

**AN INVESTIGATION OF THE UPTAKE OF VOLUNTARY  
COUNSELLING AND TESTING BY ADOLESCENTS AGED 15 TO 19  
AT TWO INTEGRATED  
YOUTH FRIENDLY SERVICE SITES  
IN GAUTENG, SOUTH AFRICA**

by

**LINDELWA NDZOMBANE**

submitted in accordance with the requirements for the degree of

**MASTER OF ARTS**

in the subject

**SOCIAL BEHAVIOUR STUDIES IN HIV/AIDS**

at the

**UNIVERSITY OF SOUTH AFRICA**

**SUPERVISOR: MS SE KOEN**

FEBRUARY 2012

## DECLARATION

I declare that “ *An investigation of the uptake of voluntary counselling and testing by adolescents aged 15 to 19 at two integrated youth friendly service sites in Gauteng, South Arica*” is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references .

Lindelwa Ndzombane

Signed:

Date:

## **DEDICATION**

This dissertation is dedicated to my late mother who inspired me and instilled the value of education. *THANK YOU MOM!*

## **ACKNOWLEDGEMENTS**

Firstly, thank you Lord for giving me strength and determination to complete this dissertation. Secondly, I thank my supervisor, Ms Elize Koen for her academic supervision and support. Her support ensured the successful completion of this dissertation. Last but not least, I thank my family for their patience and support that saw me through this journey.

## **SUMMARY**

Voluntary Counselling and Testing (VCT) is at the core of HIV and AIDS prevention, treatment and care programmes. Timely access to treatment and related services requires knowledge of one's HIV status. Adolescents are at the epicentre of the HIV and AIDS pandemic. This study investigated the factors that influence adolescents' decisions to actively seek VCT. Semi-structured, in-depth individual interviews were conducted with twelve adolescents aged 15 to 19 who were conveniently selected to participate in the study. The study found that adolescents have extensive knowledge regarding the benefits of VCT and acknowledge the need to test for HIV. However, fear of the consequences of testing positive for HIV such as stigmatisation by family and the community, inability to influence their partners to take an HIV test and the inability to make their own decisions and follow through on them still hinder their maximum uptake of VCT.

### **Key words:**

Adolescents, youth friendly service, HIV knowledge, motivation, behavioural skills, HIV and AIDS, risky behaviour, stigma, VCT uptake

## TABLE OF CONTENTS

	<b>Page</b>	
<b>DECLARATION</b>	<b>i</b>	
<b>DEDICATION</b>	<b>ii</b>	
<b>ACKNOWLEDGEMENTS</b>	<b>iii</b>	
<b>SUMMARY</b>	<b>iv</b>	
<b>TABLE OF CONTENTS</b>	<b>vi</b>	
<b>LIST OF TABLES</b>	<b>xiii</b>	
<b>LIST OF FIGURES</b>	<b>xiv</b>	
<b>LIST OF ACRONYMS</b>	<b>xv</b>	
<b>CHAPTER 1: SITUATING THE RESEARCH PROBLEM</b>		
1.1	INTRODUCTION	1
1.2	Research problem	3
1.2.1	Background to the study	3
1.2.2	Background to the youth friendly services in South Africa	4
1.2.3	Problem statement	5
1.2.4	Focus of the study	8
1.3	RATIONALE OF THE STUDY	8
1.4	OBJECTIVES OF THE STUDY	9
1.5	RESEARCH QUESTIONS	9
1.6	RESEARCH DESIGN AND METHODOLOGY	10

1.7	THE RESEARCH SETTING	10
1.8	CONCEPTUAL FRAMEWORK THAT GUIDED THE STUDY	11
1.9	DEFINITION OF KEY TERMS	12
1.9.1	Adolescence	12
1.9.2	Youth and young people	12
1.9.3	Integrated Youth Friendly Clinic	12
1.9.4	Voluntary counselling and testing	13
1.9.5	VCT uptake	13
1.9.6	Susceptibility	14
1.9.7	Chill room	14
1.9.8	groundBreakers	14
1.10	OUTLINE OF THE STUDY	14
1.11	CONCLUSION	17
 <b>CHAPTER 2: LITERATURE REVIEW AND THEORETICAL CONTEXTUALISATION</b>		
2.1	INTRODUCTION	17
2.2	THE HIV AND AIDS EPIDEMIC	17
2.2.1	Impact of HIV and AIDS	18
2.3	SOUTH AFRICAN GOVERNMENT'S RESPONSE TO THE HIV AND AIDS EPIDEMIC	20
2.3.1	Prevention	22
2.3.2	Treatment, care and support	22

2.4	VOLUNTARY COUNSELLING AND TESTING	23
2.5	HIV COUNSELLING AND TESTING (HCT)	24
2.6	BENEFITS AND ADVANTAGES OF VCT IN ADDRESSING THE HIV AND AIDS EPIDEMIC	27
2.6.1	The importance of VCT in controlling the spread of HIV and AIDS and mitigating its impacts	27
2.6.1.1	Acceptance of serostatus and coping	29
2.6.1.2	Facilitation of behavioural skills and involvement of others	29
2.6.1.3	Facilitation of access to mother to child transmission	31
2.6.1.4	Early management of opportunistic infections	31
2.6.1.5	Access to antiretrovirals	32
2.6.1.6	Access to preventive therapy and contraceptive advice	32
2.6.1.7	Referral to social and peer support	33
2.6.1.8	Normalisation of HIV and AIDS	34
2.6.1.9	Planning for the future, orphan and vulnerable children care and will making	34
2.7	MODELS OF VCT	35
2.7.1	Home-based VCT model	35
2.7.2	Free-standing VCT model	36
2.7.3	Integrated VCT model	37
2.7.4	Mobile VCT model	37
2.8	ADOLESCENTS AND THE IMPORTANCE OF VCT	38
2.9	YOUTH-FRIENDLY SERVICES	43
2.9.1	Background to youth friendly services	43
2.9.2	Essential Service Package	44



2.10	Theoretical framework	46
2.10.1	The Information-Motivation-behavioural Skills Model	46
2.10.1.1	Information	48
2.10.1.2	Motivation	50
2.10.1.3	Behavioural skills	51
2.10.2	Previous studies on the IMB model	52
2.10.3	Critique of the IMB model	53
2.11	LITERATURE REVIEW ON ADOLESCENTS AND VCT IN THE CONTEXT OF THE IMB MODEL	53
2.11.1	Adolescents' knowledge about HIV transmission and prevention and their perception regarding their own susceptibility to HIV infection	53
2.11.2	Adolescents' knowledge regarding the importance of VCT and factors that motivate them to seek VCT	57
<b>CHAPTER 3: RESEARCH METHODOLOGY</b>		
3.1	INTRODUCTION	63
3.2	RESEARCH DESIGN	63
3.3	RESEARCH SETTING	64
3.4	SAMPLING DESIGN AND PROCEDURES	66
3.4.1	Sampling criteria	68
3.4.2	Gaining access to research sites	68
3.5	DATA COLLECTION	70
3.5.1	In-depth-semi-structured interviews	70
3.5.2	The interview schedule	72
3.5.2.1	The extent of the adolescents' knowledge about	

	HIV and AIDS and their own susceptibility to contracting HIV	73
3.5.2.2	Adolescents' knowledge about VCT and its benefits	73
3.5.2.3	Adolescent' support system and ability to make own decisions and act on them	74
3.5.2.4	Adolescents' ability to handle a positive HIV result	75
3.5.3	Tape recording of interviews	75
3.6	DATA ANALYSIS	76
3.7	TRUSTWORTHINESS OF THE DATA	77
3.7.1	Authenticity	77
3.7.2	Credibility	78
3.7.3	Reliability/ dependability	78
3.7.4	Confirmability	79
3.8	ETHICAL CONSIDERATIONS	79
3.8.1	Permission to conduct research	80
3.8.2	Informed consent	80
3.8.3	Voluntary participation	81
3.8.4	Confidentiality and anonymity	82
3.8.5	No harm to participants	83
3.8.6	Provision of debriefing, counselling and additional information	83
3.9	PILOT STUDY	84
3.10	CONCLUSION	85
<b>CHAPTER 4: DATA ANALYSIS AND INTEPRETATION</b>		
4.1	INTRODUCTION	86

4.2	BIOGRAPHICAL INFORMATION	87
4.2.1	Age and gender	87
4.2.2	Level of education	88
4.2.3	Living arrangements	89
4.2.4	Relationship and marital status	89
4.3	THEMES EMERGING FROM THE INTERVIEWS	90
4.3.1	Knowledge/ information	90
4.3.1.1	Sources of HIV and AIDS information	90
4.3.1.2	Initial response to HIV and AIDS information	95
4.3.1.3	Knowledge about modes of HIV transmission	97
4.3.1.4	Knowledge about the severity of HIV and AID	100
4.3.1.5	Knowledge about protection from HIV infection	100
4.3.1.6	Knowledge about VCT	102
4.3.1.6.1	Sources of VCT information	103
4.3.1.6.2	Knowledge about benefits of VCT	104
4.3.2	Motivation	108
4.3.2.1	Knowing someone who is living with HIV	108
4.3.2.2	Perception of own risk	109
4.3.2.3	Engagement in high risk behaviour	110
4.3.2.4	Significant others	112
4.3.2.5	Marriage	119
4.3.2.6	Own and partner's protection	123
4.3.2.7	Fear of a positive result	124
4.3.2.8	Attitudes towards VCT	124
4.4	BEHAVIOURAL SKILLS	125
4.4.1	Ability to make decisions independently from	

	significant others' opinions	125
4.4.2	Visiting a VCT site	127
4.4.3	Condom use	129
4.4.3.1	Inconsistent condom use	129
4.4.3.2	Initiating condom use: gender	132
4.5	CONCLUSION	135
<b>CHAPTER 5: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS</b>		
5.1	INTRODUCTION	136
5.2	SUMMARY OF RESEARCH FINDINGS	136
5.2.1	Knowledge	137
5.2.1.1	Knowledge related to HIV and AIDS	137
5.2.1.1.1	Sources of HIV and AIDS knowledge	137
5.2.1.1.2	Knowledge about modes of HIV transmission and prevention	138
5.2.1.2	Knowledge related to VCT	139
5.2.2	Motivation	141
5.2.2.1	Adolescents' perception of own susceptibility to HIV infection	141
5.2.2.2	Factors that motivate adolescents to seek VCT	142
5.2.3	Behavioural skills	144
5.3	RECOMMENDATIONS FOR FUTURE RESEARCH	148
5.4	RECOMMENDATIONS FOR POLICY AND PRACTICE	148
5.4.1	Scaling up of interventions that facilitate communication within families and communities	149

5.4.2	Involving adolescents who have previously been tested for HIV influencing behaviour change	149
5.4.3	Scaling up involvement of male adolescents in health-related decision making	150
5.5	LIMITATIONS OF THE STUDY	151
5.6	CONCLUSION	152
<b>5.7</b>	<b>LIST OF SOURCES</b>	<b>153</b>
<b>5.8</b>	<b>APPENDICES</b>	
	Appendix A: UNISA ethical clearance	174
	Appendix B: Access letter – Pretoria	175
	Appendix C: Letter approving research – Pretoria	176
	Appendix D: Access letter – Ekurhuleni	177
	Appendix E: Consent form	178
	Appendix F: Parent consent form	179
	Appendix G: Assent form	181
	Appendix H: Interview schedule	183
	Appendix I: Letter approving research – Ekurhuleni	184

## LIST OF TABELS

Table 1:	Differences between VCT and HCT/PHICT	26
Table 2:	Percentage of youth aged 15 to 24 who had first sex by age 15	39
Table 3:	Themes and sub-themes	87
Table 4:	Age and gender distribution of research participants	88
Table 5:	Participants' level of education	88
Table 6	Participants' living arrangements	89

## LIST OF FIGURES

Figure 1:	The VCT process	24
Figure 2:	VCT as an entry point to HIV prevention and care	28
Figure 3:	IMB model as it relates to VCT	48
Figure 4:	IMB model as it relates to the findings of the study	147

## LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretrovirals
ART	Antiretroviral Treatment
CAPS	Cape Town Area Panel Study
CBO	Community-Based Organisation
CDC	Centre for Disease Control
CHC	Community Health Centre
FBO	Faith-Based Organisation
FHI	Family Health International
gBs	groundBreakers
HBVCT	Home-Based VCT
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IMB	Information Motivation Behavioural Skills Model
IPT	Isoniazid Prevention Treatment
KAB	Knowledge Attitudes and Behaviour
MDR	Multi Drug Resistant TB
MTCT	Mother to Child Transmission
NACOSA	National AIDS Coordinating Committee
NAFCI	National Adolescent Friendly Clinic Initiative



NGO	Non-Governmental Organisation
NSP	National Strategic Plan
PEPFAR	Presidential Emergency Plan for AIDS Relief
PIHCT	Provider Initiated HIV Counselling and Testing
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TOP	Termination of Pregnancy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YFS	Youth Friendly Service

# CHAPTER 1: SITUATING THE RESEARCH PROBLEM

## 1.1 INTRODUCTION

*“HIV and AIDS is the worst health crisis in at least six hundred years. It is perhaps the worst in history”* (Holbrooke cited in Global Business Coalition on HIV/AIDS [sa<sup>1</sup>:2]).

