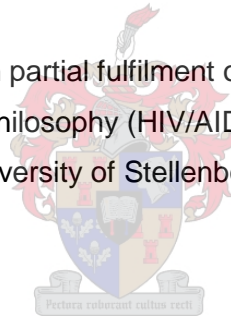


**Barriers to HIV Voluntary Counselling and Testing among Refugees and Asylum Seekers  
from African Great Lakes region living in Durban**

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Assignment presented in partial fulfilment of the requirements for the  
degree of Master of Philosophy (HIV/AIDS Management) at the  
University of Stellenbosch



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March 2012**

## **DECLARATION**

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Prudence Muiyambere

January 2012

## **SUMMARY**

Extended displacement and the disruption of refugees' lives can put them at increased risk for HIV/AIDS. While HIV/AIDS services needed by refugees already exist in their host countries, several challenges limit their access to those services. HIV voluntary counselling and testing (VCT) is an entry point for prevention and care. However, Access to VCT services remains limited and demand is often low. The study sought to determine the barriers to Voluntary Counselling and Testing among refugees and asylum seekers from African Great lakes region living in Durban in order to provide guidelines for interventions. The present study was conducted within the qualitative paradigm. In-depth interviews, semi structured questionnaires and focus groups were employed for data collection. Data were collected from refugees and asylum seekers from African Great lakes region living in Durban and from two VCT providers operating in Durban. The study used a purposive sampling and an opportunistic sampling method.

Fear was the dominant barrier to VCT among participants. It included fear of the HIV positive status as a death sentence, fear of stigma and discrimination and fear of rejection. The study also revealed that realising there is no cure, low-risk perception on the one hand and risky sexual behaviour on the other hand, not trusting health department, inconvenient testing hours, inconvenient VCT sites location, not caring if one is HIV positive or not, not knowing about VCT, being unsure where to get tested, and the perception that VCT was expensive were some of the most important barriers to VCT. The study also indicated that language was a barrier to accessing VCT services and information in Durban. Furthermore the study revealed that not having a refugee permit was a barrier to accessing VCT Services in Durban.

The study recommended that interventions to increase VCT utilization among refugees from African Great Lakes Region living in Durban are needed should focus on VCT promotion and on reducing HIV/AIDS related fear, stigma and discrimination.

## OPSOMMING

Die uitgebreide verplasing en die ontwrigting van vlugteling se lewens kan hulle 'n groter risiko vir MIV/ VIGS maak. Terwyl MIV/VIGS dienste wat nodig is deur vlugteling reeds bestaan in hul gasheer lande, bestaan daar verskeie uitdagings wat hulle toegang tot die dienste beperk. MIV vrywillige berading en toetsing (VBT) is 'n instrument tot die voorkoming en versorging van die toestand. Toegang tot VBT dienste bly egter beperk en die aanvraag is dikwels laag. Die studie poog om die struikelblokke tot vrywillige berading en toetsing onder vlugteling en asielsoekers uit die Afrika Groot Mere streek, wat tans in Durban woon, te identifiseer en ingrypings aan te beveel. Die huidige studie is uitgevoer binne die kwalitatiewe paradigma. In-diepte onderhoude, semi gestruktureerde vraelyste en fokusgroepe is aangewend vir data insameling. Data is ingesamel van vlugteling en asielsoekers van die Afrika Groot Mere streek wat in Durban woon en van twee VBT verskaffers in Durban. Die studie het 'n doelgerigte steekproefneming en 'n opportunistiese steekproefmetode gebruik.

Vrees was die dominante versperring onder die deelnemers by die VBT. Dit sluit die vrees van die MIV-positiewe status as 'n doodsvonnis, die vrees van die stigma en diskriminasie sowel as die vrees vir verwerping in. Die studie het ook aan die lig gebring dat die besef dat daar geen kuur bestaan nie, lae-risiko persepsie aan die een kant en riskante seksuele gedrag aan die ander kant, wantroue in die departement van gesondheid, ongerieflike toetsure, ongerieflike VBT webwerwe, apatie, onkunde oor VBT, onsekerheid waar toetsing plaasvind, en die persepsie dat VBT duur was, was 'n paar van die belangrikste hindernisse tot suksesvolle VBT. Die studie het ook aangedui dat taal 'n hindernis vir toegang tot die VBT dienste en inligting in Durban is. Verder het die studie aan die lig gebring dat die afwesigheid van 'n vlugteling-permit 'n struikelblok is tot VBT in Durban.

Die studie het aanbeveel dat intervensies met die oogmerk om VBT onder die groep te verhoog, moet gefokus word op VBT bevordering en op die vermindering van MIV/VIGS verwante vrees, stigma en diskriminasie.

## **ACKNOWLEDGEMENTS**

I would like to extend my sincere gratitude to my study leader Prof Elza Thomson for her invaluable comments and suggestions, support and encouragement that enabled me to bring this project to fruition.

I would like to express my deepest gratitude to Rehema Mukundente for encouraging me to finish my research assignment.

I am very grateful to Hussein Yahaya for his invaluable assistance in data collection.

My special thanks also go for all refugees and VCT site Managers who participated in the study.

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## ACRONYMS AND ABBREVIATIONS

<b>HIV</b>	Human Immunodeficiency virus
<b>VCT</b>	Voluntary Counselling and Testing
<b>HAART</b>	Antiretroviral drugs/ Highly Active Antiretroviral Therapy
<b>NGO</b>	Non-governmental organization
<b>WHO</b>	World Health Organization
<b>MTCT</b>	Mother-to-child transmission of HIV
<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>PLWHA</b>	People Living With HIV/AIDS
<b>PMTCT</b>	Prevention of mother-to-child transmission of HIV
<b>UNAIDS</b>	United Nations Joint Programme on HIV/AIDS
<b>WHO</b>	World Health Organization
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>IOM</b>	International Organisation for Migration
<b>NGO</b>	Non-governmental organisation
<b>UNAIDS</b>	UN Joint Programme on HIV/AIDS
<b>UNHCR</b>	UNHCR Office of the UN High Commissioner for Refugees
<b>ECDC</b>	ECDC European Centre for Disease Prevention and Control
<b>MSM</b>	Men who have sex with men

## CHAPTER 1

### INTRODUCTION

#### 1.1 BACKGROUND

HIV/AIDS epidemic is one of the greatest humanitarian and development challenges facing the global community in recent times and remains a major public health problem all over the world. UNAIDS Global report (2010:16) estimated in 2009 there were 2.6 million newly HIV infected people in the world and 1.8 million recently infected individuals in sub-Saharan Africa. Therefore there is need to quicken the responses towards UNAIDS vision of zero discrimination; nil new HIV infections and AIDS-related deaths.

Literature has been published on response to the prevalence of the HIV/AIDS disease in many publications. These studies highlight that VCT is an essential element in the response to the HIV/AIDS (Mariano 2005; Bwambale et al 2008; Mariano 2005:2). According to Bwambale et al; (2008:2) Voluntary Counselling and Testing (VCT) is the gateway to comprehensive HIV care and support including access to antiretroviral therapy.

UNAIDS Technical update (2000: 2) maintains VCT provides people with an opportunity to learn and accept their HIV serostatus in a confidential environment with counselling and referral for ongoing emotional support and medical care. According to UNAIDS Technical update (2000: 2) people who test seropositive can benefit from earlier appropriate medical care and interventions to treat and/or prevent HIV associated illnesses. Further pregnant women who are aware of their seropositive status can prevent transmission to their infants to ensure a healthy next generation. UNAIDS Technical update (2000:2) furthermore, claims that knowledge of HIV serostatus can help people make decisions to protect themselves and their sexual partners from infection.

The relationships between population migration and situations of risk that lead to HIV/AIDS infection are well documented (UNHCR 2009, ECDC 2010, UNHCR 2004). Refugees and asylum seekers are more likely to become separated from their family/community structures and find themselves away from shared norms and values, language and social support. As a result they could be more likely to engage in risk behaviours, thus increasing the risk of HIV infection (IOM, 2006:3-4).

In 2010 a Community Assessment in response to HIV/AIDS of Refugees and asylum seekers living in Saint Georges Settlement in Durban South Africa was conducted as an Assignment for the Course of PDM (HIV/AIDS Management) offered by the Africa Centre for HIV/AIDS Management of the Faculty of Economic and Management Sciences, University of Stellenbosch. The most striking result to emerge from the data was that most of the interviewees do not know their HIV status and they do not utilise VCT despite the availability of these services in the city. However, it is not known what barriers prevent these refugees and asylum seekers from utilising VCT (Mujiyambere, 2010).

It is against this background a decision was made to conduct a study to determine the barriers to VCT among refugees and asylum seekers from African Great lakes region living in Durban.

## **1.2 RESEARCH PROBLEM**

Conflict, persecution and violence affect millions of people worldwide, forcing them to uproot their lives in their immediate environment. At the end of 2008, there were estimated to be 15.2 million refugees, 827,000 asylum seekers and 26 million conflicts generated internally displaced persons (IDPs) worldwide (UNHCR, 2009:2).

According to The President's Emergency Plan for AIDS Relief (2006:1) extended displacement and the disruption of refugees' lives can put them at increased risk for HIV/AIDS. PEPFAR(2006:4) highlights different factors that place refugees at risk for HIV infection these include: Displacement, social instability, increased mobility, sexual and gender-based violence, exploitation and abuse, poverty and food insecurity, lack of access to health services and lack of linguistically and culturally appropriate health information (PEPFAR 2006:4).

Refugees are uprooted from their homes and communities and livelihoods are lost to support their existence. The breakdown of social networks and institutions reduces community cohesion, weakening the social and sexual norms that regulate behaviour. In addition, disruption to health and education services reduces access to HIV prevention information, sexual and reproductive health services, as well as HIV-related treatment and care for those who are in need. Again, exposure to mass trauma such as conflict can increase alcohol and other drug use and influence people's attitudes towards risk (UNAIDS 2007:2).

According to UNAIDS (2007) conflicts and displacements make women and children, particularly girls more vulnerable to the risk of HIV as during conflict rape is often used as a weapon of war. UNAIDS (2007) maintains that women and girls are also subject to sexual violence and exploitation in refugee settings. UNAIDS (2007) argues as refugees struggle to meet their basic needs such as food, water and shelter, women and girls are often forced to exchange sexual services for money, food or protection. Children living without parental support is also particularly vulnerable to sexual violence and exploitation (UNAIDS 2007:2).

While the past decade has seen great strides in expanding HIV/AIDS prevention, care and treatment programs across Africa and the rest of the world, populations displaced by conflict have been noticeably absent from many of the country and regional-level initiatives designed to combat the disease. It is critical that both refugees and surrounding host populations receive all necessary HIV related services. Failure to provide these interventions could be harmful to both refugees and the surrounding host populations.

VCT remains critical in the efforts to reach the goal of universal access to prevention, treatment and care services in a timely manner. However, many refugees and asylum seekers from the African Great lakes region living in Durban do not utilize VCT. It is therefore necessary to carry out a study in this group of people to identify the barriers that prevent them from utilizing VCT.

### **1.3 RESEARCH QUESTION**

The present study seeks to address the following research question:

What are the barriers to HIV Voluntary Counselling and Testing among refugees and asylum seekers from African Great lakes region living in Durban?

### **1.4 SIGNIFICANCE OF THE STUDY**

VCT is the cornerstone of a comprehensive approach to HIV prevention and education (Mariano 2005:2). VCT provide essential knowledge and support to individuals at risk for contracting HIV, enabling uninfected individuals to remain uninfected and those infected to plan for the future and prevent HIV transmission to others.

VCT services are available in Durban but many of refugees and asylum seekers do not utilize them. Therefore, there is a need to identify the barriers preventing refugees and asylum seekers from utilizing VCT. Knowledge from this study will be used to design interventions and to

formulate policies that can improve VCT utilization among these two groups of individuals from the African Great lakes region living in Durban.

Awareness of the barriers to VCT from the perspective of the individual and the service provider is an essential part of designing effective HIV voluntary counselling and testing programmes. Through this research project, HIV/AIDS programmes will be enlightened about the specific barriers that prevent refugees and asylum seekers living in Durban from seeking VCT. This will contribute to the formulating of practical solutions to improve VCT accessibility and utilization among refugees and asylum seekers as a measure of controlling the spread of HIV/AIDS.

The accessibility of VCT to these identified groups will benefit them because as in Meiberg et al. 2008:49 this can reduce high risk sexual practices, decrease rates of sexually transmitted infections and it is necessary for directing HIV infected people to highly active antiretroviral therapy (HAART). Furthermore, the accessibility of VCT to refugees and asylum seekers will also benefit host communities because as it is argued in UNAIDS Policy Brief 2007:2 as refugees stay a long time in host countries and live in close contact with host communities, failure to address their HIV related needs undermines efforts to address the status among host communities.

## **1.5 AIM AND OBJECTIVES**

An outline of the aims and objectives will provide guidelines of the direction of the study in Durban

### **1.5.1 Aim**

The aim of this study is to determine the barriers to Voluntary Counselling and Testing among refugees and asylum seekers from African Great lakes region living in Durban in order to provide guidelines for interventions

### **1.5.2. Objectives**

- To assess the operational aspects of VCT centres/services in Durban
- To determine the attitudes and the perceptions of the refugees and asylum seekers toward VCT and VCT centres/services in Durban
- To assess the awareness of VCT centres/services available in Durban among refugees and asylum seekers

- To provide suggestions from refugees and asylum seekers that could promote voluntary counselling and testing among this community
- To provide possible guidelines/strategies that could be used at the VCT Centre/services to improve access and utility of VCT by refugees and asylum seekers

## **1.6 RESEARCH METHODOLOGY**

The collection and analysis of the data for this study will be guided by qualitative research methodology. Christensen (2011) indicate qualitative research is an interpretive research approach that relies on multiple types of subjective data and investigating people in particular situations in their natural environment. Through this method an understanding is gained of the insiders' view. The strength of qualitative research is the description and understanding of individuals and groups with a common identity. A further strength is the manner in which a theoretical understanding can be developed. A weakness of qualitative research methods is the inability to generalise the findings due to the sample selected in a local situation. This method does not allow for hypotheses testing, however it can be a stepping stone towards qualitative research directions.

## **1.7 OUTLINE OF CHAPTERS**

The report is outlined in the following manner:

### **Chapter 1: Introduction**

This chapter will give an orientation to the study as a whole. It presents the background of the research and motivation for undertaking the study. In this chapter, the aim of the study is explained to provide direction and intention of the task, the objectives and the research questions are outlined.

### **Chapter 2: Literature review**

Chapter 2 constitutes a review of the literature relevant to VCT and refugees and asylum seekers

### **Chapter 3: Research methodology**

This chapter explains the research methodology, choice of research participants, data gathering and analysis and ethical considerations.

### **Chapter 4: Reporting of results**

This chapter presents data collected from the participants and from VCT Centres.

### **Chapter 5: Discussion**

This chapter provides a discussion of the findings.

## **Chapter 6: Conclusion**

This chapter presents the conclusion and the recommendations.

