

Health System- Related Barriers to the Uptake of Vct Services in a Rural Setting, a Case of Chivuna Southern Province

Harriet Ntalasha^{1*}, Record Jacob Malungo¹, Simona J. Simona¹ and Sonja Merten²

¹Department of Social Work and Sociology, University of Zambia, Zambia.

²Swiss Tropical and Public Health Institute. Basel, Switzerland.

*Correspondence:

Harriet Ntalasha, Department of Social Work and Sociology, University of Zambia, Zambia, E-mail: harriet.ntalasha@unza.zm.

Received: 14 March 2018; Accepted: 16 April 2018

Citation: Harriet Ntalasha, Record Jacob Malungo, Simona J. Simona, et al. Health System- Related Barriers to the Uptake of Vct Services in a Rural Setting, a Case of Chivuna Southern Province. Clin Immunol Res. 2018; 2(1): 1-9.

ABSTRACT

For the past two decades, HIV and AIDS pandemic has been one of the most challenging problems faced by humanity globally with the sub Saharan region being the most affected. Within the region, Zambia is one of the countries worst hit by the HIV and AIDS pandemic. Since 2005, the government has been providing ART free of charge in all public health institutions. To ensure access to life- saving drugs, VCT, which is the entry point to ART Uptake, has been stepped up by providing free testing services and increasing the number of both static and mobile free testing services throughout the country. However, available literature shows that despite the efforts aimed at increasing access to testing, very few Zambians have taken up testing.

Methodology: Drawing on data from a wider ethnographic study conducted in a remote Zambian rural setting on the factors influencing VCT and adherence to ART, this paper focuses on the barriers that limited people's access to VCT services within the context of the health care system.

Results: The study findings reveal and hence confirm that VCT services which were crucial for ART uptake were wide spread in a rural setting like Chivuna. However, the study found out that access and utilization of these services was not guaranteed. This was due to a number of bottlenecks within the health system itself. Among these were: lack of confidentiality among staff, inadequate training, low staffing levels, non-availability of equipment and inadequate nutritional support. This was compounded by other factors such as the challenge of travelling great distances to the nearest VCT and having to raise money for transport, securing money for food for one to use when away from home to attend VCT services in a distant place, lack of financial resources and the poor road network.

Conclusion: The study has shown a level of association between health system –related factors and people's uptake of VCT services. In this regard, it is important for stakeholders to redress barriers in the health delivery system so as to enhance early HIV testing in order to enable entry into the continuum of care for people found HIV positive. This has the potential to contribute to reduced morbidity, reduced mortality and reduced transmission of new HIV infection cases.

Keywords

Zambia, ART, HIV testing, Access to VCT, HIV, AIDS.

Background

Since its first recognition as a disease in the early 1980s, HIV and AIDS has spread throughout the world to the extent of it now being rated as the world's fourth most common cause of death

[1]. UNAIDS, reports that since the beginning of the epidemic, of the global number of people living with HIV and AIDS, some 95% were living in developing countries with approximately 2/3 in Sub-Saharan Africa; which only constitutes about 10% of the world population. With a prevalence rate of 14.7%, Zambia is currently said to be one of the most seriously affected countries, rated as one of the seven countries most seriously affected in the

whole world. Realizing that a number of Zambians were already living with the disease, the Zambian Government has since 2005 been providing free access to ART services. However in order for one to have access to these lifesaving drugs, there is need for a documented HIV test result [2].

From a public health point of view therefore, without any doubt, Voluntary Counseling and Testing (VCT) is an important entry point and hence a crucial and vital component of ART services. Promoting VCT uptake will foster HIV prevention, help to increase the prevention of mother to child transmission, help to increase the use of appropriate health services for the treatment of opportunistic diseases associated with AIDS. From the human rights perspective, people have the right to know or not know their sero-status.

To ensure access to this important service, the government and various NGOs have over the past few years embarked on making VCT more accessible. This has been done by expanding VCT services through increasing the number of VCT centers country wide. For instance the number of VCT centers increased from only about 400 in 1998 to 1023 centers in 2007 [3]. In order to make the service available to remote hard to reach communities, mobile services are also provided. As of 2009, all 1,563 private and public health facilities in the country offered VCT service [3].

Despite the number of VCT services having expanded markedly over the past few years, surveys show that relatively small proportion of adults (15%) of the entire population have been tested for HIV so far in Zambia. The increase in testing sites has therefore, not been accompanied by a corresponding number of people accessing testing and counseling services.