Since the Human Immunodeficiency Virus (HIV) was first discovered three decades ago, it is estimated that globally approximately 1.8 million adults and children had died of Acquired Immune Deficiency Syndrome (AIDS)-related illnesses by the end of 2010 (UNAIDS 2010 cited in The Stephen Lewis Foundation 2012:1). In the same year (2010), it was estimated that there were 34 million people living with HIV globally, with the bulk, 22.9 million, residing in sub-Saharan Africa. Globally, young people bear the brunt of the epidemic as “50% of people infected with HIV after infancy are under the age of 25 [while] in developing countries 60% of all new HIV infections occur among 15 to 24 year olds” (Key Global Statistics on Young [sa]:1).

HIV and AIDS represent more than just a health crisis. It is a social, cultural, economic and developmental crisis of significant proportions to which national governments and the international donor community have responded by implementing and funding a number of interventions. Voluntary counselling and testing (VCT) is one such intervention. VCT is central in both primary<sup>2</sup> and secondary<sup>3</sup> HIV prevention strategies. Among its well documented benefits, VCT affords individuals not only an opportunity to test for HIV and know their status, but also an opportunity to assess their risk of becoming infected with HIV and at the same time

---

<sup>1</sup> Sine anno (Latin word for “without a year”)

<sup>2</sup> Interventions aimed at preventing people who are not infected with HIV from becoming infected.

<sup>3</sup> Interventions targeting people living with HIV in order to prevent onward transmission of HIV.

acquire knowledge on how to protect themselves and their partners from being infected with the virus. In addition, VCT affords individuals who test positive for HIV an opportunity to access treatment, care and support services timeously (Tanzania Ministry of Health and Social Welfare 2008; WHO 2007).

Considering that adolescents are among the “at risk” groups (Shisana, Rehle, Simbayi, Zuma, Jooste, Pillay-Van-Wyk, Mbelle, Van Zyl, Parker, Zungu, Pezi & the SABSSM III Implementing Partners 2009), they should be at the core of HIV and AIDS-related interventions, particularly VCT, as the latter is an entry point to a web of services, all of which require individuals to know their HIV status. In efforts to reach adolescents with VCT and other HIV and AIDS-related interventions, the South African government, in partnership with loveLife<sup>4</sup> implemented the National Adolescent Friendly Clinic Initiative (NAFCI) in 2002, which was incorporated into the Department of Health’s Youth Friendly Services (YFS) in 2005 (loveLife 2009).

This study sought to explore and understand the factors that motivate adolescents aged 15 to 19 to actively seek VCT.

This chapter presents a discussion of the research problem, the rationale for conducting the study, the study objectives as well as the research questions. It also includes a brief discussion of the research methodology and a brief description of the two research settings in which the study was conducted. The conceptual framework that guided the study is also briefly outlined. This chapter further presents the definitions of key terms used in the study and the outline of the dissertation chapters.

---

<sup>4</sup> This is a national program for youth (under the auspices of the New loveLife Trust) promoting healthy, HIV-free living among the youth of South Africa.

## 1.2 RESEARCH PROBLEM

### 1.2.1 Background to the study

“Today’s generation of young people is the largest the world has ever known” (Women Deliver [sa]:1), as 1.8 billion of the world’s population is between 15 and 24 years of age (United Nations 2011:2). Approximately 87% of these young people live in the developing world (*ibid*: 2). A similar picture exists in South Africa, where young people younger than 18 years made up 40% of the entire population by 2007 (South Africa Department of Health National Strategic Plan 2007-2011:36).

Coupled with their numeric strength, adolescents are faced with multiple sexual and reproductive health-related problems, which place them at high risk of HIV infection. According to the UNAIDS (2010), there are disparities with regard to HIV risks in terms of age and gender. In sub-Saharan Africa, for example, young women aged 15 to 24 are eight times more likely than their male counterparts to be living with HIV and in South Africa, six girls aged 15 to 19, compared to two boys in the same age group, are living with HIV (UNAIDS 2010:131).

Although South Africa has seen a decrease in HIV prevalence rates among young people aged 15 to 24, intergenerational, mainly transactional sex, multiple sexual partners, as well as gender-related factors were identified as some of the factors that could perpetuate the risk of HIV infection for this age group for the foreseeable future (South African National Department of Health 2010; Shisana *et al* 2009:31). In light of this, adolescents should remain an important target sector of the response to the HIV and AIDS epidemics. Voluntary counselling and testing (VCT) is one such response. VCT is universally accepted as both a primary and secondary HIV prevention strategy.

As a primary HIV prevention strategy, VCT presents an opportunity for HIV negative individuals to adopt and maintain risk reduction behaviours, including safer sex, in order to avoid contracting the HI virus. As a secondary prevention strategy on the other hand, VCT affords people living with HIV the opportunity to adopt risk reduction behaviours, in this case, to protect their sexual partners and themselves from re-infection. This is particularly important for adolescents because, as Centre for Disease Control (2011) asserts, behaviours are established in early life and persist into adulthood. One of the reasons for the latter is that unlike adults, whose sexuality and risk taking is firmly established, adolescents are at a discovery stage in their lives and can adopt safer behaviour (*ibid*). The importance of VCT goes beyond prevention. Through VCT, individuals become aware that they are living with HIV, and are therefore able to access a web of crucial HIV and AIDS-related services including, timely access to medical care such as antiretroviral treatment (ART) and the treatment of opportunistic infections, such as tuberculosis (TB). VCT also provides access to on-going counselling and support and planning for the future, among others.

### **1.2.2 Background to the Youth Friendly Services in South Africa**

One of the South African government's responses to the high risk of HIV infection facing adolescents and other young people was seen in the signing of the National Adolescent Friendly Clinic Initiative (NAFCI) agreement in 2002. A set of standards through which the "youth friendliness" of a facility could be measured were developed through this initiative. In addition, NAFCI aimed to help enhance the quality of Youth Friendly Services through the provision of on-going training for personnel, as well as establishing systems for monitoring and evaluation of the program (loveLife 2009). However, following the withdrawal of funding by one of loveLife's funders in 2005, some aspects of NAFCI were adapted as it was simplified and made less costly and was "incorporated in the

Department of Health's Youth Friendly Service Strategy" (loveLife 2009:61). This culminated in the Youth Friendly Service (YFS) model currently used by the Department of Health to provide services to adolescents and other young people in need of sexual and reproductive health-related services, including VCT.

It is within the context of the YFS model and its provisions regarding VCT that the researcher in this study aimed to investigate the factors that motivate adolescents aged 15 to 19 years to seek VCT. In this way, the researcher intended to explore the effectiveness of YFS model in enabling adolescents to seek VCT. The role of voluntary counselling and testing and its applicability to adolescents, as well as the YFS model, will be discussed in detail in Chapter 2.

It is important to note from the onset that although the South African Department of Health has since April 2011, shifted from Voluntary Counselling and Testing (VCT) to HIV Counselling and Testing (HCT) or provider initiated HIV testing and counselling (PIHTC), this study was initiated at the time when services were provided based on the VCT model. However, VCT still caters for individuals who do not frequent health care facilities (Uganda Ministry of Health 2005). The completion of this study with its original aims and objectives were therefore deemed still important and relevant by the researcher. Furthermore, according to WHO (2007), the voluntariness of HIV testing should be observed even in the HCT model. The focus of the study therefore remained on VCT.

### **1.2.3 Problem statement**

Similar to adolescents worldwide, adolescents in South Africa are at risk of a multitude of problems, ranging from early sexual debut, teenage pregnancy, STIs and HIV infection (Shisana *et al* 2009). The unstable nature of their relationships exposes them to these risks, while their susceptibility to sexual abuse and lack of skills to negotiate safer sex

worsen their plight (Hope 2007). According to Michael, Alexandria and Donald (2004), the HIV and AIDS epidemic in South Africa is largely being fuelled by infections among young people, as almost half of all HIV infections in this country occur before the age of 20 (*ibid*).

A number of studies investigating the age at which sexual debut takes place among adolescents have been conducted in South Africa (Harrison, Cleland, Gous, & Frolic 2005; Shisana *et al* 2009; Volkwyn 2010). These studies found that the age at which sexual debut occurs in this country is low, as it ranges between 9 and 16 years. Early sexual debut among adolescents in South Africa, and elsewhere in the world, also varies according to geographical location, gender, access to healthcare services, access to information as well as poverty status, among other factors (Hallman 2005 cited in Bosmans 2006). These factors form complex relations that have an impact on the age at which first sex occurs among adolescents (*ibid*).

According to the South African Demographic and Health Survey of 2003 for example, (South African Department of Health, Medical Research Council and OrchMacro 2007 cited in Berry & Hall [sa]:1) the Eastern Cape Province had the highest percentage (32%) of adolescents who had had sex by the age of 15 in 2003. This survey also found that male adolescents were generally more prone to early sexual debut than female adolescents, as is evident in the case of the Eastern Cape (21% and 11% respectively). The Gauteng Province, where the study was conducted, had the third highest percentage (19%) of adolescents who has had sex by the age of 15 in the same year, with more boys (13%) than girls (6%) who had had sex by the time they turned 15 (*ibid*).

As mentioned earlier in this section, poverty plays a key role in predisposing adolescents to early sexual debut as there seems to be a positive relationship between poverty and transactional sex, which in most cases is coerced (Shisana *et al* 2009). Madise, Zulu and Ciera (2007) add

that the association between poverty and early sexual debut is more prevalent among female adolescents than male adolescents. Poverty and transactional sex are also linked to intergenerational sex, whereby young girls engage in sexual relations with older men. The fact that older men (some of whom may be unknowingly living with HIV) target younger girls for sex, thereby placing them at higher risks of contracting HIV (HSRC [sa]) makes intergenerational relationships even more complex.

Furthermore, lack of skills to negotiate safer sex, including condom use, not only with older sexual partners but also with those in the same age group, predispose adolescent girls to unplanned pregnancies, sexually transmitted infections (STIs) and HIV infection (The Transition to Adulthood Study Team 2004).

Research has also established that lack of knowledge and low perception of own risk to HIV infection actually increases adolescents' susceptibility to HIV infection (Anderson, Beutel, & Maughan-Brown 2007). Mwale (2008) adds that failure to acknowledge own susceptibility to HIV infection perpetuates risky behaviour by adolescents.

The above discussion paints a picture of the extent to which adolescents are faced with the potential of contracting HIV, each and every day of their lives. Adolescents should therefore be an important target sector of the response to the HIV and AIDS epidemic. Voluntary counselling and testing is one such response. Research supports the effectiveness of VCT in empowering individuals with information to adopt protective behaviour, in order to avoid being infected with the virus, as well as in enabling people living with HIV to adopt risk-reduction lifestyles, in order to avoid infecting their sexual partners. Linked to the above mentioned benefits, VCT also enables individuals to accept a positive HIV status (Reach Out 2010), an important condition in the facilitation of timely access to and adherence to antiretroviral treatment (Tanzania Ministry of Health and Social Welfare 2008). As adolescents represent the future of any country, enabling those



adolescents living with HIV to live long and productive lives should be a global priority.

However, despite the benefits of VCT and the risks of HIV infection they are faced with, earlier studies indicate limited VCT uptake by adolescents (Mphaya 2006). It is therefore important to understand the factors that influence (or would influence) adolescents' decision to test for HIV in order to inform the design of strategies to increase VCT uptake among this population category.

#### **1.2.4 Focus of the study**

The goal of this study was to explore and describe the factors that motivate South African adolescents aged 15 to 19 years to actively seek VCT. Particular focus will be placed on factors relating to their access to accurate HIV-related information and services, their motivation to seek VCT, and whether adolescents possessed appropriate behavioural skills that would translate into actual testing for HIV.

### **1.3 RATIONALE FOR THE STUDY**

Knowledge of a person's HIV status affords the individual the opportunity to access various HIV and AIDS-related services, including ART, psychosocial support, and prevention of mother to child transmission (PMTCT). VCT also affords individuals an opportunity to plan for the future, among other benefits. Equally important is the opportunity VCT affords to individuals to minimise their chances of spreading or contracting HIV by adopting risk reduction behaviours (such as condom use). Literature reviewed for this study however revealed that there is a low uptake of VCT by adolescents. Considering the extent of adolescents' susceptibility to HIV infection, this low uptake presents missed opportunities and efforts should be made to understand the factors that motivate them to seek VCT.

