

**A PHENOMENOLOGICAL STUDY OF FOUR STUDENTS' EXPERIENCES OF
VOLUNTARY COUNSELLING AND TESTING**

by

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PRETORIA

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DECLARATION

I, Tebogo Veronica Sefularo, declare that this research report is my own work and that all sources quoted and used have been indicated and acknowledged by means of complete references. This dissertation has not been submitted before for any degree at any other University.

SUMMARY

Voluntary counselling and testing (VCT) has become a vital process in combating the spread of HIV/AIDS. Yet little has been published on how students experience the process of VCT.

This study sought to describe and understand the experiences of voluntary counselling and testing among four students at Tshwane University of Technology. This research project focussed on students' experiences when reporting for voluntary counselling and testing. The results were used to make recommendations for strategies to increase the accessibility and uptake of VCT by students.

Using a phenomenological approach, tape recorded interviews were conducted with the four students of Tshwane University of Technology (TUT). The data were then categorised into five themes relating to the experience of VCT: emotions, perceptions, actions, thoughts and desires. The results showed that the students were mostly dissatisfied with the VCT clinic's procedures and the counsellor's attitudes. Also evident from this study was that counsellors' professionalism, peer support, and a service that offers both pre- and post-test counselling play a significant role in students' use of VCT.

The findings of this study suggest that the following could be used as strategies to motivate students to utilise VCT services of VCT: (1) increase access and acceptability of VCT for students; (2) ensure access to factual information in the form of counselling; (3) make counselling a priority.

Key terms:

Experiences

Voluntary Counselling and Testing (TUT)

Students

Tshwane University of Technology (TUT)

HIV/AIDS

Phenomenology

Qualitative research

SAUVCA

ACU

HEAIDS

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List of abbreviations

AIDS	Acquired Immune-deficiency Syndrome
HIV	Human Immune-deficiency Virus
VCT	Voluntary counselling and testing
TUT	Tshwane University of Technology
DOE	Department of Education

CHAPTER ONE

OVERVIEW OF THE STUDY

I went for testing at my local hospital after a friend was diagnosed with AIDS in 1984. In the hospital passage – with no counselling – I was informed that I tested positive for HTLV3 (the name for the virus leading to AIDS in the 1980s). I was 34. My first reaction was total denial. I saw what my infected friend was going through, so I understood what this meant: a death sentence. I left the hospital angry. I kept asking: “Why only me?” Eventually, I realised why: I went looking for it, it was my responsibility.

(Van Zyl, 2006).

It is more than two decades since HIV/AIDS entered our lives uninvited. The disease that does not discriminate in terms of gender, culture, religious belief, race or socioeconomic background invaded our lives and has spread rapidly across the world, destroying everything that came into contact with it.

HIV/AIDS is claiming the lives of the promising skilled young people in an alarming rate. The elderly people who need care themselves are left to care for their grandchildren.

HIV/AIDS have claimed many lives since it was discovered in the early 1980s. The disease is spreading rapidly mostly through sexual contact with an infected person. The disease has been given many names, including *BMW*, *Sphamo* (snatcher), and *Z3*, either out of denial or to try and normalise the disease and reduce the stigma associated with it. Van Dyk (2001) calls it a Raka, a beast; a monster that emerged from the darkness and threatens communities by destroying everything they believe in. The disease has left individuals feeling hopeless, anxious, and fearful. The metaphors mentioned above paint a clear picture of how people have come to relate

to the disease: it is fearful, unpredictable and life threatening, a death sentence, and punishment from the gods. HIV/AIDS has become part of our lives; it has consumed our identity. We may not all be infected with the disease; but we are all affected by it, many of us having lost a friend, a neighbour or a family member to HIV/AIDS.

UNAIDS/WHO (2006) estimates that a total of 40 million people were living with HIV in 2006 (2.6 million more than in 2004). The number of new infections in 2006 rose to 4.3 million in 2006 (400 000 more than in 2004). Sub-Saharan Africa is the region most affected by HIV/AIDS, with two thirds of all people living with HIV found in this region. This number totalled 24.7 million in 2006, with almost three quarters of all adult and child deaths due to AIDS occurring in this region. Most, if not all, of the 24.7 million people in sub-Saharan Africa living with HIV/AIDS will have died by 2020, in addition to the 17 million Africans already claimed by the epidemic (Barnett & Whiteside, 2006). Asia has also experienced a dramatic increase in HIV/AIDS of 21% in the past two years (UNAIDS/WHO, 2006). There are more than 17.7 million women aged 15 and above living with HIV/AIDS on this continent.

The South African government has introduced different programmes in its strategic plan to control the spread of HIV/AIDS. The media is playing a major role in trying to educate people about the disease. Songs about HIV/AIDS and its prevention have been written and performed to make people aware of the seriousness of the disease. Television, radio, and the print media have also done their part to disseminate knowledge, while movies and dramas also encourage people to educate themselves about the disease.

1.1 Awareness of the Problem – A Personal Account

I became aware of HIV/AIDS in my high school years, when HIV research was just beginning in earnest, while the disease was already making its presence felt in communities. I had read and heard about HIV but was shocked when it claimed my cousin in 1995, 13 years after the first case was reported in South Africa.

I noticed that HIV/AIDS claimed mostly young people with dreams and ambitions, people with a future ahead of them. My cousin was the first real case of HIV/AIDS that I and others from my community were confronted with. Although he did not disclose to anyone, everybody (except the family) assumed that it was HIV/AIDS. He was the first case in my community, and this made HIV/AIDS real to us. My cousin had been ill with a combination of symptoms that surprised everybody, many of whom continued to believe that he had been bewitched until his death.

HIV/AIDS brought tremendous fear to our lives, although the fear did not stop people from engaging in risky sexual practices. HIV/AIDS also continued to destroy lives, inflict pain and cause suffering by claiming more and more people. Some families were afflicted several times over, losing a number of members to the disease. Although fatalities sky-rocketed, few people took steps to change their lifestyle, which would have meant giving up everything that they knew, and adopting a radical new perspective on life.

I was a postgraduate student when I first heard about people reclaiming their lives by getting tested. This presented me with an opportunity to get to know my status. I believed that testing was the answer: that people would get tested and then change their lives. I even imagined that this might be a cure for the devastation caused by the disease. As I heard more about VCT, I decided to take the test myself, and made important decisions about my life based on this action. I also started wondering about those people who neglected the wonderful opportunity to reclaim their lives through testing, and beat HIV/AIDS before it beat them. As infection rates continued to increase, however, I realised that people did not want to know their status and avoided being tested or changing their behaviour. It became apparent to me that the messages about the disease and the actions that can be taken to prevent it still did not seem clear to many people.

All of these experiences contributed to my desire to investigate HIV/AIDS prevention programmes. The focus of this study is on one method of HIV/AIDS prevention; voluntary counselling and testing (VCT). VCT is an important tool in HIV/AIDS prevention that allows people to evaluate their behaviour and its consequences. The emphasis in the existing literature has been on the acceptability of VCT services (Boswell & Baggaley, 2002; Van Dyk & Van Dyk, 2003); however, use of this service has been found to be low (Human Sciences Research Council [HSRC], 2002; Van Dyk & Van Dyk, 2003). Other studies have focused extensively on perceptions and attitudes to voluntary counselling and testing among young people (Van Dyk & Van Dyk, 2003; Boswell & Baggaley, 2002). To date however, relatively few studies have focused on clients' experiences of voluntary counselling and testing, particularly among tertiary students. Young people between the ages of 15-35 years, the majority of whom are currently in school, colleges, and universities, have been identified as vulnerable to HIV infections (UNAIDS/WHO, 2006; Horizons Project, 2001). According to the World Bank (2001), university students in Africa are at a high risk of contracting HIV/AIDS because of high-risk activities such as "sugar daddy" practices and unprotected casual sex with multiple partners. The vulnerability of young people makes it imperative that HIV/AIDS interventions target this population. It is also important to promote VCT among the most vulnerable sectors of society. This study chose to focus on students at a tertiary institution.

1.2 Developing the Research Topic

HIV/AIDS infections continue to grow at an increasing rate, claiming lives of both young and old. Youth are considered a vulnerable group, dying before their parents and leaving children in the care of grandparents who themselves need to be cared for. The potential result is a nation lacking in skilled youth, which will lead to decline in the economy, and the growth and development of the country.

Voluntary counselling and testing gives people the opportunity to know their HIV status so that they can take charge of their life in terms of care, support and

prevention. In the last few years, HIV has continued to increase despite efforts from government and other stakeholders to make VCT available to all. Despite many advances in this area, the number of people accessing VCT remains relatively low (HSRC, 2002). Many people are afraid to be seen accessing VCT services because of the stigma attached to HIV infection, or because they see knowledge of HIV infection as a burden and would prefer not to know their status. For those who are willing to use VCT, the services available were initially limited (HSRC, 2002) even though that has changed in recent years. VCT services were limited by a lack of human resources such as trained professionals, which led to the introduction of lay counsellors to make up this shortfall. The shortage of skills and resources has been addressed with the addition of VCT centres around the country.

Due to stereotyping around HIV, many people do not volunteer to have themselves tested (Njagi & Maharaj, 2006). HIV was initially discovered amongst gay men, then commercial sex workers, truck drivers and intravenous drug users. This created the illusion that the general population was not at risk of contracting HIV.

Fear of disclosure and stigma remain the biggest barrier to HIV testing (Van Dyk & Van Dyk, 2003). VCT has become associated with death (Hubble, 2002), as many people do not take the test until they show the symptoms of AIDS and are very ill. These challenges prove that much work has yet to be done to 'naturalise' HIV/AIDS, so that people accept it as just another medical condition and encourage each other to go for testing. Voluntary counselling is a process whereby an individual decides to determine his or her HIV status (Evian, 2000). VCT as a preventative strategy to curb the spread of AIDS provides individuals with an opportunity to learn and accept their HIV status.

During VCT, individuals reporting for an HIV test are given information about HIV/AIDS in the form of confidential pre- and post-test counselling. Counselling gives individuals an opportunity to decide whether to go ahead with the test (pre-test) and provides information on ways of preventing future infections (post-test). Counselling also offers support to individuals in dealing with their fears, anxieties, worries and other problems

(Evian, 2000). Knowledge of HIV status can help individuals in deciding how to protect themselves and their partners by practising safer sex (UNAIDS/WHO, 2001).

Despite the attitudes and fears associated with HIV testing there are people who report for voluntary counselling and testing. People go for HIV testing because they are getting married; or because they fear that they have been infected by their partner; are moving to a new job or are pregnant (Van Dyk & Van Dyk, 2003). What remains unknown is the experiences that people go through as they go for voluntary counselling and testing. Hubble (2002) believes that testing specific groups such as youths, people living with HIV, and the general public can lead to rich and valuable information on the mechanisms of HIV infection.

1.3 Problem Statement

HIV/AIDS infections continue to increase rapidly despite the government's efforts to control the spread of the disease. HIV/AIDS is claiming the lives of young people at an alarming rate (UNAIDS/WHO, 2006) which leaves orphans in the care of aged grandparents or left to fend for themselves. The underutilisation of VCT services is a concern for everyone involved in the fight against HIV/AIDS. The national survey by the HSRC (2002) reports a low uptake of VCT with only one in five people in South Africa who know about VCT having been tested (Department of Health, 2004; Shisana & Simbaya, 2002). It is evident from the statistics that more must be done before we can claim containment of the problem. The underutilisation of VCT also contributed to my curiosity to know and understand the experiences of those who have reported to VCT centres and taken HIV tests. My curiosity prompted me to ask the following questions:

- What is it like to go for voluntary counselling and testing?
- What strategies do student users of VCT think can be implemented to improve the utilisation of VCT by students?

To answer these questions I interviewed four students from Tshwane University of Technology (TUT) who had experience of voluntary counselling and testing.

1.4 Aims of the Study

1.4.1 Specific aim

The specific aim of the study was to describe and understand the experiences of students who underwent voluntary counselling and testing.

I chose to focus on young people, and particularly students aged between 18-30 years because HIV/AIDS statistics show that young people are the group that is the most vulnerable to HIV infection. According to UNAIDS/WHO (2006), 18.8% of HIV infections are found in the age group of 15-49 years. In addition, young people from 17 years of age constitute the age group of students at tertiary institutions. All this contributed to me wanting to focus on students at tertiary institution.

1.4.2 General aim

The general aim of the study was to investigate possible strategies that could be used at the TUT HIV/AIDS Centre to improve access and utility of VCT by students.

The focus of this study was not on the rightness or wrongness of testing. Rather, my intention was to understand voluntary counselling and testing from the clients' perspectives. As an employee working for Student Development and Support (SDS) at Tshwane University of Technology (TUT), I chose to work with students from this institution because of easy access to research participants.

1.5. Research Design and Method

1.5.1 Research design

A descriptive qualitative approach was used to answer the research question: *“What is it like to go for voluntary counselling and testing?”* This approach was relevant for this study since the aim was to gain insight and understanding of students’ experience of voluntary counselling and testing. The students’ reported experiences are classified under five themes:

- Perceptions
- Thoughts
- Emotions
- Desires and
- Action

1.5.2 Research method

Students were recruited by means of posters advertising the study that were displayed on campus. Permission was also asked to put up posters at the AIDS Centre as a way of recruiting potential participants. The aim and objectives of the study were clearly stated on the posters. Interested participants were then invited to attend an information session where they were informed about the study and invited to sign consent forms. One-on-one Interviews were conducted with all participants at a time suitable to them. Each participant gave permission for the interview to be tape-recorded. All four participants were asked the same question: *“Have you been tested for HIV? Please tell me about your experience.”* The following questions were used to follow up on the first question:

- What feelings did you have about testing, before, during and after the test?
- What desires did you have in terms of VCT?
- What was your perception of VCT?
- What did you do/ should have done?
- What were you thinking?

1.5.3 Participant selection

Four participants were selected to participate in the study. The criteria used to select participants were as follows:

- Participants should have tested for HIV
- Participants should be students of Tshwane University of Technology (TUT)
- Participants should agree to participate in the study

1.5.4 Data analysis

The taped interviews were transcribed verbatim. The data were analysed according to a phenomenological analysis of qualitative data. All the participants were invited for second interviews to validate the data. My conclusions form the basis for a description of strategies that could be used to improve students' utilisation of VCT.

1.6 Definition of Concepts

To make sure that the reader is not confused by some terms, the following section contains definitions of important concepts discussed in this study.

- **Human Immunodeficiency Virus (HIV)**

Van Dyk (2001) defines HIV (Human Immunodeficiency Virus) as the agent that causes AIDS. It enters the body from the outside and is spread by body fluids, particularly blood and semen.

- **AIDS (Acquired Immunodeficiency Syndrome)**

AIDS is an acquired (rather than an inherited) disease. It is caused by a virus (HIV) which enters the body from outside. Immunity refers to the body's natural, inherent ability to defend itself against infection and disease. Deficiency refers to the fact that the body's immune system has been weakened so that it no longer defends itself against passing infections. A syndrome is a medical term which refers to a set or collection of specific signs and symptoms that occur together and that are

characteristic of a particular pathological condition (Whiteside & Sunter, 2000). Although often referred to as a disease, AIDS is really a collection of many conditions that manifest in the body or specific parts of the body because the body's immune system has been weakened by HIV to the extent that it can no longer fight opportunistic infections (Van Dyk, 2001)

- **Voluntary Counselling and Testing (VCT)**

VCT is the process whereby a self-referred client decides to be tested for HIV. The process is divided into three sections; the pre-test counselling, the testing process and post-test counselling. During pre-test counselling, clients' knowledge of HIV/AIDS is explored, they are educated about the meaning of a positive and a negative HIV test, their support system is explored and clients are informed about the testing process (UNAIDS/WHO, 2002). In the testing phase blood is drawn to determine the HIV status of a person. During post-test counselling client are again educated on the meaning of the test results, on nutrition and safe sexual practices.

- **Experience**

In addition to physical encounters, experience refers to people's perceptions, thoughts, emotions, desires and actions. It can be passive, referring to something that people witnesses or hear; and also active, referring to what people are doing, for example, walking or hammering a nail (Morrisette, 1999). Experience is also comprised of outward (observing what others do or say) and inward movement (focusing on one's private world). Apart from experience being a part of us, it is also situated in the world and around us (Polkinghorne, 1989).