### **1.8 CONCLUSION**

This chapter introduces the reader to the background of the study, the research problem, and the research question, the significance of the study, the aim and objectives of the study, the research methodology and the outline of chapters. The chapter briefly discusses HIV Voluntary Counselling and testing and HIV/AIDS in the context of refugees.



## CHAPTER 2

### LITERATURE REVIEW

#### 2.1. INTRODUCTION

This chapter focuses on a literature review on VCT as an entry point for HIV prevention and care, it also explores factors affecting uptake of VCT, and barriers to VCT uptake at the individual level, at the healthcare provider level, and at the institutional level. This is followed by literature on factors that prevent migrants from accessing HIV services and the challenge of HIV/AIDS and refugees.

#### 2.2. Overview of HIV Voluntary Counselling and testing (VCT)

According to (UNAIDS, 2002:6) Voluntary HIV Counselling and Testing (VCT) is a process by which an individual undergoes counselling to enable him/her to make an informed choice about being tested for the HIV (UNAIDS, 2002:6). HIV VCT has been shown to have a role in both HIV prevention and for people with the infection as an entry point to care (UNAIDS, 2000:5).

UNAIDS Global report (2010) highlights that VCT facilitates HIV treatment and care and prevention activities, increases the awareness of people living with the disease of their own status and encourages them to take protective measures and increases social awareness of the situation. UNAIDS Global report 2010 maintains that VCT can reduce the stigma and discrimination towards people living with HIV (UNAIDS Global report 2010:224).

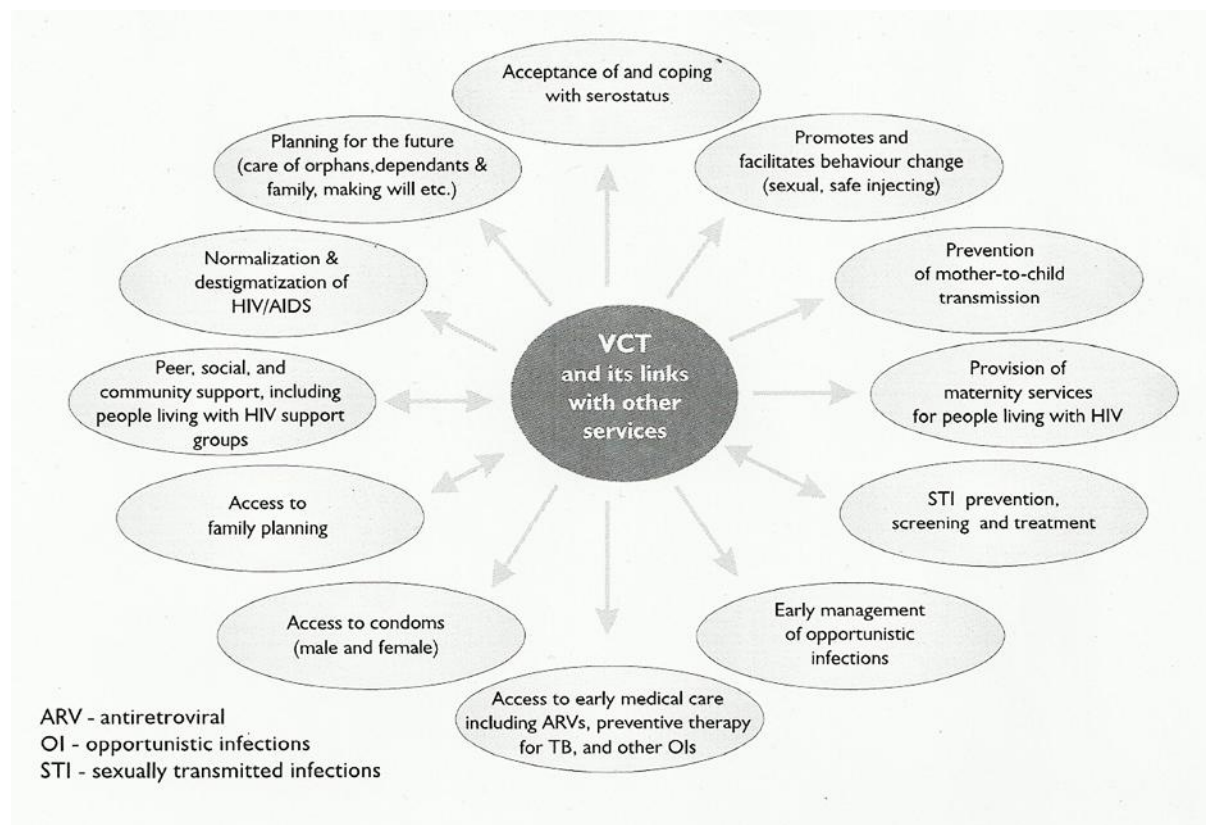
UNAIDS (2002) states the knowledge of serostatus through VCT can be a motivating force for people to adopt safer sexual behaviour, which enables seropositive people to prevent their sexual partners from getting infected and those who test seronegative to remain negative (UNAIDS, 2002:8). A further point is that VCT facilitates access to prevention services for seronegative people. This includes access to interventions to reduce mother-to-child transmission (MTCT) of HIV, interventions to prevent opportunistic infections (e.g. tuberculosis) and other medical and supportive services that can help HIV positive people to live longer and healthier lives (UNAIDS, 2002:8).

According to ECDC (2010:1) there is strong evidence that an early diagnosis of HIV infection and subsequent treatment can result in a markedly improved prognosis for the individual who can expect low morbidity, a good quality of life and a near normal life expectancy. There is also

evidence of the public health benefit of HIV testing through the adoption of safer sexual behaviour by diagnosed individuals and a reduced infectiousness related to antiretroviral treatment. The cost of treatment and care for individuals diagnosed early is significantly lower than for those diagnosed at a late stage of infection (ECDC, 2010:1). Figure 1 summarises the role of VCT and its links with other services

**Figure1:**

**VCT as an entry point for prevention and care**



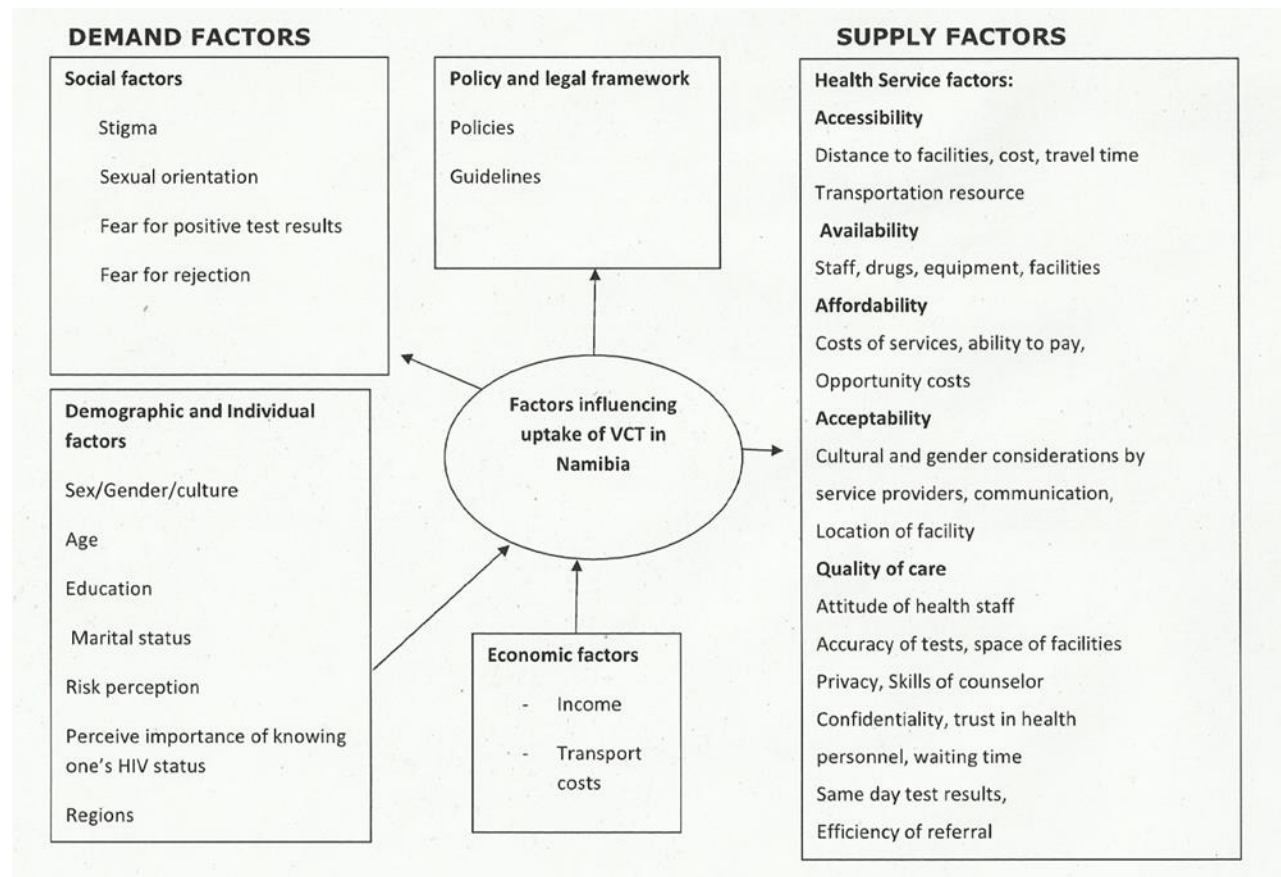
Source: UNAIDS Technical Update, May 2000

### 2.3 . Factors affecting uptake of VCT

In her thesis "Factors influencing the uptake of HIV Voluntary counselling and testing in Namibia", Maria Elizabeth Bock (2009) analysed Namibian VCT data and reviewed a large body of literature on HIV VCT in African countries with generalised related infected epidemic. Bock (2009) developed a conceptual framework for analysing VCT uptake using two independent conceptual frameworks. She adapted the first framework from a study conducted on VCT in

Uganda by Bwambale et al in 2008. This framework suggests that VCT utilization is based on individual/demographic, economic, social and policy and legal framework (Bock, 2009:10). She adapted the second framework from the Penchansky and Thomas (1981) public health model based on the four dimensions of accessibility, availability, affordability and acceptability to which quality of care was added (Bock, 2009:10) (figure 2).

**Figure 2:**  
**Conceptual frameworks**



Source: Maria Elizabeth Bock, 2009:11

#### **2.4 . Barriers to HIV VCT uptake**

Awareness of the barriers to HIV testing is an essential part of designing effective related programmes (UNAIDS, 2000:7). It was highlighted by UNAIDS (2000:5) that access to VCT services remains limited and demand is often low. There is an argument in many high-prevalence countries VCT is not widely available and people are often afraid of knowing their serostatus because there is little care and support available following testing (UNAIDS, 2000:5).

Extensive literature has been published on barriers to VCT by Tharao, Calzavara, Myers and the East African Study Team (n.d.), claim the barriers to HIV testing include myths and stereotypes around the infection (ie, fear of being labelled gay), lack of information about HIV/AIDS and related services, practices and beliefs about health and healthcare (ie, hesitancy to seek medical care/advice unless sick, not sharing or discussing health problems with others, beliefs that one should not fear death and enjoy life), providers not understanding the language, cultural differences, and issues faced by immigrants; fear of testing HIV-positive and the perceived consequences for one-self and the community (ie, not wanting to know if sick, stigma and isolation from one's community, negative impact on immigration status, concerns about confidentiality of HIV status, further discrimination for the community as a whole) (Tharao et al. n.d.).

Nguyen, Oosterhoff, Ngoc, Wright and Hardon (2008) reviewed literature on barriers to VCT among pregnant woman and found the most important barrier to use the services was found to fear the stigma attached to the interpretation by the community and discrimination, poor counselling or lack thereof and lack of awareness on PMTCT opportunities. Worryingly, Nguyen et al. (2008) found that some health staff was unwilling to provide appropriate care for HIV positive pregnant women, often because of their own fear or lack of knowledge (Nguyen et al, 2008:2).

According to the European Centre for Disease Prevention and Control, ECDC (2010:7-9) barriers to HIV testing exist at the individual, healthcare provider and institutional level.

#### **2.4.1 Barriers at the individual level**

Individual level barriers to HIV VCT uptake consist of low risk perception, low knowledge of HIV and benefits of treatment, lack of information about how and where to access testing as well information around the test itself, stigma and concerns regarding confidentiality ECDC (2010:7).

Several European studies (Deblonde, De Koker, Hamers, Fontaine, Luchters, Temmerman. (2010); de Wit, Adam (2008); Prost, Elford, Imrie, Petticrew & Hart (2008); Delpierre, Dray-Spira, CuzinL, Marchou, Massip, Lang et al (2007) cited in ECDC (2010) found that perception of risk is highly influential in an individual's decision to accept an HIV test thereby, concluding people who do not perceive themselves to be at risk of infection are less likely to test.

A large survey of Dutch men who have sex with men (Mikolajczak, Hospers, Kok (2006) cited in (ECDC 2010) reported respondents stating that they had never taken an HIV test, frequently

cited low-risk perception as a reason for not taking an HIV test although over half of them reported risky sexual behaviour.

In another European study by de Wit & Adam (2008) cited in ECDC (2010) fear was reported to be a significant barrier to testing. Fear of the negative social consequences of a positive diagnosis (stigma, discrimination, rejection) was highlighted as being more important than fear of death or illness among all populations, including migrants and MSM. This study also highlighted that people are more motivated to test when they perceive a benefit to diagnosis, but exactly which benefits promote HIV testing are not clear, although it appears the medical benefits alone are not sufficient to encourage more testing uptake.

Other European studies (Manirankunda, Loos, Alou, Colebunders & Nostlinger (2009); Nnoaham, Pool, Bothamley & Grant (2006) cited in ECDC (2010) reported that fear of stigma and negative response from healthcare providers were also a barrier to HIV testing for migrant populations.

According to Deblonde, De Koker, Hamers, Fontaine, Luchters & Temmerman (2010) cited in ECDC (2010) further barrier to testing is lack of information about where to obtain a test, what the results might mean and the facts of HIV disease.

A survey of Black African migrants living in the UK (Erwin, Morgan, Britten, Gray & Peters (2002) cited in ECDC (2010) reported concerns about where to obtain an HIV test; many were not aware that an HIV test can be obtained without the need of referral. European studies reported confidentiality to be a barrier to testing in migrant populations.

Studies of Black Africans living in the UK, (Burns Mrie, Nazroo, Johnson & Fenton (2007) and Prost, Sseruma, Fakoya, Arthur, Taegtmeier, Njeri et al (2007) cited in ECDC (2010) reported migrants found concerns about disclosure if they were seen accessing HIV or STI clinics, or through healthcare providers disclosing their status to community members.

#### **2.4.2 Barriers at the healthcare provider level**

According to ECDC (2010 :8) healthcare provider barriers consist primarily of discomfort when approaching the subject of HIV, lack of training to perform this testing and counselling, lack of knowledge on the part of healthcare providers about local disease prevalence, symptoms of undiagnosed infection and local guidance and policy on testing, logistical barriers such as cost and time constraints and cumbersome consent procedures, low knowledge levels about it resulting in poor risk assessment and discomfort approaching the subject of HIV and sexual

histories of patients. ECDC (2010:8). Lack of knowledge or information regarding HIV, including reasons for testing, symptoms of HIV infection and local HIV testing policies, were found to be a barrier to testing in European studies.

