to remain negative by assessing their own behaviour and providing solutions for behaviour change. For HIV-positive people, knowing their status ensures that they can be provided with the appropriate treatment, care and support services and assist them to live positively.

Testing for HIV antibodies is viewed as an important component of prevention and intervention programme designed to curb the spread of HIV infection. A logistic regression model showed that women; who had little knowledge about HIV and AIDS, were unwilling to work with HIV infected individuals, never had been tested for HIV and had lower awareness about HIV risk; were less likely to use a PICT programme (HE et al. 2009). Similar findings related to knowledge and willingness to disclose Yang et al. (2006) indicated that most (80.2 percent) of the study participants accepted an opt-out approach to HIV testing in clinical settings, such as integrating HIV testing into antenatal or physical examination for employment or a marriage licence. A community based, confidential and free mass HIV screening programme was also acceptable to the majority (79.5 percent) of the study participants (HE et al. 2009).

Couples who know their HIV status are empowered to make safer choices with respect to sexual behaviour, for example, condom use in discordant couples, implementation of positive living strategies, and accessing treatment for the prevention of mother-to-child transmission (PMTCT) of HIV. Pre and post-test counselling are effective avenues to impart "factual information" that facilitate informed decision-making by clients. HE et al. (2009) concurs, adding that HCT facilitates behaviour change and safer sex practices regardless of the outcome (positive or negative) of the HIV test.

From the study findings it was established that 50 percent of the youth had positive attitudes towards PICT. It was found that majority of them had been previously tested for HIV, and 37 percent of that percent were tested twice or more on their own initiative. Only 13 percent had not been tested for HIV. However, 50 percent of participants had negative attitudes as they felt coerced and were not ready to attend PITC services; they felt their rights were not considered as they had to take more time to attend this service. The implementation of the provider initiated opt-out testing model perceived as mandatory as reflected in the formulation "it is a must" not only contradicts the current global guidelines, which emphasize the rights of clients to decline or opt-out of HIV testing when offered Joint United Nations Programme on HIV/AIDS (2004); WHO and UNAIDS (2007); Ujiji et al. (2011) but also national guidelines on HIV testing (National guidelines for HIV testing and counselling in Kenya 2008). Similar concerns were raised in Botswana where in the high proportions were in favour of the opt-out testing model; a majority (68 percent) felt that it was not possible to refuse a test (Jaffe 2009; Weiser et al. 2006). The increasing normalisation of HIV testing – whether through PITC or other strategies – requires greater caution to ensure that patients' rights are protected, especially in settings where patient autonomy and participation in decision-making are not strongly embedded (Leon et al. 2010).

CONCLUSION

This study results indicated that youth demonstrated sufficient knowledge and awareness of the availability of PICT services. Ninety-two percent (92.0%) of the participants were certain

that knowing their HIV status was beneficial to them, their partners and to other people. Seventy two percent (72%) of the participants indicated that the approach is good they would not be stigmatised due to their visits to PICT centres, because is the service given to all who visited the facility. However there were mixed attitudes on the utilization of the PICT services. Fifty percent (50%) of participants had negative attitudes, they felt compelled to be counselled and tested, because they visited the health facility for other reasons than HCT. They felt their rights are not taken into consideration. The establishment of youth-friendly HCT services would encourage more youth's uptake for voluntary test after provider routine counselling. The further strengthening of post counselling would empower the youth.

RECOMMENDATIONS

The study recommended the establishment and integration of Youth-friendly HCT services into basic Primary Health Care services. It is envisaged that Youth-friendly HCT services would encourage more youth to test after provider routine counselling. Campaigns should be made to advocate the adoption of peer education programmes at all PHC facilities. To strengthen the post-test counselling as an important part of PITC. Post-test counselling, provides an opportunity for clients to learn more about HIV-related prevention, treatment, care and support services. Facilitate the utilisation of community health workers or counsellors as peer educators at the facility. This cadre would empower youth on all HCT facts and make it a normal process to do during health consultation. Encourage the formation of HIV and AIDS committees in communities. These committees should engage during regular meetings and discussions about issues that are related to HIV and AIDS, since it will assist community members to familiarise themselves with the matter and to develop positive attitudes to HIV counselling and testing programmes.

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