- **Participants**

Participants in this study are all students of Tshwane University of Technology (TUT) in South Africa, who attend class at Pretoria Campus.

- **Tshwane University of Technology (TUT)**

TUT is one of the largest universities of technology in the North West and Gauteng provinces of South Africa, born of the merger of three institutions; Technikon Northern Gauteng, Technikon North-West and Technikon Pretoria. TUT also has satellite campuses in Nelspruit and Witbank. The focus of TUT is on both traditional classroom education and on experiential learning.

- **TUT AIDS Consultancy Centre**

The AIDS Consultancy Centre was established in 2001 on the Technikon Pretoria campus as a stand-alone centre prior to the merger of three technikons (Pretoria, Northern Gauteng and Gauteng). It has since grown and amalgamated with services such as the Campus Clinic. Each of the three TUT campuses has an AIDS Clinic.

The AIDS Consultancy Centre at TUT is committed to rendering services and support to staff and students affected and infected directly or indirectly by HIV/AIDS. The vision of the Centre is to create an environment of awareness, support, care and acceptance for those infected or affected by HIV/AIDS. The Centre's services include counselling, prevention, care and support, peer education, education and training, and community outreach. The services offered at the Centre are aligned with the National Department of Health's HIV and AIDS strategy, and on a micro level with the Higher Education sector's response to HIV, with its key pillars being linked to the teaching, learning and research function of the institution (www.tut.ac.za).

The clinic makes use of peer supporters who work as volunteers and become involved in campaigns, outreach programs and HIV education.

1.7 Ethical Considerations

Researchers must adhere to certain standards to avoid causing harm or putting participants in danger. It is for this reason that the ethical standards laid down by Struwig and Stead (2001) were adhered to in this study, with regard to:

- Consent
- Confidentiality
- Anonymity
- Privacy
- Dissemination of information
- Withdrawal from the study
- Validity and reliability
- Trustworthiness

These are described in detail in chapter three.

1.8. Division of Chapters

This section provides an overview of the report, giving a brief summary of the content of each chapter.

Chapter 2 constitutes a review of the literature relevant to the research focus area and the research question. Overviews of HIV/AIDS as a global crisis and in South Africa are highlighted. A brief discussion follows on the general impact of HIV/AIDS and the responses to the disease. The impact of HIV/AIDS on education and the response by the educational sector is also included. Also discussed in this chapter is voluntary counselling and testing, the benefits and impact of VCT, the experience of VCT, and how other countries have reacted to this strategy. Lastly, the chapter examines the model of delivering VCT and ethical elements guiding this strategy.

Chapter 3 explains the research methodology, choice of research participants, data gathering and analysis.

Research findings are discussed in chapter 4. This chapter also looks at the findings yielded by the data. It forms the basis from which this study generates its conclusion.

Discussions that emanate from the experiences of VCT are categorised into five themes: *perceptions emotions, desires, actions and thoughts*.

Chapter 5 begins by reviewing the purpose and the expectations of the study and then discusses the extent to which the results are consistent with other researchers' findings. The chapter also links the research findings with the literature study.

Chapter 6 discusses the suggestions to improve the delivery of VCT to students, and limitations to the study. This is followed by recommendations for intervention and research and the conclusion.

Chapter 7 is entitled "the epilogue" and in this chapter I reflect on the lessons and the challenges I encountered during the process of this research.

1.9 Summary

In this chapter, an overview of the study was given, consisting of the background to the problem, my awareness of the problem, the problem statement, the research questions, the definitions of concepts, an overview of the research design and methods, ethical considerations as well as the divisions of chapters. The next chapter provides a review of relevant literature.

CHAPTER TWO

LITERATURE REVIEW

This chapter focuses on the global HIV/AIDS crisis as well as the situation in South Africa, as well as various responses to the disease. This chapter also examines HIV/AIDS in the education sector, how the sector has responded to it and the situation at tertiary institutions. The focus of this study is to understand and describe the phenomenon of voluntary counselling and testing (VCT) from the perspective of students' experiences. Voluntary counselling and testing, fears associated with HIV testing, the benefits of testing as well as experiences of VCT as published in other studies are therefore also discussed. The chapter also looks at a model of VCT and certain of its core elements.

According to Mouton (1996), any traveller needs a map or literature to guide her on a journey travelled by other researchers. By reviewing the work of other researchers, I may learn about their itinerary and how they have travelled the terrain (Mouton, 1996). Mouton (1996) further states that there are different types of research maps or resources to choose from when doing a literature review. These include reviewing other people's work and using personal experience, depending on what is most relevant to the study. This research study is theory driven as it focuses on studies done in South Africa and internationally, and builds on these studies.

2.1 HIV/AIDS in South Africa

Southern Africa is now considered the epicentre of the disease, with 32% of the global HIV-infected population living in this sub-region (UNAIDS/WHO, 2006). South Africa has the highest number of people living with HIV. In 1983 only two cases of people living with HIV were reported in South Africa; however, by the end of 2004 the number had grown to more than 6.29 million (Department of Health, 2004; Dorrington,

Bradshaw, Johnson & Budlender, 2004). Although the government wants to believe that the number of people living with HIV is stabilising around 6 million (Dorrington et al., 2004) as the number of people infected with HIV seems to equal the number of people dying from AIDS-related diseases, more people are getting infected every day.

2.1.1 Impact of HIV/AIDS

With everyone affected by the epidemic, the impact of the disease has also been immense. The epidemic has had a definite impact on economic, educational, health care and social aspects of the country, in addition to death and suffering on an individual and community level. Every year more and more money is pumped into fighting HIV/AIDS with less noticeable success. In 2006, the Minister of Finance, Mr. Trevor Manuel, allocated R5,3 billion to the health sector to spend on increased remuneration for health workers and an increase in staffing levels by about 30 000 people over the next five years (<http://www.info.gov.za>). The 2006 budget framework made provision for the treatment and care of about 250 000 people who are ill with AIDS, which was the number of cases anticipated by end 2007. As a result health received a further R1,7 billion for this programme. According to Mr. Manuel, spending on dedicated HIV and AIDS programmes by health, education and social development departments will exceed R5 billion by 2009/10 (<http://www.info.gov.za>).

There are more orphans now as compared to the start of the epidemic. Young and middle-aged adults are dying at an alarming rate, leaving the elderly to look after their grandchildren. HIV/AIDS has left families impoverished as it most often claims the productive members of the family. In South Africa alone, UNAIDS/WHO (2006) estimated that there were 1,2 million orphans by the end of 2005.

Life expectancy rate has been significantly reduced as many people in the 15-49 year age group are now dying of AIDS-related illnesses. Most of the youth may not live to reach adulthood or old age, they may not live to see their children graduate or finish matric. Whiteside and Sunter (2000) forecast that the death of skilled workers would

wipe \$22 billion off South African's economy by 2010. This resultant shortage of skills would slow the development of the country.

2.1.2 Responses to HIV/AIDS in South Africa

Many programmes have been put into action in response to the threats caused by HIV/AIDS. Many countries have taken urgent steps in fighting this epidemic. In South Africa, the government has launched programmes designed to prevent the spread of HIV/AIDS that covers all aspects of the media, including radio, television and print media. Programmes and advertisements on radio promotes abstinence and condoms use, and educates people on their right to say "no" and to demand safer sex. Television programmes have also been positively involved in trying to curb the infection rates among the youth through programmes like *Isidingo*, *Generations* and *Soul City*. Young people are informed and educated about HIV/AIDS by characters in local series of *Open Sesame* and *Soul Buddies*.

However, the South African government's response to the epidemic faltered in the early stages due to the government's lack of credibility in the 1990s (Abdool Karim, 2005). The response has since gained momentum with the government's announcement in 2003 that it would make free antiretroviral treatment available in the public health service (Abdool Karim, 2005). The earliest response by the South African government included the following (Simelela, 2002):

- The creation of the inter-ministerial committee (IMC) on HIV/AIDS in 1997 chaired by the then deputy president, Mr. Thabo Mbeki
- The launch of the "Partnership against AIDS" in 1998
- The launch of the South African National Aids Council in January 2000

The HIV/AIDS/STD Strategic Plan for South Africa (2000-2005) was initiated by Dr Manto Tshabala-Msimang in 1999 to encourage involvement of all stake holders in the fight against HIV/AIDS. The primary goal of this plan was to reduce the number of new

infections among the youth and the impact of the disease on families, individuals and communities. The plan also included policies concerning four major areas, namely:

- prevention
- treatment, support and care
- human rights and legal issues
- research and surveillance of the HIV epidemic

The prevention policy of the strategic plan emphasised the following:

- The promotion of safe and healthy sexual behaviour through implementation of life skills programmes at primary and secondary schools, and procurement of high quality male and female condoms
- Increased access to youth-friendly reproductive services including management of STD, VCT and rapid HIV testing facilities
- The reduction and prevention of mother-to-child transmissions by improving access to HIV counselling and testing, and family planning
- The development of national guidelines on HIV and blood transfusion to guarantee blood safety
- Increased numbers of people, especially the youth, accessing VCT sites

To beat the disease, an intervention from three levels is needed, namely, prevention intervention, care and support intervention, and voluntary counselling and testing intervention (HSRC, 2002). The prevention intervention concerns strategies to prevent people from contracting HIV, such as encouraging people to wear condoms, to abstain and to remain with one sexual partner.

It is evident from the strategy plan that VCT was given attention in the fight against HIV/AIDS even in the 1990s. VCT was introduced in the early 1990s through city-based AIDS Training Information and Counselling Centres (ATICCs), various NGOs, private sector services, and some clinics and hospitals (Birdsall, Hajiyanis, Nkosi & Parker, 2004).

2.1.3 HIV/AIDS and education

The HIV epidemic has been spreading rapidly for the past two decades, and now affects every country in the world. Each year, more people die and the number of people living with HIV continues to rise – in spite of the fact that we have developed many proven HIV prevention methods. We know much more about how HIV is transmitted than we did in the early days of the epidemic, and we know much more about how we can prevent its transmission. However, the rate of infections is still on the rise.

The key to HIV prevention is education. This entails teaching people about HIV: what it is, what it does, and how people can protect themselves. Over half of the world's population is now under 25 years old (UNAIDS/WHO, 2004). This age group is more threatened by AIDS than any other; equally, it is the group that has more power to fight the epidemic than any other (UNAIDS/WHO, 2004). Education can help to fight HIV, and it must focus on young people because of their vulnerability to HIV/AIDS infections.

In many parts of the world, young people are particularly at risk for HIV infection from unprotected sex, sex between men and from drug use because of the very high prevalence rates often found amongst people who engage in these behaviours. Young people are also often especially vulnerable to exploitation that may increase their susceptibility to infection (UNAIDS/WHO, 2004). Even if they are not currently engaging in risky behaviours, as they become older, young people are increasingly exposed to situations that put them at risk. For example, globally, most young people become sexually active in their teens; sexual initiation usually takes place before people enter university, ranging between 15 and 17 years (Uys, 2006).

In addition to learners and students being affected, teachers are also at risk, since most teachers also fall into the high risk age group of 15-49 years. Currently, an estimated 10 000 educators are in need of antiretroviral therapy (Rehle, Shisana, Glencross & Colvin, 2005).

2.2 The Higher Education Context in South Africa

With the rate of HIV/AIDS increasing among students nationwide, tertiary institutions have formulated HIV/AIDS policies to address and control the disease. The development of policies followed the “Tertiary Institutions against AIDS Conference” held on 1st October 1999, which was addressed by the then Minister of Education, Prof Kader Asmal (Martin & Alexander, 2001). Asmal expressed his disappointment and shock that only a few institutions had instituted and presented policies on HIV/AIDS (Martin & Alexander, 2001). The conference proved to be a starting point, since in the year that followed, more institutions worked on policy initiatives.

The South African Vice Chancellors’ Association (SAUVCA) and the Association of Commonwealth Universities (ACU) played a role in evaluating universities’ responses to HIV/AIDS (Martin & Alexander, 2001). HIV/AIDS at technikons was addressed by the Committee of Technikon Principals (CTP). SAUVCA investigated management, planning, programmes and policy, and produced a concise report on what was happening around the country, making recommendations for further action (Chetty, 2000). The duty of ACU was to determine views, level of existing policies and activities relating to HIV/AIDS.

A partnership between the Department of Education (DoE), the South African Universities Vice-Chancellors Association (SAUVCA) and the Committee of Technikon Principals (CTP) formed the HEAIDS (Higher Education HIV/AIDS) Programme in 2000/2001 (www.he aids.org.za). The aim of HEAIDS is twofold:

- The first dimension relates to maintaining the institution’s ability to continue functioning, thereby preventing HIV/AIDS from undermining its potential to operate and deliver mandated services
- The second dimension relates to maintaining the institution’s core functions of teaching, training, research, community engagement and service.

According to Cornelissen (2005), the umbrella organisation for tertiary education in South Africa, Higher Education South Africa, reported that students have knowledge

about the cause and modes of transmission of HIV/AIDS, and further pointed to an abundance of international research on HIV/AIDS at higher educations on knowledge, attitudes and practice (KAP) amongst students. Additional studies were undertaken by researchers across institutions to determine the KAP (knowledge, attitude and practice) of students regarding HIV/AIDS. However, Cornelissen (2005) cited a paucity of research on testing the perceptions of different role players in HIV, and particularly the youth. Uys (2006) highlights the lack of research on the perceptions, attitudes and awareness of undergraduate students at tertiary institutions. This is a cause for concern, as fresh from high school and away from the care and support of parents, these young people have a need for independence and are venturing into the unknown world seeking experience, yet are often without the wisdom to make wise lifestyle decisions.

Cornelissen (2005) analysed the knowledge, awareness and perceptions of undergraduate students at the University of Stellenbosch. A questionnaire was distributed electronically to 800 students and a total of 206 completed and returned it. The findings of the study indicate that students have knowledge about HIV/AIDS and its modes of transmission. However, it was found that the participants had no clue about the number of people infected with HIV/AIDS worldwide. This indicates a need for awareness amongst students, and the need for greater access to HIV/AIDS statistics at tertiary institutions. Cornelissen (2005) recommends more research on HIV/AIDS at tertiary institutions.

Ibe (2002) also examined the knowledge, attitude and preventive practices of 285 first year students of Port-Harcourt in Nigeria. He administered structured questionnaires with the assistance of two trained interviewers. The findings indicate partial knowledge of the definition of HIV/AIDS, modes of transmission, prevention and cure. It was also found that 70.2% of the students have had sex, with 57% of them not using a condom. Of the total, 42.1% had had multiple partners and a vast majority of 86.0% had never tested for HIV. According to Ibe (2002), there is a strong need of HIV/AIDS prevention at tertiary level through education, counselling and testing. Ibe also recommends that

HIV testing with pre- and post-test counselling be subsidised or made free for youths (Ibe, 2002).

A study conducted in Botswana by Fako (2006) sought to identify and document social and psychological factors associated with willingness to test for HIV among young people. A representative sample of 1, 294 students from secondary schools and tertiary institutions completed a self-administered questionnaire. According to the study, although over half of the students were willing to test for HIV, willingness to test was greater among students at lower educational levels than older students, and was much higher among girls. However, students who were most at risk by virtue of being sexually active were the least willing to test, possibly out of fear. Fako (2006) recommends encouraging students not yet at risk (not sexually active) to test early so that they can start living positively.

A KAP survey at Technikon Pretoria (now TUT) in 2004 by Grundling, Pillay, Bester, and Sibanda assessed the knowledge of students on HIV/AIDS, their attitude towards the disease and their risk of infection. Participants were students at Technikon Pretoria studying at the three campuses: Arcadia, Arts and Rand. A total of 1 604 students were selected for the sample. The findings indicate a high level of HIV/AIDS awareness among students. The research team recommended the development and implementation of HIV/AIDS policies, and the implementation of a life skills programme that would give students knowledge on HIV, STIs, VCT, and so on.

In addition to the above findings, the following points, highlighted by Uys (2006), also supported the choice of young people, and particularly students, as the focus of this study:

- Students are generally knowledgeable about HIV/AIDS and know how to protect themselves.
- Although students know that the use of condoms could protect them from contracting HIV/AIDS, sexually active students tend to have a negative attitude towards them.