Increasing adolescents' access to VCT would benefit not only the adolescents themselves, but also future generations (Patterson & Watson 2003). This study could provide insight into 15 to 19 year old adolescents' experiences and perceptions regarding HIV, AIDS and VCT, thereby informing programme and policy design. In addition, this study has the potential to shed light into the underlying cultural, social and economic risk factors that continue to predispose adolescents to HIV infection. Understanding these factors could in turn contribute to the design of a wide-range of strategies that not only target the provision of VCT, but other HIV and AIDS-related strategies in general. These may include stigma-reduction strategies and those strategies that target gender imbalances in relationships.

#### **1.4 OBJECTIVES OF THE STUDY**

The objectives of this study were to:

- Explore 15 to 19 year old adolescents' perceptions of their own susceptibility to HIV infection.
- Explore 15 to 19 year old adolescents' knowledge about HIV, AIDS and VCT.
- Explore and describe the reasons why 15 to 19 year old adolescents would or would not voluntarily seek VCT.

#### **1.5 RESEARCH QUESTIONS**

This study was informed by the following research questions:

- 1.5.1 Do 15 to 19 year old adolescents perceive themselves as being at risk of HIV infection?
- 1.5.2 What do 15 to 19 year old adolescents know about HIV, AIDS and VCT?
- 1.5.3 What factors motivate 15 to 19 year old South African adolescents to seek or not to seek VCT?

## **1.6 RESEARCH DESIGN AND METHODOLOGY**

A non-experimental, exploratory and descriptive research design based on a qualitative approach was applied in this study. The purpose of an exploratory research design is to enhance the researcher's comprehension of a phenomenon (Babbie 2007). In this case, the researcher sought to understand the adolescents' own experiences and perceptions regarding VCT. As Neuman (2003) asserts, the emphasis of an exploratory research design is on the participants' own words and expressions. As Mason (2002) argues this can best be done in the naturalist paradigm where knowledge of social reality is generated through asking questions and listening to people. Thus semi-structured in-depth, face-to-face interviews with twelve adolescents aged 15 to 19 years were used to collect the data for this study. Convenience sampling, a type of non-probability sampling technique, was used in the selection of adolescents who presented at the research sites (Youth Friendly Service sites). The interviews were transcribed verbatim. Thematic content analysis was used to analyse the data. This involved the identification of common themes and sub-themes.

## **1.7 THE RESEARCH SETTING**

Due to challenges associated with the sampling of research participants (fully described in Chapter 3), the researcher was compelled to conduct the study at two research sites. The initial site selected was a Youth Friendly Service (YFS) located within a 24-hour Community Health Centre (CHC) that offers a wide range of services including family planning and HIV and AIDS-related services. The CHC is located in a low to middle class suburb of Pretoria. At the time the study was conducted, the YFS was managed by a Professional Nurse (the Sister in Charge), who also single-handedly provided all clinical services. When this Sister in Charge went on maternity leave, the number of adolescents who visited the YFS dropped markedly, as they had to access clinical services at the main

clinic. The selection of research participants therefore became a challenge, as the visits to the “chill room” were also affected. As a result, the data collection process was interrupted, causing a delay in conducting the fieldwork. Mindful of time constraints, the researcher sought permission to continue with the fieldwork at a second research site.

The second research site selected was an YFS located within a 24-hour CHC in the Ekurhuleni Metropolitan Municipality. Similar to the first research site, this facility offers general clinical services, family planning and HIV and AIDS-related services. The residents of this suburb are also fall in the low to middle income bracket. Clinical services for adolescents are provided in the main clinic, although the adolescents congregate at a “chill room” (which is a park home situated behind the main clinic) for information and entertainment sessions. The chill room is staffed by loveLife peer educators called groundBreakers (gBs).

## **1.8 CONCEPTUAL FRAMEWORK THAT GUIDED THE STUDY**

In an effort to explore VCT uptake among 15 to 19 year old South African adolescents, the researcher was guided by the Information, Motivation, Behavioural Skills model (IMB) (Fisher & Fisher in DiClemente, Crosby, Kegler, & Jossey-Bass (2002). According to the IMB model, an individual must possess sufficient information, motivation, and specific behavioural skills for health-related behaviour change to take place. In the case of this study, VCT uptake was the behaviour change of interest. The IMB model proposes the use of qualitative or quantitative research methods to establish the level of knowledge (information), motivation (attitudes and perceptions) as well as behavioural skills related to the specific health behaviour. The researcher opted to use qualitative data-gathering and data analyses methods. This enabled the researcher to gain an in-depth understanding of the factors that motivate adolescents aged 15 to 19 to seek VCT and to present the latter in the adolescents’ own words. The

IMB model also informed the design of the interview schedule as well as the development of the coding frame that guided the analysis of data gathered through the in-depth interviews. The model is discussed in detail in Chapter 2.

## **1.9 DEFINITION OF KEY TERMS**

### **1.9.1 Adolescence**

“Adolescence” refers to the period of life between the ages of 10 and 19 (WHO cited in Mavedzenge, Ross & Doyle 2010). As a developmental stage falling between childhood and adulthood, adolescence is characterised by extraordinary physical, emotional, mental and social changes, coupled with a great deal of curiosity and optimism, which may be followed by disappointment and depression (Auzina, Kelle, Lapina, Lazdina & Potosova 2003). This, according to Sefularo (2002), is because adolescence involves testing alternative views, behaviours and norms. However, it is important to note that the interpretation of adolescence as a developmental stage varies according to cultural context, marital status, region, class and sex (Cavaiola & Colford 2011).

### **1.9.2 Youth and young people**

The World Health Organisation (WHO) defines “youth” as men and women aged between 15 and 24 years and “young people” as those aged 10 to 24 years (Karim & Karim 2005). These terms are used interchangeably in this study, as well as in the literature reviewed for the study.

### **1.9.3 Integrated Youth Friendly Clinic**

An “integrated clinic” is a facility in which “...more types of services previously provided separately are offered as a co-ordinated and combined service” (The Manager’s Electronic Resource Centre [sa]:5). In such a service, a patient receives various services from one health care

worker at the time of consultation (WHO 2008). For a facility to qualify as an “adolescent friendly clinic”, service provision must take into account the dynamics of adolescence, including “socio-psychological assistance” (UNICEF [sa]). According to this source, there are three principles which should guide service delivery in adolescent-friendly clinics: “accessibility, voluntariness and friendliness”.

In the context of this study, an “integrated youth friendly clinic” is a healthcare facility where adolescents can access all clinical services during one consultation at one location.

#### **1.9.4 Voluntary Counselling and Testing (VCT)**

VCT is a client-initiated process through which a couple or an individual undergoes counselling that facilitates an informed decision to be tested for HIV (Boswell & Baggaley 2002). The information given to the client enables him or her to understand the implications of testing, assess personal risk to HIV and adopt risk reduction behaviour (WHO 2007).

#### **1.9.5 VCT Uptake**

According to Bock (2009:10) VCT uptake is the “proportion of clients who received pre-test counselling, consented to testing and received post-test counselling”. It is a “dynamic process with various determinants motivating different people to opt for an HIV test” (Rinke de Wit, Borght, Schim-vander Loef, Clevenbergh, van Craneburg, Rijckborst 2006:2). The voluntariness or lack of coercion to the client is central to VCT uptake.

VCT uptake is also an important indicator for generalised epidemics<sup>5</sup>, as it specifies the percentage of people who willingly seek voluntary counselling and testing, actually get tested, and become aware of their results (WHO [sa]).

---

<sup>5</sup> This refers to countries where national HIV prevalence rate is more than 1% of the population and HIV is predominantly transmitted heterosexually.

In the context of this study, VCT uptake refers to adolescents' conscious decisions to actively request or seek VCT.

### **1.9.6 Susceptibility**

According to Holden (2004:6) susceptibility refers to “the likelihood” of being infected by HIV, which may be at individual or group level. This “chance of being exposed to the virus” (Bishop-Sambrook [sa]:1) is determined by behavioural, biological, cultural and environmental factors as well as power relations (such as gender imbalances between men and women) (Holden 2004).

### **1.9.7 Chill Room**

A chill room is a “friendly space” found within a school or a youth friendly clinic where young people meet for various reasons, including socialising and life skills informational sessions (loveLife [sa]).

### **1.9.8 GroundBreakers**

GroundBreakers (gBs) are 18 to 25 year old peer educators who work in loveLife hubs<sup>6</sup>, including Youth Friendly Services. gBs are recruited from within the local community and they assist in the dissemination of HIV and AIDS information and act as role models for other young people in their communities (loveLife 2009).

## **1.10 OUTLINE OF THE STUDY**

The dissertation is divided into five chapters as outlined below:

**Chapter 1** presents an introduction to the study, highlighting the research problem in terms of the background to the research problem, the problem

---

<sup>6</sup> These are places where the loveLife programs are run and where gBs can use as face-face contact with young people for example YFS.

statement and the focus of the study. This chapter also sets out the rationale for conducting the study, the research objectives and the research questions. Furthermore, the research methodology employed in the study is briefly discussed, followed by a brief discussion of the research setting, where the study was conducted. The conceptual framework that guided the study is then briefly discussed. Finally, key terms used in the study are defined, and the outline of the dissertation chapters presented.

In **Chapter 2**, the researcher presents a discussion of the literature reviewed for this study. The chapter gives a brief overview of the HIV and AIDS epidemic including its impacts on adolescents. This is followed by a literature review of the South African government's response to the epidemic, specifically with reference to VCT and the provision of Youth Friendly Services. A discussion of the Information, Motivation, Behavioural Skills model that guided the study, is also presented.

**Chapter 3** presents a detailed discussion of the research methodology that was used to conduct this study. The qualitative research design, as the sampling technique used and the data collection procedures as well as data analysis techniques are outlined in detail. Also discussed in this chapter are the ethical considerations that guided this study. The two research settings where the research was conducted are further described. The pilot study that preceded this research is also discussed.

The focus of **Chapter 4** is on the presentation of the data gathered through the interviews. The research findings are presented according to the main themes which emerged during the interviews and those identified in the literature review. Adolescents' knowledge about HIV and AIDS and their susceptibility to HIV infection are explored, including their knowledge of VCT. In addition, factors that motivate or could motivate them to actively seek VCT are also explored. Finally, this chapter explores the possible



behavioural skills necessary for VCT uptake that the adolescents may have.

**Chapter 5** presents a summary of the findings and conclusions of the study. Also included in this chapter are recommendations for further study as well as policy recommendations with regard to the scaling up VCT uptake among adolescents. The limitations of the study are also discussed.

## **1.11 CONCLUSION**

This chapter gave an overview of the study by highlighting the research problem and the need to target adolescents in HIV prevention efforts including VCT. In addition, the following were discussed: the background to the Youth Friendly Services, the problem statement, focus of the study, the rationale for conducting the study, the research objectives and the research questions. Also summarised in this chapter are the research design and methodology, the research settings and the conceptual framework that guided the study. This was followed by the definition of key terms used in the study. Finally, a brief outline of each chapter was presented.

The following chapter presents a discussion of the literature reviewed for this study.

## **CHAPTER 2: LITERATURE REVIEW AND THEORETICAL CONTEXTUALISATION**

### **2.1 INTRODUCTION**

This chapter begins with a general discussion of the global AIDS pandemic and the AIDS epidemic in South Africa. Also included are the latter's impacts on adolescents and other young people. This is followed firstly by a discussion of the literature on the general importance of VCT in the efforts to address the AIDS pandemic, including those aimed at adolescents. This will be followed by a discussion of the theoretical framework, the IMB model. The literature reviewed in relation to VCT uptake by adolescents aged 15 to 19 since the introduction of NAFCI in 2002 from which the concept of Youth Friendly Services (YFS) emanates, will also be discussed. Included in this literature review is a general discussion of VCT uptake by adolescents in other countries.

It is important to mention that by the time the last two research participants in this study were interviewed, the South African government had recently launched the HCT campaign, thus shifting from the client-initiated VCT to the provider-initiated HIV counselling and testing. This chapter will therefore also present a discussion of HCT/ PIHCT and highlight the differences between the two HIV testing models.

### **2.2 THE HIV AND AIDS EPIDEMIC**

Over the past three decades since the first case of HIV was diagnosed, statistics continued to indicate the AIDS pandemic's global, regional, national, age, as well as gender disparities. Out of the 34 million people globally living with HIV in 2010, 22.9 million (67%) lived in sub-Saharan Africa, while out of the 2.7 million new infections globally in the same year, 2.7 million occurred in this region, making it home to approximately 70% of the total number of global HIV cases (UNAIDS 2011 cited in U.S Global

Health Policy 2011). Southern Africa is hard hit by HIV and AIDS and South Africa is among the hardest hit countries in this region, as it has approximately 5.24 million (10.5%) people living with HIV in a population of approximately 49.9 million in 2010 (Statistics South Africa 2010:6).

