

“To know or not to know”: Service-related barriers to Voluntary HIV Counselling and Testing (VCT) in South Africa

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Abstract

Voluntary HIV Counselling and Testing (VCT) is still in its infancy in South Africa, and although the necessary infrastructure in terms of clinics and hospitals exists, a VCT culture is not yet established in the country. The purpose of this study was to determine the needs, attitudes and beliefs of a sample of South Africans towards VCT, and to investigate possible barriers affecting participation in VCT programs in South Africa. A semi-structured questionnaire was used to survey the views of 1422 people. Results indicate that while subjects were not opposed to VCT in principle, 33% would go to clinics where nobody would know them. The following problems with VCT services were mentioned: Logistical problems (not enough counsellors, long lines, lack of privacy); no trust in the health care system or fearing a breach of confidentiality; fear of rejection; and a lack of follow-up support after diagnosis. Suggestions are made on how to improve VCT services in South Africa.

Key words: HIV/AIDS, Voluntary HIV Counselling and Testing, HIV-VCT, Barriers to VCT, Confidentiality and VCT

Opsomming

Vrywillige HIV Berading en Toetsing (VBT) staan steeds in sy kinderskoene in Suid-Afrika, en hoewel die nodige infrastruktuur in terme van klinieke en hospitale bestaan, is 'n VBT-kultuur nog nie in die land gevestig nie. Die doel van hierdie studie was om die behoeftes en houdings van 'n steekproef Suid-Afrikaners teenoor VBT te bepaal, en om vas te stel wat die moontlike struikelblokke in die pad van deelname aan VBT programme is. 'n Semi-gestruktureerde vraelys is gebruik om die menings van 1422 persone te bepaal. Die resultate van die studie dui daarop dat proefpersone in beginsel nie teen VBT gekant is nie, maar 33% verkies om na klinieke te gaan waar niemand hulle ken nie. Die volgende probleme met VBT-dienste is genoem: Logistiese probleme (te min beraders, lang toue, gebrek aan privaatheid); geen vertroue in die gesondheidsstelsel nie; vrees dat inligting nie vertroulik hanteer sal word nie; vrees vir verwerping en 'n gebrek aan opvolg ondersteuning na diagnose. Aanbevelings word gemaak oor hoe om VBT dienste in Suid-Afrika te verbeter.

“I often have to give eight HIV positive results in one day. I know most of these people. They are my neighbours or go to the same church. Some days it becomes so hard, that I send people away by telling them that their results are not yet back - in the hope that they will come back another day when I am off duty...” (45 years old nurse - working in a community clinic in the Free State province, SA.)

Background

Voluntary HIV Counselling and Testing (VCT) is still in its infancy in South Africa (SA), and there are many challenges as well as opportunities facing the health services in the country. Although the necessary infrastructure in terms of clinics and hospitals exists, and even though it is one of the top priorities in the Government's 5-year HIV/AIDS plan, a VCT culture is not yet established in South Africa. VCT programmes often experience problems and barriers which limit their successful

implementation. These barriers may involve *psycho-social barriers* which impact negatively on people's willingness to participate in VCT programmes (Van Dyk & Van Dyk, 2003), or to problems with *VCT facilities and services*. Clients are often not satisfied with the service they receive, especially in state hospitals and clinics. The purpose of this study was to investigate the possible service-related barriers that may hinder participation in VCT programs in South Africa. A brief literature and research overview of VCT services in South Africa, and other sub-Saharan African countries, follows.

Logistical barriers

In many parts of Africa, VCT services are mainly hospital based and access is often limited. Queues for service are long, counselling is of poor quality, same day results are not available, and many people don't return to receive their test results (Makhubele & Pronky, 2000). According to Masuku (2001), South Africa requires more than 2500 counsellors to offer VCT

services to a mere 10% of the population. To reach the government's goal, namely to make services available to at least 12.5% of the population (mainly between the ages of 15 to 49 years) will therefore be a mammoth task. In the meanwhile, the large patient turnover and low counsellor-to-patient ratio are causes for concern. For example, the average number of patients consulted for VCT at a rural district hospital in the Eastern Cape, is 6 per hour, averaging 10.4 minutes per client (Fawcett, 2001:23). Proper HIV/AIDS counselling is simply not possible under such circumstances. This lack of personnel and heavy client load cause long waiting periods for clients, who may not have the time to line up for hours to receive HIV counselling and testing.