- Students experience peer pressure to engage in sexual activities.
- Students tend to engage in casual sex, especially when under the influence of alcohol.
- Students tend to believe that they are not vulnerable to contracting HIV/AIDS.

According to Uys (2006), there is abundance of knowledge among students at tertiary institutions about HIV/AIDS and how it is transmitted. Although students know how to protect themselves against HIV/AIDS, they still put themselves at risk because they experience pressure from their peers to use alcohol and to engage in sexual activities. Despite these dilemmas, some students accept responsibility for their lives and for protecting themselves against HIV/AIDS by finding out their HIV status. The aim of this study was to access these students, and specifically those who have gone for voluntary counselling and testing, to describe and understand their experiences.

Despite being knowledgeable about HIV/AIDS and its mode of transmission, HIV/AIDS is still claiming the lives of young women and men. Gradwell (2004) reports that an absence of feelings of self-efficacy, feelings of powerlessness and fatalism, a lack of positive role models, negative responses to behaviour change, stigma, excessive alcohol and drug usage, and lack of information are some of the reasons why young people fail to adapt their risky behaviours and protect themselves. Gradwell (2004) believes that role models that are positive and reliable, a desire to change behaviour, willingness to take responsibility for actions and a willingness to test and challenge stereotypes, could motivate behaviour change amongst young people.

Njagi and Maharaj (2006) conducted a study on perceptions of VCT among students at a tertiary institution in Kwazulu-Natal. A survey questionnaire with open and closed ended questions was used to gather information. The findings indicate a high knowledge of VCT services among students, with peers serving as the main source of information. Other students reported hearing about VCT in the media. Those students who used VCT perceived it as helpful because they were treated with respect and had enough time to ask questions. Students were satisfied with the way the counsellors

answered their questions. The students who were not satisfied with VCT were more concerned about a lack of confidentiality, especially when they made appointments; and were concerned about the lack of privacy in the waiting room. Students also feared being recognised by other students, which may result in them being discriminated against and stigmatised. It is a concern that only 14% of the sample of 200 students had undergone VCT, which supports other researchers' concerns that VCT is underutilised.

Njagi and Maharaj (2006) further report that 47% of the representative sample had not gone for VCT because they had never heard about it. Other students felt that they were not at risk of contracting HIV; therefore they did not see a reason to get tested. The low risk perception was also fuelled by the belief that HIV testing was meant to serve a diagnostic purpose, which meant that only students who suspected that they were HIV positive should get tested. Other obstacles reported were the fear of test results, and that getting tested was an acknowledgement that one was dying.

2.3 Voluntary Counselling and Testing (VCT)

The cure for AIDS is still to be discovered. As such, the focus has been placed on prevention and treatment programmes as solutions to controlling the disease. Anti-retroviral treatments are now available to those in need. Trials for the HIV vaccine are being carried out around the globe to prevent future infections. There seems to be more hope placed on the vaccine for controlling the disease than on the cure. A solution to controlling HIV should be appropriate or affordable for the poor; and reliance on the development of a vaccine may not be the answer. Behavioural interventions, microbicides and barrier methods still remain a pivotal part of the fight against HIV/AIDS.

Voluntary counselling and testing (VCT) was introduced in the early 1990s in most countries as a strategy to curb the spread of HIV/AIDS. VCT aims to provide care, support and treatment to people already living with HIV (UNAIDS/WHO, 2001;

UNAIDS/WHO, 2004). It allows people to learn their HIV status and be counselled about its implications (UNAIDS/WHO, 2001). VCT also represents a mechanism for referral into care, treatment and support (Van Dyk, 2005).

VCT gives access to the prevention, treatment and management of HIV-related illnesses, and can also lead to changes in behaviour (Baggaley, 2001). These include treatment of opportunistic infections, prevention of mother-to-child transmission (PMTCT), post-exposure prophylaxis (PEP), access to anti-retroviral treatment (ARV), as well as long-term counselling and support for positive living (UNAIDS/WHO, 2001).

2.3.1 VCT in South Africa

Since the discovery of HIV/AIDS every South African has felt the cruelty of this disease either directly or indirectly. It has brought a lot of unexpected changes to people's lifestyles and has placed a tremendous pressure on all aspects of their lives. The effects of HIV/AIDS have been felt psychologically, socially, medically, educationally, spiritually and economically (Van Dyk, 2001), which has negative implications for survival because a person's whole being becomes affected by this disease.

South Africa introduced VCT in the early 1990s through city-based AIDS Training Information and Counselling Centres (ATICCs), various NGOs, private sector services, and some clinics and hospitals (Birdsall et al., 2004). Although other countries introduced VCT at the same time in the 1990s, Swanepoel (2003) believes that the lag in introducing VCT in South Africa was due to a weak infrastructure in the testing facilities and health personnel and the lack of funding. In addition, the focus of the South Africa government was initially prevention instead of the provision of treatment and care to those already affected and infected by HIV/AIDS (Thomas, 2001). The slowness may also have been because HIV testing was mainly used for diagnostic purposes and not to educate people or prevent transmission.

VCT is a gateway to prevention and care (WHO/UNAIDS, 2004), and is a critical first step in identifying people who are HIV positive, so as to provide them with HIV treatment, care, and support services (Van Dyk, 2001). However, the national survey by the HSRC (2002) reported a low uptake of VCT, with only one in five people in South Africa who know about VCT having been tested for HIV (Department of Health, 2004).

Subscribing to the principle that knowing one's HIV/AIDS status is the first step towards combating the pandemic, Prof Errol Tyobeka, Vice-Chancellor and Principal of Tshwane University of Technology (TUT), took an HIV/AIDS test at the AIDS Consultancy Centre at the Pretoria Campus as part of the Centre's Know Your Status Campaign that ran from 31 July to 4 August 2006. He encouraged all TUT staff and students to follow his example. According to Prof Tyobeka, "HIV testing has a role in both HIV prevention and, for those infected, in ensuring an early start to obtaining care and support and managing the virus" (www.tut.ac.za).

2.3.2 Impact of VCT

VCT has encouraged some people to change their lifestyle and has increased their knowledge about the risks and the consequences of their choices. There was a decrease in the rates of unprotected sex among men and women who participated in VCT in Kenya, Tanzania and Trinidad (UNAIDS/WHO, 2002; Voluntary HIV-1 Counselling and Testing Efficacy Study Group, 2000). This study examined a random sample of 3120 individuals and 586 couples. The study reported a decrease in unprotected sexual behaviour with both steady and casual partners following a VCT intervention programme.

A study in Nigeria found that the use of VCT services by young people led to an increase in the use of condoms and a decrease in the prevalence of sexually transmitted infections (Boswell & Baggaley, 2002). Knowing one's HIV status also

provides essential information that will enable both HIV positive and HIV negative persons to plan for their future and that of their family. VCT can help to connect clients to services such as hospice care, legal services, and support for orphans and vulnerable children, as well as antiretroviral treatment (WHO/UNAIDS, 2003). VCT also helps HIV negative people make informed choices when engaging in sexual intercourse, such as having a single partner or using a condom.

A national survey by the Reproductive Health Research Unit (2003) in partnership with Love Life reported that young people have knowledge about HIV/AIDS and ways to avoid being infected. More than two thirds of the youth in South Africa were reported to have changed their sexual behaviour because of awareness of HIV/AIDS, and increased condom usage (Reproductive Health Research Unit, 2003). However, there was a concern that the majority of young people, including those infected with HIV, underestimate their risk for contracting the disease.

VCT is an effective secondary prevention tool for HIV/AIDS for people living with HIV (Solomon, Van Rooyen, Griesel, Gray, Stein & Nott, 2004). These authors also found that it is more effective in the prevention of HIV/AIDS amongst HIV-positive people than HIV-negative individuals, especially when it targets both partners.

In terms of HIV counselling, which is an important aspect of VCT, Nkosi (2003) reports that adult black women living with HIV/AIDS perceive HIV/AIDS counselling to be beneficial. It provides a safe space in which people can receive emotional support and share their fears and concerns. HIV/AIDS counselling also gives people knowledge about HIV/AIDS and educates them on a healthy lifestyle (Nkosi, 2003).

2.3.3 Barriers to VCT

Despite the impact and benefits of voluntary counselling and testing, people are still slow to use the service (Van Dyk & Van Dyk, 2003). Barriers that prevent people from finding out their HIV status include confidentiality, stigmatisation and attitudes of

health care professionals. The next section briefly discusses how these factors impact on the uptake of VCT.

2.3.3.1. Confidentiality

One of the key elements of VCT is that the results remain completely confidential. According to the study by Van Dyk and Van Dyk (2003), participants mostly feared that health care workers would not keep their results confidential, which may result in them being discriminated against and refused treatment. Of the participants, 33% were willing to test for HIV provided they would not be not recognised at the clinic (Van & Van Dyk, 2003). In addition, participants feared being rejected by partners, families and the community should the health workers not keep their results confidential (Van Dyk & Van Dyk, 2003). Similar findings were reported among young people concerned about the confidentiality of VCT services because of the stigma associated with HIV/AIDS (Horizons Project, 2001).

2.3.3.2 Stigma

The stigma associated with HIV/AIDS has prevented people from acknowledging the disease, and even from disclosing their status to loved ones. Some people have avoided seeking medical attention; others have avoided getting tested because they being stigmatised should other people become aware that they are HIV positive, or have if it is known that they visited a VCT centre. Van Dyk and Van Dyk, 2003) state that individuals do not know how to disclose their HIV positive status to their partners, and are concerned about testing services which do not offer follow-up support.

According to the findings by Kalichman and Simbayi (2003), people who have never tested for HIV are more negative about testing and demonstrate greater AIDS-related stigma, ascribing greater shame, guilt, and social disapproval to people living with HIV. A study in Tanzania also found that stigma was a major obstacle to the uptake of VCT because HIV is often associated with high risk sexual behaviour (National AIDS Control

Programme, 2001). The findings of this study were that majority of people were willing to test for HIV but were more afraid of discrimination and ostracism. It seems clear that stigma prevents people from getting tested and seeking support from family and friends. People do not normally fear the HIV itself, but rather what to tell their neighbours (Nkoeli, 2005). Boswell and Baggaley (2002) and Makwakwa (2003) agree that although the demand for VCT service is very high among young people that are getting married or are pregnant, the fear of being discriminated against often results in individuals not getting tested.

2.3.3.3 Health care professionals

The attitudes of health care professional may also serve as a barrier to VCT. Van Dyk and Van Dyk (2003) classified these barriers as structural and report that a limited number of counsellors, poor quality of the counselling process and lack of trust may lower the uptake of VCT. Health care workers who disapprove of early sexual activity among young people may discourage them from seeking VCT services (UNAIDS/WHO, 2001). The attitude of the health care workers may also reflect the stigma associated with VCT.

Makwakwa (2003) found that hostel dwellers do not utilise VCT because they mistrust the health professionals. Participants in Makwakwa's study seemed to mistrust their test results and the testing method. The participants further believed that some nurses may inject them with the HI virus and even tell clients that they were HIV positive when in fact they were negative (Makwakwa, 2003; MacPhail, Pettior, Coates & Rees, 2006). Conversely, Nkhoeli (2005) reports that users find VCT to be a more beneficial experience when counsellors convey positive test results to clients in a subtle and less confrontational manner.

Other barriers highlighted by Makwakwa (2003) that impede people's use of voluntary counselling and testing include the fear of premature death, fear of losing

employment, and beliefs that traditional healers can heal HIV/AIDS. These barriers may be particularly dangerous if people use them as excuses not to get tested.

2.4 VCT and Experience

Nkhoeli (2005) explored the experiences of prisoners in Atteridgeville of HIV/AIDS pre- and post-test counselling. The findings of the study are that undergoing an HIV/AIDS test without pre- and post-test counselling leaves clients feeling psychologically distressed. The study recommends therefore that pre- and post-test counselling be administered to every individual reporting for an HIV test.

Diedericks (2003) explored and described the perceptions of voluntary counselling and testing among first year students at the University of Port Elizabeth. The findings reveal that students would use VCT for testing, HIV information, counselling, education and skills to protect themselves and others. Further, many students would use VCT services on campus for convenience and because it is free, although others indicated that they would not use campus-based VCT services because they perceive confidentiality, professionalism, hygiene and trustworthiness to be compromised in a campus setting. Generally, the students perceived VCT to be an important prevention strategy and confirmed VCT that could cause students to change their risky sexual behaviour.

Van Dyk and Van Dyk (2003) found that 33% of their participants (40% black and 19% white) preferred going to an unknown clinic for VCT because they did not trust health workers to be discreet, because of confidentiality reasons, and for fear of prejudice and rejection. A disturbing finding was that 79% of previously tested subjects did not receive any form of counselling. Counselling was generally experienced as positive and clients expected counsellors to be empathetic, discreet, non-judgmental, supportive and directive (Van Dyk & Van Dyk, 2003).

The study on South African mine workers by Ginwala et al. (2002) found that two out of ten clients interviewed by community volunteers were not satisfied with the counselling service they received, complaining that they did not receive sufficient information on HIV and AIDS. As a result, they did not consider testing again in future. The remaining clients, including those interviewed by the nurse counsellors, were satisfied with the service.

Pronyk, Makhubela, Hargreaves, Mohlala and Hausler (2002) used two mock clients (a female and a male) to evaluate the VCT counselling services. After receiving pre- and post-test counselling, both clients were asked to mark competencies on a standardised tick sheet from which a percentage score was determined. The female client gave an average score of 95% for the pre-test and 96% for the post-test counselling, which indicated an overall satisfaction with the service. However, the male client gave 62% for the pre-test and 53% for the post-test. The low scores by the male client were attributed to the serious disruptions in the continuity of his counselling sessions and also to the fact that the male client was counselled by a nurse known to be unsupportive of VCT. The clients also reported that counselling services should be strengthened by counsellors spending more time with the clients (Pronyk et al., 2002).

2.5 VCT in Neighbouring Countries

Yoder and Matinga (2004) conducted a study in Malawi to generate information about public knowledge of and experience with HIV counselling and testing, and participants' experiences of VCT services. Their aim was to understand the work of full-time VCT counsellors. Three groups were interviewed: (a) adults in the general public, (b) clients who visited a VCT centre for an HIV test, and (c) the counsellors who worked in the centres and did the testing. Participants who visited the VCT centre indicated that they came for testing because they feared that they had been exposed to HIV by their own actions or as a result of their partner's actions, because of failing health, events such as marriage or pregnancy, and job circumstances. Yoder and Matinga (2004) further

indicated that VCT clients want VCT services that are free, provide rapid results, and that ensure privacy and anonymity. In addition, clients would like to spend time with a counsellor who would answer their questions and give them advice on certain issues. The clients were generally satisfied with the way they were welcomed. To make them feel relaxed, the counsellors allowed clients to watch a video health talk before receiving pre-test counselling.

The studies in Kenya and Uganda by the Horizon Project (2001) indicate that youths are concerned about two aspects of the testing process: they want their interaction with the counsellors to be confidential, and they would like to go for testing and leave without being seen or recognised by anyone else. The suggestion arose that a separate room should be provided for VCT. Young people also want more information about VCT and HIV, and the involvement of young people as VCT providers (Maphaya, 2006).

Adolescent participants reported negative attitudes of nurses and inappropriate testing facilities as barriers to VCT access and uptake (MacPhail et al., 2006). These adolescents also perceived counselling as the most important service in VCT. This finding was echoed by Valdiserri, Moore, Gerber, Campbell, Dillon and West (1993), who suggest that more appropriate counselling may increase the rate of youth returning for post-test counselling. Similar results regarding the negative behaviour of health care professionals working in VCT have been reported in other developing countries (Horizons Project, 2001).

There are limited studies that explore the experiences of clients of voluntary counselling and testing, and particularly their experience in terms of clients' needs, desires, actions, feelings and thoughts. This study builds on the studies by Yoder and Matinga (2004), Nkhoeli (2005), and Njagi and Maharaj (2006). Although this study is interested in the client's experience of VCT as a whole, the focus is specifically on students enrolled at TUT in South Africa who have undergone VCT. The study

explores the students' thoughts, desires, actions, emotions and perceptions associated with and experienced before and after VCT.