Studies of HIV testing in antenatal clinics in the UK (Meadows, Jenkinson, Catalan, Gazzard (1990) and Simpson, Johnstone, Boyd, Goldberg, Hart & Prescott (1998) cited in ECDC (2010) found the patients of midwives who doubt the benefits of HIV testing were less likely to accept a test when offered (ECDC,2010 :8). Also healthcare providers' discomfort or anxiety around HIV has been noted as a key barrier to offering testing to individuals in European studies.

A survey among general practitioners in the UK (Kellock & Rogstad (1998) cited in (ECDC (2010) reported raising the issue of HIV testing in primary care was associated with a high level of anxiety. The majority of general practitioners avoided rather than promoted the issue of HIV testing, even in high-risk groups. Another UK study of HIV testing strategies in antenatal services(Simpson, Johnstone, Boyd, Goldberg, Hart & Prescott (1998) cited in (ECDC (2010). found the uptake of an HIV test depends more on the attitude of the individual midwife than the method of offering the test and time spent on pre-test counselling.

In another study in Australia and New Zealand (Emerson, Goldberg, Vollmer-Conna & Post (2010) cited in (ECDC (2010 :9) barriers to testing have been reported among clinicians treating HIV indicator diseases, including discomfort with it and lack of time and skills required for pre-test counselling.

#### **2.4.3 Barriers at the institutional level**

According to ECDC (2010 :9) institutional barriers consist of lack of or poorly implemented HIV testing policies and programmes, lack of allocated resources, the presence of legal and financial obstacles in accessing care, for example among undocumented migrants and injecting drug users (2007) cited in ECDC (2010 :9) found the lack of political will, advocacy, as well as financial and human resources were factors contributing to late presentation and poor utilisation of HIV health and social care services by African migrants.

#### **2.5 . Factors that prevent migrants from accessing HIV services**

Factors that prevent migrants from accessing services broadly relate to policies and laws, service provision, migrant communities and wider society (ECDC TECHNICAL REPORT, 2009).

Between May and September 2008 The European Centre for Disease Prevention and Control (ECDC) commissioned a review of access to HIV prevention, treatment and care among



migrants to be part of a wider series of reports on migration and infectious diseases in the EU. Based on information gathered through a survey of respondents in the 27 EU member states and three EEA countries and through a literature review the ECDC Technical Report highlights factors that prevent migrants from accessing services relate to policies and laws, service delivery, migrant communities themselves and wider society. ECDC Technical Report points out policies to disperse migrants within countries limit access to prevention and treatment services. The report mentions that legal status (lack of residence status and health insurance) is most often a barrier to HIV treatment, particularly in new EU Member States. Furthermore, the report maintains that lack of culturally sensitive information in relevant languages; suitably trained professionals and services tailored to the specific needs of migrants are barriers to HIV prevention, treatment and care. The report claims that within migrant communities, culture, religion, fear of discrimination and limited knowledge of available services prevent access to services and that within the wider society, stigma and discrimination towards migrants prevent access to prevention and care services. The report points out that in particular the social circumstances of migrants are a specific barrier to accessing treatment (ECDC TECHNICAL REPORT, July 2009:5).

## **2.6 . The Challenge of HIV/AIDS and Refugees**

Several challenges limit the refugees' access to some HIV/AIDS services that already exist in their host countries. The main challenges are discussed below

### **2.6.1 Factors that place refugees at risk for HIV infection**

There are many factors that can contribute to the increased risk of HIV transmission among refugees. According to The President's Emergency Plan for AIDS Relief (February 2006) factors that place refugees at risk for HIV infection include the following: Displacement, social instability, increased mobility, sexual and gender-based violence, exploitation and abuse, poverty and food insecurity, lack of access to health services, and lack of linguistically and culturally appropriate health information.

Refugees are uprooted from their homes and communities and lose their livelihoods. The breakdown of social networks and institutions reduces community cohesion, weakening the social and sexual norms that regulate behaviour. Disruption to health and education services reduces access to HIV prevention information and commodities, sexual and reproductive health services, as well as HIV-related treatment and care for those who need it. Exposure to mass

trauma such as conflict can increase alcohol and other drug use and influence people's attitudes towards risk.

Conflict and displacement make women and children, particularly girls, disproportionately vulnerable to the risk of HIV. During conflict rape is often used as a weapon of war. Women and girls are also subject to sexual violence and exploitation in refugee settings. As refugees struggle to meet their basic needs such as food, water and shelter, women and girls are often forced to exchange sexual services for money, food or protection. Children living without parental support, whether due to separation from or death of family members are also particularly vulnerable to sexual and physical violence and exploitation.

### **2.6.2 Refugees and HIV/AIDS programmes**

According to UNHCR, national HIV programmes should ensure that person of concern are an integral part of national efforts to scale up access to HIV testing and counselling and more broadly, achieve universal access to its prevention, treatment, care and support (UNHCR 2009:19).

Refugee Rights (March 2008:13) points out that South Africans, recognized refugees and asylum seekers are all at risk of contracting HIV and suggests that those who want to know their infected status should have access to local VCT services. However, Refugee Rights maintains that since refugees and asylum seekers speak many different languages, they also may require confidential interpretation as part of their VCT process because they are also entitled to pre- and post-test counselling and follow up support after the test (Refugee Rights, March 2008:13).

UNAIDS Policy Brief: HIV and Refugees (2007:1) highlights refugees are no longer guaranteed the protection of their country of origin and that many host countries are already overburdened by the effect of HIV and are often unable or unwilling to provide the HIV related services refugees need and to which they have a right under international refugee and human rights law. UNAIDS Policy Brief: HIV and Refugees (2007:1) maintains these individuals often do not have access to HIV prevention commodities and programmes and the right to use basic related care and support is also rarely given adequate attention. Furthermore this UNAIDS brief (2007:1) points out that despite improvements in the availability of antiretroviral therapy in low- and middle income countries, very few refugees have access to the facilities.



UNAIDS Policy Brief: HIV and Refugees (2007:1) state refugees frequently face the stigma, both because of their status as refugees and because of the common misconception that HIV prevalence is higher among refugees than in host communities. Thus, UNAIDS Policy Brief: HIV and Refugees (2007:1) suggests the provision of a comprehensive and integrated national response that addresses the HIV-related prevention, treatment, care and support needs of refugees and host communities as the most effective way to reduce the risk of HIV transmission and address the effects thereof.

### **2.6.3 Obstacles to Meeting HIV/AIDS Needs of Refugees**

Several challenges limit the refugees' access to some HIV/AIDS services that already exist in their host countries. The President's Emergency Plan for AIDS Relief Report on Refugees and Internally Displaced Persons February 2006, highlights the mobility of some refugee, which poses a challenge to ensuring continuity of care, limited resources of both host countries and refugee relief organizations. The location of many refugees in rural and remote areas, which may limit their ability to access host country health services, especially beyond the most basic level, Poor roads leading to refugee camps, limiting the ability of service providers to provide health services, Language and skills barriers, including the limited availability of personnel who understand both HIV/AIDS and the languages and customs of the refugee and displaced populations, and omission of refugees from host governments' national strategic plans for health, particularly HIV/AIDS. (The President's Emergency Plan for AIDS Relief, February 2006:6).

### **2.7 Conclusion**

This literature review highlighted that VCT is an entry point for HIV prevention and care. Nonetheless, the literature review identified important barriers to VCT. Furthermore, the literature review described the main factors that increase HIV vulnerability among migrants and refugees and factors that prevent them from accessing HIV programmes including VCT in the host countries. Barriers to VCT exist at individual level, healthcare provider, and institutional level. Failure to addressing barriers to VCT in the context of refugee situation could be very harmful to both refugees and the host populations.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1. Research Design

A research project in many instances dictates the approach that will be used to gather information and then ultimately analyse the data, interpret the findings to provide a vehicle to satisfy the various objectives. In quantitative research the aim is to determine the relationship between an independent variable and a dependent or outcome variable in a population. Quantitative research designs are either descriptive (subjects usually measured once) or experimental (subjects measured before and after a treatment). Qualitative research is used to gain insight into people's attitudes, behaviours, value systems, concerns, motivations, aspirations, culture or lifestyles. Qualitative research involves the analysis of unstructured material, including customer feedback forms, reports or media clips (Babbie et al, 2001).

The present study was conducted within the qualitative paradigm. Henning et al (2004:3) defines a qualitative inquiry as “a research form, approach or strategy that allows for a different view of the theme that is studied and in which the participants have a more open-ended way of giving their views and demonstrating their actions”. Qualitative research is an “interpretative research approach relying on multiple types of subjective data and investigation of people in particular situations in their natural environment; the type of research relying on the collection of qualitative data (i.e., nonnumeric data such as words, pictures, images)” (Christensen et al., 2011:52).

#### 3.2. Data collection

Data were collected from refugees and asylum seekers from African Great lakes region living in Durban and from two VCT providers operating in Durban. Some of the refugees and asylum seekers cannot communicate in English but most of them speak Kiswahili. Therefore, the tools for collecting data from refugees and asylum seekers were translated from English into Kiswahili. A bilingual questionnaire was used and interviews and focus groups were conducted in Kiswahili and data collected were translated into English.

##### 3.2.1. In-depth interviews

According to Christensen et al. (2011: 56) an interview is a data collection method in which an interviewer asks the interviewee a series of questions often with prompting for additional information.

In-depth interviewing often involves qualitative data also referred to as qualitative interviewing. Patton (1987:113) suggests there are basic approaches to conducting qualitative interviewing namely, informational conversational interview where most of the questions will flow from the immediate context. The second approach is a guided interview that makes use of a checklist to ensure all topics are covered. Silverman (2000) consider the general interview guide approach is useful as it “allows for in-depth probing while permitting the interviewer to keep the interview within the parameters traced out by the aim of the study.” The interviews were conducted using an interview schedule translated from English into Kiswahili. These interviews assisted in the collection of information from participants who could not read and/or write.

### **3.2.2. Semi-structured questionnaires**

Christensen et al. (2011:56-57) define a questionnaire as a self-report data collection instrument completed by research participants. Semi-structured questionnaires comprise a mixture of closed and open questions.

Open-ended questionnaire were useful in collecting information from participants who can read and write. This approach allows less flexibility to the respondent, however, Patton 1987:112) argue this probing is possible depending on the interview and the skill of the interviewer.

### **3.2.3. Focus group**

According to Christensen et al. (2011:56) a focus group is a method of collecting data in a group situation where a moderator leads a discussion with a small group of people. Focus groups provides window into participants’ internal thinking and can obtain in-depth information. Furthermore, focus groups allow probing and allow quick turnaround. Two focus groups of 6 and 7 participants were conducted by the principal investigator who acted as moderator and an assistant who took notes of the proceedings. Participants were selected according to the guidelines of convenience sampling namely, those that were readily available. The focus groups were structured around a set of carefully predetermined questions on VCT.

## **3.3. Sampling**

The study population included refugees and asylum seekers from African Great lakes region living in Saint Georges, Durban. In addition, all participants ranged from 18 years or older and could speak English and/or Kiswahili.

The study used a purposive sampling that is a non-random sampling technique where a researcher specifies the characteristics of the population of interest and then locates individuals

who have those characteristics (Christensen et al 2011:159). In addition to a purposive sampling, the present study used an opportunistic sampling method. Accordingly opportunistic sampling it is method used in qualitative research that allows for identification and selection of useful cases during the conduct of a research study; it develops as the opportunity arises (Christensen et al 2011: 162). The purposive sampling and the opportunistic sampling were used because the researcher wanted to include participants of different characteristics (i.e. gender, age, literate/illiterate, language).

### **3.4. Data analysis**

Interviews and focus groups were translated from Kiswahili into English where the participants responded in Kiswahili and some editing was done. Interviews and focus groups were then transcribed verbatim and the transcripts were coded by hand. After awarding codes to different units of meaning, the related codes were then categorised.

### **3.5. Ethical consideration**

In this research, ethical issues were taken into consideration. Data collection was done after the researcher obtained the ethical clearance from Stellenbosch University. Ethics can be described a human concern of what is right and wrong, good and evil. What counts as good or evil varies across ages, cultures; there is a convergence which overrides what is known as cultural relativity (Babbie et al. 2001).

Ethical agreements that prevail in social research are (Babbie et al 2001):

- Voluntary participation – being included in a study disrupts the subject's regular activities and there should be measures to bring no harm on a personal level.
- No harm to participants – psychological damage can have far reaching consequences. The vulnerable group in society is in danger to be targeted and isolated.
- Anonymity and confidentiality – it is important to allow a faceless participant to allow for protection of outside influences. The information cannot be published and thereby expose the respondent.
- Deceiving subjects – a researcher should be honest with participants to adhere to ethical considerations.
- Analysis and reporting – honest reporting of findings should be followed at all times.

All participants were given a Participant Information Sheet written in both English and Kiswahili. The aim and objectives of the study was explained to the participants and they were informed their cooperation was voluntary. The researcher obtained written informed consent from every participant and their confidentiality and privacy was respected throughout the process of the study.

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### **3.8 Conclusion**

This chapter has discussed the methodology employed in this study. The study was conducted within the qualitative paradigm. The next chapter reports the study findings.

## **CHAPTER 4**

### **REPORTING OF RESULTS**

#### **4.1. INTRODUCTION**

The results are reported that were obtained from the administered questionnaire, the in-depth interviews and the focus group discussions. A purposive and an opportunistic sampling technique was selected and applied to select the participants. There were 39 participants who completed a questionnaire and 5 individuals were interviewed while 13 attended the focus group. The operational aspects of two VCT Services operating in Durban were evaluated. The respondents responsible for responding to the questionnaire to evaluate operational aspects of VCT Services were the VCT Service managers.

The reporting of results is divided into three sections: Section one presents the results obtained from closed questions from the questionnaire administered to the participants (refugees and asylum seekers) and interviews; Section two presents results obtained from open ended questions from the questionnaire administered to the participants (refugees and asylum seekers) and interviews and from the focus groups: Lastly section three presents the results from the questionnaire for evaluation of VCT Services.

The demographic characteristics of participants are shown in Table 4.1.

**Table 4.1:**  
**Demographic Characteristics of Participants**

Characteristics	Frequency	Percentage
<b>Age N=57</b>		
18 and above	57	100
<b>Occupation N=57</b>		
Car guards	5	9
Security officer	3	5
Hair dresser	5	9
Pizza Delivery Drivers	3	5
Religious Leaders	4	7
Professional	2	4
Student	3	5
Driver	1	2
Merchant	8	14
Cybercafé attendant	2	4
Others and/or unknown occupation	21	37
<b>Literacy N=57</b>		
Illiterate	9	16
Literate	48	84

## 4.2. RESULTS FROM CLOSED QUESTIONS

This section presents the results obtained from closed questions from the questionnaire administered to the participants (refugees and asylum seekers) and interviews.

