# THE DEVELOPMENT OF AN HIV/AIDS COUNSELLING APPROACH FOR AFRICANS

A THESIS SUBMITTED TO THE

FACULTY OF
COMMUNITY AND DEVELOPMENT
DISCIPLINES

SCHOOL OF NURSING
UNIVERSITY OF KWAZULU-NATAL

IN FULLFILMENT OF THE REQUIMENTS
FOR
THE DEGREE

DOCTOR PHILOSOPHY:
PhD

BY
ABEL JACOBUS PIENAAR

Supervisor:
Prof L R UYS
December 2004

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SUPERVISOR:
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# This work is dedicated to:

**My primary family and my extended family.**

A special recognition to my wife and daughter, Pettula and Abigail for the constant support and sacrifices they made to encourage and carry me through this journey. My parents, my mother Dipolelo and my late father, Gert, who stood the test of time in my upbringing

The participants who made this research possible, I applause you. Warm, humble people from which I learned so much in HIV/AIDS counselling. You have indeed added value to my life!

God and my Ancestors who sustain me through my journey of life.

## *Words of Encouragement*

*In every community there is work to be done.*
*In every nation, there are wounds to heal.*
*In every heart there is the power to do it!*

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# DECLARATION

I **Abel Jacobus Pienaar** declare that this thesis titled:

*"The development of an HIV/AIDS counselling approach for Africans"* is my original work, except for referenced citations in the text.

It has never been submitted for any other purpose, or at any other university.

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Signature

...10. 04 · 2005..............
Date

# ABSTRACT

HIV/AIDS care needs to be comprehensive and holistic (UNAIDS, 2002). Counselling has proved to be one of the most effective behavioral tools in the global anti-HIV/AIDS fight by equipping people mentally, emotionally, psychologically and socially for the disease (Anon, 2000). Over the past two decades researchers identified cultural factors, race, gender and class as leading inequitable treatments in general counselling situations (Coleman, 1995). This challenge happened to be the same in HIV/AIDS counselling, especially because the counselor work with sensitive information.

Nurses who forms the back-bone of HIV/AIDS counselling, are all trained on a Western model of HIV/AIDS counselling. Herbst (1990) also pointed out that knowledge concerning cultures and subcultures and its implications has become a major issue for the nurse to deliver health care in South Africa. Faced with the history of South Africa and the diverse cultures it was my personal experience as a professional nurse, counselor and researcher while I was working on the *Life health train, that the knowledge of culture is one of the most important factors of HIV/AIDS counselling. This motivated me to embark on this research.

This research aims at providing an analytical description of the experience of counselling for African (Batswana) counselees and their counselors with specific reference to HIV/AIDS counselling with view to improve this interaction. The objectives of this research was to:

a)      analyse the counselling done by Western and African counsellors in the health system, with a particular focus on HIV/AIDS counselling,

b)      establish how acceptance and decision-making is promoted, understanding of the counselee is established and psychosocial support is given, and

c)      develop a middle –range theory that describes appropriate HIV/AIDS counselling for African counselees.

Glaser's (1965; 1967; 1992) grounded theory approach was used to guide this research. Multiple data collection methods were used, which took place concurrently with the descriptive analysis. Glaser's conceptual analysis paradigm for qualitative data analysis was utilised. Based on the results of this research the importance of an HIV/AIDS counselling approach for Africans is emphasised.

# LIST OF ACRONYMS AND SETSWANA CONCEPTS

## ACRONYMS

*HIV/ AIDS:* human immunodeficiency virus/ acquired immune deficiency syndrome

*PLHA:* People living with HIV and/or AIDS

*LAC:* Local AIDS Council

*PCA:* Provincial Council on AIDS

*NGO:* Non-Governmental Organisation

*VCT:* Voluntary counselling and testing

*UNAIDS:* United Nations Programme on HIV/AIDS

*WHO:* World Health Organisation

*\*:* (asterisk) used when a pseudo-name is used

## SETSWANA CONCEPTS

*Lekgotla:*     A meeting that Batswana (Africans) have to discuss and/or resolve problems in their community

*Pitsa:*     A herbal mixture prepared in a pot by a traditional healer

*Ditlhare:*     Herbal mediction used by the traditional healer to treat patients

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# INTRODUCTION

## 1.1    BACKGROUND OF THE RESEARCH

The HIV/AIDS pandemic continues unabated all over the world and there is still no cure (Umezulike & Efetie, 2002). HIV/AIDS thus remains a serious, incurable disease confronting individuals, families and communities (Shapiro & Vives, 1999). It has become a common in-patient diagnosis in some parts of the world (Crampin & Damisoni, 2001).

There is an urgency about dealing with the disease that is driven by the rapid spread of the HIV/AIDS pandemic through the world since it first appeared in 1981 (Rogers, 2000). Rao and Svenkerud (1998) agree that the spread of HIV/AIDS has accelerated in the last fifteen years. The spread of HIV/AIDS is so fast that it has become an extremely costly exercise for health services to deal with its fallout (WHO 2001). Though it is the third decade of the HIV/AIDS pandemic the impact is only becoming obvious now (UNAIDS, 2001). HIV/AIDS is indeed a leading public health problem world wide according to Svenkerud and Singhal (1998).

Bennet & Erin (2001) have stated that the HIV/AIDS pandemic also presents novel philosophical challenges that invite serious debates rather than the moralistic approach which society tends to take. According to these authors, society has recognized that HIV/AIDS has become a disaster globally and cannot be viewed as just 'another epidemic', because of the intimate and private nature of transmission routes, which is embedded in the individual's lifestyle (Bennet & Erin, 2001).

It is a general realization that Sub-Saharan Africa is the most badly affected region in the world in terms of the burden of HIV infections (Kilewo et al., 2001). Painter (2001) says that nearly 70% of people in the world diagnosed with HIV/AIDS live in Sub-

Saharan Africa. On top of these figures Rogers (2000) pointed out that 90% of the new cases of HIV/AIDS occur in Latin America, the Caribbean, Asia and Sub-Saharan Africa. It is known that AIDS has killed more than 19 million people, and is responsible for more than half of the deaths in Sub-Saharan Africa, which is more than the combined number of people killed in both World Wars (Anon, 2000).

In South Africa, which is part of Sub-Saharan Africa, the HIV/AIDS epidemic was initially silent, but it has recently become a visible and highly politicized issue (Abdool-Karim & Abdool-Karim, 2000). These authors further stated that the HIV/AIDS rate rose more that 21-fold from 1990 to 1997 in South Africa (Abdool-Karim & Abdool-Karim, 2000). HIV/AIDS has become a humanitarian crisis in Southern Africa, putting HIV/AIDS care on central stage in especially South Africa (UNAIDS, 2002).

Mersing and Sibindi (2000) found that the majority of PLHA had factual knowledge about HIV/AIDS, but that there was a lack of in-depth understanding and conceptualization of HIV/AIDS, which has negative consequences for the management of their problems. These authors also stated that newly HIV-diagnosed persons had a number of not only factual but also social and emotional needs that should be addressed.

The mental health issues facing people infected and affected by HIV/AIDS results in a demand for counsellors to intervene in the lives of people infected and affected by HIV/AIDS (Britton *et al.,* 1999). The HIV/AIDS pandemic has brought profound emotional, social and behavioural consequences leading to a demand for counselling world-wide (Fawcett, 2001). Bennet and Erin (2001) emphasise that counselling has become important because psychological issues dominate the management of HIV/AIDS from the time of prevention, to testing, disease management and care interventions. Folkman (1997) also pointed out that the process of care in HIV/AIDS-related care-giving is intensely emotional and loaded with psychological distress.

Counselling has proved to be one of the most effective behaviour-changing tools in the global anti-HIV/AIDS fight by equipping people mentally, emotionally, psychologically and socially for the disease (Anon, 2000). This leads to risk reduction

and future planning to fight the HIV/AIDS pandemic (Anon, 2000). One of the major benefits of HIV-testing is the opportunity for individual counselling to promote behaviour changes and facilitate the referral for HIV-infected individuals to the health facilities (Kipp *et al.*, 2001).

Various studies suggest that good counselling assists people in making informed decisions and coping better with their HIV/AIDS condition as well as decreasing transmission of the disease (UNAIDS, 2002). Otniano and Shahyahan (1999) found HIV-transmission is prevented as optimal care of PLHA has been initiated through counselling and testing. Post-test counselling also increases health-care seeking behaviour, according to Eichler *et al.* (2002) and Painter (2001), who found that voluntary counselling and testing decrease risk behaviour. These authors are backed by Discenza & Nies (1996) who stated that counselling promotes, reinforces and maintains behaviour change in PLHA (people living with HIV/AIDS) and helps prevent the further spread of the disease. According to Foster *et al.* (1997) 89% of patients who received voluntary counselling and testing return to health services for care.

## 1.2     PROBLEM STATEMENT

In spite of these advantages of counselling, there are several stumbling blocks to the actual delivery of counselling services. One of these stumbling blocks is the fact that many countries do not consider HIV/AIDS counselling to be a crucial part of treatment (UNAIDS, 2002). It is also clear that voluntary counselling and testing are low priorities in some countries due to the high cost of delivering the service at a level that could make a difference (Anon, 2000). This leads to severely limited voluntary counselling and testing in developing countries like South Africa (Anon, 2000). According to Van Dyk (2001b) there are very few people who have access to trained counsellors in the sub-Saharan region.

Crampin *et al.* (2001) also state that health care workers are not adequately equipped with counselling skills and this causes a lack of empathy with PLHA. A lack

of counselling skills also leads to people who have been tested for HIV not having adequate information and support to make informed decisions (Joo *et al.,* 2000).

Airhihenbuwa and Obregon (2000) state that communication strategies of HIV/AIDS education are questionable in countries like Africa, Asia, the Caribbean as well as Latin America because of their unique cultures. Over the past two decades researchers have identified cultural factors as well as race, gender or class as leading to inequitable treatment in general counselling situations (Coleman, 1995). According to Suominen & Kovasin (1997) culture is closely interwoven with values held by a person, which is why culture is expressed in people's, beliefs, convictions and laws. Van Niekerk & Prins (2001) state that culture creates meaning during counselling, which makes culture one of the most powerful determinants of psychological sets (Tubbs & Moss, 1991). Palmer and Laungani (1999) point out that people are more culture-bound than they might realize.

The role of cultural context is often omitted in HIV/AIDS counselling even when we are aware that culture is the central feature of health behaviour. Otniano & Shahyahan (1999) say that the lack of cultural acknowledgement could lead to many members of racial and ethnic minority groups not knowing about or having access to or mistrusting services for HIV/AIDS care. Therefore culture needs to be recognised as a critical aspect of HIV/AIDS prevention (Airhihenbuwa & Obregon, 2000).

Despite of the above-mentioned shortcomings, UNAIDS and WHO still promote voluntary counselling and testing and view it as an entry point to HIV/AIDS care (UNAIDS, 2001). Several voluntary counselling and testing (VCT) sites opened in Sub-Saharan Africa and during the year 2000 the national department of health formally adopted a programme for voluntary counselling and testing to combat HIV/AIDS in South Africa (Ceaser, 2001). Nurses and midwives are in a position to provide counselling, but there is always the fear among them that they do not know enough to do this well (UNAIDS, 2002). According to Poss (1999) nurses must be able to provide care for people in various cultural societies. This leads to the tremendous burden of HIV/AIDS care in Africa on the nursing profession (Van Dyk, 2001b).

Faced with this history of South Africa and its diverse cultures, knowledge of culure is one of the most important factors of HIV/AIDS counselling. One experience that led me to this conclusion is described here.

An African female patient entered the consulting room. Being an experienced nurse and working the last four years in counselling and research in the HIV/AIDS field, I realized during the interview and assessment that this patient was probably HIV-positive and needed to be referred for appropriate health care.

We did not have a language in common, but there was an interpreter, also a male, present. When I moved to more sensitive questions, for example, sexual questions, the interpreter refused to ask the patient the questions, stating to me that it was disrespectful to ask such questions. The interpreter also stated that it was not allowed for me to do a medical examination on the woman, because it was against cultural rules. I asked then whether I could ask written permission from the woman, but the interpreter stated that only the chief of the clan could grant permission or ask the woman the sensitive questions.

The chief was called and the woman answered the questions through the chief and the chief also granted permission for the medical examination. My hypothesis was clinically confirmed and as a counsellor I wanted to make use of the opportunity to counsel the woman. The chief who was interpreting for me informed me that the woman had gone through "white treatment" (western treatment), but she did not know anything about HIV/AIDS except that it kills. When exploring the knowledge and understanding of the patient, she did not seem to have any knowledge or understanding of HIV/AIDS, though she had been through the "Western treatment".

This scenario filled me with questions and it also proved to me that culture plays a major role in HIV/AIDS care. I realized as a counsellor that the messages and strategies of Western models in HIV/AIDS counselling does not reach most of the marginalised, ethnic African minorities in South Africa, due to their different customs in their culture. Questions that were raised in me included: Is the Western framework of HIV/AIDS counselling we employ routinely an appropriate approach for Africans? What are the good and bad factors in this HIV/AIDS counselling approach from the

experience of Africans? Did we explore the needs and strengths of Africans before rolling out HIV/AIDS counselling services in South Africa?

Though voluntary counselling and testing had been adopted as a major policy strategy in managing HIV/AIDS in South Africa, we are thus faced with a number of challenges. Jonker and Cronjé (2000) state that South Africa is known for its history of racial segregation, isolation and subjugation. Behrens (1990) supports these authors by saying that culture-related communication is complex due to the influence of ethnocentrism and stereotyping. The author also states that due to the previous political constitution, South Africa is deeply segmented and complexly pluralised. This leads to poor racial and social interaction between especially African and Western cultures (Behrens, 1990). Steyn (1993) feels that although apartheid failed in other aspects, it succeeded in keeping different cultures from appreciating and understanding each other's cultures.

Another challenge is that when we provide HIV/AIDS counselling the counsellor focuses on very sensitive aspects for example, sexuality. Africans have a number of taboos and many Western people do not understand African philosophy around sexuality. For instance sexual intercourse have been viewed as the "gift of self" and this causes resistance in condom use (Van Dyk, 2001b; Schapera, 1953). These authors also state that Africans have cultural reasons for not adhering to measures preventing HIV/AIDS and professionals should find ways to work with or around the cultural reasons. Van Dyk (2001c) stresses that many Western-based AIDS education and prevention programmes have failed dismally in Africa and they may only succeed if traditional African beliefs and customs are taken into account. She therefore calls for nurses to look beyond the Western-based biomedical models and to strive to understand the traditional African world-view in HIV/AIDS care (Van Dyk, 2001b). In this research project I focus on one of the facets of care, which is counselling.

Nurses in South Africa are trained according to the Western model of counselling and also practise counselling accordingly (Van Dyk, 2001b). Because the nurse is trained according to a Western model of counselling which differs from a classical African

therapeutic interaction, a problem arises when it comes to bridging the gap between the African counselee and the Western nurse counsellor in terms of providing a HIV/AIDS counselling service which is appropriate and acceptable.

## 1.3    AIM, OBJECTIVES AND CENTRAL THEORETICAL ARGUMENT OF THE RESEARCH

This research aims to provide an analytical description of the lived-experience of counselling for African counselees and their counsellors with specific reference to HIV/AIDS counselling, with a view to improve this interaction.

The objectives of the research were to:

a)    analyse the counselling done by Western and African counsellors in the health system, with a particular focus on HIV/AIDS counselling,

b)    establish how acceptance and decision-making is promoted, under-standing of the counselee is established and psychosocial support is given, and

c)    develop a middle-range theory that describes appropriate HIV/AIDS counselling for African counselees

The central theoretical argument of this research is that the description and analysis of counselling and HIV/AIDS counselling experiences of urban and non-urban African counselees and their counsellors, who use Western or African therapeutic techniques, will lead to a theoretical framework for HIV/AIDS counselling for Africans, which may improve service delivery.

## 1.4 DEFINITION OF TERMINOLOGY

- *Culture*

The researcher agrees with the definition of Roper and Shapira (2000) who say that there are two main conceptualizations of culture. The first one is behavioural/-materialistic, where culture is seen as the patterns of behaviour and customs of a group that they produce in order to live their own way of life. Secondly, there is a cognitive approach where culture is seen as ideas, beliefs and knowledge used by a group of people as they live their lives. Culture is further seen as a catalogue of characteristics, elements or products, either created by human endeavour or it flow from human existence. The characteristics are normative (values and norms), affective (sentiments and loyalties), cognitive (knowledge, worldview, myths and beliefs), aesthetic (beautiful and pleasing) and behavioural (customs, practices and rites) (Jonker & Cronjé, 2000).

- *Africans* The worse definition of `Africans´ ever. Should have not been published. It's bias.

A group of people belonging to a dark-skinned race that originated in the continent Africa, previously known as "Bantu people", "natives" or "non-whites/non-Europeans" in South Africa (Harber & Payton, 1987 ; Tulloch, 1993). Africans are the indigenous people (first nations) of Africa. Van Dyk (2001c) further states that although Africans cultures differ in place and language, there is a general socio-religious philosophy shared by all Africans. Though the researcher focuses on Batswanas, the title of the thesis remains African, because of a shared socio-religious and philosophical beliefs of Africans.

In this research we focus on a specific African group, the Batswana of the North West Province.

- *Counselling Interaction*

According to Wallace and Lewis (1998) counselling is intended to facilitate development in a person by taking into account the psychosocial and physical environment to create a dynamic fit between the person and his/her environment. These authors also state that the mentioned psycho-dynamic approach is self-regulating in the sense that the counselee experiences a fuller awareness in order to be facilitated to healthier patterns of behaviour to grow and understand his/her problems so that s/he can make decisions.

- **Western counselling techniques**

A technique is a way of doing something, in this case counselling, usually involving a skill or skills.

Western counselling styles that are based on scientific knowledge and the therapeutic techniques are accepted and utilized by Western-trained people. Professional counsellors as well as lay counsellors utilise these therapeutic techniques (Van Dyk, 2001a).

- **African counselling techniques**

African counselling techniques are not necessarily based on scientific knowledge but are transmitted from one generation of traditional healers to another and are accepted and utilized by a specific group of people. The focus of this research is on Africans in South Africa and the counsellors are normally traditional- and faith healers (Pinkoane, 2001). These therapeutic techniques focus on purification rites; like bathing, traditional enema and forgiveness and purification rituals. The techniques also include supra-normal activities like intuitive body work, therapeutic touch, guided imagery, spiritual support and herbal (homeopathic) remedies (Engebretson *in* Kenny, 2002).

- ***Professional counsellors***

Counsellors who adhere to the criteria for professionalism, by normally having a three-year tertiary qualification and specialization in their training in a counselling facet for example, nursing, psychology and social work. These counsellors have a broad scientific framework of counselling, and are usually registered with a regulatory body.

- ***Lay counsellors***

Counsellors that do not have a formal qualification in counselling, but have a limited counselling training. They normally work under the supervision of professional counsellors and are usually not registered with a regulatory body.

## 1.5   SIGNIFICANCE OF THE RESEARCH

The significance of the research is linked to two aspects: firstly the importance of providing effective HIV/AIDS counselling in the South African (African) context and secondly the importance of striving towards providing culturally competent care in a culturally diverse context.

With regard to the importance of effective HIV/AIDS counselling, much has already been said in the background to the problem and the problem statement. It is difficult to see how an effective programme can be developed without basic research into the current situation. It is my personal experience that most authors and researchers have described approaches for HIV/AIDS counselling from a Western perspective, derived to fit an African context without any empirical work or with empirical work done from Western-bias.

In order to provide an analytic description of the current situation, which is the first step in the emerging of a theory as described by Hammersley (1992), the researcher will explore and describe the experiences of different comparison groups in the theoretical samples, for example, both urban and non-urban African counselees and

both African and Western counsellors. The counselling techniques used in Western and African counselling interactions, and the therapeutic processes used by professional and lay counsellors will be considered.  The description will present what is happening and how it is happening. The richness in diversity, comparisons as well as the identification of generic features will be highlighted (Hammersley, 1992). This will allow a descriptive theory to emerge which could lead to interaction planning and further research.

The second important aspect is the striving towards the provision of culturally competent care in a traditionally divided country. Hugo-Burrows (1998) stated that South Africans have lived in a community where separation of communities and racial groups has been the norm which influenced cultural behavioural patterns socially. Van Niekerk & Prins (2001) describes the health care situation in South Africa as Western dominant, hospital-centred care with often racially differentiated structures. He contrasts this situation with the traditional African culture that focuses more on humanity (ubuntu) and the community in their care (Haegart, 2000). Though the South African health system is trying to adopt a more community-based, people-orientated health-care system, it is often not yet observable and evident in practice.

Peltzer and Khoza (2002) said that even though 'traditional' and western health-care has operated side-by-side in South Africa since the advent of the Europeans, western healing has enjoyed greater formal acceptance by successive governments because it was seen as scientifically rational. Freeman and Motsei (1992) add that 'traditional' healing has been marginalised. The current government is making some efforts to change this situation.

Van Dyk (2001a) points out several differences in Western and African counselling in stating that African counselling is more symbolic and intuitive, while Western counselling is based on scientific and logical principals; African counsellors have a holistic approach, while Western counsellors focus more on the psychological side of counselling; African counsellors use divination, dream interpretation, rituals, music and dance, while Western counsellors focus on abstract logical reasoning. It is therefore clear that we have two systems that are very different in the process of counselling interactions.

It is very clear that knowledge concerning cultures and subcultures and its impli-cations for health care has become a major issue for nurses delivering health care in South Africa (Herbst, 1990). Therefore the main reason why I have chosen to embark on this research is to contribute to the development of a more culturally inclusive and culturally appropriate health service in South Africa.

# THE RESEARCH SETTING

## 2.1    INTRODUCTION

In the previous chapter the researcher introduced the research. This chapter focuses on the setting of the research. The setting refers to both the current and the traditional ethnography of the Batswanas, because the influence of both the western and  traditional (African) health systems.

## 2.2    CURRENT ETHNOGRAPHY

The current ethnography refers to the context where the Batswana are situated currently in South Africa.
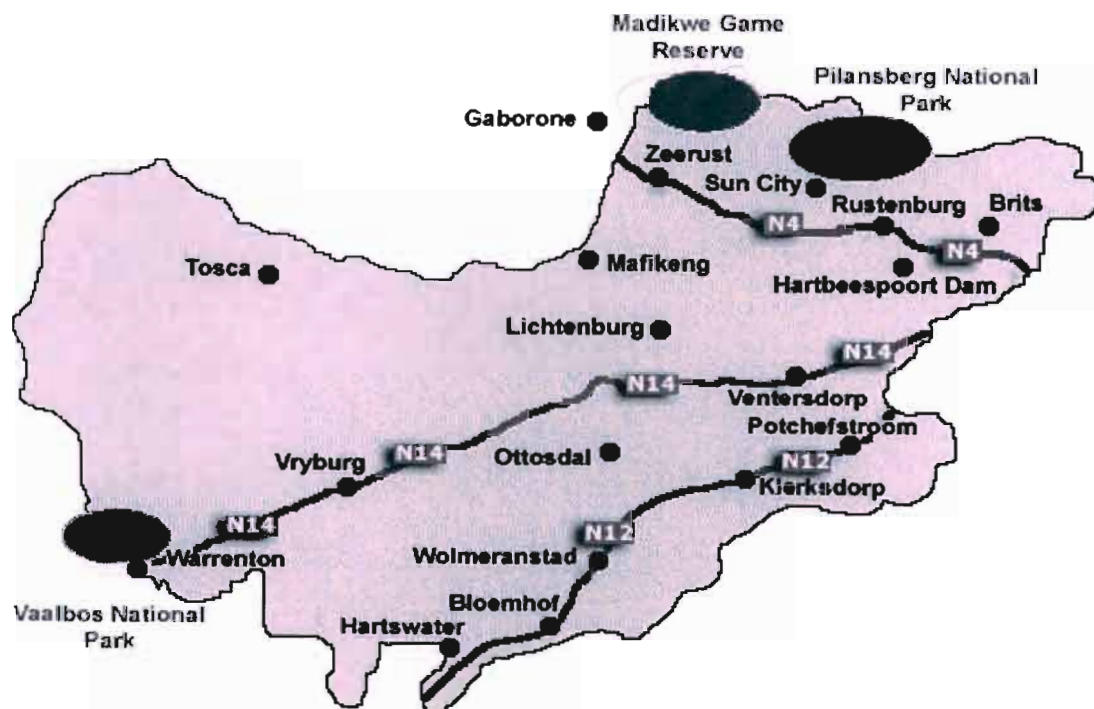


**NORTH-WEST PROVINCE, SOUTH AFRICA**

South Africa is divided into nine provinces and the research took place in the North West Province. In the North West Province 34,8 % of the population are urban and 65,2 % of the population are rural or non-urban (Department of Health, 1998).