2.6 Models of VCT in South Africa

There are many VCT delivery models currently available, each with its own benefits and challenges. These include freestanding services, integrated models (within primary health care services, hospitals and clinics), private sector models, mobile or outreach models and home-based models. The choice of a VCT model depends on the needs of the community, seroprevalence of HIV, maturity of the epidemic, attitudes, political and community commitment to VCT, availability of finance and existing VCT resources (Department of Health, 2004).

The South African national strategy on prevention and care aims to make VCT services accessible to individuals aged 15-49 years (Department of Health, 2004). The goal of this strategy is to move beyond existing integrated VCT models, such as clinics and hospitals, to stand-alone models that will cater for the needs of specific groups such as the youth.

Table 1 lists different types of VCT models, and outlines each model's weaknesses and strengths as described by the Department of Health (2004).

Table 1. VCT models

Model types	Strengths	Weaknesses
1. Stand alone - Also known as free-standing model - Generally operated by non-governmental organisations - Clients most often self-referred	<ul style="list-style-type: none"> • Easier to maintain quality control • Focuses on prevention and risk reduction counselling • Targets different groups e.g. men, youths, etc • Flexible hours of 	<ul style="list-style-type: none"> • High start-up and operating costs • Difficult to ensure medical and psychosocial support • High stigma because services are only

	operation	associated with HIV
<p>2. Integrated</p> <ul style="list-style-type: none"> - Counselling and testing services are offered in medical settings and are initiated by the health care provider - Counselling and testing is provided alongside services such as general in-and out-patient, tuberculosis, antenatal and sexually transmitted infection care - Can be provided as diagnostic counselling and testing (offered to patients who presents with symptoms of HIV and routine testing), and integrated into settings as antenatal, STI or TB clinics as part of regular care 	<ul style="list-style-type: none"> • Promoted as part of general health services • Direct involvement of health care workers in HIV prevention • Direct referral to other relevant care such as ARV therapy, TB, PMTC, family planning and welfare support • Low costs 	<ul style="list-style-type: none"> • Can dilute other health care services and lower quality of counselling and testing • Increase in client load leads to difficulty in maintaining quality and enforcing it • Can lead to a shortage of staff and competing demands for service providers' time • Only allows using trained health care professionals • Can create long waiting times and inconvenient hours of operating

3. Private sector

- Medical practitioners use their offices to offer counselling and testing
- Reaches people in the high income brackets who are less likely to use public sector services
- Practitioners are committed to high quality care because the client is paying higher fees for services
- Services are responsive to the needs of the clients
- Perceived as providing private and confidential service
- Services are inaccessible to the poor and uninsured
- Do not always adhere to national and international quality standards
- Providers often have inadequate or no training in HIV counselling

4. Mobile

- Services are taken to the community
- Counselling and testing service offered from a van or designated places in the community
- Improves access to hard-to-reach and rural populations
- Brings services to the beneficiaries
- Can be expensive and not cost-effective
- Requires many resources in terms of equipment and manpower
- Difficult to ensure follow-up after post-test counselling
- Difficult to ensure quality
- Difficult to prioritise HIV testing where clients have other pressing health needs

5. Home based

- Similar to the mobile model
- Counselling and testing is offered within the home to family members
- Referred to as family-based model
- Addresses the needs of the entire family at once
- Discussion on prevention and behaviour change may be more effective
- Expensive and time consuming as the provider must move from home to home
- Family disclosure may be difficult
- Testing everyone at the same time may mean premature disclosure

Each testing model is designed to reach different target groups and to achieve different goals. A testing model may serve as an entry point to care for people living with HIV/AIDS, while another model may help in the prevention of mother-to-child transmission of HIV (PMTCT) and yet another may serve as an HIV prevention tool for the general population. No model is better than any other; the choice of a model should be based on the targeted population and the goals of the programme (www.fhi.org). The choice of a model should also depend on the cost, cost-effectiveness, sustainability, affordability, appropriateness to the target group, epidemiological profile, socio-political situation and convenience to the client.

Although Family Health International points out that there is no ideal VCT model, the basis of all models is represented in figure 1. It is a standard requirement that the model investigates an individual's decision to get tested, gives them pre-test counselling, and for those willing to get tested, continues with testing and provides post-test counselling which will refer them to proper support. Should the client decide not to go further with testing, he or she will be then referred to preventive counselling. The model emphasises choice and free will (Venter, 2007).

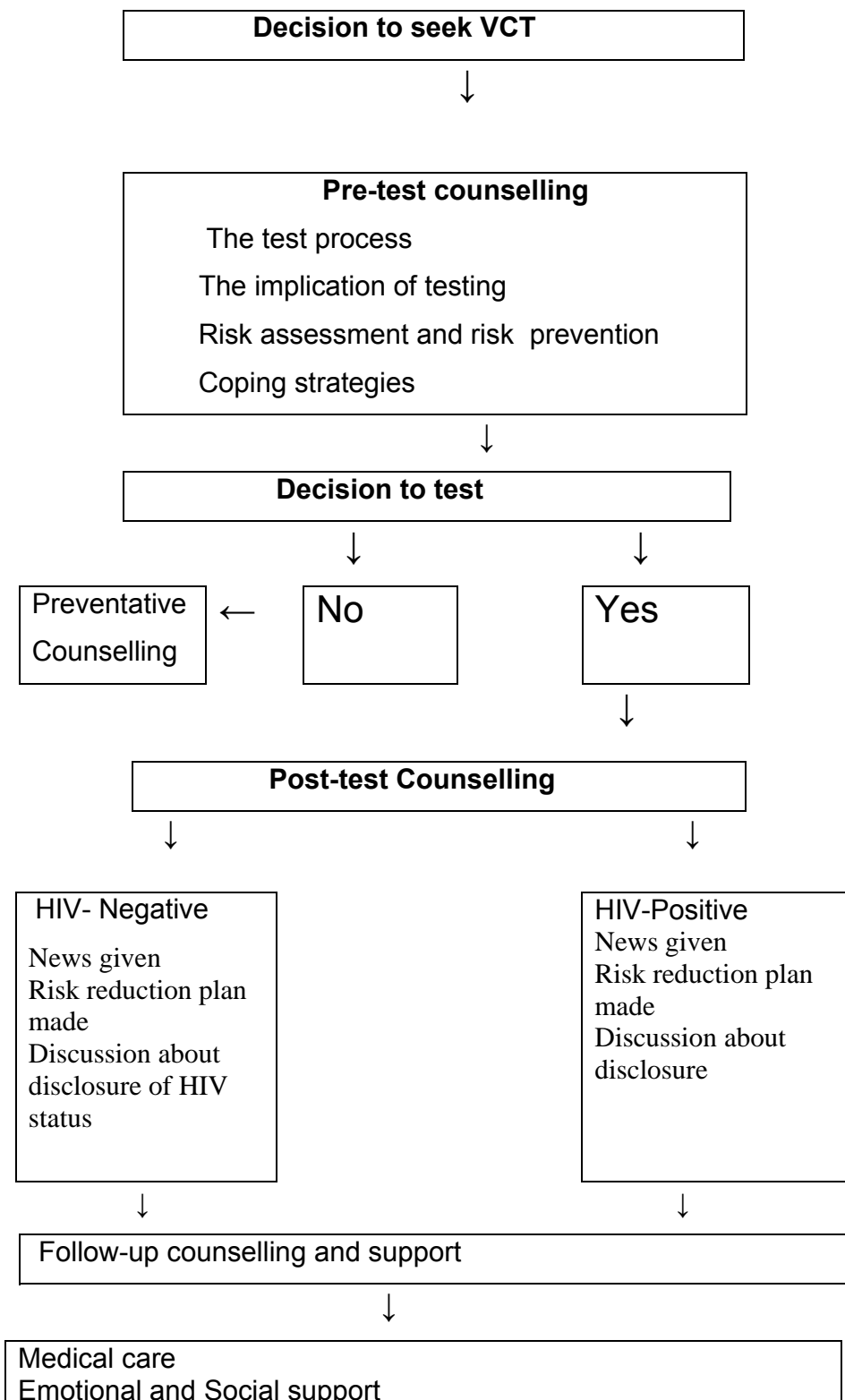


Figure 1. Process of VCT (Horizons Project, 2001)

2.6.1 Elements of VCT

This section briefly looks at the basic standards or elements required for voluntary counselling and testing as represented in figure 1. The following are required in the delivery of VCT: the test is voluntary, the client must give informed consent, the results are kept confidential, the test is accompanied by pre- and post-test counselling, and quality is ensured (Van Dyk, 2005).

Bor, Miller and Goldman (1992, P23) define HIV counselling as:

A confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour.

The counselling process is divided into pre-test and post-test counselling sections. The objectives of the pre-test counselling are to make the person aware of the nature of the test and that he or she is being tested for HIV and not AIDS (Corbitt, 1999). This process addresses issues such as clients' reasons for requesting the test, possible risk activities, potential implications of a positive and a negative test result and availability of emotional support (Van Dyk, 2001). Pre-test counselling is compulsory and always takes place before the client decides to be tested or not.

People often seek HIV testing because they are concerned about their health, their family's health, their relationship, and their future employment (Boswell & Baggaley, 2002). This makes the role of counselling all the more important as it can help provide the confidence to be tested, and to decide on possible future courses of action for the benefit of the client and their loved ones. With the client's consent, counselling may be extended to spouses or other sexual partners, and other supportive family members or trusted friends where appropriate (Baggaley, 2001).

Corbitt (1999) believes that post-test counselling is absolutely essential. The post-test counselling ensures that the client fully considers the implication of either a positive or negative test result (Baggaley, 2001). It also allows clients to ask questions that could lead to behaviour change

HIV counselling can be carried out anywhere that provides an environment that ensures confidentiality and allows for private discussion of sexual matters and personal worries. Clients benefit more if pre- and post-test counselling is carried out by the same counsellor.

- **Voluntary testing**

Rapid HIV testing is a new method currently used to test for HIV. It provides results within 10 to 30 minutes, compared to one to two weeks for the enzyme immunoassay (ELISA). The accuracy of rapid tests is comparable to the standard ELISA tests. Rapid HIV testing must be conducted according to the same ethical standards used for any other HIV test, including pre- and post-test counselling, informed consent, privacy, and confidentiality. Rapid testing gives clients the opportunity to be tested and learn their HIV status in a single visit. If a rapid test is used, a client's finger is pricked and a drop of blood is placed onto the test kit, and a chemical agent is then added on the blood sample.

Baggaley (2001) believes that rapid testing can increase the number of people undergoing HIV testing, may assist in facilitating the diagnosis of HIV infection, improve HIV testing capabilities in facilities without access to laboratories, and facilitate post-exposure prophylaxis in health workers following occupational exposure to blood and body fluids.

- **Confidentiality**

Fear of stigmatisation and discrimination by families and communities, and fear of losing employment prevents many people from seeking HIV testing. VCT services

should therefore always preserve individuals' needs for confidentiality (Baggaley, 2001). Trust between the counsellor and client enhances adherence to care, and discussion of HIV prevention. In circumstances where people who test seropositive may face discrimination, violence and abuse, it is important that confidentiality be guaranteed.

- **Informed consent**

According to Baggaley (2001), all models of VCT must ensure that testing is voluntary. Written consent should be obtained before testing. According to South African law, a person aged 14 and older may consent to HIV testing. A parent or guardian must consent if a child is younger than 14.

- **Legislation to prevent discrimination**

VCT services should not be promoted and supported if they cannot give seropositive people an assurance that they will not be discriminated against following testing at VCT centre (Baggaley, 2001).

- **Quality control**

It is essential that the quality of both testing and counselling can be assured with appropriate monitoring and evaluation as a key and planned component of interventions (Baggaley, 2001).

2.7 Conclusion

There is consensus in the literature that counselling is a vital service in voluntary counselling. It is also evident that anything that happens during the counselling process will affect the entire process, including the overall experience of the client.

Most of the literature discussed focuses on voluntary counselling and testing in terms of procedures for HIV testing, quality control of HIV testing, cost of an HIV test, cost-effectiveness of VCT services, and the impact of voluntary counselling and testing.

Many studies have focused on the viewpoints of professionals on voluntary counselling and testing (e.g. counsellors' perceptions). Other studies have examined communities' views of VCT services (e.g. utilisation of VCT in the Eastern Cape). Few studies in South Africa have explored clients' experiences (e.g. Nkoeli, 2003) and client's satisfaction with voluntary counselling and testing. Exploration of clients' experiences of VCT services may contribute to the body of information and knowledge on the needs of clients seeking HIV testing.

Studies on students have focused on their knowledge, attitude and perception of HIV/AIDS and voluntary counselling and testing. The evidence indicates that students have knowledge about HIV and modes of transmission. HIV accounts for half of all deaths in the country, yet South Africans remain in denial of their individual risk. Only 2% of South Africans test for HIV each year (Venter, 2007). Although students know about the availability of voluntary counselling, fear of being stigmatised and discriminated against influences the uptake of VCT, which is low at present. Fako (2006) recommends encouraging students not yet at risk (not sexually active) to test early so that they can start living positively. This could be achieved by using role models who are positive and reliable, who have a desire to change behaviour, who are willing to take responsibility for their actions, and who are willing to test and challenge stereotypes (Gradwell, 2004). This study approaches the students (role models) who have used VCT in the hope that they will also share information about their experiences and answer the question: *"What is it like to go for voluntary counselling and testing?"*

The majority of the studies discussed in this chapter were conducted in neighbouring African countries, which differ from the South African setting in many ways, including socioeconomic status, political background, and availability and accessibility of community resources. It is therefore relevant to describe the experiences of VCT within a South African context by focusing on experiences of clients who have accessed VCT centres for HIV testing.

This chapter included the review of literature on VCT, contributing factors and barriers to VCT, and different ways that researchers have approached the concept of VCT. The models and elements of VCT were also discussed. Background on HIV/AIDS and its impact on human lives, as well as the responses to it, were also highlighted. Chapter 3 explains the research methodology of this study.

CHAPTER THREE

RESEARCH METHODOLOGY

The focus of the previous chapter was on reviewing the literature on the impact of HIV/AIDS in South Africa. Chapter two also described the concept of VCT and the situation of HIV/AIDS at tertiary institutions.

This chapter discusses and justifies the research methodology and the research design used in this study. Qualitative research is defined and the phenomenological approach discussed. The data collection method and analysis are also stated and clarified.

The main aim of this study is to describe and understand the concept of VCT from students' perspective, and to understand how their experiences differ from student to student. Phenomenology serves as a framework of this study.

3.1 Research Strategy

It is my intention to understand and gain insight into the experiences of students regarding voluntary counselling and testing, therefore the study is qualitative and descriptive (Mouton, 1996). Since this study is about the phenomenon of VCT, and how students experience it, a phenomenological approach is best suited to arrive at answers to the research question.

3.1.1 Qualitative research

I decided to use a qualitative research approach because of the intricate details involved in experiences such as thoughts, emotions and sensations. Viewed as anti-positivistic or postmodernistic, qualitative research reflects a paradigm that examines

the subjective interpretation of events (Neuman, 2000). A qualitative researcher focuses on aspects like subjective meanings, symbols and descriptions; and tries to capture meaning by becoming immersed in the data (Neuman, 2000).

Qualitative researchers attempt to understand the significance and meaning that different individuals attach to social situations or life experiences, and to describe those meanings (Flick, 2002). Thus, the selection of qualitative data collection methods enables researchers to tap into the richness of these subjective experiences. A qualitative approach views the subject of the study as part of a whole, and does not reduce it into variables or hypothesis (Flick, 2002). When people are reduced into statistical aggregates, we tend to lose sight of the subjective nature of human behaviour (Taylor & Bogdan, 1984). The data of qualitative research are most commonly obtained from interviews and observations and can be used to describe individuals, groups, and social movements (Valle, King & Haling, 1989).

Qualitative research is less formalised than quantitative research, which allows the researcher to be guided by an evolving and flexible design. It also differs from quantitative research in that positivists seek the facts or causes of social phenomena with little regard for the subjective states of individuals (Taylor & Bogdan, 1984). The intention of the researcher is to understand the phenomenon of VCT through the eyes of four students rather than to prove relationships between variables. There are different types of qualitative research approaches that can be used, ranging from the most descriptive to the most abstract, generalisable research. Qualitative research may be classified into the descriptive type, which includes phenomenology, ethnography, ethology and participant observation (Morse, 1996). The interpretive type includes ethnography, hermeneutics and narrative inquiry. It can be further classified into the disclosive type, explanatory type or triangulated type (Morse, 1997).