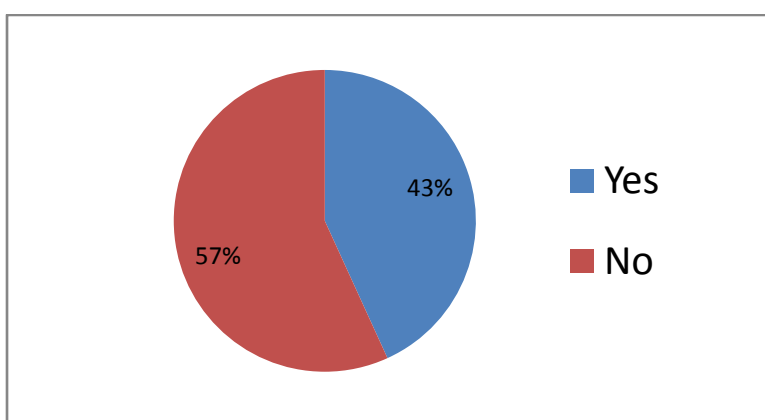
### 4.2.1. Information about VCT services available in Durban

Participants were asked if they have ever heard of HIV VCT Services available in Durban. Most of the respondents (57%) indicated they have never heard of the available services while 43% indicated that they have heard of what is available (Table 4.2 and Figure 4.1).

**Table 4.2:**  
**Aware of HIV VCT Services**

Have you ever heard of HIV VCT Services available in Durban? N=44	Frequency	Percentage
Yes	19	43
No	25	57

**Figure 4.1:**  
**Aware of HIV VCT Services**



#### 4.2.2. How the respondents got to know about HIV VCT

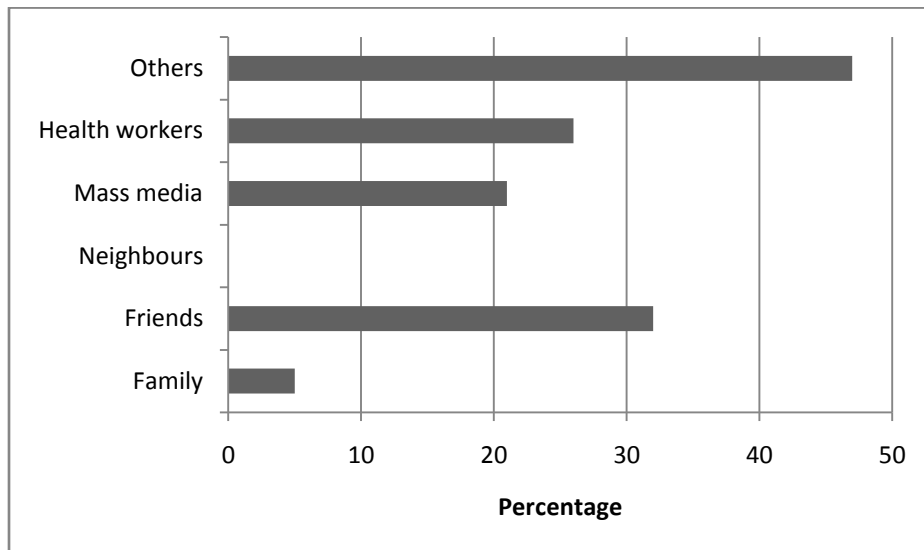
Regarding the sources of information on HIV VCT services available in Durban, Friends, Health workers and Mass media were the respondents' main source of information represented by 32%, 21%, and 26% respectively, while 5% of respondents claimed to have received information from Family whereas 47% of the respondents claimed to have received information from other sources (Table 4.3 and Figure 4.2). Other sources of information specified by respondents were peer educators, antenatal clinics, school, and religious meetings.



**Table 4.3:**  
**Information about VCT**

Where did you get information about VCT in Durban? N=19	Frequency	Percentage
Family	1	5
Friends	6	32
Neighbours	0	0
Mass media	4	21
Health workers	7	26
Others	9	47

**Figure 4.2:**  
**Knowledge about VCT**

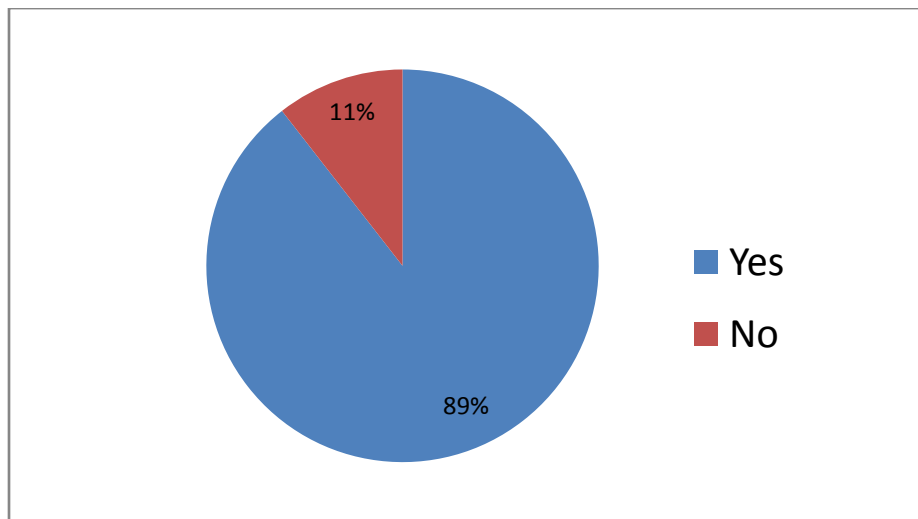


#### 4.2.3. VCT centres/services known by the respondents

Respondents who have ever heard of HIV VCT services available in Durban were asked if they could name the place where VCT service is offered in Durban. The majority of 89% could name places where VCT service is offered in Durban. The places named by respondents were Centre of Hope Clinic, DCC Hope Centre Clinic, Hospitals, and antenatal clinics (Table 4.4 and Figure 4. 3).

**Table 4.4:****Whether respondents could name place(s) where VCT Service is offered in Durban N=19**

Can you name the place(s) where VCT service is offered in Durban? N=19	Frequency	percentage
Yes	17	89
No	2	11

**Figure 4.3:****Whether respondents could name place(s) where VCT Service is offered in Durban N=19**

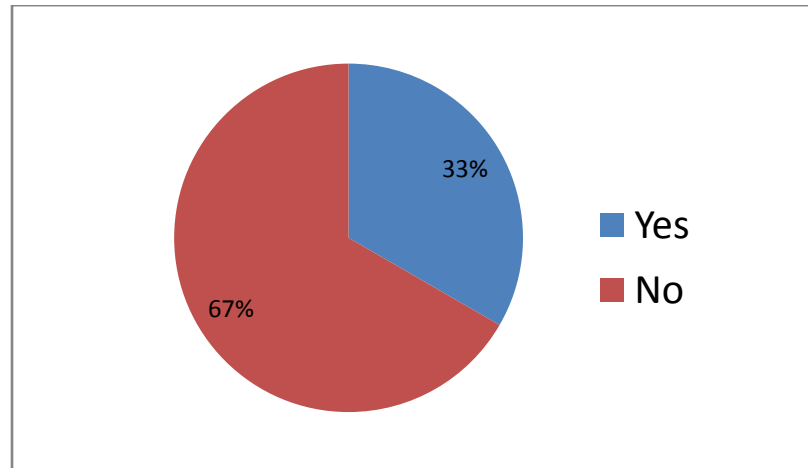
#### 4.2.4. Perceptions toward VCT in Durban

It was deemed necessary to establish whether the respondents would go for VCT in Durban. The majority of respondents indicated that they would not go for VCT in Durban, while 33% of the respondents indicated that they would go for VCT in Durban (Table 4.5 and Figure 4.4).

**Table 4.5:**  
**Whether respondents would go for VCT in Durban N=39**

Would you go for VCT in Durban? N=39	Frequency	Percentage
Yes	13	33
No	26	67

**Figure 4.4:**  
**Whether respondents would go for VCT in Durban N=39**



#### **4.2.5. To whom the participants would disclose their test results**

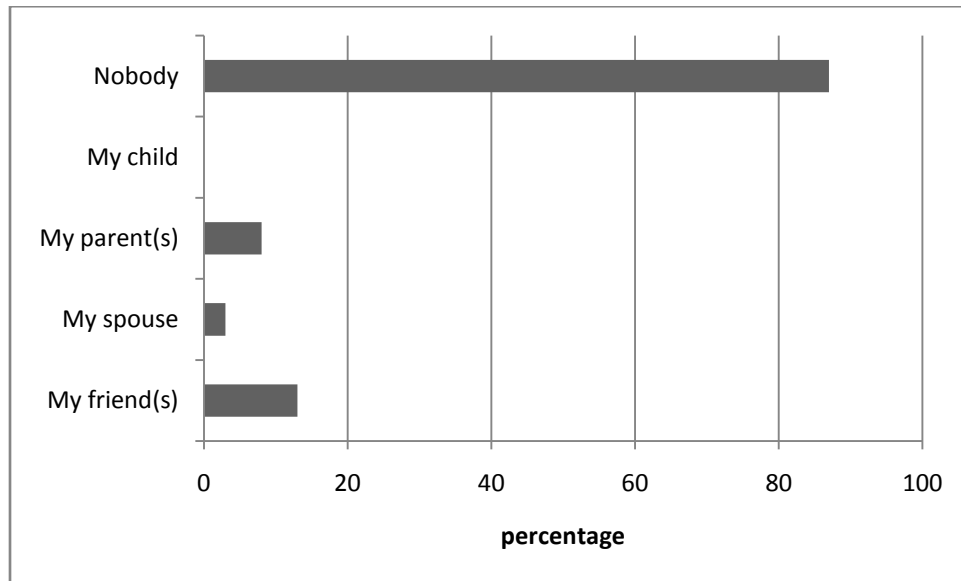
The participants were asked would they disclose their test results if they took a HIV test.

The great majority of 88% indicated that they would not disclose their results to anybody, 10% would tell their friends, 7% would disclose their results to their parents and 3% would inform their spouse. However, nobody would disclose it to their children (Table 4.6 and Figure 4.5).

**Table 4.6:**  
**Whom participants would reveal their results to N=39**

<b>If you took the test, whom would you reveal the results to? N=39</b>	Frequency	percentage
My friend(s)	5	13
My spouse	1	3
My parent(s)	3	8
My child	0	0
Nobody	34	87

**Figure 4.5:**  
**Whom participants would reveal their results to N=39**



#### 4.2.6. VCT Centre use

Participants were asked to indicate if they have ever visited a VCT Centre to get tested for HIV in Durban. A great majority of 86% of the respondents have never visited a VCT Centre to get tested for HIV in Durban, while 14% have visited a VCT Centre to get tested for HIV in Durban (Table 4.7 and Figure 4.6).

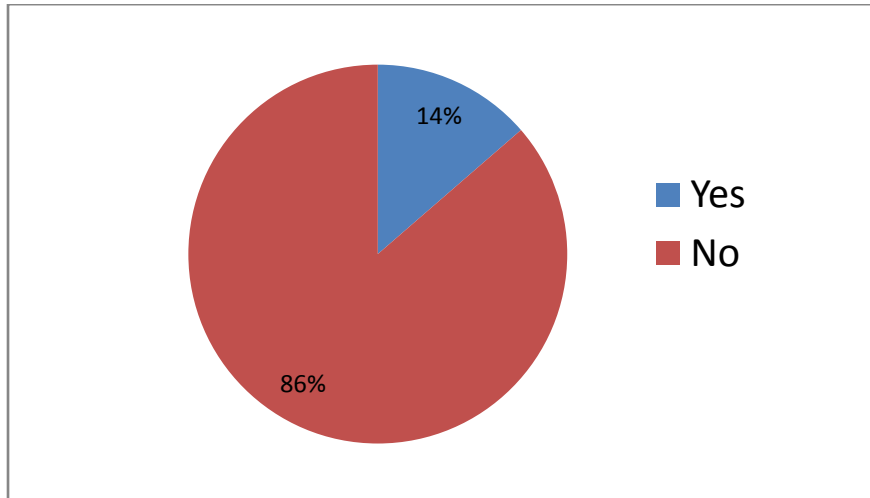
**Table 4.7:**

**Respondents who have ever visited a VCT Centre to get tested for HIV in Durban N=44**

Have you ever visited a VCT Centre to get tested for HIV in Durban? N=44	Frequency	Percentage
Yes	6	14
No	38	86

**Figure 4.6:**

**Respondents who have ever visited a VCT Centre to get tested for HIV in Durban N=44**



#### 4.2.7. Experience at a VCT Centre

It was necessary to establish whether respondents who have visited VCT Centres to get tested for HIV in Durban appreciated the service that they received at VCT Centres. Participants who have visited VCT Centres in Durban to get tested for HIV were asked whether they would return

to the same VCT Centre for HIV test. All the respondents said they would go back to get tested for HIV again at the same Centre they last tested at (Table 4.8).