Apart from the global and regional disparities regarding HIV infections highlighted above, statistics also indicate gender and age disparities. According to the UNAIDS (2006 cited in Kaiser Family Foundation 2006:1), 59% of those people living with HIV globally are women. In Asia, the proportion of women to men living with HIV doubled between 2000 and 2008 (International Centre for Research on Women [sa]:1). Gender disparities are even more pronounced among young women. Whereas African women are 1.3 times more likely to be infected than men, those women aged between 15 and 24 are three to six times more likely to be infected by HIV than their male counterparts (Welpé & Owino 2007). Similar findings were made in a survey conducted in South Africa in 2008 where HIV prevalence among girls aged between 15 and 19 years was found to be approximately three times higher (6.7%) than that of boys the same age (2.5%) (Shisana *et al* 2009:31). Research has attributed these disparities to biological factors such as abrasions occurring during sexual intercourse as well as socio-economic and cultural factors such as economic inequality between men and women, poverty and inter-generational sex, among others (Hope 2007).

### **2.2.1 Impact of HIV and AIDS**

Worldwide, the HIV and AIDS pandemic has permeated every aspect of human life either directly or indirectly. Throughout the world, countries, communities, households and individuals have experienced the pandemic's adverse socio-economic impacts at varying degrees, with many individuals either being infected or affected. As the above statistics indicate, Southern Africa has the highest burden of AIDS-related diseases in the world, therefore is the hardest hit by the impacts of the pandemic.

The Southern African region has seen a steady increase in the number of orphans and vulnerable children since the advent of HIV and AIDS. It was estimated that by 2010 the region would have up to 15.7 million orphans and vulnerable children, with South Africa alone having up to 3 million OVCs in the same period (Starfish Greathearts [sa]). This high estimated number of orphaned children is attributed to the high AIDS-related mortality rates among men and women in the child-bearing age group of 15 to 49 years. This trend has resulted in a high number of child- and grandparent-headed households, a situation which in itself compromises children's and adolescents' transition to adulthood as they lose out on educational opportunities and nurturing from parents, among others. This has a bearing on their future productivity as adults (Chilufya 2009).

In recent years, there has been an increasing demand for healthcare services in most African countries due to high AIDS-related morbidity, resulting in both the overburdening of the healthcare system and a need to allocate more funds towards healthcare. In South Africa, the National Treasury allocated R25.7 billion to the health sector for the 2011/2012 financial year, which represents an increase of 15.3% (from R21.7 billion) in the 2010/2011 financial year ([medioclubsouthafrica](#)).

The international donor community has had to increase the amount of funding to the most severely affected countries. South Africa, for example received US\$397.8 million in the 2007 financial year from the United States Government's Emergency Plan for AIDS Relief (PEPFAR) (Kaiser Family Foundation 2008: 2). Other donor governments include the United Kingdom, Germany, Australia and Belgium (*ibid*).

Research indicates that the AIDS epidemic is responsible for excess workload in healthcare facilities, as well as high mortality rates among patients, which result in loss of morale among staff members. According to South Africa's National Strategic Plan (NSP) 2007-2011, stress and low

morale interferes with healthcare workers' ability to perform their duties in terms of the required standards while health care workers living with HIV feel the pressure even more. A study conducted in 2006 at the Helen Joseph and Coronation Hospitals in South Africa found that 11.5% of the 644 nurses studied were living with HIV, 19% of whom had AIDS defining CD4 cell counts (i.e. CD4 count of 200 and below) (Conelly, Veriava, Roberts, Tsotetsi, Jordan, DeSilva, Rosen & DeSilva 2007). In Botswana, between 1999 and 2005, approximately 17% of health care workers died of AIDS-related illnesses (Botswana National Strategic Framework 2003-2009).

The impacts of the epidemic among children and adolescents are far-reaching. A study by Ferrand, Bandason, Musvaire, Larke, Nathoo, Mujuru, Ndhlovu, Munyathi, Cowan, Gibb and Corbett (2010) indicates the extent to which HIV and AIDS are responsible for increased hospital admissions among adolescents in Harare, Zimbabwe. According to this study, approximately half of all the adolescents admitted to the hospital were living with HIV with the majority of them having acquired the HI virus through mother to child transmission (MTCT).

### **2.3 SOUTH AFRICAN GOVERNMENT'S RESPONSE TO THE HIV AND AIDS EPIDEMIC**

South Africa, like many other African countries has, since the advent of the HIV and AIDS epidemic initiated a number of interventions aimed at preventing new HIV infections as well as mitigating its impacts on people living with HIV, their families and communities. The initial response by the South Africa government was to create the National AIDS Coordinating Committee of South Africa (NACOSA) in 1992. This body was assigned with the task of developing a national strategy on how the epidemic could be tackled. This culminated in 2000 in the country's first National Strategic Plan (NSP 2000-2005). The NSP 2000-2005's primary goal was to reduce the number of new HIV infections among the youth and mitigate the

impacts of AIDS-related diseases on individuals, families and communities (*ibid*). Its four priority areas were prevention; treatment, care and support; human rights as well as research and surveillance of the HIV epidemic. The review of the NSP 2000-2005 resulted in the development of the NSP 2007-2011, which also had prevention, treatment, care and support as key priority areas.

Through the National Strategic Plan 2007-2011, the South African government offered a coordinated response to the epidemic, encompassing all stakeholders and focusing beyond healthcare, through acknowledging the fact that HIV and AIDS do not only present health-related challenges but also cultural and socio-economic challenges. A brief discussion of the NSP 2007-2011 key priority areas and goals will be presented within the context of this study, with the aim of highlighting the importance and relevance of VCT to adolescents in this era of HIV and AIDS.

As an HIV prevention strategy, VCT affords the client a chance to “assess their own risk behaviours, develop a risk reduction plan, and adopt reduction behaviour, access medical and psychological referral services” (Itech[sa:45]). The South African government’s efforts to promote and facilitate access to VCT rests on the premise that this strategy cuts across all four priority areas of the country’s NSP 2007-2011. However, in the context of this study, only two priority areas will be elaborated on, namely prevention and treatment, care and support. It is encouraging to note that the recently (December 2011) released NSP 2012-2016 also has prevention as one of its major goals. Some of the latter’s goals are to reduce new HIV infections by 50% and initiate at least 80% of eligible patients on antiretroviral treatment by 2016 (NSP 2012-2016). The NSP 2012-2016 has four objectives, namely to “address social and structural barriers to HIV, STI and TB prevention, care and impact; prevent new HIV, STI and TB infections; sustain health and wellness and increase protection

of human rights and improve access to justice” (NSP 2012-2016:9). The realisation of these goals (specifically the prevention of new HIV, STI and TB infections), is only possible if individuals know their HIV status. One way of enabling individuals to know their status is through VCT.

### **2.3.1 Prevention**

As highlighted above, the NSP 2007-2011 presents a number of goals, all which are achievable once people know their HIV status. The following goals of the NSP solely rest on knowledge of one’s HIV status:

1. The reduction of the vulnerability to HIV infection which can be ensured through the promotion of an enabling HIV testing environment.
2. Reduction of sexual transmission of HIV.
3. Reduction of Mother to Child Transmission (MTCT) of HIV.

### **2.3.2 Treatment, care and support**

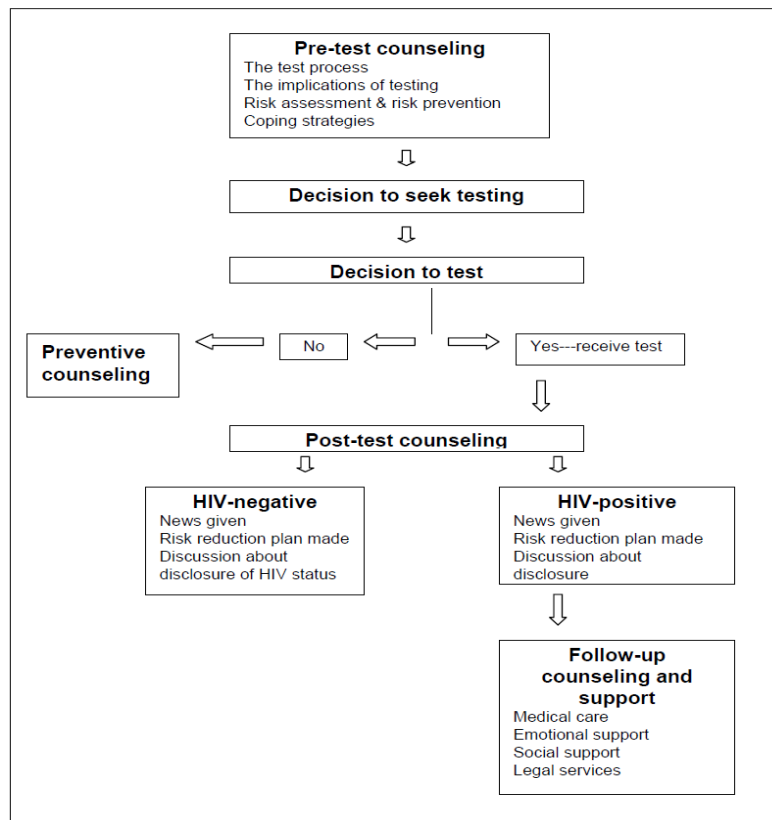
With regard to the Key Priority Area 2: Treatment, care and support, the NSP 2007-2011’s target is to “reduce HIV infections and AIDS morbidity and mortality as well as its socio-economic impacts by providing packages of treatment, care and support to 80% of people living with HIV and their families by 2011” (NSP 2007-2011:10). Knowledge of one’s HIV status is a first step towards accessing these services, therefore ensuring that, as the NSP stipulates, VCT is scaled up, and people are encouraged to adopt a culture of regular HIV testing. Within this priority area, the NSP 2007-2011 also emphasises the need for the timely identification of infants, children and adolescents living with HIV to ensure that they access treatment, care and support services. Access to these services ensures that people living with HIV (PLHIV) live long and productive lives.

## **2.4 VOLUNTARY COUNSELLING AND TESTING (VCT)**

VCT is a client-initiated process which takes place when an individual, for one reason or the other, makes a conscious decision to visit a facility offering VCT, to test for HIV. According to the Indian Ministry of Health and Family Welfare (2004), VCT is client-centred in that counselling provided during this process is designed to enable the client to make an informed decision to test and to be aware of the implications of testing for HIV. In this process, the client has the opportunity to assess his or her personal risks and make lifestyle-related decisions and changes based on information provided. The emphasis is also on the uniqueness of the client's needs, which means that the counselling must be tailored accordingly, depending on the "client's unique situation and capacity to deal with stress and trauma" (Indian Ministry of Health and Family Welfare 2004:1). Figure 1 below is a graphic presentation the process of VCT:



**Figure 1: The VCT process**



**Source:** McCauley (2004:18)

## 2.5 HIV COUNSELLING AND TESTING (HCT)

HCT is also referred to as Provider Initiated HIV Counselling and Testing (PIHCT). It was introduced in South Africa on the 24<sup>th</sup> May 2010. Its introduction was marked by a massive nationwide campaign to test 15 million people by June 2011. The Department of Health's decision to shift from VCT to HCT was informed by the need to increase the number of people who know their HIV status and who could therefore access appropriate services (South Africa Department of Health 2010).

Whereas in VCT the client initiates HIV testing, HCT emphasises that when a client visits a health care facility to receive any services whatsoever, the health care provider offers him or her an opportunity to be tested for HIV (SA Department of Health 2010). In this way, HIV testing

becomes a standard component of medical care (WHO 2007). Through HCT, unsuspected HIV infection is diagnosed and healthcare providers are able to make appropriate clinical decisions to the benefit of the client (*ibid*). The WHO (2007) emphasises, however, that despite the differences between the two HIV testing models, the “three C’s” (informed consent, counselling and confidentiality) must be observed at all times (WHO2007:19). The differences between VCT and HCT are presented in Table 1 below.

**Table 1: Differences between VCT and HCT/PHICT**

	<b>VCT</b>	<b>PHICT</b>
<b>Clients/ patients</b>	Come to receive HIV testing	Come with a medical condition
	Expect to be tested	Are not expecting testing
	Mostly asymptomatic	
<b>Providers</b>	Trained counsellor may not be health care worker	Healthcare provider trained to provide counselling
<b>Purpose</b>	Primary purpose is prevention	Primary focus on diagnosis of HIV, management of opportunistic infections and HIV, and referral
<b>Pre/Post-test encounter</b>	Client centred counselling	Health care provider recommends testing
	HIV test result discussed whether it is negative or positive	Little time is allocated for patients who test negative for HIV in terms of offering post-test counselling (less than 10 minutes of provider's time) Primary focus on positive result less than 15 minutes of provider's time)
<b>Follow-up</b>	Person with HIV positive test result referred for medical care	Care of HIV positive patient coordinated with Tuberculosis clinic (as the patient with a positive HIV test result is screened for TB and either started on TB preventive treatment or TB treatment)

**Source:** Itech [sa]:19

As mentioned above this study was initiated before the government shift to HCT policy therefore VCT and not HCT remained its focus. Furthermore, despite the policy shift in South Africa, the researcher is of the opinion that

the completion of this study was necessary, as VCT “still remains an important approach to HIV testing because many people do not regularly come to the health care setting but still need to know their HIV status” (Uganda Ministry of Health 2005:ix). In addition, for more than two decades, VCT has enabled millions of people to know their status thus affording millions to access care, treatment and related services. It was therefore still imperative to understand VCT uptake among adolescents, as this could contribute to the implementation of the HCT policy. The successes and challenges of VCT implementation may be used to inform the implementation of the HCT policy.