For the purpose of this study, a qualitative phenomenological research approach is considered most likely to achieve the objective of this study, which is to understand students' experiences of voluntary counselling and testing (VCT).

3.1.2 Research framework

A phenomenological approach forms the framework of the study. Phenomenological research is a descriptive, qualitative method that is used to understand the experienced meaning of the phenomena that are studied (Polkinghorne, 1989). It is concerned with how we are aware of the world and the manner in which we discover meaning in the world (Kruger, 1987).

The following section includes a brief overview of phenomenology, its concepts, methodological assumptions and foundational concepts.

3.1.2.1 Definition of phenomenology

Phenomenology as a term is derived from the Greek words “phenomenon” and “logos”. Phenomenon means that whatever is given, or presents itself, is understood precisely as it presents itself to the consciousness of the person entertaining the awareness (Giorgi, 1989). It is essentially the study of lived experience or the life world (Van Manen, 1990). It emphasises the world as lived by a person, and not the world or reality as being separate from the person. Leedy and Ormond characterised phenomenology as an essential study of experience with the purpose to understand phenomenology from participants’ view (see table2).

Giorgi (1989) defines phenomenology as the study of the structure and the variations of structure of the consciousness to which any thing, event or person appears.

Phenomenology is thus the study of experience or consciousness. Psychologists often use the term “phenomenological” to refer to a subjective point of view as well as to the world as seen through the perspective of a particular person (Churchill, 2002).

Table 2. Characteristics of a phenomenological study (Leedy & Ormond, 2001)

RESEARCH DESIGN	PHENOMENOLOGICAL STUDY
------------------------	-------------------------------

Definition	It is essentially the study of lived experience or the life world (Van Manen, 1997)
Purpose	To understand an experience from the participants' point of view (Leedy & Ormond, 2001)
Focus	Subjective point of view, as well as a view of the world as seen through the perspective of a particular person (Churchill, 2002).
Method of data collection	In-depth, semi-structured interviews
Method of data analysis	Categorising data into meaningful units

Phenomenological philosophy is related to other main fields of philosophy (Churchill, 2002) such as ontology (the study of being or what is), epistemology (the study of knowledge), logic (the study of valid reasoning), and ethics (the study of right and wrong).

According to Spielberg (1982), phenomenology is a movement rather than a discrete period of time. This reflects the view that phenomenology and our understanding of it is not stationary but dynamic and evolving (Laverty, 2003). It is a movement because the ideas involved in the philosophy have changed considerably both across philosophers and within philosophers (Cohen, Kahn & Steeves, 2000). Spielberg (1982) divides the phenomenological movement into three phases: **the preparatory phase** of Franz Brentano and student Carl Stumpf; **the German phase**, which included Husserl and Heidegger; and the **French phase**, whose key figures were Gabriel Marcel, Jean-Paul

Sartre and Maurice Merleau-Ponty. For the purposes of this study, Edmund Husserl's philosophy was selected as the framework.

Husserl's transcendental phenomenology puts much emphasis on subjectivity and the discovery of the essences of experience; and provides a systematic and disciplined methodology for the derivation of knowledge (Moustakas, 1994). Husserl rejected the belief that objects in the external world exist independently, and that the information about objects is reliable. He argued that people can be certain about how certain things appear in, or present themselves to, their consciousness (Groenewald, 2004). Groenewald (2004) adds that to arrive at certainty, anything outside immediate experience must be ignored; therefore in this way the external world is reduced to the contents of the personal consciousness. Realities are treated as pure 'phenomena' and the absolute data from where to begin (Groenewald, 2004). Husserl named this method phenomenology (Kruger, 1987; Moustakas, 1994).

3.2 Phenomenology and Experience

The unit of analysis of this study is the experiences of students of VCT. Experience is a product of an intrinsic relationship between a man and the world (Polkinghorne, 1989). As people continually interact with the world they form and create experiences. Phenomenological studies try to understand these experiences from the perspective of the individual. According to Koch (1995), central to Husserl's approach is the fundamental recognition of experience as the ultimate ground and meaning of experience.

Experience is not relatively passive as in vision or hearing, but is also active as in walking or hammering a nail or kicking (Morrissette, 1999). We create experiences daily as we interact with each other and as we listen to people telling their own personal stories regarding a phenomenon. Experience can be outwards, observing what others do or say; as well as inwards, focusing on the private world of thoughts, emotions and

sensations. The domain of phenomenology is the range of experiences in different forms.

Valle et al. (1989) identify perception, imagination, thought, emotion, desire and action as forms in which experience presents itself. Apart from the experience being embodied, it is situated temporally and spatially, consisting of the reception of worldly objects by the process of consciousness to constitute what presents in awareness (Polkinghorne, 1989).

Kruger (1997) takes this further by stating that experience is a reality that occurs as people become open to their awareness of the world; and it cannot be reduced to either the sphere of the mental or the sphere of the physical. Husserl introduced the concept of the 'lived-world' or 'lived experience'. This is the world as lived by people and not as seen by positivists as independent from humans (Valle et al., 1989).

3.3 Data Collection

3.3.1 Selection of participants

The participants of this study were four students from Tshwane University of Technology, attending class at the Pretoria and Arcadia Campuses. I selected participants following the criteria advocated by Polkinghorne (1989) that participants need to have experienced the phenomena under study and are willing to talk about it. To recruit participants, I used posters which were posted mostly at the AIDS Centre and at Arcadia Campus, after obtaining permission from the AIDS Centre of Tshwane University of Technology (TUT) to do so. Initially six participants were targeted, but due to the slow response I settled for four participants, given that qualitative research is fairly flexible in terms of determining sample size (Patton, 2002).

The ages of the participants ranged from 20 to 25 years old. Only females volunteered to participate in the study. Participants took part in semi-structured and open-ended

interviews. Three of the participants had taken an HIV test at the TUT AIDS Centre, and the fourth participant had consulted a private doctor for the test. One of the four participants was an HIV peer educator.

To maintain confidentiality, participants were asked to choose pseudonyms to protect their identities during the study.

3.3.2 Participants information

A concise description of participants' information is described in table 3 below.

Lebogang (Participant 1 or P1)

Lebogang is 21 years old and is studying traumatology at TUT. She does not have a boyfriend and has never engaged in any type of behaviour she considered risky. However, she decided to go for testing after losing her sister to HIV. Lebogang was very close to her sister. She helped to feed, wash and clothe, and they even shared a bed. After being informed that people could get infected if they have cuts or wounds and also if there is an exchange of body fluids, Lebogang made a decision to find out her status. She got tested at the TUT AIDS Centre following the Centre's awareness campaign. Lebogang made a first appointment during the awareness campaign which was cancelled due to a lack of staff, and made a second one after the campaign.

Thato (Participant 2 or P2)

She is a 26 year-old public management student at TUT. She is also a peer educator, meaning that she teaches other students about HIV/AIDS. Thato took an HIV test last year at the Centre during the AIDS awareness day. Though she has never thought about getting tested, she thinks that knowing her status will help her make decision about her relationship as she intends getting married next year.

Refiloe (Participant 3 or P3)

Refiloe is a 21 year-old female student doing her S4 in metallurgical engineering. She got tested in May 2006. She has always thought about getting tested one day. She talks to her friends about testing. When she got sick this year and started losing much weight, Refiloe decided to take the test.

Precious (Participant 4 or P4)

Precious is 20 years old and a traumatology student at TUT. She had thought a great deal about getting tested but just did not have the courage to take the step. She took the opportunity to be tested in 2006 during the “know your status campaign” organised by the AIDS Centre.

Table 3. Summary of biographical information

Participants	Age	Course of study	Gender
Participant 1 Lebogang*	21 years old	Traumatology	Female
Participant 2 Thato*	26 years old	Public Administration	Female
Participant 3 Refiloe*	21 years old	Engineering (Metallurgy)	Female
Participant 4 Precious*	20 years old	Traumatology	Female

* Not participants' real names

3.3.3 Interview procedure

The purpose of gathering data from a phenomenological perspective is to collect naïve descriptions of the experience under study (Valle et al., 1989). Phenomenologists need the report of the experience as it actually appears in a person's consciousness. According to Polkinghorne (1989), phenomenological researchers draw on three sources to generate descriptions of experiences: (a) the researchers' personal self reflections on the incidents of the topic that they have experienced; (b) other participants in the study, who describe the experience under investigation either orally, in response to interview questions, or in written statements; and (c) depictions of the experience from outside the context of the research project, for example, by poets, painters, choreographers and previous researchers.

For the purposes of this study data were gathered from participants by means of interviews. Interviews allow participants to give a rich and detailed description of their experiences. The interviews were open-ended and semi-structured to give participants enough time to explore the topic. The phenomenological interview involves an interpersonal engagement within a relationship of safety and trust, making rapport an important component of optimal research interviews (Kruger, 1987).

Kvale (1996) has outlined the following aspects of a phenomenological interview:

- The focus of the interview is on the life world or experience of the interviewee, and is theme-oriented and not person-oriented.
- The interview seeks to describe and understand the meaning of the central themes of the experience being investigated.
- The interview is qualitative in aiming to obtain nuanced descriptions that are precise and stringent in meaning and interpretation.
- It is literally an "inter-view", an interchange of views between two people conversing about a theme of mutual interest.

All the four participants were asked the same question: *'Have you been for voluntary counselling and testing? If so, could you tell me about your experience?'* Participants were given as much time as they needed to talk about any aspect of voluntary

counselling and testing they may wish to address. (See Appendix E for the interview guide.) I used techniques such as probing, paraphrasing, questioning and summarising to obtain more information from the participants. According to Makwakwa (2003), probing is used to enable the participants to identify and explore their feelings, behaviour and experience, while paraphrasing is used to check accuracy of listening in order to gain in-depth understanding of the participants' experience. The questioning included questions on knowledge about VCT, emotions, perceptions, actions, desires and perceptions of VCT.

3.4 Data Analysis

This is the core stage of any phenomenological research study (Valle et al., 1989), and is intended to derive from the collected data a description of the essential features of an experience. The process of analysing data began the moment I started with my interviews (Rubin & Rubin, 1995).

The first step in phenomenological analysis is called *epoche*, a Greek word meaning to refrain from judgement, to abstain from or stay away from everyday ways of perceiving things (Patton, 2002). To achieve this I had to look at those things that stood out from the transcripts and describe them. I had to put aside any knowledge that I have about VCT. *Epoche* gives the researcher an awareness of personal bias that may arise. Patton (2002) believes that to achieve *epoche*, a shift in attitude is important. The researcher needs to move beyond a natural attitude in order to gain a deeper meaning of an experience.

The next step entailed "bracketing out" the world and any presuppositions to identify the data in pure form without contamination by extraneous intrusions. I followed the four steps of analysing data proposed by Giorgi (1989).

In the first step I open-mindedly read through the data to get a sense of the whole. By doing so, I became aware of the experiences described by the participants. Giorgi

advocates a gestalt-phenomenological approach, which assumes that all parts of the data are related to each other and that one cannot understand the relationship among the parts unless one reads the entire description at least once.

The second step entailed breaking the data into manageable units. I then read through the transcription again and divided the data into themes.

During the third step, I reflected on the themes and expressed the psychological insight contained in them directly in a transformed meaning unit. The transformations are stated in the third person.

In the last step I integrated the meaning units with findings from other studies in order to obtain the structure of the experience. The structure is simply the synthesis of the transformed meaning units.

3.5 Credibility of the Research

Well-designed research should convince the researcher and the reader that it is credible by maintaining a certain standard (Rubin & Rubin, 1995). Quantitative researchers use validity and reliability to refer to these standards, although these concepts are not applicable to qualitative research (Rubin & Rubin, 1995). According to Keddy (1994), when we speak of the concepts of validity and reliability in a phenomenological study, we need to change our language and assumptions.

Keddy (1994) suggests instead using terms such as trustworthiness, credibility or transferability, as they reflect a different kind of discourse and carry with them a different sense of the research process. Polkinghorne (1989) views validity as the notion that an idea is well-grounded and supported by evidence, and that it addresses the following doubts:

- Did the interviewer influence the contents of the subjects' descriptions in such a way that the descriptions do not truly reflect the subjects' actual experience?
- Is the transcription accurate and does it convey the meaning of the oral presentation in the interview?
- In the analysis of the transcriptions were there conclusions other than those offered by the researcher that could have been derived?

Creswell (1998) believes that validity and reliability should be viewed in terms of triangulation and member checking. The credibility of this study was addressed by incorporating peer examination, transparency, consistency, communicability and transferability.

3.5.1 Transferability

Transferability refers to the extent to which the research findings can be applied to other contexts (Byrne, 2001). Terms like applicability and fitting have also been used in conjunction with this idea (Byrne, 2001). When data have to be transferred to another context, descriptions providing information on the themes, labels and constructs of a study can provide the researcher and the reader with enough information to judge the appropriateness of applying the information to other settings (Byrne, 2001). The ability to transfer or generalise the findings of this study to other contexts is of less relevance, since the purpose of the study is to describe the phenomenon of voluntary counselling and testing through the perspectives of these students, and not to generalise the findings to other settings.

3.5.2 Peer examination

Peer examination keeps the researcher honest in his or her reporting and contributes to deeper reflexive analysis by the researcher (Lincoln & Guba, 2001). I did this through ongoing consultation discussion with my research supervisor.

3.5.3 Transparency

Transparency refers to the reader's ability to see the basic processes of data collection (Rubin & Rubin, 1995). I therefore maintained a careful record of what I did, saw and felt during the research process to be as transparent as possible. To maintain transparency I also described in detail the methods that were used to collect, analyse and interpret the data.

3.5.4 Consistency

According to Rubin and Rubin (1995), researchers need to check the finding of their research for any inconsistencies. The idea is not to eliminate the inconsistencies but to understand why they happened (Rubin & Rubin, 1995). The consistency of this study was assessed by checking what other researchers have found in their studies and also by checking the transcripts for any inconsistencies.

3.5.5 Communicability

The presentation of the research report should be real to convince the reader and communicate what it means to be part of the study (Rubin & Rubin, 1995). Only those participants with first-hand experience in voluntary counselling and testing were interviewed. This gave me an opportunity to obtain a rich and detailed description of the phenomenon.

3.6 Ethical Considerations

3.6.1. Permission

Ethical issues and standards were critically considered in the study to avoid causing harm to participants. Participants were invited to be part of this study and were given full information about the study, including their rights, before agreeing to participate.

They were assured that anything discussed in the interview was meant for the participants' group only. Participants were allowed to withdraw from the interview if they felt threatened, and were not penalised for withdrawing their participation (see Appendix A). All the participants signed consent forms (Appendix B). Permission was also sought from the participants for the interviews to be recorded on a Dictaphone tape recorder to be transcribed, and for information to be used for research purposes (see Appendix C).

3.6.2 Institutional permission

In order to continue on the experiences of students of voluntary HIV counselling and testing, permission was sought from TUT AIDS Centre to put up posters at the Centre. A letter explaining the purpose of the study was sent to the head of the Centre to request permission to conduct this study. Permission was also granted by the Directorate of Student Development and Support (SDS) to use their offices to hold interviews with clients (see Appendix D).

3.6.3 Autonomy and confidentiality

Anonymity refers to the principle that the identity of the participant is always kept secret (Mouton, 2001). Participants were asked to choose a pseudonym from the beginning of the study to protect their identities while linking them to the responses. All the information obtained during the study was kept confidential.

3.7 Conclusion

This chapter discussed phenomenology as the framework of the study. This was followed by a description of qualitative research. Thereafter an overview of the research design was presented. The criteria used to select participants, methods of collecting and analysing data were also discussed. This was followed by a discussion

of methods to maintain the credibility of a qualitative research study. Finally, the ethical principles guiding the study were presented.

In the following chapter the research findings are discussed, and are presented in the form of themes.

CHAPTER FOUR

RESEARCH RESULTS

This chapter presents and discusses the findings of the study. The presentation of the results matches the aims of the study, namely to describe the experiences of VCT among TUT students. Interviews were used as the main tools of collecting data. All the participants were asked the same questions; however, the questioning did not follow a particular pattern, but were adapted according to the participants' responses to previous questions. Participants' responses were recorded verbatim.