Studies carried out within the region have attributed failure to test to various factors ranging from poverty and livelihood insecurity, fear of stigma [4,5]. However, so far there has been little examination of the factors that may influence people's utilization of VCT services within the context of the health care system itself. It has been assumed that once the VCT services are provided, people will automatically use them. This paper therefore, makes an attempt to investigate these factors. It is hoped that the findings will contribute to evidence based interventions aimed at improving equity in access to HIV and AIDS related treatment and care. This is critical for a country like Zambia where many people are already living with the virus.

Methods

Study area and population

The study was carried out in Chivuna, a rural community located approximately 100 km South-East of Lusaka the capital city of Zambia and 35 Km from the Great North Road which is the main road in the area. The main ethnic group is the Tonga speaking, a matrilineal and patrilocal group of people. The main source of livelihood is subsistence farming. Like most rural areas in Zambia, poverty levels are quite high. While nearly all the health facilities in the area offer VCT, ART services only exist at Chivuna and

Mbayamusuma health facilities.

Data collection and analysis

The data presented here was part of a bigger qualitative, ethnographic study conducted over a period of 1 and half years on people's experiences and views related to testing, ART uptake and adherence. The study used a descriptive and exploratory design including qualitative approaches such as participant observation, key informant interviews [19], focus group discussions [15], and in-depth interviews [67]. Both the tested and not tested were included. All interviews except for Key informants were conducted in Tonga the local language of the area.

For the purpose of quality control, all focus group discussions were moderated by the principal investigator. With permission from the study participants, interviews were also tape recorded and transcriptions done as soon as possible to avoid any loss of data. Repeated observations were conducted at the health facility and some of the areas of focus were the health care provider – client interaction, availability of equipment and drugs, physical space, provider-patient relationships, staffing, time of reporting and counseling sessions. All interviews conducted in the local language were transcribed and interpreted into English after which all data were put into a word processing application version and analyzed using the ATLASTI. Ethical approval for the study was obtained from the Research Ethics Committee at the University of Zambia. For all the individuals that took part in the study, informed consent was sought.

Theoretical framework

To explore factors that influence people's entry and retention in the HIV and AIDS continuum of care and treatment, the study from which this article is extracted was guided by the social-ecological model (SEM). SEM is an approach to health promotions that offers a broader perspective because it recognizes that most public health challenges are too complex to be adequately understood from single level analysis.

This model views human behavior as a function of personal and environmental factors, which include socio-economic, political and health factors. Health seeking behavior is therefore not construed as something that exclusively resides in the individual but as a reflection of wider interactive situational processes. The individual health seeking behavior is located in social, institutional and physical environment and consequently behavior is shaped by social environment. Thus, individual behavior is determined to a large extent by the social environment such as community norms and values, regulations and policies and the most healthy behavior would be a combination of efforts at all of the above levels: individual, interpersonal, organizational community and public policy.

The model situates the individual in a dynamic social ecology in which individuals adapt their behavior to their social environment and make decisions based on information, influences and interactions available through local social networks, relationships

and institutions. This means that in analyzing health seeking behavior, this framework looks beyond the individual by taking into consideration the social environment in which the individual exists and the influence that the social world has on the individual. This leads to the assumption that the world we live in influences our behavior including health seeking behavior. Additionally, health system related and based factors are also taken into consideration.

This approach therefore, avoids exclusive focus on either the individual or the environmental factors as separate analytical factors but takes into consideration the dynamic interaction of both personal and external non-personal factors in explaining health seeking behavior.

The social-ecological model categorizes the factors influencing people's health seeking behavior into four main categories namely individual, social, programmatic and structural factors. Structural factors are those over which the individual has completely no control. These factors include poverty, livelihoods, health policies, laws and the financing of health care systems all which are linked to the national economy. Programmatic factors are those that are related to the health system and basically relate to the way health systems are organized and delivered including availability and accountability of services, attitudes of health providers, waiting times and distance to the health facilities.

Social factors include interpersonal relations such as those between married partners, family members, peers that in turn affect individual actions. Community level factors such as the relationship with and the influence of the social systems, institutions like the church, social exclusion, discrimination, stigma, traditional health care systems, local illness ideologies and concepts which are all embedded in people's socio-cultural systems [4]. The relationship between the formal health sector and its professionals on one hand and the local people on the other is also seen as part of the social level factors and viewed as capable of influencing treatment seeking behavior because it is viewed as being structured by the social order. Individual factors are the personal determinants of health seeking behavior over which an individual has control on such as personal characteristics which include perceived severity of the disease, wellness, interpretation of illness and attitudes towards treatment, knowledge, as well as somatic responses to medication.

