

University of Pretoria etd – Kotzé, S C (2005)

**RETHINKING HIV/AIDS PRE-TEST
COUNSELLING IN SOUTH AFRICA**

by

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Submitted in partial fulfilment of the
requirements for the degree of

MASTERS OF ARTS IN COUNSELLING PSYCHOLOGY

in the

DEPARTMENT OF PSYCHOLOGY

at the

UNIVERSITY OF PRETORIA

MAMELODI CAMPUS

SUPERVISOR: W.P. LOUW

APRIL 2005

PRETORIA

For the HIV/AIDS Counsellor

The best time to plant a tree is twenty years ago...

The next best time is now.

- African proverb (Van Dyk, 2001a, n.p.)

ACKNOWLEDGEMENTS

To my brothers:

Gerhard, I truly miss you and, yes, we know, "... swart twee suiker...".

Pieter, thank you for always being close enough for me not to burn my fingers completely.

Dirk – "...dat die Kaap vir altyd so mooi bly en al lê die berge nog so blou..."

To Willem, thank you for Rae, and "There is no such place as far away!" en dankie vir jou aandeel en deel in my ervarings op die Mamelodi kampus van sielkunde, Martha, en natuurlik die mastieke uil!

To my beautiful parents – thank you for choosing me!

Namasté

DECLARATION

I declare that *Rethinking HIV/AIDS pre-test counselling in South Africa* is my own work, that all the sources used and quoted have been indicated and acknowledged by means of complete references, and that this dissertation has not previously been submitted by me for a degree at another university.

SUMMARY

This study is concerned with the pre-test counselling conversation (as regulated by policy-governing and training documents) that occurs between HIV counsellors and their clients. It attempts to explore and describe some of the assumptions underlying HIV/AIDS pre-test counselling in South Africa, and reflects on how these assumptions determine the content and process of HIV pre-test counselling. This exploration has been done by means of an analysis of a selection of official and non-official documentation on pre-test counselling.

The aim of HIV/AIDS counselling in general is to support and educate infected/affected clients about the HI-virus. Pre-test counselling (the conversation that takes place before an HIV-test is administered) forms the entry level to HIV counselling service delivery in South Africa, and it is often the only opportunity a counsellor has to support and educate a client about HIV/AIDS. Policy-governing pre-test counselling and training documents on such counselling confirm the role played by counsellors. The pre-test counselling conversation is based on the assumption that education about the HI-virus will enable clients to make informed decisions about their health which will help them to live long and healthy lives once they are aware of their HIV-status. However, this educational approach does not seem to be successful, as a change in risk behaviour is often not achieved. My recognition of this situation motivated this study and its focus on the conversation that takes place between counsellors and their clients in pre-test counselling. I was curious about what is discussed during pre-test counselling and why, if we acknowledge that counselling plays a major role in infection rate prevention, risk-reducing behaviour is not being achieved.

This qualitative study was based on a social constructionist paradigm and document analysis was used as a research method. This study offers an alternative approach to health education – a drive towards client-centred pre-test counselling where the client's needs become the focus of the pre-test counselling conversation.

Key words

Counselling assumptions

Clinical service delivery

Counsellor

Document analysis

Empowerment

Health education

HIV/AIDS counselling

Innate knowledge

Pre-test counselling conversation

Personalised risk-reduction plan

Social constructionism

Client-centred approach

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List of acronyms, abbreviations and key terms

AIDS	Acquired immune-deficiency syndrome
Antibodies	Special protein complexes produced by the immune system to fight against specific disease-causing organisms
ARV	Anti-retroviral
Anti-retroviral	Drugs which suppress or prevent the replication of HIV
ARVT	Anti-retroviral therapy
ATICCs	AIDS Training Information and Counselling Centres (South Africa)
CDC	Center for HIV STD and TB Prevention
False positive	A test that is positive when the person is actually or truly HIV-negative
False negative	A test that is negative when the person is actually or truly HIV-positive
HIV	Human immune-deficiency virus
HIV/AIDS	Acquired immune-deficiency syndrome / Human immune-deficiency virus
HIV-negative	Antibodies to HIV are not present in the blood stream and this means that the person has not been exposed to the HIV virus, or might be in the 'window' period.
HIV-positive	Antibodies to HIV are present in the blood stream and this means that the person has been exposed to the HIV virus.
SAMHS	South Africa Military Health Services
Serostatus	The absence or presence of antibodies for a particular antigen
Seronegative	The term seronegative means a blood test done for a possible infection that shows a negative result
Seropositive	The term seropositive means a blood test done for a possible infection that shows a positive result
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TASO	Training AIDS Support Organisation
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
USAIDS	Unites States of America AIDS Support Programme
USAID	Unites States of America AIDS Relief Programme

‘Window’period The time between the initial (first) HIV infection and the development of detectable HIV antibodies. During this time the antibody test will be falsely negative. The test will be negative even though the person is actually infected with HIV.

CHAPTER ONE

INTRODUCTION

This study focuses on the prescribed format and content of pre-test conversations¹ between HIV/AIDS counsellors and their clients, as documented in several texts on HIV/AIDS counselling in South Africa. The aim of the study was to explore and describe some of the assumptions underlying HIV/AIDS pre-test counselling in South Africa. In this study I reflect on how these assumptions might influence the content, process and results of pre-test counselling. This aim was pursued via an analysis of a selection of South African pre-test counselling documentation.

In Chapter Two, I discuss the need to explore assumptions about counselling and the influence these assumptions might have on a pre-test counselling conversation. HIV/AIDS care and counselling as prevention strategies are contextualised, especially at a macro level. This has been done to promote an understanding for the decision to let this study focus on pre-test counselling conversations and not on any other form of ongoing HIV/AIDS-related counselling, such as bereavement, couples or marriage counselling.

Chapter Three explains the qualitative nature of the research design. A social constructionist paradigm was used in the study, and a document analysis was done using Scott's (1990) criteria. Official and non-official policy-governing and training documents were selected as the artefacts for this research.

¹ In this study, wherever I refer to “the conversation”, I mean the pre-test counselling conversation. This “conversation” may consist of one or more counselling sessions. The term “conversation” is meant to reflect the notion of a particular discourse used in such sessions. This discourse consists of a specific way of speaking about HIV/AIDS, of a specific way of approaching the client and of specific content in such sessions.

Chapter Four presents the documents on pre-test counselling selected for the analysis. Eight different documents on HIV care and counselling are analysed, focusing on two relational positions: firstly, the position of the counsellor and, secondly, the position of the client. These relational positions are explored in documentation regarding pre-test counselling conversations in South Africa. The documents selected, which are mainly policy-governing and HIV counselling training texts, have been evaluated in terms of Scott's (1990) criteria and are classified as official or non-official documents. The latter distinction mainly reflects the availability and the purpose of the documents, and the audiences for whom they were intended. Not all these documents are in the public domain. Acknowledging the source and intent of a document contextualises the use of documents in the analysis and enhances the credibility of the selected documents. The quality of the document analysis is likely to be influenced by the quality of the selection of documents used in the analysis.

Chapter Five contains the document analysis. This analysis is set out as a discussion of recurring themes taken from the selected pre-test counselling policy-governing and training documents.

The title of Chapter Six is "Rethinking HIV/AIDS pre-test counselling in South Africa". In this chapter, client-centred pre-test counselling is discussed, proposing the use of a personalised risk reduction plan. An alternative pre-test counselling conversation is suggested, in which the client's needs form the focus of the conversation, rather than generalised training or education on HIV/AIDS, as is the case with existing pre-test counselling.

Chapter Seven contains an overview of the research and consolidates the information that has been gathered. Recommendations are made for client-centred pre-test counselling conversations.

CHAPTER TWO

PRE-TEST COUNSELLING AND PREVENTION

Introduction

The aim of this chapter is to contextualise the HIV/AIDS counselling situation in South Africa.

Chapter Two takes the reader through the HIV/AIDS care and counselling situation in South Africa, statistics on the current rate of infection, combination treatment requirements, the definition of counselling (particularly pre-test counselling), the role of funders, the various settings in which care and counselling are provided (predominantly clinical in nature), and the role of Voluntary HIV counselling and testing (VCT) clinics.

In this chapter, HIV/AIDS care and counselling service delivery in South Africa is discussed under the following headings:

- Point of departure;
 - HIV/AIDS statistics for South Africa;
- counselling as an instrument in an HIV/AIDS prevention strategy;
 - defining HIV/AIDS counselling;
 - HIV/AIDS care and counselling as a prevention strategy;
 - HIV/AIDS care and counselling service delivery settings in South Africa;
 - pre-test counselling as a unique opportunity;
- the psychosocial impact of an HIV-positive diagnosis;
 - assumptions or themes in HIV/AIDS counselling;
 - secrecy;
 - complexity;
 - relationships and interaction;

- uncertainty;
- the instructive vs the collaborative approach; and
- understanding the HIV/AIDS pre-test counselling conversation context.

Point of departure

My interest in pre-test counselling conversations originated in my curiosity about what exactly was said in this conversation, because pre-test counselling is acknowledged as an important (and often the only) opportunity to educate clients about the HI-virus. I wanted to find out how this “golden” opportunity was utilised. The more I read about HIV/AIDS care and counselling in South Africa, the more I wondered about the content of pre-test conversations. I became aware of the different role players involved in HIV/AIDS care and counselling, and I realised that, in general, funding drives service delivery. In short, my understanding of the implementation of HIV/AIDS care and counselling practises in this country is that they have mostly been shaped by the influence of international funders. Those who make funding available do so under certain conditions. These conditions determine implementation and ultimately service delivery.

Another influence I became aware of while reading about HIV/AIDS- related counselling in South Africa is the assumptions that underlie an HIV-positive and HIV-negative diagnosis. I became curious about how these assumptions might influence service delivery in South Africa. In this chapter, some of the assumptions about an HIV-positive and HIV-negative diagnosis are discussed. I argue that if a counsellor is trained to counsel clients based on assumptions about an HIV-positive and an HIV-negative diagnosis, the conversation would pre-empt the clients’ actual responses and would have a pre-arranged agenda. I am curious about how this “expert” position of counsellors influences pre-test counselling conversations.

HIV/AIDS statistics for South Africa

Statistics about the influence of HIV/AIDS in South Africa are inconclusive. So, for example, it is claimed that HIV/AIDS has already infected approximately 20 to 25% of the South African population (Public Affairs Office of the United States Embassy in South Africa, n.d.). It is suggested in the same source that nearly five million men, women and children are infected. Life expectancy is said to be dropping significantly, and there were expected to be 1.3 million AIDS orphans by 2005. The South African government has developed prevention, research, treatment, care and support programmes to curb the growing rate of infection. However, the South African HIV/AIDS infection rate remains largely uncontrolled (Public Affairs Office of the United States Embassy in South Africa, n.d.).

Statistics like these are common and sadly seem to have little effect on the people of South Africa. It is as if they have become desensitised in a way, I think, mainly due to the overwhelming enormity of this disease.

Government has implemented an HIV/AIDS prevention strategy. This prevention strategy acknowledges the role of counselling as instrumental in Government's approach to bringing about a change in risk behaviour. Pre-test counselling forms part of a range of HIV/AIDS-related counselling services. My interest in this study, *Rethinking HIV/AIDS pre-test counselling in South Africa*, is based on an understanding that counselling has already been identified as instrumental in the South African prevention strategy designed to curb the growing rate of infection and to reverse the disappointing success rate.

Counselling is an instrument in an HIV/AIDS prevention strategy

HIV/AIDS care and counselling, in combination, are said to have a higher success rate (Mellors, 2002) and this implies that treatment without counselling and counselling

without treatment are not beneficial. Hence, the role of counselling and, more specifically, pre-test counselling as an HIV/AIDS infection prevention strategy is discussed below.

HIV/AIDS was recognised as a problem in the early 1980's (Bor, & Miller, 1991). Large volumes of literature (Bekker, 2002; Department of Health, 2001a, 2001b; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b) support the notion that a diagnosis of HIV/AIDS has a profound effect on the psychosocial circumstances of an individual who is diagnosed as HIV-positive. HIV/AIDS counselling has been developed in response to the psychosocial problems that arise (Bor, & Miller, 1991). Van Dyk (2001a) argues that an HIV-infected individual needs to find ways to live a psychologically and physically healthy life when he or she is diagnosed and would need extensive counselling to achieve this. If this is so, given the infection rates in South Africa, the need for counselling, according to Van Dyk (2001a), will soon exceed the capacity of trained counsellors in South Africa. How then is HIV/AIDS counselling defined?

Defining HIV/AIDS counselling

Literature on HIV/AIDS defines counselling in a variety of ways. Three different definitions of counselling are used in the literature on HIV/AIDS care and counselling in South Africa, and are set out below. For the purposes of this study, the definitions by Johnson (cited in Van Dyk, 2001a), Evian (2000a) and Jürgens (n.d.) are used.

Johnson (as cited in Van Dyk, 2001a, p.200) defines counselling as “a structured conversation aimed at facilitating a client's quality of life in the face of adversity”.

Evian (2000a) defines counselling as

a process that helps people understand and deal with their problems. The counsellor discusses and explores feelings, worries and concerns of the client. Together they look at ways of dealing and coping with these feelings and concerns as best as possible (p. 269)

Jürgens (n.d.) defines HIV/AIDS counselling as

the development of a relationship between a counsellor and a client for the purpose of assessing risk for HIV infection or transmission, developing a plan to reduce risk, and assisting the client to cope with emotional and interpersonal issues related to HIV. (p. 5)

From these definitions it can be deduced that counselling refers to helping people to help themselves. Pre-test counselling in HIV/AIDS infection would then have to help people to help themselves to improve their quality of life when they are infected with the HI-virus and to refrain from infecting others.

The implementation of HIV/AIDS care and counselling programmes in South Africa did not come about easily (Thomas, 2001). An overview of the HIV/AIDS care and counselling prevention strategy introduced by Government follows below.

HIV/AIDS care and counselling as a prevention strategy

HIV/AIDS care and counselling has not always been readily and inexpensively available to all citizens in South Africa and the South African government has not always shown an unambiguous commitment to the prevention of and treatment of the HIV infected and affected. Implementation (Thomas, 2001) has taken years and this has had an effect on the HIV/AIDS service delivery in South Africa as we know it today.

According to Thomas (2001), the South African government's focus was initially on prevention, trying to curb the growing rate of infection, as opposed to the provision of treatment and care to those already infected and affected by HIV/AIDS. It has taken 20 years since the first information about HIV/AIDS became available before the South African government expressed a public political commitment to take action (Piot, 2002).

Mellors (2002) has noted that there is a critical link between prevention and treatment. Successful prevention interventions should include treatment and successful treatment interventions should include prevention strategies (Mellors, 2002). Funding from the Emergency Plan for AIDS Relief has recently been made available, which includes funds for antiretroviral therapy, as well as counselling, as part of a strategy to prevent and treat HIV/AIDS in South Africa (Office of the Press Secretary: White House President George W. Bush, 2003).

Counselling has been identified as instrumental in the prevention strategy of the South African government and is said to empower people to make informed choices about living with the HI-virus (CDC, n.d.a; Evain, 2000a; Van Dyk, 2001a).

HIV/AIDS counselling has been incorporated in the South African HIV/AIDS prevention strategy, and there is support for views such as that of Mellors (2002), in his statement that successful prevention interventions should include treatment and *vice versa*. This combination, however, has several implications for the clinical setting in which HIV/AIDS care and counselling services are rendered.

HIV/AIDS care and counselling service delivery settings in South Africa

Many public and private United States organisations are involved in health activities in South Africa (Office of the Press Secretary: White House President George W. Bush, 2003). South Africa is participating in President Bush's new five-year *Emergency Plan for AIDS Relief* programme. This \$15 billion programme intends to

help South Africa to treat AIDS via the public health system and to expand prevention and care initiatives throughout the country. South Africa is also a major recipient of grants from the Global Fund to Fight AIDS and other infectious diseases. According to the Public Affairs Office of the United States Embassy in South Africa (n.d.), 50% of the funding from the Global Fund to Fight AIDS comes from the United States.

The implementation of the United States of America's *Emergency Plan for AIDS Relief* is based on a "network model". According to the Office of the Press Secretary: White House President George W. Bush (2003), the network model involves a layered network of central medical centres, called CMC's, that support satellite centres and mobile units, with varying levels of medical expertise in treatment. According to the Office of the Press Secretary: White House President George W. Bush (2003), the network model employs uniform prevention, care and treatment protocols and prepares medication packs. Some benefits of this model are that drug administration is made easier and that it can build on to existing clinics, sites and or programmes that have been established through the United States Agency for the International Development of Health and Humanitarian Services, non-governmental organisations, faith-based groups and or willing host governments. According to the Office of the Press Secretary: White House President George W. Bush (2003), the network model is implemented in the following settings:

Central Medical Centres (CMCs): These should be existing hospitals staffed by physicians with expertise in HIV and infectious diseases, doctors-in-training, nurses, nurse practitioners, and laboratory technicians. The centres should provide the highest level of care and should be capable of managing complicated medical issues (Office of the Press Secretary: White House President George W. Bush, 2003).

Primary satellites: These should be independent medical centres with doctors, nurses, pharmacists, counsellors and medical technicians, who should provide basic medical care, including the prescription of anti-retroviral treatment. Primary satellites could have doctors on staff or doctors routed through from the CMCs. Many private and

public clinics run by faith-based groups and non-governmental organisations fall in this category (Office of the Press Secretary: White House President George W. Bush, 2003).

Secondary satellites: These should be staffed by nurses and nurse practitioners. Medical technicians and counsellors should perform tests to diagnose HIV and other infectious diseases. Patients with the disease should be referred to Primary Satellites or CMCs for evaluation and the initiation of ARV treatment. However, routine evaluation and care, including the filling of prescriptions, should occur at these secondary sites using standards protocols and prepared medication packs (Office of the Press Secretary: White House President George W. Bush, 2003).

Rural satellites and mobile units: These are remote sites staffed by lay technicians, possibly rotating nurses, and local healers, who should be trained in standard clinical evaluations and the distribution of medication pack refills (Office of the Press Secretary: White House President George W. Bush, 2003).

HIV/AIDS care and counselling service delivery in South Africa is clinically driven, as can be deduced from the above details. HIV/AIDS care and counselling service delivery in South Africa is based on such a “network model”, referred to as the TASO (Training AIDS Support Organisation) model (TASO, n.d.). The TASO model is a Ugandan hospital-based model of HIV/AIDS care and counselling that provides medical home care and sets up community-based programmes. South Africa has adopted this model (TASO, n.d.). Medical doctors, laboratory and nursing staff play a dominant role in the TASO model. The United Nations Emergency Plan for AIDS Relief supports the TASO strategy using a hospital-based model. The United Nations Emergency Plan for AIDS Relief is currently one of the main HIV/AIDS care and counselling funders in South Africa (Office of the Press Secretary: White House President George W. Bush, 2003).

HIV antibody blood testing in terms of the TASO model is the entrance level to clinical service delivery in South Africa. Once a person has been tested, and in the event

of an HIV-positive result (if HIV antibodies are present in the bloodstream), combination drug therapy is made available (Department of Health, 2001d; Gasa, 2001). It is a legal and ethical requirement that HIV testing be accompanied by informed consent, which requires pre-test and post-test counselling (Department of Health, 2001c; Gasa, 2001).

