

Research Article

Nurses' experiences of delivering voluntary counseling and testing services for people with HIV/AIDS in the Vhembe District, Limpopo Province, South Africa

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Abstract

Voluntary counseling services are seen as a cost-effective strategy for HIV prevention and management because they help people to cope with their illness and reduce infection rates in others. This study explored and described the experiences of 20 nurses who rendered voluntary counseling in the Vhembe district, Limpopo Province, South Africa. A qualitative and contextual research design was used, with data gathered from in-depth individual interviews and analyzed using an open-coding method. The main experiences of the nurses rendering voluntary counseling and testing arose in the following themes: challenges related to inadequate resources; the emotional drain associated with stress and burnout; and frustration related to certain behaviors and practices of clients and community members. The main conclusions drawn from the findings were that nurses are continuously exposed to emotionally draining activities with very little support from their supervisors, which makes them prone to experiencing burnout.

Key words

HIV/AIDS, nursing, South Africa, voluntary counseling and testing.

INTRODUCTION

HIV/AIDS is a major problem in South Africa. South African statistics show a gradual increase in the number of people who are infected by HIV. In 2000, the number was 4.2 million people (Department of Health, 2001). By the end of June 2006, 5.4 million people were living with HIV and AIDS and it is postulated that the number will go higher as it has not yet reached a plateau. The prevalence rate is 11.2% with 527 000 new infections (Dorington *et al.*, 2006). More than 20% of workers are HIV-positive while 50–60% of the bed occupancy in public hospitals is filled by HIV-positive people (Spencer, 2003).

The estimated HIV prevalence among antenatal clinic attendees for Limpopo Province shows a gradual increase from 2001 to 2005 as follows: 2001: 14.5%; 2002: 15.6%; 2003: 17.5%; 2004: 19.3%; and 2005: 21.5% (Department of Health, 2005). At the end of June 2006, the total mid-year statistics reported the population of Limpopo Province as 5.7 million, with 396 877 people infected with HIV: 47 000 new infections, 39 474 people already sick, and 24 000 AIDS-related deaths (Dorington *et al.*, 2006).

Voluntary counseling and testing (VCT) is a process whereby clients are counseled about an HIV test, so that they will be able to choose freely whether to be tested or not. If they accept, they are expected to sign the consent form and get tested with a rapid test kit, post-test counseling is done, and then the results are given. It includes ongoing counseling and support for clients who are HIV-positive. This service is rendered by professional nurses who are trained as VCT counselors over and above their daily function as nurses during working hours, though sometimes it might be done after hours according to the clients' needs. The expansion of VCT was considered to be a cornerstone of the United Nations' (UN's) 2001 to 2005 strategic plan for HIV and AIDS prevention (UNAIDS, 2002), particularly because it:

1. Helps people to learn more about HIV, their status, and how to prevent being infected or infect others.
 2. Serves as an entry point to other HIV prevention and care services, such as family planning, support groups, anti-retroviral drugs, planning for the future, prevention of mother-to-child transmission of HIV, sexually transmitted infections (STIs), prevention and management of opportunistic infections, normalization and destigmatization of HIV.
 3. Assists clients to accept and cope with their HIV status.
- Voluntary counseling and testing is considered to be an effective and cost-effective means of facilitating behavior change.

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The HIV/AIDS epidemic has increased the demands on counselors. Most nurses' responsibilities have increased as a result of their nursing duties and also having to work with HIV/AIDS patients (Van Dyk, 2001). This might have an impact on the lives of the counselors, both professionally and personally.

Nurses in South Africa are expected to offer VCT services in their workplace. This is because of the nature of their job (Van Dyk, 2001). Before the scourge of HIV, this was the responsibility of laboratory technicians and technologists, but because of the shortage of these groups, this is done by nurses as they form the backbone of the health-care delivery system. Before doing a test, the client needs pretest counseling. The counselor explores the risk factors, giving sufficient information, explaining the test, the meaning of different results, identifying myths and correcting them, identifying support systems, and obtaining consent for testing (Evian, 2000; Department of Health, 2001). There are legal requirements for obtaining informed consent that need to be addressed with the client, based on accurate information given by the counselor, unless the person is incapacitated due to age, mental status or the level of consciousness (Achmat, 1997; Evian, 2000; Van Dyk, 2001; Klinck, 2003).