Thus, according to this theory, a more comprehensive approach to health promotion requires changing the practices of social systems that have wide spread effects on human health rather than solely changing the habits of the individual. This framework shows that all these factors are interlinked and interwoven to enforce each other in influencing the individual's treatment seeking behavior. While at times the interplay of two factors may be involved such as reduced waiting times (health sector factor), may improve patient adherence through motivation to seek treatment (individual factor), sometimes a combination of several factors may be involved. For instance, pervasive stigma (social factor) or waiting times at the ART clinic (health related) may all reinforce each other leading to

lack of motivation (individual factor) and consequently result in attrition from ART care.

Due to its comprehensive and multi-faceted approach, the social-ecological model avoids the theoretical divide between individual and structural models by treating both paradigms as complimentary and lying on the same continuum. Used with modifications, this model was found to be useful for this study because of its multifaceted approach of analyzing health seeking behavior which addresses the reciprocal interplay between self-regulatory and environmental determinants of health seeking behavior. By the use of this theoretical framework, it was therefore possible for the study to investigate not only individual factors but also other factors at all levels which make up one's social environment. In the context of this article, it was possible to investigate health facility barriers and how they influenced people's uptake of VCT services.

Using this framework, key relational variables under study were investigated at five levels, namely Structural (poverty and food insecurity), programmatic (health system level), community - level (perceptions, local illness ideologies) individual (personal determinants) and the medication-related factors (size of tablets, pill burden, dosage and side effects). It should be noted that for the purpose of this article which is focusing on health system related barriers influencing uptake of VCT, only health system level factors were used for analysis.

Results

Among the factors that were perceived as making a complete package for ART services and hence influencing VCT from within the health system included availability of VCT services, availability of adequately trained staff in terms of competence, confidentiality and numbers, availability of free drugs and continuous supply, nutritional support, staffing levels, availability of physical structures such as separate private rooms for confidential counseling and testing equipment. However, study findings show that some of these components were not always readily available. Compounding this were other factors such as the challenge of travelling long distances to the nearest VCT and having to raise money for transport, securing money for food for one to use when away from home to attend VCT services in a distant place, lack of financial resources and the poor road network.

Testing and diagnostic equipment

Although the Chivuna ART centre acquired a CD4 count machine from CHAZ, the institution lacked kidney and liver functioning machines. With the assistance from CHAZ, the institution has made arrangements to transport blood samples to Mazabuka District Hospital. However lack of financial and human resources sometimes hampered the service. For instance, though the facility had more than one vehicle, with one specifically for ART services, there was only one driver for the whole facility. Additionally, sometimes, frequency of delivering blood samples was affected due to lack of fuel.

Such scenarios usually led to the need for retaking of blood

samples, which in turn led to mistrust of health care providers as elucidated by the statements below:

“That happens a lot (referring to retaking of blood samples), like for me, they have collected blood samples more than two times from me. Because of drawing blood from you on a daily basis in the end, they drain the last of drop of blood from you, sometimes you start thinking of other things happening, we do not know what happens may be our blood is being sold.” (female ARV user, mixed clinic based FGD).

"Sometimes you hear some clients jokingly saying," Where do you take our blood, do you sell it?" (Male health care provider).

Some key informants feared that such mistrust could lead to underutilization of available services. It was noted that retaking of blood samples more than once from the same people sometimes raises resistance from some clients who suspect some of the health care providers to be involved in Satanism. This mistrust of health care providers can lead to shunning of the services by some people even when they are readily available. Some health care providers reported of some who never returned for test results after fruitless efforts of getting their results.

Inadequate physical infrastructure was one of the factors mentioned as barrier for testing. All the study participants strongly felt that the available space was inadequate to accommodate all the services that were being offered. Therefore, much as the health staff could be aware of the need for privacy in counseling in ART services, the available space did not allow the kind of privacy that was desired. For instance, due to limited space, at one of the ART clinics, the room where counseling was conducted was also the place where patients' records were kept. This situation raised concerns among study participants who viewed it as compromising privacy and confidentiality required for counseling and testing. The concerns can be illustrated by the following quotes below:

“We also need a bigger building so as to accommodate all these services that we are providing. For counseling we need privacy so that patients can be free and comfortable. At the moment this is lacking and as a result clients are limited as to how much they can share with the counselor because instead of having only 2 people in a room there are usually more than 2 people in the same room because registry is also the counseling room. So even when they happen to have questions about their treatment, some may not say anything.” (male health care provider).