The North West Province is further divided into four health regions, the Southern, Mafikeng, Bojanala and the Bophirima regions. The regions are divided into different health districts. Health Services consist of four provincial hospitals, two psychiatric hospitals, fourteen district hospitals, thirteen community hospitals, 330 clinics and health centres and about 100 mobile clinics (Department of Health, North West Province, 2003).

In the North West Province there is a Provincial Council on Aids (PCA), which is divided into the four health districts which are further divided into eighteen Local Aids Councils (LAC). The Provincial Council on AIDS constitutes the provincial body that governs HIV/AIDS care in the province and the Local Aids councils coordinate HIV/ AIDS care in the province (Provincial Council on AIDS Act, 2002).

The HIV prevalence of the North West Province is 22,9 %. According to the four regions the prevalence is as follows: Southern 28,4%; Mafikeng 24,4%; Bojanala 22,5% and Bophirima 17,1% (Department of Health of the North West Province, 2003).

The research took place in the Southern and Bojanala regions, which are urban and non-urban/rural populations respectively. The Local AIDS Councils' staff members served as mediators, because the different services that render HIV/AIDS care are being coordinated by these councils. Two Local AIDS Councils were selected for the context of the research (the city and rural councils).

The Rural Local Aids Council serves a non-urban population of about 208 000 people and is situated in the Bojanala district. The City Local Aids Council serves an urban population of about 1657000 people (LAC, 2003).

## 2.3    TRADITIONAL ETHNOGRAPHY

Traditional ethnography refers to the origin and lifestyle of the traditional Batswana.

### The Batswana people

This descrption is based on the ethnographic work Schapera (1953 & 1977) did among the Batswana community of South Africa.

- *Origin and location*

The Batswana people are one of the three major groups into which ethnologists classify the Basotho group of the African community in South Africa. There are three Basotho groups, viz. the Southern-Sotho group, living in the Free State Province, the Northern–Sotho group, spread over in Mpumalanga and the Limpopo Province and the Western-Sotho group found in the North West and Northern Cape Province. Little is known about the origin of the Basotho people except that they originated from East-Africa and were already in South Africa during the 1600s.

- *Domestic differentiation*

Batswana are divided into two sub-groups, the Western-Tswanas situated mostly in the North West Province of South Africa and the Eastern-Tswanas mostly situated in the Northern Cape.  Each clan has its own chief.

The clans are divided into different sections, with their own headmen or leaders. These sections are further divided into wards that consist of different family groups and these family groups are divided into smaller households, in which extended families live.

Batswana live in large compact settlements called villages. The chief resides in the middle. Every household has a kraal with several huts and family groupings live next to each other and form a ward. Different family groupings form a section and different sections form a cluster or a tribe.
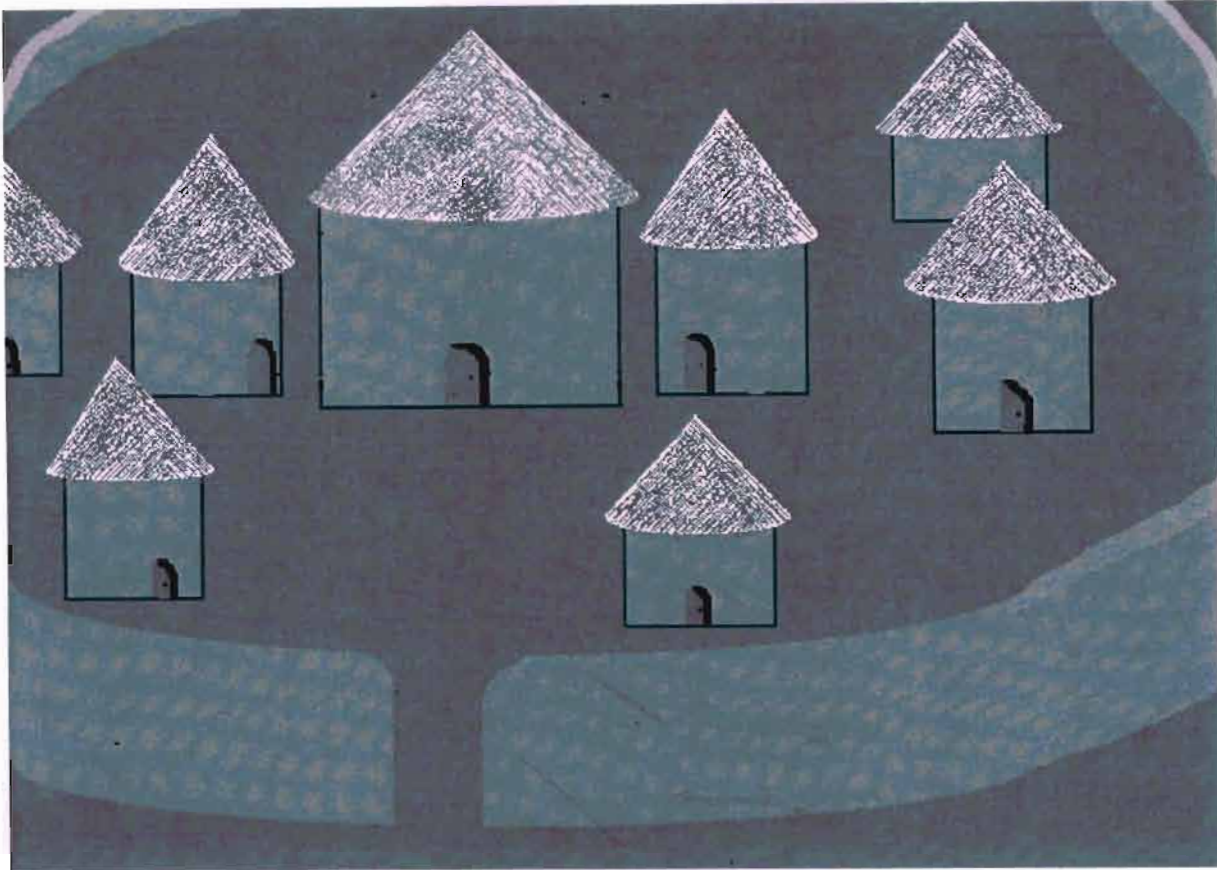
- *Social class differentiation*

Batswana people do not have rigid social classes or rankings, because "commoners" can be promoted to be headmen such positions are normally associated with commitment and hard work in the tribe.

The chief is the head of the tribe and this position is usually filled by a man, but there have been women in these position in particular situations. The chieftainship is a lifelong position and the chief 's successor is normally his eldest son.

- *Customs and beliefs*

*Lekgotla*

Though the chief is the head of the tribe, he does not have autocratic decision-making power. If there is a new law or policy in the tribe, the chief will consult with the men of the council. The first consultation is confidential and private. It used to take

place by night, but currently it also happens during the day. The men of the council (*kgotla*) discusses the matter and comes to a conclusion or decision.

The next step is then to discuss it with all the headmen and the members of the community. This meeting is open. The chief shares the matter and opens it up for discussion. He does not divulge the decision made in the confidential meeting. After debate and discussion, he makes a decision. The members of the *lekgotla* can differ from him and the final decision is only taken when everyone agrees on the decision.

## Religion

The Batswana people believe in God (Modimo), but their belief system is that the God that is unknown is their creator. God is unknown to them, which is why they have to pray to the unknown God through their mediators, the ancestors. They thus believe in their ancestors, their forefathers.

## Practices

They also believe in traditional and spiritual healers. The traditional healers normally use medication called *dihlare* which means trees. This is medication from plants. He/she also uses animal fat and it is usually burned to obtain good fortune. He/she also uses divination, that is, the use of bones to see into the past, present or future of the client.

The spiritual healers usually do not use medication, but depend on spiritual powers to heal. These spiritual powers are embedded in the religious beliefs, for example, they make contact with the ancestors through different rituals (e.g.slaughtering of a goat) and then sustain the good fortune of the family through these rituals.

Certain events, such as ringing of the ears or dreams, are very important for the Batswana people and they are interpreted by the traditional or spiritual healers.

Sorcery is also part of the belief systems. The Batswana people believe that people (witches) harm them through using bad powers and medicine.

- *External influences*

Through labour and migration the Batswana people have moved to different areas and therefore the culture is continually influenced by other African or the Western cultures. As mentioned previously in the research, culture is dynamic and it can be refined. The description above is of a typical Tswana culture, but as no culture lives in isolation so that it can assume different shapes at this stage.

## 2.4    CONCLUSION

In the South African context Batswana usually make use of certain traditional rituals, even if they live in a western dominant community. There seems to be no 'pure' westernisation in any African population in South Africa.

# RESEARCH METHODOLOGY

## 3.1     RESEARCH DESIGN AND METHOD

### 3.1.1     Research design

A qualitative design was used to explore and describe the experiences of African counselees as well as their counsellors (Denzin & Lincoln, 1994). Three phases as discussed by Polit and Hungler (1999) were followed in this qualitative design.

- *The orientation phase*

This was the first step in this research, to explore the unknown by developing an applicable interview schedule for data collection. The main aim was to explore and describe the experiences of African counselees as well as their counsellors for the development of an HIV/AIDS counselling approach for Africans (Batswana). Participants consisting of a group of urban and non-urban Africans (Batswana) that received general and/or HIV/AIDS counselling from western counsellors were selected to form the first comparison group in the theoretical sampling. An open-ended question was asked, for example, How did you experience the counselling session?/How was your counselling? These questions were tested and the most appropriate (understandable) questions for the participant group were selected.

- *The focused exploration phase*

A more focused interview schedule was developed in this phase (*See schedule*, for central questions: *Annexure E* ). A series of comparison groups were selected and interviewed, to achieve objectives a, b and c (as stated in chapter one). After the first

group (Western counsellors) were interviewed, the first categories (abstractions) were developed, because data collection and data analysis took place at the same time. Then a group of Africans, counselled by western counsellors were interviewed and the categories were confirmed and new ones were added. Other comparison groups were Batswana who received African (traditional) counselling and African (traditional) counsellors to examine the categories and their representivity in the existing categories. Professional as well as lay-counsellors using western counselling techniques and African counsellors using African therapeutic counselling were included. These comparison groups were selected to describe, verify and elaborate the categories found in the initial group. At the same time the researcher compared and contrasted the categories and established the interrelationships of the categories.

- ### *The confirmation and closure phase*

Data were collected continuously to confirm findings and to reach data saturation (Polit & Hungler, 1999). Member checking was not done in this research, because participants were mostly interested in their concrete lived-experience and did not understand the abstract analysis. Lived-experience is also time-bound and situational (Sandelowski, 1993).

However, experts in the HIV/AIDS counselling field who have had exposure to Africans were approached to discuss the first level of findings after data-analysis, before categories in the emerging theory were refined.

For this research the confirmation and closure phase were when the grounded theory started emerging (Neuman, 1997).

## 3.1.2    Research method

A grounded theory approach was used in this research. This method was used to identify the concepts active in this area and explore the relationships between them. Thick descriptions of the processes and concepts were done. These actions

constitutes the first step of an emerging theory (Morse & Fields, 1995 ; Hammersley, 1992). In this research counselling and HIV/AIDS counselling were explored from homogeneous and heterogeneous comparison groups to identify similarities or contrast differences from which the analytical description emerged (Glaser & Strauss, 1967).

General and HIV/AIDS counselling of Africans was explored. The exploration led to the description of what was happening or the process by which general and HIV/AIDS counselling happened. Grounded theory method was used because the main aim was to develop an inductive theory for African counselling. This method also gave the researcher freedom to explore general and HIV/AIDS counselling in-depth in order to develop the theory (Glaser, 1992).

Comparative analysis was used to compare and contrast Western counselling phenomena with the African counselling phenomena. This constant comparison method of analysis in grounded theory used in this research allows the researcher to validate, contrast and elaborate on the categories found.

Glaser's epistemological and methodological strategies were used in this research, as they fit in with the qualitative paradigm used. I believe that the emergence of a grounded theory must be flexible and guided by the participants' lived-experience and their socially-constructed reality, which links to Glaser's school of thought. In the process the generation of the theory emerges spontaneously and is not forced into a pre-conceived framework as stated by Strauss and Corbin (Babchuk, 1997). Open-coding, theoretical sampling and constant comparison were used and through these inherently flexible strategies it was felt that the theory would emerge to serve the 'world' of the participants or informants of this research (Babchuk, 1997).

## 3.2    SAMPLING

Theoretical sampling as discussed by Glaser and Strauss (1967) was used. This involved choosing comparison groups that were theoretically relevant. For the purpose of this research non-urban and urban Batswana as well as their counsellors were the target populations. These comparison groups were selected as the focus,

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because the researcher knows Setswana and could therefore have direct access to the target group. The Batswana community also has had exposure to both Western and African (traditional) counselling approaches, which made comparing and contrasting possible.

Different comparison groups were chosen in the above sample. This allowed similarities and differences to emerge during data-analyses. The usefulness of the categories found during analysis could also be verified in order to establish a clear comparative analysis (Glaser & Strauss, 1967).

Glaser & Strauss (1967) require that comparable groups be chosen based on their theoretical relevance, and that such groups not be stipulated at the start of the research, but to be developed as the analysis of initial groups made it necessary. They state that the scope of the theory developed and the external validity can be carefully controlled by such choices. The selection of groups was therefore aimed at the scope of the theory to discover and to describe the various theoretical properties. If a group with minimal differences from the previous one should be chosen, one should find similar categories, and this would serve to verify the initial categories. Furthermore, basic properties of a category are brought out, and small differences accentuated. Similar groups also help to establish a definite set of conditions under which a category exists. Once such similar groups have been dealt with, groups that maximize differences should be selected, thus ensuring that different and varied data about the categories are collected, while strategic similarities become visible.

The main population first approached were non-urban and urban Batswana who have received HIV/AIDS counselling from Western counsellors. Their lived experience of HIV/AIDS counselling was explored, described and analysed. Thorough probing was done to promote saturation of the data. Themes/categories/abstractions were formulated around the research questions, but the researcher undertook to add other themes and categories as needed.

Difference was minimised by the following comparison groups:

•     Western counsellors who counselled Batswana counselees.

Difference was maximised by the following comparison groups:

•     Traditional counsellors of Batswana specifically interviewed with regards to their HIV/AIDS experience.

•     Batswana counselees who received traditional counselling related to HIV/AIDS.

The staff members of Local Aids Councils in urban and non-urban areas in the North West Province were approached to act as mediators to select the initial group of Batswana counselees who received HIV/AIDS counselling. This selection represented urban as well as non-urban populations. When theoretical saturation was reached with one group, other groups were selected as described to minimize or maximize differences between categories.

Theoretical saturation was accomplished when categories revealed no further properties and categories could be arranged by spontaneous emergence in a theory that fitted (Glaser, 1992).

Triangulation of the initial findings were done in two ways:

•   Comparing what the traditional healer and the counselee did in their interaction during traditional healer- client sessions. This interaction came from video footage used in a previous research that described the therapeutic interaction between traditional healers and their clients. This interactions were viewed and triangulated with the findings of the lekgotla

•   Comparing the experience of the researhcer in research interviews done as part of the research with emerging concepts *(See 4.4)*.

## 3.3    DATA COLLECTION

Multiple data-collection methods were used. The data-collection methods used were in-depth, unstructured individual and focus group interviews, groups/gatherings which African people use to discuss matters within a "*lekgotla*" and participative observation. All interviews were recorded, with validation done by semi-structured individual or focus group interviews, clarifying the concepts (abstractions) found during data-analysis. Video recordings where traditional healers consult with their clients, that was used in another research were also observed for triangualtion with information of the lekgotla.

Data-collection and data-analysis took place concurrently and data collection continued until categories were saturated (Glaser, 1992 ; Chenitz & Swanson, 1986).

### 3.3.1    Individual in-depth unstructured interview

One central open-ended question was asked: *"How was your counselling? / How do you counsel?* On the answer of the participant the researcher facilitated further elaboration and discussion (Morse & Fields, 1995), *See Annexure D for an example*. The techniques are described by Okun (1997), for example:

o    Minimal verbal response:  Agreeing by nodding your head or gestures. The interviewer also makes use of neutral verbal responses like, mmm…

o    Non-verbal communication skills:  The interviewer makes use of silence, eye contact, relaxed and open body posture.

o    Paraphrasing:  The verbal message or the words of the participants are repeated in other words or means of synonyms by the interviewer.

o    Clarifying:  When the interviewer wants to understand the basic nature of the participants statements he/she clarifies.

o    Reflecting:  No interpretation is done, but the interviewer shows empathy and signs that he/she hears the participant.

o   Summarizing: The interviewer synthesizes what is said during the interview and hereby highlights the important affective and cognitive themes.

## 3.3.2   Focus group interviews

In the focus group interview the interviewer is normally called the moderator according to De Vos (1998) because the role of the interviewer is to stimulate the participants to communicate. The moderator uses the same interviewing techniques as in the individual interview, but the moderator needs to stimulate communication from the participants. He/she needs to facilitate the group through:

o   identifying and utilizing the group dynamics;

o   exploring the range of attitudes, opinions and behaviours in the group; and

o   observing and facilitating the process of agreement and consensus in the group.

The same question was used as the question put to the individuals.

- ***The lekgotla***

*Lekgotla* is a Sotho word that directly translated means *council meeting*, a gathering or an assembly (Schapera, 1953). The *lekgotla* follows a specific process. First the chief becomes aware of a matter. The first consultation of the chief is private, confidential and informal. He opens the matter with his private advisors. These advisors are normally his paternal uncles or people with in-depth experience of the matter, for example, traditional healers. There is a trust relationship among the chief and these advisors. Their duty is to remind, counsel and advise the chief on the particular matter.

After the above-mentioned support and empowerment of the chief, he invites a public meeting or assembly. There is no limit on who may and may not come to the meeting, but it is normally the headmen, their friends and family. During this public meeting the chief opens the matter for discussion by the meeting. He does not

disclose the decision that they took in the previous smaller group. After the opening the chief allow the members of the meeting to discuss and debate the matter. There is minimal or no interference and the members of the meeting have freedom of speech. The chief then takes a decision. This decision can be disputed by the meeting and is debated until they reach agreement.

For the purpose of the research the researcher contacted the chief, discussed the research problem with him and then negotiated a *lekgotla* with the chief. The chief selected ten traditional healers who have experience in HIV/AIDS related care.

During the lekgotla the researcher could not go directly to the research question due to cultural reasons. In the African culture there is a statement: " You should not fall with the door in the house". That means any serious conversation is started in a non-threatening way. For that reason the researcher started vague and then moved into the research questions (*See Annexure E)*

### 3.3.3    Participative observation

During the individual or group processes the researcher utilized the framework described in Morse and Fields (1995) to observe. Two types of observation was used in this research.

*(i) Participant-as Observer and Observer-as-participant*

This happened during the individual as well as the focus group interviews and the lekgotla. The participants are aware of the role of the researcher, but the interviewer facilitates the group as well as being a part of the process of the interview. Since the interviews were also done with Batswana, and many participants talked freely about their HIV/AIDS experiences, the research interviews became part of the data about how people experience counselling.

*(ii) Complete observer*

During the *lekgotla* the researcher was at times a complete observer, while the mediator facilitates the assembly. The video recordings of traditional healers seeing their clients were observed in the role of a complete observer

During this process of data-collection the researcher took field notes. These field notes were either written or spoken on an audio-tape. The field notes are according to Cresswell (1994):

o    Descriptive notes:  They describe the participants, the setting and how the participants behave or during the interview.

o    Reflective notes:  These are the reflecting thoughts of the researcher during and after the interview – thus what he/she became aware of that will help him in the interview.

o    Demographic notes:  These reflect the time, date and context of the interview.

## 3.3.4    Role of the researcher during data collection

The researcher did the following:

Contact the chief of the clan for consent for the research.

Arrange meetings for interactions.

Form part of the *lekgotla*/indaba as an observer.

Facilitate the research interviews.

## 3.4 DATA ANALYSIS

Coding was done by combining the methods of the following authors creatively (Tesch *in* Creswell, 1994; Glaser, 1992 and Chenitz & Swanson, 1986:91-101).

The initial coding was done according to the guidelines of Tesch (in Creswell, 1994). The following steps were followed:

- Transcripts were typed.

- All the concepts were read through to get a sense of the whole.

- The most interesting or shortest transcript was chosen and read through.

- The initial categories were created.

- All transcripts were coded using the initial categories.

- New categories were added as necessary.

- This analysis was refined by translating it into scientific language/concepts or abstractions. These concepts described the explicit or implicit (underlying) meaning.

The following steps were followed to enhance the emerging of a grounded theory as described by Glaser (1992).

- The concepts that were formed in the previous round of data-collection and analysis were categorized to a higher level of abstraction by searching for patterns within the description of the incidents (data).

- Coding continued by constant comparison of incidents in the comparison groups of the theoretical sampling.

- Open coding followed to formulate core categories. Data were not forced or reified, the analyst remained open. In this step the analyst was only guided by the act of constant comparison of data.

- Substantive codes were developed to describe the patterns of substantive variations.

- Theoretical codes were conceptualized. These codes had to be a discovery that identified models or relationships in the emerging grounded theory (however, they should relate with the substantive codes).

An analytical distance was maintained throughout the data-collection and comparison by bracketing preconceived ideas and allowing of the data to guide the emerging of the theory.

Data were described according to the guidelines in Chenitz and Swanson (1986). The first level of description presented the concrete process of what was happening in general and HIV/AIDS counselling according to the comparison groups who had participated in the theoretical sampling. A second level of description emanated as data was interpreted at a deeper, abstract level. Categories were trimmed or collapsed to form themes. The third level, which was the refining of the theory, was developed by trimming, collapsing and linking the categories and themes to be woven into a theory.

A comparative method of analysis was utilised to analyse the data from the different groups in order to verify the initial categories, to identify new categories, to contrast categories and to establish patterns among the categories in order to conceptualise a counselling approach for Africans (Chenitz & Swanson, 1986).

## 3.5    RIGOUR OF THE RESEARCH

I used the framework as highlighted in Morse and Fields (1995) as well as Krefting (1991) to describe the rigour in this research. Where other authors are used, it is stated in the text.

- *Truth-value*

The truth-value or credibility of this research was found in the method of data-collection and data-analysis. The researcher reflected the lived counselling experiences of the participants in the research by conducting in-depth, unstructured interviews with open-ended questions. Various groups of participants were used for data-collection and the fact that data-collection and data-analysis happened simultaneously promoted maximum variation and verification in the data.

The several comparative groups utilised in the research for data-collection also allowed full generality and contrasting of categories, and this promoted the clear description and presentation of the findings (Wilson, 1985).

Multiple methods of data-collection, for example, participative observation, individual and focus group interviews were used to promote the saturation of the data. This method of triangulation in data-collection strengthens the credibility of the research.

- *Applicability*

Applicability refers to the transferability or fit of the research. This research was done in a specific setting and the researcher did not aim to generalize the findings, but to apply the same principles in a similar setting, for example, other African populations. The findings could be transferred to a similar setting as that in which the research was done, which is why sufficient description of the research process as well as the findings was done to promote transferability. The fact that the data-collection took place in a natural setting minimized the variabilities and strengthened the *transferability of the research.*

- *Consistency*

Consistency or dependability of the research was ensured by the clear description of the research process. The researcher also aimed to analyse variations of experience, rather than identical replication of research, because respect for the uniqueness of a human situation was taken into consideration.

- *Neutrality*

In this research the neutrality or confirmability was ensured by minimizing the bias. The researcher provided a written "bracketing" of his own counselling experience that could be used to check the data collected with the findings of this research. Another factor that strengthened the confirmability of this research was the prolonged involvement of the researcher in the fields of counselling and HIV/AIDS that led to the stimulation of this research project. The researcher also provided a clear description of the research process in order to strengthen the rigour and support the chain of evidence in the findings of this research.