## **2.6 THE BENEFITS AND ADVANTAGES OF VCT IN ADDRESSING THE HIV AND AIDS EPIDEMICS**

### **2.6.1 Importance of VCT in controlling the spread of HIV/AIDS and mitigating its impacts**

In South Africa, and elsewhere in Africa, VCT is central in HIV and AIDS prevention and treatment efforts. According to the South African National Health Department Cluster HIV/AIDS and TB (2002), as a primary and secondary prevention strategy VCT plays a crucial role as it helps to:

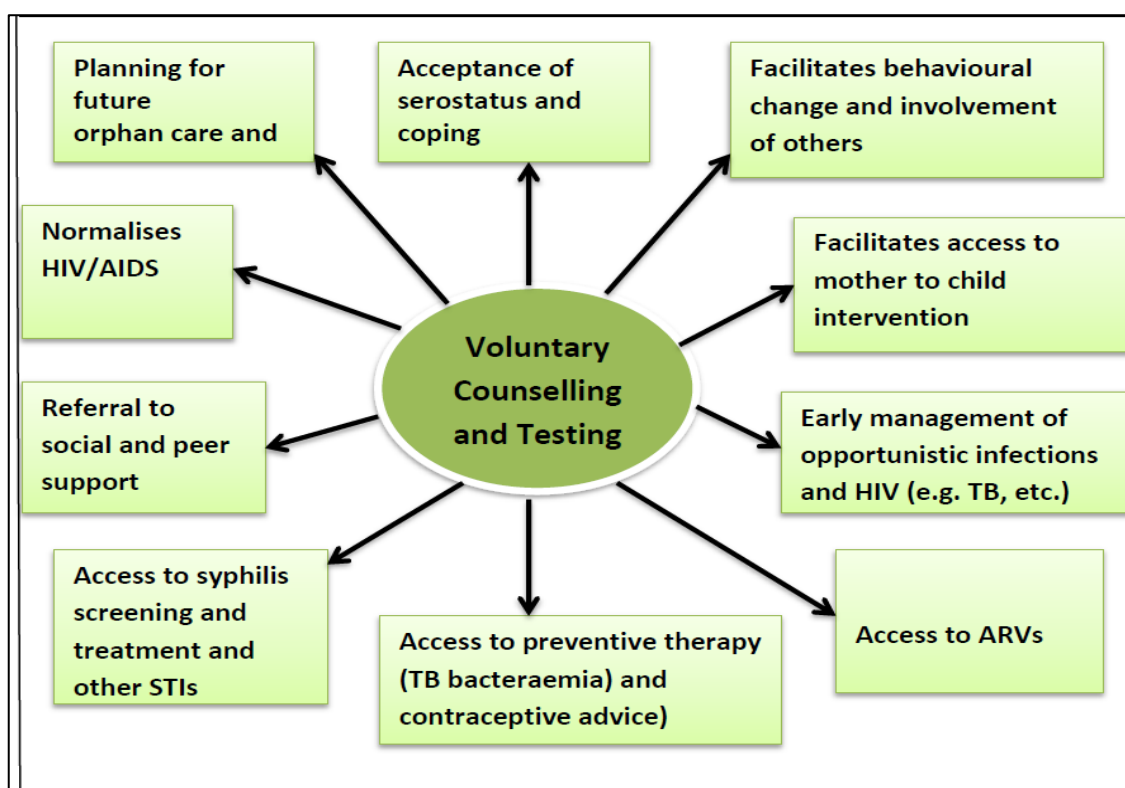
- prevent the spread of HIV;
- facilitate access to the continuum of care, treatment and support;
- reduce stigma and discrimination through knowledge and mutual support;
- empower people to adopt preventive behaviours.

However, according to Obiajulu (2010) VCT is more effective as a secondary, rather than a primary prevention strategy. This is because knowledge of HIV status is associated with safer sexual behaviour among people living with HIV, as condom use was more likely to be reported among the latter than those who had a negative HIV status (Nelson Mandela Foundation/HSRC 2005). On the contrary, a study conducted in

Rwanda in 2006 by Mukabarasi, Kamenga, Murray, Ngabonziza, Price and Ndabamenye (2006) concluded that VCT is effective as both a primary and secondary HIV prevention strategy. This study found that following VCT, there was a net decrease of 12.3% in the number of sexual partners among respondents between the time the baseline information was gathered and 6 months later. In addition, there was an increase in condom use with non-regular partners from 33% at baseline to 64% at 6 months (Mukabarasi *et al* 2006).

As presented in Figure 2 below, VCT is an entry point to a web of HIV/AIDS-related services, and also offers individuals an opportunity to make life changing decisions, which may help improve one’s quality of life, with the HIV infected person living positively into the future (Johnson, 2003 cited in van Dyk 2008:220).

**Figure 2: VCT as an entry point to HIV Prevention and Care**



**Source:** Tanzania Ministry of Health and Social Welfare (2008:4)

### **2.6.1.1 Acceptance of serostatus and coping mechanisms**

Allen and Nesta Ferguson Trust (2007:3) define VCT as “a confidential dialogue between a client and a provider aimed at enabling the client to cope with stress and take personal decisions related to HIV and AIDS”. This provision of emotional support to people who choose to go for VCT is one of the major objectives of VCT (*ibid*). In this way, VCT empowers individuals to accept an HIV positive result, and develop coping mechanisms and this is one of its most important benefits.

In an article by Reach Out (2010:32), a Kenyan woman narrates a story of how she got to know of her HIV positive status and how this helped her cope with her new status when she said: “Knowledge is power ... knowing and accepting one’s HIV status is true liberation”. This liberation includes being able to disclose that one is living with HIV, an important step towards positive living<sup>7</sup>. The role played by supportive significant others and a supportive home environment cannot be underestimated, as evidence indicates that ARV patients from such environments are less likely to default on taking their medication (WHO 2006).

### **2.6.1.2 Facilitation of behavioural change and involvement of others**

Voluntary counselling and testing has a number of benefits, including the facilitation of positive behaviour change, hence it is considered a major HIV and AIDS prevention strategy (Van Dyk 2008;). Pre and post-test counselling are effective avenues to impart “factual information” that facilitate informed decision-making by clients (Care [sa]). Mkaya-Mwamburi *et al* 2000 (cited in Van Dyk (2008) concurs, adding that VCT facilitates behaviour change and safer sex practices regardless of the outcome (positive or negative) of the HIV test. In addition, by virtue of its

---

<sup>7</sup> Includes having a positive attitude towards life, keeping one’s body and spirit healthy and avoiding transmitting HIV(Adolescent HIV Care and Treatment Module 9-1 [sa]).

psychosocial support component being aligned to the teachings of many religions, VCT is an effective behaviour change agent (WHO 2007).

A study conducted in Kenya by Arthur, Nduba, Forsyth, Mutemi, Odhlambo and Gilk (2007) to investigate behaviour change (among other factors) in health-centre based VCT clients found, six months post-VCT, that there was a significant reduction in the number of sexual partners and an increase in condom use. There was also a reduction in the incidence of sexual intercourse with non-primary partners. Another study conducted in Lagos, Nigeria to examine the possible role VCT could play in reducing risky sexual behaviour among undergraduate students in, Wusu & Okoukoni (2009) concluded that through VCT, risky sexual behaviour can be reduced. There was a reduction in the average number of partners for both male and female students following VCT. In addition, the proportion of males who engaged in frequent sex declined from 35.8% to 24.1% and for females it declined from 25% to 24.7%.

Studies conducted to assess the impact of VCT among discordant couples also indicate positive behaviour change following VCT. According to Collini & Obasi (2006) cohort studies indicated a decrease in unprotected sex among discordant couples who had undergone VCT as compared to those who had only received health education.

VCT has also been found to facilitate the involvement of significant others through disclosure. A study conducted in Uganda among HIV positive members of TASO found that people who had disclosed their status (69% to their most recent sexual partners) reported positive outcomes following the disclosure of serostatus. These positive outcomes included open and honest communication, risk reduction and facilitation of partner HIV testing (Adedimeji 2010). Benefits among pregnant women include easier partner notification among those whose HIV positive status was diagnosed

through VCT, as opposed to those who were tested as part of antenatal care visits (Collini & Obasi 2006).

#### **2.6.1.3 Facilitation of access to mother to child transmission interventions**

In Southern Africa, women account for approximately 60% of all people living with HIV, and the majority of them are in the childbearing age of 15 to 49 years (UNAIDS 2010). This therefore explains the resultant high HIV infection rates among infants and young children born to women living with HIV, which, according to the UNAIDS (2010), is approximately 90%. It is estimated that between 15% and 25% of these infections occur during pregnancy or delivery, while 15% of the infections occur during breastfeeding (UNICEF [sa]:1) The identification of women living with HIV, and ultimately preventing MTCT, can be achieved through counselling and testing during antenatal care and post-delivery of babies (South Africa Department of Health 2010).

#### **2.6.1.4 Early management of opportunistic infections**

People whose immune systems have been weakened by HIV easily get sick from infections that do not normally have the same effect on HIV people who are HIV negative (Van Dyk 2008). The most common opportunistic infection for people living with HIV in Africa is Tuberculosis (TB) (*ibid*; Karim, Churchyard, Karim & Lawn 2009). South Africa is currently faced with a high burden of TB/HIV co-infection, as more than half of all newly diagnosed TB cases are also infected with HIV, some with multi-drug resistant TB (MDR) (Karim *et al* 2009).

Other common opportunistic infections are sexually transmitted infections (STIs) such as syphilis. A person with an STI can both acquire and transmit HIV easily due to physiological conditions that exist when one has



an STI (van Dyk 2008). STI diagnoses during VCT can lead to timely referral to treatment.

#### **2.6.1.5 Access to antiretrovirals**

Increasing access to treatment in the form of antiretroviral treatment (ARVs) is one of the key priority areas of the South African NSP 2007-2011 as well as of the NSP 2012-2016. Through the NSP, the government of South Africa is committed to expanding access to care and treatment services to 80% of all people living with HIV by 2016 (South Africa Department of Health 2010). However, access to treatment is only possible if a person's HIV status is known, and VCT is one of the ways through which an individual can get to know his or her status. Timely initiation of treatment, before the onset of "full blown AIDS<sup>8</sup>" is crucial; hence guidelines specifying treatment eligibility have been developed and updated over the years.

A study conducted in Uganda indicates VCT clients' awareness of the important relationship between VCT and access to treatment (Nsabagasani & Yoder 2006). When interviewed, these clients mentioned that seeing an improvement in the health of community members who were taking ARVs gave them hope that they too would live longer. In addition, some clients tested for HIV because their relatives had promised to buy them ARVs if they tested positive for HIV.

#### **2.6.1.6 Access to preventive therapy and contraceptive advice**

TB screening of VCT clients who test positive for HIV facilitates the timely identification of those clients who would be eligible to be started on Isoniazid Preventive Therapy (IPT). IPT is a prophylactic (preventive) treatment used to protect HIV infected individuals from contracting TB.

---

<sup>8</sup> The final stage of AIDS during which the patient experiences a number of severe symptoms and becomes very thin (Health24 [sa]).

Furthermore, IPT can greatly reduce the burden of disease in high HIV prevalence areas (StopTB [sa]).).

VCT can also be used as an opportunity to impart reproductive health (family planning) information to all clients (Mengistu, Kibret, Nougua (2011). Risks of MTCT could be made clear to clients who test positive for HIV and they could be provided with information regarding dual protection<sup>9</sup> (*ibid*). A study conducted in Ethiopia (Bradely, Tsui, Kidanu & Gillespie 2010) indicates women's need for such information during VCT. According to this study, approximately 34% of women who had accessed VCT indicated that their reproductive health information needs were not fulfilled as VCT counsellors did not offer contraceptive counselling. Integration of reproductive health into VCT is considered as one of the ways in which this gap can be closed.

#### **2.6.1.7 Referral to social and peer support**

There are various forms of support that PLHIV can access outside the home and healthcare facility, such as home-based and community-based care. This refers to any type of care that people living with HIV receive either from their homes or from the community (Tanzania Ministry of Health and Social Welfare 2008). Community-based organisations (CBOs), faith-based organisations (FBOs) or non-governmental organisations (NGOs) often provide such services.