**Table 4.8:**  
**Whether respondents would go back to get tested for HIV again at the same VCT Service where they last tested at N=6**

Would you go back to get tested for HIV again at the same VCT Service you last tested at? N=6	Frequency	Percentage
Yes	6	100
No	0	0

#### **4.2.8. Reasons for not visiting VCT Centre to get tested**

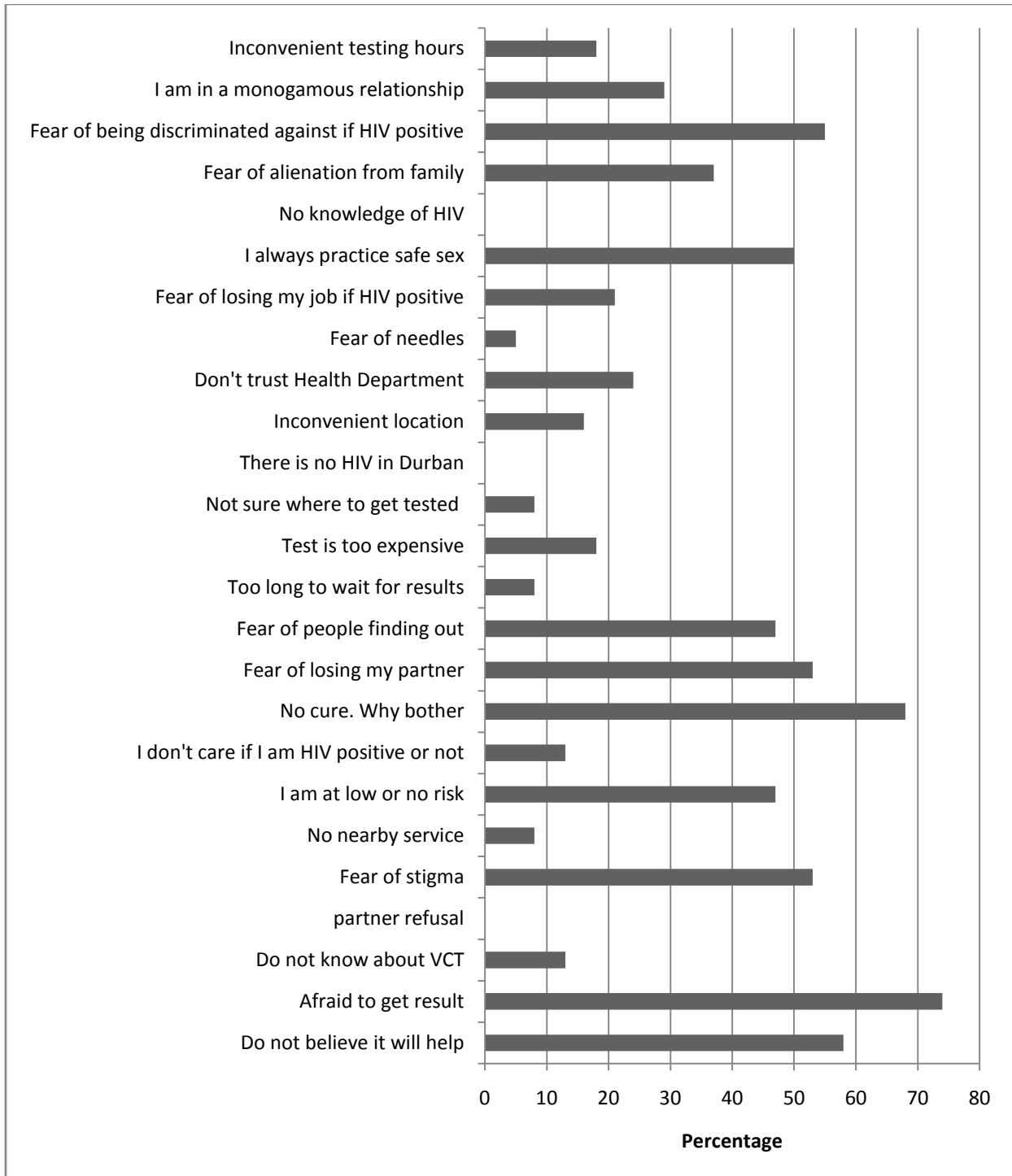
An interest was shown in determining participants' reasons for not visiting VCT Centre to get tested. The participants were asked who have never visited a VCT Centre to get tested for HIV in Durban to indicate the reasons why they have never visited a VCT Centre to get tested for HIV in Durban. The majority of respondents who have never visited a VCT Centre in Durban to get tested for HIV namely 74% indicated being afraid of the test results as a reason why they did not visit a VCT Centre to get tested in Durban. A number represented by 68% claimed they did not bother to visit a VCT Centre to get tested because there is no cure; 58% indicated they did not believe VCT will work; 55% feared being discriminated against if HIV positive while 53% said they feared stigma. Fear of losing my partner was also reported by 53% of the respondents. Half of the respondents 50% indicated they have never visited a VCT Centre to get tested in Durban because they always practice safe sex, while 47% of the respondents reported they have never visited VCT Centre to get tested in Durban because they were at low or no risk of infection. Again 47% indicated fear of people finding out as a reason why they did not visit VCT Centre to get tested for HIV in Durban.

Other reasons for not visiting VCT Centre to get tested for HIV in Durban given by participants were fear of alienation from family represented by 37%, being in a monogamous relationship was 29%, not trusting Health Department 24%, fear of losing their jobs if HIV positive 21%, inconvenient testing hours 18%, being expensive to take a test 18%, and inconvenient location was indicated by 16% (Table 4.9 and Figure 4.7).

**Table 4.9:**  
**Reasons for not visiting VCT Service to get tested for HIV for respondents who have never visited VCT service to get tested N=38**

<b>What are your reasons for not visiting VCT Service to get tested for HIV? N=38</b>	<b>Frequency</b>	<b>Percentage</b>
Do not believe it will help	22	58
Afraid to get result	28	74
Do not know about VCT	5	13
partner refusal	0	0
Fear of stigma	20	53
No nearby service	3	8
I am at low or no risk	18	47
I don't care if I am HIV positive or not	5	13
No cure. Why bother	26	68
Fear of losing my partner	20	53
Fear of people finding out	18	47
Too long to wait for results	3	8
Test is too expensive	7	18
Not sure where to get tested	3	8
There is no HIV in Durban	0	0
Inconvenient location	6	16
Don't trust Health Department	9	24
Fear of needles	2	5
Fear of losing my job if HIV positive	8	21
I always practice safe sex	19	50
No knowledge of HIV	0	0
Fear of alienation from family	14	37
Fear of being discriminated against if HIV positive	21	55
I am in a monogamous relationship	11	29
Inconvenient testing hours	7	18

**Figure 4.7:**  
**Reasons for not visiting VCT Service to get tested for HIV for respondents who have never visited VCT service to get tested N=38**





#### 4.2.9. Reasons why respondents think other refugees would not go for a HIV test at VCT Centre in Durban

The researcher also wanted to find out what the respondents regard as the reasons why other refugees would not go for a HIV test at VCT Centre in Durban.

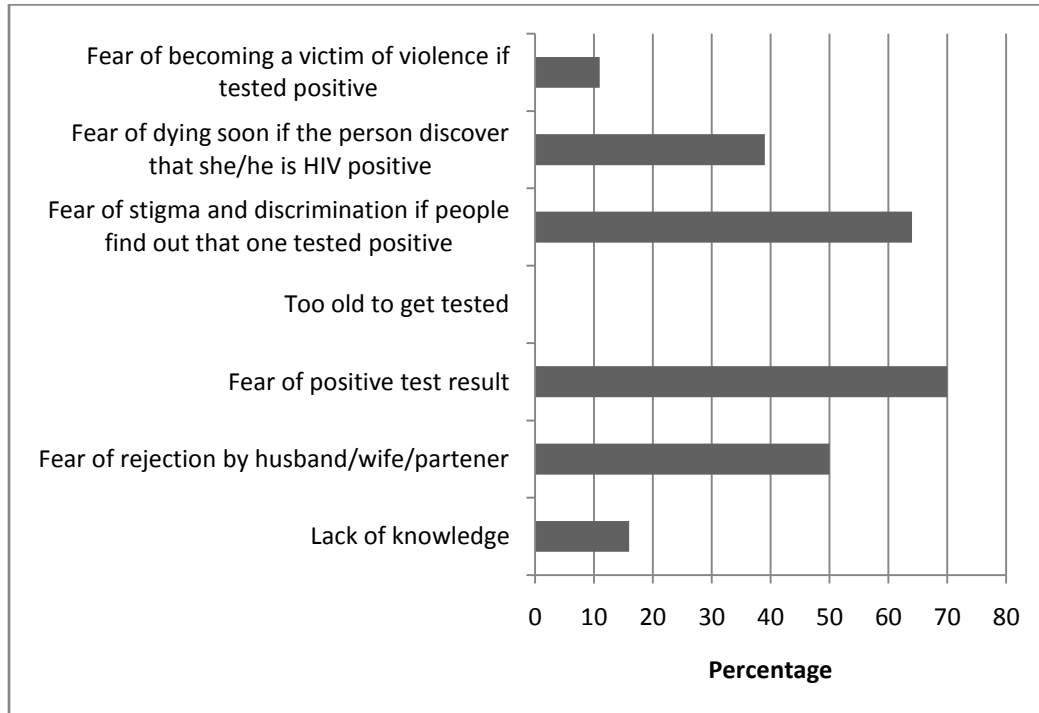
The majority of the respondents of 70% responded the fear of positive test result fear was the reason for not testing. Fear of stigma and discrimination if people find out was regarded as a reason by 64%. Fear of rejection by husband/wife/partner was also reported as a reason why refugees would not go for a HIV test at VCT Centre in Durban. Other reasons mentioned included fear of dying soon if the person discovers that she/he is HIV positive 39%, Lack of knowledge by 16%, and fear of becoming a victim of violence if tested positive was indicated by 11% (Table 4.10 and Figure 4.8).

**Table 4.10:**

**What participants think is the main reason why a refugee would not go for HIV test at VCT Centre in Durban N=44**

<b>In general, what do you think is the main reason why a refugee would not go for HIV test at VCT Centre in Durban? N=44</b>	<b>Frequency</b>	<b>Percentage</b>
Lack of knowledge	7	16
Fear of rejection by husband/wife/partner	22	50
Fear of positive test result	31	70
Too old to get tested	0	0
Fear of stigma and discrimination if people find out that one tested positive	28	64
Fear of dying soon if the person discover that she/he is HIV positive	17	39
Fear of becoming a victim of violence if tested positive	5	11

**Table 4.8:**  
**What participants think is the main reason why a refugee would not go for HIV test at VCT Centre in Durban N=44**



### 4.3 RESULTS FROM OPEN-ENDED QUESTIONS AND FOCUS GROUP

Part of the administered questionnaire (self-administered questionnaire) and in-depth interviews comprised open-ended questions. Furthermore, some of these open-ended questions used in the self-administered questionnaire and in the in-depth interview were also part of the Focus Group. Therefore, results from open-ended questions used in the self-administered questionnaire and in the in-depth interview and from the focus groups is presented.

#### 4.3.1 Information about HIV VCT Services available in Durban

##### Question 1: Have you ever heard of HIV VCT Services available in Durban?

There were four participants (One in the focus group 1 and three in the focus group 2) who have heard of HIV VCT Services available in Durban. However, the rest of the focus group participants said they have never heard of these services in Durban. One participant remarked: *“I only heard that there is VCT at Broad Street now in this discussion. I never heard of VCT Centres/Services available in this area before”*. (Participant Focus Group 1)

**Question 2: Where did you get information about VCT in Durban?**

Respondents who were aware of VCT Centres operating in Durban mentioned friends, health workers, posters, pamphlets, and fun walk organised by an NGO in Durban as their sources of information about VCT Service available in Durban

Some participants mentioned more than one source of their information about VCT.

**4.3.2 VCT Services known by the respondents**

**Question 3: Where do people go for VCT service in Durban?**

Participants mentioned Hospitals and Clinics as places to get the service.

**4.3.3 Experience at a VCT Centre**

**Question 4: Have you ever visited a VCT Centre to get tested for HIV in Durban?**

Only one participant claimed to have had VCT in Durban.

**Question 5: Would you go back to get tested for HIV again at the same Centre you last tested at?**

The lone participant who has had VCT in Durban said that he would go back for VCT at the same centre where he went before. He explained the reason why he would go back to the same centre as follows: *“The reception is good and the counsellor explained everything very well”*.

However, the same respondent was unhappy about the arrangement of the counselling room and the waiting room and said: *“I only have one problem: at the centre when you enter and come out the counselling and testing room people in the waiting room can see you and if the results are bad they can gossip about you”*.

Other participants could not comment on that because they never used the VCT service in Durban.

**Question 6: What are the requirements that a person must meet before a person can receive VCT in Durban?**

The lone participant who has had VCT in Durban said that at VCT Centre they asked him for his Identity Book then he produced his asylum seeker permit and he was allowed to proceed and took VCT.

#### 4.3.4 The perception toward VCT in Durban

##### Question 7: Would you go for VCT in Durban?

There were three participants from the focus groups 2 and one participant from focus group 1 who said that they would go for VCT in Durban.

##### Question 8: What are your reasons for not visiting VCT Centre to get tested for HIV?

The comments below reflect the reasons why respondents would not go for VCT in Durban: *“I cannot cope with HIV positive status”*.

*“Not knowing my status is better. If I can learn that I am HIV positive. Worries of being HIV positive can kill me soon”*.

*“I am already struggling for life here if I do the HIV test and test positive my situation will be worst”*

*“I never sleep around”*.

##### Question 5: What do you think is the reason why other refugees would not go for a HIV test at VCT service in Durban?

Regarding what participants think is the reason why refugees would not go for a HIV test at VCT service in Durban, respondents pointed out various reasons including the fear of the negative social consequences of HIV positive results (stigma, discrimination, and rejection, there were to responses: *“People do not want to be rejected by the community, if people know that you are HIV positive they do not treat you as a normal person”*.

*“If these Swahili people (refugees and asylum seekers) learn that you are HIV positive, you will be the talk of the town”*.

Another reason mentioned was low-risk perception as religious refugees may perceive themselves as having a low risk of HIV infection. A respondent remarked: *“We have a very religious community many refugees are Christians others are Muslim. They behave very well and they don’t engage in promiscuous sexual activities. Obviously they do not have HIV then why would they go for a Test?”*

Equally important, another respondent pointed out their risky sexual behaviour as a reason why refugees do not go for VCT: *“There are many People here who engage in promiscuous sexual activities and they do not want to confirm their HIV positive status”*. Participant focus group 1

Realising there is no cure for HIV was also mentioned as a reason why refugees would not go for VCT: *“There is no point of undertaking VCT because a person may undertake VCT and learns that he/she is HIV positive, but still there is no cure”*. Participant focus group 2

Inconvenient VCT Service location and inconvenient testing hours were also cited as reason why refugees would not go for VCT: *“Refugees work from early in the morning until late in the night to put bread on the table. Many refugees work as security officers or car guards, some run small business others work in the shops. If they go to VCT during the working hours, they lose their income of the day”*.

**Question 6: What are the challenges facing refugees in accessing VCT services in Durban? Is there any cultural, religious legal/immigration practice/issue or service delivery related problem in the area that could prevent VCT service utilization among refugees and asylum seekers living in Durban?**

The lone participant who has had VCT in Durban said: *“At VCT service, everything is done in English or isiZulu. It can be impossible for many refugees who do not speak any of these languages since there is a pre-test counselling and a post-test counselling and it is done in English or isiZulu”*.

The lone participant who has had VCT in Durban added: *“Refugees who are still sorting out their papers cannot access VCT because at VCT they ask for a South African Identity Document or a refugee document”* The lone participant who has had VCT in Durban

Participants mentioned information on HIV VCT does not reach the refugee community. They pointed out sometimes they get leaflets, pamphlets and see posters at clinics but some people cannot read, and other cannot understand the language in which the information is written.

#### **4.3.5 Desired improvements**

**Question 6: What could be done to encourage refugees and asylum seekers living in Durban to go for VCT?**

Respondents suggested the VCT Services work with Churches, Mosques and Department of Home Affairs Refugee Reception Office in promoting VCT among refugees.

The following two responses were recorded: *“Hundreds of refugees sit at Department of Home Affairs Refugee Reception Office every day. They should be multimedia campaign on HIV/AIDS*

*at refugee reception centres. VCT Service should use Department of Home Affairs Refugee Reception Office to screen films about HIV/AIDS and to inform refugees about VCT.”*

*“Because faith leaders are highly respected among refugee community, the VCT Services should work with refugees Christian faith leaders and Muslim faith leaders, and train them on issues around HIV/AIDS then they can work together to promote VCT in the churches and Mosques as faith leaders have access to many refugees, and they can speak English and our Kiswahili.”*

Respondents also suggested VCT Services should be offered even on weekends and even after hours to accommodate those who are working who do not get time during working hours.