- *External validity*

External validity was ensured in this research by the researcher informally engaging in member validation by clarifying or elaborating the meaning and intention of the participant during the research interview (Sandelowski, 1993). This action not only supported the emerging theory, but also enhanced the confirmability. No member checking was done after data-analysis, because participants were more interested in concrete descriptions of their own experiences than in abstract synthesis. Lived-experiences are also time-bound interpretive, political and moral acts (Sandelowski, 1993).

Different comparison groups were carefully selected to minimise or maximise differences between categories

The multiple method of data-collection, for example, interviews, participative observation and field notes, was also used to promote saturation of the data and served as a triangulation method to strengthen external validity. The exhaustive exploration of the counselling and HIV/AIDS counselling that uses comparison groups, for example, homogeneous and heterogeneous groups, contributes to the comparing and contrasting of the categories, which enhances the transferability and thus the external validity.

- *Reflexivity*

The style of reflexivity that is clear in this research is the strategy associated with self-critique and personal quest. This research emerged because of my personal quest that came through experience and empathy with Africans in a counselling context. Secondly it was true that self-critique would be highlighted through the methodological process applied in the research. Thirdly the style of positioning was considered in this research, where I assumed that work on this research was incomplete and required responses from others in the same or different positions from me to refine the research (Koch & Harrington, 1998).

Through my discussion of the rigour or trustworthiness of this research, I indicated that I wanted to make the counselling practice visible and audible by following scientific guidelines for an African approach to emerge. It is thus not a matter of proving that this approach is the only correct approach.

## 3.6 ETHICAL RESPONSIBILITIES OF THE RESEARCHER

A framework consisting of the ethical standards for nurse researchers accepted in South Africa (SANA, 1991) as well as ethical responsibilities in ethnography in nursing as described by Roper and Shapira (2000) was used to clarify the ethical responsibilities in this research.

- *Issues of informed consent*

Informed consent is based on truthful information about the research to ensure that the participants make an informed decision was drawn into the research. Informed consent was obtained in a written or verbal form from the relevant authorities, for example ethical committees, chiefs, government authorities and participants. Transparency regarding the type of data collected, method of data-collection, the possible benefits was maintained towards the authorities as well as the participants.

The consent adhered to the legal requirements by respecting the human rights of the participants according to the constitution of South Africa.

- *Confidentiality*

Confidentiality was ensured by the researcher through numbering the interviews and removing all personal identification from the data.

- *Protection of the participants*

The research focused on sensitive information and the researcher was committed to assess any possible physical or psychological discomfort or harm after the commencement of the research. If the participant experienced any discomfort or distress, the researcher assisted or referred participants for appropriate treatment or support. No harm or discomfort was foreseen, but the researcher made sure that participants in interviews and focus group discussions experienced closure at the end of the interviews.

- *Identifying the role of the researcher during the research process*

A comfortable research role as insider and outsider was established.

- The researcher contacted the authorities responsible to give consent for the research, for example, government, non-governmental organisations, other participants.

- The researcher arranged meetings for data-collection, and

- Facilitated the research interviews.

- *Ensuring the quality of the research*

The researcher used his knowledge and skills obtained by prolonged involvement in research and counselling during the whole research process. This facet was

supported by the involvement of a supervisor in the research project,as well as the scrutiny of the protocol by the School and Faculty Boards.

Conformation to the principles of scientific research as well as the assurance of rigour in the research was adhered to.

The personal, cultural and professional belief systems, for example, "bracketing of researcher" and "clarification of the role of the researcher" that may cause bias to the research were identified and exposed in this research. Other measures were put in place to avoid bias, for example clear description of the research process as well as the findings.

## 3.7    BRACKETING OF THE RESEARCHER

As far as I can remember, my first experience of counselling or therapeutic interaction was sharing with my father something that I could not understand or had difficulty with. He was already in his late sixties and retired when I grew up. If one shared anything with him, he would always make use of the oportunity to create a learning moment. My father often told a story, sometimes even the same story just with a different learning message. This story would always be linked to your problem and how to manage or resolve this problem.

Another experience of counselling that I had was the family meetings (family *lekgotla*). When a family member had a problem, for example a marital problem, the problem would be reported, the family would meet and then call in the person or people involved for a discussion of the problem. It always depended on the severity of the problem whether my father and mother would manage it alone or whether they would call in the selected team from the extended family, for example, uncles, aunts or my grandmother. The family *lekgotla* could have a number of sessions until the problem had been resolved to their satisfaction. In the primary family, my father would chair the sessions, but when the extended family was called in, my grandmother would chair the meetings.

The first counselling contact that I experienced outside the family setting was with the traditional healer or sometimes a spiritual healer. They would act as family consultants and external support to the family. When I was a teenager, I started to question the role of the traditional healer and spiritual healers. It did not make sense to me, for example, to bath a person with a white chicken to promote luck. However, some members of my family still continued to consult the traditional or spiritual healers.

I then started to study nursing and made contact with counselling from the Western perspective in mental health and psychiatric nursing. It appeared to be logical and it made sense to me. After my basic degree I decided to specialize in psychiatric nursing. During this time I made use of Western counsellors as support and peer group counsellors.

As a professional nurse, counsellor and educator I worked in a relatively rural community in the North-West Province, and was again exposed to traditional and spiritual healers. It made me wonder whether traditional therapeutic interaction did not have a role to play in counselling in these communities, because the community trust and believe in them as part of their health providers.

## 3.8    CONCLUSION

After applying basic operational strategies and methods in this research, the data were formulated into an analytical endeavour of a grounded theoretical approach for HIV/AIDS counselling for Africans. This approach was built to fit the context from which the data derived. The realities of the participants were the main concern of this emerging theory.  It is not a final product, but the conceptual beginning of the development for a counselling approach intended to serve Africans.

# REALISATION OF DATA-COLLECTION AND -ANALYSIS

## 4.1 INTRODUCTION

This chapter describes the two types of counselling (Western and African) and adds the data from an analysis of the research interviews themselves. In-depth individual interviews, focus group discussions, an African lekgotla and video tapes were analysed.

## 4.2 WESTERN HIV/AIDS COUNSELLING

### 4.2.1 Introduction

In-depth interviews were done with counselees who received western HIV/AIDS counselling and their counsellors. Four individual in-depth interviews and two focus group interviews were done with counselees who received HIV/AIDS counselling. Two individual in-depth interviews were done with professional nurses and three focus group interviews done with lay counsellors.

This sample consists of 30 (thirty) participants. Six (6) of the participants were men and twenty four (24) of the participants were women.

Twelve of the participants were counsellors of whom only two were male. The rest of the participants were counselees (African men (4) and women (12)). Open-ended questions were asked at the inception of interviews. These comparison groups were used to enrich the data as planned in the methodology chapter.

The question asked to the participants that received HIV/AIDS counselling was, "How was your counselling?". A question posed to professional counsellors was, "What is your process of counselling? Or "How do you counsel?, " and to lay counsellors the latter question. Where counsellors had difficulty in understanding, the latter question had better results (Chenitz & Swanson, 1986:95). Further probing was done by using the interviewing skills discussed in chapter three to enrich the data.

Basic questions about the process of counselling were used to code data at the first level of analysis after the first interviews. The process that was followed is: **Who** is doing the counselling?; **what** is he/she doing?; to **whom** is the person doing the counselling?; in which **situation?**; **how** it was experienced by the counselee? and what does the counselee or the counsellor see as the **ideal** situation?. The researcher focused on lived-experiences only (Chenitz & Swanson, 1986).

## 4.2.2    Who counsels?

In this discussion 'who' refers to the person who actually does the HIV/AIDS counselling. The counsellors are usually health professionals, mostly trained in HIV/AIDS counselling, but participants are also referred to lay counsellors. In South Africa there is also a National Non-Governmental Organisation (NGO) that has a toll-free line that caters for HIV/AIDS counselling. This line is mostly manned by lay counsellors.

Most of the counselling described by participants was done by professional nurses working in a clinic or in an occupational health setting. Lay counsellors were also common. Most of these nurses are trained in HIV/AIDS counselling and others are using their basic counselling skills, which they learnt as part of psychiatric nursing training. This is clear through the following statements (reported verbatim and not corrected for language usage):

> "So I was counselled by a sister"
>
> "It was a professional nurse"
>
> "Miss ..., she is a nurse and she is also trained by the Department of Health for counselling"

HIV/AIDS counselling is also done by the doctors, lay counsellors and sometimes by friends and family members. The data indicates that docters are perceived to ave a higher status by some counselees. Lay counsellors do the HIV/AIDS counselling in primary health care or clinic settings, but they have to refer back to the professional nurse for follow up care, such as medication. Other lay counsellors who counsels, especially in occupational settings, are soldiers and police.

> "I went for a test, I was more strong, because the doctor counselled me...the differences between the doctor and a nurse, a nurse does not get the treatment or the training that the doctor has"
>
> "*Sergeant Lee, he was doing us the counselling" ;
>
> "I stayed with my friend, she was strong for me. And she counselled me as well" ;
>
> "My uncle counselled me"

## 4.2.3    What does the counsellor do?

The category refers to what the counsellor does, the counsellor's behaviour and input in the counselling session. This includes the perception and description of the counselee of what the counsellor did during the session, as well as the descriptions of counsellors of their behaviour and input during a counselling session. These descriptions are discussed under verbal-, non-verbal- and other interactions.

## Verbal interactions

Verbal interactions refer to a conversation between the counselee and counsellor, where there is an exchange of words.

*Introduction*

The professional nurses as well as the lay counsellors said that they would introduce themselves. Some counsellors waited for the counselee also to introduce him-/herself. This appears to be the initial stage of all counsellors in order to make contact with the patient or to build rapport:

> "I will introduce myself. Let the person introduce him/herself";
>
> "… the patient comes in and then you introduce yourself to the patient"

According to some counsellors this introduction is intended to establish trust, so that the counselee knows who s/he is talking to. The same introduction is not expected from the counselee. This is to maintain confidentiality.

> "We introduce ourselves and welcome them, for them to feel welcome. We say, make yourself feel welcomed. And how may I help you. The person will say what their problem is. We assure them that everything we talk about is confidential. Nobody is going to know about them and what's going on. No name-calling. Nobody will know about what you came here to do"

*Social conversation*

Some counsellors indicated that they try to make counselees feel at ease by first starting to engage in social conversation.

> "But when they come to me and when I did it, what I normally do is to get the person at ease. And then we will talk a little bit about the weather and whatever."

*Asking*

Most counsellors ask counselees different questions to get more information in their counselling session. Counsellors ask counselees why they came to the clinic and why they want to be tested. Counselees are also asked whether they know the repercussions or consequences of a positive HIV test. Another question asked, was how the counselees feel about the test and/ or results. This is done to determine whether the counselee really wants the HIV-test to be done. The latter question led to counsellors referring counselees back to think again and return when they were ready to do the HIV-test.

> "The first when I entered she asked me what I'm going to do... Then she ask me the reason why..., did I know the repercussions...So she said to me are you ready to wait for any consequences of those results"
>
> "...She just ask if I was scared; ..She ask me whether I'm going to cope with the results; ...So I must go think again"

The counsellors confirm the above statements of the counselees. Most counselees said that they were asking why the counselees had come to the clinic. According to the counsellors this question was asked to make sure the counselees wanted HIV-testing voluntarily. Counselees were also asked why they wanted to know more about HIV/AIDS. The following statement from the counsellors confirms the question,

> "And I will ask, what can I help with, why are they here?" ;
>
> "For instance if someone asks that, OK, I want to know the signs of HIV. Then ask why, what are your reasons for wanting to do that"

Counsellors also said that they asked the counselees why they wanted to do the HIV-test. Lay counsellors also added to this that the counselees were referred sometimes and they wanted to make sure that the counselee wanted to do the HIV-test, because counselees were not 'enlightened' or were forced by other health professionals to do the HIV-test.

> "Why do they feel they must do the test?";
>
> "Yes, because they are not enlightened. And they don't understand why must they do the test.";
>
> "Sometimes this is a referral client to us, to test. So we want to make hundred percent sure that does this people want to test or it is just the sister said so."

Most counsellors also asked if the counselees were not scared or whether they had any fears about doing the HIV-test.

> "… you ask the patient about fears, whether he has fears." ;
>
> "I normally ask, are you afraid"

Some counsellors explored whether counselees were ready for the HIV-test. Counselees also said that the counsellors gave them some time to go and think about their decision to do an HIV-test

> "So she asked me are you ready … That's why I said to her, OK. I am ready now because first time I was here so I think about what you said"

Counsellors also stated clearly that they determined whether the counselee was ready to do the test. Readiness, according to the counsellors, was when the counselee was prepared to deal with the consequences of the HIV-test, whether it was negative or positive. The counselees had to be prepared to know their HIV status.

> " …you ask, whether he is ready to do the test itself. Ready to me might be that a person, a patient say I want to. I am willing to deal with the consequences, whether I'm having a positive or a negative results. I want to know. And that is readiness to me"

Another question that counsellors asked, was what the counselee was going to do when the test turned out positive. Some counsellors said that this question was intended to bring the counselee into contact with his/her feelings. This emerged through the following statement, viz.

> " … how are you going to feel now if the test is positive…And make contact with that feeling that you have now…"

Counsellors also asked other questions to assess the counselee's demographic situation in order to understand him/her better.

> "I normally ask what type of work do you do, where do you work and include the children. As well as, where do you live?... to me is very important to have that information to understand my patient better.";
>
> "I ask him how many are they, Are your parents still alive?"

## Telling

Secondly, counsellors told counselees about HIV/AIDS and/or about their test results. Counsellors told counselees about HIV/AIDS and related illnesses. They also alerted counselees to the impact of HIV/AIDS on their body.

> "He was telling us about HIV/AIDS and other diseases related to the HIV-virus" ...What is the impact of HIV/AIDS"; They did nothing...So they took my file and they talked to me.."

Counsellors agreed with the above discussion on what they tended to tell the counselees. Except from telling them about HIV/AIDS, related illnesses and test results, counsellors also informed them about the testing equipment in order to alleviate fear.

> "I will explain to them precisely that, that they must know that they could be negative or positive. And then I will tell them they are negative. I will then tell them, look there, it looks good, there is no problem";
>
> "I explain how the person with HIV is, he doesn't have signs and symptoms. He is healthy. But if he doesn't take good care of himself, he will reach a stage where he got AIDS. Then how does he get to that

> stage. The most important thing is to use a condom. Because viral load is the thing that makes a person to reach that stage where he got AIDS".
>
> "And I then I will explain to them exactly. What it does to the body. I will show all the different tools to them. Some of the tests I used before with other people, I will take a negative one and a positive one"

Most counsellors interviewed told the counselees about the window period, especially when the counselee had a negative HIV-test result.

> "tell a story about the window period";
>
> "Then I will tell him that there is something we call the window period";
>
> "And if its negative I will explain the window period"

Some counsellors shared their experience with other people they counselled. This was normally done in support or motivation of the counselee or sometimes to determine the counselee's level of readiness.

> "He said I'm the first person he counselled that is so strong...When he counselled other people, they die, maybe is because of the shock"

Other counsellors also promoted spiritual activity by saying that counselees had to pray in order to comfort them. This emerged from the following statement

> "He said I must pray. He said I'm not alone"

Most counsellors also suggested safer sex practices and promoted a healthy life style to counselees. Counsellors said that they did that irrespective of a negative or positive result, because if the counselee was positive, he/she wanted to avoid re-infection or wanted to boost their immune systems.

> "I will try to link it and if it helps to a deeper conversation that's on a more private level to get more knowledge about their sexual behaviour.";
>
> "So a person must help his body to boost the immune system. By exercises, eating healthy food and to sleep eight hours and the rest."

Telling in this instance is mostly information-driven. According to most counsellors information was intended to educate or empower the counselee about HIV/AIDS and also to encourage counselees to live a healthy life-style.

Some counselees were also of the opinion that the counsellors did not communicate respectfully with them. Counselees would then either remain quiet and not take part in the interaction anymore or agree with the counsellor even if they knew they would not comply with the prescribed action.

> "Also at the clinic the sister did not speak well to me. She scared me worse and made my heart sore more worse. That sister at the clinic, I then stood up and left" ;
>
> "We don't take out complains, you just agree. We just sign..."

Non-verbal interaction

Non-verbal interactions refer to the communication between the counselee and counsellor, where there is no exchange of words. This interaction is dominated by

expression or body language, but also includes comments about the lack of verbal communication.

Some counselees said that the counsellor just tested them for HIV without informing them in order to make an informed decision.

> "No they just tested me. They never did anything. They never did anything, I don't want to lie. They just tested me and told me I'm HIV-positive..."

In some instances counsellors did not disclose the counselee's HIV-status verbally to them. Non-disclosure happened by design or counselees discovered their HIV-status by accident.

> They didn't tell me about it... They were afraid I would miscarriage...They checked me and gave me a letter";
>
> "I didn't get counselling. I took my baby to the clinic, and found my file. And I read my file thus when I found out that I am HIV-positive"

Some counsellors responded emotionally to the test results, especially during the disclosure of the HIV-results. Counsellors showed sadness and anxiety. According to the counselees this behaviour confused them, especially when they did not know the outcome of their results yet.

> "She was moving around crying.... She took about 30 minutes before she could tell me what is happening"

Other counsellors used physical contact to comfort counselees and counselees generally felt comforted by such contact with the counsellors.

> "After crying, you give him a hug"
>
> "I also think it helped me a lot. He took my hand, we sat and he explained how I should manage my life."

Counsellors stated that they were observing and trying to interpret the counselee's non-verbal behaviour in order to give extra support.

> "And one tries to look onto the non-verbal response, because what he might say, it might not be what he is actually feeling. But one tends to learn to see non-verbal and you make your own conclusion, that this one needs extra support." ;
>
> "And I will look at the body language…"

In some instances the body language of African counselees was confusing to European counsellors, especially when they expected a certain response and counselees responded differently. This is common in the Black community as stated by a counsellor

> "You know that was strange to me … It was a Black man and he wasn't very emotional. He was actually not emotional at all.  And I must tell you at a stage I really didn't know what to do. There was a lot of silence between us. But I was wondering whether this person really understands what is happening…The person was not emotional. He was positive on the confirmatory test as well. He did not respond emotionally. As if it is another person and it was as I have lost contact with him after the test and after it was positive."

*Other interaction*

Other interactions refer to actions, rather than direct communication, either verbal or non-verbal, usually a procedure.

The actions of most counsellors included doing an HIV-test. Counsellors did the rapid test, followed by the confirmatory test and sometimes referred the counselees to do other blood tests, like the ELISA. The test was done to determine an HIV-positive or negative status.

> "But in the two cases what I did is that only one of those cases was actually positive.But the other confirmatory test was negative. So if the patient want to do the test again or if I give the choice to the patient to go for an Elisa"

Some counsellors stayed in contact with counselees after initial counselling. Counselees found it supportive when counsellors followed up with them after the initial counselling session

> "You can see that she is a person who do care. She was not the person who just care give counsel and leave you like that...she is no longer working here, but every time, sometimes she calls and ask, how are you"

Physical care and the fact that counsellors addressed the basic needs of the counselees also comforted them

> "I had nothing, no food, nothing with me. He gave me soft porridge then I drink and slept. After thirty minutes I felt fine" ;
>
> "And then he gave me a lift"

This is also clear in some counsellors' statements,

"You give him a glass of water and a tissue. Then you get him settled."

Most counsellors also made use of a referral system for further support to counselees as stated as follows:

"I did also refer him to … The pastoral counsellor"

Some counsellors also verbalized that they had an open attitude of just being there for the counselees in order to support them. The attitude was made clear through the following statement:

"Whoever you are, I'm OK, you can come in. Whatever you are going to discuss with me, I'm OK."

## 4.2.4    To whom (counselee)

This refers to the person receiving the counselling (counselee). The counselling described by participants was done individually or in a group. The interviews were done with African men and women who had received western HIV/AIDS counselling as this was the criterion that was used to select the first group of participants. Some counselees experienced the group as less anxiety-provoking, because they felt supported by the number of people as stated:

"We were not individual.  Yes. It was not so much scary, because there was many people there"

On the other hand, some participants felt that counselling would have been more effective if they had been counselled individually, because there would have been more time for processing what happened in the counselling session.

> "I wish you are going to get counselled, you know, they do it in as an individual. Like not in a group, because in a group like you don't take it like into too much"

Some counselees also pointed out that their feelings depended on how the group was facilitated.

> "... we were in a group like mothers, as pregnant mothers. So they told us that we must know that there is a VCT counselling and testing. So we have to be tested for the sake of the babies, we are in a group, they did not take us one by one. So we can get pre-counselling and understand why are you being counselled and tested"

Although the pre-counselling was done in a group, in all cases informing counselees about the results was done individually and sometimes by a different person from the one who had done the pre-test counselling:

> "...the post counselling was individual...It was the other lady. I don't know her name .It was one of the people that worked there, but she didn't say much to me after...and then she told me I'm negative."

## 4.2.5    In what situation/condition

This category refers to the situation that encouraged or forced the counselee to go for HIV/AIDS counselling and testing. The category describes why the counselee went for HIV/AIDS counselling and testing.

Most counselees went for counselling and testing while they were pregnant. The counsellors were also told that it was in the best interest of their babies that they tested. Some counselees were tested while they were pregnant and no results were disclosed to them after the HIV-test.

> "So they told us that we must know that there is a VCT counselling and testing. So we have to be tested for the sake of the babies…";
>
> "After they checked me they gave me a letter. They did not tell me about it. They were afraid I would have a miscarriage..";
>
> "I took my baby to the clinic, and found my file. And I read my file thus when I found out I am positive"

Some counselees went to a health facility because they were sick or they were experiencing persistent health problems, while other counselees went because they had been raped. These counselees were encouraged by the health professionals to have an HIV-test done.

> "I went to the hospital, because I had a problem with my feet. They said I must test…";
>
> "I had something that looked like a rash. It was watering the whole body…";
>
> "Firstly I realized something on my body that I'm not fit like before. I'm struggling. Like for instance, coughing, sweating, loosing weight…";
>
> "I was attacked in my house in the shack. It was two boys. They raped me, then after that. They raped me on Saturday then Monday I went to the clinic to test and they said to me I was HIV-positive"

Other counselees went voluntarily to be tested for HIV, because they were experiencing health problems, or their partners were HIV-positive and sometimes they suspected their partners of not being faithful to them.

> "I went to test, because I felt changes in my body, but I knew what my problem was...";
>
> "They asked me why. I said that I took my boyfriend to the doctor and the doctor told me he is HIV-positive";
>
> "...the reason for me to go there I was, just like I want to know my status... I was having a partner, so the reason is like I didn't trust him..."

The lay counsellors, who receive referrals, verbalized that they always gave counselees time to reflect on the decision to be tested, but when there were health problems and the counselee wanted to be tested, they did the HIV-test.

> "Unless he feels the changes on his body, then when he feels the changes that's the thing that makes him to come and test. So you cannot deny him."

In another situation counselees applied for jobs and they were requested to have a HIV-test. The counsellor also suggested that the job required HIV-negative people. This situation put pressure on counselees to go for an HIV-test.

> "...it was an interview for the job...So he was telling as part of the job you are not supposed to be HIV-positive, because it weakens the immune system."

### 4.2.6 How was the HIV/AIDS counselling experienced by the counselee and counsellor and what was the outcome of these sessions?

Here I am describing the lived experiences of the counselees as well as counsellors and what was the outcome after HIV/AIDS counselling session.

Counselees described a range of experiences. The experience of the counselees who were tested while they were pregnant expressed feelings of shock, sadness, fear, anger, guilt, helplessness, the need to be accepted and difficulty in accepting that they were HIV-positive. Symptoms of depression were also prominent in some counselees.

"When I came out from the clinic, ooh I was shocked. I could not even … I was crying all over the way until the taxi.";

"…and they saw I'm scared… He gave me the letter and I read it myself and I screamed. I took the letter and torn it."

"I used to spend the whole day and night without waking up. I just sleep, I don't speak, I don't do anything. I don't know what is happening with my life. I never bath I just sleep like that. Three or six months doing nothing."; " I never went out of the house. I was afraid of people. When I was sitting outside I would think people see me, even when they don't. I used to sleep always and not eat. I never use to wake up and go out. I never use to open the door".

"You don't cough it out, it eats you inside alone"; "We hide these things in our heart"

Some counsellors described the initial response of counselees as shock and encouraged them to return to the clinic for counselling later.

> "In my experience I have realized that the person get shocked and just switch off. So I normally say come tomorrow or two days later..."
>
> "Try to take them through the steps of feelings, the shock..."