South Africa has many resource-poor areas, and it is frequently not possible for people to go for VCT, or to go back to receive their test results, that may only be available two to three weeks later. Although rapid HIV antibody tests are being used in many of the testing sites in South Africa, they are often not available in remote rural clinics and hospitals. These rural testing sites often don't have the necessary equipment to do antibody testing and they therefore have to send blood samples away for testing. For this reason they are usually not able to inform clients when their results will become available, causing clients the discomfort of having to visit the clinic repeatedly until the test results arrive - a situation which leads to a loss of confidence in the VCT system (Fawcett, 2001:23). Poor clients just don't have the money or transport to repeatedly go back to testing sites for results. Masuku (2001) found that up to 80% of clients, who were tested for HIV in certain clinics in South Africa, did not go back for their test results. The greater availability of rapid HIV antibody tests will solve this problem to some degree. However, the training of enough health personnel to conduct the tests with proper counselling is time consuming.

As previously stated, HIV counselling and testing frequently take place in state hospitals that are not the most conducive settings for relationship building or for encouraging openness about sensitive and often taboo subjects. Many clients prefer not to go to hospitals for VCT due to stigmatisation and a lack of privacy (Lie & Biswalo, 1994:147). Another common practice in hospitals is to demarcate a special room for HIV counselling. This practice makes clients reluctant to go to these hospitals because they are afraid that they will immediately be labelled as being HIV positive (Fawcett, 2001:25).

To try and cope with the heavy patient load, some hospitals and clinics offer group sessions for pre- HIV test counselling. Group sessions may have their place, for example, for counselling polygamous marriage groups, or for providing useful information to clients (Campbell, Marum, Alwin-Edyegu, Dillon, Moore & Gumisiriza, 1997:102), but group counselling may not be appropriate in many circumstances due to a person's need for privacy and/or confidentiality.

Training and selection

Although *minimum standards for HIV/AIDS counselling and training* are in place, and although the Department of Health is in the process of establishing standardised training programmes, proper counselling and training networks are not yet fully functioning in South Africa. The lack of standardised

programmes often results in situations where counsellors are not properly selected, trained, evaluated or supervised (Brouard, 1998:15), but are nonetheless forced to offer VCT services because of the nature of their work (e.g. because they are nurses), rather than because of their interest and commitment to the course. Such a situation may cause counsellors to offer a poor service due to a lack of skills or burnout, especially because support and de-briefing services are often not available to counsellors.

Confidentiality issues as barriers

It is often found that clients are, in principle, not against VCT, but that they have serious problems and anxiety about breach of confidentiality (Van Dyk & Van Dyk, 2003). Firstly they fear the reactions of their sex partners (violence, break-up of marriages etc.) should health care professionals disclose their serostatus without their permission (Campbell et al., 1997:93; Grinstead, Gregorich, Choi & Coates, 2001; Kilewo et al., 2001; Mamam, Mbwambo, Hogan, Kilonzo & Sweat, 2001:595; Tomasevski, 1992:540). Secondly, they fear the reactions of health care professionals themselves. In a study on the attitudes towards VCT among pregnant women in rural south west Uganda, Pool, Nyanzi and Whitworth (2001:605) found that although the women were prepared to be tested, there was a widespread fear that maternity staff might refuse to assist them deliver their babies. There were also pervading rumours that medical staff intentionally kill HIV positive patients to stem the spread of infection.

Fear about the lack of confidentiality was also a key service-related barrier affecting participation in VCT services in Kenya and the following problems were identified: Fear in case others learnt their results, unfamiliarity with the benefits of knowing one's status, and fear of stigma both of being tested and of being HIV positive (Arthur et al., 2000; Ngatia, Arthur, Mutemi, Odhiambo & Gilks, 2000). In a study of people who were not tested before, and who didn't plan to be tested, Phillips, Coates, Eversley and Catania (1995:160) found that participants (especially women in stable relationships, black people, younger people and those with a lower income) were only willing to be tested if no one else could access their results.