Voluntary HIV counselling and testing (VCT) is a process whereby an individual undergoes pre-test counselling that enables him or her to make an informed choice about being tested for HIV. According to Gasa (2001), Baggaley (2001), Finger (2002) and CDC (n.d.c), VCTs play a vital role in HIV/AIDS care and counselling practices. In August 2001 the Department of Health published the National Policy on Testing for HIV, and VCTs have become more prevalent since the implementation of this policy (CDC, n.d.b).

VCT clinics were introduced as a result of the United Nations Emergency Plan for AIDS Relief's preference and clinical requirements for the network and TASO model. In these VCT settings, services such as HIV/AIDS test counselling, HIV/AIDS antibody blood testing and anti-retroviral therapy treatment are rendered (Baggaley, 2000a, 2000b, 2000c, 2000d, 2001; Caldwell et al., 1993; CDC, n.d.c; USAIDS, n.d.; USAID, 2000).

According to USAID (n.d.) and CDC (n.d.c), four of the most common South African scenarios in the provision of HIV counselling are the following:

Free-standing (Volunteer Counselling and Testing (VCT) service: here the client generally requests HIV testing; informed consent is critical and counselling services should emphasise prevention goals (USAIDS, n.d.).

Antenatal care clinics: HIV testing can support intervention concerning the health of the mother and the unborn child, as well as the prevention of HIV transmission to infants and young children (USAIDS, n.d.).

Clinical care settings: the focus in these clinics is making a diagnosis and deciding about testing in the presence of a suspected HIV infection. The attending health care worker has to request HIV testing and counselling and has to obtain informed consent. Both medical and psychological considerations should be included in a comprehensive care package or treatment plan. However, according to USAIDS (n.d.) and CDC (n.d.c), there is some tension between establishing a diagnosis and the treatment plan and attending to the client's psychological needs. Health care workers are not always equipped to address both these diverse demands.

Sexual and reproductive health care settings: HIV considerations play a critical role in family planning and reproductive health counselling services. The counselling process in this setting needs to address sexual and reproductive health care needs, as well as HIV prevention and care issues (USAIDS, n.d.).

The clinical nature of HIV/AIDS service delivery in South Africa has been shown above. In South Africa, the start of care and counselling is based on a confirmation of the client's HIV status, and this requires a blood test. To take blood, health care staff need to be employed. Consent from the client is needed before (pre-test counselling) and after (post-test counselling). Consent from the client is further needed before blood results can be requested and/or are made available. The literature (as argued below) on pre-test counselling emphasises the utmost importance of the pre-test counselling conversation – the field of interest of this study.

Pre-test counselling as a unique opportunity

HIV/AIDS test counselling includes pre-test, post-test and ongoing counselling (Bekker, 2002). Finger (2002) describes the content of these counselling scenarios as follows: during pre-test counselling, the focus should be on the testing process, the implications of testing, risk assessment and risk prevention, coping strategies and the decision to take the test. During post-test counselling, the focus should be on giving the news, risk-reduction (including making plans to reduce risk), and discussions about

disclosure of the individual's HIV status. Follow-up (ongoing) counselling and support should focus on medical care, emotional and social support.

Pre-test, post-test and ongoing counselling have specific goals and represent the majority of HIV/AIDS counselling opportunities in South Africa. Van Dyk (1992; 2001a) suggests that a very important function of HIV/AIDS counsellors is counselling people who need HIV testing: "Probably the most common reason for health professionals to counsel in South Africa today is in the context of HIV testing" (Bekker, 2002, p. 30). Finger (2002) indicates that counselling services in South Africa are predominantly once-off pre-test encounters. The majority of people, irrespective of the test result, are said to attend one or, at most, two pre- and post-test sessions. Follow-up counselling is often not wanted or sought (Finger, 2002).

Anyone can be infected with HIV, the virus that causes AIDS. People may remain symptom-free for years, and it is only through a blood test that HIV-infection can be determined (Department of Health, 2001b; Evian, 2000b; Gasa, 2001; SAMHS, n.d.).

According to Van Dyk, (2001b), Finger (2002) and Bekker (2002), pre-test counselling is one of the most important current prevention strategies against the growing rate of infection. Pre-test counselling is often the only opportunity for the counsellor to support and educate the client about HIV/AIDS, according to Van Dyk (2001b). During pre-test counselling, the focus is on sex education and achieving changes in sexual behaviour to support the implementation of safe sex principles (Bekker, 2002; Department of Health, 2001d; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992; 2001b).

Pre-test counselling represents the start of service delivery in South Africa. No blood can be taken for testing before the client has undergone counselling. The first conversation that takes place between counsellors and clients about HIV/AIDS is a pre-test counselling conversation, and often it is the only opportunity, not only for the

counsellor, but also for the client, to talk about HIV/AIDS. I am curious about the content of these first (and often only) conversations.

Unfortunately, a number of assumptions are commonly made about how an individual might react to an HIV/AIDS diagnosis (Bor, & Miller, 1991; Van Dyk, 2001a). The content of the pre-test counselling conversation is affected by underlying assumptions about individuals' reactions to an HIV/AIDS diagnosis. It is broadly postulated that an HIV-positive result has a profound effect on the life of the individual, whereas an HIV-negative result seems to be experienced as a relief and a second opportunity for life. These assumptions about individuals' reactions to their HIV/AIDS status create a pre-set understanding of the perceived needs of an individual seeking HIV testing. Van Dyk (2001a) and Bor and Miller (1991) discuss these and other assumptions about what reactions can be expected, and therefore what to focus on when dealing with a client who has tested HIV-positive or HIV-negative.

The psychosocial impact of an HIV-positive diagnosis

I have already indicated that the literature on HIV/AIDS care and counselling supports the notion that a positive HIV/AIDS diagnosis has a profound effect on the psychosocial circumstances of individuals (and that HIV/AIDS counselling has been developed in response to potential psychosocial problems), according to Van Dyk (2001a) and Bor, and Miller (1991). However, Rose (1998) comments that with access to anti-retroviral therapy there are also many hopeful developments to acknowledge and celebrate. According to Rose (1998), many HIV-positive people are reclaiming a future in a hopeful shift away from the despair and resignation felt in the past.

Current literature on the psychosocial aspects of HIV/AIDS reveals that several assumptions are generally made about the impact of HIV/AIDS on people. The assumptions that are made about people's reactions to a positive diagnosis can influence

conversations between counsellors and clients (Bor, & Miller, 1991). Below, some dominant assumptions about reactions to an HIV/AIDS diagnosis are discussed.

Assumptions or themes in HIV/AIDS counselling

Psychological problems often seem to be regarded as inevitable when an HIV-positive diagnosis is made. The psychotherapeutic focus is usually on the relief of symptoms such as anger, depression and withdrawal. According to Bor and Miller (1991), assumptions about the reactions to an HIV-positive or HIV-negative diagnosis on the part of the counsellor could impede rather than facilitate counselling conversations. They warn that resistance and denial may become the focus during counselling sessions. Counsellors and their clients might then have to compete to assert their views and beliefs during these counselling conversations.

Bor and Miller (1991) list and discuss some dominant assumptions with regard to an HIV-positive or HIV-negative diagnosis. They are secrecy, complexity, effects on relationships and interaction, and uncertainty.

Secrecy

Loneliness seems to be a common complaint of people living with HIV/AIDS and is due mostly to the social stigma associated with HIV/AIDS. Most counselling sessions would include discussions on who should or should not be informed about the diagnosis (in reaction to the stigmatisation dilemma) once the person is diagnosed with HIV/AIDS (Bor, & Miller, 1991).

Complexity

Due to the complexity of HIV infection, from a biomedical and social point of view, service delivery introduces a number of interventions where different people become involved with the client. Professional and non-professional sub-systems become involved with the client and a great number of encounters take place between the client and different service delivery agents. The involvement of different people in discussions about HIV/AIDS creates opportunities for confusion to arise (Bor, & Miller, 1991).

Effects on relationships and interaction

Because of the fear of contamination and the impact of this fear on sexual relationships, an HIV/AIDS diagnosis can create relationship problems. This can lead to anxiety about isolation and an inability to enter into a relationship or to sustain an existing relationship (Bor, & Miller, 1991).

Uncertainty

Many clients have very little knowledge about the HI-virus and clients are often uncertain about the impact of the diagnosis on their lives. As a result, clients frequently seek reassurance, certainty and predictability, particularly from the counsellor (Bor, & Miller, 1991).

Johnson (cited in Van Dyk, 2001a), concurs with the assumptions indicated by Bor and Miller (1991). Johnson (cited in Van Dyk, 2001a), adds to the list. Johnson (cited in Van Dyk, 2001a), does not refer to “assumptions” about an HIV-positive or HIV-negative diagnosis but to “themes” readily discussed during HIV/AIDS counselling. The themes that Johnson (cited in Van Dyk, 2001a) highlights correlate with the list of “assumptions” drawn up by Bor and Miller (1991).

Johnson (cited in Van Dyk, 2001a, p.289) lists ten themes related to an HIV-positive or HIV-negative diagnosis and encourages counsellors to spend time exploring these themes with their clients. Prominent themes, according to Johnson (cited in Van Dyk, 2001a, p.289), are

- uncertainty about the progress of the disease, especially as current treatment options lengthen life expectancy;
- relationship problems with significant others;
- issues surrounding the disclosure of HIV-positive status;
- dealing with the fear, stigma and stereotypes associated with HIV infection;
- career and financial concerns;
- sexual relationships;
- stress and anxiety;
- depression and suicidal thinking;
- spiritual and existential matters; and
- issues about death and dying.

The counselling assumptions listed by Bor and Miller (1991) and the unique themes listed by Johnson (cited in Van Dyk, 2001a), are indicative of the content of HIV/AIDS counselling conversations. Counsellors would need to provide directive counselling. They prefer to focus on some of the issues listed above. The conversation would then need to focus on secrecy (loneliness due to stigmatisation and who should or should not be informed), complexity (the involvement of many people delivering a medical service that could confuse the client), relationships and interaction (fear of infecting the self and others and the impact on sexual relationships) and uncertainty (seeking assurance from the counsellor). Counsellors might assume the needs of the client and counsel accordingly.

Bor and Miller (1991) and Rose (1998) challenge this response to counselling on HIV/AIDS and argue the possibility that a client might respond differently to an HIV-positive and or HIV-negative diagnosis than the counsellor anticipates.

The instructive vs the collaborative approach

Ideally, an HIV/AIDS counsellor is expected to ensure the complete and constructive integration of a person living with HIV into the community (Van Dyk, 1992; 2001a). These expectations place a large responsibility on counsellors and could obligate counsellors to give as much information as possible to their clients about how to live a long and healthy life with the HI-virus.

Sadly, given the time pressures and limited counselling opportunities available to them, many counsellors are more concerned about the HIV/AIDS status of their clients and about obtaining disability grants for their clients than about the client (Finger, 2002; Richter, Van Rooyen, Solomon, Griesel, & Durrheim, 2001). They may pre-empt the reactions of clients once clients have been diagnosed with or are awaiting confirmation of their HIV/AIDS status. Before a client even seeks testing, the counsellor might have preset ideas about the possible reactions of the individual to an HIV-positive diagnosis, and the counsellor may have been trained to counsel accordingly.

Counsellors are expected to focus on changing behaviour and not just on creating insight (AIDS Info South Africa, n.d.; ATICCs South Africa, n.d.; Department of Health, 2001d; Gasa, 2001). According to ATICCs South Africa (n.d.), counsellors are trained to listen and to provide accurate information to assist people with decision-making. They should offer ongoing support, information and advice to HIV-positive people, their partners, friends and family (AIDS Info South Africa, n.d.; ATICCs South Africa, n.d.).

Documentation on pre-test counselling conversations, as presented in Chapter Four of this study, has been analysed with the following research questions in mind: What are the assumptions about the role of the counsellor and the client in texts on pre-test counselling conversations? The counselling approach seems to be more instructive than collaborative. Counsellors in general inform, advise, educate or instruct clients (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b).

The above mentioned approach to counselling conflicts with other counselling approaches, such as the collaborative approach advocated by Anderson and Goolishian (1988). Anderson and Goolishian (1988) argue that a counsellor should not lead the client towards discovering a solution that the counsellor has already decided upon. Counsellors should not assume a position of knowledge, expertise or power in the therapeutic relationship – clients are the experts in their own lives. The counsellor's role is only to create a context where new meanings and new descriptions can be created (Anderson, & Goolishian, 1988). It can be safely assumed that a pre-test counselling interview would take a completely different form and content from the present form if it were to be based on a more collaborative approach to counselling. Currently, however, this is not the case, and this should be apparent to any reader who reads carefully the guidelines to pre-test counselling as they appear in the policy-governing and training documents documented in this study.

In this study, pre-test counselling conversations (as documented in policy-governing and training documents on HIV/AIDS care and counselling) are presented. The aim is to analyse these documents in terms of the assumptions underlying the position of the counsellor and that of the client during pre-test counselling conversations. Pre-test counselling conversations have been selected because of their acknowledged importance and dominance in the South African antibody test-counselling scenario (Bekker, 2002; Finger, 2002; Richter et al., 2001; Van Dyk, 2001b).

Understanding the HIV/AIDS pre-test counselling conversation context

According to Anderson and Goolishian (1988), counselling should be seen as the creation of a conversational context where there is a consensual domain. This is where the client and counsellor can share some meanings and realities around a problem. Counsellors should not manipulate clients in order to bring about change. Change, in such a consensual space, is seen as the result of the co-creation of a new reality.

However, at present, pre-test counselling conversations are structured and have clearly defined goals (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). The counsellor is requested to provide individuals who consider testing with information on the technical aspects of the test and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV-positive or HIV-negative (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). It is regarded as beneficial to the counsellor to investigate why the individual wants to be tested. The counsellor is also expected to explore the nature and extent of the client's previous and present high-risk behaviour (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). The additional information will help the counsellor in the counselling situation (Van Dyk, 2001a). It is interesting that the rationale for obtaining information on the reason for testing and possible risk behaviour indicated above is to benefit the counsellor. Are counsellors not to ask these questions to benefit the client?

Sexual education and changes in sexual behaviour to include the practice of safe sex principles is a dominant theme in pre-test counselling in South Africa (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). However, on the basis of a recent survey about condom use in South Africa, Joubert (2001) reported that over 90% of South Africans know that they should wear a condom, yet less than 20% had done so in their most recent sexual encounter. This survey supports the value of awareness programmes on HIV/AIDS infection, but raises questions about the effectiveness of counselling as a prevention strategy. Risk-reducing behaviour does not seem to have been achieved.

Although behaviour change is indicative of a more complex understanding of the psychological dimensions of the individual, Joubert (2001) indicates that it is the individual's psychological intervention that is vital in the fight against the disease. The only real control there is over the spread of the HI-virus, according to Joubert (2001), resides in the actions of individuals.

The counsellor has the opportunity during pre-test counselling to intervene at the micro level, which is that of the individual. I am interested in conversations about pre-test counselling that takes place at this level and in the co-creation of new and or alternative meanings about an HIV/AIDS diagnosis.

Overview

In this chapter, the HIV/AIDS care and counselling service delivery in South Africa has been contextualised.

Test counselling dominates HIV/AIDS counselling in South Africa (Bekker, 2002) and necessitates the clinical setting and need for medical intervention in the form of staff and treatment. Consent to be tested is a medical legal requirement (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b), and necessitates counselling before the test and when the results are made available. Counselling before testing is referred as pre-test counselling. VCTs have been introduced in response to this need and pre-test counselling has emerged as the most-utilised, dominant counselling intervention in South Africa (Bekker, 2002; Finger, 2002; CDC, n.d.c; Richter et al., 2001; Van Dyk, 2001a).

HIV/AIDS treatment and prevention in combination seems to be more successful (Mellors, 2002) than either treatment or prevention in isolation and this implies the inclusion of counselling services as part of the treatment plan. Counselling is now acknowledged as instrumental in the fight against the growing rate of infection. During pre-test counselling, counsellors predominantly focus on education about HIV/AIDS and about risk reduction practices.

Assumptions on the reaction(s) of individuals to an HIV-positive or HIV-negative diagnosis have also been discussed in Chapter Two. I have argued that if counsellors are trained to give counselling based on a belief that HIV-positive or HIV-negative clients

generally react in a similar way to such a diagnosis, this belief could influence the HIV-related counselling and therefore also pre-test counselling conversations.

It is my contention that the pre-test counselling conversation as it is currently conceptualised and advocated in policy governing and training documents could contribute to resistance to risk-reducing behaviour.

In the remainder of this document I expose some of the assumptions about the position of the counsellor and that of the client in selected texts on HIV/AIDS pre-test counselling. I attempt to show that pre-test counselling conversations are designed according to an instructive rather than a collaborative stance and follow a very specific agenda that is perhaps more useful to the counsellor in feeling that his or her job has been done than in achieving the “real” aim of behaviour change. This agenda is to educate, inform and advise clients and to make suggestions about how to live a longer, healthier life once a client has been diagnosed as HIV-positive.

CHAPTER THREE

METHODOLOGY

In this chapter, the approach of the study is explained, and details on how the research was conducted are provided. The focus of the study and the method of research are also contextualised.

Baggaley (2000a, 2000b, 2000c, 2000d) indicates that there is a need for further research on the effectiveness of VCT settings. According to Finger (2002) and Richter et al. (2001), limited research is available on the success rate of VCTs and HIV/AIDS test counselling in general. As has been stated in Chapter One, this study aims meet part of the already identified need for research on test counselling in general and to focus on pre-test counselling conversations as documented in texts on HIV/AIDS in South Africa in particular.

Overview on the need for further VCT research

The areas in HIV/AIDS care and counselling for which further research is required, according to Richter et al. (2001), are:

- the level of support received by individuals;
- how change in behaviour (if any) is brought about;
- whether change is influenced by VCT services;
- the effectiveness of different counselling approaches, content, models of delivery and levels of intensity;
- alternative approaches to the traditional one-to-one counselling setting; and
- critical elements of effective multicultural counselling.

(p.152)

This study aims to contribute to further research about the success rate of VCT settings by exploring pre-test counselling conversations, and questioning the effectiveness of the health education approach that seems to be the current focus. Most counsellors are said to be trained in, and attempt to practise, a non-directive form of exploratory counselling in a one-to-one format (Richter et al., 2001). However, when one analyses documentation on the pre-test counselling conversation, it is clear that the agenda to educate the client about the HI-virus and risk reduction behaviour (safe sex practices) is dominant in the discussion (Bekker, 2002; Department of Health, 2001a, 2001b, 2001c; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). I argue for the need for an alternative approach to pre-test counselling. This is an approach in which the client's needs are central to the discussion and not the counsellor's assumptions about the reactions of individuals to an HIV-positive or an HIV-negative diagnosis.

How the study was conducted

Position of the researcher

Deciding on the research method for this study was not an easy process, since there could be many alternative approaches to this research. However, the use of documents as artefacts is an approach traditionally used by historians and it seemed to be an appropriate approach to answering the following research question: What are the assumptions about the role of the counsellor and the client in documentation on HIV/AIDS care and counselling that influences pre-test counselling conversations in South Africa?