Support groups are also another form of providing support for PLHIV as they could assist with disclosure to families as well as with emotional and moral support from peers. In an article by Reach Out (2010:32) a woman who benefited from a support group is quoted as saying "I have lived positively [since attending the support group], as members of the group interact freely and support each other through group counselling and

---

<sup>9</sup> Combined use of condoms and oral or injectable contraception.

development of entrepreneurship skills”. There is empirical evidence for the effectiveness of support groups in helping PLHIV to cope with stigma and discrimination.

Other support services available for PLHIV include disability grants and nutritional support, as in the case of South Africa.

#### **2.6.1.8 Normalisation of HIV and AIDS**

HIV and AIDS-related stigma and discrimination pose a major challenge in efforts to manage the epidemic. Misinformation and myths, such as that sleeping with a virgin can cure AIDS-related illnesses also perpetuate the misunderstanding and mystery surrounding the disease. In many countries, HIV and AIDS are still associated with immorality and specific population groups (such as men having sex with men, truck drivers and sex workers) (Huson 2009). Through information sessions that are part of VCT, individuals and communities are able to receive factual information related for example to HIV transmission. In addition, because VCT is voluntary in nature, people are afforded an opportunity to make informed decisions on whether to test for HIV or not, as well as make choices regarding preventive behaviour. In this way, VCT clients feel respected and are more likely to change their attitudes towards people living with HIV (*ibid*). Anderson (2006 cited in Rohleder , Swartz, Kalichman, Simbayi & Cameroon 2009) argue that the reduction of HIV and AIDS-related stigma through widespread VCT may lead to the normalisation of the HIV epidemic as more people know their HIV status, are able to live longer and healthier lives, therefore contributing to the reduction of HIV-related stigma and discrimination .

#### **2.6.1.9 Planning for future orphan and vulnerable children care and will making**

Globally, the HIV and AIDS epidemics disproportionately impact on the child-bearing population group, thus resulting in more children being

orphaned and made vulnerable. This necessitates planning for the future care of dependents, including will making. Evidence from Southern and East African women's narratives of personal experiences that were compiled by the Human Science Research Council (Izumi 2006) point to worsened abuse of children as the pandemic progresses, as they often get displaced in the event of parental death. Planning in advance, if HIV status is known, could lead to a decrease in the unnecessary suffering of children.

## **2.7 MODELS OF VCT**

Conventional VCT proved to be insufficient in increasing the number of South Africans who knew their HIV status (Rohleder *et al* 2009). Research found that some population groups, such as men, may not seek VCT due to the fact that they rarely seek medical assistance even when they are unwell. A study conducted in Mozambique found that unlike men and older women, women of child-bearing age use VCT services at higher rates because it is integrated into other services such as antenatal care (Bhana 2006). These missed opportunities therefore necessitated adaptation of the conventional VCT and the development of new models, with the aim of making access to VCT more widespread (Rohleder *et al* 2009).

### **2.7.1 Home-based VCT (HBVCT) model**

Home-based voluntary counselling and testing (provided by counsellors and community health workers in clients' own homes) (HBVCT) is designed to help reduce stigma associated with facility-based voluntary counselling and testing as it eliminates the chances of the tester being seen queuing for testing or result collection at the facility, while at the same time it eliminates the inconvenience and costs of travelling (Rohleder, Leslie, Swart, Seth & Kalichman 2009; Negin Wariero, Mutuo, Jan & Proryk 2009). Another advantage of this VCT model is that it is

beneficial for people who reside in rural areas, who might otherwise not have access to VCT (Rohleder *et al* 2009).

Negin *et al* (2009) implemented a three month long HBVCT programme in rural Kenya in 2008, to investigate the acceptability and cost-effectiveness of HBVCT. Communities were sensitised about this model through a community outreach programme and 63.9% agreed to be visited by the lay counsellors. Of these, 97.6% agreed to be tested. A number of children below the age of 15 (399) were tested following parental consent, while 606 people above the age of 50 were also tested. This study concluded that HBVCT is both feasible and cost-effective and has the potential to encourage HIV and AIDS-related discussions between the different generations within the homes.

In another study to assess the acceptability of HBVCT conducted in Zambia (Mutale, Michelo, Jurgensen & Fylkesnes 2010) it was found that there was an increase in the percentage of people tested for HIV (from 18%) prior to the HBVCT intervention to 38% post HBVCT intervention.

According to van Ruyen *et al* [sa] in Rohleder *et al* (2009), this model has some disadvantages, which may include issues of disclosure in the case of couples who may not be ready to disclose to each other, lack of privacy in urban areas and operational costs. In addition, adolescents are found to be uncomfortable with HBVCT as it may arouse suspicion from neighbours if they are seen to be visited by health-care workers (*ibid*).

### **2.7.2 Free-standing VCT model**

Free-standing VCT also referred to as “stand-alone VCT” sites are not connected to a specific health facility but are independently owned by non-governmental organisations (NGOs) and are usually located in densely populated areas characterised by high HIV prevalence (FHI 2005).

Some of the advantages of this model, according to FHI (2005), include its ability to offer flexible hours and sufficient personnel to ensure quality of service delivery. Since only counselling and testing are offered, there is enough attention given to prevention and risk reduction counselling (*ibid*).

Disadvantages of the free-standing VCT model include high start-up and operating costs as well the possibility of people who visit them to be stigmatised by communities, considering that the services provided are associated with HIV and AIDS.

### **2.7.3 Integrated VCT model**

In an integrated model, VCT is offered within health facilities and it is integrated into normal services like family planning, PMTCT, STI and TB treatment. The advantage of this model includes its ability to reach a high number of people as they visit health care facilities (FHI 2005). Integrated VCT also facilitates referrals for further treatment or care within the facility. As health care workers also play an important role in promoting VCT, this may contribute to the normalisation of HIV (*ibid*). In addition, integration of VCT into other services also has the potential to reduce stigma, therefore making it easier for people to use VCT (Mphuru, Perchal, Barone & Luiola [sa]).

Integrated VCT also has its weaknesses. Offering VCT in this way may result in missed opportunities for population groups such as young people and men, who have poor health seeking behaviours and rarely visit healthcare facilities. In addition, staff may be overwhelmed by service demand in an integrated model, resulting in the neglect of certain services, which may include VCT (FHI 2005).

### **2.7.4 Mobile VCT model**

Mobile teams provide VCT from vans or selected areas in the community, targeting hard-to-reach groups (such as sex workers, truck drivers and

street children) (Morin, Khumalo-Sakutukwa, Charlebois, Vaki, Fiamma, Coates 2006), thereby ensuring improved access to VCT (FHI 2005).

However, mobile VCT also has its disadvantages, including limited ability of staff to follow-up on post-test counselling, high costs of equipment and its dependence on intense community mobilisation to promote use of the service (*ibid*).

## **2.8 ADOLESCENCE AND THE IMPORTANCE OF VCT**

“Adolescence is a period in the life cycle when the risk-related sexual ... activities begin” (Hein, 1987, cited in DiClemente *et al* 1992:8). According to Rosenbloom (2003 cited in Fennie 2011) the adolescent stage is characterised by tendency to seek sensation and “thrills”, therefore engaging in risky behaviour. Their “sense of invulnerability” presents challenges to interventions aimed at preventing HIV infection not only among adolescents but also other young people (Karim & Karim, 2005).

Although adolescence all over the world is characterised by high degrees of experimentation, problems experienced during this stage vary according to contexts, for example socio-economic or cultural contexts. In generalised epidemics, where HIV is predominantly transmitted heterosexually, adolescence is an even higher risk period for contracting the HI virus (USAID 2009). South Africa is one such country. The fact that this country has a generalised epidemic has worsened the plight faced by adolescents in the wake of the HIV and AIDS epidemics (*ibid*).

There are various risky lifestyles that predispose adolescents to HIV infection, including early sexual debut. The age at which children initiate sexual activity is a significant HIV and AIDS risk factor (Anderson, Beutel & Maughan-Brown 2007; Shisana *et al* 2010. Anderson *et al* (2007) add that delayed sexual initiation reduces the number of years that an individual becomes exposed to the risk of contracting HIV.

In South Africa, age at sexual debut is low. In a household census conducted in a rural sub-district of KwaZulu-Natal in 2003 (Harrison, Cleland, Gous & Frohlich 2005) 13.1% of the respondents reported having had first sex before the age of 15 (between 9 and 14 years old). These findings are in line with those of a 2008 national HIV prevalence survey (Shisana *et al* 2009), which found that apart from high sexual activity among 15 to 18 year old South African adolescents, 8.5% of 12 to 14 year olds who participated in the survey reported that they were sexually active. A later study by Volkwyn (2010) conducted in an urban area (Port Elizabeth) found that on average, age at first sex was 16 years. Table 2 below presents percentages of youth (15 to 24 years old) who had first sex by age 15 by province in South Africa (Department of Health, Medical Research Council & OrchMacro 2007).

**Table 2: Percentage of youth (aged 15-24) who had first sex by age 15**

Province	Female	Male
Eastern Cape	11%	21%
Free State	6%	15%
Gauteng	6%	13%
KwaZulu-Natal	2%	6%
Limpopo	9%	14%
Mpumalanga	9%	10%
North West	6%	12%
Northern Cape	6%	9%
Western Cape	5%	12%
<b>South Africa</b>	<b>6%</b>	<b>12%</b>

**Source:** Department of Health, Medical Research Council & OrchMacro (2007 cited in Berry & Hall [sa]:1)

Studies to assess the age at first sex among adolescents have been conducted in South Africa and elsewhere around the world. These studies



highlight a myriad of contextual, factors, some of which form part of a web of complex factors that impact on early sexual debut among adolescents. According to Hallman (2005 cited in Bosmans 2006) these factors include poverty, access to education and healthcare, location, ethnic group and gender.

In a study of sexual behaviour among youth, conducted in South Africa by Zambuko & Mturi (2005) it was found that enrolment at a high school or possession of a high school qualification minimised adolescents' likelihood of engaging in risky sexual behaviour (including early sexual debut) as compared to those who were not at school. However, the findings of a study conducted in Southern Malawi (Grant [sa]), found that enrolment at school influenced girls' and not boys' age at sexual debut, as more than 40% of males reported being sexually active in 2007 regardless of whether they were in or out of school. For girls, on the other hand, being at school was found to delay sexual debut as only 20% of them reported ever having sex in the same period as opposed to 38% of those who were not enrolled at school. Contrary to these findings, national surveys of adolescents aged 12 to 19 years conducted in four African countries namely Burkina Faso, Ghana, Malawi and Uganda found that being at school placed adolescents at higher risk of early sexual debut (Madise, Zulu & Ciera 2007). The researchers gave two possible explanations for this. Firstly, more children were enrolled at schools due to free education, and secondly, schools presented opportunities for "greater interaction and socialisation away from the prying eyes of parents" (Madise *et al* 2007:96).

Poverty is yet another factor that influences age at sexual debut. According to Bosmans (2006) and Shisana *et al* (2009), poverty predisposes women and girls to transactional and coerced sex. In support of this assertion, findings of national surveys conducted in the four countries mentioned above (Burkina Faso, Ghana, Malawi and Uganda) (Madise *et al* 2007), indicate that the relationship between poverty and

early sexual debut is more prominent among females than males. These national surveys also found that poor girls initiate sex earlier than “rich” ones in some countries, with those residing in poor urban areas being more likely to engage in early sexual debut than those residing in rural areas. Similar findings were made by a study conducted in the United States of America in 2006. This study found that location played key role in influencing age at first sex. According to this study, students who resided in rural areas initiated sexual activity at an older age than those who resided in a suburban area. It also found that students who resided in an urban area initiated sex at an even younger age. Gender also played a major role in determining age at first sex, as males initiated sex earlier than girls according to this study (March 2006).

Besides early sexual debut, adolescence is also characterised by the tendency to engage in multiple concurrent sexual relationships, mainly with people five or more years older, referred to as “intergenerational sex” (The Transition to Adulthood Study Team (2004); (Shisana *et al* 2009). One of the factors that promote intergenerational sex is household poverty, according to Hope (2007), who conducted a literature review of both published and unpublished material as well as key informant interviews in order to understand intergenerational / cross-generational sex. Some of the findings of the review indicated that although intergenerational sex is voluntary and perceived as being different from sex work, adolescents and other young people engaged in the former type of relationship faced a host of disadvantages. These include unplanned pregnancies and risky abortions, a high risk of STI and HIV infection due to inability to negotiate sex and condom use, as well as the possibility of forced sex in exchange for gifts and favours received (*ibid*). Sexual coercion has also been linked to gender role expectations that are dictated by society. While males are traditionally expected to be dominant in relationships and usually possess economic power and the power to have multiple partners, women are socialised to be submissive and are not

expected to negotiate on issues that impact on their sexual health and rights, including condom use (Hope 2007). As a result, female adolescents' risk to become infected with HIV and to experience other reproductive health-related problems, are heightened (Lawoyin & Kanthula 2010).