The following abbreviations are used to facilitate a reading of the interviews: **Q** represents a question asked to a participant; while **P (1, 2, 3, 4)** symbolises the participant's response.

4.1 Interview Reports

Question 1. All the participants were asked the same question: **“Have you been tested for HIV?”**

All the participants reported having been tested for HIV in the last year.

Question 2. **“What do you know about voluntary counselling and testing?”**

P1: I think is all about knowing your status, if maybe you are HIV positive or negative. Mmm... I think it is about... mmm... It is for my own health and my safety to know my status so that I can protect myself. I know that when a person goes for testing, she should be counselled before being tested.

P2: It is when a person takes an initiative to get tested for HIV so that she can know her status. This process allows you to receive counselling and before and after testing.

P3: Voluntary means a person go by herself to test; she is not forced by anyone to take the test. And then.... I know that HIV testing is free at the clinic. The results are confidential.

P4: Okay...eee.... I know it is when a person decides to go to counselling, eee....e... so that they can do an HIV test and then they ...when you go there they will ask you questions about your HIV status and then... they will ask you what you will do should you find out that are HIV positive. They will also ask you about whether you care about your sexual life or you use condoms or you are just ignorant.

In the following questions, participants were asked the same question although the follow-up questions and words of encouragement were different, and were based on the words and descriptions of the participants themselves. The following question was asked to all the participants, starting with Participant 1 (P1).

Question 3: Tell me about your experiences.

P1: The thing is, I went there the first time, I have made an appointment and when I got there the counsellor told me that she will have to reschedule my appointment because she was alone that day. She said that someone was supposed to have contacted me and she does not know what happened. I was very disappointed because I wanted to get this over and done with and I was ready for this.

Q: So your appointment was rescheduled, what happened in the second appointment?

P1: For the second appointment I was met by the same counsellor, I was not comfortable. I do not know why. I just felt uneasy. I spend almost five minutes with the counsellor. She asked me my name and age and why I wanted to take the test and

then ...mmm.... I told her my reasons. She said that the risk for me to be HIV positive were low and asked me the question again; “why exactly do you want to do the test?”

Q: How did this make you feel?

P1: It made me feel like she is...mmm... I do not know... she is like.... It was like I was lying. This hurt me, I gave her my reasons but she kept asking the same question over and over again. She then said that she was not going to counsel me since my reason was not valid enough for me to be tested. The counsellor then told me that should the test come positive I should not be disappointed because I still have a life and that I can live for long with the disease and then ... after she gave me something to take with to the clinic.

Q: What was your experience of the testing process?

P1: The person, who did the test, the nurse, told me that she was going to test me and it was not going to be painful. She also asked me why I was taking the test and I gave her my answer. Then she asked what if the test comes positive? I also gave her my reasons. Thinking of what happened with the counsellor I wanted to make my reasons valid so that she will test me, though I began feeling that it was not a good idea to get tested. Mmm.... Eish! I was shaking, these people did not seem to believe me. I got an impression that, that I may be, that eish..... I am not who I say I was. That is 21 years old, never slept with a boyfriend. She did test me and told me to go back to my counsellor to get my results.

Q: How were you feeling at that moment?

P1: I was 99% negative about everything, feeling frustrated and disappointed. I heard that before you agree to be tested, a person should be counselled and this will give her an opportunity to decide whether to go on with the testing or not. At this point I felt more and more confused. Another thing I was not sure about the procedures, I thought the counsellor was going to test me but when she sent me to another person, I got scared.

Q: You said the nurse send you back to the counsellor, what happened when you got your results?

P1: When I got back to the counsellor, she told me to wait in the waiting room as she was waiting for my results and then ayoung guy... he looked like a student, came in with an envelope and went to the counsellor's office. As she was leaving, the young man told me that the counsellor said I should come in. She said mmm.... You are... she told me that ...mmm and she then after that just said thanks and asked me to close the door. No ... open the door.

Q: What were you feeling at that moment?

P1: The nurse did her job. She was sure that I was told everything during counselling. She told me what she was going to do. She said ...a finger...finger something.

Q: A finger prick test.

P1: Yes! A finger prick test. After she then told me to go back to my counsellor for the results.

Q: Based on the knowledge you had on HIV testing, what were your expectations about testing?

P1: I wanted Information during counselling and during testing. I do not blame the nurse because she was just doing her job. However she gave a serious... a strict look that indicated to me that I needed to cooperate. I tried to do that...to cooperate to avoid her shouting at me.

Q: Go on...

P1: The way she called me and talked to me. She said to me, Oh! It is you. She said I should come in and close the door and showed me where to sit. I was nervous and shaking. I guess she noticed that I was not okay.

Q: What did the nurse say?

P1: I had my student card in my hand and as I was taking a seat, I dropped it. When I tried to pick it up, my bag also fell. It was like...oh! And then I stood and looked at her but she did not look at me or say anything. I picked up my things and waited for her.

Q: What do you think things happened the way they did?

P1: The counsellor was a young person, maybe forty, so it is not that she was that old. I think that she preferred certain people to me. Oh! During the session the counsellor's phone rang and she answered it and after she finished talking ...mmm... she said sorry. I did not like this because she kept me waiting, I was nervous, she should have asked for my permission.

Q: What could make the experience different for you?

P1: I expected proper counselling. The counsellor could have asked me how I was feeling and tried to make me comfortable. She should have told me about HIV and AIDS and the difference between the two. Since she did not believe my reason for testing, she should have told me about ways that people get infected with HIV. I did not like the way the session ended. Mmm..... I mean the last session when I got my results. I thought she was going to counsel me even if the tests came negative.

Q: What could you as a client do to make things different?

P1: Mmm....I think maybe... ask questions. I could have asked the counsellor the procedures involved to make things easy for me. I could also be outspoken about my feelings.

Q: Would you consider testing again in future?

P1: Maybe at another place or by a different person. I had a terrible... terrible experience.

Q: What did you like about the whole experience?

P1: The fact that I know my status; this is what I wanted to know. *(End of conversation with P1.)*

The same questions were asked Participant two (P2)

Q: Tell me about your experiences.

P2: I got tested during the Centre's awareness day. It was so busy. I was working as a peer educator giving students information about where to go for testing. Mmm.... It was informal. A lot of students wanted to be tested and the counsellors decided to see students in groups of ten for counselling. I was standing right at the door indicating to students to come in at the same time was part of the group to be tested next. The counsellor just told us in brief that we all know why we were there...that is to get tested. The counsellor then informed us that we will be tested by a trained nurse and we should all proceed to the clinic for testing. The counsellor did not say much maybe because we were a group instead of one-on-one as they are used. From then as a peer educator I directed the students to the clinic for testing. I could see the doubts and fear in their eyes. I was also afraid. Fear is always there no matter what. I knew I was negative, I am careful but suddenly I just had this fear... fear that I might be positive. I was not sure I wanted to test anymore.

Q: How did you experience the testing session?

P2: The nurse called us in one by one. The contact was very brief, not much was said. The nurse said that she needed to prick my finger to get blood so that she can test if I was infected or not. Mmm...then she told me to go back to the counsellor to get my results. I guess this is where she referred other students.

Q: What happened when you went to get your results?

P2: I do not know..... Maybe because the counsellor knew who I was (peer educator) she was informal and did not talk a lot. She just said good news you are HIV negative and keep it that way.

Q: What expectations did you have about the testing?

P2: I guess...so... I have been educating people about HIV and AIDS and showing them where to go for information but that day when I went to test as a student, I was disappointed. The counsellor did not assure me of confidentiality, I think the counselling sessions were just a waste of time because they did not give me information nor motivated me to test. I did not gain any vital information from the counsellor. It seems as if they assume that we have information. It is not that I regret going to test; I do not have any regrets. I am just worried about the students who tested that day if they were informed and knew what steps to take after. If they received the same little information as I did, they probably felt what I am feeling; frustration and disappointment.

Q: What will make your experience different?

P2: Mmm..... I think that privacy is very important. Being counselled in a group makes client to close up. No one wants to share information that others can use against her. A one-on-one session will make me feel important and protected. Eee... another thing... from what I know the purpose of pre-test counselling is to assist the client to make a decision about getting tested by giving them information, asking them questions and educating them. Counsellors should stop assuming that we know. They should treat people equally and give them information that is relevant and useful. Counsellors should also treat every session as if it was the first session. There is no point of trying to reach your target (50 students a day) on the other hand compromising quality. More staff should be employed or train peer educators to be HIV counsellors.

Q: Would you consider testing again in future?

P2: Definitely I will test again and continue encouraging others to test.

Q: How would you rate the experience?

P2: I am not satisfied, I am not. (*End of conversation with P2.*)

The same questions were asked the third participant (P3).

Q: Tell me about your experiences of VCT?

P3: Mmm..... I was tested but did not receive any counselling. I heard that when you test you should be counselled before and after the test. All I did was the blood test and received my results the day after. Eee... just imagine you are sick and decides to test, this is scary. I knew that chances for me to be HIV were low but still I was very scared. If the counsellors spend time to give me the information this would have made things better. I think that they assume that we know. I did not expect that it would go as it did.

Q: What type of information were you expecting?

P3: I should have been asked why I wanted to test. Received more information about HIV and AIDS, asked about my fears regarding needles or blood, explained what a negative and a positive test result means and also told me about the procedures to be followed that day.

Q: What did the doctor discuss with you?

P3: The doctor said that he was going to do the test.... nothing much really. He referred me to the nurse for the test.

Q: How did this make you feel?

P3: Should the doctor have explained that the nurse was going to test me it would have made things much better. I felt I was just wasting my time, I even thought of asking to go to the bathroom and escape from there. Procedures need to be communicated at all times.

Q: You mentioned earlier that you received your results the following day, how was the experience?

P3: Eee.... I could not sleep that night. The waiting was stressful. I got sicker. The following day I went back to get my results and was told I was negative. The doctor told me to come back after three months as I might be in the window period.

Q: Did you understand what your results meant (HIV negative) and window period?

P3: Mmm.... Only that I was not infected with the virus. The doctor explained what a window period meant and that was it.

Q: What would make the experience different?

P3: If I receive counselling before and after the test and I get counselled and tested by people who are friendly and warm. During counselling you are asked very personal information, so then... if the counsellor is not friendly how can people share information. I have spoken to my friends and all of them told me that they were counselled. Maybe it is only certain people who are counselled.....

Q: It seems as if the experience was not pleasant for you, not being prepared for what was going to happen. Would you consider testing again in future?

P3: Oh yes! I will. I will however get tested where pre- and post-test counselling is offered. *(End of conversation with P3.)*

The fourth participant was asked the same questions.

Question 3: Tell me about your experiences.

P4: Personally I had to get tested for my own benefit. I was so scared. I did not know what was going to happen...and then I made an appointment to test. When my results came I was told that I was in the window period. I did not understand what it meant and did not ask the counsellor. I wanted the whole thing to end ...that is why I did not ask questions.

Q: How did you experience the session before you were tested?

P4: The counsellor told me to take a seat and asked me my age and my name. She then asked why I wanted to test. I gave her my reasons. She did not ask anything else or say more except that I should go the clinic to get tested. Oh! The counsellor also asked what I will do should the results come out positive.

Q: What were you feeling at that moment?

P4: I have spoken a lot about testing with my friends and the information I received from those who have tested, I gathered that there was more information missing. I did not feel like I wanted to be there, that is, continue with the test. It was just a short session.

Q: How did you experience the testing session?

P4: I was scared. I hate needles and cannot stand the sight of blood. And then.... The first time when the nurse tried to draw blood nothing came out. It was painful. I was shaking and the nurse held my hand very firm. The nurse tried again and everything was fine. I was not relaxed; maybe it was because I was standing. I was standing when the nurse was doing the test. I was then told to go back to my counsellor for results.

Q: Okay.....

P4: The counsellor told me that I was in the window period. She said I should come again to check my results. I made an appointment for the following day. The counsellor said goodbye and I went to class. Yoooo.....on my way to class, I was so confused, I did not know what it meant to be in a window period. I still don't know. I thought the counsellor did not want to tell me that I was positive and decided to say that I was in a window period. I went back to the Centre the following day and the counsellor said that I was negative. This was too confusing for me. My results were different from the previous day. I still did not get any explanation; I did not understand what happened.

Q: So you did not ask the counsellor about the window period?

P4: I was in a hurry to get out of that place. She was not friendly. The counsellor made me feel as if I was lying. Whenever she asked me a question and I answered, she looked at me and told me to be honest. I was honest.

Q: How would you rate your experience then?

P4: I am not satisfied.

Q: what expectations did you have about testing?

P4: I did not know what was going to happen. I did not have information. My friends only said that it was a nice experience for them. With me it was different.

Q: What will make your experience different?

P4: I want a counsellor that is friendly and warm. She should not be so serious. The counsellor should firstly explain what was going to happen. I know they are going to test me but I want to know the procedures and everybody involved. The counsellor should not assume that I have the information. She should make you comfortable and relaxed. She should ask if you want a glass of water. The environment should also be comfortable. They could give you something to read. The counsellor should clearly explain the procedures. They should give more information about HIV and AIDS and say why they think testing is important. It will make things different if we hear a bit from them. They should not think that we all know, even if we know, our information may not be correct. And then...maybe the counsellors could suggest that we find someone to talk to immediately and if there is not anyone maybe go for more counselling. You know just so that we do not feel that we are alone.

Q: It seems as if you were not satisfied with the testing and you also felt uncomfortable and scared by the experience. Will you consider testing again in future?

P4: I will test again. The information will benefit me.

I thanked **P4** for coming but before leaving, she asked permission to ask me a question. She wanted to know what it meant to be in a window period. I spend almost ten minutes explaining to her the difference between a positive and a negative HIV test and a window period. I also suggested that she go back to the Centre if she needed more information on HIV/AIDS.

4.2 Research Themes

After transcribing the data, they were categorised into five pre-decided themes to make analysis manageable: **Emotions, Thoughts, Perceptions, Desires and Actions.**

Table 4. List of themes

CATEGORY	SUB-CATEGORY	EVIDENCE
Emotion	<ul style="list-style-type: none"> - Sadness - Judgment - Mistrust - Depression - Uneasiness 	<p>(P1) I was not comfortable, I just felt uneasy, I was shaking, this hurt me, frustrated and disappointed, I got scared, she kept me waiting.</p> <p>(P2) Doubts and fear, fear is always there no matter what, not much was said, I was disappointed, worried.</p> <p>(P3) Was very scared, waiting was stressful, and I got sicker, could not sleep that night.</p> <p>(P4) Was so scared, painful, shaking, was not relaxed, was so confused, I did not understand.</p>
Perceptions	<ul style="list-style-type: none"> - Quality - Time - Two-way relationship - Motivation - Assumptions - Information 	<p>(P1) I did not like the way the session ended, I know my status, this is what I wanted to know, she should have asked for my permission, she gave a serious... a strict look that indicated to me that I needed to cooperate, counsellor's phone rang and she</p>

	<p>answered it then said sorry.</p> <p>(P2) It was informal, brief, did not give me information nor motivated me to test, they assume that we have information, I did not gain any vital information from the counsellor, I do not have any regrets, being counselled in a group makes client to close up, there is no point of trying to reach your target (50 students a day) on the other hand compromising quality, more staff should be employed or train peer educators to be HIV counsellors, she was informal and did not talk a lot. She just said good news you are HIV negative and keep it that way.</p> <p>(P3) They assume that we know, nothing much really was said, should the doctor have explained that the nurse was going to test me it would have made things much better, the doctor preferred certain people, if the counsellor is not friendly people cannot share information.</p> <p>(P4) More information missing, short session, they should not think that we all know, it is confusing especially the way the results are communicated, I</p>
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	<p>still did not get any explanation.</p>
<p>Thoughts</p> <ul style="list-style-type: none"> - Lies - Doubt/waste 	<p>(P1) These people did not seem to believe me, it was like I was lying, whether to go on with the testing or not, she preferred certain people to me.</p> <p>(P2) Not sure I wanted to test anymore, think the counselling sessions were just a waste of time.</p> <p>(P3) I was just wasting my time, escape from there.</p> <p>(P4) Did not feel like I wanted to be there, maybe it was because I was standing.</p>
<p>Desires</p> <ul style="list-style-type: none"> - Information about Testing/counselling - Comfortable - Confidentiality/ Time - Friendly and warm counsellor 	<p>(P1) I wanted Information during counselling and during testing, proper counselling, counsellor could have asked me how I was feeling and tried to make me comfortable, she should have told me about HIV and AIDS and the difference between the two, she should have told me about ways that people get infected with HIV, counsel me even if the tests came negative.</p> <p>(P2) information about HIV/AIDS that is</p>

	<p>relevant and useful, confidentiality, privacy is very important, counsellors should stop assuming that we know, they should treat people equally, treat every session as if it was the first session and told about procedures.</p> <p>(P3) More information about HIV and AIDS, asked about my fears regarding needles or blood, explained what a negative and a positive test result means, receive counselling before and after the test, tested by people who are friendly and warm.</p> <p>(P4) Counsellor that is friendly and warm, firstly explain what was going to happen, to know the procedures and everybody involved, hear a bit from them.</p>
<p>Actions</p> <ul style="list-style-type: none"> - Asked for more - Information - Test with counselling 	<p>(P1) Asked the counsellor about the procedures, outspoken about my feelings, test at another place or by a different person.</p> <p>(P2) Asking them questions, I will test again and continue encouraging others to test.</p> <p>(P3) I will however get tested where pre- and post-test counselling is</p>

	<p>offered.</p> <p>(P4) I will test again. The information will benefit me.</p>
Overall experience	<p>(P1) terrible experience</p> <p>(P2) I am not satisfied, I am not</p> <p>(P3) experience was not pleasant</p> <p>(P4) not satisfied with the testing</p>

4.2.1 Students' emotions about VCT

The theme of emotions refers to the feelings that the participants experienced before and throughout the entire process of voluntary counselling and testing. Feelings of uncertainty, uneasiness, frustration and disappointment associated with the process of VCT describe the overall emotions experienced by the participants. For example, one participant reported, "I was so scared, painful, shaking, was not relaxed".