According to Creswell (1998), the perspective the researcher chooses to write from is an indication of the personal concerns of the researcher. I am interested in the way the pre-test counselling opportunity is utilised in South Africa. This study focuses

on the documented pre-test counselling conversation and the assumptions that underlie this conversation. The research question has been approached qualitatively, from a postmodern perspective and from within the paradigm of social constructionism, mainly because of the explorative and rich nature of this approach.

The paradigms of postmodernism and social constructionism

According to Creswell (1998) and Pauw (1999), postmodernists focus on changing ways of thinking rather than on calling for action. This study attempts to do exactly that, by suggesting an alternative way of thinking about pre-test counselling conversations.

Social constructionism does not argue for any definitive, objective truths, but sees the social processes between people as the creating forces of reality. All behaviour is seen within a social context or the social domain in which it takes place; and all knowledge, including scientific knowledge, is understood and interpreted within the social contexts in which it is created (Pauw, 1999). Language is a strong focus in this approach (Creswell, 1998; Pauw, 1999), because it is the means by which social interaction takes place. The outcome of the social context is influenced by the type of language used. The first basic assumption of social constructionism (Pauw, 1999) is that people create their realities through social interaction. The interaction between people and the consensus reached between them creates a reality, according to Pauw (1999). It is therefore not possible to know an objective reality fully – the reality available to us is one created through social interaction (Pauw, 1999).

This study focuses on pre-test counselling conversations from a social constructionist perspective. It describes and explores the creation or construction of a particular pre-test counselling reality, as documented in texts on HIV/AIDS care and counselling in South Africa. The focus is on the assumptions present in the documentation governing this process. These assumptions guide counsellors on what to

include in conversations with clients around HIV and how to conduct such conversations, but cannot cover the actual conversation that takes place between the counsellor and client. The “reality” that is therefore created in texts on HIV/AIDS pre-test counselling pertains to an ideal reality of the pre-test counselling conversation, and not actual, pre-test conversations. This ideal reality influences the applied reality and the implementation of the pre-test counselling conversation in South Africa.

It may be argued that, surely, how we write about the conversation that is to take place between the counsellor and the client should emphasise the views we hold about the purpose of pre-test counselling as a prevention strategy in the HIV/AIDS situation in this country.

The selected conversation guidelines have been analysed qualitatively. The purpose was to ascertain the language that we use in this conversation and what the language that we use says about our perceptions about pre-test counselling as a prevention strategy in South Africa.

Rationale for a qualitative approach

Qualitative research provides rich descriptions of the experiences of people (Durrheim, 1999; Ritchie & Lewis, 2003; Terre Blanche & Durrheim, 1999) and has been selected specifically for this reason. Qualitative research begins with no formal goal, except to understand a complex social situation on its own terms, without prescriptive limits (Morse, 1994). According to Stiles (1993), qualitative research is a natural language of which the results tend to be expressed in words rather than primarily in numbers. Events are understood and reported in their context. Stiles (1993) argues that a central purpose of qualitative research is empowerment. According to Patton (1980a, 1980b), qualitative research examines what people are doing and how they interpret what is occurring.

In this study, the pre-test counselling conversation, as documented in selected texts on HIV/AIDS, has been analysed qualitatively. Meanings and assumptions underlying the use of language are speculated about in this study. I have chosen a qualitative approach because of the richness of experience that it offers.

Method of analysis

In this study, a selection of documentary sources on pre-test counselling in South Africa has been analysed. Document analysis has been used as the method of inquiry. This method is explained below, based on the views of Robson (1993), Terre Blanche and Durrheim (1999), Kelley (1999), Manning and Cullum-Swan (1994), Berg (1989) and Hodder (2000).

Document analysis is also referred to as content analysis (Robson, 1993). Document analysis has been defined as a research technique used to make replicable and valid inferences from data to their context. According to Terre Blanche and Durrheim (1999), Kelley (1999) and Manning and Cullum-Swan (1994), document analysis is also said to stress relationships between content and context. This context includes the purpose of the document, as well as its institutional, social and cultural aspects. Robson (1993) comments that documents are written with a purpose, and suggests that this purpose is important in the analysis of the documents.

According to Terre Blanche and Durrheim (1999), Kelley (1999) and Manning and Cullum-Swan (1994), texts are often intended to do a number of things simultaneously, for example, advance a particular ideology, tell the truth or motivate the reader to act in a particular way. Terre Blanche and Durrheim (1999), Kelley (1999) and Manning and Cullum-Swan (1994) suggest reflecting on textual activities, for example, by looking for recurrent terms, phrases and metaphors that are present in the text, and more specifically, the particular way of speaking that is inclusive of the content of what has been said, as well as of how it has been said. Terre Blanche and Durrheim (1999),

Kelley (1999) and Manning and Cullum-Swan (1994) claim that consideration should be given to the way that the text speaks about the human subject.

Berg (1989) and Hodder (2000) indicate that all communication has three main components, namely the message, the sender and the audience. They suggest that document analysis should be used to assess the effect of the message on the audience.

Robson (1993), Terre Blanche and Durrheim (1999), Kelley (1999), Manning and Cullum-Swan (1994), Berg (1989) and Hodder (2000) have set out their views on document analysis as a research method. They propose reasons why documents can be used as artefacts in research, and suggest ways to validate the use of documentation such as the pre-test counselling documentation used in this study. They explain that documents have been written with a purpose and for a specific audience and that, once contextualised in terms of its quality and source, a document itself can form the focus of research.

Recurring themes

In Chapter Five recurring themes have been selected for document analysis and are discussed. These themes have been selected to answer the following research question: What are the assumptions about the role of the counsellor and the client in documentation on HIV/AIDS care and counselling that influences pre-test counselling conversations in South Africa?

Language

Due to the social constructionist paradigm of this study, the language used in documents on pre-test counselling conversations are significant. Language reflects on how selected texts speak about counsellors and their clients. The language used in the

texts is reflected in the themes selected from the document analysis. These themes clearly indicate the assumptions underlying the role of counsellors and clients in the current pre-test counselling conversation in South Africa.

The human subject

The themes selected in Chapter Five also indicate the way texts on pre-test counselling conversations speak about counsellors and clients. What is evident from the document analysis is the expert position as well as the dominant voice of counsellors in comparison with the subordinate position and voice of the client.

Recurring themes, language and the way the texts on pre-test counselling conversions speak about people – in this study, that is counsellors and their clients – are discussed in detail in Chapter Five, the document analysis chapter.

The selection of documents on pre-test counselling conversations is representative of South African HIV/AIDS care and counselling documentation. Eight documents have been selected and the rationale for this selection is discussed below.

Selection of data: HIV/AIDS pre-test counselling documentation

The selection of the documentary sources for analysis was based on the principle that policy-governing and training documents on HIV/AIDS care and counselling in South Africa represent the required standards for implementation and service delivery in the country. The training of HIV/AIDS counsellors in South Africa is regulated by the *Minimum Standards for Counselling and Training* guidelines (AIDS Helpline, Department of Health and Centres for Disease Control and Prevention South Africa, 2000). AIDS Training Information and Counselling Centres (ATICCs) are the governing bodies for HIV/AIDS training education and support in South Africa (AIDS INFO South

Africa, n.d; ATICCs South Africa, n.d; CDC, n.d.b). Eight different documents have been selected for the analysis. They represent South African-based policy-governing and training documentation on HIV/AIDS. This selection of documents has been analysed according to the relational position of the counsellor and the client. The focus is thus the position of the counsellor and the client with regard to each other during the pre-test counselling conversation. These eight documents are the artefacts of study, in other words, the raw data the analysis is based upon. In the next section, the selected documentation are evaluated according to Scott's (1990) criteria for the use of documents as artefacts. The inclusion of this step in the methodology validates the use of the specific selection of documents and ensures the scientific nature of the analysis. With this step I have ensured that the raw data I am using in the analysis is credible. The next step was to do the document analysis. In the selected eight documents, guidelines are given for the format, content and flow of the pre-test counselling conversation. These guidelines are representative of the South African HIV/AIDS counselling reality as documented in policy-governing and training documents.

The eight documents are presented below, not in alphabetic or chronological sequence but in the order in which they are discussed in the chapters to follow. Documents A to E are official documents – compiled by the Department of Health or the National Defence Force and can only be obtained from these institutions. Documents F to H are non-official documents – written by individuals from South Africa universities and obtainable from academic libraries, in scientific journals and or academic bookshops. The documents are the following:

- A. Department of Health. (2001c). *Pre-test counselling: Ten Days HIV/AIDS Counsellor Training Course Participant's Manual*. Pretoria: African Watermark Graphics.
- B. Department of Health. (2001b). *Counselling and HIV/AIDS, Fact Sheet 7*. Pretoria: African Watermark Graphics.

- C. Department of Health. (2001a). *HIV/AIDS Policy Guideline*. Pretoria: African Watermark Graphics.
- D. Gasa, N.B.K. (2001). *SACMA: HIV/AIDS information: A guide for HIV/AIDS peer education programmes*. Pretoria: African Watermark Graphics.
- E. SAMHS. (n.d.). *Masibambisane – United in the fight, educational officers HIV training participants manual: Counselling*. Pretoria: African Watermark Graphics.
- F. Evian, C. (2000b). HIV testing and pre- post-test counselling. In C. Evian (Ed.), *Primary AIDS Care: A practical guide for primary health care personnel in the clinical and supportive care of people with HIV/AIDS* (3rd ed). (pp. 51-52). Johannesburg: Jacana.
- G. Van Dyk, A. (2001b). Pre-and post-HIV test counselling. In A. Van Dyk (Ed.), *HIV/AIDS Care and Counselling: A multidisciplinary approach* (2nd ed). (pp. 238-246). Cape Town: Maskew Miller Longman.
- H. Bekker, L. (2002). HIV counselling. *Southern African Journal of HIV Medicine*, (8), 30-31.

Documentary sources need to be evaluated according to specific criteria to ensure their quality as evidence in social research. Scott (1990) introduces such criteria to assess the quality of the evidence.

Scott's criteria

The documentary sources used for analysis in this study have been evaluated according to the criteria that Scott (1990) suggests as the foundation of scientific research. Scott (1990) suggests using the following criteria to evaluate documentary sources:

- authenticity: the evidence is genuine and of unquestionable origin;
 - credibility: the evidence is free from error and distortion;
 - representativity: the evidence is typical of its kind, and, if not, the extent of its untypicality is known; and
 - meaningfulness: the evidence is clear and comprehensible.
- (p.6)

Once a document meets these criteria, such a document can be acknowledged as credible. It is important to include credible documentation in the analysis. If the source documents are not solid, the validity and credibility of the analysis can be questioned. The assessment of quality is central to the rationale to use documentary sources as evidence (artefacts).

The evaluation of a document in terms of Scott's criteria (authenticity, credibility, representativity and meaningfulness) provides the format for this research. Provided that the documents used for this analysis adhere to the criteria, in other words are authentic, credible, representative and have relevant meaning, the material for analysis can be regarded as being of good quality (Scott, 1990).

A thorough rationale for the selection of the eight documents used in the analysis is provided below. These documentary sources have been evaluated according to Scott's (1990) criteria and all adhere to these criteria. Scott's criteria were applied as a precursor to the analysis. The quality of the analysis is directly related to the quality of the documentary sources.

Authenticity, credibility, representativity and meaningfulness

According to Scott (1990), social research is based on the quality of the evidence available for analysis. The assessment of its quality is central to the whole argument of using documentary sources as evidence. All eight documents are authentic – the evidence is genuine and of unquestionable origin. They are credible – the evidence is free from error and distortion. They are representative – the evidence is typical of documented pre-test counselling conversations, and is a comprehensive selection of documented pre-test counselling conversations in South Africa. They are also meaningful – they are specifically related to HIV/AIDS care and counselling.

Authenticity

Scott (1990) defines authenticity as a criterion by pointing at the need to prove the genuineness and the unquestionable origin of the evidence. The documents used in the analysis have been obtained directly from their original source – their origin is unquestionable. All eight documents used in the document analysis are authentic.

Credibility

Scott (1990) defines evidence as credible when it is free from error and distortion. All eight documents are credible; the copies and original documents used in the analysis are of good quality, easily readable and undistorted.

Representativity

Scott (1990) defines evidence as representative when it is typical of its kind, and, if not, the extent of its untypicality is known. All eight documents used in the analysis are typical of policy-governing and training documents on HIV/AIDS counselling in South Africa and therefore all are representative.

Meaningfulness

Scott (1990) defines meaningful evidence as clear and comprehensible. All eight documents are directly concerned with HIV/AIDS care and counselling in South Africa and, more specifically, they relate directly to the documented pre-test counselling conversation. The meaningfulness of the documents used for the analysis is unquestionable.

The selection of data presented in this study is limited specifically to HIV/AIDS pre-test counselling documentation evaluated according to the criteria suggested by Scott (1990). Documents about the pre-test counselling conversation are presented as “artefacts” and the authenticity, credibility, representativity and meaningfulness of the documents or “artefacts” were established before the document analysis was done.

Overview

This is a qualitative study which uses document analysis as its preferred method of study. This method is based on the historical study of texts by historians, in which writers sift evidence, balance testimony and demand verified assertions (Barzun, & Graff, 1977; Hodder, 2000). In this indirect research tradition, the particular kind of “artefact” under study is a written document which has been produced for a purpose other than that

of being studied or investigated. Documents about pre-test counselling conversations are presented as such “artefacts”.

In the inquiry used in this study, specific steps were followed, as explained in this chapter. First, the use of a document analysis as a historical research method has been discussed. Secondly, the search for recurrent terms, language and the way the texts speak about the human subject have been discussed. In a document analysis, the use of themes, language and the way texts speak about the human subject are important for reflection. They are said to tell a lot about the document that is being researched. Third, a selection was made of documentary sources on the pre-test counselling conversation. These documents became the evidence or the data sources in the study and needed to be scientifically evaluated. Fourth, the documentary sources were evaluated according to Scott’s (1990) four scientific criteria for such artefacts: authenticity, credibility, representativity and meaningfulness.

The authenticity, credibility, representativity and meaningfulness of the documents or “artefacts” have been established in this chapter. The documents themselves are presented in Chapter Four.

CHAPTER FOUR

PRE-TEST COUNSELLING CONVERSATIONS:

A SELECTION OF DOCUMENTS

Introduction

This chapter contains the source data used in this study¹. In this chapter, a selection of HIV/AIDS-related material used in pre-test counselling conversations is presented (*verbatim*). This selection provides examples of official and non-official documentation on the topic of pre-test counselling in South Africa. These documents represent the assumed reality of or ideal pre-test counselling conversations in South Africa.

Written documents have features that distinguish them from other kinds of source material. For this reason, Scott (1990) indicates the necessity of understanding written documents in the wider context of the whole range of sources used in social research. Script, according to Scott (1990), is the written expression of a spoken language and therefore contains a “text”. This text is the central and most obvious feature of a document. Scott (1990) explains that documents are written with a different intent than their use as artefacts for research. Documents are primarily written for a specific audience and are action- or result-driven: they are written to achieve something.

¹ The texts are cited *verbatim* and, hence, the grammar and idiom errors in them are not marked or corrected, so as not to distract the reader of this study from the focus of the study, namely an analysis of the content and meaning of these texts. Full stops at the end of sentences or items appear as in the original text, therefore the use of full stops is not consistent in the texts presented. The term “pre-test” is hyphenated or not, as it appears in the original texts (sometimes it appears as “pretest” or “pre test”).

Presentation of raw data: an application

In this section, the reader is presented with *verbatim* selections from eight different documents. These documents are categorised as official or non-official. All the original (*verbatim*) text is boxed and is printed in italics.

Official documents

Six official documents are presented, namely

- A. Gasa, N.B.K. (2001). SACMA: *HIV/AIDS information: A guide for HIV/AIDS peer education programmes*. Pretoria: African Watermark Graphics.
- B. Department of Health. (2001a). *HIV/AIDS Policy Guideline*. Pretoria: African Watermark Graphics.
- C. Department of Health. (2001b). *Counselling and HIV/AIDS, Fact Sheet 7*. Pretoria: African Watermark Graphics.
- D. SAMHS. (n.d.). *Masibambisane – United in the fight, educational officers HIV training participants manual: Counselling*. Pretoria: African Watermark Graphics.
- E. Department of Health. (2001c). *Pre-test counselling: Ten Days HIV/AIDS Counsellor Training Course Participant's Manual*. Pretoria: African Watermark Graphics.
- F. Evian, C. (2000b). HIV testing and pre- post-test counselling. In C. Evian (Ed.), *Primary AIDS Care: A practical guide for primary health care*

personnel in the clinical and supportive care of people with HIV/AIDS (3rd ed). (pp. 51-52). Johannesburg: Jacana.

The documents presented here have been compiled by and can be obtained from the Department of Health of South Africa and are used in training HIV/AIDS counsellors.

To make it easier for the reader to locate and contextualise the details cited in Chapter Four, the original documents have been coded. Each document has a unique alphanumeric number (“A” to “H”) and each new sentence or conceptual fragment is allocated a number, starting from 1. For example, “A” represents *Document A: HIV/AIDS information: A guide for HIV/AIDS peer education programmes* (the first document) and incorporates codes from A1 to A29.