Nurses who have been trained to deliver VCT services are expected to do other nursing activities. Despite the lack of compensation, support, and debriefing, which leads to burnout, nurses go the extra mile, continuing to render those services against all odds (Lindsey, 2000; Van Dyk, 2001). They are expected to cope with increasing levels of workload stress due to the high number of patients who come for VCT, as well as the increasing shortage of staff due to the ill health and death of colleagues from HIV and AIDS (ECSACON, 2001).

Grinstead and Van der Straden (2000) found that there is a high level of stress among the VCT counselors and a need for mentoring and support to improve their motivation, reduce stress and burnout, and sustain a high-quality service. Lindsey (2000) mentioned that counseling services are fragmented due to a lack of compensation and support for the counselors, who therefore suffer from burnout.

Study setting

Limpopo Province is one of the poorest, rural provinces of the nine provinces in South Africa. Most nurses migrate to other provinces seeking better job opportunities. The province ensures that more nurses are trained so as to provide VCT services for the community. As VCT training was started in 2001, the province has trained >300 nurses. In Vhembe District, Limpopo Province, where the study was conducted, only 20 nurses were still rendering VCT services. After training, many nurses leave the service to pursue other areas of interest.

Study aim

The aim of the study was to explore and describe the experiences of nurses who render VCT services in Vhembe Dis-

trict, Limpopo Province, as there seems to be poor retention of the nurses who are VCT counselors, despite ongoing training.

METHOD

Design

Qualitative, exploratory, descriptive, and contextual approaches were used in order to explore and describe the experiences of nurses rendering VCT in Vhembe District, Limpopo Province, South Africa.

Participants

Professional nurses who had been trained as providers of VCT services in Vhembe District, Limpopo Province, according to the Department of Health's national minimum standards for the training of HIV counselors (Department of Health, 2000), were purposively selected.

The criteria for selection of the participants included nurses who were VCT counselors, who had been involved in VCT in government hospitals or clinics for at least 2 years, and who had been trained according to the national minimum standards for HIV/AIDS counselors (Department of Health, 2000).

Data collection

In-depth individual interviews were conducted with the participants who volunteered and gave their written consent. The researcher interviewed each participant at a time convenient for the participant. All interviews were initiated from a broad central question: "What are your experiences as a VCT counselor?" All other questions emanated from this central question. The interviews were flexible and took the direction indicated by the participants. The researcher ensured that focus on the topic was maintained in an unthreatening manner (Mayan, 2001). The information was audiotaped and later transcribed verbatim in a notebook. The researcher used field notes for observations that could not be captured on audiotape, including non-verbal gestures, the interview settings, and personal impressions (Mayan, 2001).

Measures to ensure trustworthiness

The strategies described by Lincoln and Guba for trustworthiness, namely, truth value, applicability, consistency, and neutrality, were applied (Krefting, 1990). In this study, it was ensured that all the findings were purely from the experiences of the VCT counselors. The researcher had worked with some of the participants and had visited some of them several times in their working situation, which assisted in building a trusting relationship. The researcher ensured that the data obtained were the real experiences of the participants by asking open-ended questions. The interviews were audiotaped and supplemented by written field notes. The findings were discussed with the supervisors and fellow students.

Ethical measures

This study was conducted with the ethical approval of the University of Venda, Limpopo Provincial Ethical Research Committee, and Vhembe District. The hospital and clinic supervisors where the participants came from were contacted and also gave their permission. The rights of the participants were protected by maintaining the ethical standards, as stipulated in the *Ethical Standards for Nurse Research*, set out by the Democratic Nursing Organization of South Africa (1998). The research was explained to the participants and written information was given in a consent form, which included information on withdrawing from the study at any time, confidentiality, and anonymity.