“Those ones are also (referring to the counseling rooms) not enough and so there is no privacy, you find you are talking to the counselor and there is another nurse giving out files and so people are going in and out of the same room and you find you can't free to say everything you want to tell or ask the counselor” (Female ARV user, IDI).

Staffing

The facility was found to be faced with a shortage of staff. As a result almost all the health care providers interviewed complained

of increased workload with the introduction of the ART clinic. They noted that ART services were introduced while numbers of staff remained the same. For instance, there were only 2 nurses and one ART supporter running the ART clinic against an average of approximately 78 clients per day. The two nurses also worked as counselors. The full establishment for a clinical officer was 2 but the health facility only had one. Consequently, long queues were usually a common sight at the ART clinic with some people waiting as long as 6 hours before they could be attended to. On some ART days, the visibly tired health care workers struggled to attend to all the clients by extending working hours, exhibiting a lot of commitment towards their work. A female health care provider in her mid-thirties shared her experiences:

“Sometimes we are really overwhelmed by numbers of clients we have to attend to yet there are only a few of us, so we have to do away with both tea break and lunch and we do not knock off until all clients have been attended, we avoid any of the clients going back unattended because some of them have to cover long distances to reach the health facility.”

The staffing situation was ably summarized by another health care provider when she narrated:

“The ART clinic was introduced without any changes in the number of staff. This has led to increased work load for the few staff available. For instance, the full establishment for the health facility even without the ART clinic is 2 on but we only have 1. So on each ART day, the only clinical officer has to first do the rounds in the wards and attend to any emergencies at the OPD before going to the ART clinic. This contributes to long queues and long waiting times that clients are subjected to. Not having enough staff is also partly the reason why the ART clinic is limited to only two days in a week.”

Similar sentiments were expressed by several ART users:

“The attitude of most health care providers is just okay but the problem is that the doctor (referring to the clinical officer) is just alone and patients are just too many and no one to help. Some people can wake up around 04:00hours and they would be number 3 or so. The doctor (referring to the clinical officer) is just alone and she has to work at OPD and in wards and after she has finished, that is when she attends to patient patients at ART. Even if you were the first one to arrive, you will go home around 13:00 hours. The workload is just too heavy for the doctor,, if the government could at least send one or two more doctors so that they can assist each other,” (Male ART user).

The understaffing, amidst increasing patient levels with the introduction of ART, was viewed as not only having increased the workload for the few health providers available but also viewed by many health care providers interviewed as negatively impacting on quality of services that they ultimately delivered. They pointed out that this was mainly because in most cases the few staff available was required to attend to huge numbers of clients in a day leading to exhaustion among staff. These concerns can be illustrated by the

view of one of the health care providers:

“Even counseling if it has to be adequately done we need more counselors considering the numbers of patient that we deal with. We are supposed to be with one patient for at least not less than 20 minutes but because sometimes there would be a lot of people to be seen and just a few of you to attend to all these many people, this becomes very difficult. And also because many of them cover long distances to reach the clinic, you try to squeeze in as many as possible to ensure that all are attended to and by the end of the day you are completely exhausted.”

Similar views on the quality of counseling were expressed by some users as illustrated by this quote below:

“If services are to be improved, there is need for the government to bring more counselors and also build more rooms for counseling so that patients can have enough time with the counselors not the way it is now, At the moment, we are too many but the people who attend to us are too few and so when they are giving us advice and encouragement concerning these medicines, they just spend a few minutes with each one of us,” (Female ARV user, community based FGD with people living with HIV).

Repeated observations did prove the assertions made by study participants. It was also reported that inadequate staffing also hampered the provision of mobile services intended for the hard to reach communities in terms of mobile testing and community sensitization on the importance of VCT. For instance, it was repeatedly revealed by the health care providers that it was difficult to implement the outreach and mobile services partly due to limited staff to undertake such activities. This was elucidated by a health worker found working at one of the ART clinics:

The available numbers of staff are at times inadequate to go out in the communities to carry out outreach programs such as community sensitization and mobile ART services because we now have two clinics to run yet the number of staff has remained the same. The same staffs who work at the ART clinic also conduct general health services. We are also supposed to have 2 drivers but we only have one at the moment, so it is quite difficult for us even if we have a vehicle specifically meant for the ART clinic, Sometimes you find that you are arrange to go out for sensitization or to do mobile ART services, but meanwhile there are other operations somewhere that need a driver or maybe there is an emergency. This means that we have to abandon whatever activities we had planned for that day”.