A lack of incentives as barrier: "Why test if there are no treatment options available?"

Another aspect of VCT that presents a huge problem in SA, is that proper follow-up and support services after diagnosis are not always available. An issue that is often debated, is whether it is ethical to introduce VCT services in areas without basic HIV care and support services (Campbell et al., 1997:98). It has even been proposed by various researchers that to know one's HIV status without any follow-up support services or treatment, can be detrimental to a person's mental and physical well-being. Feelings of fatalism and depression were reported by clients who believed that there was nothing they could do about AIDS. Indeed this fatalism may actually prevent any form of sexual behaviour change or self care (Kipp, Kabagambe & Konde-Lule, 2001:102; Macintyre, Brown & Sosler, 2001:161; Stein, 2002:2; Van Dyk & Van Dyk, in press). Gaillard et al. (2000) found that 15% of the HIV positive women in their study felt that it would have been better not to know their status,

because this knowledge led to depression, since there is no cure for HIV infection. Similar results were found in a study where the majority of sex workers in KwaZulu-Natal - who were willing to be tested monthly for HIV - did not want a positive test result disclosed to them. They believed that the knowledge of a positive result would result in mental anguish, that it would threaten their relationship with steady partners and that they would lose their clients and income (Morar & Ramjee, 2000). It is only when incentives for knowing one's HIV status exist, that many people are willing to be tested. For example, in Gaillard et al.'s study, it was only the women who were able to take better care of their health, who found it useful to know their HIV positive status.

In the light of the problems experienced by VCT services in Africa, the purpose of this study was to investigate the possible service-related barriers affecting potential participation in VCT programs in South Africa.

Method

Students, who were enrolled for an *HIV/AIDS care and counselling* course at the University of South Africa (Unisa) in 2001, were used as field workers to collect the data for this study as part of a voluntary assignment. Each fieldworker was required to randomly select at least two subjects from their communities to complete a questionnaire (or, if the participants could not read or write, to answer the questions posed by the fieldworker). The only criterion for inclusion in the study was that participants were not to be family members, friends or colleagues of the fieldworker. To ensure anonymity, subjects were asked to place their completed questionnaires in an envelope and to seal it before handing it over to the fieldworker. An advantage of using Unisa students as field workers, is the variance of subjects that could be reached with the questionnaires. Because Unisa is a distance education university with students residing all over South Africa, the sample included urban as well as rural inhabitants of all nine provinces of the country. Questionnaires were filled in by 1422 participants.

A semi-structured questionnaire with 22 closed- and open-ended questions was used to collect data for the study. The purpose of the questionnaire was to establish the beliefs and attitudes of the participants towards voluntary counselling and testing. The questionnaire obtained the following information:

- Biographical information (age, sex, residence, ethnic group, marital status, academic qualifications and occupation);
- Availability and accessibility of VCT services in the participant's community (e.g. clinics or hospitals);
- The importance (in principle) for every person to know his or her HIV status, as well as reasons for the answer (open-ended question);
- Personal willingness to be tested for HIV, as well as reasons for the answer (open-ended question);
- Preferred testing site: Would participants go to their nearest clinic or doctor, or would they rather go to a place where nobody would know them? Reasons for the answer were to be given (open-ended question);
- Preferred test: Did participants prefer rapid HIV tests with immediate feedback, or did they prefer to go back for their test results at a later stage?

- Participants were also asked, in open-ended questions, to share their previous experiences with HIV testing and counselling.

The closed questions were coded and analyzed by using the SPSS statistical package. Chi-square tests were used to analyse the differences between groups, and the level of significance was set at 5%. The open-ended questions were content analysed.