Data analysis

The open-coding method was used, following the eight steps identified by Tesch (Creswell, 1994). After collecting all the data, the researcher read the whole report and identified ideas that came to mind. Similar topics were grouped together and arranged in columns, major topics, unique topics, and leftovers. Data saturation occurred after in-depth interviews with 20 participants.

DISCUSSION AND LITERATURE REVIEW

This study revealed that nurses providing VCT services experience the following themes: challenges relating to inadequate resources, emotional drain associated with stress and burnout, and frustration due to setbacks in VCT programs related to certain practices and behaviors of community members and clients. These main categories were subdivided into categories and subcategories, as presented in Table 1.

Challenges relating to inadequate resources

Two main areas of inadequate resources were identified in the analysis of data regarding the experiences of nurses providing VCT services; namely, a shortage of material resources and inadequate human resources.

Shortage of material resources

A shortage of material resources was identified as inadequate counseling rooms, insufficient testing facilities, and a lack of educational material. The participants expressed the lack of an appropriate counseling room as follows:

No proper counseling room, room is also used as a storeroom.

Other counseling rooms are used for all other services, like the treatment of minor ailments. One participant put it this way:

While counseling is in session, the phone also rings and you cannot put it aside as the room is also an office.

This meant that while counseling was in process, other clients would be waiting and when they saw that the participant was taking a long time with a client, they would start to grumble as they did not know what was happening behind the closed doors. The participants mentioned that there were disturbances like the noise of clients waiting outside and the ringing of telephones. Another study done in Zambia also revealed that finding a suitable place for counseling was a challenge to HIV counselors (Riber, no date).

The participants experienced pressure due to shortages of testing material. The following quote reflects how one participant put it:

Table 1. Categories of the findings

Theme	Category	Subcategory
Challenges relating to inadequate resources	Shortage of resources	Shortage of material resources Inadequate human resources
Emotional drain associated with stress and burnout	Dealing with HIV/AIDS clients in different situations and at different stages	Giving HIV-positive results Couples with discordant HIV results Young rape victims Deteriorating and dying clients due to HIV-related conditions, including AIDS Dealing with HIV-positive colleagues
	Lack of support	Lack of supervision and mentoring Lack of commitment Lack of cooperation Lack of counselors' update Lack of recognition
Frustration due to setbacks in VCT programs related to certain practices and behaviors of community members and clients	Clients who do not disclose their status	Problems associated with confidentiality Fear of stigma and discrimination
	Intentional exposure of community members to the risk of being infected	Government grants Attention given to HIV-positive clients
	Cultural practices by community members	Funeral rituals Multiple marriages

VCT, voluntary counseling and testing.

You find that there is no buffer and, if you phone the hospital, they say there is no transport and the service should stop because there is no car to deliver the kit.

Most times, the participants said they did not have test kits or buffers (solutions used while doing the HIV test to make the blood move through the test strip). This put pressure on them as clients would come for VCT but they would only be able to do pretest counseling and would thus request clients to come back another day for testing. Most of the time, the clients did not come back. The participants mentioned that they could not keep extra kits as they expired quickly, especially the buffer that usually expired 3 months before the test kit.

There was also a lack of adequate material at the clinic, such as consent forms and relevant promotional material:

We have pamphlets and there are posters written in English, not in Venda. Most people don't understand English and some cannot even read. The few pamphlets written in Venda do not even have adequate information.

This made the VCT counselors' work difficult because they could not test clients without signed consent forms, which was required before doing an HIV test. There were legal requirements for VCT counselors to obtain informed consent from the client on the basis of accurate information given by the counselor (Achmat, 1997; Evian, 2000).

The participants mentioned that there were very few pamphlets written in the local languages that provided information on HIV and AIDS. The result was that people had very little knowledge about VCT, requiring counselors to spend more time explaining information that was supposed to be given through promotional material. A report from an AIDS information center (AIC) in Uganda described the waiting room as having HIV and AIDS brochures for reading and health education posters decorating the walls. The clients were shown a variety of HIV/AIDS and other locally produced health education videos (AIC, 2001).