Without being properly prepared for testing the clients could be left feeling uneasy, doubtful, confused and fearful. The waiting period for the results could also become stressful. One participant reported feeling very nervous and shaky:

I had my student card in my hand and as I was taking a seat, I dropped it. When I tried to pick it up, my bag also fell. It was like...oh! And then I stood and looked at her but she did not look at me or say anything. I picked up my things and waited for her.

Another participant reported:

I could not sleep that night. The waiting was stressful. I got sicker. The following day I went back to get my results and was told I was negative.

4.2.2 Perceptions

The second theme, perceptions, includes assumptions of VCT and the participants' views of the counsellor. Participants reported that they did not like the way the session ended though they were happy that they knew their HIV status. They all reported that the contact with the counsellor was short. Some felt that the sessions with the counsellor did not motivate them to go ahead with the test. Two of the participants attributed the brief sessions to the counsellor's assumptions that they have information about testing. The participants also doubted the confidentiality of the process as nothing was mentioned about maintaining confidentiality.

When I got back to the counsellor, she told me to wait in the waiting room as she was waiting for my results and then ayoung guy... he looked like a student, came in with an envelope and went to the counsellor's office. As she was leaving, the young man told me that the counsellor said I should come in. She said mmm.... You are... she told me that ...mmm... (Whatever)... and she then after that just said thanks and asked me to close the door.

One participant said that the only benefit that she derived was that she discovered her status.

Should the doctor have explained that the nurse was going to test me it would have made things much better. I felt I was just wasting my time, I even thought of asking to go to the bathroom and escape from there. Procedures need to be communicated at all times.

All the participants reported not being satisfied with the counsellor. The contact with the counsellor was too short and not motivating. The participants felt that some clients received preferential treatment from the counsellors. The following quotes illustrate this:

The counsellor was a young person maybe forty, so it is not that she was that old. I think that she preferred certain people to me.

During counselling you are asked very personal information, so then... if the counsellor is not friendly how can people share information. I have to my friends and all of them told me that they were counselled. Maybe he preferred certain people and he counselled them.....

I do not know..... Maybe because the counsellor knew who I was (peer educator) she was informal and did not talk a lot. She just said good news you are HIV negative and keep it that way.

Participants were also not satisfied with the way the results were communicated. The sessions were brief and there was no follow-up communication with the participants.

On my way to class, I was so confused; I did not know what it meant to be in a window period. I still don't know. I thought the counsellor did not want to tell me that I was positive and decided to say that I was in a window period. I went back to the Centre the following day and the counsellor said that I was negative. This was too confusing for me. My results were different from the previous day. I still did not get any explanation; I did not understand what happened.

She was informal and did not talk a lot. She just said good news you are HIV negative and keep it that way.

4.2.3 Thoughts

The theme of thoughts refers to what the participants were thinking as the process was unfolding, and what they generally thought about the entire process. The participants reported during the pre-test counselling the counsellors seemed not to believe the information they were disclosing to them. One of the participants stated:

It was like I was lying. This hurt me, I gave her my reasons but she kept asking the same question over and over again. She then said that she was not going to counsel me since my reason was not valid enough for me to be tested. Eish..... I am not who I say I was. That is 21 years old, never slept with a boyfriend. She did test me and told me to go back to my counsellor to get my results.

Three of the participants also thought of not proceeding with the testing:

(P2) I was not sure I wanted to test anymore... I think the counselling sessions were just a waste of time.

(P3) I was just wasting my time, I even thought of asking to go to the bathroom and escape from there.

(P4) I did not feel like I wanted to be there.

4.2.4 Desires

This theme encompasses the needs and expectations of participants, based either on what they had previously heard about VCT or based on this experience. Participants reported being unhappy with the counselling process as they expected the sessions to empower them with knowledge about HIV and AIDS, and the differences between the two. They also indicated that the results should be explained in detail, regardless of the outcome.

One participant stated:

I have spoken a lot about testing with my friends and the information I received from those who have tested, I gathered that there was more information missing. I did not feel like I wanted to be there, that is, continue with the test. It was just a short session.

All participants indicated that they would like a counsellor that is warm and friendly. A counsellor should give them time to ask questions and not assume that we know they should treat people equally. They should treat every session as if it was the first. The participants further stated that the procedures should be explained and that everybody involved should be introduced. One participant added that counsellors could suggest to clients that after testing, they find someone to talk to immediately; and if there is no one to talk to, maybe more counselling should be recommended.

4.2.5 Actions

Action refers to the participants' stance on what should be done to improve the service in the future. Although all the participants indicated a need to get tested again, they believe that they should have made the sessions more comfortable for themselves by asking questions when they had doubts, and should have been more outspoken about their fears.

Despite not being satisfied with their experience, all the participants emphasised the importance of testing and said that they would encourage others to go and test. However, they had some conditions that had to be observed should they be retested:

I will test at another place or by a different person.

I will however get tested where pre- and post-test counselling is offered.

4.3 Conclusion

It is evident from the findings of the study that students have knowledge about VCT services and the benefits of getting tested. This chapter highlighted the various factors that make up the experiences of VCT among students. The factors that constitute the students' experiences were grouped into five themes: **emotions, desires, perceptions, actions** and **thoughts**. It seems that the entire testing process left the participants hurt, sad and depressed. During the process, participants became unsure that they wanted to go through with the testing. Participants also reported feeling judged by their counsellors. All the participants wanted to meet the test team; they required more information and education about the testing process and HIV/AIDS; more time with a friendly and a warm counsellor. The participants reported to wanting to get tested again only if they receive counselling, while one participant indicated that she would prefer being tested by a different counsellor or using another VCT Centre.

The next chapter contextualises these findings in terms of the literature and the research question.

CHAPTER FIVE

CONCEPTUALISATION

This chapter discusses the five pre-determined themes described in the previous chapter in terms of the purpose of the study, and discusses whether the results are consistent with the findings of other researchers, as discussed in the literature review (chapter 2). This chapter concludes by answering the research questions.

The aim of this study was not to evaluate VCT, but to provide a phenomenological description of VCT through the experiences of four students of Tshwane University of Technology (TUT). This chapter argues that although only a small number of people report for VCT, much can be learned from clients who have used VCT centres. This study found that students are informed about voluntary counselling and testing and the benefits of knowing their HIV status. However, the results indicate that insufficient information during counselling could leave clients with a number of negative feelings and impressions.

The conclusions based on the research findings discussed in chapter four will be used to answer the research questions which were formulated in chapter one:

- What is it like to go for voluntary counselling and testing?
- What strategies can be used to improve utilisation of VCT by students (from the students' point of view)?

5.1 Discussion of Findings

5.1.1 Formation of sub-categories

After the data were transcribed and categorised into five pre-determined themes, they were analysed and checked for consistencies and inconsistencies. Six sub-categories emerged from the process: **the importance of counselling, the lack of counselling, the need for better service, counsellors' professionalism, a two-way relationship and peer support**. In the section to follow I discuss the sub-categories and use them to answer the research questions: *“What is it like going for VCT and what strategies can be used to improve utilisation of VCT by students?”*

- **Importance of counselling**

The results of this study indicate that the students consider counselling to be an important process that determines whether to get tested or not. The students would like the counselling process to include information about HIV/AIDS, methods of testing and prevention. The results also indicate that students would like to use the counselling sessions as an opportunity to relax and make informed choices about testing.

- **Lack of counselling**

The results further indicate that insufficient or lack of proper counselling leave students with feelings of self-doubt, fears and confusion, and even more anxious and stressed than they were before getting tested. One participant reported that she was confused by her results as she did not know what they meant. The students were fearful of the counsellor, as a result could not ask questions even if they did not understand something. The results also indicate that students felt anxious and uncertain as a result of lack of information and lack of preparation. Without proper counselling, the students reported that they would consider retesting in future only if they are tested by a different counsellor or another centre.

- **Need for better service**

According to the findings of the study, students would like to spend more time with a counsellor to ask questions. Students want VCT services that offer rapid results and ensure privacy and anonymity. They would like their visit to the centre be kept confidential. The counsellor should also act professionally, and be warm and friendly.

The students would also like to see more awareness campaigns on HIV/AIDS across campuses. Students want to be properly informed about testing procedures and members of the testing and counselling team. The results also indicate a need for follow-up support.

- **Counsellors' professionalism**

The results further indicate that counsellors' professionalism is of concern. The students were unhappy about the counsellors' lack of professionalism. The first major concern was the counsellors' lack of trust in participants' reasons for wanting to get tested. The students found it difficult to relate to the counsellors because they were not reassuring: they were judgemental, lacked a smile, were not friendly and warm, and were also inconsiderate - one student mentioned that the counsellor answered the telephone during their meeting without apologising or asking permission from the student.

- **Two-way relationship**

Students see counselling as a two-way relationship that gives them an opportunity to ask their counsellors questions about HIV/AIDS and related issues. They recommend that clients should also take responsibility for making the sessions more comfortable for themselves to ease the anxiety. They suggest that client could be open about their emotions and fears relating to HIV/AIDS and testing.

- **Peer support**

Participants would like to be counselled by counsellors of their own age. It would also benefit them to find support in friends and peers after getting tested as a way of normalising their feelings. The results also indicate that the students would like to see more students involved as either peer helpers, health promoters or as lay counsellors.

5.2 Research Questions Answered

This section answers the two research questions stated below.

What is it like going for voluntary counselling and testing?

After reviewing all the sub-themes it was evident that testing without both pre- and post-test counselling is not ideal. Lack of proper preparation during counselling leads to:

- Uncertainties
- Anxiety/ distress
- Self-doubt
- Misinformation or lack of knowledge
- Loss of potential clients of VCT
- Assumptions by counsellors and clients

What strategies can be used (from students' point of view) to improve utilisation of VCT by students?

The study shows that participants would like to have certain interventions implemented before they would consider retesting, and which may motivate other students to utilise the service. Such interventions are listed in table 5.

Table 5. Proposed VCT interventions

What needs to be done	How to do it
Increase access and acceptability of VCT for students	<ul style="list-style-type: none"> • Train and retrain VCT counsellors to ensure quality service • Develop appropriate communication materials

	<p>targeting students</p> <ul style="list-style-type: none"> • Establish VCT promotional campaigns at all campuses to all target students • Train students as peer supporters and as lay counsellors
<p>Ensure access to factual information in the form of counselling</p>	<ul style="list-style-type: none"> • Pre-test counselling should be used as a platform to answer clients' question • If the counsellor cannot give the client an answer during the pre-test session then questions should be addressed during post-test session • If the counsellor is unsure about the needs of a client then the counsellor should refer the client to a senior person with knowledge • More time should be allocated for the counselling session
<p>Make counselling a priority</p>	<ul style="list-style-type: none"> • Counsellors' adherence to all the elements of voluntary counselling and testing should be enforced • The process of counselling should be of a high quality that ensures confidentiality, privacy

	and anonymity
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Having these measures in place could be the first step to ensuring that the participants will re-test in future.

5.3 Contextualisation of Findings

The findings of this study highlight the importance of counselling as a channel for information and education about HIV/AIDS and related matters, including nutrition, prevention and testing. If people are well informed during counselling they will feel safe, relaxed and comfortable with the counsellor and with the testing process. These findings support Nkhoeli (2003), who indicated that counselling is a vital process of HIV testing as it provides a safe space in which people can receive emotional support and share their fears and concerns. The study also indicates a need for ongoing support, which is echoed by Kotze (2005), who stresses that counselling should take place before and after testing. According to Diedericks (2003), students seek VCT to get information on HIV/AIDS, counselling, education and skills to protect themselves and others.

Lack of counselling often leaves clients distressed, filled with self-doubt and uninformed. Baggaley and Churchyard (2002) found that two out of ten of their clients interviewed by the community volunteers were not satisfied with the counselling service because of a lack of information on HIV and AIDS. According to Nkhoeli (2003), counselling should provide a safe space in which people can receive emotional support, share their fears and concerns, and have their questions answered (Yoder & Matinga, 2004). If counselling is not done, clients often feel psychologically distressed (Nkhoeli, 2003).

Counsellors influence the uptake of voluntary counselling and testing. Counsellors that are warm and friendly make clients feel safe and relaxed. Counsellors who give clients

time to ask questions produce clients that are happy, satisfied and empowered. If counsellors spend more time with their clients, this will strengthen the counselling service (Seale, 1999; Pronyk et al., 2002). Nkosi (2003) believes that a warm, kind, and empathetic relationship with counsellors is the key to a positive experience; and the opposite is also true. These results are further supported by MacPhail et al. (2006), who indicated that negative attitudes of nurses and inappropriate testing facilities have an influence on the access and uptake of VCT. These results are also supported by the findings by the Kaiser Family Foundation (1999), who found that the negative attitudes of health care professionals can heighten clients' anxiety about testing.

Lack of confidentiality and privacy may result in clients reconsidering their decision to test. The findings of this study indicate that a lack of confidentiality and privacy contributed to students' reluctance to be retested by the same centre or counsellor, and influenced their decision to retest for HIV/AIDS only if the testing is done by a different counsellor. Van Dyk and Van Dyk (2003) found that 33% of the participants (40% Black and 19% White) preferred going to an unknown clinic for VCT because they do not trust health workers to be discreet, for reasons of confidentiality and for fear of prejudice and rejection. The same results were reported in Malawi by Yoder and Matinga (2004), who found that clients want VCT services that ensure privacy and anonymity. These results were echoed by the Horizon Project (2001), which indicated that youth are concerned about two aspects of the testing process: confidentiality, and that they would like to go for testing and leave without being seen or recognised by anyone else.

As in this study, Pronyk et al. (2002) also found that a lack of professionalism and disruptions in continuity of the counselling session (such as counsellors answering the phone during sessions) often leave clients feeling negative about themselves and about the testing. Diedericks (2003) reported that students would not use VCT on campus because they perceive confidentiality, professionalism, hygiene and trustworthiness to be compromised in an on-campus setting.

Clients expect counsellors to be empathetic, discreet, non-judgmental, supportive and directive. This was supported in this study by the participants' observations that they would only test at the campus clinic again provided they are counselled by a different counsellor who is warm and friendly. Participants also felt that the counsellors had preferences in terms of the clients they want to deal with. These findings are consistent with the findings of Yoder and Matinga (2005), which were that clients want VCT services that are free, that provide rapid results, and ensure privacy and anonymity; and that the clients would like to spend time with a counsellor who would answer their questions, give advice on certain issues and invite clients to ask questions.

