Moving voluntary counselling and testing to the people

Social scientists are constantly trying to find new and pioneering ways to change sexual behaviour in the unrelenting battle against HIV. One proven method is to increase the uptake of voluntary counselling and testing (VCT). This is what Project Accept will try to achieve, writes Heidi van Rooyen, Admire Chirowodza, Sindisiwe Sikotoyi, Phillip Joseph and Linda Richter.

Project Accept is a potentially groundbreaking, large-scale HIV/AIDS-prevention trial, conducted in five sites in four countries. The five sites are in Vulindlela (outside Pietermaritzburg), Soweto, Tanzania, Zimbabwe and Thailand.

The study aims to compare the advantages, including cost-efficacy, of two VCT approaches to HIV prevention. The one approach is health-facility based VCT; the other uses a combination of strategies: mobilisation of the community around HIV testing plus sameday mobile VCT and referral to post-test support services once people know their status.

These strategies operate on the assumption that increased knowledge of HIV status is important to reduce stigma and to encourage preventative behaviour. As the study moves towards implementation of the intervention in April 2006, this article reflects on some of our preparatory work conducted in the last year.

The health –facility-ased VCT approach: We conducted interviews with 50 stakeholders involved in community, prevention, treatment, care and social support services in the Vulindlela area. The aim was to identify what VCT services existed in this rural community, as well as to identify stakeholders' perceptions of current VCT services, and possible community responses to the intended mobile VCT service.
Stakeholders regarded the poor quality of the services provided in health facilities, the limited operating hours, and the lack of confidentiality surrounding HIV testing in these sites as key factors that limited uptake of VCT in this rural area.

Stakeholders had noted a small increase in the uptake of VCT since the introduction of rapid HIV testing, but generally felt that community members were reluctant to test because of the perceived lack of benefits available to them. Many felt that current VCT services tended to attract clients who were ill or symptomatic, and that this created an additional strain on service providers.

Most stakeholders had mixed feelings about the mobile VCT service we hoped to provide. Some thought that mobile VCT had advantages, such as greater accessibility and no transport and service costs for the community, and that this would encourage people to come forward. Others felt that because the mobile VCT will be branded as such (and likely to be associated with HIV and AIDS), many people would be reluctant to come forward for testing for fear of being stigmatised and discriminated against.

The mobile VCT pilot study approach: From the stakeholder interviews, it was clear that a good mobilisation strategy was essential. to rouse community interest and to encourage them to use the services. So we prepared communities a few weeks before the pilot, using multiple strategies, such as promotional material drop-offs in community homes and venues.

The mobile caravan was fully staffed and then rotated through various locations. Despite stakeholder reservations about possible community readiness for mobile VCT, we were extremely surprised by the immediate and positive response to the mobile VCT pilot service.

The graph below indicates the flow of participants in any phase of the mobile VCT pilot process over the 10-week period. Of the 407 participants who were recruited, 89% participated in all phases of the mobile VCT pilot (that is, phases 1–5 of the mobile VCT process, illustrated above).