Results

Biographical information

The mean age of the 1422 subjects was 32.3 years ($SD=10.2$ years), 37.8% were males and 62.2% were females. The age distribution was as follows: 8.2% of the participants were younger than 20 years, 36.7% between 20 and 30 years, 30.4% between 30 and 40 years, and 24.7% were older than 40 years. Of all the respondents, 37.4% were married, 53.5% were single, and 9% were either divorced or widowed. The participants represented most of the major ethnic groups in South Africa, with 57.2% blacks, 27.4% whites, 8.6% coloureds, 6.5% Asiatic, and 0.3% represented other ethnic groups. Of all the respondents 39.4% resided in cities, 34.5% in towns and 26.1% in rural areas. In terms of academic qualifications, 0.4% of the respondents had no formal schooling, 11.6% received between one and ten years of formal schooling, 32.2% completed grade 11 or grade 12, and 55.8% had post-matric qualifications. The majority (62.1%) of the respondents were employed in the education, medical/social, administrative or commercial fields, while 14.3% were unskilled labourers, 12.8% were students, and 10.8% were unemployed. Of the subjects who participated in the study, 41.8% ($n=591$) said that they knew somebody with HIV infection or AIDS; 12.4% thought that they knew somebody with HIV infection or AIDS but were not sure, and 45.8% said that they did not know anybody who was HIV positive.

Attitudes and behaviour with regard to VCT

Most of the participants (87.3%) believed that every person should know his or her HIV status, 79.1% were personally prepared to go for VCT, and 51.4% had already been tested for HIV. Only 12.8% of the participants said that they would definitely not go for VCT, while 8.1% were not sure. Significantly more black (16.9%) than white (5.4%) participants said that they were definitely not prepared to go for VCT ($\chi^2=44.02$; $df=2$; $p=0.000$).

The reasons given by the participants as to why people should know their HIV status were mainly to prevent the transmission of the virus to others (49.5%), to access treatment (3.4%), to enhance surveillance and awareness programmes (2.6%), and to prepare for death, the future of children and a will (1.01%). Many participants (34.3%) gave multiple reasons as to why they thought that every person should know his or her HIV status, the main reason being prevention.

Participants who believed that it is NOT advisable for every person to know his or her HIV status ($n=181$), gave the follow-

ing reasons: A disturbing number of the participants (66.7%) believed that to know your HIV status will cause depression and bring about an early death; 13.9% asked what is the point of knowing your status if there are no treatment options; 11.7% believed that to know your status is to be rejected by loved ones and the community; 5% believed that most people won't know how to care for themselves; and 2.8% believed that knowledge of one's HIV status may contribute to the acting out of myths in communities. As one respondent explained: This person may not know what to do with the information (being HIV positive) and go out to rape babies to rid himself of the curse.

The following groups were the most likely to have been previously tested for HIV: City people (city = 57.4%; town = 49.9%; rural = 44.3%, $x^2=15.63$; $df=2$; $p=0.0004$), white people (white people = 64.1%; black people = 46.9%, $x^2=30.0670$; $df=1$; $p=0.00$), unmarried people (unmarried = 63.4%; formerly married = 56.6%; married = 42%, $x^2=57.43$; $df=2$; $p=0.00$), people with a higher education (62.1% = tertiary education; 37.4% = high school or lower, $x^2=74.85922$; $df=3$; $p=0.00$), and subjects who knew somebody with HIV (knew somebody = 59.5%; not knowing somebody with HIV = 47.1%, $x^2=19.13$; $df=2$; $p=0.00$).

Accessibility and choice of facility

More than half of the respondents (61.6%) indicated that there was a clinic, offering HIV/AIDS services, easily accessible to them; 12.8% did not have a clinic easily accessible to them, and 25.6% did not know if there were clinics in their communities.

In answer to the question: 'Would you go to your nearest clinic or doctor for VCT, or to a place where nobody knows you?' 67.2% of the 1422 subjects said that they would go to their own clinics or doctors, while 32.8% said that they would go to a clinic or doctor where nobody would know them. Some of the reasons given as to why participants ($n=948$) would go to their own clinics or doctors were: Trust in these health services (51.8%); logistics - that is, their own clinics were close by and they could not afford to travel to a distant clinic (24.6%); or they felt that they had nothing to hide, because they were probably HIV negative (14.6%). The 462 participants who indicated that they would definitely go to an unknown clinic or doctor, gave the following reasons: No trust in the health care system (50.3%), fear that confidentiality would not be observed (29.6%), fear of prejudice and rejection by health care workers (8.6%), a preference for total strangers (7.22%) and fear of stigmatisation and embarrassment (4.3%). Some responses, voicing a distrust in the health care system, were: The nurses always gossip and they will tell everybody that I have AIDS; She will be nice now, and when I go back with my baby, she will refuse to treat me or my baby.