This is in line with Kotze's (2005) recommendations that counselling should be a process of shared knowledge between the client and the counsellor. The voice of the clients should be heard more clearly during this conversation (Kotze, 2005). Clients of VCT need to feel that they are being listened to and should therefore be given an opportunity to discuss any matters of concern. The participants also suggested that students become involved as lay counsellors or health promoters, to make the testing process as comfortable as possible for other students. The Horizon project (2001) echoed these findings by reporting that the age of a VCT counsellor plays a major role during HIV testing.

It is evident from the findings of the study that the counselling process as well as the role of the counsellors plays a major role in the uptake of VCT. These findings concur with the findings of Van Dyk and Van Dyk (2003) and Nkhoeli (2005). These authors further recommend that pre- and post-test counselling be administered to every individual reporting for an HIV test.

5.4 Conclusion

In this chapter the sub-categories that emerged from the pre-determined themes were discussed. Thereafter the six sub-categories were compared with the findings in the

literature review to check for similarities and differences in the results. The sub-categories were also used to answer the two research questions: *What is it like going for VCT and what strategies can be used to improve utilisation of VCT by students?*

In the following chapter the recommendations and limitations as well as implications of the study are highlighted.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This chapter contains a summary of the research questions, methods and answers addressed in the research, and present the conclusions to the study. Implications of the findings are discussed, and recommendations are made based on these findings. .

6.1 Summary of Research Questions and Answers

The study started with my curiosity to understand people's experiences of voluntary counselling and testing. The following questions were formulated to help formulate an understanding of clients' experiences of VCT:

- What is it like to go for voluntary HIV counselling and testing?
- From a student's point of view, what strategies can be used to improve the utilisation VCT by students?

To answer the research questions a phenomenological approach was chosen as a framework for the study, and a convenience sample of four students was selected from Tshwane University of Technology (TUT). The four students were interviewed and the emerging data were analysed qualitatively. Data were categorised into five pre-determined themes, namely: *emotions, thoughts, desires, perceptions and actions*. I then checked for consistencies and inconsistencies in the five pre-determined themes to formulate six sub-categories: (1) the importance of counselling; (2) a lack of counselling; (3) the need for better service; (4) counsellors' professionalism; (5) two-way relationship; and (6) peer support. Information from the sub-categories was then used to answer the research questions. The findings show that students have knowledge of voluntary counselling and testing. The counselling process as well as the VCT counsellors themselves contributes to the access and utilisation of VCT by

students. Voluntary counselling and testing that lacks sufficient counselling leads to anxiety, misinformation, uncertainties, self-doubt and loss of potential VCT clients. VCT counsellors that are not warm and friendly leave clients feeling judged; unapproachable counsellors also leave make clients uncomfortable and very anxious.

The following strategies, as suggested by the student participants, could improve the utilisation of VCT by students:

- **Increase access and acceptability of VCT for students:** Train and retrain VCT counsellors to ensure quality service. Develop appropriate communication materials to target students. Establish VCT promotional campaigns at all campuses to all target students. Train students as peer supporters and as lay counsellors.
- **Ensure access to factual information in the form of counselling:** Pre-test counselling should be used as a platform to answer clients' questions. If the counsellor cannot give the client an answer during the pre-test session then questions should be addressed during post-test session. If the counsellor is unsure about the needs of a client then the counsellor should refer the client to a knowledgeable senior person. Finally, more time should be allocated for the counselling session.
- **Make counselling a priority:** Counsellors' adherence to all the elements of voluntary counselling and testing should be enforced. The quality of the counselling should allow clients to feel reassured of the confidentiality, anonymity, and privacy of the process.

6.2 Recommendations

The recommendations that follow are based on the previous discussion.

Voluntary counselling and testing gives students an opportunity to know their HIV status. One of the requirements of HIV testing is for clients to receive counselling before and after testing. The results of this study indicate that all of the participants had

a negative experience with VCT. This was because they received insufficient information during counselling, and because they perceived the counsellors as being unprofessional. Following the findings of the study the following recommendations are made:

- Train and retrain VCT counsellors on a VCT model
- Make counselling a priority
- Allocate more time for the counselling session to allow clients to ask questions and for the counsellor to provide answers
- Develop appropriate communication materials targeting students
- Establish VCT promotional campaigns on campuses to target all students
- Involve and train students as lay counsellors or health promoters

The training of VCT counsellors should emphasise client service. To do so, the training could be based on the humanistic model proposed by Nkosi (2003), which encourages counsellors to treat clients as equals, to be empathic and to understand the particularities of their clients' histories and experiences.

Additional studies on clients' experience of VCT should be encouraged. The focus could be on other underrepresented groups such as staff at TUT, counsellors and male students. Other tertiary institutions should also embark on similar studies. Similar studies are currently being undertaken in Tanzania (Kipitu) and Mozambique (Marciano), and this will hopefully address the paucity of literature on clients' experiences of VCT.

6.3 Implications of the Study

One of the implications of this study is that the success and of HIV testing, and a satisfactory experience, lie with both the counsellor and the client. Clients should be able to approach counsellors and ask questions regarding HIV/AIDS and related issues without fear of being stigmatised. Counsellors should also be allowed to ask clients

questions to get background information and then provide clients with answers. This implies that the counselling session will require more time.

A second implication is that counselling is an important information session that equips clients with knowledge on HIV/AIDS and prepares them for testing. It functions to address and erase doubts that clients might have regarding testing.

One of the participant mentioned that her reasons for testing off campus was that she did not know that VCT services existed on campus. Other participants thought that the testing only happens during the awareness day. The implication of these findings is that a more aggressive marketing strategy is needed to market the AIDS Centre and its services.

Participants also preferred to share knowledge and testing results with other young people immediately after testing. This indicates that students are comfortable with trusting and sharing sensitive information with people of their same age. Therefore it might benefit the clients if more students are trained as lay counsellors or health promoters.

6.4 Limitations of the Study

The findings of this study must be interpreted with the following limitations in mind:

HIV/AIDS is a sensitive issue and asking people to talk about their experiences may be met with some reluctance. The participants' reluctance was observed when only female students volunteered to participate in the study. This resulted in the qualitative data being drawn from female students only. The views of these participants may differ across gender.

Only TUT students with experience of VCT were recruited because of the easy access and availability of the research participants. However, the experience of other parties,

such as VCT counsellors and different participants, could also be included in future research.

The study design was highly focused and reveals a number of areas that would require further exploration. For instance, the study focused only on students of TUT and thus highlights the need to know more about the experiences of students from other institutions. Therefore the results should be seen to provide insight into a phenomenon rather than being viewed as a static model. Furthermore, only students were considered, therefore attention should also be focused on the experiences of staff members.

6.5 Conclusion

This research was undertaken to gain some understanding of the experience of voluntary counselling and testing among four students. This study demonstrated that the students believe that VCT is a viable prevention strategy in the fight against HIV/AIDS.

However, the study also demonstrated that VCT counsellors could do more harm than good if they are not knowledgeable about the subject matter and about the needs of the clients. A model that empowers both the client and the counsellor might motivate accessibility and utilisation of VCT by clients. It is hoped that the findings of this study will be carefully examined and that they may make a difference in the lives of students of TUT if implemented. In this way, more students may come to know about VCT services on the campus and utilise these services; students may trust counsellors with sensitive issues' and students may be empowered to take responsibility for their own health.

CHAPTER 7

EPILOGUE: HOW DID THE RESEARCH CHANGE ME?

**A journey of a thousand miles
starts with a single step**

(Chinese proverb)

This has been my mantra since I started on this research journey. I always had dreams that I would make it in life, which meant taking the first step. I started this research as a traveller on a journey using past researchers' work as my itinerary. My journey started when I got accepted into the Psychology Masters programme. I saw this as a breakthrough. I was going to sail through this programme as I did my undergraduate studies. However, this became a very long journey with challenges on the way. I would like to believe that the challenges became part of my experiences and personal growth.

Ever since that first step I knew what I wanted to focus my study on **VCT** or **disclosure and acceptance**. I knew from a mini-project that I did in my first year of study that VCT was a subject that was going to lead me to the final step. I began my research study whilst still busy with my internship in 2004.

I wanted to give up on my dream many times along the way simply because I doubted myself. I did not believe that I had the capability to complete a research study. I felt that I had put my performance ceiling very high; I was too ambitious. I felt like this every time after I had been to see my supervisor. He would tell me to correct this and that, and I saw this as a shortcoming on my side.

All the things that seemed to go wrong along the way stretched my journey more and more. When I started this journey I was only armed with the basic knowledge that there was qualitative and quantitative research. The distinction between the two was very simple to me: one deals with numbers and the other with words. In a way this is half-correct. I tried using grounded theory, narrative research, case study method and testimonial research to try and answer my research question. I changed my research proposal about four times to try and make it fit in the research method. My supervisor was patient and supportive. At various points he would suggest that I change something and I would go and change the entire methodology. This is an indication of how confused I was by the numerous research terms I encountered. I put off looking at the research for three months. However, the confusion proved to be beneficial as it made me read much more about qualitative studies. The disadvantage was that it added more days and weeks, which eventually became years, to my studies.

- When I finally found the courage to persevere, the self-doubt also subsided. A number of people and events gave me the will that I needed to persist: I remembered that first step which started with selections into the Masters programme – someone believed that I could do it. I remembered my mother, who always reminded me that I needed to finish writing “the book” – I needed to finish the dissertation to have a better future. And then there was my husband, who had to deal with my frustration, moaning and desperation; and who sometimes chose the worst times to ask for feedback and progress on my work. Finally, watching my friends and former class mates graduating as psychologists inspired me.

I encountered other challenges along the way. My study was also delayed by almost three months because of the ethical processes involved in selecting research participants. I had to re-start this process as it played a significant role into the completion of my research. When I thought that I was finally nearing the end, I was told that my research needed more input. My focus was on voluntary counselling and testing and I was advised from the beginning that I should therefore only focus on VCT. I therefore did not include any information about HIV/AIDS as it was not the subject

under study, and the background to my study only focused on VCT cases. This meant that I had to undertake another intensive literature review; and I almost lost hope that I would ever get to finish my study. I developed a resentment towards psychology as a subject, and for what we have to go through to qualify.

A significantly positive change that this research brought into my life was the skill of persistence, which brought me this far. I have also learned that research is not a combination of some parts that are forced together to make a coherent fit. I used to hate the subject “research methodology” at school because I was told about the difficulty and the complexity of the subject. My attitude has shifted since I embarked on this study. Research makes sense as it involves reporting truthfully what a researcher has discovered. Research is not about being an expert, but about acknowledging the uniqueness of each study embarked on. I have also come to realise that finishing a research project is not about the time spent on it; but about the quality and understanding of what is being produced. Most of all, I believed that I could do it and I did. Doing this study did not make me an expert on research, but it did impart knowledge which I hope will improve as I embark on more research studies in future.

If I am given the opportunity to do another research project, I will do things differently, incorporating everything that I have learned. Most importantly, I intend to have fun and enjoy doing research.

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APPENDIX A

Respondent Information Leaflet and Informed Consent

Each respondent must receive, read and understand this document before the start of the study

Title of the Project

A phenomenological study of students' experiences of voluntary HIV counselling and testing

Introduction

You are invited to volunteer for a research project. This information leaflet is to help you decide whether you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions that are not fully explained in this leaflet do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about all the procedures involved.

What is the purpose of the research?

The purpose of this research is to study individuals' experiences of voluntary HIV counselling and testing. The researcher would like to investigate your thoughts on voluntary counselling and testing? What were your experiences? What were your expectations? What motivated you to go for HIV testing?

The researcher will invite you to take part in an interview on voluntary counselling and testing. During the interview several questions will be posed about HIV testing and what you think about the process involved.

What is expected of you during this study?

The research entails the following:

The researcher will interview all the participants individually and the duration of this interview should be about one hour. The researcher will tape record the session but no names will be used in the research to ensure that anonymity is maintained. The participants will not be forced to answer any questions or be asked to reveal their HIV status.

What are your rights as a participant in this project?

Your participation in this project is entirely voluntary and you can refuse to participate or stop at any time without stating any reason and without prejudice. The researcher retains the right to withdraw you from the study if it is considered to be in your best interest.

Will the research result in discomfort or inconvenience?

The researcher does not foresee any discomfort caused by the research. The researcher will tape record the interview session. If this causes discomfort the participants can listen to the tape. The researcher will also be available to answer any questions that the participants may have.

What are the risks involved in this research?

There will be minimal risks attached to the researcher. The researcher realizes that HIV/AIDS is a sensitive issue and she will make herself available if any of the participants need debriefing or need to continue the discussion with her for personal reasons. The participants will be told how they can contact the researcher.

Source of additional information

If at any stage you feel that you need more information regarding the project and its purpose, please do not hesitate to make contact the researcher, Tebogo Sefularo or her supervisor Mr Willem Louw.

Confidentiality

All information obtained during the course of this study is strictly confidential. Data that may be reported in psychological journals will not include any information that identifies you or your family as participants in this investigation. No names or identifying data will appear in the research.

Researcher: Tebogo Sefularo (012) 318 6117 or 072 298 9666 Supervisor: Mr Willem Louw: (083) 360 8672 or (012) 420 2907

APPENDIX B

Respondent Informed Consent

I hereby confirm that I have been informed by the researcher, **Tebogo Sefularo**, about the nature, conduct, benefits and risks of the project: **Experiences of voluntary HIV counselling and testing**. I have also received, read and understood the written information in the information Leaflet regarding the project and its purpose.

I am aware that the results of the project, including personal details regarding my sex, age, date of birth and initials will be anonymously processed into a final report for a Master's dissertation as undertaken by **Tebogo Sefularo** for her MA Psychology.

I may at any stage, without prejudice, withdraw my consent and participation in the project. I have had sufficient opportunity to ask questions and (of my free will) declare myself prepared to participate in the project.

Participant's name _____ (Please print)
Participant's signature _____ Date _____

The following is only necessary if working with participants who cannot read the information leaflet for themselves, and has to be done in the presence of a witness.

I, **Tebogo Sefularo**, here within confirm that the above client has been informed fully about the nature, conduct and risks of the above study.

Researcher's name _____ (Please print)
Researcher's signature _____ Date _____

APPENDIX C

Consent Form for the Interview to be Audio-taped

I..... (Name of participant) agree to have my interview audio taped for analysis purposes. No other person would have access to the audio taped material. However, my supervisor will have access to the audio taped material because I am still under training and need supervision. My supervisor can be contacted at this number (083) 360 8672 or (012) 420 2907

Signature

Date

APPENDIX D



**Tshwane University
of Technology**

We empower people

DIRECTORATE: ACADEMIC SUPPORT

Rand campus

ATTENTION : Tebogo Sefularo

CC: **Research Committee**
Department of Psychology
University of Pretoria
Pretoria 0001

FROM: Ilze Grobler
Deputy Director: Student Development and Support
Tshwane University of Technology

DATE: 2006-03-29

RE: Permission to use SDS premises for research

Dear Tebogo

Your request to conduct a phenomenological study of students' experiences of voluntary HIV counselling and testing at Tshwane University of Technology refers.

I hereby grant permission, on behalf of the Directorate for Student Development and Support (SDS), to conduct unstructured and open ended interviews and conversations with TUT students / identified participants who have volunteered to partake in the research study. As these conversations are part and parcel of the services rendered by SDS, you also have permission to make use of the counselling premises on campus.

Sincerely

Ilze Grobler

APPENDIX E
Interview Guidelines

BIOGRAPHICAL DETAILS (Participant)	
Name*	
Age	
Course	

Heading 1: Opening questions
<p>1.1. "Have you been tested for HIV?"</p> <p>1.2 What do you know about voluntary counselling and testing?</p>
Heading 2: Introductory questions
<p>1.1 Please tell me a bit yourself and reasons that made you decide to test.</p> <p>1.2 When did you test?</p>
Heading 3: Transitional questions
<p>3.1. Please tell me about your experiences regarding VCT</p>
Heading 4: Key questions
<p>4.1. How did it make you feel?</p> <p>4.2. What did you do?</p> <p>4.3. What were you expecting?</p> <p>4.4. What would make your experience different?</p>