Apart from inadequate number of staff, training of staff in HIV and AIDS related services was found to be inadequate. For instance, at Chivuna ART Centre, the CO and ART Coordinator have had official training in ART services, (inclusive of both adult and pediatric ART services). Nearly all the health care providers, lay counselors, and volunteers (ART/ Adherence supporters) interviewed indicated the need for further training in ART delivery. They noted that the training that they had received so far was not adequate to enable them deal with all the aspects of HIV and AIDS. Thus expressing concerns about training needs, some

study participants explained: ‘We definitely need further training in ART delivery because so far we have just been oriented for two weeks, under normal circumstances, the course we did should have been done in 2 months but it was compressed and so we covered it in one week. We were trained in both counseling and palliative care but this is still not enough.’ (Male lay counselor).

Lack of confidentiality and trust for health staff

Another issue raised where staff was concerned was confidentiality. Participants feared that the health staff would inform other people in the community about their sero-status, as expressed by the following statement:

“Some do keep, others do not because people are different, but I have heard some people complain about the issue of confidentiality among some of the health care providers who come to work at the ART clinic. I think these people need more training so that they can know how to handle such issues of confidentiality. You know at Chelstone clinic (referring to health facility in an urban setting of Lusaka the capital city of Zambia), where I started from, health care providers are better trained to handle such an issues, you do not find people complaining”, (63 year old male ARV user, clinic based IDI).

Similar concerns were expressed by several other ART users. For instance, during one of the community based in-depth interview, a middle- aged female ART user retorted:

“Then you also have some health care providers who do not keep secrets and they go and publish what you have shared with them to everybody out there, you are just the two of you and the next day you hear it being talked about at Copper (referring to a popular drinking place in the area) and then you start wondering how did these people come to know about it?”.

Such sentiments were similarly expressed by some health care providers as explicitly noted by one of them:

“Another thing is that some people do not have confidence in us as health care providers. I have heard some people say “people who work at the clinic do not keep secrets, you would share something with say an ART supporter health provider and the next thing you hear about it beer halls” so I think we need to work on confidentiality if people have to come and utilize these HIV and AIDS service and stop shunning them”.

Because of these confidentiality concerns, some people said they avoided those health staff they did not trust and selected to see those they trusted. In their frantic effort to access the services they desperately needed, some clients even went to the extent of preferring to attend far off located health facility where they felt confidentiality would be maintained. This created what would be referred to as “artificial long distance” to VCT services and what Samuels et al. [6], referred to as, “mobile clients”. However, such actions often worsened the situation as it often it led to delay in testing and consequently delay in accessing treatment and care.

For some of the ART clients however, their main concern was not with the conventional health care givers but with the ART supporters. Firstly, they complained about what they termed “as too many ART supporters on each ART day”. Secondly, they also viewed ART supporters as being worse than the health facility based health care providers in terms of lack of confidentiality. They explained that this was because of the fact that they personally knew them considering that they lived together in the same community. The above concerns are illustrated by the following quotes:

“We trust the health workers, but on my side I don’t trust the ART supporters. They are too many and they come from the community where we live and they are the ones who start spreading the information of people who are on ART, some of them can’t keep their mouths shut, they cannot keep secrets at all, those people need training so that they can know the importance of keeping secrets for patients, you know ,because this discourages a lot of people from coming to the clinic when they know that their information will be broadcasted in the community, such that even as you walk everyone knows in the community and they would be pointing fingers and laughing at you,” (amid agreement from the rest of the group participants, ART user, clinic based male FGD).

In addition to confidentiality concerns, some participants accused some of health care givers of being fond of blaming clients, of being un empathetic, uncaring, rude and using unpalatable language. They pointed out that their condition as people living with HIV required being treated with understanding, kindness and care. A number of study participants attested to having had bad encounters with some of the health care staff as some of them shared their experiences:

“Some are good while others can be very bad the way they treat patients, some like telling off patients and pass comments like: We were not there when you were getting infected, and yet they know that us patients are short tempered, you know this disease is a difficult one, patients require people who are kind and understanding”, (Male ART user, male FGD).