Participants who preferred to go to a distant clinic for VCT, where nobody would know them, were younger subjects (39.5% < 25 years; 33.5% between 25 and 40 years; 24.9% > 40 years, $x^2=10.55$; $df=2$; $p=0.005$), unmarried people (unmarried=38.5%; formerly married=28.6%; married=25.5%, $x^2=24.74$ $df=2$ $p=0.000$), participants living in the rural areas (rural =36.7%; towns =34.5%; cities=28.6%, $x^2=7.65$; $df=2$; $p=0.022$) and black people ($x^2=49.49$; $df=1$; $p=0.000$). While 19.3% of white people indicated that they would go for VCT to a clinic or doctor where nobody would know them, 39.6% black participants were not prepared to use health services where they were known. People who knew somebody who is HIV positive, were also more

inclined to go to a clinic where nobody would know them (35.27%) than people who did not know an HIV positive person (27.86%), ($x^2=8.1692$; $df=1$; $p=0.0043$).

Preference of testing method

Most of the participants (84.7% or 1187) said that they would prefer rapid HIV antibody tests, where the results are almost immediately known, mostly because they would find the waiting period very stressful, and because it is often logistically difficult for them to go back to the clinic for the results at a later stage. However, 15.3% of the participants indicated that they would not want their test results immediately, because they would need time to adjust to the possibility of being HIV positive, and because they were not sure if they wanted to know the results at all. Rapid testing was preferred mostly by respondents living in cities (cities=89.4%; towns=84%; rural=78.6%, $x^2=20.03$; $df=2$; $p=0.000$) and by white participants (white=96.1%; black=79.3%, $x^2=58.97$; $df=1$; $p=0.000$). While 20.8% black people said that they did not want their results immediately, and would prefer to go back for their results at a later stage, only 3.9% whites did not prefer rapid testing. Ten percent of the participants indicated, however, that they would not be able to go back to clinics to get their results at a later stage, mainly due to financial problems and transport difficulties. Significantly more black people (12.2%) were not able to return later for their HIV results than whites (4.7%), ($x^2=17.51$; $df=1$; $p=0.000$).

Some of the participants, who were previously tested for HIV, made the following remarks with regard to the method of testing and the waiting period for results: (1) "I was very scared and nervous while waiting for the results, and that is where improvement is needed"; (2) "I had to go back twice before my results were available. I almost did not go back again. I slowly died in that time."

Previous experiences with HIV counselling and testing

Of the 719 (51.4%) subjects who indicated that they were tested for HIV before, a shocking 79.6% ($n=572$) were tested without pre- and post- HIV test counselling. More blacks (28.1%) than whites (12.1%) received counselling with testing ($x^2=23.35$; $df=1$; $p=0.0000$), probably because white people often visit private doctors or private hospitals, where testing is often not accompanied by counselling.

Subjects who received pre- and post- HIV test counselling were asked to share their experiences with the researcher, and to make suggestions for improvement where necessary. Experiences were mostly favourable and described as being professional, compassionate, supportive and informative. Participants also felt that the structured situation helped them to think about the results and its consequences and to make informed decisions. Participants generally appreciated a positive and hopeful attitude ("My doctor did not present my HIV positive results as a death sentence, and he discussed treatment options, treatment success, recent research, and known expertise with me. I felt like I knew what to do if I tested positive. It prepared me for what to expect, but it was also very frightening.")