Inadequate human resources

Inadequate human resources was highlighted as one of the major problems that the participants experienced. This was expressed as work overload that was caused mainly by the integration of VCT services with other services.

The problem was raised of inadequate time due to the integration of services, leading to the expectation that the counselor should do everything in the unit. This made the participants feel that there was work overload and they considered counseling as overwork. There was no time to mobilize the community or to follow up the clients. For example, one participant said:

Integration of services where the VCT counselor is supposed to do all services, such as child health clinic, antenatal clinic, treatment of minor ailments, deliveries, geriatric services, management of chronic conditions, VCT services, and management of opportunistic infections in one day is frustrating and gives us no time to rest or to do proper VCT services as time becomes limited.

The participants mentioned that they would prefer the VCT site to be run as a unit specifically for VCT. One said:

I think counseling should be centralized in the clinic, focusing only in HIV and AIDS and STI. I can give the example of Gauteng Province, where there are clinics used only for HIV and AIDS.

The participants indicated that, to render proper VCT services, adequate time was needed as they needed time to do pretest counseling, testing, and post-test counseling. They said that there was not adequate time as they were not focusing only on VCT, but also on other routines of the institution, like attending to minor ailments and other services: "I am overloaded with clients". The participants discussed the fact that sometimes they found themselves in a dilemma when they saw that there was a long queue of clients waiting to be assisted: they did not know whether to start with the VCT clients or with other clients, or whether they should send VCT clients home and let them come the following day. The literature reviewed showed that fulfilling multiple roles is one of the experiences of HIV counselors (Coyle & Soodin, 1992).

Emotional drain associated with stress and burnout

Emotional drain occurs in VCT counselors as a result of daily encounters with HIV-positive clients. Most of the time, VCT involves the "breaking of bad news" as it includes telling the client about HIV-positive results or reporting death to relatives (UNAIDS, 2000). This will be discussed under the following subheadings identified from participants' information: dealing with positive results in different situations and a lack of support.

Dealing with positive results in different situations

Different situations identified from the data collected included giving HIV-positive results, young rape victims, couples with discordant HIV results, deteriorating and dying clients due to HIV-related conditions, and HIV-positive colleagues.

The participants mentioned that they were not comfortable when giving HIV-positive results. Others said that giving positive results made them sad regardless of whether they knew the patient or not. One participant said:

I also feel sad after giving positive results because to give positive results, irrespective of whether you know the client or not, you feel how she is feeling, especially if she does not express herself.

Another participant indicated that counseling was good for her at the beginning of VCT because she was only getting negative results for all the clients, until one day, she got positive results. She felt stuck not knowing what to do in such a situation. Another participant said:

The problem started with positive results, I did not know what to do.

As has been previously mentioned, giving clients HIV-positive results is one of the challenges faced by counselors (Coyle & Soodin, 1992).

Some participants expressed feelings of frustration and stress about positive results that had resulted from rape. The participants experienced difficulties when dealing with rape victims and young clients:

Sometimes, you feel overworked and frustrated not knowing what to do, like most of the time after counseling a rape client, I feel so stressed especially when the client is a child.

The reviewed literature showed that VCT providers are often unsure or uncomfortable about dealing with HIV and AIDS among the youth, which agrees with other participants' problems when dealing with young clients (USAID, 2005).

Some participants explained that they experienced difficulty when post-test counseling a couple whose results were not the same. One partner's HIV status would be negative whereas the other partner's results would be positive. The participants expressed frustration with such results and sometimes they phoned others for their opinion, as they did not know how to handle the situation. For example, one participant said:

When the results were out, they were discordant, which means that they were not the same. The husband's results were negative and the wife's were positive. I was shocked, so I retested them again using confirmatory test without telling them that their results were discordant. I didn't know what to do . . . Even though the couple was supportive of each other, the results were stressing to me.