Document A: HIV/AIDS information: A guide for HIV/AIDS peer education programmes

This selection is taken from the Department of Health’s guide for HIV/AIDS peer education programmes (Gasa, 2001). This pre-test counselling document was written by a delegation from the Department of Health of South Africa. The document is intended for peer educators. Gasa (2001, p.1) defines a peer educator as a person who has been specially trained to conduct an education programme aimed at his or her peers. Pre-test counselling, according to this policy-governing document, should involve the following steps:

- A1. *Giving the person basic knowledge about HIV infections and AIDS so that they understand*
- A2. *Exploring why s/he wants the test*
- A3. *Providing a brief outline of the nature of the test to be conducted and what both negative and positive results mean*

- A4. *Exploring how the person might feel and what s/he might do if the test is positive or negative*
- A5. *Discussing possible psychosocial support from loved ones, family and friends. This may include asking him/her to think about who to tell the results to (for emotional support)*
- A6. *Providing information on the medical care available to ensure that people living with HIV can leave [live] healthier for longer*
- A7. *Assessing the person's risk to HIV infection*
- A8. *Giving advice regarding safer sexual practices. VCT counsellors also explore whether the client knows how to prevent the spread of HIV infection. This may include a demonstration for how to use condoms*
- A9. *Informed the person about when and how they can get the results*
- A10. *Assuring the person about the maintenance of confidentiality in the context of prevalent stigmatisation and discrimination against people living with HIV*
- A11. *After the above issues have been explored, a person is then asked whether they still want to undergo the test or whether they would like to think about it a little longer, thus ensuring informed consent*
- A12. *Some people may request counselling sessions between testing and getting results and arrangements should be made for this to happen*
- A13. ***Giving a positive result***
- A14. *The individual is informed about his/her HIV test result*
- A15. *S/he is given the opportunity to express their fears and concerns. Feelings may include anxiety, fear, shock and disbelief, anger, guilt, sadness, etc.*
- A16. *The counsellor provides psychological support for all the emotions the person may be going through*
- A17. *Information about HIV/AIDS in general and how to live positively with HIV/AIDS is also shared*
- A18. *Treatment options may also be discussed*
- A19. *The counsellor also inspires hope in the client by emphasizing the a HIV positive test result does not mean a death sentence*

A20. *The counsellor encourages the client to seek support from others when the client feels ready to and has identified the individuals whom [who] are more likely to be supportive*

A21. *The counsellor also informs the person about safer sexual practices and how to prevent infecting others and/or re-infecting oneself. Demonstrations for how to use condoms may be done by the counsellor and the pair may discuss how to introduce condom use to one's partner*

A22. *The counsellor and the client also explore, when necessarily, the implications of the test results for one's personal life including partners, family and children and future decisions such as having children*

A23. *Counselling for an HIV positive test result may continue for a considerable amount of time as determined by the client's needs and concerns*

A24. ***Giving a negative test result***

A25. *The individual is informed about his/her test result*

A26. *The client is given an opportunity to express their feelings, which may include relief, excitement, disbelief, etc. S/he is supported accordingly*

A27. *The client is then encouraged to remain negative by practicing safer sex. The counsellor may demonstrate how to use condoms. Condom negotiation with partners may also be discussed*

A28. *The counsellor may recommend retesting if the counsellor and the client have identified risky exposure within 6 weeks before testing*

A29. *More information may be given about HIV/AIDS, if required*

Document B: HIV/AIDS Policy Guideline

This text forms part of the South African *HIV/AIDS Policy Guideline* for 2000. It is important to note that this document represents the views of the Department of Health of the Republic of South Africa and greatly influences the implementation and service delivery of pre-test counselling in the country. The *South African HIV/AIDS Policy*

Guideline (Department of Health, 2001a, p.5) writes about the pre-test counselling conversation in the following way:

B1. *Pre-test counselling should occur before an HIV test is undertaken. It should be a confidential dialogue with a suitably qualified person, such as a doctor, nurse or trained HIV counsellor, undertaken as a means of passing on information and gaining consent.*

B2. *Posters, pamphlets and other media (including videos) may be used in making information on HIV/AIDS available, but cannot be regarded as a general substitute for pre-test counselling.*

B3. *A doctor, nurse, or trained HIV counsellor should accept, after personal consultation, an individual's decision to refuse pre-test counselling and HIV testing. Psychological competence in understanding and dealing with the diagnosis of a life-threatening condition, rather than educational or social status, should be the yardstick for this decision. Such a decision should only be made on a case-by-case basis and should be recorded in writing.*

B4. *Checklist of points to be covered in pre-test counselling*

B5. *Identify who you are in relation to the rest of the health care team.*

B6. *State how much time is available for counselling.*

B7. *Stress confidentiality.*

B8. *Ask what it is that has led to the patient coming for the test.*

B9. *Identify risk activities with patient.*

B10. *Check knowledge about transmission and prevention.*

B11. *Discuss the "window period" before HIV antibodies might develop.*

B12. *Discuss what the test is, and what it is not. It is not a test for AIDS.*

B13. *Identify whose idea it is that the person comes for the test.*

B14. *Assess why they are coming for the test at this stage.*

B15. *Discuss the personal implications of having the test and the meaning of the result, both negative and positive, for them and others.*

B16. *Discuss the practical implications of the test such as life insurance, sexual relationships, work situations and medical follow-up.*

- B17. *Describe the procedure for having blood taken, how long he/she will wait for the result and how he/she will be told about the result.*
- B18. *Discuss healthy lifestyle irrespective of possible test result (safer sex, food, sleep, exercise, etc.)*
- B19. *Identify how the patient will protect sexual partners in the interim.*
- B20. *Discuss how the patient might cope with a negative or positive result.*
- B21. *Discuss who the patient would want to tell and who the patient considers ought to be told.*
- B22. *Identify what social support is available.*
- B23. *Discuss the patient's views about the general practitioner sharing the patient's care with the hospital team if the HIV antibody test result is positive (if appropriate).*
- B24. *Discuss who the patient can contact while waiting for the result, and the procedure for this.*
- B25. *Arrange a follow-up session.*

Document C: Counselling and HIV/AIDS Fact Sheet 7

This text reveals the manner in which the Department of Health sees the pre-test counselling conversation and believes it should be conducted. It is important to note that this document represents the views of the Department of Health of the Republic of South Africa and greatly influences the implementation and service delivery regarding pre-test counselling in the country. The *HIV/AIDS Fact Sheet 7* (Department of Health, 2001b, pp. 7.1 - 7.7) writes about pre-test counselling conversations as follows:

- C1. *Aim of pretest counselling***
- C2. *The aim of pretest counselling is to provide information to the individual about the technical aspects of testing and the various implications of being diagnosed as either HIV positive or negative.*

C3. *Pretest counselling should focus on two main topics: (a) the person's personal history of risk behaviours, or having been exposed to HIV, and (b) assessment of the person's understanding of HIV/AIDS (including methods of transmission) and the person's previous experiences in crisis situations.*

C4. *Information should be up to date and given in a manner that is easy to understand. Pre-marital testing of couples and testing of blood donors is different from testing of those suspected of having HIV/AIDS. However, both groups require sensitivity.*

C5. *Testing should be discussed as a positive act that is linked to changes in risk behaviour, coping and increasing the quality of life.*

C6. COMPONENTS OF PRETEST COUNSELLING

C7. Assessment of risk

C8. *Assessing the likelihood that the person has been exposed to HIV requires considering the following:*

C9. *Frequency and type of sexual practices, in particular, high risk practices such as vaginal and anal intercourse without a condom, or unprotected sex with prostitutes;*

C10. *Whether the person was/is part of a group with high risk prevalence of HIV infection (intravenous drug users, male and female prostitutes and their clients, prisoners, refugees, migrant workers, homosexual and bisexual men, and health care workers where the use of Universal Precautions (Fact Sheet 11) is erratic or incomplete.*

C11. *Whether the individual has received a blood transfusion, organ transplant, or blood or body products. Note that in some developing countries, testing of blood for HIV might not occur.*

C12. *Has the person been exposed to non-sterile invasive procedures, such as tattooing, scarification, female and male circumcision.*

C13. Assessment of understanding

C14. *The following questions should be asked in assessing the need for HIV testing:*

C15. *Why is the test being requested?*

C16. *What are the behaviour patterns or symptoms of concern?*

C17. *What does the person know about the test and its uses?*

C18. *What are the person's beliefs and knowledge about HIV transmission and its relationship to at risk behaviours?*

- C19. *Who could provide emotional and social support (eg. family, friends, etc)?*
- C20. *Has the person sought testing VCT before, if so, when, from whom, for what reason and what was the result?*
- C21. *Has the person considered what to do or how he/she would react if the result is positive, or if it is negative?*
- C22. ***Preparation for pre-test counselling***
- C23. *Effective pre test counselling will prepare the person for the test by:*
- C24. *Discussing confidentiality and informed consent for the HIV test including providing an understanding of the policies governing consent*
- C25. *Explaining the implications of knowing one is or is not infected.*
- C26. *Exploring the implications for marriage, pregnancy, finances, work, and stigma*
- C27. *Facilitating discussion about ways to cope with knowing one's HIV status (For example, has the person considered what to do or how she/he would react if the test is positive, or if the test is negative?)*
- C28. *Promoting discussion on sexuality and sexual practices.*
- C29. *Promoting discussion on relationships, with emphasis on the benefits of shared confidentiality between the person and his/her loved ones.*
- C30. *Promoting discussion on sexual and drug related risk behaviours, as appropriate.*
- C31. *Exploring emotional coping mechanisms and the availability of social support.*
- C32. *Explaining how to prevent HIV transmission.*
- C33. *correcting myths, misinformation and misunderstandings related to HIV/AIDS.*
- C34. ***Benefits of pre test counselling***
- C35. *Pre test counselling helps people to make informed choices.*
- C36. *However, it is important to note that people who do not want pre test counselling before taking the HIV test should not be required to have it.*
- C37. *In addition, a decision to be tested should be an informed decision.*
- C38. *Informed consent implies awareness of the possible implications of a test result (including the window period).*
- C39. *In some countries the law requires explicit informed consent; in others, implicit consent is assumed whenever people seek testing.*

- C40. *The nurse/midwife must help the person understand the policy on consent, and should explain the limits and consequences of testing.*
- C41. *Therefore, it is important to be knowledgeable about the policies and guidelines governing your region.*
- C42. *Access to pretest counselling is not always available, and some people might refuse this option.*
- C43. *However, if the test is positive, there are considerable benefits to providing this service which include:*
- C44. *improved acceptance of HIV status and improved ability to cope*
- C45. *empowerment, including greater involvement of PLHA [People Living With HIV/AIDS]*
- C46. *facilitation of behavioural change*
- C47. *reducing the risk of mother-child transmission (Fact Sheet 10)*
- C48. *early management of opportunistic infections (Fact Sheet 4 and 5) and preventative therapy, (Fact Sheet 12)*
- C49. *contraceptive advice, and other information and education (Fact Sheet 8)*
- C50. *early social and peer support*
- C51. *normalizing HIV/AIDS*
- C52. *instilling hope and addressing the quality of life*
- C53. *planning for future care (Fact Sheet 3), making a will (Fact Sheet 8) and orphan care (Fact Sheet 5)*
- C54. ***HIV-positive test result counselling***
- C55. *When the test result is positive, the nurse/midwife should tell the person as gently as possible, providing emotional support and discussing how best to cope with the results.*
- C56. *This is not a time for speculation, but rather a time to give clear, factual explanations of what the news means.*
- C57. *Assess the emotional impact of the news, and validate the person's reactions as normal.*
- C58. *Fear of dying, job loss, family acceptance, concern about the quality of life, the effects of treatment and response by society can be explored.*

C59. *If there is a concern that the person might not return for follow up counselling, then information about relevant health services should be mentioned. This would include available medical treatments such as antiretroviral therapy or treatment for opportunistic infections, and social services for financial and ongoing emotional support.*

C60. *However, if follow up counselling is an option, then it would be advisable to leave this information to a later date when the person is better able to absorb the details and explore the available options.*

C61. *Assess the person's understanding and ability to use preventative methods. Free condoms can be given out during this session, together with advice on how to use them and where to get more.*

C62. ***How the news of HIV infection is accepted often depends on the following:***

C63. *The person's physical health. People who are already ill often have a delayed response, and can only absorb information when they grow stronger.*

C64. *How well the person has been prepared for the news.*

C65. *How well supported the person is, both in the community and by family and friends.*

C66. *The pre test psychological condition of the person.*

C67. *Where psychological distress existed before the result, learning the result could make the distress greater.*

C68. *The cultural and spiritual values attached to AIDS, illness, and death. In some communities people might take a fatalistic attitude, whereas in other communities, AIDS is sometimes seen as evidence of antisocial or blasphemous behaviour.*

C69. *Counselling and support activities need to address feelings of shock, fear, loss, grief, guilt, depression, anxiety, denial, anger, suicidal activity or thinking, reduced self-esteem, and spiritual concerns.*

C70. *In addition, social issues such as loss of income, discrimination, social stigma, relationship changes, and changing requirements for sexual expression need to be explored.*

C71. ***HIV-negative test result counselling***

C72. *If the HIV test is negative, then counselling about risk behaviours and methods of prevention are vitally important (see Fact Sheet 12).*

C73. Also, the counsellor must explain about the “window period” (between 3-6 months) when a negative result may be a false negative.

C74. If there is concern about the HIV status of the person, counsel them to return for a repeat test in 3-6 months, and ensure that they take appropriate precautions in the meanwhile, explaining that they could become infected at any time.

C75. The counselling session is an ideal time to discuss sexual practices and preferences, potential drug abuse (particularly intravenous drug use) and other at risk behaviours.

C76. Upon learning their HIV-negative status, the person may be more open to learning about safe sex practices and modifying risk behaviours.

C77. Free condoms can be given out during this session together with advice on how to use them and where to get more when needed.

Document D: Masibambisane – United in the fight, educational officers HIV training participants manual

The pre-test counselling conversation material below sets out the views of the *Masibambisane – United in the fight, educational officers HIV training participants manual* (SAMHS, n.d.). This document represents the view of the South African Military Health Services (SAMHS, n.d.) and greatly influences implementation and pre-test counselling service delivery in the country. *Masibambisane – United in the fight, educational officers HIV training participants manual* was mainly written for training participants. *Masibambisane – United in the fight, educational officers HIV training participants manual* (SAMHS, n.d., pp. 9-1-9-30) writes about pre-test counselling in the following way:

D1. *The aims of pre-test counselling*

D2. *To ensure that people are fully informed of the sometimes medical, personal, social and legal implications when tested and to provide information on risk reduction to the client whether testing positive or negative (SAMHS, n.d., pp. 5.29-5.30).*

D3. **Establish confidentiality.** *This is especially important in the light of the Appeal Court decision in the case McGeary vs Kruger.*

D4. **Explain or determine the reasons for HIV testing.** *Medical reasons should be fully and clearly explained. Information about HIV/AIDS should be provided verbally and in writing.*

D5. **Current and previous sexual behaviour (history).** *Sensitively elicit information about the person's current and previous sexual behaviour. This will determine their risk factor, and assist with partner notification in the event of a positive result.*

D6. **Provide information about the HIV-antibody test.**

D7. *It is necessary to check and confirm the patient's knowledge and understanding of the test and to explain that it is not a test for AIDS.*

D8. *It should be made clear that the test only detects antibodies in the blood which indicate previous exposure to HIV.*

D9. *It may take from 6 - 12 weeks, and sometimes longer, for the antibodies to show. The window period needs to be explained if appropriate – if the person is in the window period, he/she can transmit the virus.*

D10. *An HIV-positive result shows that a person is infected and capable of transmitting the virus to others; however, the results give no indication of severity of the infection or prognosis.*

D11. *It will be useful to ascertain whether the client has had the test before or has ever given blood and to reassure him/her that the test itself will not transmit HIV.*

D12. *The client should also be informed of how blood is taken, costs of testing if applicable, when results will be known, as well as how the results will be communicated.*

D13. *It is strongly recommended that no test results, either positive or negative, be given over the telephone.*

D14. **Review the implications of a positive test result.** *All the possible implications of a positive test result should be discussed:*

D15. **RISKS**

- D16. *The client may jeopardize his/her employment/career with resultant financial difficulties.*
- D17. *The client may experience difficulties (outside SANDF) in receiving medical and dental treatment.*
- D18. *The client may not be able to obtain life assurance or mortgage facilities.*
- D19. *The client may suffer from loss of self-confidence, avoidance, rage, self-imposed isolation and loss of control over life.*
- D20. *The client has to live with the uncertainty of waiting to see if and when he/she will develop signs and symptoms of HIV infection.*
- D21. *The client [may] experience problems with relationships (love, family and friendship).*
- D22. *The client may face stigma, prejudice and blame.*
- D23. **Potential benefits**
- D24. *Relieve anxiety.*
- D25. *Having the test could help to motivate persons who practice high-risk behaviours to reduce these behaviours.*
- D26. *Allow for planning – e.g. a pregnant women can make an informed decision about possible termination of pregnancy or planning care of the child in the event of her death.*
- D27. *More effective management of opportunistic infections can be carried out.*
- D28. *The client can be encouraged to focus on a healthy lifestyle.*
- D29. **Anticipation of a positive test result**
- D30. *Most individuals want or expect confirmation of a negative result and do not anticipate a positive one.*
- D31. *Pre-test counselling should explore coping with the waiting period while the test results are being confirmed.*
- D32. *It is useful for the client to consider what a positive result would mean to him/her and to reflect on questions such as:*
- D33. *Who would I tell?*
- D34. *Who would I tell first?*
- D35. *Why?*
- D36. *What might happen?*

D37. *How will my friends and family respond?*

D38. *These questions help the counselor to assess the ability of the client to cope with and adjust to a positive result.*

D39. *They provide the client with insight into some of the implications of a positive test result.*

D40. *The client needs to be aware of possible reactions by family, friends and employers to a positive result and the issues around disclosure need to be addressed.*

D41. *In light of a possible positive test result, it is important to advise the patient to use a condom during sexual intercourse until they are sure about their actual HIV status.*

D42. *It is often a good idea to teach and demonstrate the correct use [of] a condom at this stage.*

D43. ***Obtain informed consent***

D44. *Legally, the doctrine of implied consent (implied acquiescence to routine procedures upon requesting treatment) does not cover HIV antibody testing.*

D45. *Explicit informed consent must therefore be obtained in writing.*

D46. *The decision to be tested is the patient's alone, and even if he/she decides not to be tested, the counseling interview may have imported useful information about safer sexual practices.*

D47. *Within the SANDF, not giving consent have implications in certain circumstances, which have to be fully explained to the client.*

Document E: Pre-test counselling: Ten days HIV/AIDS counsellor training course participant's manual

Document E is a document on pre-test counselling called *Pre-test Counselling: Ten Days HIV/AIDS Counsellor Training Course Participant's Manual* published by the Department of Health (Department of Health, 2001d, pp. 93–94). This training manual is an official document and is intended for course participants who are being trained to do pre- and post-test, as well as ongoing, HIV/AIDS counselling. This ten-day HIV/AIDS

training course is presented by ATICCS, the largest HIV/AIDS counsellor training institution in the country. Their views on what pre-test counselling conversations entail greatly influence implementation and service delivery in South Africa. Pre-test counselling conversations in the *Pre-test Counselling: Ten Days HIV/AIDS Counsellor Training Course Participant's Manual* have been divided into four stages and are presented accordingly below.