Unfavourable experiences with *counsellors* included a lack of

knowledge, experience, skills, depth and sensitivity. Subjects complained that counsellors could often not answer their questions about AIDS; that the information given was often too general and vague, or too technical; that the counsellor was too young and inexperienced; that he/she was too embarrassed to speak openly and frankly about sex; or that the counsellor was impersonal and distant. Some respondents also raised cultural issues, such as language problems, eye contact ("she stared at me all the time, which made me very uncomfortable"); sex and age ("it was embarrassing for me as an old man to be counselled by a young woman") and cultural insensitivity ("counselling was based on my colour. She said that because I am black, my chance of having it is higher.") Unfavourable experiences with post-HIV test counselling had mainly to do with the counsellor being too serious and too cautious: ("I was just being told as if it is a death sentence"; "counsellors should smile more" and "they should concentrate on life after a positive diagnosis. I am not going to die tomorrow.")

Unfavourable experiences related to the *counselling process* included the following: (1) a lack of enough counsellors - especially in governmental health departments, long lines and long waiting times to be counselled ("They should appoint more counsellors". "We have to wait for hours for one counsellor to help us"); (2) the lack of privacy ("They don't give counselling alone. They counselled us in a group with others. This AIDS is too private and personal to do that". "They have this AIDS room in the hospital. Who wants to go into the AIDS room?"); (3) impersonal contact in some cases ("They gave me a form with all the information to read and to sign [pre-test counselling]. I had no opportunity to ask questions. And how do they know that I can read and understand it?"). Some participants also complained about unsatisfactory post- HIV test experiences that were mainly attributed to a lack of proper training of counsellors ("My post-test experience was very bad. They said nothing and just gave me this printed medical certificate [the formal laboratory results]. They asked me to read it, but I did not understand the words. It was horrible. And after a long while, they said: Do you understand it? You are positive.")

Apart from suggestions for more counsellors, which would solve logistical problems, and for provision of more private (as opposed to group) facilities, participants were especially concerned about support during the long waiting period for results. They also needed follow-up counselling and support for themselves and their families after diagnosis, referral to HIV positive support groups, and they voiced a special need for spiritual counselling. Some of the responses were: "The counsellor must be available in the waiting period - for my family as well; I need follow-up counselling to help me to accept my diagnosis"; "I want to be introduced to other HIV positive people - who will advise me on how to live and cope with HIV"; "She must visit me and my family at home; I need somebody from the church to support me"; and "She must always be available - also after hours when my family needs help and support".

Discussion

What do VCT services look like, and what are the needs of the clients

South Africa has the physical infrastructure to offer comprehensive health services through its public health clinics, and it is also evident from the research results that the participants were generally aware of the HIV/AIDS services that are offered, especially in the black communities living in rural areas. People in towns and cities (especially whites) are less aware of the availability of HIV/AIDS services offered by clinics, possibly because they tend to consult private practitioners, rather than go to clinics. Services offered by clinics should, however, be advertised more broadly, as 25.6% of the participants did not know if there were any clinics close to them offering HIV/AIDS services.

Although clinic services are available, they are not always readily accessible to people due to distance, transport problems and high transportation fees - as indicated by 17.5% blacks. Participants also complained about the lack of enough counsellors, long lines and the lack of privacy. Apart from appointing and training more counsellors, the possibility of establishing more mobile services to bring the clinics to the people should be investigated - not only to make services more available, but also to assure the confidentiality and anonymity of the clients.

The SA department of health is in the process of introducing rapid HIV antibody testing in most of its clinics, and it seems that this is also what the majority of the participants (85%) in the current study preferred. Not only because they find the waiting period very stressful, but also because they often find it logistically difficult or impossible to go back for the test results (Masuku, 2001). Counsellors should, however, be sensitive to the fact that some people prefer not to receive their results immediately after testing. In the current study, especially black people (21%) indicated that they need time to adjust to the possibility of being HIV positive, or they need the time to decide if they want to receive the results at all. Health care facilities using rapid tests should therefore ask their clients if they are ready to receive the results directly after the test. Clients may also be offered the choice between rapid HIV antibody- and ELISA antibody testing after the advantages and disadvantages of both have been explained to them.

The finding that almost 80% of the subjects, who were tested for HIV before, did not receive any pre- or post- HIV test counselling, indicates that the national policy on testing is not yet properly implemented in South Africa, especially in private practices and private hospitals. Kassler (1997:28) reported similar findings in the USA where 59% of the subjects, who were tested for HIV in the private sector, did not receive pre-test counselling, while 71% did not receive post-test counselling.