Some of them are very sarcastic, imagine nurse telling a patient: Don’t trouble me because I am not the one who gave you the illness. It is like people just went out to get sick anyhow. There is one nurse there at the clinic that has such an attitude. Some times when a client asks about food, this nurse would become very angry and would even throw away your file. This I have seen with my own eyes. Sometimes the nurses can just be chatting with each other un worried that people start off from their homes early so that they can be seen early, sometimes they are just scattered and walking up and down yet they start late attending to us and then there would be long queues ,”(Middle aged Female ART user, clinic based IDI).

“Some of those nurses do stigmatize a lot, you see them not wanting to sit close to you, especially if you are coughing”, They discriminate), sometimes you even hear some of them saying, You can end up being infected too.

Despite the negative perceptions about some of the health care providers by some clients, there were also some of them who had very positive perceptions about some of the health care provider they had interacted with. Therefore, when asked the question, “How do you view your health care providers?” during one of the FGDs with male ART users, some participants expressed the following views:

“Some are very good and very encouraging, like Sr Jennifer for me she was very helpful when my wife was very ill and at that time Chivuna rural health facility was not yet there so I was supposed to take my wife to Monze Hospital for a test,and I had no transport money ,she organized transport for us to go to Monze and there because we had to wait for the results, she gave me transport money for transport back to Chivuna, while at Monze hospital I also decided to test and I was also found positive For me I can say that Sr Jennifer is my God because I would have been dead by now, or may be my wife would have been dead too,” (Male ART User).

Distance to VCT centers

Despite there being a number of health facilities in surrounding communities such as Hanzala, Mwanza, Nkonkola and Mainza, health facilities, many communities were still affected by distance to VCT centres. For instance Namaila and Nadongo were located approximately 55 and 57 km from Chivuna Rural Health facility respectively. For Mbayamusuma rural health facility, the furthest community using VCT a service was estimated to be located more than 100 km away.

Therefore, when responding to the question, ‘ What would discourage someone to go for VCT ?’, the challenge of covering long distances to ART centres was frequently raised by many informants and discussants particularly, those from remote communities. This was literally put as; the long distance to the Mission is the biggest problem.’) When asked to rank the major barriers to ART, distance to ART centres was usually ranked as number 1 by some people from the distant communities covered in the study.

‘Distance is problem number one for us .Imagine how long it took you to travel here from the Mission and yet you came by a vehicle. Can a sick person manage to cover such a distance?’ (Male discussant, FGD, community 20km from Chivuna Rural Health Facility).

Discussions with study participants who were affected by distance clearly showed how much delay was caused to access VCT and consequently delay to access ART services due to distance:

It took about 2 years I used to have rashes the whole body. Some people advised me to go to Puckie but it was too far and I had no transport money. The rashes persisted, so when Chivuna ART centre was opened, I decided to come here for testing and they told me that I had the virus in my blood (female ARV user clinic based IDI).

“I started thinking about the distance to the Mission. It is very far to the ART clinic from where I live. Every time I was unwell I could think of the journey. It’s about 8 hours walking from my village to the clinic. Each time I thought about the distance felt discouraged. Fear continued in my heart. 8 hours walking is not a joke.”(Male ART user).

The situation for a resource poor area like Chivuna was compounded by poverty and food insecurity experienced by some households. This made it difficult for affected communities to mobilize resources needed to cover transport costs to VCT centre reducing many to depend on walking to VCT centers. This scenario even made the whole situation more complicated because in the event that one became very ill, covering long distances on foot and hence accessing health care service became almost impossible. Additionally, with the pressing need of food, spending limited resources on transport to access VCT particularly, when one was still feeling healthy would be out of question.

Many key informants and community discussants irrespective of location were emphatic on the need of increasing access to VCT centers. As a strategy for scaling up access to VCT, health care providers from Chivuna Rural Health facility through assistance from CHAZ have made attempts to alleviate the distance barrier by providing mobile VCT services to remote communities. Many study participants attested that mobile VCT facilities do encouraged people to test as shown by statements below:

“Then you have mobile testing, this also helps because what discourages some from testing is distance to VCT centers, so when these services go closer to the people a lot definitely do decide to test (Middle aged male ART user).

“Whenever we go out in the community to test, people come in large numbers after sensitization because they do not suffer the distance problems”, (Healthcare- provider).