- E1. ***First stage: helping the person tell his/her story***
- E2. ***Establish relationship***
- E3. *welcome the person*
- E4. *introduce yourself*
- E5. *explain confidentiality*
- E6. *explore more about the person e.g. family background*
- E7. ***Assess risk of possible infection***
- E8. *explore why the client has come for a test*
- E9. *what makes the person feel s/he might have been infected*
- E10. *explore risk activities*
- E11. *check window period – communicate this information to the client*
- E12. ***Give the client sufficient information to make an informed decision about whether or not to test***
- E13. *establish the client's knowledge of HIV Aids*
- E14. *existing information on*
- E15. *transmission*
- E16. *previous unprotected sex*
- E17. *blood transfusion*
- E18. *accidents*
- E19. *traditional healers incisions or drug abuse*
- E20. *inform the client if your exploration reveals that s/he has been at risk or not (if pregnant, possibility of infection crossing over to the unborn baby)*
- E21. *check and correct myths or incorrect information*
- E22. ***Assist the client to understand the test and what the results mean***

- E23. *explain how the test is done*
- E24. *when will the results be available*
- E25. *possible results*
- E26. *negative*
- E27. *positive*
- E28. *indeterminate*
- E29. *explain what each of these mean*
- E30. ***Second stage: helping the person explore implications of HIV testing (options)***
- E31. ***Explore with the client what each could mean to him/her looking at the***
- E32. *implications for self*
- E33. *implications for the partner*
- E34. *implications for the family*
- E35. ***Identify the client's support networks***
- E36. *who will the client tell*
- E37. *what fears/concerns does the client foresee*
- E38. *how did s/he cope with crises previously*
- E39. ***Third stage: helping the person make a plan***
- E40. *discuss the decision on having the test*
- E41. *explain how the results will be given e.g. personal, not per phone*
- E42. *sign the consent if the client decides to test*
- E43. *risk reduction:*
- E44. *explore how the client intends to protect the partner in the interim*
- E45. *infection control measures*
- E46. ***Conclusion***
- E47. *next appointment*
- E48. *importance of post test counselling*

Document F: Pre-test Counselling (Dr Evian)

This document is cited from Dr Clive Evian's book *Primary AIDS Care; A practical guide for primary health care personnel in the clinical and supportive care of people with HIV/AIDS* (Evian, 2000a). This document is treated as an official document because Evian discusses reasons for pre-test counselling and important issues which should be explored and discussed before an HIV test is done (Evian, 2000b, pp. 51 - 52). Evian is a primary care and community health physician and this book is a practical guide for primary health care personnel who provide clinical and supportive care to people with HIV/AIDS. The book has been endorsed by Professor Bruce L.W. Sparks, Professor and Head of the Department of Family Medicine at the University of Witwatersrand, Johannesburg. This book is not generally available for sale but is used for HIV/AIDS training in South Africa. *Primary AIDS Care; A practical guide for primary health care personnel in the clinical and supportive care of people with HIV/AIDS* (Evian, 2000a) can be ordered directly from the publisher and is used for training purposes only. Dr Evian writes about pre-test counselling conversations in the following way:

F1. ***Counselling before the test***

F2. ***Reasons for pre-test counselling include:***

F3. *To ensure the person understands the basic facts about HIV infection and AIDS*

F4. *To assist the patient in understanding the test and what the results mean and to prepare him / her to receive this result*

F5. *To consider and explore what he/she might do if the test is positive or negative*

F6. *To explore potential support from loved ones, family, friends etc.*

F7. *To understand that if he/she is HIV positive, there is medical care / monitoring which can help to keep him/her healthier for longer (see Chapter 5)*

F8. *To ensure that the person has confidence in the confidentiality of the test result i.e. that it will be kept private*

F9. *To advise on safer sexual practices (see page 93)*

F10. *To enable the person to make an informed decision whether to take the test or not*

F11. *To make an assessment of risk of possible HIV infection*

F12. *Some of the most important issues which you should explore and discuss BEFORE an HIV test is done:*

F13. *Does the patient understand the basic information about AIDS and HIV infection? Explain these and clear up any misunderstandings.*

F14. *Does the patient understand what the test is and what a positive or negative result would mean? Remember it is an antibody test and does not tell whether you have the AIDS phase of the disease.*

F15. *Explore why he/she wants the test, or explain why you have suggested the test, and what benefits there are in knowing you are HIV positive. Has he/she been at risk for acquiring HIV infection?*

F16. *It is also important to discuss how the patient thinks he/she might feel and react if the test is positive. How would he/she tell the news of the result to the sexual partner? If the result is positive, the sexual partner may also need a test.*

F17. *It is best if he/she thinks carefully about who to tell the results to. Employers, friends, and even some family members may not keep the result to themselves. Many people have lost their jobs, friends and lovers after telling them the positive result.*

F18. *Does he/she know how to prevent the spread of HIV infection? Does he/she know how to have sex in a safer way? Can he/she get condoms or do you need to provide them? Does he/she know how to use them correctly? You may need to explain in detail about the importance of practising safer sex from now onwards (see Chapter 14). Remember this may be the last time you will see the patient.*

F19. *Explain when and how he/she can get the result. HIV results should be given to patients in person and in privacy. The result must be kept confidential.*

F20. *Let him/her know that you understand the difficulty and anxieties involved in having an HIV test. Let him/her know that you, or another health worker, will be available to give the result. Tell him/her that it will be kept confidential and that there will be ongoing support and advice if needed.*

F21. *After exploring the above issues, it is important finally to ask if he/she still wants to undergo the test, or would he/she like to think about it a little longer? In this way he/she will be able to give informed consent to have the test.*

F22. *It is best for the client to make the final decision and choice to have the test or not.*

Non-official documents

Two non-official documents are presented below. These documents are available from academic libraries and private bookshops. They can be ordered from the editor and seem to be used for training purposes in private settings.

G. Van Dyk, A. (2001b). *Pre-and post-HIV test counselling*. In A. van Dyk (Ed.), *HIV/AIDS Care and Counselling: A multidisciplinary approach* (2nd ed). (pp. 238-246). Cape Town: Maskew Miller Longman.

H. Bekker, L. (2002). HIV counselling. *Southern African Journal of HIV Medicine*, (8), 30-31.

Document G: Pre-test Counselling (Van Dyk)

The text below contains the views on pre-test counselling presented by Dr A. van Dyk in her book *HIV/AIDS care and counselling: A multidisciplinary approach HIV/AIDS Counselling in South African* (Van Dyk, 2001b, pp.238-246). Van Dyk is a lecturer in Psychology at the University of South Africa.

G1. PRE-HIV TEST COUNSELLING

G2. *The purpose of pre-test counselling is to provide individuals who are considering being tested with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or HIV negative.*

G3. *The purpose of pre-test counselling is further to find out why individuals want to be tested, the nature and the extent of their previous and present high-risk behaviour, and the steps that need to be taken to prevent them from becoming infected or from transmitting HIV infection.*

G4. *The following guidelines should be used for HIV pre-test counselling.*

G5. ***Reason for testing***

G6. *Explore why clients want to be tested. Is it for insurance purposes, because of anxiety about lifestyle, or because the person has been forced by somebody else to take the test?*

G7. *What particular behaviour or symptoms are causing concern to the client?*

G8. *Has the client sought testing before and, if so, when? From whom? For what reason? And with what result?*

G9. *These questions provide the counsellor with an opportunity to ascertain individuals' perceptions of their own high-risk behaviour and with an opportunity to assess whether they intend to be tested and whether their fears are realistic or if they are unnecessarily concerned.*

G10. *If you as a counsellor have suggested to the client that he or she be tested for HIV, explain to the client the reason why you think a test would be advisable.*

G11. *The following are some of the reasons that clients who want to be tested often adduce:*

G12. *Their partner has requested it.*

G13. *They want to determine their HIV status before starting a new relationship.*

G14. *They want to be tested prior to getting married.*

G15. *They feel guilty and concerned about having had multiple sex partners.*

G16. *They have had recent sexual encounters in which they did not use condoms.*

G17. *They are manifesting symptoms that are giving them cause for concern.*

G18. *They have been referred by an STD or TB clinic because they have tuberculosis or a sexually transmitted disease.*

G19. *They have come to reconfirm a positive HIV test.*

G20. *Their current partner is HIV positive, or they were once involved with a partner who was HIV positive.*

G21. *They plan to become pregnant and want to check their HIV status before falling pregnant.*

G22. *They have been raped or assaulted.*

G23. *They need to be tested after an occupational exposure (e.g. a needlestick).*

G24. *They are simply curious.*

G25. *The reason why a client wants to be tested is important because it sets the scene for the rest of the pre-test counselling session.*

G26. **Assessment of risk**

G27. *Assess the likelihood of whether the person has been exposed to HIV by considering how much and how frequently he or she has been exposed to the following factors and lifestyle indicators:*

G28. *What is the client's sexual risk history in terms of frequency and type of sexual behaviour? Has the client been involved in high-risk sexual practices such as vaginal or anal intercourse with more than one sex partner without the use of condoms? In the case of anal sex, was it anal-receptive or anal-insertive sex? Did the client have sex with a sex worker (or prostitute)? Or is the client's sex partner HIV positive?*

G29. *Are there any other risk[s] involved? Is the client an injecting drug user, a prisoner, a migrant worker, a refugee or a sex worker? Did the client at any time receive money, gifts or drugs for sex? Has the client ever been raped or coerced to have sex with another person? Does the client have another sexually transmitted disease or tuberculosis?*

G30. *Has the client received a blood transfusion, an organ transplant or blood or body products? (Testing transfusion blood for HIV may not take place in some developing countries).*

G31. *Has the client been exposed to possibly non-sterile invasive procedures such as tattooing, piercing or traditional invasive procedures such as male or female circumcision and scarification?*

G32. *Has the client been exposed to HIV-infected blood in the work situation?*

G33. **Activity:** *What question will you ask Frances so that you will be in a position to assess the likelihood of whether she has been exposed to HIV or not?*

G34. **Beliefs and knowledge about HIV infection and safer sex**

G35. *Determine exactly what your client believes and knows about HIV infection and AIDS and correct errors by providing accurate information about transmission and prevention.*

G36. *Ask your client questions about his or her past and present sexual behaviour and provide information about safer sex practices and a healthier lifestyle.*

G37. *Find out if the client knows how to practice safer sex, how to use a condom correctly, and where to get hold of condoms. Give them condoms if necessary.*

G38. Information about the test

G39. *It is important to ensure that your client know what the HIV test entails (see 'HIV testing as diagnostic tool' on page 57). Explain the following points to the clients:*

G40. *There is a difference between being sero-positive and having AIDS. The HIV antibody test is not 'a test for AIDS'. It indicates that a person has HIV antibodies in the blood and that the person is infected with HIV. It does not say when or how the infection occurred, or in what phase of infection the person is.*

G41. *The presence of HIV antibodies in the blood does not mean that the person is now immune to HIV. On the contrary, it means that he or she has been infected with HIV and that he or she can pass the virus on to others.*

G42. *The meaning of a positive and negative test result (see Questions on page 60 to 62).*

G43. *The meaning of the concept of the 'window period' (see "The window period on page 59). Stress the need for further testing if the person practises high risk sexual behaviour and test negative.*

G44. *The reliability of the testing procedures. A positive HIV antibody test to always be confirmed with a second test and the reliability of the test results is high. False-positive or false-negative results may however occasionally occur despite the general reliability of HIV test (e.g. a false negative test because the person is in the widow period).*

G45. *The testing procedure. Explain how blood is drawn for the test, where it is sent, when the results will be available and how the person will be informed of the outcome.*

G46. *You don't want to overload your clients with information during the pre-test counselling session, and you want to send them home with something to read. Design a pamphlet in which you explain everything they need to know about the HIV antibody test.*

G47. The implications of an HIV test result

G48. *The possible personal, medical, social, psychological, ethical and legal implications of a positive test result should be discussed with clients prior to testing. Informed consent about all the advantages and disadvantages of testing. The following advantages can accrue from taking the test;*

G49. *Knowing the result may reduce the stress associated with uncertainty.*

G50. *One may begin to make rational plans for preparing oneself emotionally and how actually to live with HIV.*

G51. *Symptoms can be confirmed, alleviated or treated.*

G52. *Prophylactic (preventative) treatment can be considered.*

G53. *Anti-retroviral treatment can be considered.*

G54. *Adjustments to one's lifestyle and sex life can protect oneself and one's sex partners from infection.*

G55. *One can make decisions about family planning and new sexual relationships.*

G56. *One can plan for future care and orphan care.*

G57. *The disadvantages that might accrue from taking an HIV test (especially if it is positive) include:*

G58. *Possible limitations on life insurance and mortgages*

G59. *Having to endure the social stigma associated with the disease*

G60. *Problems in maintaining relationships and in making new friends*

G61. *A possible refusal on the part of uninformed medical and dental personnel to treat an HIV-positive person. (A refusal to treat HIV-infected individuals of course goes against the provisions of the South African Constitution.)*

G62. *Possible dismissal from work (although it is illegal to dismiss people because they are HIV-positive)*

G63. *Possible rejection and discrimination by friends, family and colleagues*

G64. *Emotional problems and a disintegration of one's life*

G65. *Increased stress levels and uncertainty about the future*

G66. *The stress and negative effects of maintaining a secret if the person decides not to disclose his or her test results*

G67. *Assure the client (if he or she is HIV positive) that medical treatments which can help to keep him or her healthier for longer are available.*

G68. *Anticipate the results*

G69. *It is important for the counsellor to anticipate a positive HIV antibody result and to talk about how the client will deal with a positive test outcome.*

G70. *Anticipating a positive result helps the counsellor to ascertain the client's ability to deal with, and adjust to, a positive result.*

G71. *The counsellor also gains insight into some of the potential problems associated with a positive test outcome.*

G72. *To prepare the client for the possibility of a positive test result paves the way for more effective post-test counselling.*

G73. *Alberts (1990) suggests that in order to prepare the client for the test result, the following questions should be asked:*

G74. *How would you feel if you tested negative? How would you feel if the test were negative but you were advised to be tested again in three to six months' time because you may still be in the window period?*

G75. *What would your reactions and feelings be to a positive test? Would a positive test change your life? How? What negative changes would you anticipate? What positive changes can you imagine?*

G76. *Do you intend to tell others if you test positive? Who would you tell? Why that person? How would you tell them? Why would you tell them?*

G77. *Clients must be warned about people's possible reactions. Often those closest to the client cannot cope with such news.*

G78. *The counsellor must help clients to think not only of themselves but also of those who are to be told. (For example, if the client says to you: "The news will surely kill my old and frail mother", you may ask: "Why do you want your mother to know?").*

G79. *Clients must also be warned that some people may not keep the information to themselves, and that this might have harmful effects for the client.*

G80. *How would you tell your sex partner? If the result is positive, the sex partner also needs to be tested.*

G81. *How would a positive test result change the circumstances of your job, family, your relationships? Would your relationships be improved or hindered telling people you are HIV positive? What do you believe their reactions will be?*

G82. *Where would you seek medical help? How do you feel about a disease that requires a lot of care, lifestyle changes, commitment and discipline? Do you have members of your family or friends who could help you to be disciplined about your health? Could you take medication every four hours if necessary?*

G83. *Who could provide (and is currently providing) emotional and social support; (family, friends, others)?*

G84. *The choice to be tested remains the client's prerogative.*

G85. *The advantages of testing can be explained to clients, but clients should not be forced to be tested if they indicated that they will not be able to deal with the results.*

G86. *The mere knowledge of people's HIV status will not necessarily protect them, or their loved ones, from infection.*

G87. *People who prefer not to be tested should however live as if they are infected, practice safer sex at all times.*

G88. *People who suspect they are HIV-infected should refrain from donating blood.*

G89. **Activity:** *After discussing her extra-marital affairs with you. Frances decided that she should be tested. She is however extremely worried about what and how she is going to tell her husband if her test result comes back positive. You decide to do a role play with Frances. Simulates the role play situation by asking a friend to play the role of France's husband. While you take the part of Frances.*

G90. **Confidentiality of test results**

G91. *The counsellor should stress the confidentiality of test results. Assure clients that their right to confidentiality will be respected at all times.*

G92. *If individuals choose to disclose their status, they must be reassured that no information will be communicated without their prior permission to anyone.*

G93. *The client's consent must be obtained before anyone can pass on any information about his or her HIV status to any other health care professional who also treats the client.*

G94. *If the counsellor explains why other health care professionals need to know about the client's HIV status, most clients will consent to this information being given out.*

G95. **Informed consent**

G96. *The decision to be tested can only be made by the client and their informed consent must be obtained prior to testing.*

G97. *Consenting to medical testing or treatment consists of two elements: information and permission.*

G98. *Before an HIV test can be done, the client must understand the nature of the test, and he or she must also give verbal or written permission to be tested. A client may never be misled or deceived into consenting to an HIV test.*

G99. **Confidentiality Enrichment:** *Health care professionals are ethically and legally required to keep all information about their clients confidential. Any information about a patient's illness or treatment can only be given to another person with the patient's consent. The right of HIV-infected people to be treated fairly and confidentially should be recognised and accepted. If clients do not have the assurance that health care professionals will keep their diagnosis confidential, they might be too scared to go for treatment. Because people living with HIV infection often face discrimination and prejudice, it is even more important to keep the information about their infection confidential.*

G100. **Informed consent Enrichment:** *According to the law, health care professionals may not do an HIV test on a person unless he or she clearly understands what the purpose of the test is, what advantages or disadvantages testing may hold for him or her as client, why the health care professional wants this information, what influence the result of such a test will have on his or her treatment, and how his or her medical protocol will be altered by this information. The psychosocial impact of a positive test result should also be discussed with the client (Fine, Heywood & Strade, 1997).*

G101. **Information about giving the results and ongoing support**

G102. *Explain to the client when, how and by whom the results of the test will be given to him or her.*

G103. *Assure the client of personal attention, privacy, confidentiality and ongoing support and advice if needed.*

G104. *Arrange the follow-up interview where the results will be made available.*

G105. *Take note of the fact that some traditional black people bring family members with them when they come back for the results. One should accommodate such preferences when patients require them.*

G106. **Waiting period**

G107. *Waiting for the results of an HIV antibody test can be an extremely stressful period for the client.*

G108. *This waiting period can last from 2 to 14 days, depending on where the test is done (whether by a private practice, a governmental health service or a rural clinic).*

G109. *The results of rapid HIV antibody tests are, of course, available within 10 to 30 minutes see 'Rapid HIV antibody tests' on page 58).*

G110. *However, if the client has to wait for the test results, the counsellor should anticipate this difficult waiting period by discussing the following points with the client:*

G111. *Find out the names of people whom the client might contact for moral support while waiting for the results.*

G112. *Encourage him or her to contact you or a colleague if they have any questions.*

G113. *Counsel the client on how to protect sex partners (e.g. to use condoms) during interim period.*

G114. *Encourage the client to do something enjoyable keep himself or herself occupied while waiting for the results (e.g. hiking, going to the movies or play soccer with friends).*

G115. **Activity:** *As a lawyer, you are asked by a friend to act on his behalf. While he was in the hospital blood was drawn and an HIV test was done without his consent. The superintendent of the hospital insists that your friend did give his consent for the HIV test by signing the form below. What is your opinion?*

G116. **Consent to blood tests [Wording only]:** *I, the undersigned, agree to the drawing of a blood specimen to be tested for the presence of blood transmissible pathogens.*

Name of patient: _____, Signed: _____, Date: _____. Devise a legally acceptable consent form for an HIV test for this hospital.