Counsellors also verbalised that counselees sometimes responded with fear because they had to undergo an HIV-test. Most counselees were afraid, even before the results were known.

> "Just because they made the decision to come for a test was as if they was anxious to be here"

Counsellors found the facilitation of counselees to express their feelings was challenging. This counselors found it difficult to reflect the feelings of African (Batswana) counselees. According to them African counselees also found it frustrating to express their feelings

> " Yes, is a bit difficult, because the concept of counseling in Tswana is new. And is difficult to reflect the feelings. Like how do you feel by being HIV-positive." ; ...
>
> You find that the person gets impatient with you. He doesn't understand that why should you ask him that how does he feels.";
>
> "The way to talk about feelings especially in black people. We are not used to. Is not always that we express ourselves".

Acceptance of the situation was expressed in the following statement,

> "I told the children that I am HIV-positive, I got it from a man. Is the sickness that infected me. That's all I can do, I accepted it. My child accepted and said mom take good care of yourself."

Counsellors also expressed a feeling of helplessness in challenging situations during HIV/AIDS counselling,

> "And I must tell you... at that stage I really didn't know what to do. There was a lot of silence between us.."

Other counselees did not experience anything, because the counselling session was too short and they did not feel counselled at all.

> "We did not have to wait. They took us from one place to the other, just like that...I don't know what to expect in that time" ; "I did not get counselling"

According to counsellors they had a problem with the shortage of staff, which is why they spent such a short time with counselees. The following statement explains it:

> "Looking into the shortage of staff. But at least this person comes in, whether it is on informal basis, but at least you have ten or fifteen minutes time that you spend with a person"

However, some counselees described helpful experiences and outcomes as verbalized by some counselees. The first one is the fact that counselees now knew their HIV- status. Counselees reasoned that they could practice a better life-style based on this knowledge.

> "I think what was helpful for me, then it was to know my status....So when you know that you are positive, then you are able to take care of yourself"

When counselees volunteered themselves to be tested, they were more prepared to accept the outcome of the HIV results.

> "I went to the test with confidence. I told myself that everything can happen, I will accept the results"

Some counselees went when they were sick, they were given time to think and went back voluntarily when they were ready. These counselees also accepted the outcome more readily.

> "She said to me she cannot counsel me and at the same time she test me...So I must go and think again. That's why I said to her, OK I'm ready now, because the first time, I was here...So I indicated before that, I'm doing this, I have to cope with things like this"

Counselees found it helpful when the counsellor talked to them about their life, the fact that they had to accept themselves before they accepted somebody else.

> "They talk to you about your life, how to accept your life. You must start to accept yourself before you can go and accept somebody else"

Counsellors in the HIV/AIDS field felt that the availability of a rapid testing kit that gave immediate results was an improvement because counselees did not have to wait so long anymore.

> "I would just like to say that we are glad that we have a new test, called the VCT. We give you the counselling in which you get the results...You don't have to wait so long for the results..."

Some situations were experienced as unhelpful by counselees.

When counsellors did not listen, counselees experienced them as being uncaring and then they went into to a passive state of just agreeing, without engaging in the interaction with the counsellors. This is clear from the following statement:

> "Like the sister in the clinic, they disagree with you about something that's happening to you, something you are feeling. She will say you are lying while you are talking about something you feeling, something happening to you. But she disagrees with you." "Sisters are having that problem when you are going to get the pills, of asking you how you are feeling. When you say I feel pains they say...They would tell you it must be like that...They are careless"

A concern was verbalised by some counselees saying that most counsellors did not allow counselees to say what they want. Counsellors imposed their ways on the counselees,

> "... we don't give patients much time to say what they want...I have seen people going the cultural route or the traditional road and its working. We focus on western and that's it. We impose, we more of imposing our belief in this is how it should be."

Some counsellors also expressed some feelings of inadequacy about addressing the needs of the counselees, because they do not have enough experience in HIV-counselling and testing.

> "Maybe I, is because in my situation I feel I don't have enough experience with the testing. …I can get more experience to know how to react on the people's reaction"

## 4.2.7 The counselee and the counsellor's ideal situation in HIV/AIDS counselling

Most counselees preferred a well trained counsellor who was committed to counselling them.

> "I want a proper counsellor to counsel those people…If he can motivate a person, then that person can come now…they just say that and that and that. The next one come, that and that and that"

Counselees also would like the counsellors to be experienced, to listen and to be more knowledgeable than the mass media.

> " …the people who are counselling are inexperienced counsellors. He must know that what he is doing is another  person's life…you are stressed, you are mixed up. He start telling you about things you know. They talk about them on TV and on radio. And you don't want that way, you want him also to listen to you"..It's like the sister in the clinic, they disagree with you about something that is happening to you, something you are feeling".

Some counselees expected counsellors not only to tell them their diagnosis, but also to show interest in their lives:

> "They don't sit to tell you. You understand. They must sit with you and ask you how you live, how you feel, how is it in the house. We don't take out complains, you just agree..."
>
> "When a person counsels you he must ask you how your life is. What has been happening with you...I was given counselling, I went there and the person was already explaining AIDS"

Other counselees also required help on medication and diet-related issues. Counselees failed to comply because counsellors neglected to explain the correct purpose of the medication:

> "There people who takes pills and not feel better. But is not the pills, is the way you take your food. Most of us we eat things that are not needed...spices or any meat think of you just frying it.";
>
> "Those pills I'm taking them, I asked but I never got an answer."
>
> "I also ask her if I have TB. She said no you don't have TB. I just want to know what they are for, what do they do. They can't answer me";
>
> "Is like the treatment we are looking for. They don't explain it to people , because we all know that this disease cannot be cured"

Most counselees would prefer HIV/AIDS counselling to take place individually and in private rather than in a group. They also requested confidentiality as part of the privacy.

> " ...in counselling you have to look professional and take a person private..."
>
> "I would like to add is that I wish you are going to get counselled, you know, they do it in an individual. ...because in a group like you don't take it like into too much consideration.";
>
> "Give a person confidential in a private side"

The reason why counselees felt so strongly was because they had experience of counsellors disclosing their results without their consent:

> "So they have got these tendency that if the results is coming, they open the results and then going to gossip about our results"

Some counselees verbalized that they preferred to be counselled by people who were HIV-positive in case of a positive test, because when the counsellor was not HIV-positive, s/he did not really empathize with the counselee's experience.

> "Thus why I'm saying you should be counselled by someone ...who got it on him, the thing that happened to him...he mustn't tell you about something he read in a book. He must talk about something that's on him, something that happened to him."

This was also supported by some counsellors who experienced that counselees improved the moment they referred them to someone who was HIV-positive after the initial counselling.

> "I had a client who was young and HIV-positive, well known in the community and she was quite scared of the stigma around it. But the minute I encouraged her to meet somebody who is positive, diagnosed for more then ten years and was doing very well....I think she progressed well"

Most counselees felt strongly about follow-up services, especially for the HIV-positive people, because according to them, clients were seen only in home-based care again when they got very sick.

> "And when they tell you that you are HIV-positive, they must make a follow up... Because at home you might not come back to the clinic again or to the doctor again...I wish that like they do before you get very, very sick"

Counsellors also verbalized the need for support groups for follow-up services for the HIV-positive counselee.

> "But we try to, but is difficult to try to get the support group... So there is actually no support groups."

Lay counsellors also verbalized the need for support for themselves in order to debrief.

> "Especially when you know someone, it hurts really, but we don't get any counselling"

Some counselees also felt that it was frustrating to do HIV-testing for occupational purposes, since testing should not be used to discriminate against individuals.

> "Because you are thinking you want a job, you are poor. And they just tell you no, you can't be hired here, you are HIV-positive. You get frustrated.

Counsellors highlighted gender inequalities as a severe problem in the HIV/AIDS phenomena.

> "The patriarchal power has always been the problem. In whatever culture, whether its western culture or not. Patriarchal hierarchy has always been a problem.".

# 4.3    AFRICAN (TRADITIONAL) COUNSELLING

## 4.3.1    Introduction

For this part of data-collection a chief was contacted telephonically. This chief was the chairman of the traditional assembly in the North West government. The research problem was discussed briefly, he then asked me to call him back in about a week's time. The chief and I had both previously been involved as advisors on the Provincial Council on AIDS of the North West Province.

After a week a verbal agreement was reached. I was referred to a mediator who coordinated the 'lekgotlas' of the traditional healers in the North-West Province. A further agreement was reached, which was that data-collection could take place during the subsequent 'lekgotla' scheduled in their annual plan.

Ten (10) traditional healers attended the 'lekgotla'. These traditional healers were all experienced in the treatment of HIV-positive clients. Three male and seven female were in the traditional healers' group. A question "what is your view on HIV/AIDS?" which was later rephrased with support of the traditional healers to "what is your view

and your treatment regime, when you manage a patient that is HIV-positive? What is your process of counselling? The researcher was only involved in clarifying issues and the coordinator (mediator) facilitated the discussion process. The 'lekgotla' had a spontaneous flow focusing on the research context. This legkotla's duration was about two hours where the traditional healers elaborated on their process of counselling an HIV-positive client.

The purpose of the 'legkotla' in this research was to collect data on the mutual engagement in a process of problem-solving between traditional healers and their HIV-positive clients.

The findings of the 'legkotla' were further triangulated with two video-tapes used in another research project. This video footage presented the interaction between traditional healers and clients who focused on the general traditional health services. The video had four interaction sessions between traditional healers and their clients. This material was observed and observational notes were written to thicken the discussion on the findings of African (traditional) counselling.

The data of 6 (six) participants who had utilised both Western and African (traditional) health services for HIV/AIDS counselling were also used to describe this part of the research. Four female and two male participants were in this group.

A similar process was followed to order the findings. The following process was used: **Who** is doing the counselling?; **what** is he/she doing?; to **whom** is the person doing the counselling?; in which **situation?**; **how** it was experienced by the counselee or counsellor and what does the counselee or the counsellor see as the **ideal** situation?. The researcher focused on lived-experiences only (Chenitz & Swanson, 1986: 95).

## 4.3.2    Who counsels?

As in the previous discussion the 'who' referred to the person or the people who did the African (traditional) or HIV/AIDS counselling in the African culture. These counsellors were traditional healers, the uncles and aunts in the family, the family

unit (which included the nuclear and or the extended family as well as friends from the same community).

> "My brother's wife said I musn't go for an operation. I just went to the traditional healer. He was the one that was helping me" ;
>
> "My uncle counselled me. After I talked to my uncle, I started taking action" ;
>
> "I said my aunt should come, because my baby's father ran away to his friend…My aunt asked why I can't get out of bed?" ;
>
> "I accepted when I saw my family. And also I saw that my friend was strong for me, I was comforted. I saw my friend everyday , I was comforted."

A classic finding in the data was that all counselees who attended traditional counselling also utilized Western HIV/AIDS counselling. No counselee could be found who only used the traditional health system, whereas some African counselees only utilized Western HIV/AIDS counselling services.

## 4.3.3    What does the counsellor do?

In this data set **counsellor** mostly refers to the traditional healer. In this discussion we differentiate between the role of the family and friends (community members) and the role of the health practitioner in the African culture, who is the traditional healer. Counsellors as well as counselee's descriptions are discussed under the headings, verbal-, non-verbal and other interactions.

Verbal interactions

This refers to an exchange of words between the counselee and the counsellor. These actions are discussed more or less in the order they took place according to the counsellors and counselees.

*Divination*

Though divination included a verbal and non-verbal interaction, the verbal part is discussed under this section. Divination, according to the traditional healers, refers to the divine power given to them by their Ancestors. Most of the time the traditional healers use a medium such as bones, mirror, water, etc., to call verbally on the Ancestors to support them in the managing of the counselee.

*Introduction*

Family and friends in the community already had a relationship with the counselee, so when they interacted with the counselee no special introduction was needed. They would mostly intervene at the request of the counselee or other family members.

What is significant is that traditional healers are also known to the counselee. There was a previous introduction, either by divine powers (Ancestors) or the counselee heard about the traditional healer from others. There had been 'prior contact' between the counselee and the traditional healer.

> "Some they were sent by the Ancestors";
>
> "My Ancestors tells me that there is a person who is sick at this kind of a place." ;
>
> "Others are told by others that we were helped by this kind of a person, who is sick at this kind of a place. They bring themselves."

According to the traditional healers it was also important for the interaction to receive the counselee well.

> "He will tell me my problem is one, two, three. If you receive him well."

*Telling/ confirming*

This telling was more a confirmation that took place between the traditional healer and the counselee. Different issues were confirmed like the clan, surname and the complaint of the counselee. According to the traditional healers they felt a pain sensation in the body part where the 'illness' of the counselee lay and then confirmed the complaint with the counselee. The consultation therefore was a telling and confirming process.

> "The Ancestors have shown that person that he must do this and this and this. When you arrive there you explain that there is this person, my surname is, and here, I have been sent by my Ancestors. You explain everything.";
>
> "He (traditional healer) does not tell us. We are the ones telling him. He will hear from us.";
>
> "We are not the same as whites. You (client) just answer what we (traditional healers) are saying. When I (traditional healer) say you feel the pain on the head, here (show), then you (client) say yes…"

It was observed in the videos that traditional healers mostly used allegories to 'reveal' the counselee's problem. These allegories were quite general.

> "I see darkness in your life"
>
> "You are followed by a dark shadow wherever you go"

Counselees were also told only to agree with the things they knew were true (as observed on the videos).

> "Agree with what you know, not what you don't know"

The traditional healer told the counselee his blood was weak or dirty (this is the way traditional healers 'diagnose' any blood disease like STI's and HIV). Traditional healers said it was only the Western health practitioners who could make a definite diagnosis of HIV. The traditional healers looked at accompanying signs and symptoms to diagnose HIV (e.g. rash, burning urine, a discharge that does not disappear after three bottles of the herbal mix).

> "Because you tell him, I feel your blood is weak. So is better that you go to the clinic and draw blood";
>
> "People with HIV you see them with different signs. The signs of this one won't be the same as that one's. The other thing that we identify with them, is you just don't make a conclusion that he has got it. Is the way you look at him and you give him the 'pitsa's' herbal mixtures.";
>
> "We cannot explain immediately, because it might be STD as we speak. Now we have to help you with this STD first. And you cannot drink three to four bottles then the STD is not right. You have to understand."

Traditional healers have a direct, concrete approach in telling the counselee about sickness or advising the counselee about a healthy life-style. This only happened when both the traditional healer and the counselee confirmed that he was HIV-positive.

> "I will sit him down. When I'm sitting with him down I will explain this thing well. This is not the end of the world. He musn't loose hope. So until he gets well and say I am well. Then we continue with this life…"

*Asking/confirming*

Asking is an integrated part of telling. This happens in the same process, for example when the traditional healer asks whether the counselee agrees, he can say 'yes' or 'no'. The traditional healer will also ask the client to confirm where his/her complaint is, while s/he (traditional healer) touches different parts of his/her own body.

> "He does not get the treatment first. You counsel him first, you examine him: 'I feel the headache, the cough', then he agrees with you. 'I feel the waist' , you see. You counsel him step-by-step"…You see, ' Now where you feel that the pains are, because you are the ones who is feeling the pains'

It can be observed in the video-material that the traditional healer did ask the counselee why s/he had come to him. The counselee answered not by stating a complaint, but by requesting a procedure. Mutual understanding of these requests was observed in the interaction.

> "Ke kopa tlogo (I ask for a head / advice)"
>
> "Ke kopa go laola (I ask you to throw the bones and tell me)"

## Non-verbal interaction

This interaction between the counselee and the traditional healer was dominated by non-verbal expressions or behaviour.

*Divination*

The non-verbal part of divination started with the preparation, by means of which the traditional healers kept contact with the Ancestors to show the traditional healer what was going to happen or what was happening. The contact with the Ancestors actually happened from the time of their calling and was continually strengthened through dreams or rituals. Divination is considered to promote contact with the Ancestors. Divination is a preparation as well as a strengthening activity for the traditional healers to do their job, which is facilitating the process of healing.

> "Before you go to be trained for healing, you will see when you are sleeping, they will show you the animal skin laid. You will see all things that involve your healing powers";
>
> "So we play drums, we shout. It becomes noisy. So when we are doing like that we are calling our Ancestors to come and see that here are our children, they are ill"; ... And we dance"

*Using of medium to contact Ancestors*

All traditional healers use a medium to facilitate contact with the Ancestral Spirits. They then identify the problems of the counselee through this medium. This medium is used as part of the spiritual divination process.

> "So there are different things that you make contact with the spirit and you use whatever you use. There are water, bones, mirror, bible, the candle." ;

> "We are made aware by the spirit when we are using the bones, with the bones the spirit comes and tell us."

*Physical position during counselling*

During the counselling process, the traditional healer as well as the counselee would take off their shoes and sit on the floor on traditional mats (mostly animal skins). Their explanation for this position was that they were following in the footsteps of their Ancestors to make contact with the Ancestral Spirits.

> "You sit down first with him";  On the floor";
>
> "...That's the way your spirit will come. The way you have been made. The way we are doing for our Ancestors. Because you cannot do this work before you respect it, never." ; Long time ago our Ancestors did not have chairs. You still remember. Yes there were no chairs before. They were laying animal skins on the floor. When they killed goats and sheep the skins were put aside. They were chairs."

Both the traditional healer and the counselee sat 'flat' on the floor and the counselee's legs were stretched out in front.

> "And the people that you are going to examine, they sit down and stretch their legs. Then you examine them"

*Waiting*

The traditional healer threw the bones and communicated with the Ancestors to reveal the complaint of the client. After this divination the traditional healer would tell the client the complaint and the client confirmed. The traditional healer would then wait for the client to ask for help or either ask the client whether s/he wanted help before the helping process continued. This waiting was mostly done in silence.

Silences were clearly observed during the interaction of the counselee and the traditional healer. A comfort with silence was observed in the video. These silences were for the counselee to process what the traditional healer had said and also while the traditional healer listened to the counselee's 'story'. This interaction was done patiently. Counselees often used silence during the telling of their stories.

> "Again we mustn't talk to them rushing them. So that he can tell you all his story when he tells you that I have this kind of a problem"

According to the traditional healers they waited for the counselee to request help from them before they engaged further in the healing process. They did not invite and did not promise a cure to the counselee.

> "You cannot say come to me I am going to help you and whatever, no. You see. I must know why did you come to me. And then from there he will start telling what's wrong and what help did he want."

Time seems to be not an issue according the traditional healers. The counselee determines the time s/he spends with the traditional healer and there is no time pressure.

> "We cannot say how long, because the other person starts crying... So you cannot say go and cry outside..." ; "Again we mustn't talk to them, rushing them. So that he can tell you all his story, when he tells you I've got this kind of a problem"

Traditional healers also wait for the patients to disclose their HIV-status to them, before intervening to care for the patient. They are patient and would not say anything unless the patient disclosed information.

> "Others don't talk. Even when you see what the person has got. The other one says people say I have got AIDS. But he can see how he is. So you must comfort her."

*Putting aside of medication for 'pitsa' herbal mixture*

It was observed on the videos that the traditional healer put aside medication with each symptom 'diagnosed' while s/he was in interaction the counselee. This medication was used later to prepare the herbal mixture 'pitsa'.

*Observing of non-verbal behaviour of counselee*

While the traditional healer examined the counselee he would look for discomfort when moving through the body system. Such observation directed him to what the problem might be. If he sensed any discomfort in a certain area, he directed his questions to explore what the problem was. This was also demonstrated during the 'lekgotla'.

*Social discussion*

Traditional healers said that during this counselling process, the social discussion started while the traditional healer prepared the herbal mixture 'pitsa'. It was the

experience of the traditional healers that the counselees relaxed and shared more personal information during these moments.

<u>Other interaction</u>

*Feeding*

According to the traditional healers, they believed that the herbal mixtures 'pitsa" needed to be fresh. They boiled it while the counselee was waiting and the counselee took the first dose at the traditional healer's house. The counselee also got tea and or porridge while s/he was waiting for the herbal medication.

> "So when the person is at my place, while I am busy cooking this medication I can make tea as well. While is still cooling down I can make porridge she eats"…he drink while you are with her right here"

Traditional healers not only focused on the health needs of the counselee, but also on the counselee's basic needs, such as hunger, as the above quotation shows

*Referring*

Most traditional healers are also comfortable to refer to Western health practitioners. It is clear through their discussion that they understand their role in the health system and refer the counselee if they think they cannot handle the problem. They are also comfortable that the counselee should make a choice of provider based on his/her belief system.

> "No, it depends on our beliefs. Like when a person goes to the hospital, if you belief that the pills will help you, they will help you. That's why I am saying it depends on a person's belief when he says he only drinks the 'pitsana' and it will help him. But us the way we work, we work together with the clinic and the hospital" ; "So white doctors don't refer people to us, we refer people to them";

> "At the clinic they always tell them that traditional healers give you the 'spuit' (African enema). She's the one doing this to you, you see. They discourage them.";
>
> "...he comes again and he come and tell us that my results are saying HIV-positive. So now I give him 'pitsana' (herbal mixture). And he drinks pitsana and also those pills."

*Respecting*

Another aspect in the interaction of the traditional healer and the counselee is the management of emotions. Most traditional healers said that they identified the feeling and when the counselee experienced the feeling, they remained silent with the counselee or communicated in a caring manner to the counselee.

> "We cannot say how long, because the other person starts crying and when you say to them go and cry outside. Is you who is stuck with the pain of the patient. Because maybe she will be fighting with the husband yesterday and now you say that: I feel you have been crying yesterday. And she starts crying. She starts crying again. So you cannot say go and cry outside there are some patients in here. You just have to sit and let the patient be all right";

> "Because other are arrogant. When you come in he shouts you. So you must sit down and relax. Talk to him nice. Crack some jokes, then he laughs and shout you.";
>
> "The other one when you just enter the gate, she says go away with those things, you are going to irritate me. They are arrogant. So we have learnt how they are. They have no patience. You sit there, no matter what she do, you just sit. You must be nice to him..."

*Disclosing*

Traditional healers do not agree with the approach of confidentiality of the Western health system. They feel doctors are scaring the counselee by saying his/her HIV-status is confidential. According to them the counselee must disclose his/her HIV-status.

> "We fight for confidentiality. Why do doctors say its confidential. Because they scare now. The doctor told him its confidential, don't tell anyone. So in the house he's quiet he doesn't tell the parents that he's got it. So that's the way, how are you going to find help. How will your years be extended if you don't look for help for yourself. So we are also asking this confidentiality be finished"

The traditional healers were also respectfully involved in the disclosing of the counselee's HIV-status to the family, after the counselee had disclosed his status to them. This only happened after the counselee agreed to disclose his/her HIV-status. The disclosure was not done abruptly, but they first explored the family's view, then they disclosed to the family and educated them on the support of the counselee. They moved from the known to the unknown in their health education.

> "I will tell him first the child is sick and he only got TB. So now you know TB goes and make so many things. That's why the child does not get well. So mommy how do you take the child? Will you be able to stay with him and treat him well at home. They will explain their feelings. Then I will ask them that mommy like now the child is sick, do you know the HIV illness? Is just an illness is like this TB and cancer in normal sense. So the person like that can you stay with him in the house. They will explain yes or no. But I am not saying he's got it. I just wanted to know a person like that can you stay with him? If they say its fine if this person got HIV or TB we can live with him at home. That's when I say, the child is got a problem like this and this. So he's scared

> to talk and he said I must accompany him to come and explain what his
> problem is." ; No you cannot leave the mother to stay. You explain to
> them from that day so that they understand. Because there are many
> dangers too."

*Follow up*

Traditional healers also did a follow up at the counselee's house as well as
accompanying the counselee to the clinic in their healing process.

> "You want me to take you to the clinic and meet the sisters.  And then
> the sisters go and tell mom at home, or what do you want me to do. It
> will come from him that go with me at home or let's go to the clinic…"

## 4.3.4    To whom (the counselee)

According to the traditional healers, the counselee referred to an individual, but in
most cases they requested the counselee to bring someone with, either the partner
or the mother, to sit in and listen for further clarification or to serve as a witness of
what had been said in the interaction. This was also observed on the video.

> "Each and every person talks for himself/herself. If is a woman, she
> comes with her husband. Another person does not want other people
> to know her secrets. So you cannot choose for her. We agree is it is a
> woman, she comes with her husband. So that they can help each other
> to listen. The other one when you talk does not understand very well.
> The other one will help the other. The same that the child must come
> with the mother, the mother has got the responsibility"

Counselees agreed with this approach. Some of them verbalized that they had gone with their mother to the traditional healer.