However revealed that despite such a strategy being a good method of getting people tested and consequently for accessing ARVs; it was being hampered by many challenges. These were summed up by one of the informants from the health facility:

“What encourages people to come for VCT is reduced distance. For example when we carry out mobile VCT services, you see more people coming for testing. However, these mobile services are usually hampered due to lack of financial resources for fuel and manpower. You see with such constraints, it is usually difficult to say or plan the number of visits we are going to do per month; it is not frequent, so we only do it as and when the resources are there. Additionally, some of these places we are talking about are inaccessible even by 4 by 4 vehicles due to poor road network.”

In related discussions, the need for the government to work on the roads and maintain bridges was also mentioned by many informants and community discussants. It was pointed out that this was the only way the provision of mobile VCT services would be

possible. During a social mapping exercise done in the central part of Chivuna, a heated discussion erupted over the state of the roads in the area, when an elderly man in his late fifties, while vigorously using both of his hands to express his point and unanimously supported by all other group discussants, expounded:

‘The roads in this area are really bad especially when you go this side(pointing in the south east direction), beyond the mission , I think the last time these roads were graded was after independence in 1964, bridges are not maintained, in fact beyond the mission there aren’t even any roads to talk about. No vehicles can travel on these roads, not even a scotch cart only a sledge can go there, and now imagine you are carrying a patient’.

Another middle aged man, amid laughter and applause from the other participants added:

‘Those ministers and the president should not just sit in their nice offices; they should come here and see some of these roads we are talking about.’

In adding a voice to the state of the road network middle aged man during an in-depth interview retorted:

‘Even if one was to sell a chicken and be able to have a bit of money for transport to reach the health facility, in a place like Namaila where vehicles do not reach, there would be no vehicle to get on.’

This is a clear indication that the challenge of accessing available services was exacerbated by the poor road network in the area.

Lack of special counseling rooms

One of the most important motivators for voluntary counseling and testing was pre-test counseling. However, the study found out that there was shortage of space. Several participants strongly felt that the available space was inadequate to accommodate all the services that were being offered. Therefore, much as the health staff could be aware of the need for privacy in counseling in ART services, the available space did not allow the kind of privacy that was desired for proper counseling environment. This was seen as negatively impacting on the quality of counseling. For instance, due to limited space at the ART clinic, the room where counseling was conducted was also the place where patients’ records were kept. This situation raised concerns among both key informants and community members who viewed it as compromising privacy and confidentiality required for counseling. These concerns can be illustrated by the following quotes:

“We also need a bigger building so as to accommodate all these services that we are providing. For counseling we need privacy so that patients can be free and comfortable. At the moment this is lacking and as a result clients are limited as to how much they can share with the counselor because instead of having only 2 people in a room there are usually more than two people in the same room because registry is also the counseling room. So even when they happen to have questions about their treatment and condition, some may not say anything.” (Male health care provider).

This study sought to investigate factors that influence VCT within the health care system. Many factors were found. Among these were: issues of staffing in terms of numbers, training, confidentiality and competence. All these characteristics though critical for effective delivery of HIV and AIDS related services, were reported to be inadequate. This inadequacy can undoubtedly affect access and effective utilization of available services.

Confidentiality concerns about health workers was also observed by Meiberge et al. [7], in their South African study as militating against treatment seeking behavior as people were afraid that health care providers would share their secrets with other community members. It should also be noted that people who have had prior experience with the system did not live in isolation but interacted and shared their experiences with other people in the community. There is a possibility therefore, that even those who had never had that experience may tend to shun because of this interaction with those who had some experience with the system.

Several other studies carried out in other Sub-Saharan countries for instance, Kenya [8], Mali [5], Uganda; Zambia [2], and in other parts of the world such as North America [9], all show the role that trust and confidentiality of health care providers can have in influencing treatment seeking behavior such as HIV testing.

Study findings also show that some study participants viewed some health workers as unsympathetic, judgmental, and blaming the affected people rude and uncaring. Such concerns could act as a barrier to accessing HIV and AIDS treatment and care. Earlier studies have also made a similar observation. For instance, in the South African study, Aspelling [10], notes that participants prefer an HIV care provider who was available, confidential, competent, approachable, non-judgmental, caring, encouraging and supportive. The study findings are also consistent with those of Angotti et al. who, in their Malawian study also report of repeated stories of health personnel being rude and not keeping secrets.

Lack of testing equipment also emerged as a concern. This led to delay in getting test result and consequently delayed in ART initiating because as noted by Hardon et al. [11], machines like the CD4 count machine was needed to monitor the efficacy of treatment and also to decide when to initiate treatment. In their Zambian study, Samuels et al. [6] also alluded to the challenges that arose from the lack of testing machines. Repeated tests led to some people being suspicious of Satanism among some of the health care practitioners and could lead to shunning of services.