G117. **Conclusion**

G118. *Pre-HIV test counselling is extremely important.*

G119. *It should not only be seen as preparation for the HIV test, but as a golden opportunity to educate people about HIV/AIDS and safer sex.*

G120. *Remember that this may be the one and only time that the counsellor will see the client because he or she might decide not to be tested, or not to come back for the test results after all.*

G121. **Activity:** *How would you handle the following phone call? ‘Hello, my name is Mrs Johnson. I sent my nanny, Frances, to you a week ago for an AIDS test. I am just phoning to get her results.’*

G122. **Note:** *Don’t be abusive or angry. Use this as an educational opportunity for Mrs Johnson.*

Document H: Pre-test Counselling (Bekker)

The recommendations below were compiled by Linda-Gail Bekker (MBChB, FCP, PhD) from the Infectious Disease Clinical Research Unit at the UCT Lung Institute, Cape Town. The selected text is a checklist for use during pre-test counselling conversations. This article was published in the *Southern African Journal of HIV Medicine* in July 2002 and is a non-official academic document. It targets the professional medical disciplines. Bekker (2002, pp. 31-32) writes the following about pre-test counselling in South Africa:

H1. PRETEST COUNSELLING

H2. Checklist for pretest counselling:

H3. *Assure the client that both counselling and testing are confidential procedures.*

H4. *Be sure that if more than one session is required it can be offered.*

H5. *Provide information about HIV infection and transmission and its link to AIDS, sexually transmitted infections and tuberculosis.*

H6. *Provide information on the technical aspects of testing, the ‘window period’ and its implications and the meaning of the terms ‘positive’ and ‘negative’.*

H7. *Discuss the implications of a positive or negative diagnosis.*

H8. *Provide information about the client's legal rights in terms of who to tell (sexual partner/s) or not to tell (e.g. the employer, third parties, etc.). Clients are not obligated to tell anyone apart from their sexual partners.*

H9. *Evaluate risk behaviour: find out why the individual wants to be tested, and the nature and extent of previous and present high-risk behaviour, and discuss the steps that they should take to prevent future infection or transmission.*

H10. *Determine the client's coping resources and support systems in the event of a positive result.*

H11. *Contain the client's emotions as they deal with issues about relationships.*

H12. *Determine whether the client wishes to be tested that day or not, and whether they would like to receive the result that day or not.*

H13. *Assure the client that you respect their decision.*

H14. *Provide a sense of support and hope for the client.*

H15. *A person who has tested HIV-positive may never have the same quality of life again.*

H16. *HIV-positive people who are properly and appropriately counselled not only feel better following the support, but also are better able to talk about their fears and feelings, and to plan their future.*

H17. *With ongoing emotional and psychological support the HIV-positive person can change his or her behaviour from destructive to positive living.*

H18. ***Both pre- and post-test counselling are very important. It is dangerous to compromise the counselling process and take short cuts in the counselling room.***

Overview

In this chapter a selection of policy-governing and training documents on pre-test counselling have been presented. This selection constitutes the documentary sources used in the document analysis set out in the next chapter.

CHAPTER FIVE

ANALYSIS OF PRE-TEST COUNSELLING DOCUMENTS

In this chapter the selected documentary sources on pre-test counselling in South Africa are analysed. These documents form the raw data. They have already been evaluated in terms of Scott's (1990) scientific criteria of authenticity, credibility, representativity and meaningfulness, as explained in Chapter Four. Document analyses also are sometimes referred to as content analyses. Such analyses can be defined as a research technique used to make replicable and valid inferences from data to their context (Robson, 1993). In this chapter, the analyses of the documents are combined with an introduction to alternatives that could increase the voice of the client in the pre-test counselling conversation.

In this chapter I discuss the relational position of the counsellor and the client according to a number of themes that stood out for me in these documents. The position of the counsellor and the position of the client in the selected texts on pre-test counselling are discussed separately. I demonstrate the presence of each theme by means of quotes from the literature in support of my reasoning. A coding system (as explained in Chapter Four) was used to enable seamless referencing between the analysis and original texts. I argue in this chapter that the client, as portrayed in the selected literature, does not "own" the pre-test counselling conversation. I also demonstrate the "expert" position taken by the counsellor in the selected pre-test counselling documentation. Examples from the texts that refer to the various themes are presented throughout the chapter. Specific reference is made to the "one up" position of the counsellor in the document analysis.

Document analysis and the position of the researcher

When a counsellor tells, informs, advises or educates a client about HIV/AIDS and how he or she should live a longer and healthier life, the counsellor adopts the position of expert and the assumption is made that the counsellor presumably holds the answers on how to live a long and healthy life with a positive HIV/AIDS diagnosis. By contrast, if the counsellor were to access inherent knowledge belonging to the client about how he or she can reduce the risk of infection and re-infection, the ability of the client would then be the focus of the discussion. In the second instance, the client is the expert on reducing the risk of infection. The client is then the expert on his or her own life. His or her own skills, resources and circumstances can be used as the basis for conducting a conversation on reducing the risk of infection. The expert position of the client in the therapeutic relationship has a tradition in a client-centred paradigm according to which it is the therapist's task to understand the client's world. In this tradition, when the therapist communicates understanding of the client's felt meanings, especially those meanings that have not yet been conceptualised into awareness, the client broadens his or her understanding of him- or herself and allows into awareness more of his or her innate experiencing (Meador, & Rogers, 1984). But this is not happening in HIV/AIDS counselling.

Most HIV/AIDS counselling in South Africa takes place in VCT clinics. These clinical settings best accommodate HIV antibody test counselling. Pre- and post-test counselling services are therefore mostly rendered by health care professionals within a medical expert model. In this model, the counsellor is the "expert" about HIV/AIDS and is assumed to hold all the answers to living safely with the HI-virus. Counsellors within this model focus on health education – advice about HIV/AIDS infection and risk reduction (safe sex practices). The aim seems to be to influence the client to make informed decisions about his or her health. According to CAPS (1995), a client-centred approach to HIV counselling is designed to decrease the emphasis on education, persuasion and test results in favour of a personalised risk assessment and the development of a personalised risk reduction plan for each client. Meador and Rogers

(1984), CAPS (1995) and Finger (2002) are in favour of a client-centred model similar to that recommended in this study, namely the use of a client-centred pre-test counselling model in South Africa.

The raw data on pre-test counselling presented in Chapter Four is riddled with examples that point to the expert position of the counsellor (the “one up” of the counsellor versus the “one down” position of the client). This power relationship has a tradition in Berne’s Transactional Analysis (TA) theory treatment and techniques (Dusay, & Dusay, 1984). The pre-test counselling documentation presented in Chapter Four suggests that the counsellor needs to work very hard during the conversation. The counsellor is reminded of the urgency of using this vital and often only opportunity to educate the client on HIV/AIDS and on preventative behaviour to reduce the risk of infection to those infected and affected. Pre-test counselling seems to be seen mainly as an opportunity for the counsellor to educate clients about HIV/AIDS and to prevent the spread of HIV/AIDS infection. The conversation often does not focus on assessing the needs of the client who is seeking pre-test counselling. The counsellor might have the following agenda: the counsellor may assume that he or she knows exactly what the client needs, and uses the pre-test counselling opportunity to convey the information he or she assumes a client needs about how a client could live a longer and healthier life once diagnosed with HIV/AIDS, or how to live risk-free in the event of an HIV-negative result, irrespective of the client’s unique embeddedness in a certain context.

There is undoubtedly a place for the counsellor to impart information on HIV/AIDS to the client to achieve the goal of informed consent. However, I would argue that it is questionable whether this supposedly empowering opportunity is relevant to the experience of the client. When a counsellor tells a client what to do instead of asking the person what he or she would like to do, the counsellor takes away the ability of the client to claim his or her life, the ability to make a choice. I believe that the pre-test counselling conversations as presented in the selected documents support my argument that these conversations are predominantly owned by counsellors and not by their clients.

According to Gasa (2001, p.12), talking about HIV/AIDS involves more than telling people what NOT to do. Experience has taught us that just giving people information and warnings about risk of infection is not enough to change people's behaviour. Based on Gasa's (2001) view, it can be argued that people in general do not listen to advice; they need to experience for themselves for their behaviour to change. The pre-test counselling conversation should be a useful experience for client – a facilitation of their needs – and not a counsellor-dominated monologue based on the assumed needs of clients during pre-test counselling, already pre-empted by the counsellor – a conversation which is ready with answers and a hidden agenda. The argument made here is contextualised in more detail later in this chapter.

This study (*Rethinking HIV/AIDS pre-test counselling in South Africa*) looks at the position of the counsellor and the client during pre-test counselling as documented in South African policy-governing¹ and training documentation. This relational position is discussed in more detail below under a number of themes. The five themes related to the position of the counsellor that stood out for me are the following:

- Theme 1: Pre-test counselling is an educational opportunity for the counsellor
- Theme 2: Knowledge is power
- Theme 3: Knowing your serostatus is instrumental in the fight against infection
- Theme 4: Counsellors know what a client needs to live a long and healthy life
- Theme 5: The pre-test counselling monologue

The counsellor's relational position is discussed in terms of the above five themes. The relational position of the client and the themes evident in the texts that constitute the client's position are discussed later in this chapter.

¹The use of the term "policy-governing document(s)" should be understood in terms of the functionality and original source of the document(s). The official documents were compiled by the Department of Health of South Africa or the National Defence Force and govern HIV/AIDS service delivery and training in South Africa. Evian (2000a), Van Dyk (2001a) and Bekker (2002) represent document(s) from the academic sector and mostly guides training in HIV/AIDS in South Africa.

Themes are discussed individually and examples from the texts, in coded format, are cited to support my reasoning. Reference has been made to the document line number indicated in the previous chapter (for example, A1 refers to Document A, line 1). Where necessary, the platform statement introducing a point is repeated (for example: **F2. Reasons for pre-test counselling include:** [...] F11. *To make an assessment of risk of possible HIV infection*). As in Chapter Four, the original is translated *verbatim*, including its punctuation.

Relational position of the counsellor

Theme 1: Pre-test counselling is an educational opportunity for the counsellor

The documented guidelines for pre-test counselling conversations are clear on what a counsellor should focus on during pre-test counselling and create a “reality” for the counsellor that emphasises the “expert” role of the counsellor during pre-test counselling. Below, I cite extracts from the selected texts on pre-test counselling that demonstrate the presence of the first theme.

C69. *Counselling and support activities need to address feelings of shock, fear, loss, grief, guilt, depression, anxiety, denial, anger, and suicidal activity or thinking, reduced self-esteem, and spiritual concerns*

C70. *In addition, social issues such as loss of income, discrimination, social stigma, relationship changes, and changing requirements for sexual expression need to be explored*

C75. *The counselling session is an ideal time to discuss sexual practices and preferences, potential drug abuse (particularly intravenous drug use) and other at risk behaviours*

D28. *The client can be encouraged to focus on a healthy lifestyle.*

D38. *These questions help the counselor to assess the ability of the client to cope with and adjust to a positive result.*

D46. *The decision to be tested is the patient's alone and even if he/she decides not to be tested, the counseling interview may have important useful information about safer sexual practices.*

F2. Reasons for pre-test counselling include: [...] F11. *To make an assessment of risk of possible HIV infection.*

F12. Some of the most important issues which you should explore and discuss BEFORE an HIV test is done: [...] F18. *Does he/she know how to prevent the spread of infection? Does he/she know how to have sex in a safer way? Can he/she get condoms or do you need to provide them? Does he/she know how to use them correctly? You may need to explain in detail about the importance of practicing safer sex from now onwards [...]. Remember this may be the last time you will see the patient.*

G5. Reason for testing: [...] G9. *These questions provide the counsellor with an opportunity to ascertain individuals' perceptions of their own high-risk behaviour and with an opportunity to assess whether they intend to be tested and whether their fears are realistic or if they are unnecessarily concerned.*

G26. Assessment of risk: G27. *Assess the likelihood of whether the person has been exposed to HIV by considering how much and how frequently he or she has been exposed to the following factors and lifestyles indicators: ...*

G106. Waiting period: [...] G110. *However, if the client has to wait for the test results, the counsellor should anticipate this difficult waiting period by discussing the following points with the client: ...*

It seems that counsellors are well prepared and trained about what to address during pre-test counselling. The focus of the interview is on these assumptions and not on the actual needs of a client. Before a client can indicate his or her needs, the counsellor already knows exactly what aspects the counsellor intends to address during a pre-test counselling conversation.

According to Sherr and Quinn (cited in Richter et al., 2001), the term “counselling” used in HIV/AIDS counselling is used as a catch-all phrase for a multitude of interventions, from lay counsellors’ using scripts to in-depth psychotherapeutic engagements. According to Sherr and Quinn (cited in Richter et al., 2001), counselling should refer to one of a series of planned interpersonal encounters aimed at influencing clients to explore personalised alternatives and responses to conditions, and these authors call for a more client-centred counselling approach.

“Knowledge is power” is the second theme identified in these documents. This notion is based on the belief that health education enables and empowers individuals to make informed choices about their health.

Theme 2: Knowledge is power

Educating individuals about HIV/AIDS and about safe sex practices is a dominant issue in documentation on pre-test counselling and such education is referred to extensively in the literature. So, for example, Caldwell et al. (1993) emphasise that having fewer sexual partners will reduce the risk of other sexually transmitted infections (STIs) as well as AIDS, and they endorse education on STIs and HIV/AIDS infection.

The belief that knowledge about HIV/AIDS empowers people and produces behaviour change is a strong theme in the literature on HIV/AIDS in South Africa (Bekker, 2002; Department of Health, 2001a, 2001b; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). Van Dyk (2001a) argues that one of the main educational functions of health care professionals is to discourage unsafe sexual behaviour. Health care professionals should teach safe sex practices, as well as prevent HIV transmission. They are required to act as HIV/AIDS educators. According to Van Dyk (2001a), the general public urgently needs information about HIV/AIDS, as well as continued education on issues related to the prevention of infection by and care of people with HIV/AIDS.

The TASO Service Centre (TASO, n.d.) states that its primary aim is to provide accurate information on HIV/AIDS to help people to make informed decisions, especially about testing. Emotional support should be given to those undergoing testing and they should be helped to examine the implications of their situation. According to a survey by the USAID Development Partners Resources (USAID, 2002), an estimated 86% of the youth recognise the risks of unprotected sex, although relatively few (12.6%) see themselves at personal risk. A comprehensive mass media campaign has been launched (USAID, 2002), designed to equip adolescents with knowledge related to abstinence, healthy lifestyles, delaying sex and early pregnancy, and preventing HIV infection and STIs. The South African Minister of Education has also signed on to use *The Revised Reproductive Health-Training Manual* for the use of school guidance counsellors. Counsellors are now in the process of integrating *The Revised Reproductive Health-Training Manual* into existing curricula and programmes (USAID, 2002).

The theme “knowledge is power”, is contextualised in detail above. The belief appears to be held that the more information is available to the infected and affected, the more informed and responsible their decision-making will be. The prevalence of the notion that “knowledge is power” seems to have created the impression that information about HIV/AIDS is important and, hence, education forms the backbone of the South African prevention strategy to curb the growing rate of infection.

Listed below are some examples from the selected pre-test counselling documentation that reveal the prevalence of this assumption. The focus in pre-test counselling conversations seems to be the education of clients about HIV/AIDS and the teaching of the principles of infection. .

A1. *Giving the person basic knowledge about HIV infections and AIDS so that they understand*

B1. *Pre-test counselling should occur before an HIV test is undertaken. It should be a confidential dialogue with a suitably qualified person, such as a doctor,*

nurse or trained HIV counsellor, undertaken as a means of passing on information and gaining consent.

B4. Checklist of points to be covered in pre-test counselling [...] B10. Check knowledge about transmission and prevention.

C1. Aim of pretest counselling C2. The aim of pre-test counselling is to provide information to the individual about the technical aspects of testing and the various implications of being diagnosed as either HIV positive or negative.

F1. Counselling before the test. F2. Reasons for pre-test counselling include:
F3. To ensure the person understands the basic facts about HIV infection and AIDS.

F12. Some of the most important issues which you should explore and discuss BEFORE an HIV test is done: F13. Does the patient understand the basic information about AIDS and HIV infection? Explain these and clear up any misunderstandings.

G34. Beliefs and knowledge about HIV infection and safer sex G35. Determine exactly what your client believes and knows about HIV infection and AIDS and correct errors by providing accurate information about transmission and prevention

G68. Anticipate the results G69. It is important for the counsellor to anticipate a positive HIV antibody result and to talk about how the client will deal with a positive test outcome.

G68. Anticipate the results [...] G70. Anticipating a positive result helps the counsellor to ascertain the client's ability to deal with, and adjust to, a positive result.

G68. Anticipate the results [...] G71. The counsellor also gains insight into some of the potential problems associated with a positive test outcome.

G68. Anticipate the results [...] G78. The counsellor must help clients to think not only of themselves but also of those who are to be told. (For example, if the client says to you: "The news will surely kill my old and frail mother", you may ask: "Why do you want your mother to know?").

Bekker (2002), Gasa (2001) and Van Dyk (2001a) point out that mere knowledge of a person's status does not necessarily protect that person or his or her loved ones from infection. Pre-test counselling conversations seem to be educational and focused on prevention, aiming for an understanding of HIV/AIDS infection, and promoting the

adoption of risk reduction behaviour to prevent re-infection. Ample examples of the assumption of a need for this form of education have been cited from the selected documents.

Surveys about the use of condoms after educational strategies for safer sex practices have been implemented, however, do not support the belief that knowledge about prevention and risk reduction curbs the spread of the virus (Joubert, 2001; USAID, 2002). Statistics (Joubert, 2001) on the non-compliance of infected and affected people with regard to condom use raise questions about the emphasis on health education in pre-test counselling. Thus far, education about safer sex practices and informed consent does not seem to give the HIV/AIDS affected and infected a strong enough voice to speak up and make informed choices about their health.

Knowing your serostatus is also said to be instrumental in the fight against HIV/AIDS infection – this is the third theme identified in the analysis. This assumption and its representation in the texts are explored below.

Theme 3: Knowing your serostatus is instrumental in the fight against infection

As shown above, the belief that knowledge about HIV/AIDS empowers people and produces behaviour change is a strong theme in the literature on HIV/AIDS in South Africa. The reasoning about the need to know your serostatus is linked to the “knowledge is power” debate. The Center for HIV, STD and TB Prevention (CDC, n.d.b) states:

High public awareness of the increasing numbers of persons sick and dying with AIDS, and knowledge of personal risk behaviours result in an increased desire to learn one’s serostatus. People who learn they are seronegative can be empowered to remain disease-free. Medical and supportive services can help those living with HIV to live longer, healthier lives and prevent transmission to others.

Learning one's serostatus with prevention counselling can be a powerful prevention and care strategy. Knowledge of personal risk behaviour and serostatus is power.

Knowing your HIV status is said to empower. It is assumed that once a person knows what to do to prevent infection and reduce risk behaviour, the infection rate will decrease. Examples of this assumption are presented below:

A3. Providing a brief outline of the nature of the test to be conducted and what both negative and positive results mean

A4. Exploring how the person might feel and what s/he might do if the test is positive or negative

A13. Giving a positive result *A14. The individual is informed about his/her HIV test result*

A13. Giving a positive result [...] *A17. Information about HIV/AIDS in general and how to live positively with HIV/AIDS is also shared*

C1. Aim of pretest counselling [...] *C5. Testing should be discussed as a positive act that is linked to changes in risk behaviour, coping and increasing the quality of life.*

C22. Preparing for pre-test counselling [...] *C25. Explaining the implications of knowing one is or is not infected.*

C54. HIV-positive result counselling *C55. When the test result is positive, the nurse/midwife should tell the person as gently as possible, providing emotional support and discussing how best to cope with the results.*

C71. HIV-negative test result counselling *C72. If the HIV test is negative, then counselling about risk behaviours and methods of prevention are vitally important (see Fact Sheet 12).*

D23. Potential benefits [...] *D25. Having the test could help to motivate persons who practice high-risk behaviours to reduce these behaviours.*

F12. Some of the most important issues which you should explore and discuss BEFORE an HIV test is done: [...] *F14. Does the patient understand what the test is*

and what a positive or negative result would mean? Remember it is an antibody test and does not tell whether you have the AIDS phase of the disease.