**Question 7: What are your opinions about how VCT service should be delivered to meet the demand of refugees and asylum seekers community in Durban?**

The respondents were asked to provide areas that need to be improved to make the service both effective and efficient respondents mentioned working hours and convenient location of VCT centre: *“VCT centre should be a place where there are other activities taking place and not a place known for just testing so that when you go there people will not know the real reason of going there”.*

Most of the respondents stressed VCT centres should have a counsellor who can speak a language that refugees will understand: *“They should involve some refugees to offer VCT so that those who cannot communicate in English and isiZulu can also benefit from VCT”.*

**4.4 RESULTS FROM THE EVALUATION OF OPERATIONAL ASPECTS OF THE VCT SITES AND SERVICES IN DURBAN**

In this study part of UNAIDS tool for VCT site evaluation was adapted for use in evaluating the operational aspects of two VCT Services in Durban.

**4.4.1 Services offered**

Both VCT Services offered pre-test counselling, post-test counselling, on-going counselling, HIV testing, and HIV diagnostic counselling (without testing)

**Table 4.11:****Services offered at VCT Sites and the number of VCT Sites offering the services N=2**

<b>Services offered at VCT Sites</b>	<b>Number of Sites offering the services N=2</b>
Pre-test counselling	2
Post-test counselling	2
On-going counselling	2
HIV testing	2
HIV diagnostic counselling (Without testing)	1

**4.4.2 Opening times**

Both VCT Services were open on a daily basis (Monday – Friday) and operated during normal office hours. In addition one of the VCT was open on Saturdays.

**Table 4.12:****Opening times**

<b>Are you open at any of the following times? N=2</b>	<b>No</b>	<b>Yes</b>
Early evening (after 17:00)	2	0
Lunch hour	0	2
Weekends	1	1

**4.4.3 Appointment system**

At one VCT Service appointment was not required and patients were served on a first come first serve basis. On the contrary the other VCT service had an appointment system but if clients came without an appointment they were usually seen the same day.

**4.4.4 Adequacy of space to ensure counselling sessions can be private**

At both VCT there was adequate space for counselling. VCT sites had a closed area for counselling and testing.

*“We have 4 rooms that are used for counselling. For the safety of our female counsellors, we have a window in the doors.” (VCT Manager)*

#### **4.4.5 Waiting area**

Both sites had a waiting area, where clients seat while waiting.

*“It is an open area with 20 chairs and we have a television in the area.” (VCT Manager)*

#### **4.4.6 Steps that have been taken to ensure confidentiality**

Both sites had a written policy on confidentiality and at both sites counsellors have received specific guidance on confidentiality. In addition, clients’ files are kept in a locked filing cabinet.

*“All our clients have files which are kept in a file cabinet and no unauthorised person can reach them.” (VCT Manager)*

*“Counselling rooms are private, Files are kept in a locked cupboard, and Electronic database is password protected” (VCT Manager)*

#### **4.4.7 Referral system**

Both VCT sites already had working relationship with other Service providers like Medical services, Social services, other counselling services, Family planning services, TB/chest clinic, STI services, Spiritual/religious groups.

**Table 4.13:**

#### **Referrals to other services**

<b>Do you refer to any of the following? N=2</b>	<b>Yes</b>	<b>Occasionally</b>	<b>No</b>
Medical services (e.g. clinics/hospital)	1	1	0
Social services	1	1	0
Other counselling services		2	0
Family planning services	1	1	0
TB/chest clinic	1	1	0
STI services	1	1	0
Spiritual/religious groups	1	1	0



#### **4.4.8 How the referral systems works**

VCT Services used a formal letter when referring clients to other services. However, although one manager said that their clients always got help from the services where they referred them to, the Manager at the other VCT Service indicated there was lack of feedback from the services where they referred their clients.

*“We have a good relationship with other stakeholders so we do not have problems in terms of referring our clients. Our clients always get help” (VCT Manager)*

*“We have a form which has a place for the referral institution to respond to us. However, most places do not send the client back with information on the sheet we have sent.” (VCT Manager)*

#### **4.4.9 Adequacy of referral services available, particularly for the needs of people who test positive**

At both sites the Managers stated there were adequate referral services available for seropositive people. However, one Manager noted there were few social workers who could assist with the social issues.

*“There are adequate referrals. Our government has made it easier to have an access to health facilities”. (VCT Manager)*

*“At the moment, there are many places providing medical assistance, however, few social workers who can assist with the social issues.” (VCT Manager)*

#### **4.4.10. Waiting time for HIV test results**

Both VCT Services used rapid HIV tests and they were able to provide HIV test results within 10-20 minutes. The most frequently used HIV tests were rapid test. However, a CD4 test had a turnaround time of 72 hours.

*“The waiting time is 10-15 minutes when the rapid test is done.” (VCT Manager)*

*“We utilise Rapid HIV tests which provide results within 20 minutes. We do CD4 tests which have a turnaround time of 72 hours.” (VCT Manager)*

#### **4.4.11. Eligibility for both refugees and local populations to the services offered**

*“We see anyone” (VCT Manager)*

#### **4.4.12. The next step in treatment if a refugee is found to be HIV positive**

*“We would do a CD4 to assess for eligibility for HAART- If eligible we would refer to a local clinic or hospital or the clients choice. If they are not eligible we would keep them on the wellness programme and do frequent CD4 tests and provide on-going counselling and vitamin and cotrimoxazole prophylaxis.” (VCT Manager)*

#### **4.4.13. Cost**

At both sites the service is free of charge. Counselling, testing, and on-going counselling were free of charge.

#### **4.4.14. VCT promotion**

Both sites had posters written in English and isiZulu and they advertise in their churches. One VCT also advertised VCT through outreach programs. Furthermore both sites use electronic media to promote VCT services.

*“Individuals find out about our services mainly via word of mouth but we are also on a few internet websites that promote VCT services, we do community outreaches, we print brochures.” (VCT Manager)*

#### **4.4.15. The requirements that a person must meet before a person can get tested at the VCT Service**

*“They must be over 12 years if consenting themselves for a test or have a parent if less than 12 years”( VCT Manager)*

#### **4.4.16. The challenges facing refugees in accessing VCT services**

*“Language is a barrier at our clinic as the counsellors can only converse in English, Afrikaans and Zulu or Sotho. They also encounter problems when referred to district level hospitals in the area.”(VCT Manager)*

#### **4.4.17. Opinions about how VCT service should be delivered to meet the demand of refugees and asylum seekers community in Durban**

*“Probably, mobile services with a translator for French and Portuguese as well.” VCT Manager*

## **4.5 CONCLUSION**

After the results have been discussed and placed in context of the research paradigm a final comprehension of the value of the project is presented. Research is only of value if it can be extrapolated and present opportunities to look at the road ahead through sound recommendations.

## CHAPTER 5

### DISCUSSION

#### 5.1 INTRODUCTION

Research is of value once the data has been collected and manipulated to present it in a meaningful manner. After the data was collected and translated into visual aids the final step in a project is to discuss the findings and place it in context with regards to the formulated objectives. This study sought to determine the barriers to VCT among refugees and asylum seekers from the African Great lakes region living in Durban in order to provide guidelines for interventions.

The following objectives were formulated to provide guidance for the practical fieldwork and in the final instance to interpret the findings in a meaningful discussion. The discussion will be based on the objectives, however, to ensure a logical progression through the arguments there will not be chronological evolution.

- To assess the operational aspects of VCT centres/services in Durban
- To determine the attitudes and the perceptions of the refugees and asylum seekers toward VCT and VCT centres/services in Durban
- To assess the awareness of VCT centres/services available in Durban among refugees and asylum seekers
- To provide suggestions from refugees and asylum seekers that could promote voluntary counselling and testing among this community
- To provide possible guidelines/strategies that could be used at the VCT Centre/services to improve access and utility of VCT by refugees and asylum seekers

#### 5.2 Objective 3

##### **To assess the awareness of VCT centres/services available in Durban among refugees and asylum seekers**

This study found a low level of awareness of VCT Services available in Durban among the participants. This is consistent with a survey of black African migrants living in the UK. Erwin,

Morgan, Britten, Gray and Peters (2002) (cited in ECDC, 2010:8) reported many black African migrants living in the UK were not aware that an HIV test can be obtained without the need of a referral. Furthermore, European studies reported that the lack of information about where VCT is offered is a barrier to testing (ECDC, 2010:8).

The study revealed participants who have heard of VCT Services available in Durban became aware of this information from friends, health workers, mass media and family. Others sources of information specified by participants were posters, pamphlets and fun walk organised by an NGO in Durban.

In addition the study found the majority of respondents who have heard of VCT services available in Durban could name the place(s) where they could receive attention. This showed that the media through which participants received the information about VCT services in Durban were effective as the individuals could take action. However, the study did not establish whether, these media informed participants on the operational aspects of the VCT services.

Furthermore, the study revealed that not having a refugee permit was also a challenge facing these people in accessing VCT Services in Durban. A participant said: *“Refugees who are still sorting out their papers cannot access VCT because at VCT they ask for a South African Identity Document or a refugee document.”* Consistent with these findings, in European studies, “Legal status was mentioned most often as an obstacle to accessing HIV treatment” (ECDC 2009:6).

### **5.3. Objective 2**

#### **To determine the attitudes and the perceptions of the refugees and asylum seekers toward VCT and VCT centres/services in Durban**

The study found that the majority of respondents would not go for VCT in Durban as only 30% of the respondents (N = 52) said they would go for VCT in Durban. The study also revealed a great majority of participants 88% (N=57) have never visited a VCT Centre to get tested for HIV in Durban.

This study found participants who have had VCT in Durban were satisfied with the services offered where they last tested in Durban since all participants who have had VCT in Durban (N = 6) said that they would go back to get tested for HIV again at the same place where they last tested. This indicated a possible good and effective service is delivered at VCT Services in

Durban. A participant of the focus group explained: *“The reception is good and the counsellor explained everything very well”*. However, the same respondent was unhappy about one problem: The arrangement of the counselling room and the waiting room. He said: *at the centre when you enter and come out the counselling and testing room people in the waiting room can see you and if the results are bad they can gossip about you”*. It must be noted that although a participants explained the reason why he would go back to get tested at the same VCT Service where he last tested, and that although going back to the same VCT Service where one tested before can be an indication of no strong barriers to VCT from the VCT provider, this study did not specify the reasons why participants would go back to get tested for HIV again at the same VCT Services where they last tested in Durban.

This study found that fear of the HIV test results was the dominant reason for not visiting a VCT Service to get tested for HIV in Durban. The study also found realising there is no cure and not believing that VCT will work were reasons for not visiting a VCT Service to get tested. Similar findings have been reported in a European study (de Wit, Adam (2008) (in ECDC 2010:8) that one is more motivated to undergo HIV test when one perceives a benefit to diagnosis. Similarly, studies of HIV testing in antenatal clinics in the UK (Erwin, et al. 2002, Meadows et al. 1990 cited in ECDC 2010:8) found the patients of midwives who doubt the benefits of HIV testing were less likely to accept an HIV test offered.

The study also revealed that fear of being discriminated against if HIV positive, fear of stigma, fear of alienation from family, fear of people finding out, fear of losing one’s partner, fear of becoming a victim of violence if tested positive were participants’ reasons for not visiting a VCT Service to get tested for HIV in Durban. According to (ECDC, 2010:8) fear was highlighted by five European studies as a significant barrier testing. de Wit, Adam (2008) (in ECDC 2010:8) reported that fear of the negative social consequences of a positive diagnosis (stigma, discrimination, rejection) was more important than fear of death or illness among all population, including migrants. Equally important, a systematic review (Mahajan 2008 cited in ECDC 2010:8) highlighted the fear of HIV related stigma is strongest amongst those dealing with other pre-existing stigmas, such as that associated with being a migrant.

This study also found fear of dying soon if the person discovers that she/he is HIV positive, was a barrier to VCT. This is supported by Deblonde et al 2010 (in ECDC 2010:8) “the perception of HIV infection as a deadly disease rather than a manageable condition was more common among migrant populations than among non-migrants”.

This study also revealed that always practicing safe sex, low-risk perception on the one hand and risky sexual behaviour on the other hand, being in monogamous relationship, were reasons why refugees would not go for VCT in Durban. Perception of individual risk as an important barrier to testing has also been demonstrated in thirteen European studies (ECDC, 2010:7). Findings from studies (Deblonde et al. 2010, de Wit et al. 2008, Prost 2008, Delpierre et al. (2007 cited in ECDC 2010:7) showed that perception of risk is highly influential in an individual's decision to accept an HIV test, they highlighted that people who do not perceive themselves to be at risk of infection are less likely to test (ECDC, 2010:7).

Consistent with the findings in a survey (Mikolajczak 2006 (cited in ECDC 2010:8) of Dutch MSM, respondents identified low-risk perception as a reason why they had never undergone an HIV test although over half of them reported risky sexual behaviour.

Likewise, two studies of sexually transmitted infection (STI) clinic attendees in the Netherlands and the UK revealed that those who had engaged in higher risk behaviours appeared less likely to opt for an HIV test (Van der Bij et al. 2008, Tipnis and Fox (2006) (cited in ECDC, 2010:8).

According to the results of the study, not trusting health department was another reason for not visiting a VCT Service to get tested for HIV in Durban cited by participants, which is consistent with two studies (Manirankunda 2009, Nnoaham (2006) (cited in ECDC 2010:8) they revealed that fear of stigma and negative response from healthcare providers were also barrier to HIV testing for migrant populations.

Other reasons attributed to not visiting a VCT Service to get tested for HIV cited by participants were: fear of losing one's job, inconvenient testing hours, inconvenient location, not careering if one is HIV positive or not, not knowing about VCT, being unsure where to get tested, and the perception that VCT was expensive.

According to ECDC (2010:8) lack of knowledge or information regarding HIV, including reasons for testing, symptoms of HIV infection and local HIV testing policies were found to be a barrier to testing in eleven European studies.

Results that emerged from this study also revealed the perception of being HIV positive as a death sentence, fear of failure to coping with results if HIV positive, fear of worries of being HIV positive, were barriers to VCT. The study also indicated that language was a challenge facing refugees in accessing VCT Services in Durban as one participant said: *"At VCT Service, everything is done in English or isiZulu. It can be impossible for many refugees who do not*

*speaking any of these languages since there is a pre-test counselling and a post-test counselling and it is done in English or isiZulu*". ECDC (2010:8) suggest that HIV prevention and testing messages, including the benefits of knowing HIV status, need to be tailored to the cultures of those receiving the messages.

Equally important, the study revealed that written information on HIV VCT delivered by means of leaflets, pamphlets and posters does not reach part of the refugee community because some refugees cannot read and others cannot understand English and isiZulu the languages in which the information is written. However, "there is good evidence that use of mass media in HIV testing campaigns increases HIV testing uptake" (ECDC, 2010:10). "A meta-analysis of fourteen studies in developed countries (seven of which from the UK) that compared media interventions with a control in relation to promotion of HIV testing found that all individual studies results showed positive impacts of mass media on HIV testing" (ECDC, 2010:10), and "A review of 29 media interventions in developed countries (including 17 from the UK and one from France) reporting outcomes of HIV testing campaigns found an average 53% increase in the number of HIV tests after implementation of the media campaigns." (ECDC, 2010:10).