> "Yes my mother went with me to that person she said I must go to. Maybe he can help me with the illness I was having."

A mediator can also stand in as go-between for other counselees at the traditional healers, especially when the counselees are in the same support group and they trust each other. This discussion in the focus group interview described this process.

> "He has a lot of customers on the 15<sup>th</sup>..." ; Will you also take for us when he comes on the 15<sup>th</sup>. When we come here, we come with the money and you take it from us and do for us."

## 4.3.5    In what situation/condition?

As stated in the previous quotation, most counselees consulted with the traditional healer when they were sick. Most of the counselees verbalized that they knew they were HIV-positive before they went. They consulted for help, not to clarify a diagnosis. In previous statements the traditional healers also verbalized implicitly that the counselees were ill.

> "I went to another one. And I explained to him that I am HIV-positive and I need help from him. Does he know anything that can help me."; "But I did not go and find out. I already knew what is happening with me. I just explained my problem, then he gave me the medication"

## 4.3.6 How was the HIV/AIDS counselling experienced by the counselee and the counsellor and what was the outcome of these sessions

Counselees as well as the traditional healers were not very expressive about the experience. Some counselees said that the intervention of the traditional healer had made them strong or made them feel better. Other counselees verbalized that traditional healers exploited them financially and they did not feel better after drinking the herbal mixture.

"He only told me is my blood. My blood is dirty. He ask if I have a baby and I say I don't have a baby. He said you did well, you must not have a baby now because if you have a baby, your baby is going to have a problem. He said I must drink the 'pitsas'. My mom asked if there is nothing, if there is no witching. He said no, there is no witching. He said she must only take the 'pitsa' because her blood is dirty. She's got dirty blood...He helped me a lot, because I got cured. I used to be tired, I could not do anything... Since I was drinking them that tiredness disappeared. I am becoming well like before"; "Then he made muti for me, but he also helped me. Because I was weighing 45, he helped me to gain, I was weak, weak , weak. So he helped me a lot with his muti"

"He said to me, I need R1600.00. Those things he was giving to me. African potatoe was not there. There was another, they call it Mathunda. I told my wife this doesn't make me feel well and my heart says to me I must not take this"; "I said to him the doctors said I won't be cured. It won't cure. I will be cured when I'm buried. She said I must leave her"

### 4.3.7 The counselee and the counsellor's ideal situation in HIV/AIDS counselling

Most counselees did not have many recommendations except that some traditional healers had to stop saying people were bewitched when they were actually HIV-positive.

> "They will say someone is bewitching you, he poisoned your food... So traditional healers will tell you, no, no, you are not HIV-positive this and this, is your neighbors and that. In the meantime you are dying"

Most traditional healers felt that they wanted to be acknowledged in the health care system, to have their own practice where they could work. They also recommended that western practitioners should refer HIV-positive counselees to them.

> "I was thinking about working together as in they should also hear us as people. They must refer to us people who have HIV so that we can help each other there. The second thing is we have asked before. So we found that, we ask that we have the traditional healer clinic."

## 4.4 RESEARCHER-COUNSELEE INTERVIEWS

Although the researcher focused on the research question, counselees narrated their stories about living with HIV/AIDS. These phenomena made the data-collection process, which was the researcher-counselee interviews, part of the realization of data.

During the research interviews the narrating of a life story with HIV/ AIDS came naturally from the counselees. Though the question was: "How was your counselling" or "How did you experience the counselling session", the whole life story influenced by this tragic experience, HIV/AIDS, was unpacked by the counselees. Glaser and

Strauss (1965:6) talk about this happening as a natural lull, which first appears in the field notes and becomes part of the implicit coding. After exploration this becomes part of the explicit coding as it is described as part of data realisation.

The themes that unfolded in the story can be compared with the structure of a tragic drama. That is why a tragedy line in the drama, *King Oidipus*, written by Sophokles is used to describe the unfolding of the told story (Sophokles, 1974).

- ### *The tragic story*

It was as if the tragedy of an HIV-positive diagnosis had shocked the counselee into numbness, leaving him/her helpless and without hope. An HIV-positive result was an enormous event, changing their lives forever. This event caused a catastrophe in the 'story' of their lives. In analysing the data and asking questions one become part of a life story with the "horror", HIV/AIDS, playing a central role.

The story enters or begins with the 'tragedy' or 'stepping off the edge'-experience. This is a story trauma. This exodus (end) is the awareness that "I might be HIV-positive" or the reality that "I am HIV-positive". The reason why this experience is an exodus is because most counselees experienced this phase in their lives as final - the event being linked with finality, death and dying.

> "I couldn't accept the result, what is going to happen!....."; " Actually, I don't think there is a person that will be ready to hear that he is going to die eventually"

### The emotions

The experience of the counselees was based on the fear they had of the HIV/AIDS pandemic.  When they realised that this pandemic had become their reality, counselees were burdened with emotions of helplessness, anxiety and pain. Indeed, they faced a tragic, hopeless catastrophe.

> "When I came out of the clinic, ooh I was shocked. I could not even...I was crying all the way until the taxi."; and they saw I'm scared... He gave me the letter and I read it myself and I screamed. I took the letter and torn it."

The despair caused by the tragedy did not only leave the counselee with turbulent feelings, but with internal conflict of disbelief, though the implicit or explicit strive to be accepted by others, though they might have accepted the situation.

> "I told the children that I am HIV-positive, I got it from a man. Is the sickness that infected me. That's all I can do, I accepted it. My child accepted and say mom take good care of yourself." :
>
> "And I must tell you...at that stage I really didn't know what to do!"

> "I used to spend the whole day and night without waking up. I just sleep, I don't speak, I don't do anything. I don't know what is happening with my life. I never bath I just sleep like that. Three or six months doing nothing"
>
> "I never went out of the house. I was afraid of people. When I was sitting outside I would think people see me, even if they don't" ; . I use to sleep always and not eat. I never use to wake up and go out. I never use to open the door";
>
> "...He start te lling you about things you know. They talk about them on TV and on radio. And you don't want that way, you want him also to listen to you.";
>
> Those pills I'm taking them, I asked, but I never got an answer..."

## The personification

The telling of the story often involved a very strong personification of HIV/AIDS. Counselees concretise HIV in their stories. Some talk of HIV as if it was a person.

> 'HIV is there'; and
> another statement is 'I am HIV'.

Some of them also talked about death in a personified way by verbalizing that

> 'Death is there'.

HIV is not seen as a virus, but as a much bigger, powerful 'person'. This person took over the counselee's life as a visible entity. This illustrate the power that the 'HIV persona' had, because according to counselees they had to be strong to travel through this journey.

> "I became strong and  when my child was born I was strong" ; "I was already strong they didn't counsel me."

In the story HIV/AIDS was personified - and more so, most counselees described it as a war that they were fighting. Loosing this war means death. Therefore they had to be 'strong'.

When comparing this personification with what happens in the tragedy, *King Oidipus* by Sophokles (1974) the concreteness of HIV/AIDS can be compared with the dragon.  The dragon is described as a creature with a beautiful face, like a woman and a body and claws like a lion that devours people that make contact with it. In African proverbs HIV/AIDS is sometimes described as a 'ladybird' that is beautiful, but causes damage in a maize plantation. This is what Africans believe happens to the body. The proverb could be compared with the pleasure and beauty experienced

during sexual intercourse, but the concomitant is horrific consequences that can occur if your partner is HIV-positive.

*The discovery*

As the person grapples with the tragedy that has struck him/her further information about the disease and its prognosis tends to unsettle the counselee more. On the other hand it also contributes to discovery of his/her own truth by the counselee. This discovery presents the counselee with answers that lies in the self. The reality that only him/herself can accept and manage this tragedy. The new beginning is to accept and care for the self. This discovery is different for every person, and they each seem to find a unique "truth" that allows them hope and acceptance.

> "After they tested me, they counseled me. They were talking to me, asking me... I don't have any problem my life is OK. I live nicely like a living person."

*The need to tell and share the story*

The need to tell or share the story is evident in the way in which the stories took over the research interviews. The telling also granted the counselees the platform to verbalise what hindered the unfolding of their tragedy during their counselling session. During the research interview the need in the counselees need to talk was so big that they experienced the research interview as a counselling session, by saying, 'thank you for the counselling', whereas the researcher only listened and probed for the data.

This suffering experience was potentiated by the lack of experience and the lack of involvement of counsellors,

> " ...the people who are counselling are inexperienced counsellors. He must know that what he is doing is another person's life...you are stressed, you are mixed up. He start telling you about things you know. They talk about them on TV and on radio. And you don't want that way, you want him also to listen to you"..

That is why counselees experienced it as more traumatic that the counsellors started talking about HIV/AIDS without listening to them, listening to how they were doing or where they lived – in all the ways that HIV/AIDS had evolved in their lives.

> "They don't sit to tell you. You understand. They must sit with you and ask you how you live, how you feel, how is it in the house. We don't take out complains, you just agree..."
>
> "When a person counsels you he must ask you how your life is. What has been happening with you...I was given counselling, I went there and the person was already explaining Aids"

In some situations it was more painful when the counsellor asked them how they were, but did not listen. Some counsellors admitted to this in the following kind of statement:

> "We don't give patients much time to say what they want...I have seen people going the cultural route or the traditional road and its working. We focus on western and that's it. We impose, we more of imposing our belief in this is how it should be".

In this tragedy, counselees also experienced their lived-experiences being played down by some counsellors, through the following kind of statement:

> "Like the sister in the clinic, they disagree with you about something that's happening to you, something you are feeling. She will say you are lying while you are talking about something you feeling, something happening to you. But she disagrees with you."

Their experiences with HIV/AIDS had been undermined. The need to share such a big event had been taken away from them by the previous interactions of some counsellors. One counselee mentioned that the counsellor did not even know that she had tried to commit suicide.

> "He did not understand that for how long have I stayed being HIV-positive. That I tried to kill myself"

This non-caring attitude or lack of knowledge of the individual's story by counsellors seemed to make the suffering of counselees worse during their journey in this story. I became aware that an HIV/AIDS counselling session was only short-lived, but the counselee had to go on, experiencing these dramatic events in his/her story.

- **Significant landmarks in the story**

In this story, significant landmarks were discovered, which the counsellor could use to follow and direct the storyline, if s/he should be listening.

> "When I'm sitting with him down, I will explain this thing well. That is not the end of the world, he must not loose hope. The problem is when we get to the family and tell them, there are those who will fight, there are those who will tell him a lot of things..."

This is in preparation of the counselee to disclose the HIV-status to the family. Truth and reality were not withheld from the counselee. The direct focus on the reality and consequences directed the counselee towards acceptance and the taking of responsibility to live his/her life effectively. These landmarks became counselees' and/or counsellors' realities of what was appropriate or inappropriate in the counselling interaction.

*The purpose of HIV/AIDS counselling*

In this story a gap was communicated between the purpose of the counselling for counselees and counsellors. Counselees experienced counsellors as uncaring, though the counselors did not find a problem with the 'job' they were doing. If one followed the activities in the first level of data-analysis, the counsellors did nothing wrong, they followed a monotonous procedure.

> "I explain how the person with HIV is, he doesn't have signs and symptoms. He is healthy. But if he doesn't take good care of himself, he will reach a stage where he got AIDS. Then how does he get to that stage. The most important thing is to use a condom. Because viral load is the thing that makes a person to reach that stage where he got AIDS".

This 'recipe' of asking the counselee questions, telling then about HIV/AIDS, giving them other information about safer sexual practices and a healthy life-style and testing the counselee for HIV/AIDS created this gap. Counselees on the other hand had an overflowing mug to share about what was happening in their lives and they

needed someone to listen to them and follow their pace, directing them in their journey.

> "And at that time you are stressed, you are mixed up. He start telling you about the things that you know. They talk about them on TV and on radio. They are things you hear every day. And you don't want that way, you want him also to listen to you."

This gap developed between the counsellor and the counselee because of the difference in focus. No one was wrong, because the focus of the counsellor was information searching and giving, in order to make a diagnosis, so that treatment could start as soon as possible. The counselee, on the other hand, needed someone to ponder with him on this complex issue, the dramatic event threatening to rock his/her lifeboat. Counselees thus needed the counsellor to be there and to listen in order to guide them in their journey of spiritual, emotional and physical self-growth.

*Time*

In order to ponder on something, one needs time. It came out clearly in this analysis that one of the most important themes in the storyline of counselees was time. It was found that counselees first needed time to make a decision to do the HIV-test, after they were given information, through this kind of statement:

> "We did not have to wait. They took us from one place to the other, just like that...I don't know what to expect in that time" ; "I did not get counselling".

The fear of the counselee not only included the decision to have an HIV-test, but also the fear of HIV threatening his/her whole life. Though some counselees were sick when they visited the clinic, they accepted an HIV-positive result more easily when the counsellor sent them home to think about whether they wanted the test or not.

> "She said to me she cannot counsel me and at the same time she test me…So I must go and think again. That's why I said to her, OK I'm ready now, because the first time, I was here…So I indicated before that, I'm doing this, I have to cope with things like this"

Their feeling was that the counsellor respected them by giving them time to decide. This time granted gave the counselee the power to make the decision to do the test and also the ownership in dealing with the outcome of the test. It emerges clearly from this kind of statement,

> "She advised me, Go home and think about this, and look at the situation how you live. And then after that, I'm asking you, please, you cannot come with one problem every time, one problem. Please do me a favour and think about this. And I went home and I tried and tried and tried, I stayed with it, and after I stayed with it I said no, this is the right thing (to test)…that is why I felt open"

In this interaction it also emerges clearly that traditional "rules of therapeutic communication", such as non-directiveness, were not important in the communication between the counsellor and the counselee. The approach was quite direct, but the purpose was to give the counselee the time and space to make a decision.

Another issue of time that prevailed was the duration of the whole counselling session. The duration from the pre-test counselling session to the post-test counselling session according to counselees was at the most fifteen minutes. This is too little time for the counselee to process activities in the HIV/AIDS counselling session. In a counselling session the counselee does not only need time for the interaction between the counselee and the counsellor, but also for the counselee to intra-act with him/herself and 'digest' this complex happening. Most of the counselees verbalized that they thought they were fine when they received an HIV-positive result, but exploded when they left the clinic.

> "OK I accept it for a little while, that second, that minute when I was there. When I came out of the clinic, ooh I was shocked. I couldn't even...I was crying all over the way..."

It thus seems impossible to debrief an HIV-positive counselee in fifteen minutes.

> "Looking into the shortage of staff. But at least this person comes in, whether it is on informal basis, but at least you have ten or fifteen minutes time that you spend with a person"

The counsellors, especially professional nurses, have always been seen as very busy and most of the time they do not have time to debrief counselees. Another issue that threatens the need for spending more time with the counselee is a severe shortage of staff in the clinics.

This time concern is bridged by the traditional healers as found in the data, for they allowed the counselee to guide them concerning time.

*Distance*

Most counsellors interviewed were female and they always talk about the counselee as he (men) or 'they or them'.

> "They don't understand why must they do the test. And then when he gets the results, he is embarrassed"

Another situation that is deduced from the data is the fact that some counsellors talk in the third person.

> "You would inform the person about VCT" you ask the patient about fears, whether he or she has fears"

Traditional healers mentioned that the counselee could observe whether you accepted him/her after s/he had disclosed to you that they were HIV-positive.

> "He is watching how you treat him after you have known that he's got AIDS."

This indicates that there is a distance between the counsellor and the counselee. The counsellor is not involved and the counsellor needs someone to listen and be there to guide him. In this storyline a distance is created between the counselee and the counsellor. Being with the counsellor narrating this big event happening in his life, the counselee is 'alone' with no one to guide and support.

*The conditions for counselling and testing*

Along the story of the counselees it became clearer that the condition that makes the counselee to go for the test would determine his/her acceptance of the HIV-results. Counselees differentiated between voluntary compliance, exemplified in the following:

> "I went to the hospital, because I had a problem with my feet. They said I must test..."; I had something that looked like a rush. It was watering the whole body..."
>
> "Firstly I realized something on my body that I'm not fit like before. I'm struggling. Like for instance, coughing, sweating, loosing weight...";
>
> "I went to test, because I felt changes in my body, but I knew what my problem was...";
>
> "They asked me why. I said that I took my boyfriend to the doctor and the doctor told me he is HIV-positive";

> "...the reason for me to go there I was, just like I want to know my status... I was having a partner, so the reason is like I didn't trust him..."

> and non-voluntary testing as in the following:

> So they told us that we must know that there is a VCT counselling and testing. So we have to be tested for the sake of the babies...";

> After they checked me they gave me a letter. They did not tell me about it. They were afraid I would have a miscarriage.";

> "I took my baby to the clinic, and found my file. And I read my file thus when I found out I am positive";

> " ...it was an interview for the job...So he was telling as part of the job you are not supposed to be HIV-positive, because it weakens the immune system."

All counselees went to traditional healers because they were sick or had an emotional or social problem.

In their narration circumstances seen as non-voluntary are situations where the counselee did not make an informed decision to be tested for HIV. These situations are when the counselee is pregnant and the counsellor 'forces' the counselee to make that decision for the sake of the baby and also when the counselee might be looking for employment and one of the prerequisites is to do an HIV-test.

A voluntary condition is where the counselee is sick and the counsellor encourages him/her to do an HIV-test or when the counselee decides voluntarily, because of a personal challenge like distrust of a partner, to do the HIV-test.

Voluntary counselees are more accepting of an HIV-positive result than non-voluntary counselees, because of the level of preparedness that accompanies their internal decision-making.

> When I came out from the clinic, ooh I was shocked. I could not even...I was crying all over the way until the taxi."; ...
>
> and they saw I'm scared... He gave me the letter and I read it myself and I screamed. I took the letter and torn it.";
>
> "I used to spend the whole day and night without waking up. I just sleep, I don't speak, I don't do anything. I don't know what is happening with my life. I never bath I just sleep like that. Three or six months doing nothing.";

> "I never went out of the house. I was afraid of people. When I was sitting outside I would think people see me, even when they don't. I used to sleep always and not eat. I never use to wake up and go out. I never use to open the door".

Traditional healers do not seem to have a problem in waiting for the counselee to disclose, but thereafter they intervene to disclose the HIV-status of the counselee.

*'Readiness'*

Both the counselees and the counsellors highlighted the theme about readiness in the story.

> "...you ask, whether he is ready to do the test itself. Ready to me might be that a person, a patient say I want to. I am willing to deal with the consequences, whether I'm having a positive or a negative result. I want to know. And that is readiness to me"

In this journey along the storyline, readiness is the beginning.

> "So she asked me are you ready...That's why I said to her, OK. I am ready now because first time I was here so I think about what you said"

Readiness is described as the willingness to do the HIV-test as well as the preparedness to deal with complexities of an HIV-positive diagnosis. It is thus important that the counselee should make the decision him/herself to do an HIV-test,

> "Just because they made the decision to come for a test was as if they was anxious to be here"

because it allows the counselee to accept the outcome.

> "Actually, I don't think there is a person that will be ready to hear that he is going to die eventually"

## Need to identify/ sense of belonging

Another significant observation that the researcher became aware of along the storyline is that most counsellors who are working for HIV/AIDS NGOs are also HIV-positive and most of the counselees interviewed for this research are working for HIV/AIDS NGOs. This seems to address this need to identify with other HIV-positive people which is important in the context of searching for identity and venturing into the HIV-field during this research to address the need to understand and support others who are HIV-positive. This need is also made clearer by some counselees requesting that they would prefer to be counselled by someone who is HIV-positive,

> "Thus why I'm saying you should be counselled by someone ...who got it on him, the thing that happened to him...he mustn't tell you about something he read in a book. He must talk about something that's on him, something that happened to him."

*Acceptance*

Acceptance is when the counselee accepts that s/he is HIV-positive and takes responsibility for his/her life.

> "I went to the test with confidence. I told myself that everything can happen, I will accept the results"

This has been described by counselees as an 'acceptance' of the self' and also an acceptance of HIV as part of the self. It is also important that most people who are HIV/AIDS counsellors are PWA (people living with HIV/AIDS) themselves. This is as if the counselee accepts a new identity. The counselee becomes part of a new 'in-group'. Being part of an HIV-positive group and the need to support the venture, rather than being scared to be discriminated against by HIV-negative people,

> "Thus why I'm saying you should be counselled by someone ...who got it on him, the thing that happened to him...he mustn't tell you about something he read in a book. He must talk about something that's on him, something that happened to him."

This action also occurs when counselees make deliberate decisions not to spread the HI-virus and take ownership in promoting a healthy life style.

> "I had a client who was young and HIV-positive, well known in the community and she was quite scared of the stigma around it. But the minute I encouraged her to meet somebody who is positive, diagnosed for more then ten years and was doing very well....I think she progressed well"

> "I am positive. My lover is also HIV-positive. I live the way I live. My family has also accepted me with the illness I have. I am asking that people who are having this illness must be like us."

The outcome of HIV/AIDS counselling in this context describes clearly that acceptance is not an individual issue, but an inclusive issue that a partner and family should also accept in order for the counselee to have a 'fuller' life. When the counselee accepts the situation there is a clear shift from 'existence' to 'life'. They are aware that they can live life to the fullest. The description below also focuses on the process towards 'acceptance'.

Counselees are also more at ease when family - and some community members know about their HIV-status. This is discussed under 'context'. All counselees who accepted are having a 'fuller' life. Their ending was a new beginning, where they live life to the fullest.

- ***The counsellor***

*Kind of person that counsels*

In this story basic therapeutic communication skills were not a barometer in the guidance of the counselee through this process. Through this statement made by a counselee of an ideal counsellor along his/her story s/he describes the person as follows

> "They talk to you about your life, how to accept your life. You must start to accept yourself before you can go and accept somebody else"

Counselees also describe an underlying message of non-verbal care that can build a trust relationship. This kind of person that counsels according to the counselees is someone that conveys 'visible' empathy. This is not an empathy that is verbalized, but it goes beyond verbal caring. It is an empathy that shows in certain actions that even stretches beyond the 'boundaries of therapy'.

> "You can see that she is a person who do care. She was not the person who just give counsel and leave you like that...she is no longer working here, but every time, sometimes she calls and ask, how are you"

> This is a more 'concrete' empathy. This is portrayed in behaviours described by the counselees as s/he 'gave me a lift' or
>
> 'she played a mother-role, called every time just to find out whether I'm still doing fine'.
>
> "I had nothing, no food, nothing with me. He gave me soft porridge then I drink and slept. After thirty minutes I felt fine" ;
>
> "And then he gave me a lift"

This empathy is filled with humanity acts and is not only verbalized but emerges in the behaviour of counsellors, like touching the counselee.

> "I also think it helped me a lot. He took my hand, we sat and he explained how I should manage my life".

*'Professional' counsellor*

A professional counsellor has been described as, understanding and caring people.

> "professional people understand and they have that care...And they went to school for that"

Counsellors are also described as people that accept themselves, before they accept others:

> 'you must start to accept yourself before you can go and accept someone else",

start to know things and is trained to talk to people. It is also important to the counselees that this person is not only trained, but s/he also communicates gently

> "they talk nicely" to people. ." ...in counselling you have to look professional and take a person private..." Some counselees feel that been counselled in a group avoids you from taking counselling into consideration,
>
> "I would like to add is that I wish you are going to get counselled, you know, they do it in an individual. ...because in a group like you don't take it like into too much consideration.";

Confidentiality and privacy became a core request from counselees along their storyline.

> "Give a person confidential in a private side";

They were hurt by counsellors who disclosed their HIV-status without their consent.

> "So they have got these tendency that if the results is coming, they open the results and then going to gossip about our results"

The view of confidentiality differs from the view of the traditional healers. They believe in respectful disclosure after you reached agreement with the counselee. Their view is based on protection for the family and support to the counselee, should he get sick.

An inference that is made from the above discussion is that the professional counsellor needs to be 'passively involved' during a counselling session. It is also clear that the counselees need a turn to talk and to be listened to. Time and space seems to be important facets of the counselling session. This includes a need for genuine caring behaviour by the counselee.

• **The context**

This story is embedded in a specific belief system (Ancestors/ Christianity or both). As the traditional healers verbalized, the healing of the counselee is based in his/her belief system. Whichever health system the counselee uses, if s/he believes, s/he will be healed.

Belief system is a 'deep' foundation of a person, this became clear, when some of the counselees who believe very strongly that they do not believe in traditional healers, expected the care rendered by traditional counsellors from the Western

counsellors. Some of those values are so deeply part of the counselees, though they do not realize it most of the time.