F12. *Some of the most important issues which you should explore and discuss BEFORE an HIV test is done:* [...] F15. *Explore why he/she wants the test, or explain why you have suggested the test, and what benefits there are in knowing you are HIV positive. Has he/she been at risk for acquiring HIV infection?*

G47. *The implications of an HIV test result* [...] G49. *Knowing the result may reduce the stress associated with uncertainty.*

G47. *The implications of an HIV test result* [...] G50. *One may begin to make rational plans for preparing oneself emotionally and how actually to live with HIV.*

G47. *The implications of an HIV test result* [...] G54. *Adjustments to one's lifestyle and sex life can protect oneself and one's sex partners from infection.*

According to Powers (2003), health education is not necessarily empowering. Pre-test counselling conversations seem to support the principle that knowing your HIV status will curb the spread of the virus.

This principle is used by the Center for AIDS Prevention Studies at the University of California San Francisco CA, USA (CAPS, 1995) with regard to a personal risk assessment with the emphasis on the individual's designing a plan for his or her life to reduce the risk of HIV/AIDS infection. The spirit of the intervention is interactive and respectful of participants' circumstances and readiness to change. Rather than just telling clients about HIV, CAPS (1995) encourages counsellors first to ask clients what they know or what they have heard, and correct their misperceptions through discussion. CAPS (1995) trained counsellors do not tell clients how to reduce their HIV-related risk behaviour. Instead, counsellors elicit from each client an individualised risk profile and, through discussion, they assist the client to develop a specific risk reduction plan.

In the documentary sources selected for this study, risk reduction or attempting to alter at risk sexual behaviour does form part of the interview protocol during pre-test counselling. However, the emphasis is not on the client's own knowledge. The

assumption is made that the counsellor is the expert who will anticipate any possible risk of infection and will facilitate the reduction of risk behaviour during pre-test counselling conversations (Bekker, 2002; Department of Health, 2001a, 2001b; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). The emphasis in these six documents is very different from that of CAPS (1995). These documents reinforce the “expert” position of the counsellor and support the argument in this study that pre-test counselling conversations are not owned by the client, but by the counsellor. So, for example, in Document C, in lines C8 to C12, the assessment of risk focuses on obtaining information from the client about risk behaviour which could be indicative of a high or low risk to infection. Risk assessment done in this way is less interactive and seems to be designed to help the counsellor to facilitate the session. The client’s innate knowledge(s)¹ are not utilised. Examples are:

C6. COMPONENTS OF PRETEST COUNSELLING. C7. Assessment of risk
[...] C9. *Frequency and type of sexual practices, in particular, high risk practices such as vaginal and anal intercourse without a condom, or unprotected sex with prostitutes;*

C6. COMPONENTS OF PRETEST COUNSELLING. C7. Assessment of risk
[...] C10. *Whether the person was/is part of a group with high risk prevalence of HIV infection (intravenous drug users, male and female prostitutes and their clients, prisoners, refugees, migrant workers, homosexual and bisexual men, and health care workers where the use of Universal Precautions (Fact Sheet 11) is erratic or incomplete.*

C6. COMPONENTS OF PRETEST COUNSELLING. C7. Assessment of risk
[...] C11. *Whether the individual has received a blood transfusion, organ transplant, or blood or body products. Note that in some developing countries, testing of blood for HIV might not occur.*

C6. COMPONENTS OF PRETEST COUNSELLING. C7. Assessment of risk
[...] C12. *Has the person been exposed to non-sterile invasive procedures, such as tattooing, scarification, female and male circumcision?*

¹The use of the unusual plural “knowledges” is suggested by Anderson and Goolishian (1988), referring to the accumulation of experiences belonging to individuals.

The fourth theme represents the expert position of the counsellor and the sharing of “knowledge” by the “knowing” counsellor on how to live a long and healthy life with the HI-virus.

Theme 4: Counsellors know what a client needs to live a long and healthy life

The pre-test counselling conversation documentation is riddled with examples of the “expert” position of the counsellor, the giving of advice on what to do to live longer healthier lives with HIV/AIDS, and on what to do to reduce the risk of infection to the self and others. The counsellor’s voice on knowledge about risk reduction is the strongest in the selected texts and often the client has no voice.

The counsellor spends time with the client during pre-test counselling, advising the client on HIV/AIDS, but many counsellors themselves cannot give effect in their own lives to the advice they give clients, according to Richter et al. (2001). To me, knowing that counsellors themselves cannot apply the advice they give others during pre-test counselling raises questions about the use of “advice-giving”. I wonder about the senselessness of spending time with a client, knowingly giving advice that most probably cannot be applied. I believe that the information about counsellors themselves having difficulty in applying the advice they give clients supports my argument in this study for a client-centred counselling approach.

Advice given, as shown by Richter et al. (2001), pertains to the disclosure of HIV status, communication with the client’s partner(s) about sexual risk and protection, as well as the use of condoms. If the counsellors themselves do not benefit from the advice they give others, and more importantly, do not seem to be able to incorporate this knowledge into their lives, the function of giving advice during pre-test counselling conversations should be questioned. I believe that the statistics presented by Joubert (2001) further support my argument: people know, for example, that they should use condoms, but seem to be choosing not to.

In this study I argue for an alternative way to talk about HIV/AIDS “do’s and don’ts”. I believe that if we acknowledge the role of counselling in HIV/AIDS infection, then counselling principles should be applied. In this study I consistently emphasise that there is a need for health education on HIV/AIDS infection. Awareness, unfortunately, does not change behaviour. I am curious about counselling results approached from a client-centred model and reasons set out in this study for the benefits of such an approach. I believe that the “expert” position of the counsellor inhibits clients from taking some responsibility in living long and health lives with the HI-virus.

Below are some examples from the selected documents on pre-test counselling that reveal the assumption that counsellors are the experts and hold the only answers to living a longer, healthier life before and after infection.

A6. Providing information on the medical care available to ensure that people living with HIV can leave [live] healthier for longer

A8. Giving advice regarding safer sexual practices. VCT counsellors also explore whether the client knows how to prevent the spread of HIV infection. This may include a demonstration for how to use condoms

A13. Giving a positive result [...] A17. Information about HIV/AIDS in general and how to live positively with HIV/AIDS is also shared.

A13. Giving a positive result [...] A21. The counsellor also informs the person about safer sexual practices and how to prevent infecting others and/or re-infecting oneself. Demonstrations for how to use condoms may be done by the counsellor and the pair may discuss how to introduce condom use to one’s partner

A24. Giving a negative test result [...] A27. The client is then encouraged to remain negative by practicing safer sex. The counsellor may demonstrate how to use condoms. Condom negotiation with partners may also be discussed

B4. Checklist of points to be covered in pre-test counselling [...] B18. Discuss healthy lifestyle irrespective of possible test result (safer sex, food, sleep, exercise, etc.)

C22. Preparation for pre-test counselling [...] C32. Explaining how to prevent HIV transmission.

C22. Preparation for pre-test counselling [...] C46. *facilitation of behaviour change*

C22. Preparation for pre-test counselling [...] C49. *contraceptive advice, and other information and education (Fact Sheet 8).*

C71. HIV-negative test result counselling [...] C77. *Free condoms can be given out during this session together with advice on how to use them and where to get more when needed.*

D29. Anticipating of a positive test result [...] D40. *The client needs to be aware of possible reactions by family, friends and employers to a positive result and the issues around disclosure need to be addressed.*

F1. Counselling before the test. F2. Reasons for pre-test counselling include: [...] F9. *To advise on safer sexual practices (...)*

F12. Some of the most important issues which you should explore and discuss BEFORE an HIV test is done: [...] F19. *Does he/she know how to prevent the spread of HIV infection? Does he/she know how to have sex in a safer way? Can he/she get condoms or do you need to provide them? Does he/she know how to use them correctly? You may need to explain in detail about the importance of practicing safer sex from now onwards. Remember this may be the last time you will see the patient.*

G34. Beliefs and knowledge about HIV infection and safer sex [...] G36. *Ask your client questions about his or her past and present sexual behaviour and provide information about safer sex practices and a healthier lifestyle.*

G34. Beliefs and knowledge about HIV infection and safer sex [...] G37. *Find out if the client knows how to practice safer sex, how to use a condom correctly, and where to get hold of condoms. Give them condoms if necessary.*

G68. Anticipating the results [...] G79. *Clients must also be warned that some people may not keep the information to themselves, and that this might have harmful effects for the client.*

G106. Waiting period [...] G114. *Encourage the client to do something enjoyable keep himself or herself occupied while waiting for the results (e.g. hiking, going to the movies or play soccer with friends).*

G117. Conclusion [...] G119. *It should not only be seen as preparation for the HIV test, but as a golden opportunity to educate people about HIV/AIDS and safer sex.*

G117. Conclusion [...] G120. *Remember that this may be the one and only time that the counsellor will see the client because he or she might decide not to be tested, or not to come back for the test results after all.*

CAPS (1995) indicates that one way to change HIV risk behaviour is to provide information about HIV transmission or infection. However, CAPS (1995) also comments that it is unclear whether this approach is the most effective method of helping clients to change their risk behaviour. They suggest a client-centred approach to HIV counselling, designed to decrease the emphasis on education, persuasion and test results in favour of a personalised risk assessment and the development of a personalised risk reduction plan for each client. This approach teaches ability and takes control out of the hands of the counsellor and places it in the hands of the client. The client is the expert on his or her life and is directly responsible for living with the virus. Joubert (2001) also highlights the importance of the individual in the fight against the growing infection rate.

Personal risk reduction seems to be an important step in the pre-test counselling conversation, an opportunity for the client to assess his or her risk of infection, as well as an opportunity for the client to think about what an infected or affected person can do to protect others and him- or herself against infection, an opportunity where the client is not told what to do, but has a choice to decide on what can be done. This step provides the client with an opportunity to own the discussion.

The fifth theme focuses on the counsellor's agenda during pre-test counselling. The documents emphasise the limited opportunity during pre-test counselling conversations for attending to the client's individual needs. Pre-test counselling conversations seem to be structured to allow counsellors to utilise what is often the only opportunity to educate clients about HIV/AIDS infection.

Theme 5: The pre-test counselling monologue

The purpose of pre-test counselling is to provide individuals who are considering testing with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV-positive or -negative (Bekker, 2002; Department of Health, 2001a, 2001b; Evian, 2000b; Gasa, 2001; SAMHS, n.d.; Van Dyk, 1992, 2001b). The purpose of pre-test counselling is to find out why individuals want to be tested, the nature and the extent of their previous and present high-risk behaviour, and the steps that need to be taken to prevent these individuals from becoming infected or from transmitting the HIV infection. The position of the counsellor in the selected documentation on pre-test counselling is mostly that of an expert on living with HIV/AIDS. The counsellor's role is to advise, inform, provide and explain HIV/AIDS care and counselling-related information. The mandate to explore, assess and ask questions is less prevalent in documentation on pre-test counselling. It is important to notice that any exploring done by counsellors is mostly done to benefit the counsellor during the conversation, making his or her task easier. An good example to substantiate my reasoning is visible in Document G, line 9. Van Dyk (2001b) writes that questions asked by the counsellor (under this heading) provide the counsellor with an opportunity to ascertain individuals' perceptions of their own high-risk behaviour and to assess whether the clients intend to be tested and whether their fears are realistic, or whether they are unnecessarily concerned. Such questions are not designed to access the existing knowledge of the client on how to refrain from unsafe sex or how to reduce his or her possible risk of infection. Some other examples in the texts are:

D1. *The aims of pre-test counselling* D2. *To ensure that people are fully informed of the sometimes medical, personal, social and legal implications when tested and to provide information on risk reduction to the client whether testing positive or negative (...).*

D6. Provide information about the HIV-antibody test. [...] D12. *The client should also be informed of how blood is taken, costs of testing if applicable, when results will be known, as well as how the results will be communicated.*

G2. *The purpose of pre-test counselling is to provide individuals who are considering being tested with information on the technical aspects of testing and the possible personal, medical, social, psychological, legal and ethical implications of being diagnosed as either HIV positive or HIV negative.*

G3. *The purpose of pre-test counselling is further to find out why individuals want to be tested, the nature and the extent of their previous and present high-risk behaviour, and the steps that need to be taken to prevent them from becoming infected or from transmitting HIV infection.*

G38. Information about the test G39. *It is important to ensure that your client know what the HIV test entails (...). Explain the following points to the clients:*

G38. Information about the test [...] G40. *There is a difference between being sero-positive and having AIDS. The HIV antibody test is not 'a test for AIDS'. It indicates that a person has HIV antibodies in the blood and that the person is infected with HIV. It does not say when or how the infection occurred, or in what phase of infection the person is.*

G38. Information about the test [...] G41. *The presence of HIV antibodies in the blood does not mean that the person is now immune to HIV. On the contrary, it means that he or she has been infected with HIV and that he or she can pass the virus on to others.*

G38. Information about the test [...] G42. *The meaning of a positive and negative test result (...).*

G38. Information about the test [...] G43. *The meaning of the concept of the 'window period' (...). Stress the need for further testing if the person practises high risk sexual behaviour and test negative.*

G38. Information about the test [...] G44. *The reliability of the testing procedures. A positive HIV antibody test to always be confirmed with a second test and the reliability of the test results is high. False-positive or false-negative results may*

however occasionally occur despite the general reliability of HIV test (e.g. a false negative test because the person is in the window period).

G38. Information about the test [...] G45. *The testing procedure. Explain how blood is drawn for the test, where it is sent, when the results will be available and how the person will be informed of the outcome.*

G38. Information about the test [...] G46. *You don't want to overload your clients with information during the pre-test counselling session, and you want to send them home with something to read. Design a pamphlet in which you explain everything they need to know about the HIV antibody test.*

H2. Checklist for pretest counselling: [...] H5. *Provide information about HIV infection and transmission and its link to AIDS, sexually transmitted infections and tuberculosis.*

H2. Checklist for pretest counselling: [...] H8. *Provide information about the client's legal rights in terms of who to tell (sexual partner/s) or not to tell (e.g. the employer, third parties, etc.). Clients are not obligated to tell anyone apart from their sexual partners.*

Relational position of the client

In the above pages the emphasis has been placed on the relational position of the counsellor, and evidence has been offered to show that these documents position the counsellor as the expert in the pre-test counselling conversation. The two themes that reveal the relevant position of the client that stood out for me during the analysis are

- Theme 6: HIV/AIDS – a devastating diagnosis
- Theme 7: The non-dominant voice of the client

The position of the client in the selected documentation on pre-test counselling in general is a “one down” position. The clinical model of service delivery also contributes to this subordinate position of the client, who might more accurately be referred to as a

“patient”. The expertise of the counsellor or health care professional is called upon, and the emphasis is on providing as much information as possible about HIV/AIDS prevention and risk reduction. The aim is to address the pre-test counselling agenda that is known to the counsellor and that this expert must convey, and that will hopefully ensure a longer and healthier life for the client. The assumption is made that an HIV/AIDS diagnosis must be devastating, and that the reaction to such a diagnosis is always one of disbelief and a sense of disaster. Below are some examples of how the client’s reaction to an HIV-positive or -negative diagnosis is pre-empted.

Theme 6: HIV/AIDS – a devastating diagnosis

Even before the client has been diagnosed, the assumption is made that once he or she is diagnosed with HIV/AIDS, the individual will be devastated. “Being diagnosed with HIV/AIDS, or becoming sick from the conditions, often causes a crisis for the person and his/her immediate family or partner” (Evian, 2000a, p. 268). Rose (1998) writes that for everyone affected by HIV disease, underlying uncertainty runs strong and deep. These assumptions and many others are prominent in the selected texts on pre-test counselling as listed below:

D15. RISKS [...] D19. *The client may suffer from loss of self-confidence, avoidance, rage, self-imposed isolation and loss of control over life.*

D15. RISKS [...] D20. *The client has to live with the uncertainty of waiting to see if and when he/she will develop signs and symptoms of HIV infection.*

D15. RISKS [...] D21. *The client [may] experience problems with relationships (love, family and friendship).*

D15. RISKS [...] D22. *The client may face stigma, prejudice and blame.*

D23. Potential benefits D24. *Relieve anxiety.*

D29. Anticipation of a positive test result D30. *Most individuals want or expect confirmation of a negative result and do not anticipate a positive one.*

G47. *The implications of an HIV test result* [...] G59. *Having to endure the social stigma associated with the disease.*

G47. *The implications of an HIV test result* [...] G60. *Problems in maintaining relationships and in making new friends.*

G47. *The implications of an HIV test result* [...] G63. *Possible rejection and discrimination by friends, family and colleagues.*

G47. *The implications of an HIV test result* [...] G65. *Increased stress levels and uncertainty about the future.*

G106. *Waiting period* [...] G110. *However, if the client has to wait for the test results, the counsellor should anticipate this difficult waiting period by discussing the following points with the client:*

H2. *Checklist for pretest counselling:* [...] H15. *A person who has tested HIV-positive may never have the same quality of life again.*

H2. *Checklist for pretest counselling:* [...] H17. *With ongoing emotional and psychological support the HIV-positive person can change his or her behaviour from destructive to positive living.*

Bor and Miller (1991) are concerned about the assumed position of the counsellor and the effect this position has on HIV/AIDS service delivery in general. They write that the psychotherapeutic focus is usually on the relief of symptoms, such as anger, depression and withdrawal. Bor and Miller (1991) suggest that assumptions based on reactions to a diagnosis on the part of the counsellor may impede rather than facilitate the management of the client. Resistance and denial might become the focus of the sessions, and counsellors and their clients might “compete” to assert their views and beliefs.

Opportunities for clients to discuss their needs in pre-test counselling are limited. The pre-test counselling conversation is pre-planned and has an agenda to provide health education and to teach safe sex practices, whether the client has indicated a need for such education or not. In the conversation, the counsellor assumes the position of knowing what the client would need to live with an HIV-positive or -negative test result, and uses this opportunity accordingly.

I am concerned about the voice of the client, because I believe that counselling should ultimately be about the client and the client's needs. The client does not seem to have a dominant voice in pre-test counselling conversations.

Theme 7: The client does not have the dominant voice

The dominant voice in the selected documentation on pre-test counselling is that of the counsellor. There are some examples in the selected texts where the client is asked questions about his or her reactions to positive or negative test results; however, the counsellor dominates the pre-test counselling conversation. This is revealed in the texts by examples such as the following:

G68. Anticipate the results G69. *It is important for the counsellor to anticipate a positive HIV antibody result and to talk about how the client will deal with a positive test outcome.*

G68. Anticipate the results [...] G70. *Anticipating a positive result helps the counsellor to ascertain the client's ability to deal with, and adjust to, a positive result.*

G68. Anticipate the results [...] G71. *The counsellor also gains insight into some of the potential problems associated with a positive test outcome.*

G68. Anticipate the results [...] G87. *People who prefer not to be tested should however live as if they are infected, practice safer sex at all times.*

G68. Anticipate the results [...] G88. *People who suspect they are HIV-infected should refrain from donating blood.*

There are ample examples where the focus is not the client at all:

A2. *Exploring why s/he wants the test*

A3. *Provide a brief outline of the nature of the test to be conducted and what both negative and positive results mean*

A4. *Explore how the person might feel and what s/he or she might do if the test is positive or negative*

A6. *Providing information on the medical care available to ensure that people living with HIV can leave [live] healthier for longer.*

B4. Checklist of points to be covered in pre-test counselling [...] B6. *State how much time is available for counselling.*

B4. Checklist of points to be covered in pre-test counselling [...] B7. *Stress confidentiality.*

Van Dyk (2001a) emphasises that counsellors “must” allow their clients to verbalise their fear, anxiety, anger, sorrow, guilt or shame, because this will give the counsellors the opportunity to identify possible problem areas that will need to be addressed and processed. I believe that this statement once again emphasises the “expert” position of the counsellor and supports the argument in this study that pre-test counselling is not owned by the client. I argue in this study that it is essential to give the client more of a voice during pre-test counselling conversations. The need for the client’s voice to be heard and the belief that he or she has the ability to keep him- or herself and his or her partner(s) safe from infection are the most important messages of this study. The selected documents presented for analysis in this study emphasise the need to educate and teach those affected and infected how to live long and healthy lives with HIV, but are lacking in that they fail to show counsellors how to help clients believe that they have the ability to live with this disease. If others tell me how to live my life and that they surely know better than I do what is good for me, the responsibility to be safe is not mine, but becomes the responsibility of the government, of drug companies and the counsellor.