Counseling couples was identified as a special challenge by the AIC (AIC, 2001).

Most participants described the intense stress when they saw that the clients were not recovering but deteriorating. One participant said:

AIDS patients never recover; you find that they are deteriorating day by day.

Others mentioned that they were stressed by seeing patients dying, especially when the patient was still young or when the patient had left small children:

Almost every day, you find that HIV patients are dying, some of the clients were still very young, leaving small kids.

Others said that they became stressed in such a way that it also affected them socially and psychologically. The following quotation confirms that:

Sometimes, I was afraid of having sex, thinking that I may be infected, so I imagined myself going through those stages and felt that I cannot cope. I was overprotective to my kids, thinking that they might be raped and get infected.

Members of the East Central Southern Africa College of Nursing highlight that HIV and AIDS caregivers and health-

care workers need to be supported, as caring for terminally ill patients is painful and makes workers feel exhausted (ECSACON, 1999). Dealing with HIV and AIDS focuses mainly on diseases and, ultimately, on death and grieving, which is stressful. Dealing with death and bereavement is identified as one of the causes of stress of HIV counselors. Coyle and Soodin (1992) and Catalan *et al.* (1996) indicated that health-care providers dealing with people suffering from serious illnesses and exposure to multiple deaths are at risk of developing work-related psychological disorders, like burnout. Demmer (1999) identified that contact with young patients, the unpredictable nature of the disease, grief, and continual loss are major stressors for health-care workers dealing with AIDS patients.

Most of the participants said that they had problems when it came to counseling and dealing with a colleague who was HIV-positive. They further said that they became stressed, especially when they saw that person. For example, one participant said:

The other thing which stresses me is when I have to counsel a colleague. Most of the time, I refuse, but others insist. It is very stressful because if you find that a person is positive, and you are seeing her almost every day, it is not nice.

The reviewed literature indicated that nurses are expected to cope with increasing levels of stress due to the high number of patients and increasing shortage of staff due to the ill health and death of colleagues from HIV and AIDS (ECSACON, 2001).

Lack of support

A lack of support was also discussed, focusing on a lack of mentoring and supervision, a lack of cooperation, a lack of commitment, a lack of updates for counselors, and a lack of incentives.

All the participants expressed concern about the lack of support as a major problem. They said that there was nobody who cared about and supported them as counselors, including their own supervisors:

Nobody seems to care about what we are doing as counselors. No support, no nix. You may deal with your problems alone, as there is no other external support. Supervisors are not supportive, all they need is statistics.

The participants felt there was no support either in their own institution or from external sources. They mentioned that, as counselors, they dealt with the problem alone, that there was nobody with whom they could discuss their problems. Other participants felt that the supervisors had a bad attitude towards VCT.

The participants said that there was no one who directly coordinated the VCT services and this left them doing different things and using different kits. All the participants raised the problem of not having a mentor to support the VCT counselors and to assist them in the counseling and testing processes.

The reviewed literature agrees with the necessity of support, monitoring, and well-skilled VCT counselors. Coyle & Soodin (1992) identified a lack of support as one of the problems among HIV counselors. Van Dyk (2001) argued that nurses are expected to offer VCT services because of the nature of their job, despite a lack of support and debriefing, leading to burnout. Grinstead & Van der Straden (2000) indicated the need for mentoring and support for VCT counselors to reduce stress and burnout and to improve motivation.

The participants expressed that there was no cooperation from their colleagues, as they did not consider that what they were doing was important. They seemed to consider counseling as the VCT counselor's personal responsibility. For example, one participant said:

They are not cooperative, including the supervisor, who also says, "Is your things" when referring to anything related to HIV. I am saying that they are not cooperative because they do not assist me with VCT and HIV clients.

Other participants mentioned that HIV clients were not assisted, even when they were at the clinic for something else that was not HIV and AIDS-related; colleagues referred them to the VCT counselor or referred them back home. Some participants expressed concern as some colleagues would not bathe or feed HIV-positive patients or reinsert an i.v. when it came out. This left HIV patients belonging solely to the VCT counselor:

Nurses neglect HIV-positive patients. You find that they are not bathed. You will have to feed and bath them.