Confidentiality, trust, negative attitudes and prejudice

Distrust in the public health care system is a huge stumbling block in the provision of comprehensive VCT services in South Africa - as it is in many other parts of the continent (Arthur et al., 2000; Ngatia et al., 2000; Pool et al., 2001:605). Fear that results will not be kept confidential by health care workers, is evident in the finding that a significant proportion (33%) of the subjects, who were prepared to be tested for HIV, said that they would definitely go to a clinic where nobody would know them.

Due to the closely-knitted community life and extended family systems in many communities in Africa, it is often inevitable for health care professionals to be familiar with most of the clients whom they are counselling, and their roles as nurses, counsellors, friends and family often become blurred (Van Dyk, 2001a:124, 2001b:9). Many counsellors often do not observe confidentiality and they see it as their 'moral' duty to disclose a client's HIV positive status to the client's partner - and often to other members of the client's community to 'protect' them (Personal communication by health care workers in focus groups, 2002). It should be stressed to counsellors that this is a breach of the appropriate ethical and legal procedures. Clients therefore often have valid reasons not to trust health care professionals with their HIV positive test results.

Confidentiality and trust in the health care system are major public concerns, and everything possible should be done to overcome this barrier if VCT is to be a successful part of HIV care and prevention programmes. One of the major challenges for the South African health services, is to change the image of its counsellors as people who tell to people who can be trusted. The importance of confidentiality, and the breakdown of negative attitudes and prejudice cannot be emphasized enough in training programmes. Anonymous VCT sites where clients are unknown to the counsellors, or where they can use pseudo names, mobile clinics, or an exchange system where counsellors work in areas not known to them, may also offer a solution - not only to assure confidentiality, but also to assist the counsellor who has to face people they know with HIV positive results. The downside of anonymous testing, is that clients who prefer anonymity, will also often not access follow-up counselling or much needed health services.

Need for follow-up support

The subjects, who participated in this study, expressed a very specific need for follow-up counselling and support for themselves and their families, both in the period awaiting results, as well as after diagnosis. The question why test if there are no treatment or care options available underlaid the answers of 86% of those subjects who felt that it was not advisable for someone to know his or her HIV status. These individuals felt that to know one's HIV positive status, without any possibility of follow-up care and support, is only to cause depression, despair and death. Similar results in other parts of Africa were found by Gaillard et al. (2000), Macintyre et al., (2001:172) and Morar and Ramjee (2000).

VCT programmes should therefore, in both pre- and post- HIV testing, place much more emphasis on positive living after the diagnosis, on self-care and nutrition, as well as on prevention and treatment options for opportunistic infections. By doing this, the advantages of going for VCT will become more visible to people in the community and contribute towards the success of VCT programmes.

The need for follow-up support poses a real challenge in a health care system that makes use of rapid HIV testing, where clients may pay only a once-off visit to the clinic. A very strong referral system should therefore be in place, and the possibility to establish post-test support groups or 'clubs', where HIV positive as well as HIV negative people can support each other,

should be investigated. The importance of the development of post-test support services is emphasized by many researchers in Africa. Long-term social support is, for example, provided in Uganda through post-test clubs where both HIV positive and negative club members meet for mutual support and reinforcement of long-term behaviour change (Campbell et al., 1997:104). HIV positive clients with symptoms should be referred to home-based-care programmes and other AIDS support organizations. Participants in the current study also showed a strong need for spiritual counselling.

Conclusion

Although much has already been done in South Africa to make VCT services available and acceptable to the public, the road ahead is still steep. A comprehensive VCT service in South Africa faces various challenges, such as the appointment of enough counsellors, the establishment of trust in the counselling services, adequate testing sites and a general availability of rapid testing. One of the most important factors for VCT to succeed in South Africa, is the proper training and support of counsellors. It will be expected from nurses, who already carry a very heavy burden in this epidemic, to form the backbone of VCT services. If they are not properly selected, trained, supported and de-briefed, it may lead to burnout and provision of unsatisfactory services to their patients.

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