Studies conducted in South Africa indicate that there is high prevalence of intergenerational sex. There is also a tendency by men to target young girls for sex, particularly virgins (HSRC [sa]). The 2008 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (Shisana *et al* 2009) found a marked increase (from 18.5% in 2005 to 27.6% in 2008) with regard to the percentage of female adolescents aged 15 to 19 who reported being engaged in intergenerational sex. For males, there was a decrease from 2.5% to 0.7% during the same period.

Other factors that influence HIV infection among adolescents include alcohol and recreational drug use, which are often linked to impaired judgement that leads to casual sex and incorrect or inconsistent condom use as well as early sexual debut (Phorano, Nthomang & Ntseane 2005; Shisana 2009).

The above discussion, which clearly presents multiple HIV risk factors faced by adolescents puts into perspective the importance of voluntary counselling and testing for this population group, not only in South Africa but globally. As a two-pronged approach to HIV prevention (primary and secondary prevention), VCT could benefit uninfected adolescents though empowering them with information on how to maintain an HIV negative status. As a secondary prevention strategy, on the other hand, VCT would benefit adolescents living with HIV in accepting their status and living positively.

## 2.9 YOUTH-FRIENDLY SERVICES

### 2.9.1 Background to Youth Friendly Services

According to the South African Department of Health (DOH 2001:8), problems faced by adolescents are interrelated. Social, economic, cultural and political conditions of the wider society, including their living conditions, family context, educational level and income level cumulatively shape an adolescent's life (*ibid*). In addition, adolescents are prone to unhealthy lifestyles and risky behaviours which may in turn lead to unprotected sex, thus resulting in STIs and HIV infections (WHO 2006). Apart from lifestyle related issues, adolescents' vulnerability to HIV also results from a lack of life skills, financial dependence, lack of parental support and mentoring, abusive and coercive sexual relationships as well as limited access to health care facilities (*ibid*). Apart from these problems, adolescents are also prone to eating disorders such as anorexia nervosa and bulimia, among other problems (de Haan, Dennhill & Vasuthevan 2005).

It is against this background that the South African Department of Health and loveLife signed an agreement in 2002. This agreement culminated in the National Adolescent Friendly Clinic Initiative (NAFCI), with the ultimate goal to "effect positive behaviour change ... to reduce teenage pregnancy, sexually transmitted infections and HIV and AIDS" (Department of Social Development & Mabitsele [sa]:1). The signing of this agreement acknowledged that addressing problems faced by adolescent required a multi-sectorial response, comprising of health, education, sport and other sectors of government as well as civil society (Ashton, Dickson & Pleaner 2009). In addition, the public health system was considered a pivotal and sustainable avenue through which HIV infection among adolescents and other young people could be reduced (*ibid*). As a result, YFS (which include reproductive health and general medical services) are provided in primary healthcare facilities. Young people themselves also played an

important role in shaping the national adolescent friendly clinic initiative. Communities were also consulted to ensure their “buy-in” to the initiative.

NAFCI’s key objectives were therefore “to make health services accessible and acceptable to adolescents; to establish national standards and criteria for adolescent health care in clinics throughout the country and to build the capacity of health care workers to provide quality adolescent health services” (Department of Social Development & Mabitsela [sa]:1).

Ten standards that define a “youth friendly” service were developed by NAFCI in consultation with national and international experts as well as young people themselves, who indicated what their expectations were. According to Stadler & Hlongwa (2002, cited in Mokabane 2010), the NAFCI standards were developed around the essential elements of client care; management capacity to support effective implementation of YFS; availability of policies that support adolescent rights; accessibility of appropriate services; the creation of a conducive environment of care; availability of medication, supplies and equipment; information, education and communication; trained staff; appropriate physical assessment and individualised care as well as continuity of care for adolescent clients.

### **2.9.2 Essential Service Package**

The Essential Service Package rests on the guiding principles of NAFCI, which include the recognition of the uniqueness of every adolescent, addressing gender inequalities, adolescents’ rights to a full range of sexual and reproductive services, as well as the need to adopt a holistic approach towards addressing adolescent health needs (Dickson-Teteh, Ashton, Silimperi, Moleko & Ladha 2000). The Essential Service Package was compiled by the South African National Department of Health, drawing on the World Health Organisation’s recommendations for primary health care services and also bearing in mind the capacities of public health facilities (Ashton *et al* 2009).

Although health is the major focus of the YFS package, the following also form an important part of this package (Ashton *et al* 2009):

1. Information, education and counselling on sexual and reproductive health.
2. Information, counselling and appropriate referral in cases of violence / abuse and mental health problems.
3. Contraceptive information and counselling, provision of contraceptives including oral contraceptive pills, emergency contraception, injectables and condoms.
4. Pregnancy testing and counselling, antenatal and postnatal care.
5. Pre- and post-termination of pregnancy (TOP) counselling and referral.
6. Information on sexually transmitted infections (STIs), including information on the effective prevention of STIs, including partner notification.
7. HIV information, pre- and post-test counselling and appropriate referral with regard to voluntary counselling and testing if services are not available.

Furthermore, clinics that meet the standards of “youth friendliness” also have an information centre for young people as well as a “chill room” where they socialise and receive counselling from peer counsellors (Michael, Alexandria, Donald 2004). YFS have groundbreakers (gBs), who are peer counsellors and role models to adolescents and other young people. Groundbreakers are young people aged between 18 and 25 years who, for a period of one year, volunteer to be champions in spreading HIV prevention messages in their communities (loveLife 2009). Groundbreakers are also in charge of the information centres and chill rooms and provide counselling to adolescents and other young people who visit the chill rooms.

The factors discussed above in this section make a facility “youth friendly”, and it is clear that such a facility does not only concentrate on health-related issues faced by adolescents and other young people, but also on issues that impact on all aspects of their lives. This is a “holistic approach that takes cognisance of [adolescents’] physical and mental wellbeing” (African Youth Alliance/ Pathfinder 2003:13). In addition, integrating the services (by offering a wide spectrum of both clinical and reproductive health services) provided to adolescents helps in retaining the adolescent clients, as it minimises their need to travel and therefore reduces the risks of being seen at sexual and reproductive health or VCT site. According to Matubatuba (2002), this is important to adolescents, as they seem to value their privacy.

## **2.10 THEORETICAL FRAMEWORK**

This section discusses the constructs of the Information-Motivation and Behavioural Skills Model (IMB), which theoretically guides this study. As a social-cognitive model, this theory has been used in promoting HIV preventive behaviour, including VCT. In the context of this study, this model was chosen as it fits in with NAFCI’s emphasis on the provision of information (including information about VCT), development of life skills (including behavioural skills) and the involvement of communities as a holistic approach towards addressing problems faced by adolescents and other young people.

### **2.10.1 The Information Motivation Behavioural Skills Model**

The Information Motivation Behavioural skills Model (IMB) was designed specifically to address HIV prevention (Fisher, Fisher, Bryan & Misovich 2002 cited in DiClemente 2009). This theoretical framework has been widely used in designing culturally appropriate interventions in countries experiencing a high HIV prevalence (DiClemente, Crosby, & Kegler 2009). It allows for a broad understanding of the factors that influence HIV

prevention and other health behaviours (*ibid*). It has been used in designing interventions aimed at people with chronic conditions such as arthritis (Schoster, Callahan, Meier, Mielenz & DiMartino 2005). Aral, Douglas & Handsfield (2008) commend the IMB model for being practical and suitable for both primary prevention campaigns that are aimed on individuals who do not yet have the disease, and secondary interventions that are aimed at those who already have the disease.

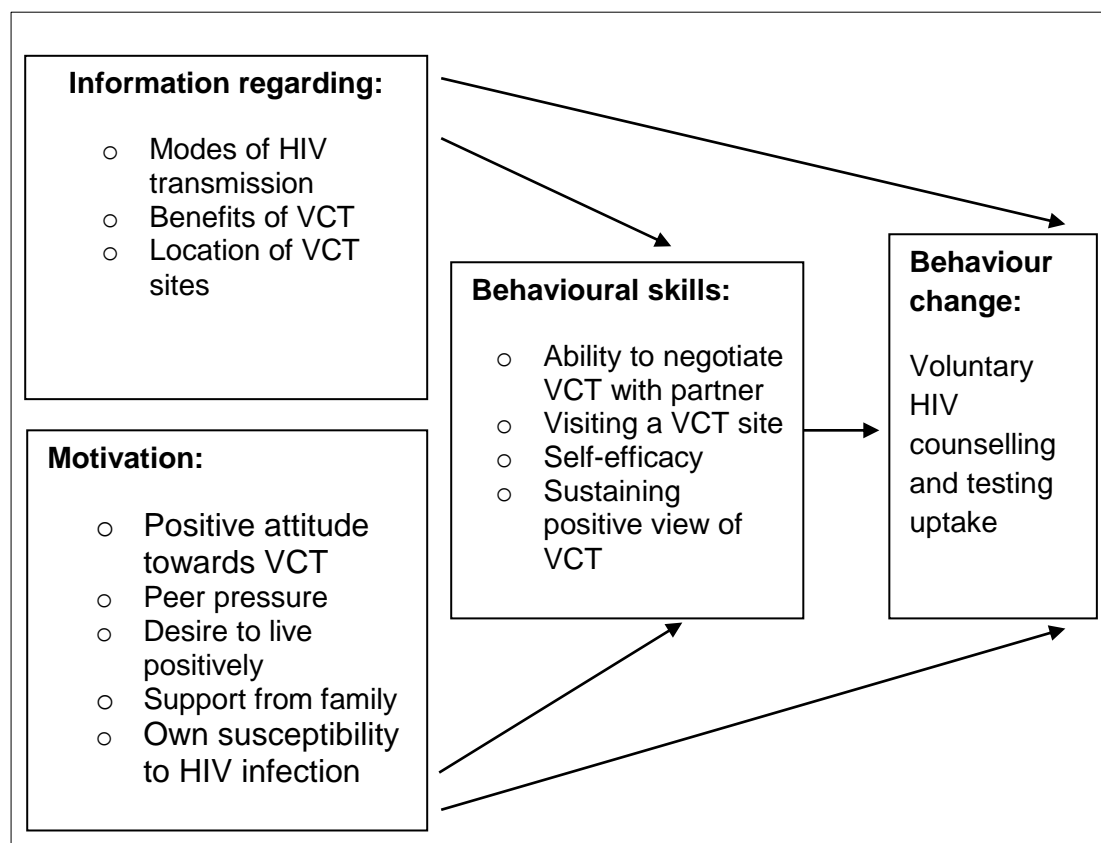
According Fisher *et al* 1996 cited in DiClemente *et al* (2009), there are three key determinants of HIV preventive behaviour according to the IMB model, namely information directly relevant to preventive behaviour; motivation to change the HIV risk behaviour and behavioural skills for performing specific HIV-preventive behaviour.

In essence, the IMB model argues that when an individual is well informed, motivated to act, and possesses the behavioural skills required to act effectively, he or she will be likely to initiate and maintain patterns of HIV preventive behaviour. The emphasis of this model is on the role played by an individual's own (cognitive) views of the advantages and disadvantages of a specific health-related behaviour, as well as constraints or enablers (social factors) thereof (MacDowell, Bonell, Davies & Davies 2006:45). DiClemente *et al* (2009) concur, adding that the specific health-related behaviour should be acceptable within the individual's community for an individual to enact it. In this way, the model attempts to incorporate the role played by an individual's significant others (social norms) in actually practicing the behaviour (*ibid*). In short, this model's focus is on the 'what', 'why', and 'how' as well as the 'where' (resources) of health behaviour (From Theory to Practice in Peer Education[sa]).



Figure 3 graphically presents the IMB model as it relates to HIV voluntary counselling and testing. Each construct of the model is discussed below, including how it relates to VCT.

**Figure 3: IMB Model as it Relates to VCT**



**Adapted from:** Fisher & Fisher in DiClemente *et al* (2002:52)

### 2.10.1.1 Information

The information construct of the IMB model refers to the extent to which an individual is informed or knowledgeable about a specific health-related behaviour, such as sexually transmitted infections (STIs) and their prevention (MacDowell, Bonell, & Davies 2006). It also encompasses the knowledge regarding the resources that facilitate actual enactment of the health-related behaviour, which include places where the services can be

accessed, such as youth friendly services (From Theory to Practice in Peer Education [sa]).

In the context of this study, as indicated in Figure 2, individuals' decisions to seek HIV voluntary counselling and testing depends on the knowledge or information they have about HIV and AIDS in general. This includes modes of HIV transmission and prevention. This knowledge is the first step towards acknowledging one's own susceptibility to HIV infection. In addition, individuals must know the benefits of VCT and places where they can access this service (deGraft-Johnson, Paz-Soldan, Kasote & Tsui 2005).