Some counsellors also verbalized that Africans from non-urban areas are more culture bound, than Africans from urban areas. Most Africans belief system is thus embedded in both African (traditional) and Western beliefs.

Another facet of the context is the history of Africans, which constitutes either 'apartheid' or colonialism. In the data this context is only highlighted through the domination of the Western health system. Race was not an issue, because it is the 'kind of person' that does the HIV/AIDS counselling that seems to matter.

What is clear in the findings is the comfort of counselees to integrate the strengths of the two health systems to serve their needs.

There is a general belief among Africans that the health of one person (counselee) is part of a bigger system (family and community). It is also clear through the statement about confidentiality by the traditional healers, and most counselees also felt more at ease when their family members knew about their HIV-status.

This brings me to he conclusion that the 'batho' (people) of Africans stretch beyond themselves, their family or own (African) community. This includes all the mentioned people as well as the western health system, traditional health system and spirituality. The 'worldview' is redefined locally and global.

## 4.5    CONCLUSION

**TABLE 1:**    Concepts identified in the data.

| Process | Western Health System | African (Traditional) Health System | Researcher – Counselee interviews |
|---|---|---|---|
| **Who counsels?** | • Professional Counsellors✓<br><br>• Lay Counsellors✓ | • Traditional Healers✓<br><br>• Family members (Aunts/Uncles) | • Professional Counsellors<br><br>• Lay Counsellors<br><br>• Traditional Counsellors |
| **What are they doing?** | • Introduction✓<br><br>• Social skills<br><br>• Asking<br><br>• Telling | • Introduction✓<br><br>• Divination<br><br>• Telling-confirming✓<br><br>• Asking-confirming✓<br><br>• Waiting✓ | • The tragic story✓<br><br>• Emotions<br><br>• Personification<br><br>• Discovery✓<br><br>• Acceptance✓ |
| **To Whom** | • Counselee | • Counselee<br><br>• Significant other✓ | • Counselee✓ |
| **Context/Situation** | • Pregnancy<br><br>• Illness<br><br>• Job application<br><br>• Their partners were HIV-positive | • When they were ill<br><br>(Illness) | • Time✓<br><br>• Purpose✓ |

*The table (Table 1) summarises important concepts identified in the data (4.2 to 4.4).

✓- Key concepts identified during data-collection and confirmed during first level discussion with the participants. These concepts were used in the description of the emerging theory.

The first level findings were validated by a first level discussions with nurse counsellors who do HIV/AIDS counselling to Africans as well as traditional healers and counselees who received Western as well as African (traditional) counselling. Two (2) nurse counsellors, two (2) traditional healers and one (1) counselee (patient) participated. In these discussions the found data (first level) were discussed to validate findings, which is not an interaction to verify/test processes. The techniques that are marked emerged spontaneously as core categories *(See table 1.)* These techniques are also emphasised as important by participants during first level discussion.

Findings of western HIV/AIDS counselling were discussed with nurse counsellors and traditional (African) counselling was discussed with traditional healers. Both systems were discussed with the counselee, because he used both systems. These discussions were done on separate occasions.

During the first level discussion I became aware of the intense need of the counselee to integrate these two health systems peacefully with awareness of the comfort of the counselee to use the strength of both systems, but also a frustration of the external conflict, some health professionals, who sometimes make it impossible for counselees just 'to be'. This awareness links to Higgs' (2003) argument that education should be relevant and useful and we should draw from each others' strengths to develop an appropriate education system for Africans. Therefore I propose an HIV/AIDS counselling approach for Africans that is relevant and useful, because both the health systems discussed in this chapter have the same goal, which is to promote and maintain good health practices through counselling interaction. The following diagram illustrates this framework.

# DESCRIPTION OF THE EMERGING COUNSELLING THEORY

## 5.1    INTRODUCTION

Emanating from the in-depth individual interviews, focus group discussions, video footage and the 'lekgotla' was the understanding that an "African friendly" counselling approach does not necessarily consist of different stages of the counselling process. Neither does it have radically different concepts. Instead, each western concept should be given an appropriate African meaning.

Abstractions, that forms the foundation of these concepts, emerged from this level by asking questions in the descriptions, with the objective of this research in mind, e.g. What happened? and Why?. Memos were written for data-collection and analysis to continue in searching for the craft of the underlying description of the emerging theory.

Two strategies that are constantly used in this level to dense the description is the collapsing and trimming of abstractions by linking similar abstractions as well as omitting those that does not fit in the logic description. These methods also brought forward the thickening of abstractions that led to the formation of themes/categories.

While constant comparison and contrasting, (Glaser 1992) a spontaneous pattern emerged between categories. These categories, with its properties were ordered to form three phases. The three phases identified in the approach are the first phase, which is **Counselling before an HIV-diagnosis**; second phase, **Informing of an HIV-positive test result** and the third phase, that describes **Counselling after an HIV-positive result** (See fugure 1). Three phases emanated in this research forming core categories with properties which guides the emerging theory as discussed (Glaser, 1992).

**AN HIV/AIDS COUNSELLING APPROACH FOR AFRICANS**

PURPOSE

DECISION-MAKING | DISCOVERY | ACCEPTANCE AND RESPONSIBLE LIVING WITH HIV/AIDS

TECHNIQUES
- Introduction
- Creating a comfortable counselling setting
- Confirming
- Respectful waiting

OUTCOMES

Comfort to make an informed decision to be tested for HIV

A supportive environment to maintain ownership of his/her decision

TECHNIQUES
- Gentle communication and support
- Confirming and respectful waiting
- Discover with the counselee

OUTCOMES

Coping with initial shock

Decision to continue counselling

TECHNIQUES
- Asking for the story
- Negotiate responsible disclosure
- Teaching
- Ritual of closure

OUTCOMES

Finding meaning to live responsible with HIV/AIDS

Empowered to make informed health choices

PHASE I : Counselling before an HIV diagnosis → PHASE II : Informing of an HIV positive result → PHASE III : Counselling after an HIV-positive result
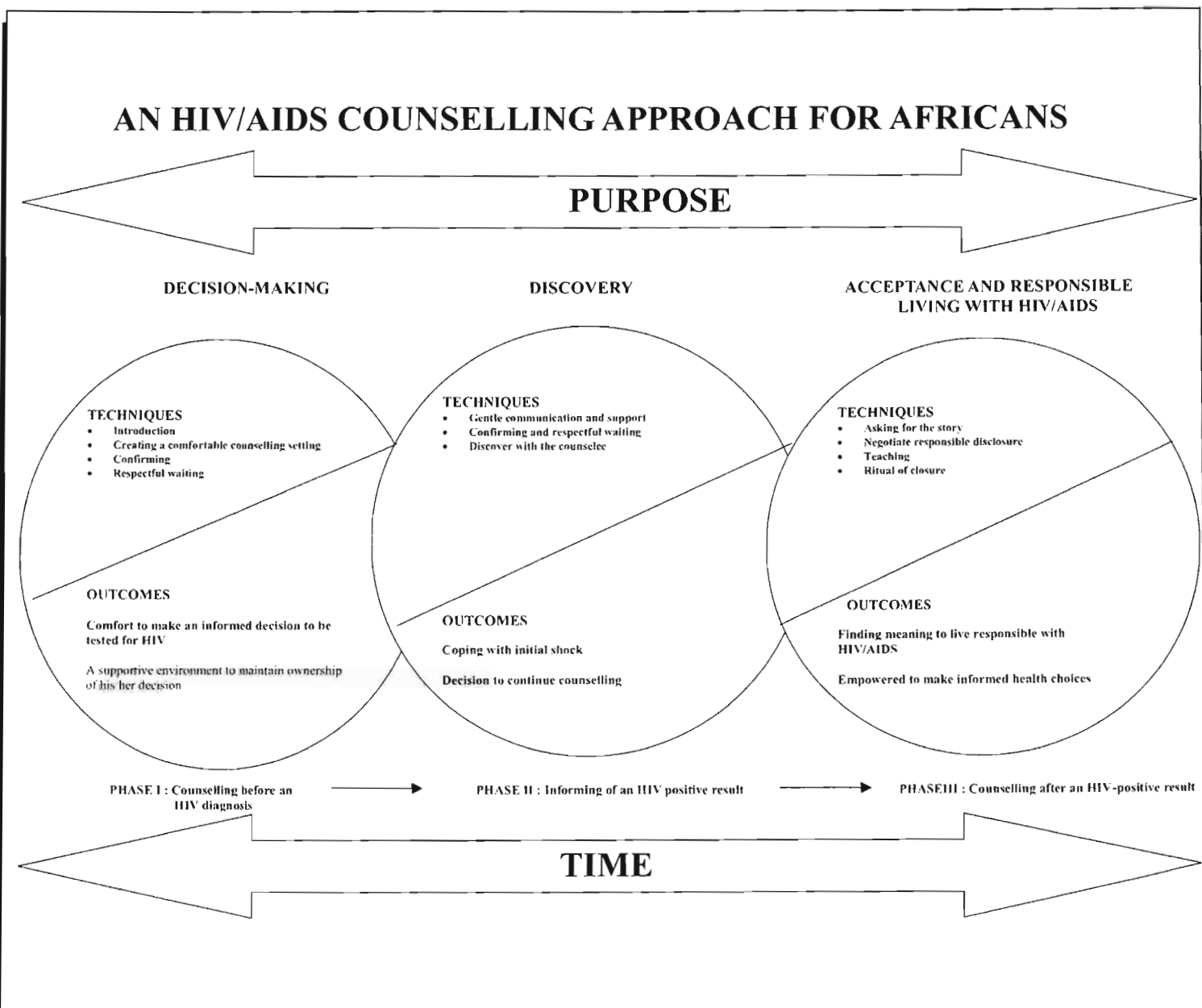
TIME

Figure 1: An HIV/AIDS Counselling approach for Africans

The approach for African HIV/AIDS counselling is discussed below. The use of literature in this section of the research is not to verify the found results, but to relate the literature with the discussion of the findings (Glaser, 1992).

## 5.2.1   Phases

The following three phases emerged:

- Counselling before an HIV diagnosis (Phase I)

- Informing of an HIV-positive result (Phase II)

- Counselling after an HIV-positive result (Phase III)

The first phase starts before the counselee made a decision to be tested and ends when the counselee made a decision to be tested or not tested. The second phase starts when the counselee is informed of an HIV-positive result and the third stage is after the counselee received an HIV-positive result. This approach can be used for both people affected and infected with HIV/AIDS. Each of these phases will be illustrated with the Setswana idiom, which seems to encaptulates the content of the phase.

The models of HIV/AIDS counselling that are used in South Africa focus mainly on aspects of pre-test and post-test counselling. During pre-test counselling the counsellor explores the reason for testing, meaning of a positive result, meaning of a neative result, fears and concerns of the counselee, which tests are available, possible reaction of the counselee, previous stressors of the counselee and high risk behaviour of the counselee. The counsellor interpret the results for the counselee, make recommendations on prevention and risk behaviour and offers support concerning adherence to medication during post test counselling (Kaplan, Sadock & Grebb, 1994). This clearly focuses on the experience from the professional point of view of the counsellor and not from the need of the counselee. The current models also look at a short-term solution, rather than long-term engagement.

### 5.2.1.1 Counselling before an HIV diagnosis

During this pase the counselee might be totally unsuspecting and therefore shocked after an HIV-positive diagnosis or the counselee might be expect an HIV-positive diagnosis and therefore be anxious and uncomfortable. The counselee is under the impression that s/he is living his/her own life, but only after successful counselling processes through the other two phases of counselling that s/he realises that s/he only existed and not lived life to the fullest.

> ## 'KE PHELA BOPHELA BA KA' (I LIVE MY OWN LIFE...)

Outcomes of this phase

The counselee will experience:

- Comfort to make an informed decision to be tested for HIV

- A supportive environment to maintain ownership of his/her decision

Techniques

There are important techniques that the counsellor utilises in order to reach the outcomes of this phase. These techniques are introduction, creation of an appropriate counselling setting for the counselee, respectful waiting, asking, telling and confirming.

- *Introduction*

Definition:    Introduction means that the counsellor gets to know the name, family name as well as the clan of the counselee.

Introduction as discussed in this emerging theory is broader than social introduction in a western context. In the western context the professional nurse will introduce him/herself as "Sister X and the patient introduce him/herself as Mr./ Mrs. Y", which is merely a formality. The introduction for an African counselee, however, stretches beyond the individual; it includes the primary and extended family as well as the clan, which includes the community. After mutual introduction, the counsellor should identify the clan and family of the counselee e.g. "Are you Manamela, from Ga-Manamela in Moletsi area under chief Manamela". This manner of introduction is done by Africans and is emphasised by traditional healers during introduction. The interaction is also described as 'receiving the counselee well' in the previous chapter, which derives from the African health system where traditional healers are acquainted to where their clients come from.

The above manner of introduction promotes a sense of identity and belonging in Africans. It also emphasises the eminent history of social- organisation of Africans as described by Shapera (1977). This author points out that Africans belong to a tribe (clan), with different domestic groupings under several kinships (chiefdoms). Ochieng in Dupont-Joshua (2003) adds that Africans are not only concerned about their individual expectations in a situation, but also of the concerns of the immediate-extended family as well as the clan. This author (p46) also points out that an African strives for an identity and this identity finds meaning in the group (family/clan).

This introduction is still relevant for Africans and is often only understood by Africans. Nwachuku & Ivey (1991) points out that culture-specific behaviour must be interpreted from the orientation of the insider, which are Africans. My personal experience is also that Africans in South Africa introduce themselves with the emphasis on the identity of social orientation and kinship. This way of introduction is also an indirect way of mobilising a support system, because the family and community support is seen as important amongst Africans.

Problems that can occur during this phase is that the counsellor might mistake the clan of the counselee. The counselee will correct the counsellor and in this interaction support could be mobilised as supported by Ochieng in Dupont-Joshua

(2003) who pointed out that the discussion of family and clan re-afirm cultural bonding.

It is important that counsellors that works with an African community aquaint themselves with the leadership and clans in the area. This action can strengthen therapeutic relations amongst counsellors and African counselees.

This is not only an African phenomenon. In the Afrikaans culture an introduction of "Koos van der Merwe" will often be followed by the question "From which van der Merwes are you?" This question establishes the "herkoms" or background of the person. Similarly, the use of titles for royalty in Europe establishes the individuals heritage. These usages are perhaps less strong than in African tradition, but can be used to help western counsellors understand and relate to the African introduction.

- *Creating of a comfortable counselling setting*

Definition:    A comfortable counselling setting is a physical setting that is similar to the social environment of the African counselee e.g. traditional mats in the counselling room

A second technique is the creating of a comfortable counselling setting. In the western context this means a setting that is private, quiet and comfortable. Most of the counselling rooms in clinics are furnished like administrative offices. There is no need for furniture, such as desks and chairs during African counselling. A set-up that is proposed in this emerging theory suggests that having chairs/ benches or traditional mats in the counselling setting might contribute to the comfort of the counselee.

In African counselling and social settings, as well as the researcher-counselee interviews, chairs are seldom used. Benches and traditional mats are the norm. It was clear in the research situation that the counselees did not have a problem that the researcher sat on a bench. Respect and listening were more important than a physical position of the counsellor during the research interviews. However, counselees felt more comfortable sitting on the ground or floor. The contact with the

ground symbolises contact with their Ancestors, which bring safety and protection as well as a sense of belonging for the counselees.

A problem that could arise from this technique is the overloaded Western health services lack space to create a comfortable setting and also the allocation of standard office furniture by the government. This problem could be addressed by involving other health workers e.g. lay counsellors and traditional healers to do counselling in a more natural setting. Thorough training can be facilitated and also support to these health workers by working under the direct or indirect supervision of professional counsellors.

- *Confirming*

Definition: Confirming is a communication strategy that involve the counsellor in listening, asking, telling and asking, listening and reconfirming to clarify the problems as well as the support systems of the counselee.

In the western context the counselee is initially overpowered with a number of questions for example Why is s/he has an appointment with the counselor? What...? This leads to the counselee giving a lot of information before the counsellor can proceed with counselling. In the African context the counsellor asks the counselee the reason for the visit. When the counsellor uses this technique, s/he must wait respectfully for the counselee to answer the question for the process to flow. Further questions are asked to identify the need of the counselee and the counsellor should wait for the counselee to confirm the needs. This technique comes from counsellors in the Western health system who were successful and is always practiced in the traditional health system by traditional healers. During the researcher-counselee interviews the counselees made it clear that they expect the counsellor to listen to them. Knott *in* Uys and Cameron (2003) talks about a benevolent curiosity where active listening and communication is used. Active listening is supported in the findings of this research, but counselees requested more listening and less interference during HIV/AIDS counselling. Counselees has an enormous need to share and expect listening, minimal verbal response and asking to confirm their needs.

In African counselling the counsellors explore the problem in a different way. Telling and confirming also takes place at the same time of asking and confirming. The counsellor tells the counselee what s/he observes or become aware of during counselling session: "I can see you are very sad, you bent your shoulders." This interaction is moving beyond the reflection of content, which is highlighted in Western counselling, it is a trust in the counsellors 'gut feeling' or intuition. This technique is usually done by traditional healers, where they tell counselees what is 'wrong' through their intuitive , observational skills. Masoga, Nel and Moleleki (2004) pointed out in their discussion about African diviner healers that most traditional healers cannot read and utilises skills observing, listening, touching and feeling to interpret the esoteric codes for the client. These authors also said that divine-healers are performers and artists and they strengthen the art of healing by using drumming and dancing. This practice is still widely used and stood the test of time during marginilisation according to these authors. Normally Africans experience this interaction as supportive and promotes sharing. After the counsellor told the counselee, there is a confirmation by the counselee sharing his/her needs or problems. The counsellor waits respectfully for the counselee to share. Silences are usual during this process.

Arries (1998) determined different factors to describe intuition. The factors highlighted by this author focuses on the situational as well as the process of intuition. Situational factors within a certain context refer to the characteristics like knowledge, experience, empathy as well as incomplete data and uncertainties. A process of intuition follows when these characteristics occur, which is an integrated process characterised by a more synthetic-analogic than analytic that includes holistic interpretation, which is irrational, but goal orientated. According to this author the practitioner's intuitive skills are refined by re-implementation.

In this context the counsellor's intuitive skills will grow by confirming what is sense with the counselee and constant implementation of this skill. Intuition in this context is based on the knowledge and experience of counselling Africans and the comfort of disclosing and confirming synthetic-analogic situations during counselling, e.g. 'you seem sad, your shoulders are hanging' or sometimes more irrational "I sense severe

bitterness..." The counsellor should thus become aware of the counselee's holistic context, because Africans are high-context communicators, for the reason that they say less verbally, though still communicating.

Orlando describes an interactive theory between the nurse and the mental health care user. In this theory Orlando highlights a four central points. The first point is that the individual should receive prime attention and secondly that certain behaviour is a plea for help. In the context of this research the tragic story of the counselee should receive prime attention, because the process of healing is guided through the unfolding of the story (George, 1980).

Another facet that Orlando suggests is that the nurse should react to the verbal or non-verbal behaviour of the patient and wait for response to identify the need. This reaction should be for example when the patient walks up and down, " You are walking up and down". If there is no response the nurse should add a feeling e.g. "It must be anxiety provoking to be in this situation", the nurse thus presumes the feeling and stand to be corrected if it is not accurate. In this research asking-confirming and telling-confirming describes a similar proces during counselling (George, 1980).

Lastly Orlando describes the action of the nurse as automatic or deliberate. Automatic actions are those actions decided upon for reasons other than the patient's needs and deliberative actions addresses the patients needs (George, 1980). In the context of this research the HIV/AIDS counselors had automatic matic actions by been information driven instead of person-driven, because according to the researcher-counselee interviews the needs of the patient is not always information. Counsellors thus need to make a shift from automatic actions to deliberative actions in order to address the African counselee's needs. This approach supplies a framework to assist this action.

Problems that occur during this technique could be the need to clarify (interfere) by the counsellor. Constant clarifying might interfere with the sharing of the counselee. Counsellors should teach themselves to listen and wait for the counselee to answer after a question was asked. Another problem that causes the high interference by counsellors, is that the counsellors are in a hurry and have limited time to listen to the counselee. Developing a broader system of care by involving other health workers could also alleviate this problem.

After clarifying the situation the counsellor ask the counselee whether s/he would like to be tested for HIV in order to deliver appropriate health care. This is important, because traditional healers mentioned that only western health professionals could confirm an HIV diagnosis. UNAIDS (2001) supports this interaction by their statement that voluntary counselling and testing reduce fear, ignorance and stigma surrounding HIV and normally leads to better support and care.

A problem that occurs during this stage is the need for the counsellor to test and the feeling that s/he failed when the counselee decides not to test. This is potentiated by the need of statistics by the Department of Health in South Africa. Successful counsellors in the Western health system normally supports counselees and send them home to think about testing and return when counselees decided they are ready.

- *Respectful Waiting*

Definition:   Respectful waiting means that the counsellor is caring and patient while s/he allows the counselee to share or to make a decision or think things over.

This brings us at the process during this phase, which is that the counsellor determines whether the counselee expect or does not expect an HIV diagnosis. When counselees expect an HIV diagnosis they are more acceptable, but when they do not expect an HIV diagnosis the impact of the second phase to be discussed is more severe. Counsellors also need to determine whether the counselee is ready for an HIV test, before they do the test. The counselee deciding or not deciding to test for HIV determines this readiness. The technique of respectful waiting empowers the

counselee to make his/her own decision and therefore is prepared to take responsibilities for his/her decision. Pushing and coersion is disempowering and may lead to poor responses, such as not coming back for the test results or defying the diagnosis

Readiness eminates from the researcher-counselee interviews, where counselees stated clearly that they were ready for the consequences of an HIV-positive diagnosis, when they decided to test for HIV. Counsellors should alert themselves with the level of readiness of the counselee. The same problems that occurred in the previous discussion might occur during the support to readiness by the counsellor.

### 5.2.1.2 Informing of an HIV- positive result

The counselee experiences the contrast that sexual intercourse is enjoyable, but it might result in shocking consequences such as an HIV-positive diagnosis. During this phase the counselee is supported through his/her painfull experience.

> **BOPHELO KE THLAKANTSUKE YA MONATE LE BOSULA (LIFE IS A DIRTY MIXTURE OF PLEASURE AND DEADLY BAD THINGS)**

Outcomes of this phase are:

- Coping with the initial shock;

- Decision to continue counselling

Techniques

- *Gentle communication and support*

<u>Definition</u>:    Gentle communication and support rises beyond words. The technique involves with visible empathy and respect.

Techniques that is important for this phase is gentle communication. This interaction is beyond Western verbal therapeutic communication skills e.g. open ended questions, probing, tracking, etc.. During the researcher-counselee interview counselees requested gentle communication. Asking-telling and confirming are a central parts of this phase. Another core technique that is of utter importance in this phase is respectful waiting and silence.

Part of the respectful waiting is effective listening techniques. The counsellor uses minimal verbal response and attentive, active listening in this phase. The mentioned techniques the counsellor applies serves a dramatic purpose allowing for tension to build up to create a catharsis, which leads to healing.

During gentle communication visible empathy is defined through distance between the counselee and the counsellor. In the western health system boundaries are defined as professional and therapeutic. It is expected from counsellors to keep a clinical distance during counselling. In the traditional (African) health system the traditional healer addresses the basic needs of the counselee during counselling, e.g. preparing porridge for them while they are waiting for the herbal mixture. African counselees experience the western technique as less caring. Counselees verbalised that they need counsellors to reduce their therapeutic distance and show genuine care to them. Genuine caring behaviour according to counselees are when counsellors phone them just to hear how they are doing or sometimes visit them at home as well as taking their basic needs e.g. hunger in consideration for example, *"One cannot counsel a person in physical pain, who is also hungry"*. This genuine care is thus not only verbalised, but visible in the caring deeds of the counsellor. The therapeutic distance needed by the counselees includes social as well as clinical boundaries, viewed from a western health perspective.