Overview

In the selected documents on pre-test counselling, the HIV/AIDS counsellor is presented as the expert about HIV/AIDS in South Africa. Counsellors are well trained on

what to expect during pre-test counselling conversations and counsel clients on the basis of these assumptions, regardless of the fact that many counsellors themselves cannot apply the advice they give about risk behaviour change in their own lives (Richter et al., 2001). The counsellor is presented as knowing the exact goals of pre-test counselling, and the need of counsellors to educate and support is the focus in the current pre-test counselling conversation. Determining the needs of the client does not seem to be the focus in the selected documents on pre-test counselling. Predominantly, the counsellor seems to tell, inform, advise or educate the individual about HIV/AIDS, and, to a lesser extent, he or she may facilitate the needs of the client by asking questions. It is presumed that the counsellor already “knows” what the client needs. Client-centred service delivery does not seem to be the focus in pre-test counselling conversations in South Africa.

Rose (1998) emphasises that care providers need to look far beyond the traditionally defined parameters of HIV issues in order to assist the full spectrum of clients. People’s counselling needs must be assessed realistically in terms of the clients’ own skills, work and education (Rose, 1998). Counselling needs have changed (Rose, 1998), as people prepare for a future full of new possibilities. Antiretroviral therapy is becoming more accessible to the HIV infected, and they are no longer doomed to a bleak and short future.

CHAPTER SIX

RETHINKING HIV/AIDS PRE-TEST COUNSELLING IN SOUTH AFRICA

In the previous chapter, a selection of documents on pre-test counselling was analysed to explore the position of the counsellor and that of the client. These documents on the pre-test counselling conversation are riddled with assumptions about the position of the counsellor and his or her role in educating the client, whose voice is marginalised in the pre-test counselling conversation. In this chapter I argue for the use of a more client-centred model to be used in pre-test counselling. There seems to be a standard pre-test counselling conversation that is predominantly focused on health education. The argument in this chapter revolves around the reasoning that health education is not necessarily the same as counselling, and that a more client-centred approach to pre-test counselling would place the client and his or her needs at the centre of the conversation.

Health education is not counselling

The central message of the HIV/AIDS campaign is the principle that HIV/AIDS is preventable through an individual's choice to act responsibly on the grounds of the information given to the individual about the disease (Richardson, 1990). However, although education about HIV/AIDS infection is made available, clients' compliance rate in terms of making healthy choices about their health seems to be significantly low. It can therefore be concluded that giving information about HIV/AIDS to motivate clients to make informed choices about their health is not as successful as initially anticipated.

A major criticism of this approach to HIV/AIDS prevention is that it presents advice about risk reduction in a social vacuum. It fails to acknowledge that choices and

decisions concerning safer sex and substance use are not only shaped by what we know, but also by our fears and prejudices about the disease, as well as by our limitations or means to act on the advice given (Richardson, 1990, p. 169).

Most of the public education about HIV/AIDS tends to assume that people are capable of making informed decisions about their health. According to Powers (2003), this assumption underlies health education practices in general. Health is normally regarded as something over which an individual has personal control. The goals of health education fall within this framework of personal control (Richardson, 1990). Health education, firstly, ensures that people have access to information concerning their health and, secondly, encourages people to make informed decisions about their lives.

According to Freire (cited in Powers, 2003), education is never an ideologically neutral process. Powers (2003) expresses the fear that some health care professionals might think that to educate in itself is liberating and that health education in itself is empowering. To counter such assumptions, Powers (2003) quotes Gibson (1991):

Health care professionals cannot empower people; people can only empower people; people can only empower themselves, and it is the results of self-awareness and resources that empower – not the services provided. (Gibson 1991 in Powers, 2003)

The selected documentation on the pre-test counselling conversation clearly supports the view that health care education on HIV/AIDS in South Africa is important as a prevention strategy. When information about the disease is given to the individual, he or she is said to be able to make informed choices on how to live his or her life. In the pre-test counselling conversation, it seems that the main focus of counsellors is to educate and support the client. I argue in this study that what happens in the pre-test counselling conversation is health education, and not counselling. Sherr and Quinn (cited in Richter et al., 2001) point out that the term “counselling” is used as an “all catch phrase” that is

supposed to cover the solution to all HIV/AIDS services delivery needs, ranging across a broad psychosocial spectrum.

Redefining counselling

There is a difference between health care education and counselling. For the purposes of this study, the definitions of counselling used by Bor and Miller (1991), Johnson (cited in Van Dyk, 2001a) and Powers (2003) are applicable. HIV/AIDS counselling conversations between clients and counsellors should focus on facilitating solutions to problems, solving the problems, helping people to grow and to develop, and facilitating the expression of the client's feelings (Bor, & Miller, 1991). The main function of an HIV/AIDS counsellor is to be supportive of infected or affected clients, to listen to their problems and to empower them to solve their problems and improve their lives (Van Dyk, 2001a). Empowerment seems to be the aim of counselling. Powers (2003) highlights the fact that to empower does not mean that individuals should make the decisions that the counsellor believes to be the correct decisions. Healthcare professionals believe they are performing a service by "empowering" individuals to make correct choices in their lives. Patients are often only considered empowered, however, if they make the correct choices as defined by the health care provider (Powers, 2003, p. 227).

Pre-test counselling conversations in South Africa at present clearly focus mainly on education about HIV/AIDS and are aimed at influencing the client to make the "correct" decisions. CAPS (1995) and Finger (2002) suggest the implementation of a more client-centred approach to HIV/AIDS counselling. This approach (an opportunity for clients to own the counselling session) is the alternative offered in this study. This approach is discussed in more detail below.

A client-centred pre-test counselling conversation

My concern regarding the documented pre-test counselling position at this stage seems best formulated by Thomas (2001). He states that the HIV/AIDS crisis is not only a crisis of knowledge and of state policy; it is a crisis at the level of the individual body. Thomas (2001) writes that we cannot experience the pain and suffering endured by others, but we can listen to the accounts of the client's experiences. Such listening is the most direct means we have to reach an understanding of the place of illness in the clients' lives. This principle of understanding the place of illness (HIV/AIDS) in the client's lives, in my opinion, revolves around meaning. I argue in this study that it should be the client's responsibility to determine this "place (meaning) of illness (HIV/AIDS) in his or her life", and not that of the counsellor. Currently, texts on pre-test counselling conversations acknowledge the task of counsellors to educate clients about HIV/AIDS. Instead, I argue in this study that it should also be the task of counsellors to assess the place of illness (HIV/AIDS) in clients' lives and not to pre-empt the place (meaning) of an HIV/AIDS diagnosis in the lives of clients.

The place of illness in the lives of clients

One way to attempt change in HIV risk behaviour is to provide information about HIV/AIDS transmission. It is unclear whether this is the most effective method of helping clients to change their risk behaviour (Finger, 2002). The client-centred approach to HIV counselling, according to CAPS (1995), has been designed to decrease the emphasis on education, persuasion and test results in favour of a personalised risk assessment and the development of a personalised risk reduction plan for each client. The emphasis in client-centred counselling is on developing a risk reduction plan for each client that takes into account the client's emotional reactions, interpersonal situation, social/cultural context, specific risk behaviour and readiness to change (CAPS, 1995).

The content of pre-test counselling sessions and the amount of counselling that each client receives should be determined by the client's level of knowledge and his or

her specific, personal concerns about HIV/AIDS (CAPS, 1995). Rather than to provide standardised information about HIV/AIDS, the counsellor should solicit information about what the client already knows or has heard and then correct misperceptions and provide additional information through discussion. The counsellor should assist the client to cope with emotional reactions and to cope with the consequences of his or her HIV risk behaviour. Rose (1998) writes that people living with HIV do not necessarily expect answers to all their questions, but that they do need to ask questions regarding the following areas:

How long new treatments will remain effective, whether particular strains of the virus will become resistant, what short-term or long-term side effects might develop, whether the next wave of treatment alternatives will come along in time, and whether these new alternatives will be made available to all those who need them. Some people fear that they will make major life changes, get sick again, and then feel more vulnerable – physically, emotionally, and financially – than before. (Rose, 1998, p.3)

The pre-test counselling conversation is currently dominated by the voice of the counsellor and the need to utilise this opportunity to educate the individual about HIV/AIDS and to change sexual behaviour. The goal of client-centred pre-test counselling, according to CAPS (1995), is to facilitate the development and enactment of a risk reduction plan applicable to each individual.

The aim of client-centred HIV/AIDS counselling

The individualised risk reduction plan is said to help the client cope with the emotional reactions to HIV counselling and testing, as well as with the interpersonal and familial consequences of HIV counselling and testing (CAPS, 1995). Following the counselling intervention, individuals are expected to have increased their accurate knowledge about HIV/AIDS, to have accurately assessed their risk for HIV and to have

an individualised risk reduction plan. One goal of the counselling intervention is behaviour change; participants are counselled with the aim of reducing risk behaviour. In order to work towards this goal, clients are also expected to increase their belief in their ability to change their HIV-related sexual behaviour risk and to gain or improve behavioural skills associated with risk reduction (for example, condom skills and negotiation skills). The counselling intervention is also expected to help the participant to cope with the emotional, interpersonal and other consequences of engaging in HIV counselling and especially with learning their HIV serostatus.

To conduct effective HIV counselling, it is important for counsellors to understand and to practise the difference between giving advice and giving information. In the case of HIV counselling, giving advice is not helpful (CAPS, 1995), because of the sensitive nature of the behaviours involved and the possibility that clients and counsellors most probably do not share the same values about these behaviours. Once the client perceives that the counsellor is judging his or her behaviour, he or she may be reluctant to disclose anything further. The opportunity to help the client to reduce risk is consequently reduced (CAPS, 1995).

Conducting an individualised risk assessment

CAPS (1995) discusses client-centred HIV counselling in terms of the development of a personalised risk reduction plan for each client. In order to create this plan, the client's individual risk situation must be assessed. This risk assessment includes gathering information about the participant's sexual and other risk behaviour, as well as his or her emotional, interpersonal, social and resource situation. The counsellor may initiate the assessment by asking the client what he or she knows about the ways in which HIV can be transmitted. The client's readiness to change risk behaviour and perceived self-efficacy (ability) to change risk behaviour should be assessed. Gasa (2001, p. 27) states that a change in risk behaviour is the most effective approach to controlling the HIV epidemic.

After the risk assessment is completed, the counsellor should ask the participant to propose some ideas about how to reduce his or her own risk of exposure to HIV (CAPS, 1995). At this point CAPS (1995) suggests that counsellors initiate the discussion of risk reduction by listing and considering alternative risk-reduction strategies indicated by the client. For each risk-reducing behaviour, the counsellor should assess internal and external barriers to change, the client's perceived efficacy in enacting the new behaviour, readiness to change and the availability of resources to change. In supporting the client's enactment of the personalised risk reduction plan, the counsellor acknowledges and supports the client's strengths, such as social support, self-efficacy and previous success in changing behaviour. Counsellors might also offer solutions in areas of concern or assist with expected difficulties in enacting the plan.

Finally, the counsellor elicits a commitment from the client to make specific behaviour changes before the next counselling session. CAPS (1995) warns that the risk reduction plan should be challenging, but not so difficult that the client will fail to complete it or become frustrated. It can be useful to provide several goals, according to CAPS (1995) – some that are easy and some that are more difficult to attain. It might be useful to break the new behaviour up into steps and encourage the client to change his or her behaviour one step at a time. CAPS (1995) suggests that if the client can read and is not concerned about the privacy of this information, the risk reduction plan may be written up and given to the participant to take home.

Developing a personal risk reduction plan places the focus on the client and gives the client a voice, encouraging him or her to believe that he or she has the ability to keep free from infection and to refrain from infecting others. The client's needs and ability to live with a possible HIV-positive diagnosis and protecting the individual against infection is the focus in this approach. The approach used by CAPS (1995) is supported by the argument in this study that the client's needs should be the focus in pre-test counselling conversations.

Client-centred pre-test counselling conversations

The counsellor should engage the client in pre-test counselling by first asking the client what he or she knows about the antibody test and by asking the client about any previous testing experiences (CAPS, 1995). The counsellor should provide information about the test as needed and correct any misconceptions about testing and test results. The meaning of an HIV-negative test result and an HIV-positive test result should be explicitly stated (including an explanation of the “window period”). Clients should be asked to make a specific plan of action in the case of a negative test result and in the case of a positive test result. This should include what they are planning to do while waiting for the test result and whom they are planning to share the test result with. The interpersonal implications of an HIV-negative or an HIV-positive test result for clients should also be discussed at this time, including whether the participant is aware of his or her partner's serostatus.

When scheduling the post-test counselling appointment, the counsellor should negotiate a specific plan for the participant to return for test results, and solicit a personal commitment from the client to return. According to CDC (n.d.b), effective counselling requires a client-centred approach and should include risk reduction planning and skill-building as part of the strategy. The CDC (n.d.b) approach is supportive of CAPS's (1995) client-centred counselling approach. Ideally, a client-centred approach should involve several sessions, which is often not the case in South Africa. Multiple sessions would require the training of more counsellors to cope with the work volume, and the adoption of a client-centred approach might require some retraining of existing counsellors. Those who fund HIV/AIDS counselling should be encourage to support more client-centred pre-test counselling.

Overview

In this chapter an alternative way of thinking about pre-test counselling conversations has been presented. The CAPS (1995) client-centred approach to HIV/AIDS and specific reference to the pre-test counselling conversation has been discussed here. This approach acknowledges the importance of education on HIV/AIDS, but places more emphasis on the belief of the client that he or she has the ability to make informed choices about living a longer and healthier life by introducing the opportunity to each individual to compile a personalised risk reduction plan. This strategy, I believe, is in line with Powers's (2003) belief that people can only empower themselves. To acknowledge that you and your partner(s) are at risk and that you have a plan to keep yourself and others free from HIV infection safe sounds liberating. This approach focuses on what the individual **can** do to keep safe and not on only what he or she **should** do.

CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

Rethinking HIV/AIDS pre-test counselling in South Africa aims to create an understanding of the role of the counsellor and the client in the pre-test counselling conversation in this country. In this chapter, some recommendations are made. The chapter includes a summary and some concluding arguments.

Summary of the argument

The study sought to understand the role of counselling in the prevention of HIV infection in South Africa. It shows that counselling is regarded as instrumental in the infection preventative strategy and that South Africa therefore predominantly focuses on counselling before (or after) testing for a client's HIV-status. Pre-test counselling has been identified as the most important opportunity to educate and teach the infected and affected about HIV/AIDS infection, risk reduction and safer sexual practices. However, surveys regarding the growing rate of infection as well as non-compliance regarding condom usage raise questions about the effectiveness of pre-test counselling in South Africa. The individual has been acknowledged as instrumental in the fight against growing HIV infection.

I am interested in this study in the pre-test counselling conversation, as documented in literature on HIV/AIDS in this country. The roles of the counsellor and the client in pre-test counselling conversations, as documented in selected policy-governing and training literature on HIV/AIDS, were therefore identified as the focus in the study. The study was approached qualitatively, from a social constructionist perspective, and document analysis was used as the primary research method.

The analysis of the data confirms the role of the counsellor to be that of an educator on HIV/AIDS infection. This educational role of the counsellor has been highlighted in the study and several assumptions about the power relationship between counsellor and client have been exposed. The role of the client seems less defined, and the documents emphasise the assumption that the client is seen as needing education on HIV/AIDS infection to make informed decisions about being tested and living a longer healthier life, whether the diagnosis is that the client is HIV-negative or HIV-positive.

Recommendations

This study argues that shared knowledge about HIV/AIDS infection and the ability to live longer and healthier lives should be created between the counsellor and the individual. If the counsellor enters this relationship with a pre-set agenda or with involved assumptions about the reactions of a particular individual to an HIV-positive or -negative test result, the client may be bereft of an opportunity to communicate his or her needs. The belief that health education is necessarily empowering is challenged in this study and an alternative approach to HIV counselling and, more specifically, pre-test counselling in terms of the CAPS (1995) client-centred, personalised risk reduction plan is suggested.

In this client-centred approach, the belief that the individual can live longer and more healthily and is able to live risk-free forms the emphasis of the discussion. Creating a reality where the client and counsellor construct a plan to live longer and healthier, and where both believe that the client has the ability to reduce the risk of HIV infection for the client and his or her partner(s) becomes the focus. This study argues for a more client-centred, ability-based pre-test counselling conversation between counsellors and clients than is not the norm in South Africa at present. It proposes that the voice of the client be heard more clearly in this conversation.

Concluding remarks

Postmodernists focus on changing people's ways of thinking rather than on calling for action (Creswell, 1998; Pauw, 1999). I would like to conclude with this statement, and emphasise that it is not the intention of this study to criticise any of the work that has been done for people living with HIV/AIDS or the drive to educate people about this disease. However, this study offers an alternative way of thinking about the approach towards HIV/AIDS infection and the pre-test counselling scenario in South Africa.

Reflecting on this research experience, I have become increasingly aware of my own discomfort with the growing rate of infection and the fact that counselling, even though it has been identified as strategic in the prevention strategy, does not seem to make a real difference. The need to make sense of this realisation has driven me to explore pre-test counselling conversations as documented in selected literature on HIV/AIDS.

The selected documents focus on the role of counsellors in health education, based on the assumption that information about HIV/AIDS infection enables clients to make informed decisions about their health. This study offers an alternative approach to health education in the form of client-centred pre-test counselling, an alternative that might be successful in curbing the growing rate of HIV infection in the country, because of its focus on the instrumental role of individuals in achieve success for themselves and their sexual partners.

The drive to educate is based on the assumption that health education empowers (Powers 1993). Similarly, the drive towards empowerment by offering a more client-centred approach – where the client is said to have the ability to facilitate his or her own personal risk reduction plan during pre-test counselling conversations – is also an assumption. However, I believe that this view has been contextualised in this study as an

alternative way of thinking about pre-test counselling conversations. Rose (1998) appeals to people living with HIV to reclaim their lives. We as counsellors should be careful to not facilitate our own discomfort in counselling people who may be diagnosed as either HIV-positive or -negative and we should take special care not to obstruct and limit what might be the clients' growth experience.

I began this study with an African proverb (Van Dyk, 2001a) – “*The best time to plant a tree is twenty years ago... the next best time is now*”. I would also like to conclude with this quote: Let us start planting now, because it is the next best time.

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