#### **5.4 Objective 1**

##### **To assess the operational aspects of VCT centres/services in Durban**

The evaluation of operational aspects of the two VCT sites and Services in Durban revealed that both VCT services offered pre-test counselling, post-test counselling, on-going and HIV diagnostic counselling (without testing). Also the evaluation of operational aspects of the two VCT sites and Services in Durban revealed that both VCT services opened on a daily basis (Monday – Friday) and operated during normal office hours and that one of the VCT Services opened also on Saturdays. Furthermore, this evaluation of operational aspects of the two VCT sites and Services in Durban established that one VCT service did not have an appointment system and therefore the clients were served whenever they came and that even at the VCT service that had an appointment system the clients who came without an appointment were served the same day. It emerged from the evaluation of operational aspects of the two VCT sites and Services in Durban that both VCT services had adequate space to ensure counselling sessions could be private and that both sites had waiting area where clients sat while waiting to undergo VCT.



It also emerged from the evaluation of operational aspects of the two VCT sites and Services in Durban that both VCT Services ensured confidentiality (There was adequate space to ensure counselling sessions could be private as the VCT Services had private closed counselling rooms, clients' files were kept in a locked cupboard or in filing cabinet where no unauthorised person could reach them, and electronic database was password protected at the VCT Service that used computers).

The results of this evaluation of operational aspects of the two VCT sites and Services in Durban showed that both VCT Services had adequate referral system. VCT Services referred their clients to other service providers like Medical services, Social services, other counselling services, Family planning services, TB/chest clinic, STI services, and Spiritual/religious groups.

The evaluation also showed VCT Service used rapid tests and they were able to provide HIV test results within 10-20 minutes and that a CD4 test had a turnaround of 72 hours.

Furthermore, the results showed that both refugees and local populations were eligible to VCT. However, it was required the clients be over twelve years old if consenting themselves for a test or be accompanied by a parent if less than twelve years old. The results also revealed that VCT was free of charge.

It emerged from this evaluation of operational aspects of the two VCT sites and Services in Durban that if a refugee was found to be HIV positive a CD4 would be done to assess for eligibility for HAART and if eligible, VCT Service would refer him/her to a local clinic or hospital or the client choice. If he/she was not eligible VCT would keep him/her on the wellness programme and do frequent CD4 tests and provide on-going counselling and vitamins and cotrimoxazole prophylaxis. However, this evaluation of operational aspects of the two VCT sites and Services in Durban revealed that there were also challenges facing refugees in accessing VCT Services as one VCT Manager mentioned: *“Language is a barrier at our clinic as the counsellors can only converse in English, Afrikaans and Zulu or Sotho. They also encounter problems when referred to district level hospitals in the area.”*

Another challenge related to the operational aspects of VCT sites and Services in Durban was service promotion as the results showed that VCT Services advertised their services in two languages English and isiZulu by means of posters pamphlets, brochures, internet and community outreaches to promote their Services, and respondents claimed that information on

VCT did not reach the refugees who could not read and and/or refugees who could not understand the language in which the information was written.

#### **5.5 Objective 4**

##### **To provide suggestions from refugees and asylum seekers that could promote voluntary counselling and testing among this community**

Respondents in this study suggested that VCT Services work with Churches, Mosques and Department of Home Affairs Refugee Reception Office in promoting VCT among refugees.

The following two responses were recorded: *“Hundreds of refugees sit at Department of Home Affairs Refugee Reception Office every day. They should be multimedia campaign on HIV/AIDS at refugee reception centres. VCT Service should use Department of Home Affairs Refugee Reception Office to screen films about HIV/AIDS and to inform refugees about VCT.”*

*“Because faith leaders are highly respected among refugee community, the VCT Services should work with refugees Christian faith leaders and Muslim faith leaders, and train them on issues around HIV/AIDS then they can work together to promote VCT in the churches and Mosques as faith leaders have access to many refugees, and they can speak English and our Kiswahili.”*

Respondents also suggested VCT Services should be offered even on weekends and after hours to accommodate those who are working who do not get time during working hours.

One respondent also suggested the following to make the service both effective and efficient: *“VCT centre should be a place where there are other activities taking place and not a place known for just testing so that when you go there people will not know the real reason of going there”.*

Moreover, most of the respondents stressed that VCT centres should have a counsellor who can speak a language that refugees will understand: *“They should involve some refugees to offer VCT so that those who cannot communicate in English and isiZulu can also benefit from VCT”.* One VCT Manager suggested mobile services with a translator for French and Portuguese to deliver VCT Services that meet the demand of refugees and asylum seekers community in Durban.

## **5.6 Conclusion**

This chapter has presented the study results and analysis of the data generated from the questionnaires completed by the respondents.

## **CHAPTER 6**

### **CONCLUSION**

This chapter presents the conclusion, highlights the limitations of the study and presents recommendations to increase VCT utilization among refugees from African Great Lakes Region living in Durban. The discussion was based on the objectives, however, to ensure a logical progression through the arguments there was not chronological evolution.

#### **6.1 CONCLUSION**

The study determined the barriers to Voluntary Counselling and Testing among refugees and asylum seekers from African Great Lakes Region living in Durban in order to provide guidelines for interventions.

The study showed a low level of awareness of VCT services available in Durban among the participants.

Results of the study indicated that there were negative attitudes among refugees towards VCT in Durban. However, the study found satisfaction with service received among participants who have had VCT in Durban.

Fear was the dominant barrier to VCT among participants. It included fear of the HIV positive status as a death sentence, fear of stigma and discrimination and fear of rejection.

The study also revealed that realising there is no cure, low-risk perception on the one hand and risky sexual behaviour on the other hand, not trusting health department, inconvenient testing hours, inconvenient VCT sites location, not caring if one is HIV positive or not, not knowing about VCT, being unsure where to get tested, and the perception that VCT was expensive were some of the most important barriers to VCT.

The study also indicated that language was a barrier to accessing VCT Services and information in Durban. Furthermore the study revealed that not having a refugee permit was a barrier to accessing VCT Services in Durban.

In view of the above, the study formulated recommendations that could be used in designing interventions that increase VCT utilization among refugees from African Great Lakes Region living in Durban. These would focus on VCT promotion and reducing HIV/AIDS related fear, stigma and discrimination.

## **6.2 LIMITATIONS OF THE STUDY**

There are limitations that were identified during the course of the study that need to be taken into account in interpreting the study results.

The data were collected from only 57 refugees and asylum seekers from African Great Lakes region living in the Saint Georges area in Durban. Therefore, the findings might not be generalizable to refugees and asylum seekers from African Great lakes region living in other areas of Durban or to refugees from regions other than the African Great lakes region.

The evaluation of operational aspects of the VCT sites and Services in Durban was conducted for two VCT only and they were both Free-standing VCT sites. In other words, the evaluation of the VCT sites and Services did not include VCT services within the public hospitals and other public Health centres, public Clinics and Private Clinics or private hospitals. Therefore, the findings from VCT sites might be limited to the two sites where the evaluation was conducted and should be generalised with caution.

## **6.3 RECOMMENDATIONS**

Based on the findings of this study the research recommends the following to improve the use of VCT service in refugees and asylum seekers from African Great lakes region living in Durban.

- More information on HIV/AIDS and VCT should be provided to refugees
- Provide posters and reading material in Kiswahili or other language used by refugees
- They should be multimedia campaign on HIV/AIDS at refugee reception centres. VCT Service should use Department of Home Affairs Refugee Reception Office to screen films about HIV/AIDS and to inform refugees about VCT.
- The VCT Services should work with refugees Christian faith leaders and Muslim faith leaders, and train them on issues around HIV/AIDS then they can work together to promote VCT in the churches and Mosques as faith leaders have access to many refugees, and they can speak English and Kiswahili.
- VCT Services should be offered even on weekends and even after hours to accommodate those who are working who do not get time during working hours.

- VCT site should be a place where there are other activities taking place and not a place known for just testing so that when you go there people will not know the real reason of going there
- VCT centres should have a counsellor who can speak a language that refugees will understand; they should involve some refugees to offer VCT so that those who cannot communicate in English and isiZulu can also benefit from VCT.
- Provide Mobile VCT units with a translator to deliver VCT Services that meet the demand of refugees and asylum seekers community in Durban.
- VCT services should engage with policy makers on how undocumented refugees could access VCT. VCT should be made accessible to everybody.
- VCT services should work together with refugees by training refugees so that they can be active as peer educators
- Develop comprehensive VCT promotion campaign to reduce the fear for HIV positive results. This campaign could include a focus on the benefits of undergoing VCT like access to early medical care including ARVs, preventive therapy for TB, early management of opportunistic infections, and other benefits.

## REFERENCES

UNAIDS (2010) Global Report

[http://www.unaids.org/documents/20101123\\_GlobalReport\\_em.pdf](http://www.unaids.org/documents/20101123_GlobalReport_em.pdf)

Esmeralda Mariano(2005), Clients' perceptions of HIV/AIDS Voluntary Counselling and Testing (VCT) in Mozambique, Eduardo Mondlane University, Maputo, Mozambique ,

[www.gfmer.ch/PGC\\_RH\\_2005/pdf/HIV\\_Mozambique\\_R.pdf](http://www.gfmer.ch/PGC_RH_2005/pdf/HIV_Mozambique_R.pdf)

Bwambale et al; (2008) BMC Public Health 2008, 8:263 Voluntary HIV counselling and testing among men in rural western Uganda: Implications for HIV prevention

<http://www.biomedcentral.com/1471-2458/8/263> 23-3-2011

UNAIDS (2000) Voluntary Counselling and Testing (VCT) Technical update, UNAIDS Best Practice Collection 22-5-2011

UNHCR, 2009 Policy Statement on HIV Testing and Counselling in Health Facilities for Refugees, Internally Displaced Persons and other Persons of Concern to UNHCR

[www.unhcr.org/4b508b9c9.pdf](http://www.unhcr.org/4b508b9c9.pdf) 07-4-2011

ECDC, (2010) HIV testing: Increasing uptake and effectiveness in the European Union. Stockholm.

[http://www.ecdc.europa.eu/en/publications/Publications/101129\\_GUI\\_HIV\\_testing.pdf](http://www.ecdc.europa.eu/en/publications/Publications/101129_GUI_HIV_testing.pdf) 05-4-2011

IOM (2006) (HIV/AIDS and Populations Mobility Overview of the IOM Global HIV/AIDS Programme2006

[http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published\\_docs/books/IOM\\_Global\\_HIV\\_pdf.pdf](http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs/books/IOM_Global_HIV_pdf.pdf)

Mujyambere, P,(2010) Community Mobilization in response to HIV/AIDS; A Community Assessment of East African Refugees and Asylum Seekers living in Saint Georges Settlement in Durban South Africa, Unpublished Research

*The President's Emergency Plan for AIDS Relief* Report on Refugees and Internally Displaced Persons February 2006 21-5-2011

PEPFAR (February 2006) Report on Refugees and Internally Displaced Persons <http://www.state.gov/documents/organization/63694.pdf>

UNAIDS (2007) Policy Brief: HIV and Refugees.

[http://procaponline.unocha.org/docs/library/01.02.07FinalPolicy\\_Brief\\_Refugees.pdf](http://procaponline.unocha.org/docs/library/01.02.07FinalPolicy_Brief_Refugees.pdf) 21-5-2011

Larry B. Christensen et al (2011) *Research Methods, Design, and Analysis* Pearson Eleventh Edition

UNAIDS (2002) HIV Voluntary Counselling and Testing: a gateway to prevention and care Five case studies related to prevention of mother-to-child transmission of HIV, tuberculosis, young people, and reaching general population groups

[http://data.unaids.org/publications/IRC-pub02/jc729-vct-gateway\\_cs\\_en.pdf](http://data.unaids.org/publications/IRC-pub02/jc729-vct-gateway_cs_en.pdf) 23-3-2011

UNAIDS, UNHCR (October 2005) Strategies to support the HIV-related needs of refugees and host populations. [http://data.unaids.org/publications/irc-pub06/jc1157-refugees\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc1157-refugees_en.pdf)

Maria Elizabeth Bock (2009) Factors influencing the uptake of HIV Voluntary counselling and testing in Namibia, KIT (Royal Tropical Institute) Vrije Universiteit Amsterdam, Amsterdam, The Netherlands 05-4-2011

E Tharao et al (n.d.), To test or not to test: Factors influencing HIV testing in East African communities living in Toronto

<http://www.cahr-acrv.ca/english/resources/abstracts/abs/abs408.htm>

Nguyen et al (2008) *AIDS Research and Therapy* 2008, 5:7, Barriers to access prevention of mother-to-child transmission for HIV positive women in a well-resourced setting in Vietnam <http://www.aidsrestherapy.com/content/5/1/7>

ECDC Technical Report (July 2009) Migrant health: Access to HIV prevention, treatment and care for migrant populations in EU/EEA countries, Stockholm viewed 05-4 2011.



Refugee Rights (March 2008) Information Booklet (March 2008) Information for Refugees and Asylum Seekers in Cape Town [www.refugeerights.uct.ac.za](http://www.refugeerights.uct.ac.za) 07-4-2011.

Babbie E & Mouton J (2008) *The practice of social research*, Oxford University Press.

Elizabeth Henning et al (2004) *Finding your way in qualitative research*, Van Schaik Publishers.

Patton M. Q. (1987) *How to Use Qualitative Methods in Evaluation*. California: Sage Publications

Silverman D. (2000) *Doing Qualitative Research: A practical handbook*. London: Sage

UNAIDS (2000) *Tools for evaluating HIV voluntary counselling and testing*,

[http://data.unaids.org/Publications/IRC-pub02/jc685-tools-for-eval\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/jc685-tools-for-eval_en.pdf) 23-3-2011

**APPENDICES**

**Appendix A:**

**Questionnaire (refugees/asylum seekers)**

***Maswali kwa washiriki***

**Translated version English-Kiswahili**

1. Have you heard of HIV Voluntary Counselling and Testing Services available in Durban?

*Je, Uliisha wahi kupata taarifa kuwa hapa Durban kuna vituo vinavyo towa ushahuri nasaha na kupima maradhi ya ukimwi?*

Yes  No

Ndio  Hapana

2. If Yes where did you get information about VCT in Durban?

*Kama jibu ni ndio wapi ulipata hiyo taarifa?*

Family  Mass media

Ndugu  Vyombo vya habari

Friends  Health workers

Marafiki  Wanyakazi wa idara ya afya

Neighbours  Other (Specify) \_\_\_\_\_

Majirani  Taja kamakuna namna nyingine \_\_\_\_\_

3. Can you name the places where this service is offered in Durban?

*Unaweza kutaja wapi hizo huduma zinapo tolewa hapa Durban?*

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4. Would you go for VCT in Durban? Yes No

Reason for the answer above

*Je, Unaweza kupendelea kwenda kupima afya yako?  Ndio  Hapana*

*Kama jibu ni ndio wala hapana taja sababu?*

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5. If you took the test, to whom, would you reveal the results?