- *Confirming and respectful waiting*

<u>Definition</u>:    The counsellor clarifies, listen and give the counselee time to experience and work through his/her emotions

The catharsis usually presents with the active or passive expression of feelings. The management of feelings are different for African counselees, depending on their expectations. For some counselees it is acceptable to reflect and ventilate feelings, for other counselees it is a frustrating activity. This frustration is not because the counselee is not in contact with his/her feelings, but rather because s/he wants to experience feelings in his/her own cultural manner. In the African (Setswana) culture verbal phrases to describe feelings are limited and verbal expression of feelings are more concrete than in western cultures. In this research it became clear that counselees experience a tumult in emotions on receiving the diagnosis. Gegory & Russel (1999) stated that patients with a terminal illness experiences an ebb and flow emotionally and should be supported through that. The mentioned authors (p130) said that tears during this process is a cleansing experience.

Counsellors will be guided by the counselee, but a strategy that traditional healers use, which is also highlighted by some western counsellors is to identify the feeling and remain in silence with the counselee while s/he expresses the feelings. This techniques is based the traditional health system and the researcher-counselee interview, although successful counsellors in the Western health system also pointed out the difficulty in the management of feelings for African counselees.

In comparing these techniques with the techniques prescribed in Western counselling, we realise that counsellors have to shift from a verbal active, 'interfering' approach to a more passive-involved approach.

Problems that can elude from this phase are the fact that all professional counsellors are trained on Western counselling and it could be difficult for them to make these shifts. Another problem is that counsellors complain of staff shortage and work over-load, which hinders them to allocate more time to counselees. These problems could be aleviated by training all professional counsellors on this HIV/AIDS counselling

approach. Ochieng *in* Dupont-Joshua (2003) points out that counsellors must aquaint themselves with other approaches of counselling, e.g. approach for Africans, because to apply Western approaches in an African context is to misunderstand Africans as individuals. This author is also of the opinion that a different approach is like different flavours. The taste is in the eating of the flavour and if you (counsellor) never tested an approach, you cannot talk about it, because you do not have something to compare it with. This specifies that there are different approaches and the matter is not whether the counsellor like it or not, but an approach that works the best for the counselee.

- *Discover with the counselee*

Definition:   This takes place after the counselee worked through his/her emotions. There is a mutual discovery of the counselee's strength in his/her own truth and meaning of 'life with HIV'. This discovery empowers the counselee to rise back or beyond the level of comfort

Another techniques discussed in this approach is to move concomitantly with the counselee through the falling of the edge process, where the counselee experiences a range of turbulent feelings. The counsellor should develop awareness that the counselee search *for his/her own truth* and need support by the counsellor who listens to this truth without judgement. Once the immediateshock wears off, the person begins a process of making sense of what has happened. S/he has to find a way of explaining it, or making it part of their life story. Others sometime try to hasten this resolution by offering "solutions" such as "God has a plan with this" or "You can beat it if you fight it". However, people has to find their own unique resolution. This *search of the counselee for his/her own resolution is also known as the search for the his/her own truth and a sense of identity,  which* takes place during this phase. Most counselees were involved in NGO's caring for other PLHA's. These techniques come from the researcher-counselee interview, when counselees narrated their stories.

Gregory & Russel (1999) however pointed out in their book on cancer stories on life and suffering, that a disease becomes known by the suffering it inflicts on those who lives it. This emphasises the search for their own truth and identity during suffering by

the PLHA that was found in this research. These authors (p73) also points out that patients with terminal illnesses have the need to take their journey through the illness at their own pace.

The counselee's own truth also gives meaning to his/her situation. Viktor Frankl in states that meaning is based on avenues ( Havenga-Coetzer, 2003). These avenues (p 16) are creative, in the sense that one does a deed or work to create meaning, secondly one find meaning by experiencing something, someone or nature by giving or receiving love. Thirdly, attitudinal values, where a tragedy is transformed into a triumph.

In this research PLHA found meaning in caring for other PLHA, receiving and giving love from significant others, but mostly from discovering meaning in their suffering and own truth.  It is thus important that the counsellor discover these avenues with the counselee.

The success of this phase is not to play the experience of the counselee down, but to move with him/her through the falling of the edge phase. This interaction is emphasised by Gregory & Russel (1999) in their statement that patients with cancer finds the phrase 'cancer can be beaten' demoralising and a minimisation of their plight to support. According to these authors experiences this phrase as if the health professional is casing them as failures. The same experience was verbalised by the counselees in this research that is why counsellors should avoid playing the consequences of HIV/AIDS down during counselling. Counsellors should thus move with the counselee in his/her journey in searching for his/her own truth and new identity.

### 5.2.1.3    Counselling after an HIV-positive result

Over a shorter or longer period, the counselee learns to live with the diagnosis and the illness.

## 'KE PHELA BOPHELA BA KA' (I LIVE MY LIFE IN ABUNDANCE)

<u>Outcomes of this phase</u>

The counselee will be:

- Finding meaning to live responsible with HIV/AIDS

- Empowered to make informed health choice

<u>Techniques</u>

- *Asking for the story*

<u>Definition:</u>   Allow the counselee to narrate his/her story of suffering, while you are listening attentively. Listen for the landmarks in the story (discussed in chapter 4) and guide the counselee through this important landmark.

Techniques used in the previous phase used are respectful waiting, minimal verbal response and silence. These techniques still continue in this phase. Caring during this phases are more practical. The practical interactions were suggested by successful counsellors in the Western health system as well as traditional healers. Counselees verbalized such physical caring as 'the kind of person who counsels' during the researcher-counselee interviews. Knott in Uys and Cameron (2003) adds that certain values are needed in HIV/AIDS counselling, which is listening and genuine, practical caring techniques by the counsellor.

This technique has some similarities with narrative counselling. According to Monk et al (1997) narrative counselling is embedded in the story behind the story (narrative) that counselees live. The counsellor embarks on a co-exploration by discourse or the creative use of language to search for the strengths and possitives of thecounselee, that is hidden by the problems of life. Winslade & Monk (1999) emphasize that we live the stories we tell ourselves and others tell about us. These authors also point

out that most of the dominant stories that rule our lives were generated in our childhood. Monk et al (1997) claim that narrative counselling requires an optimistic counsellor.

The process of narrative counselling starts when the counselee tells and re-tells the story of his/her life; the counselee explores alternative knowledge and skills by identifying his/her own cultural history to search for deeper knowledge and skills of culture; thickens the description by clarifying why they do what they do; enriching the description of their stories with alternative stories, by challenging his/her own story and thickens and enriches his/her description by re-telling the story contiuously (White, 2002).

In this ermerging theory the counsellor ask for the story, but unlike the narrative approach, the counsellor does not interfere. The counsellor uses the discussed techniques for the story to unfold and give the counselee time to tell his/her tragic story. The tragic story of the counselee is not challenged, because this story constitutes a unique experience, not a dominant discourse. Telling this tragic story helps the counselee discovering his/her own truth which is important to find meaning for to live responsible with HIV/AIDS.

Problems that might occur during this stage is lack of time by the counselor. Lack of time contributes to the counsellor to be in a hurry and thus omit to allocate enough time to the counselee.

- • *Negotiate responsible disclosure*

Definition:    Encourage the counselee to disclose for mutual benefit for him/her and his/her significant others

Traditional healers always negotiate the responsible disclosure of an HIV diagnosis to significant others and support the counselee during and after disclosure. They also invest in training the significant others in caring for the counselee. Disclosure enables the counselee to have support form his significant others and also allows significant others to practice safety precautions, while they are caring for the counselee. In the

light of the appropriateness of this counselling approach I propose a responsible disclosure. Dalal (2002) points out that Africans post colonialism experiences an internal conflict of individualism versus groupings. In this case the counselee might prefer to keep the diagnosis secret, but needs care from the family and/or clan. This necessitates the negotiation of the best option for both parties.

The care-counselling model for AIDS patients in rural Malawi discusses community care, when the community is involved in mobilizing support and resources (Sliep, 1994). Strategies, such as, the patient narrates his personal story while the counsellor makes use of counselling skills, sometimes direct confrontation, to encourage narration. Other strategies that the counsellor utilises are to negotiate with the counselee, family and community to mobilize support and assistance and to delegate responsibilities to extend support to the support system of the counselee (Sliep, 1994). The previous discussion links closely with the findings in this research, where the counselee is seen as part of the family as well as the community. According to this research counselees need support from the family, Western health professionals, traditional (African) health practitioners as well as the broader community.

In a South African context this interaction can invite debates, though it was also clear during the researcher-counselee interviews that counselees who disclosed their HIV status to their significant others were more relaxed and had a fuller life. Nevertheless disclosure should happen with full conscent of the counselee and must not be forced or exploited by external forces e.g. the media and companies contributing money, because the latter causes severe internal conflict for the counselee.

- *Teaching*

Definition.    Empower and support the counselee to understand his/her health-illness experiences with HIV or AIDS in order to make constructive decisions in the choice of appropriate health care.

Another technique during this phase is teaching. Appropriate teaching moments need to be identified and utilised by counsellors. Counselees usually request information or the counsellor and ask whether the counselee understand how to take care of

him/herself. What is also important for counsellors is the explanation of HIV/AIDS. It is found in this research that counselee personifies the pandemic. There is thus a need for concrete, logic sense for counselees, rather than abstract knowledge. If this necessitates using the known proverbs in the community, let it be. In-depth knowledge of HIV/AIDS as well as well as medication is also of ultimate importance for the counsellor to be successful this phase. Kareem and Littlewood (2000) points out that counselling is primarily for managing problems as well as teaching and learning. The counsellors thus have a dual role, which needs to be used appropriately as requested by the counselee. WHO (1988) also pointed out in 1988 already that health education should be tied in the proverbs of the local setting to make it more educational?

Problems that occur during this phase are the same as the previous phase. Additional problems are the lack of knowledge of cultural acceptable approaches in this phase. This can be elevated by exploring the wants and needs in the particular culture.

- *Ritual of closure*

Definition: The ritual of closure is letting-go of the counselee to carry on with his/her life, e.g. when an African male go through traditional initiation he carries on as a man after the ritual.

The outcome of HIV/AIDS counselling using this framework is accepting a HIV-positive results and living a responsible life within a caring family and communty network. In this approach acceptance stretches further than the individual counselee. Acceptance is seen in the family as well as the community. The outcome is thus acceptance and taking responsibility for the self and significant others. As mentioned previously, counselees who disclosed their HIV-positive status live a more fuller life

Gregory & Russel (1999) points out that a learning that took place during the suffering of cancer patients, was that life still unfolds despite a cancer diagnosis and patients can still live a full life despite of a terminal diagnosis. The same lessons became clear in this research. PLHA started to engage actively in life after they

accepted their HIV-positive diagnosis. 'The bouncing back, beyond the equator of life!'

## 5.2.2    Principles of the counselling approach for Africans

Two important principles emanated in this research, which leads to the successful utilisation of this approach. These two principles are time and purpose.

- *Time*

The principle of time, as discussed in the previous chapter, is suggested directely as well as indirectly. Time is suggested directly by both counselors and counselees. In the Western health system time seemed to be an issue, because of workload and lack of staff, whereas in the traditional health system the counselees received appropriate time. During the research interviews, counselees requested time to share their experience being diagnosed with HIV/AIDS.

Indirectely time is suggested by the interaction of counselors giving the counselee time to think or to decide in the Western health system. These counselors are decribed as successful by their counselees. In the traditional health system, traditional healers wait respectfully for clients to respond and uses silences comfortably during consultations. This action allows the counselee to share his/her story and also to work through his/her internal processes in order to make decisions.

In this approach time is suggested for the counselee to share his/her tragic story. Time is also important for the counselee to think, experience his/her emotions and to make informed decisions and appropriate health choices when s/he is ready.

- *Purpose*

The purpose of this approach is in closely linked with the previous principle, time, as well as the outcomes of the phases. The purpose principle means that the counsellor focuses on the purpose of the counselee, and not on external "professional" tasks.

The purposes of the three phases are counselee-focused and the counselee is allowed to move from the one to the other in his/her own time. The counsellor follows the counselee and not the other way round.

Another purpose is thus not to deny or minimize the counselee's suffering, but for the counselor to move comcomittedly with the counselee during these three phases. Core purposes of the three phases are in the first phase, the counselee decides to be tested for HIV or not, the second phase is the discovery of the counselee's HIV-status as well his/her own truth and the third phase is an acceptance to live responsible with HIV/AIDS. Harmony is not only important between the counselee and counsellor, but also between the two principles, time and purpose.

## 5.3    CONTRIBUTION OF THIS APPROACH

This approach contributes to the knowledge and skills of HIV/AIDS counselling. The contribution of this approach is discussed below:

- *A combination of strength of both Western and African (traditional) approaches*

This approach suggests a combination of both Western and African (traditional) approaches. The suggestion comes from the comfort with which the counselees drew strenghth out of both health systems. Most counselees did not suggest that one of the systems is unimportant. The ability to live with seeming contradictions of Africans was illustrated by the counselees either using both systems or suggesting that behaviours of the counselors in the Western system should be equal to the tradional healers' behaviour, e.g. practical care to provide basic needs (when they are hungry). This contribution also emphasises the 'holistic care' outlook of Africans whereas the Western health care system focusses more on 'specialsed care', e.g. a more psychological counselling.

- *Deals with different concepts*

In this approach the counselor deals with different concepts  than these which are usually mentioned in western counselling theories, for instance time and the tragic

story are not fimiliar in common counselling theories such as descibe by Egan (1998) and Van Dyk (2001a).

Time is emphased throughout the counselling process in this approach. Without the appropriate time to decide, think and experience emotions, counselling cannot be successful if one uses this approach. Time is also a central aspect during the sharing of the tragic story. Unlike the narrative approach described by Monk et al (1997) the counselee is not challenged or confronted during the narration of his/her story. The counselor listens and allows the counselee to tell the tragic story. This story is also not interpreted according to the dominant discourse, but the counselor listens and focuses in during the significant landmarks, described in chapter 4 of this research (White, 2002). The counselee also discovers his/her own truth and creates meaning to live with HIV/AIDS.

Concepts in this approach agree with some concepts suggested by the person-centred model, though in a different context (Rogers, 1961; Rogers, 1984). Rogers (1961) suggest that the concepts of counselling is embedded in the relationship, the motivation for change and the outcome. The context of this approach the outcome of counselling in the first phase is build on developing culture friendly trust relationship and assisting the counselee to make an informed decision to be tested or not. In the second phase the counselee is supported to continue with HIV/AIDS counselling.

Rogers (1984) suggests that the counselee must be motivated to discover his/her capacity, whereas this approach emphasises the discovery of the counselees own truth in order to find meaning to live with HIV/AIDS.

- *Uses techniques not part of the Western counselling approaches*

When one explores techniques suggested by Western counselors e.g. tracking, summarizing, atending, probing, questioning, immediacy, reflecting, paraprasing, etc. (Egan, 1998; Donigian & Malnati, 1997; Van Dyk, 2001a), there seems to be no end to the list. The approach for counselling Africans suggests less techniques that

differs from the techniques used in Western counselling. Techniques circle around the two principles, time and purpose of HIV/AIDS counselling for Africans.

Techniques previously discussed such as confirming, respectful waiting, gentle communication, discover with the counselee, asking for he story, negotiate possible disclosure and ritual of closure is unique to this approach.

- *Phases differ from the usual phases of HIV/AIDS counselling*

The usual phases for HIV/AIDS counselling are devided into pre- and post-test counselling (Kaplan, Sadock & Grebb, 1994). This approach suggests three phases based on two principles as discussed in 5.2.

Two models that were evaluated are the traditional are HIV/AIDS counselling in a traditional African context (Van Dyk, 2001b) and the care-counselling model for AIDS patients in rural Malawi (Sliep, 1994). Both these models focus on Western HIV/AIDS counseling strategies of pre- post-test counselling and the first model does not seem to be empirically verified. The second model, however, addresses the facet of community care and involvement as suggested by this approach.

## 5.4 EVALUATION OF THIS EMERGING THEORY

This approach adheres to the criteria of an emerging theory according to Neuman (1997), which is discussed under the following headings, direction of reasoning, level of social reality it explains, whether it is formal or substantive, forms of explanation and the theoretical framework..

An *inductive*, grounded theory means that the emerging theory is based on a detailed observation in the practice. In this research data is obtained from both the Western and African health systems as well as the researcher-counselee interviews. A grounded theory inquiry was utilized for data-collection and data-analysis. Categories emerged through coding of data. These categories emerged into a systematic pattern as discussed in 5.2

The research initiates a *macro level social theory*, because it describes an approach to HIV/AIDS counselling for Africans, which describes the cultural system of a society. As discussed earlier in the research, the approach is developed to enhance the skills of counsellors to deliver relevant, culture-appropriate HIV/AIDS counselling for Africans.This approach is thus developed for a specific area of concern, which is HIV/AIDS counselling for Africans, which makes it a *substantive theory*.

Glaser and Strauss (1965) identified five criteria for the development of a substantive theory. The first criterium is the joint strategy of collecting and analysing data. In this research as highlighted in chapter 3 and 4,data-collection and analysis took place at the same time. This criterium also describes the keeping of memos in order to be sensitive for the 'natural lull' during data collection. The latter process is discussed thoroughly in Chapter 4 (4.3).

Secondly the use of comparison groups is pointed out as a criterium. Different comparison groups are used to compare and contrast similarities and differences in this research as discussed in Chapter 4.

Another criterium is that the researcher should belief in what s/he is doing and live 'data-collection and –analysis'. Both the researcher and the research-supervisor are constantly involved in culture orientated, HIV/AIDS research and development projects, which emphasise the passion for the involvement of the researchers in this research. The fact that the research is conveyed to other researchers for evaluation also enhance the process of the development of a substantive theory.

Lastly the development of this research is not based on testing, that is why there is no concrete assumptions made out of the research. Further research need to focus on modifying the emerging grounded theory and is  based on continuous discovery.

This research fosters understanding of the HIV/AIDS counselling approach for Africans by *interpretive explanation*. Data is analysed and interpreted to form a systematic pattern in the description.

The approach is a looking at the  world of counselling from a functional point of view. The current approach for HIV/AIDScounselling appears not to be effective in the

practice, that is why the researcher embarked on this research. Due to the fact that this theory is still emerging, it is 'fluid' in time and space. That means that with further research this emerging substantive theory can be modified into a formal theory to continue its fit and relevance for an approach for African counselling (Glaser, 1992). This framework of an emerging theory is not written in stone, it is modifiable through further research Glaser (1992).

## 5.5　THE IMPLICATIONS OF THIS APPROACH

* **_For education and training_**

Transformation has been an educational discourse since the uproar in the 70's in South Africa. After democracy in South Africa the transformation discourse in education became stronger, challenging the dominant western education systems (Higgs, 2003). This research also challenges the Western dominant education in counselling. As Higgs (2003) stated in his discourse, African communities in South Africa must participate and be responsible for their own educational development.

Janz (2001)　points out that we cannot ignore the expertise and local knowledge amongst Africans. This is quite clear, because even when the traditional (African) health system has been side-lined for years in South Africa, traditional (African) health practioners still attracted about 80% of Africans. This health system stood the test of time and is still progressing.

Wiredu (2003) elaborates that African philosophy is currently embedded in two traditions, the African and the Western tradition. This also emanated clearly in the context of this research. Most counselees made use of African as well as Western health systems concurrently. Counselees do not have a problem with this dichotomy, though there have been　expectations from counselees who only uses Western health systems, that western health practitioners potray the same care as traditional health practioners. This approach emerged through exploring, describing and analysing the lived-experiences of participants.

Alternative ways of knowing supports justice to non-western intellectual traditions in this era (Moodie, 2003). In this research education and training in counselling, with specific reference to HIV/AIDS counselling , western counselling is transform to promote justice for Africans. This challenge do not only face nursing education, but all steakholders in the education and training of HIV/AIDS counselling.

This approach represents a combining of both the African as well as the Western counselling systems and educators need to make a mind shift from a Western dominant counselling approach to include the African tradition. This research serves as an empirical guideline to adjust curriculums for HIV/AIDS counsellors to be more cultural friendly towards African counselees. Counsellor training according to Nwachuku & Ivey (1991) has always culturally encapsulated. This emerging theory strives to create a less bias, culturally distinct approach for HIV/AIDS counselling for Africans. To be able to train counselors to use this approach, training material and techniques need to be developed.

- **_Practice_**

Most nurses and other health workers might become anxious when they work through this process of counselling. Questions that may occur are ' Where do we get the manpower?'; Where do we get the time to apply this HIV/AIDS counselling process?; Where is the infrastructure to continue with this HIV/AIDS counselling process?

If we also focus on the three critical challenges related to nursing shortages the impact of HIV/AIDS top the list. The other two challenges are internal and international migration (WHO, 2004). The mentioned challenges are global. It is therefore indeed an enormous problem to apply this approach in the already overloaded health systems.

WHO, (2004) propose the utilisation and skill mix to deal with the staffing problems. This means the integration of voluntary workers ( lay counsellors) traditional health practitioners (traditional healers) as well as the counselees relatives.

Further research can be done to explore the employment conditions for nurses and other health workers. This exploration can lead to a policy framework to incorporate other health workers into this overloaded health system.

- *Policy*

Though several authors pointed out that the HIV/AIDS pandemic rest heavily on the nurses globally, nurses' work continues to be undervalued. Nurses are given limited access to resources, especially in the practice, to deliver effective jobs and careers (WHO, 2004).

This challenge can be bridged by allowing nurses to be part of decision-making processes in the highest order of the health system of a country. In South Africa we are all aware that nurses are the heartbeat of the health system, that's why I propose that they become actively part of policy formulation around HIV/AIDS issues.

Most nurses are already actively part of NGO's which support with health care delivery on the HIV/AIDS arena. This strength could be formalised in policy development for HIV/AIDS. The role and contribution of the nurse in comparison with other health care workers should be redefined to enhance the HIV/AIDS care and counselling.

- *Research*

Further research recommended for this study is the application of this emerging theory in similar research settings in African populations. Implementation and evaluation of this research is important.

All these strategies will contribute to the modification of the emerging theory, because it is based on discovery, rather than testing.

## 5.6    LIMITATIONS OF THIS RESEARCH

There were more women than men in both the counsellor and counselee groups. Men were recruited, but since participation was voluntary, some men chose not to take part in the research. Gender disparity can be explained by the fact that more women than men follow a professional counselling career in South Africa and more women are involved in lay counselling for NGO's. Also, in many groups in South Africa, the profession of sangoma (diviner) is traditionally a female profession. In Africa it is also a fact that more women are tested for HIV, because they attend antenatal services. These are the different reasons why more women than men took part in this research.   Nevertheless, the limited number of male respondents is a limitation.

## 5.7    CONCLUSION

The approach that emerged through this research is embedded in the harmony between the experience of the counselee and the techniques the counsellor applies, described in the previous sections of this chapter.

Counsellors have a *concomitant* role in taking the counselee through the discussed process. The techniques should be in harmony with the process unfolding to reach an acceptable outcome for the counselee. This concomitant role of the counsellor comes from the realization through the stories of the counselees that the counsellor must walk all the way with the counselee in the counselling process. Facilitate seems to be a distant interaction and the contextual meaning for Batswanas of accompany is 'taking halfway' (khapha / bhuledisa). Concomitance is thus needed from the counsellors for the process to harmonize; 'Walking all the way with the counselee'.

Ochieng *in* Dupont-Joshua (2003) points out that a counsellor can only counsel effectively in an African context, when s/he take on a different set of rules, either than applying Western approaches straight in an African context. The theory emerged in this research is the beginning in the different set of rules.

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13 August 2003

Mr A J Pienaar
Potchefstroom University
Nursing Science
Private Bag X6001
POTCHEFSTROOM
2520

Dear Mr Pienaar

RE: RESEARCH PROPOSAL

I am writing to advise that your Research Proposal was approved by the Research Committee of the Faculty of Community and Development Disciplines at the meeting held on 4 August 2003.