Another participant put it like this:

So, it is a problem because even if the supervisor is aware of it, they do nothing about it as they also knock to come and ask for minor things.

This shows a lack of cooperation by co-workers.

The participants were worried about other counselors who had been trained for VCT but they were not involving themselves in VCT. Disengaged VCT counselors worsened the problem of work overload. The participants said that there were people who were trained as VCT counselors but who were not doing any VCT. They considered poor selection criteria for the selection of nurses to attend VCT counselor workshops as the cause of those VCT counselors not assisting in HIV/AIDS programs. The participants complained that most supervisors at the clinics considered seniority as a criterion for attending VCT counselor workshops without considering other factors. This led to a majority of people being trained who were not serious about VCT. This was revealed by some of the participants, one of whom explained:

With other VCT counselors, they have just attended the workshop because it was run in the hotel and they needed certificates.

A study done by the Pre-art Guideline Committee shows that counseling requires time and commitment that might be difficult in a busy and understaffed clinic (Martin *et al.*, 2004).

All the participants raised the issue of not having up-to-date knowledge regarding VCT. They complained that the

only information they had was that which they had received from the VCT workshop and this was due to a lack of counselors' updates and in-service training. They were concerned that the HIV and AIDS program changed daily:

I also think that, as counselors, we need to attend counselors' update every 3 months because HIV/AIDS programs are changing every day.

This lack of information and not attending updates was frustrating to participants as some of the clients had more information about HIV/AIDS. The participants felt embarrassed as sometimes clients commented that the counselors did not know what they were doing as different counselors were giving different information. The only reference they had was the participants' manual that they received during the VCT workshop, and some of the information in this was outdated.

The participants expressed the need to meet as counselors to share their experiences. A UNAIDS study confirms the participants' concerns (UNAIDS Health, 2003). Another study showed that the management of VCT sites must support staff to sustain high-quality service provision, retain skilled staff, and prevent burnout of the counselors (FHI, no date). Treating HIV-related problems without adequate knowledge was considered to be one of the burdens experienced by HIV/AIDS counselors and caregivers (ECSACON, 1999). Coyle & Soodin (1992) identified inadequate training as one of the experiences of VCT counselors.

The participants expressed concern that they were not recognized by anybody, including the government, as they were not given any incentives. The participants complained about a lack of HIV/AIDS material for their own personal use, like caps and T-shirts, whereas people that were not involved in HIV/AIDS had different types of material. Other participants were requested by the relatives of some patients to assist clients after hours. Some of the patients who were HIV-positive wanted to visit the clinic after hours as they could not wait for a long time in a queue during the day. Sometimes, the participant was called to go and assist the client at home and sometimes the clients might request assistance by telephone, which required the participant to phone the client back. One participant put it like this:

So, I feel that counselors should be compensated with regard to their phone and also traveling and working overtime because some relatives might even come and call you during the night to come and assist some patient.

This contributes to counselors having inadequate time to rest.

Incentives, such as acknowledgment of the work done by counselors, are necessary. If this is not done, it leads to counselors being less motivated and feeling that counseling is a burden. The lack of support and compensation are considered to be the cause of the fragmentation of counseling services (Lindsey, 2000).

Frustrations related to certain behaviors and practices of community members and clients

The participants were frustrated as there seemed to be no visible progress in the work they were doing. This is related mainly to clients who do not disclose their status but continue to infect others. The confidentiality clause allows clients to shop for tests as nobody will identify them or mention their status to anyone. People fear discrimination as well; therefore, they would rather not disclose their status. The following discussion and associated quotations show the frustration of VCT providers.

Problems associated with confidentiality

The participants were concerned about clients who did not disclose their status due to problems associated with confidentiality, fear of stigma and discrimination, and shopping for HIV tests.