Consistent with other studies within the region [6, 12], was lack of specialized counseling rooms at the facility. This was an issue because without privacy, confidentiality, a factor which is very critical for sexuality issues was compromised. This made people wanting to go for testing either reluctant to do so or delayed in doing so.

Lastly, the data from this study indicate that although ART services have been expanded to different parts of the country including

rural areas like Chivuna, some communities were still faced with limited access to testing due to long distances to VCT centers. Hence, despite the fact that the cost of accessing testing and treatment has been removed by abolishing clinical fees, people were still required to meet the cost of travelling to VCT centers. This is a clear indication that although the whole ART package was made available free of charge, treatment related costs in form of transport expenses were still a barrier for some communities limiting them from being tested. This made it either difficult or impossible for some people who may be eligible for ART to access it early enough. Therefore, as observed by Tuller et al. [13] in their Tanzanian study, 'Free provision of ART services has not completely removed treatment related cost.' Similar observations were made by Mshana et al. in their Tanzanian qualitative study of Kisesa District, AIDS Alliance, and Grant et al., in the Zambian studies.

Conclusions

The study has revealed that although services have indeed been rolled out to rural areas like Chivuna, inadequacies in the health care system that prevent optimum use of available services still exist. This has resulted in some people delaying in taking up testing and consequently delaying in accessing the life prolonging medicines. Therefore, the findings suggest, as put by Grant et al. [2], that it should not be assumed that rolling out of HIV and AIDS related services automatically leads to people accessing and utilizing them. As revealed by the study people were pursuit of a "full package". Therefore, the challenges that militate against access and effective utilization available services need to be addressed so as to avoid delays in testing and consequent delay in accessing treatment and care. This is critical if demand for early testing and diagnosis is to increase so that people can access HIV treatment and care early enough so as to save lives.

References

1. UNAIDS The Report on the Global AIDS epidemic, A UNAIDS 10 th Anniversary Special Edition Switzerland. 2016.
2. Grant L, Dorothy L, Masura M, et al. Factors facilitating and challenging access and adherence to ART in a township in the Zambian Copperbelt A qualitative study, *AIDS Care*. 2008; 20: 1155-1160.
3. Ministry of Health and National AIDS Council. Zambia Country Report Multi-Sectoral AIDS Response Monitoring and Evaluation Biennial Report, 2006-2007 submitted to the United Nations General Assembly Special Session on AIDS declaration and Commitment Revised Edition 2008 Lusaka, Zambia. 2008.
4. Musheke MH, Ntalasha S, Gari O, et al. A systematic Review of qualitative findings on factors enabling and deterring uptake of HIV testing in Sub-Saharan Africa. *BMC Public Health*. 2013.
5. Castle S. Douting the existence of AIDS, A barrier to VCT in urban Mali. *Health Policy and Planning*. 2003; 18: 146-155.
6. Samuels G, Simbaya GJ, Ndubani P. Social aspects of free AIDS Medicine ARVs. Access in public health setting in

-
- Tanzania and Zambia, Zambia Country Study. 2008.
7. Meilberg A, Bos A, Onya HE, et al. Fear of stigmatization as a barrier to voluntary HIV counseling and testing in South A. East African Journal of Public Health. 2008; 5: 49-53.
 8. Unge C, Johansson A, Zachariah R, et al. Reasons for unsatisfactory acceptance of antiretroviral treatment in the Urban Kibera Slum Kenya AIDS care. 2008; 146-149.
 9. Mills E, Singh S, Wilson K, et al. The challenges of involving traditional healers in HIV/AIDS Care. International Journal of STD and AIDS. 2006; 17: 360-363.
 10. Aspelling A, Heiler E, Wyk Neltjie. Factors associated with adherence to antiretroviral therapy for the treatment of HIV infected women attending an urban care facility International Journal of Nursing practice. 2008; 14: 3-10.
 11. Hardon AP, Akurut D, Commoro C, et al. Hunger waiting time and transport costs time to confront challenges to ART adherence in Africa, AIDS Care. 19: 658-665.
 12. Layer EH, Kennedy CE, Beckham SW, et al. Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania. PLoS ONE. 2014; 9: e104961.
 13. Tuller DM, David R. Bangsberg, Jude Senkungu et al. Transport costs impede sustained adherence and access to HAART in a clinic population in South Western Uganda, a qualitative study published online. 2010; 14: 778-784.