Enclosed please find the signed Research Ethics Committee form

Yours sincerely,

Mrs E Tait
Faculty Officer
Community and Development Disciplines

cc Prof L Uys

# RESEARCH ETHICS COMMITTEE

Student: Abel Pienaar

Research Title: The development of a HIV/AIDS counselling approach for Africans

A.  The proposal meets the professional code of ethics of the Researcher:

                    YES    X        NO

B.  The proposal also meets the following ethical requirements:

|  | | YES | NO |
|---|---|---|---|
| 1. | Provision has been made to obtain informed consent of the participants. | X | |
| 2. | Potential psychological and physical risks have been considered and minimised. | X | |
| 3. | Provision has been made to avoid undue intrusion with regard to participants and community. | X | |
| 4. | Rights of participants will be safe-guarded in relation to: | | |
| 4.1 | Measures for the protection of anonymity and the maintenance of confidentiality. | X | |
| 4.2 | Access to research information and findings. | X | |
| 4.3 | Termination of involvement without compromise. | X | |
| 4.4 | Misleading promises regarding benefits of the research. | X | |

Signature of Student: _____ Date: 19 · 02 2004

Signature of Supervisor: _____ Date: 9/7/03

Signature of Head of School: _____ Date: 11/07/2003

Signature of Chairperson of the Committee: _____ Date: 30 IY'03
(Professor F Frescura)

# tshepong AIDS project

P.O. Box 40105, Ikageng, POTCHEFSTROOM, 2531
E.Mail: tshepong@telkomsa.net
Tel / Fax; (018) 295 4582
Mobile: 073315 3285

Abel Pienaar
North West University: Potchefstroom Campus
Private Bag x6001
Potchefstroom
2520
20 June 2003

**TO WHOM IT MAY CONCERN**

We hereby grant the researcher, Abel Pienaar, permission to do research
in our region on HIV/AIDS with written or verbal consent of the
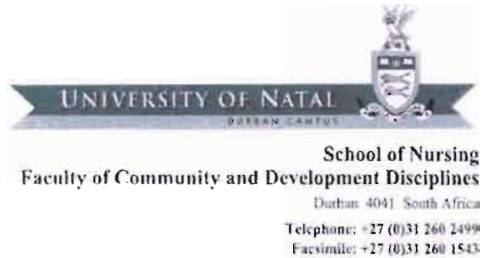participants in our project.

Thank you.

Yours Faithfully,

**T S Mohloua**
**Project Co-coordinator**

TSHEPONG AIDS PROJECT
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**10 September 2003**

The HIV/AIDS Co-ordinator
Potchefstroom/ Klerksdorp/ Moreteletsi
P/Bag
Potchefstroom
2520

Dear Sir/ Madam

**REQUEST TO ACT AS MEDIATOR IN THE RESEARCH: THE DEVELOPMENT OF A HIV/AIDS COUNSELING APPROACH FOR AFRICANS**

I am currently doing a PhD- degree in Community Development Disciplines (Nursing) at the University of Natal, Durban Campus. The title of the research project is "The development of a HIV/AIDS counseling approach for Africans and the specific focus is on the Batswana population of the North-West Province.

Herewith the request to act as a mediator to come in contact with counselees that received HIV/AIDS counseling as well as counselors that provides the counseling. Included is a shortened research proposal as well as a proof of ethical clearance from the research committee of Natal University.

Yours sincerely

Abel J Pienaar
Senior Lecturer: Psychiatric Nursing Science

Prof. Dr. L R Uys

PhD-promotor: University of Natal

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Tel     (018) (018) 299 1834
Fax     (018) (018) 299 1827
E-Mail  vpkajp@puknet.puk.ac.za

**10 September 2003**

The participant


Dear Participant


**WRITTEN PERMISSION TO PARTICIPATE IN THE RESEARCH: THE DEVELOPMENT OF A HIV/AIDS COUNSELING APPROACH FOR AFRICANS**

I am currently doing a PhD- degree in Community Development Disciplines (Nursing) at the University of Natal, Durban Campus. The title of the research project is "The development of a HIV/AIDS counseling approach for Africans and the specific focus is on the Batswana population of the North-West Province.

Your written or verbal permission is requested to conduct an in-depth interview/ focus group interview with you after explanation of the purpose of the research.

The researcher will ensure that your identity is protected and the information will be used for research purposes only.


I................................ (participant) the undersigned give herewith permission that the research interview is recorded.


................................
Researcher

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# ANNEXURE D

## An example of an individual indepth interview with a western counselled female

| ANALYSIS (see numbers on text, explanation follow below) | | |
|---|---|---|
| | P- | Let me say, for the first time it was so difficult. I couldn't accept the result, what is going to happen. So my challenge was if they come negative was then, if they are positive what then. I was not so much related with this, the answer. |
| | R- | Just to go back, for the first time where did you go? Did you to clinic? How did it happen that you get tested? |
| | P- | For the first time I tested in…(3) I was tested in clinic in town. So I was counseled by a (1) sister, a white sister. And then that time I was pregnant. Then she couldn't tell me when the results came back. She was moving around crying. So I asked myself what is happening here. (2) She takes about 30 minutes before she can tell me what was happening. And then she ask me how … if if somebody came came to me and tell me that I'm HIV positive or negative how am I going to react. Then I just take it simple, Then I said no, I said, because I didn't thought that my results were HIV positive. After that she turn again, she didn't give me exactly. She turned and went to the office and came back. And then she told me that I must be strong, eat healthy food, she didn't give me the results exactly. I must call … where does my boyfriend stay? Can I call him to the clinic? There is something that he want to talk to them, I said why. Because I didn't think about the results that they are negative or positive. After that she told me that I'm HIV positive. (5) Okay I accept it for a little while that second, that minute when I was there. |

The ANALYSIS column header also appears on the right side of the table.

| | | | |
|---|---|---|---|
| | | When I came out from the clinic oooh I was shocked. I couldn't even ... I was crying all over the way until to the taxi. When I go home, my parents asked me what was happening, then I said I am having a headache. I couldn't tell ... I couldn't accept that I'm HIV positive. Even my boyfriend took three months before I could tell him that I'm HIV positive. Cause every time I was crying. | |
| **ANALYSIS** | R- | Then if you can think back of the counseling as you say, before she did the test, what was it exactly that she doing? Or did she do a test on you only because you were pregnant? | **ANALYSIS** |
| | P- | Yes, before the counseling was not like now. When you go as a **(4)** pregnant person they didn't even counsel in the right manner. **(2)**They just took the test and then they told us that you have to be tested as a pregnant mother for the consequences of the child. That's all. And then after the results then they will retell you that you are HIV positive. And the second thing ... the third thing is that they are going just to counsel you or advice you how to live a positive lifestyle. That's all. | |
| | R- | So they didn't really ... how long did it take more or less for them to ... to, or they just told you that you need to be tested. | |
| | P- | They referred me to **(1)** *Halalane. And then they told me that I will get the counsel there. But it tooks me time before I go to Halalane. | |
| | R- | Oooh, they didn't the test and they gave you the results, then they referred you. | |
| | P- | Then they referred me to *Halalane. | |
| | R- | Is that system still working sometimes | |
| | P- | No it doesn't work. It doesn't work. Because most of the reports that we get from our counselors is that sisters, they are the one who are doing counseling most of the time and they do test the people. They don't refer people. So we get nurses that sticks on counseling and testing. | |
| | R- | So when she told that in pre-counseling, she didn't anyway prepare you that what if it would be | |

positive or what was the discussion with you?

| ANALYSIS | P- | (2) No, they just told me, we were in group like mothers stating there as pregnant mothers. So they told us that we must know that there is a VCT counseling, testing. So we have to be tested for the sake of the babies, we are in group, they didn't take us one by one. So that we can get pre-counseling and understand why are you being counseled or tested. They didn't do that. After the results they just call you in and they ... but you can see with the condition if you realize now. By the training's and whatever you could have seen those people didn't have ... they did have but didn't have the heart how to talk to you about the condition. | ANALYSIS |
|---|---|---|---|
| | R- | And what was now, what was working in that counseling for you? | |
| | P- | From *Halalane's side, from the clinic's side? | |
| | R - | Yes. Before we go to *Halalane, from the clinic's side. | |
| | P- | (5) Actually let me say from the clinic we don't get it so much. Because the sisters are too busy. They don't even have the time to sit down with you. You don't gain so much because they are there just for the report. So you don't gain so much unless there are people there, sit there doing counseling, they I can say I have gained something, but at the time I didn't gain. | |
| | R- | And when you went to *Halalane, how was the counseling there? | |
| | P- | (2) Okay, they started from the scratch, they explained for me what was supposed to be done before. And then they asked me how was I counseled, then I told them I didn't do counsel, I don't understand these counseling. Then they explained to me what is counseling, what was supposed to be done. And then I went to sessions, they took me to sessions of counsel in Johannesburg. Where i was in counsel for treatment thing. Then after that, I started to | |

| | | realize that this thing is there, the virus is there. I have to accept to live positive life style. And that's it. | |
|---|---|---|---|
| **ANALYSIS** | R- | And in that sessions what did they do? Except in that sessions in counseling. | **ANALYSIS** |
| | P- | (2)They talk to you about your life, how to accept you life. You must start to accept yourself before you can go and accept somebody else. And things will start to come very easily to you if you accept yourself. Whatever is not only HIV. In general, you have to accept yourself, and then start to know things. And be trained or talk to other people, share your problems, talk to your family, and then they advice you the more you come open. And live your healthy life style. | |
| | R- | How was it for you as a Tswana person to accept and to, did you talk to your family about it? | |
| | P- | (2) Information was there, and we were the first people to be photo, to be taken out in the TV and we were not sure about that. We were not being told that you are the person that you are going to be shown in the media, on a TV. And then when we came from Bara we went to Pretoria north, we went to drop one of our friends. And then we said lets look at the news see what is going to happen. Oooh, we were shocked, three of us, you the reporter how do they report, they shoot three of us we were standing there, they said this three people they are the one living with HIV. | |
| | P- | (5/7)I was so shocked, I couldn't even when I came back how am I going to address that to my parents. When I enter at home it was half past eleven to twelve. I get my mother sitting there, the lights were switched off looking for the TV. When I enter she told me that how can you do this to me. Then I just thought that she look in TV and she sees what happened. Then I ask her what. You just leave like that you say, you said to me …you told me that you help the people living with AIDS. All of a sudden is you that you are living with the virus. | |

| ANALYSIS | | | ANALYSIS |
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| | P- | Then I said no, you know the reporters, but I was shocked. You know the reporters they are just reporting whatever they see is not only me, you have seen that it was a crowd there and many people were there. You cannot say only is me, then she said you are lying to me because you were with two guys, one lady ... two ladies and one guy and the TV just exposed you there to be HIV positive. Then I said what then. I can hide I cannot hide but already people have seen outside that I am HIV positive. But as long as that I know myself that I'm not HIV positive, knowing exactly that I'm HIV positive. And then after a period of two years people started to talk. She is having a baby the boyfriend living just like that because she HIV positive, she was at a TV. But it was so difficult for me to cope, I couldn't even move in the street. When I move I just see people looking for me with AIDS. And then again department of health with the trainers or whatever, so the trains that we attend. so from there I started to realize that I'm a normal person although people can look at me, I not written HIV positive the thing is I deserve this, I have to deal with the situation, I have to accept the situation. I'm there and if I believe in myself I'll be just like each and every body who's living positively with his own live. And there I, although difficulties sometimes are there but I'm still going on. | |
| | R- | And you never disclosed to your parents? | |
| | P- | No, I in 2000 we hold the event here at the stadium where we invited the people from Bara, the MEC of  Health, that was the support group together with the Bara people and it's consortium and Good Hope whereby I felt that I cannot live in the situation of people gossiping about me although I know I'm HIV positive. The thing is then that I'm going to, I've prepared myself I've disclosed to the meeting. Now I don't care who is going to say whatever, what you can say. I'm going to tell the media, outside the people that I'm HIV positive and I've accepted it, they must stop to go | |

| ANALYSIS | P- | around and gossip, if they want more information they can come I'll help, I'll say where is necessary. And the after the.... I didn't tell me parents, I just do it at the stadium. And then my brother he is having a wife in Mafikeng, in Rustenburg and then she saw the event in Bob TV and she phoned my brother and told him she saw in the TV disclosed that I'm HIV positive. And my brother came to me and asked me Yvonne!! Why you couldn't tell me that you are HIV positive. Then I asked him what?, if you could tell me one reason why should I have to tell you that I'm HIV positive because I'm not sick. I'm a normal person I have never realized any symptoms since I have tested for HIV. But he asked me, why do you have to tell the community outside before telling us, then I said You are my brother, I know that you have got the feeling that I'm HIV positive, but the fact remains that I'm HIV positive and you have to look for your own live. So I have to look for my own live. So, we have heard from the TV, that's fine. So, you have been told, I have never been born with HIV, you have never been born with HIV. So here am I what is the problem?. But it took a very long time, but he didn't have attitude to me. He started want to treat me as a baby. To nurse me and whatever then I said no. I don't want to be treated like a baby. Don't look after my back, whatever I'm doing you are behind me. I'm not going to die. It's only God who know when is a person going to die or this human being is going to die, because you will thought that I will and then you die, what then. Then he went to my mother and tell my mother that I'm HIV then that is went my mother started to become sick. Mother was very very sick in 2001. | ANALYSIS |

| ANALYSIS | P- | We took her to the doctors, traditional healers she was so sick, we didn't even know now what to do and we took her to Medicity the Dr was Dr Heys. The he told us that my mother was having a heart attack, then I started to talk to her. What is the cause?, You my son, you , I couldn't believe it it's you being HIV positive. Then I ask why you couldn't talk to me ,why can't you sit down and share, because you sit down there with pain, hearing outside not asking me. Lets sit down and talk, and understand what is HIV. We started from there talking, to her discussing the issues of HIV AIDS, talking , talking, every time I'm talking ,I'm sharing some times I'm making jokes about that. Then I said, I've cooked today, you must know the HIV is there, if you are afraid of HIV, then you must know that you have eaten HIV in your food. Then they started to laugh in the house and saying you are lying there is nothing like that, if you have cooked your blood there, then your blood is dead because you have cooked the food. Then I said that is the way we have live, because I don't believe there somebody who take his blood and put it the hot water or hot food then found that HIV is there. You will never get HIV by touching somebody. You never get HIV by kissing somebody, it depends how you kiss that person. Because if you just kiss a person with a normal kiss there is no virus. Whatever you can do you can eat, there is no virus. Then she started to turn and come back but now she is stopped. They have accepted that the virus is there. And they have seen my people when they go outside sometimes I took the pictures and they show them when a person is HIV positive and it turns to the terminal stage who does a person look likes. And if a person doesn't take a treatment or take care of themselves what is happening. She started to accept although it was so difficult for her to accept but now she is living. And she is the one now who is teaching others. When a person come in talking about HIV, she is the one, she is the teacher now. | ANALYSIS |
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| | R- And the counseling, *Ms X, the counselling that you received at that time what is bad about it? As you said that it was so terrible. They just told you in a group you have to be tested, cause of your baby. So what was bad about that counseling? | |
| | P- **(6)** I mean is, let me say is bad because is just not fine when people are saying you know there is virus being called HIV-AIDS, virus. So we have to test, amongst the group of people. I mean you don't feel comfortable. You just begin to ask yourself. What if it's me? How am I going to react? How this counter is going to look me we I turn back from that room. Because you will be crying. And people started to look at you. So you start to realize something is wrong here. And you start to become, I am not going there, I'd rather leave. You decide many things. And sometimes you find that I'm not going to test until I deliver my baby. You think about many things.And on the side of counseling I think is not a proper counseling. Maybe you can say is a health talk. But, I mean in counseling you have to look professional take a person private, because people have their rights. As you have the rights. Give a person confidential in a private side. Talk to him nicely. Let a person understand what are you talking about. Then the person can decide what to do. And know its you, when that person counseled. I mean is professional, and the person can accept the situation. Although is not easy to accept but you know that confidentiality is there. Rather than to do it in a group discussion, unless we are doing the group discussion talking about health issue. But if you say you have counseled the person, they are standing there. Tell them that the virus is there they have to test if you are HIV positive. That is a trauma. | |
| | R- And you said specifically that is a white sister that counseled you. Would feel better if it was a Tswana sister that counseled you? | |

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| | P- | (8)No. I think it depends what kind of a person she is or he is. Because from the first time, as I have said, the way they were doing the counseling it was not right. But after I have tested HIV positive, she was so positive to me. She build that relationship although she didn't do that counseling the proper way. But she started to be concerned. Every time she tried to, she called me and asked how do I feel where is the baby. Sometimes she just give me the transport fee to reach the clinic, so that she can see the baby, how the baby is coping. Sometimes by seven o'clock or eight o'clock when she come from the work she visited my place. Just to come and see how am I doing how am I coping. She was so caring. She was just like my mother or somebody that cares for somebody that. | |
| | R- | So the caring part afterwards made up for, even if she didn't come you were okay. | |
| | P- | (8)Yes. She plays a role as a mother, although she didn't do counsel but she plays her part. After the results what happened. You can see the person do care. She was not the person who just give counseled and leaves you like that. And still now she is in CapeTown. She is no longer working here in potchefstroom. But every time, sometimes she calls and ask, how are you? Where is the baby? I am doing well she is doing well you can see that still, she don't forget a person, were ever she is. She still think that there is somebody. I don't know is for me or about the others. But for me she was there. | |
| | R- | So what is there that you could add that, if you look at an ideal counseling situation? You mention the thing of caring only. The support. | |
| | P- | To be added at a counseling services or at the clinic? | |
| | R- | Anywhere at a HIV counseling circle. | |

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| | P- | The thing that I have realize now. Many people are doing counseling and sometimes people are just doing counseling for sake of, let me say, poverty now is a greater thing and people are looking earning. Some they don't go for paper work they just go for an earning. Because sometimes now I have realized now people come in to me complain that a counselor disclosed status to somebody else and all those things. If they can, I don't know how, but if they can consider people who are living a virus. Because if you start to gossip about somebody else it shows that you don't care. But including professionalism inside because I think professionalism people can understand and they have that care. And they went to school for that. | |
| | P- | (6)They know what is confidentiality. But just to take a normal person and they must or they went for training for a period of one month, a week then they do. That is not a proper counseling. Because your have to start within yourself, before you can say now you are ready to go and counsel people. Because in counseling there are challenges that people might ask you. And you must be able to answer, not to say you are perfect, but be able to put a person in a right situation. Why am I saying that, because I have three four patient who come to me complaining about the counselors who are do counseling now at the clinics. because you went to the third person, that person know me, she come back tome and tell me that, that person was here telling another person my status and all those things. I think if we can change that style. Because if you are HIV positive no matter you have disclosed you have the part. You know how to take care of a person or a professional person, if a person living with HIV. I am not saying I'm isolating but if you start to disclose somebody else. What about you? So you have to think about yourself. | |

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| | R- If you look at the two cultures, is there anything that you think there is a difference in, cause you were trained on the western counsel methods when you went for training. And if you look at our Tswana culture is there something's that thinks good, is there something's that you think bad? | |
| | P- I will say before in 1980's, it was difficult to accept the issue of HIV virus. Because they were saying is a western born thing. There nothing like the virus HIV in our culture. But now I have realized that our people are starting to realize that the virus is there and is living. And we are living in a democratic country. So our people decide not to marry home with, to live with so we cannot say the virus is not there. Although still now there are using traditional healers medication. They do accept that the virus is there. Because is your choice, you want to use the western medication, you want to use our culture medication, they accept. And they are encouraging people to use both. You use the western born medication, you use our culture medication. They don't have any stigma anymore like before. Although the stigma is there but not like before is now, you can see that things are changing. | |
| | R- And if people, have you ever talked to people that went to traditional healer? | |
| | P- Yes. | |
| | R- What is the principle of counselling when they go to the traditional healer? | |
| | P- Since I have done my counselling, I have never decide for a person. Any time when I do that I say to you it depends from your culture. Is whether you take it. I am not a person who is going to say don't go to your culture, go to the western one because maybe I might be giving you the wrong information saying go to the western one after you die. Or you become sick you are going to blame me. So it's up to you to decide whether you stick to the western whether you go to your, is up to you. | |

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| | P- | After you will realize by yourself that where are, are boosting your immune system by the western medication or our cultures medication? Is up to you. Then from there maybe you go the private doctor or whatever or the clinic. You can tell the I'm using my medication and it helps me so much. So you give them more information, so that they can take the medication and go make a research. And they can help the people. And many people that I'm with some they saying our traditional healer medication can help more than the western. | |
| | R- | So basically is the person's believe. And they haven't discussed with you what their traditional healers do when they counseling? | |
| | P- | No, I have, I am always with them but most of the time I'm not asking. Because most the time they are saying they have been trained on the western broad side. So I'm not asking them what are you doing? What kind of counseling are them giving people? But I will try to ... I will go, I will ... it was the thing that I didn't thought of asking. | |
| | R- | I would come back and maybe if you select a group of ... like the gentleman that was here from the support group. He says he is in the support group. Maybe if you can select quite a few people that has been at the traditional healers or so. You have a group you discuss what is good and what is bad of that. | |
| | P- | Okay, Okay. No I will do that. | |
| | R- | But I will come back to you. Most possibly ... are the people working? | |
| | P- | Actually they are staying in extension six. Most of the support group that we are working with. Here we have only few. | |
| | R- | When are they coming in? | |
| | P- | Wednesday and Friday. | |
| | R- | Wednesday and Friday | |

| ANALYSIS | | | ANALYSIS |
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| | P- | Wednesday we are here then Friday we are at their side. | |
| | R- | Okay. What time are you meeting on Friday? | |
| | P- | At twelve o'clock. | |
| | R- | At twelve o'clock. This Friday it will be out for me but I will come back later. | |
| | P- | This Friday I will be going to the department of health meeting tomorrow from half past eight until late. | |
| | R- | So no not this Friday we can meet the other Friday, I am in Natal. Cause I'm travelling quite a lot to Natal. I'm studying with them. | |
| | P- | Okay. | |
| | R- | So I will make an appointment with you and then I will come. On a Wednesday or Friday. But then we just have a discussion of what they think is good and what they is bad. | |
| | P- | No, I will phone you. | |
| | R- | And select especially those that went to the traditional side. | |
| | P- | No, I will do that. Because some of us they are going to the traditional healers. And they will tell you is good go to somebody else, they will help me. I don't believe it. Is up to a person but I don't believe it. | |
| | R- | No is up to a person's believe system. | |
| | P- | But they are talking to us and saying I went to a person some where. And she is good she can help you. But I'm not ... because I have never used a traditional healer's medication. And I have never come to see the symptoms. Maybe when the times go on I will realize that. | |

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| | R- | No, you see with me when I'm looking in the study, I think I personally believe there some things that's help, that helps. And the some things of the western side that helps. So we need to search on both sides and take those two and maybe used in our community. Not necessarily that you go to them but there are certain of their strategies that might be helpful. | |
| | P- | Because I was listening to one lady. She from Joburg in the radio. There is another medication, they call it masututsa. Is masututsa, is msindiso, another one is tshipi but I have never used them. So every time sometimes when we sit in the supporting group I'm asking about, did they buy those medications. They said yes. They I ask them what does the medication do. They say is boosting and we feel strong. Then were do you buy? at another shop in town, is a muti shop. The bottle is R35. And after you have eat, the is a measurement that you have to dilute before you drink it. After the meals of one o'clock again and at night. And they say it help so much. But I have said I will try and maybe use that, may be there will be changes. They say feel that now that now you are a normal human being. But I have heard from the radio. Then we sit down and discuss that. | |
| | R- | No, please if I can have that support group and especially those that has used both sides or even if they just used the traditional. But mostly they used both sides for that's what I realized. Cause most people told me that, now even if I take that, even there in the clinic they tell me that, even if I take this medication I do go to the traditional person. | |
| | P- | Yes, they do go. | |

| ANALYSIS | R- | And maybe if I can also have that traditional people just to ask how do you guys do it. But later on. Let's first talk to them and then we talk to the support group. | ANALYSIS |
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| | P- | Okay. No, I will organize them. | |
| | R- | Thanks. | |
| | P- | Okay. | |

## KEY OF CODES ON THE PREVIOUS INTERVIEW:

| 1. | Who counsel | Professional nurse<br><br>Lay counsellor (NGO) |
|---|---|---|
| 2. | What does the counsellor do | TELL<br><br><br><br>ASK |
| 3. | To whom | - counselee |
| 4. | In what situation/condition | - during pregnancy |
| 5. | How was the hiv/aids counselling experienced by the counselee and counsellor and what was the outcoe | -Tragic story |
| 6. | The counselee and the counsellor's ideal situation | -trained counsellor<br><br>- confidentiality |
| 7. | Tragic story | |
| 8. | The counsellor | |

# ANNEXURE E

- **COUNSELLOR PARTICIPANTS**

How do you counsel?

What is your process of counselling?

- **TRADITIONAL HEALERS**

What is your view on HIV/AIDS?

What is your view and your treatment regime when you manage a patient who is HIV-positive?

How do you counsel?

What is your process of counselling?

- **COUNSELEE PARTICIPANTS**

How was your counselling?

How did you experience the counselling session?