The participants complained about confidentiality, which was regarded as contributing to the spread of HIV because clients do not disclose their status to anybody, including their partners and relatives. They said that sometimes clients did not disclose their status until they died and if it was a married woman who had died, the husband might marry a younger sister of the wife to come and take care of the children. The participants blamed confidentiality because they thought that if the relatives had been told, they would not allow such a thing to happen. They indicated that other clients still refused to believe that there was such a thing as HIV/AIDS because they had never seen anyone who was HIV-positive or heard of a person they knew who had died of AIDS:

I think this issue of confidentiality should be done away with and allow HIV to be notifiable like any other condition. This might also reduce the spread of HIV.

The reviewed literature differed from the participants' views as it emphasized confidentiality by saying that testing for HIV should be done under conditions of strictest confidentiality (UNAIDS, 2003). Other literature indicated that it is essential to ensure medical confidentiality when testing for HIV. Confidentiality is considered to be a cornerstone principle in medical ethics and is documented in many sources, such as the Promotion of Access to Information Act and the Bill of Rights in the South African constitution (Klinck, 2003).

Fear of stigma and discrimination

The participants expressed a concern that there was still a negative attitude attached to HIV/AIDS. They tried to protect the client from being stigmatized by not labeling the room used for counseling. Other clients requested the counselor to not take too long when counseling, as they thought that this would make other clients waiting outside the counseling room suspect that the client might be HIV-positive if more time was spent with them than with the other clients waiting just outside. The other staff members also discriminated against clients who were HIV-positive. One participant mentioned:

If an HIV patient's drip is out, nobody will reinsert it. If one decides to reinsert it, he will exaggerate the wearing of protective clothing instead of putting on only gloves as a universal precautionary measure. One will put on double pairs of gloves, plastic apron on top of nurse's gown and mask. This embarrassed the patient as other patients will start to know that the patient is positive, which leads to stigmatization and isolation.

Some participants mentioned that HIV patients were not assisted in the clinic by other staff members even when they visited a clinic for other problems that could be handled by any staff member. They were referred to the VCT counselor or sent back if the counselor was on leave.

The negative attitudes of people towards HIV/AIDS clients are of major concern and pose a great challenge to the prevention and management of HIV. This reduces the effectiveness of services and increases the risk of exposure to infection (Gammon & Mulholland, 1996; Sherman, 1996).

The reviewed literature confirmed that there is discrimination against HIV-positive people at work and in education, making people reluctant to use VCT services (UNAIDS, 2000). This was in line with the report, *Health Care in the Developing World*, that stressed the need to ensure non-discrimination towards persons faced with HIV-related prejudice and stigma (PHRMA, 2004). The other literature reviewed confirmed that HIV-related stigma and discrimination contribute to a barrier to the participation in VCT, the disclosure of HIV status and seeking care, and the treatment and support of people living with HIV/AIDS (UNAIDS Health, 2003). Gammon and Mulholland (1996) mentioned that negative attitudes towards AIDS pose a major challenge.

Intentional exposure to the risk of being infected with HIV

The participants were concerned about clients who put themselves at risk of being infected for the sake of getting grants. This will be discussed under disability grants and child grants.

The participants were worried about the grants that are given to HIV-positive patients. They thought that the grant is not given to the right people because it is given to HIV-positive people who are healthy and it is making those people boast about being HIV-positive:

People who are HIV-positive even boast that they are enjoying life being HIV-positive. They are getting paid every month because they are HIV-positive.

The participants said that this was encouraging other people who were HIV-negative to get infected so that they also would have grants, amounting to \$R (South African Rands) 780 per month. Other clients that tested HIV-negative wanted to be HIV-positive. They went from one site to another requesting to be tested. Others wanted to be infected so that they would get disability grants and they went to the site frequently to be tested, hoping that they might have been infected.