*Kama umepimwa nani unaweza kumwambia majibu yako?*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> My friend(s)       | <input type="checkbox"/> My spouse(s)         | <input type="checkbox"/> My parent(s)  |
| <input type="checkbox"/> <i>Rafiki</i>      | <input type="checkbox"/> <i>Mme/Mke wangu</i> | <input type="checkbox"/> <i>Wazazi</i> |
| <input type="checkbox"/> My child           | <input type="checkbox"/> Nobody               |  |
| <input type="checkbox"/> <i>Mtoto wangu</i> | <input type="checkbox"/> <i>Hakuna</i>        |  |

6. Have you ever visited a VCT Centre to get tested for HIV?

*Uliisha wahi kwenda kituoni ukapimwa?*

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Yes         | <input type="checkbox"/> No            |
| <input type="checkbox"/> <i>Ndio</i> | <input type="checkbox"/> <i>Hapana</i> |

7. What are the requirements that one must meet before one can receive VCT in Durban?

*Mambo gani yanahitajika ili Mtu akubaliwe kupokelewa kwenye kituo cha kupima ukimwi?*

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8. Would you go back to get tested for HIV again at the same centre you last tested at?

*Unaweza kurudi kupima tena ukimwi kwenye hicho kituo?*

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Yes         | <input type="checkbox"/> No            |
| <input type="checkbox"/> <i>Ndio</i> | <input type="checkbox"/> <i>Hapana</i> |

9. If no why would you not go to the same VCT centre?

*Kama njibu ni hapana, kwa nini huwezi kurudi tena kwenye hicho kituo ambapo ulipimwa mwanzo?*

- |   |  |
|---|--|
| <input type="checkbox"/> It is too far away             | <input type="checkbox"/> Lack of confidentiality/privacy         |
| <input type="checkbox"/> <i>Ni mbali sana</i>           | <input type="checkbox"/> <i>Hakuna uwaminifu wala siri</i>       |
| <input type="checkbox"/> Waiting time is too long       | <input type="checkbox"/> The centre is located near my relatives |
| <input type="checkbox"/> <i>Mda wakusubiri ni mrefu</i> | <input type="checkbox"/> <i>Kituo kiko karibu na ndugu zangu</i> |

Other (please specify)

*Kama kuna sababu binafsi taja hapo chini*

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## 10. What are your reasons for not visiting VCT centre to get tested, for HIV in Durban?

*Jambo gani linalo sababisha usiendi kituoni kupima afya yako dhidi ya ukimwi hapa Durban?*

- |   |  |
|---|--|
| <input type="checkbox"/> Do not believe it will help              | <input type="checkbox"/> Not sure where to get tested  |
| <input type="checkbox"/> <i>Hakuna umuhimu</i>                    | <input type="checkbox"/> <i>Sijuwi wapi wanapo pima ukimwi</i>                                 |
| <input type="checkbox"/> Afraid to get the result                 | <input type="checkbox"/> Fear of needles   |
| <input type="checkbox"/> <i>Naogopa kupata jibu</i>               | <input type="checkbox"/> <i>Naogopa sindano</i>  |
| <input type="checkbox"/> Do not know about it                     | <input type="checkbox"/> There is not HIV/ AIDS in Durban                                      |
| <input type="checkbox"/> <i>Sielewi mambo hayo</i>                | <input type="checkbox"/> <i>Durban hakuna ukimwi</i>   |
| <input type="checkbox"/> Partner refusal                          | <input type="checkbox"/> Inconvenient location   |
| <input type="checkbox"/> <i>Mme/Mke wangu hataki</i>              | <input type="checkbox"/> <i>Sifurahiya mahali kituo cha kupima kipo</i>                        |
| <input type="checkbox"/> Fear of stigma                           | <input type="checkbox"/> Don't trust Health Department   |
| <input type="checkbox"/> <i>Naogopa kutengwa</i>                  | <input type="checkbox"/> <i>Siamini idara ya afya</i>  |
| <input type="checkbox"/> No nearby service                        | <input type="checkbox"/> I always practice safe sex  |
| <input type="checkbox"/> <i>Hamna kituo jiri na mimi</i>          | <input type="checkbox"/> <i>Huwa najilinda ninapo fanya</i>                                    |
| <input type="checkbox"/> I am at low or no risk                   | <input type="checkbox"/> Fear of losing my job if HIV+   |
| <input type="checkbox"/> <i>Si husiki na hayo mambo</i>           | <input type="checkbox"/> <i>Naogopa kupoteza kazi yangu itakapo kundulika kuwa nina ukimwi</i> |
| <input type="checkbox"/> I don't care if I am HIV+ or not         | <input type="checkbox"/> No knowledge of HIV   |
| <input type="checkbox"/> <i>Kama nina ukimwi wala sina sijali</i> | <input type="checkbox"/> <i>Sitambuwi lolote kuhusu ukimwi</i>                                 |
| <input type="checkbox"/> No cure, why bother                      | <input type="checkbox"/> Fear of alienation from family  |
| <input type="checkbox"/> <i>Hamna haja maana ukimwi hautibiki</i> | <input type="checkbox"/> <i>Naogopa kutengwa na familia yangu</i>                              |
| <input type="checkbox"/> Fear of losing my partner                | <input type="checkbox"/> Fear of being discriminated against if HIV+                           |
| <input type="checkbox"/> <i>Naogopa kumpoteza Mme/Mke wangu</i>   | <input type="checkbox"/> <i>Naogopa kubaguliwa na jami ikiwa nitakutwa na ukimwi</i>           |
| <input type="checkbox"/> Fear of people finding out               | <input type="checkbox"/> I am in a monogamous relationship                                     |
| <input type="checkbox"/> <i>Naogopa watu wasi juwi</i>            | <input type="checkbox"/> <i>Nina Mme/Mke tu</i>  |
| <input type="checkbox"/> Too long to wait for results             | <input type="checkbox"/> Inconvenient testing hours  |
| <input type="checkbox"/> <i>Itacukuwa mda kupata majibu</i>       | <input type="checkbox"/> <i>Sipendelei masaa ya kupima</i>                                     |
| <input type="checkbox"/> Test is too expensive                    |  |
| <input type="checkbox"/> <i>Bei ya kupima ni kubwa saana</i>      |  |

Other reason – please describe:

Kama kuna sababu zingine taja hapo chini:

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11. In general, what do you think is the reason why a refugee would not go for HIV test at VCT Centre in Durban?

*Kwa jumla unafikiri ni sababu gani zinazo mfanya mtu asipimi ukimwi?*

- Lack of knowledge
- Kutoelewa*
- Fear of rejection by her husband/His wife
- Kuogopa kumpoteza Mme wala Mke*
- Fear of positive test result
- Kuogopa kunduliwa na virusi vya ukimwi*
- Too old to get tested
- Kuwa na umri mkubwa*
- Fear of stigma and discrimination
- Kuogopa kutengwa na kubaguliwa na jamii*
- Fear of dying if she discovers she is HIV positive
- Kuogopa kufa ikiwa utagundiliwa kuwa umekwisha athirika*
- Fear of becoming a victim of violence if tested positive
- Kuogopa kushambuliwa ingapo utakutwa una ukimwi*

Other (please specify)

*Kama kuna sababu zingine taja hapo chini*

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12. What are the challenges facing refugees in accessing VCT services in Durban? Is there any cultural, religious legal/immigration practice/issue or service delivery related problem in the area that could promote/ prevent VCT service utilization among refugees and asylum seekers living in Durban?

*Mambo gani yanayo wakabili Wakimbizi wa Durban kuhusu swali la kupima ukimwi? Kuna tatizo lolote lile kuhusu Utamaduni, Dini, Sheria, Uhamiaji au tatizo lolote linaloweza kusababisha kutojumika katika swala la kupima ukimwi katika jamii ya wakimbizi wanawo ishi Durban?*

- Yes  No  
 Ndio  Hapana

Specify

*Kama kuna la ziada eleza hapo*

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13. What are your opinions about how VCT service should be delivered to meet the demand of refugees and asylum seekers community in Durban?

*Zipi fikra zako kuhusu namna huduma ya kupima ukimwi inaweza ikawafikia wakimbizi wanawo ishi hapa Durban?*

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**THANK YOU VERY MUCH!**

**Appendix B:**  
**Interview Schedule (refugees/asylum seekers)**  
**Translated version English-Kiswahili**

1. Have you heard of HIV Voluntary Counselling and Testing Services available in Durban?

*Je, Uliisha wahi kupata taarifa kuwa hapa Durban kuna vituo vinavyo towa ushahuri nasaha na kupima maradhi ya ukimwi?*

- Yes                       No  
 Ndio                       Hapana

2. If yes where did you get information about VCT in Durban?

*Kama jibu ni ndio wapi ulipata hiyo taarifa?*

- Family                       Mass media  
 Ndugu                       Vyombo vya habari  
 Friends                       Health workers  
 Marafiki                       Wanyakazi wa idara ya afya  
 Neighbours                       Other (Specify) \_\_\_\_\_  
 Majirani                       Taja kamakuna namna nyingine \_\_\_\_\_

3. Have you ever had VCT in Durban?

*Uliisha wahi kwenda kituoni ukapimwa?*

- Yes                       No  
 Ndio                       Hapana

4. What are the requirements that a person must meet before a person can receive VCT in Durban?

*Mambo gani yanahitajika ili mtu akubaliwe kupokelewa kwenye kituo cha kupima ukimwi?*

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## 5. What are your reasons for not visiting VCT centre to get tested, for HIV?

*Jambo gani linalo sababisha usiendi kituoni kupima afya yako dhidi ya ukimwi?*

<input type="checkbox"/> Do not believe it will help	<input type="checkbox"/> Not sure where to get tested
<input type="checkbox"/> <i>Hakuna umuhimu</i>	<input type="checkbox"/> <i>Sijuwi wapi wanapo pima ukimwi</i>
<input type="checkbox"/> Afraid to get the result	<input type="checkbox"/> Fear of needles
<input type="checkbox"/> <i>Naogopa kupata jibu</i>	<input type="checkbox"/> <i>Naogopa sindano</i>
<input type="checkbox"/> Do not know about it	<input type="checkbox"/> There is not HIV/ AIDS in Durban
<input type="checkbox"/> <i>Sielewi mambo hayo</i>	<input type="checkbox"/> <i>Durban hakuna ukimwi</i>
<input type="checkbox"/> Partner refusal	<input type="checkbox"/> Inconvenient location
<input type="checkbox"/> <i>Mme/Mke wangu hataki</i>	<input type="checkbox"/> <i>Sifurahiya mahali kituo cha kupima kipo</i>
<input type="checkbox"/> Fear of stigma	<input type="checkbox"/> Don't trust Health Department
<input type="checkbox"/> <i>Naogopa kutengwa</i>	<input type="checkbox"/> <i>Siamini idara ya afya</i>
<input type="checkbox"/> No nearby service	<input type="checkbox"/> I always practice safe sex
<input type="checkbox"/> <i>Hamna kituo jiani na mimi</i>	<input type="checkbox"/> <i>Huwa najilinda ninapo fanya</i>
<input type="checkbox"/> I am at low or no risk	<input type="checkbox"/> Fear of losing my job if HIV+
<input type="checkbox"/> <i>Si husiki na hayo mambo</i>	<input type="checkbox"/> <i>Naogopa kupoteza kazi yangu itakapo kundulika kuwa nina ukimwi</i>
<input type="checkbox"/> I don't care if I am HIV+ or not	<input type="checkbox"/> No knowledge of HIV
<input type="checkbox"/> <i>Kama nina ukimwi wala sina sijali</i>	<input type="checkbox"/> <i>Sitambuwi lolote kuhusu ukimwi</i>
<input type="checkbox"/> No cure, why bother	<input type="checkbox"/> Fear of alienation from family
<input type="checkbox"/> <i>Hamna haja maana ukimwi hautibiki</i>	<input type="checkbox"/> <i>Naogopa kutengwa na familia yangu</i>
<input type="checkbox"/> Fear of losing my partner	<input type="checkbox"/> Fear of being discriminated against if HIVpositive
<input type="checkbox"/> <i>Naogopa kumpoteza Mme/Mke wangu</i>	<input type="checkbox"/> <i>Naogopa kubaguliwa na jami ikiwa nitakutwa na ukimwi</i>
<input type="checkbox"/> Fear of people finding out	<input type="checkbox"/> I am in a monogamous relationship
<input type="checkbox"/> <i>Naogopa watu wasi juwi</i>	<input type="checkbox"/> <i>Nina Mme/Mke tu</i>
<input type="checkbox"/> Too long to wait for results	<input type="checkbox"/> Inconvenient testing hours
<input type="checkbox"/> <i>Itacukuwa mda kupata majibu</i>	<input type="checkbox"/> <i>Sipendelei masaa ya kupima</i>
<input type="checkbox"/> Test is too expensive	
<input type="checkbox"/> <i>Bei ya kupima ni kubwa saana</i>	



Other reason – please describe:

*Kama kuna sababu zingine taja hapo chini:*

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6. If you test positive for HIV, would you tell any of the following individuals about your HIV test result?

*Kama umepimwa na ikagundulika kuwa una virusi vya ukimwi unaweza ukawajulisha watu wafatao?*

- |   |   |
|---|---|
| <input type="checkbox"/> Your spouse          | <input type="checkbox"/> Your neighbours              |
| <input type="checkbox"/> <i>Mme/ Mke wako</i> | <input type="checkbox"/> <i>Zirani zako</i>           |
| <input type="checkbox"/> Your family          | <input type="checkbox"/> Your religious leaders       |
| <input type="checkbox"/> <i>Familia yako</i>  | <input type="checkbox"/> <i>Viongozi wako wa dini</i> |
| <input type="checkbox"/> Your sexual partner  | <input type="checkbox"/> Your community leaders       |
| <input type="checkbox"/> <i>Kmpenzi wako</i>  | <input type="checkbox"/> <i>Kiongozi wakowa jamii</i> |
| <input type="checkbox"/> Your relatives       | <input type="checkbox"/> Your children                |
| <input type="checkbox"/> <i>Ndugu zako</i>    | <input type="checkbox"/> <i>Watoto wako</i>           |
| <input type="checkbox"/> Your friends         | <input type="checkbox"/> Your employers               |
| <input type="checkbox"/> <i>Rafiki zako</i>   | <input type="checkbox"/> <i>Matajiri wako</i>         |

7. What are the challenges facing refugees in accessing VCT services in Durban? Is there any cultural, religious legal/immigration practice/issue or service delivery related problem in the area that could prevent VCT service utilization among refugees and asylum seekers living in Durban?

*Mambo gani yanayo wakabili Wakimbizi wa Durban kuhusu swali la kupima ukimwi? Kuna tatizo lolote lile kuhusu Utamaduni, Dini, Sheria, Uhamiaji au tatizo lolote linaloweza kusababisha kutojumika katika swala la kupima ukimwi katika jamii ya wakimbizi wanawo ishi Durban?*

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Yes         | <input type="checkbox"/> No            |
| <input type="checkbox"/> <i>Ndio</i> | <input type="checkbox"/> <i>Hapana</i> |

Specify

*Kama kuna la ziada eleza hapo*

---

---

8. What are your opinions about how VCT service should be delivered to meet the demand of refugees and asylum seekers community in Durban?

*Zipi fikra zako kuhusu namna huduma ya kupima ukimwi inaweza ikawafikia wakimbizi wanawo ishi hapa Durban?*

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**THANK YOU VERY MUCH!**