This encouraged other people who were unemployed to want to get infected. One participant put it this way:

I have experienced several clients who come for VCT and, when you tell them that they are not infected, they start to grumble, saying that we only give positive results for our relatives, so that they will get pension. They usually say that they will come every 3 months until they get positive results. When you try to explain the danger of being infected with HIV, they say that they rather be killed by HIV, which will kill you later, being famous and getting money, instead of being killed now by hunger.

This frustrated the counselors as the clients took the message of being HIV-positive or negative differently from what the counselor expected and went and lived completely differently in order to increase the risk of being infected.

The participants were concerned about the grant, which was given to women as a child-support grant. They assumed that it was contributing to the problem of HIV and was seen as a drawback to their efforts to combat HIV, as young women no longer practiced safe sex as they wanted to fall pregnant in order to get children so that they would receive child grants. They were frustrated as their efforts seemed to be fruitless. This made counselors have to deal with more HIV-positive clients and more positive children, of whom some would become orphans:

They say they want to fall pregnant like other girls so that they will get child-support grant. When you discuss the risk of being infected, they ignore that, saying that some girls are really enjoying the money. Others who already have children will be boasting, saying that they are getting \$R180 or \$R360 and they will soon add more so that they will get more money.

This might be attributed to the selection criteria for social grants, which seem to include almost everybody.

The criteria in South Africa for qualifying for disability grants are that the applicant should have a letter from the medical officer to show that a person has been assessed, be ≥ 18 years, and unable to work or earn money to look after themselves as a result of disability (Department of Social Welfare, 2005).

The criteria for qualifying for child-support grants in South Africa are listed as follows (Department of Social Welfare, 2005):

- 1 The applicant should be the primary caregiver of a child; that is, an individual who takes the main responsibility for a child.
- 2 The applicant should have a South African identity document.
- 3 The applicant should have a birth certificate of a child.
- 4 The applicant should provide proof of the applicant's marital status.
- 5 The applicant should be earning $< \$R13\ 200$ per year ($\$US1\ 848$ per year).
- 6 The dependent child should be < 14 years old.

Certain cultural practices by community members

The findings from this study showed that certain behavior and practices contributed to setbacks in the work of the

VCT counselors, including funeral rituals and multiple marriages.

The participants were concerned about some cultural practices that might be contributing to the spread of HIV. Statements like this were uttered:

It is their culture that if a woman dies being married, a younger sister who is not married should get married to the sister's husband in order to take care of the children. This contributes to the spread of HIV/AIDS.

The participants also mentioned some rituals that were performed after the death of a relative, where the family was infected by the sharing of a razor blade.

The participants also mentioned the problem of men marrying many wives. For example, one described an old man who was a pensioner marrying a 21 year old woman while he already had three other wives. This contributed to the spread of infection as, in many cultures, women have no control over sexual relationships. This frustrated the participants as it contributed to an increased risk of HIV infection. The reviewed literature agrees that some cultural practices contribute to the spread of HIV and AIDS. Multiple marriages have been practiced since long ago. In the bible, multiple marriages are mentioned in several instances (Good News Bible, 1997). In Genesis 16: 1–4, there is a story about Abraham, who was requested by his wife to make love to her slave, and in Genesis 25: 1–2, Abraham married another wife after the death of his wife. In the same book of Genesis, 29: 15–28, Jacob married two wives, Rachel and Leah, who were sisters. Other literature reviewed mentions that, in many cultures, it is very difficult for a woman to successfully negotiate the use of a condom by her partner, which puts her at risk of being infected (Gilman *et al.*, 1998).

Limitations of the study

The study was conducted in one of the five districts of the Limpopo Province; therefore, the findings cannot be generalized.

CONCLUSION

In this study, the experiences of nurses who rendered VCT for HIV and AIDS patients were explored and described. A detailed discussion of the findings, as well as a literature control, was done to support the findings. It is clear that the participants experienced great struggles in their daily work under what could seem to be insurmountable obstacles. They described daily difficulties as a result of inadequate resources, emotional drain associated with stress and burnout, and frustration as a result of the behaviors and practices of clients and community members that further increase the spread of HIV and AIDS.

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