In order to improve HIV risk reduction behaviour, including increased VCT, the planning and implementation of the Phaphama risk reduction intervention (in Cape Town, South Africa) was guided by the IMB model (Mathinti, Simbayi, Jooste, Kekana, Nibe, Shasha, Bidla, Magubane, Cain, Cherry & Kalichman 2005). In this intervention, counsellors were trained to provide counselling within the framework of all the three constructs of the IMB model. Within the information construct, the counsellors provided clients with general information regarding HIV and STI, what HIV is; modes of transmission and prevention; HIV and AIDS statistics (in order for the clients to situate themselves within the epidemic); as well as information to dispel myths and stigma. This intervention proved to be a success with the clients and demonstrated improved knowledge about sexually transmitted infections (STIs), including HIV and AIDS among the participants.

Although information forms the basis for behaviour change, it is, on its own, insufficient to effect behaviour change, according to this model (DiClemente *et al* 2009; Rew 2005). The evaluation of the Phaphama intervention supports this assertion as the control group, which was only exposed to information and not motivation and behavioural skills

components, demonstrated lower degrees of behaviour change as compared to those who were exposed to all the three constructs of the model (Mathinti *et al* 2005). A study conducted in Bela-Bela, South Africa, also supports the assertion that information alone does not lead to the enactment of a health-related behaviour. In this study, De Koker, Lefevre, Matthys, van der Stuyft & Delva (2010) sought to establish the extent to which VCT uptake had increased in Bela-Bela, Limpopo, South Africa following 13 years of information dissemination through awareness campaigns by the HIV/AIDS Prevention Group. The study found that although the community indicated that they could easily access information and attend the awareness campaigns, they did not feel ready to test for HIV based on the particular nature of the information. The community felt that the information did not equip them enough “to overcome their fears, to make well considered decisions towards VCT uptake and to incorporate preventive sexual behaviours”. De Koker *et al* (2010) therefore acknowledge the necessity for a motivation and behavioural skills component to complement the awareness campaign information.

#### **2.10.1.2 Motivation**

Fisher & Fisher (2000, cited in MacDowell, Bonnel, Davies 2006) assert that motivational factors (highlighted below in this sub-section) are crucial in the prediction of health-related behaviour. This is because once “optimal levels” of knowledge are reached, the provision of further information would not yield any further behaviour change (MacDowell *et al* 2006:71). MacDowell *et al* (2006) asserts that a person’s motivation to enact specific health behaviour plays a key role. This means therefore that other factors, such as an individual’s attitude, perceived personal vulnerability and susceptibility, as well as perceived support from peers and family to enact the behaviour, must be taken into account when trying to understand health-related behaviour (Donenberg, Schwarts, Emerson, Wilson, Bryant

& Coleman 2005). As a determinant of health-related behaviour, the motivation construct provides both a cognitive and social normative explanation to health behaviour, where both the individual and the significant others play a role in the final decision.

In the context of this study, and as Figure 3 above indicates, some of the factors that may motivate an adolescent to seek VCT are peer support, desire to live positively, support from family, positive attitude towards VCT as well as acknowledgement of own susceptibility to HIV infection.

### **2.10.1.3 Behavioural skills**

The behavioural skills construct explains the extent to which an individual “is able to implement [health-related behaviour]” (MacDowell *et al* 2006: 71). Behavioural skills may include the ability to enforce condom use and negotiating VCT with a partner (Rew 2005; DiClemente *et al* 2002) as well as the ability to seek and obtain HIV voluntary counselling and testing. Other behavioural skills essential for HIV preventive behaviour are “self-acceptance of sexuality ... and consistent performance of preventive behaviour” (Fisher & Fisher 1992, cited in Rural Centre for AIDS/STI Prevention 1995:2).

As seen above, “information and motivation are independent constructs (do not have a direct relationship), but are each directly related to prevention behaviour, as they stimulate the application of HIV behavioural skills to effect HIV preventive behaviour” (DiClemente *et al* (2002:50); Rew (2005) & MacDowell (2006). In the context of this study, an adolescent may have sufficient information regarding the benefits of VCT, yet fear being stigmatised by family and friends, or lack confidence in her ability to approach a facility and request it.

However, in uncomplicated health-related situations such as when a patient is instructed by a healthcare worker to take headache medication at specific times, motivation and information can lead directly to behaviour

change, whereas in complicated cases (such as VCT), relevant behavioural skills are essential (DiClemente *et al* (2002)).

### **2.10.2 Previous studies based on the IMB model**

DiClemente *et al* (2002) site a study involving a sample of predominantly heterosexual university students who received an IMB-model based intervention. Results indicated that two to four months following the intervention, there was an increase in seeking voluntary counselling and testing by the research participants.

Another study by Donenberg, Schwartz, Emerson, Wilson, Bryant, Coleman (2005) used the IMB model to explain HIV risk behaviours among youth in psychiatric care. This study tested the model's cognitive constructs (information and motivation), as well as its behavioural constructs (behavioural skills), among boys and girls in psychiatric care. Information or knowledge about AIDS was assessed using a 37-item true-false self-report instrument, to assess knowledge and misconceptions about modes of HIV transmission. To assess the motivation construct, on the other hand, attitudes and beliefs towards HIV and AIDS (perceived risks of getting infected, peer norms) were investigated, and a 38-item-report was used to score the responses. Perceptions of self-efficacy to prevent HIV transmission, for example whether an individual found it very hard or very easy to enforce condom use (assertive, performance, and refusal self-efficacy) were used to measure behavioural skills. The findings of this study indicate that although enhancement of the model's three constructs had the potential to contribute to minimising risk behaviour among the group studied, they could not, on their own, sufficiently explain the group's sexual risk taking. The researchers therefore concluded that factors such as gender and age (which affects an individual's "intellectual maturity") of the target group, played a big role in the achievement of the final result. The researchers therefore conclude that in order to be able to

practice behavioural skills to reduce risky behaviour (based on the information gained), “a certain level of intellectual maturity ....is necessary.... abilities [which] have yet to develop in teens.....” (Donenberg *et al* 2005:1).

### **2.10.3 Critique of the IMB model**

The IMB model emphasises the individual rather than the social environment, as the determinant of health-related behaviour (MacDowell *et al* 2006). The disadvantage of this kind of paradigm is that it negates the importance of socio-economic and cultural contexts within which an individual exists (Solomon *et al* 2004).

Although MacDowell *et al* (2006) criticise this model for its emphasis on the individual rather than the social, cultural, political and economic environments as the determinant of health-related behaviour, these authors also commend the IMB model for including social “normative factors” (for example the influence of significant others) in explaining an individual’s health-related behaviour. This inclusion makes the IMB model a suitable model for this study, as it accommodates a holistic approach as proposed by the YFS Package and allows for the important role that significant others could play in adolescents’ health related behaviour.

## **2.11 LITERATURE REVIEW ON ADOLESCENTS AND VCT IN THE CONTEXT OF THE IMB MODEL**

### **2.11.1 Adolescents’ knowledge about HIV transmission and prevention, and their perception regarding their own susceptibility to HIV infection**

Accurate knowledge regarding HIV prevention and transmission is crucial if adolescents are to understand the relevance of the epidemic to their lives. Acknowledging one’s susceptibility to HIV infection facilitates the adoption of preventive behaviour, and knowledge plays a key role in this

(Wodi 2005; Anderson *et al* 2007). Failure to acknowledge one's susceptibility to HIV infection actually raises one's risks of being infected (UNICEF 2002 & UNAIDS 2004). Paradoxically, adolescents are "typically viewed as being unable to judge risk appropriately and as having strong beliefs in their invulnerability to harm" (Millstein & Halpern-Felsher 2002:1). This is evident in the studies cited in this section.

Studies that have been conducted globally indicate that although adolescents have adequate knowledge relating to the transmission and prevention of HIV, this does not necessarily translate to behaviour change such as condom use, abstinence or reduction in the number of sexual partners (Mwale 2008). In South Africa, evidence indicates that knowledge of HIV transmission and prevention is as high as 95% among 15 to 24 year olds (loveLife 2006), although studies conducted here indicate low perception of HIV risk among this population category (Macintyre, Rutenburg, Brown & Karim 2004; Tillotson and Maharaj 2001 cited in Anderson *et al* 2007). Shisana *et al* (2005) add that the majority of South African youth know that HIV is transmitted heterosexually.

A study conducted in Port Elizabeth, South Africa (Volkwyn 2010) sought to measure knowledge, attitudes, beliefs and reported sexual behaviour among adolescents in a healthcare centre. This study found that although knowledge about HIV and AIDS was "moderately high" among the participants, it did not lead to actual behaviour modification. In addition, this knowledge did not result in improved (i.e. more positive) attitudes towards people living with HIV and AIDS. Regarding preferred sources of information, this study found that the majority of the participants (45%) indicated that they preferred health care workers as sources of information, followed by trained peer educators (41%) and lastly parents.

Anderson *et al* (2007) conducted a study to determine HIV risk perceptions and first sexual intercourse among youth in Cape Town. They used data from the first (2002) and third (2005) waves of the Cape Town

Area Panel Study (CAPS). Results indicated that 82% of males and 83% of females perceived themselves to be at low risk or no risk at all of HIV infection, with only 7% of the full sample perceiving themselves to be at high risk of HIV infection. This study also found that engaging in sexual activity and knowledge of a person who was either living with HIV and AIDS or had died of HIV and AIDS-related illnesses was positively related to adolescents' perception of own susceptibility to contracting HIV.

Findings of the above mentioned study collaborates those of a survey conducted in 2005 among 15 to 24 year old South Africans (Pettifor, Rees, Steffenson, Hlongwa-Madikizela, MacPhail, Vermaak, & Kleinschmidt 2004). This survey found that there were low levels of self-perception of HIV risk among this population category, According to this survey, 36% of the respondents believed that they were not at risk of contracting HIV, 35% reported being at small risk, 12 % thought they were at moderate risk, and only 14% indicating that they thought they were at high risk of contracting HIV. This survey also found that more females than males perceived themselves to be at risk, and that 15% of females had been tested, as opposed to 9% males. Of those who already had a positive HIV status, 62% thought they were at no risk at all, and 73% of those who tested negative for HIV thought they were at no risk at all. Although 60% of the total sample said they were interested in getting tested, the majority had never been tested for HIV (Pettifor *et al* 2004). In another survey conducted by Shisana *et al* (2005), it was concluded that those respondents who said they had never tested for HIV perceived themselves to be at low risk of HIV infection.

Studies conducted in other parts of Africa have also found a mismatch between levels of knowledge and actual behaviour change by adolescents. A study conducted in Zomba, Malawi (Mwale 2008) found that although adolescents were well informed about HIV and AIDS transmission and prevention, they did not change their risky behaviour based on this knowledge. Knowledge, attitudes and behaviour (KAB)



questionnaires were administered and focus group discussions conducted with adolescents from three different schools with the aim of investigating the reasons behind the lack of behaviour change despite the amount of knowledge received. It was found that although 87.5% of the respondents knew the modes of HIV transmission and prevention, a significant percentage (65%) indicated that they were not worried about dying from AIDS-related illnesses since one could die from accidents or any other illness. Regarding the existence of HIV and AIDS, 55% of the respondents indicated that they did not believe it actually did exist. This study also found that 87% of the respondents believed that HIV and AIDS messages calling for abstinence were unrealistic as they found it impossible to abstain from sex.

A longitudinal survey was conducted in Southern Malawi among 14 to 16 year old adolescents to establish the relationship between three constructs: being at school, perceiving oneself as being susceptible to contracting HIV, and sexual behaviour (Grant [sa]). Initial data was collected in 2007 with follow-up data collected in 2008. Preliminary findings of this study indicated that among the adolescents who were at school, 87.5% perceived themselves as having “no chance” of contracting HIV in the future. Among out-of-school adolescents, 75.1% perceived themselves as having “no chance” of contracting the HI virus. The preliminary findings also indicated that only 45.6% of adolescents who were at school perceived themselves as having a “great chance” and only 25.6% of those who were not at school felt this way.

Similar to the findings of the above studies, a study conducted in Nigeria (Wodi 2005) found that despite high levels of awareness (93%) about HIV and AIDS, there was no accompanying behaviour change or an attempt to prevent HIV infection by the participants. On the question regarding how worried they were that they might contract HIV in the future, 67% said they were either not worried or somewhat worried. This study also found that

this knowledge did not change negative attitudes towards people living with HIV, nor did it fully address HIV and AIDS-related misconceptions such as believing that mosquitoes can transmit HIV.

In an attempt to explain this irony, Boler & Jellema cited in Bosmans (2006) attribute this mismatch to the nature of HIV and AIDS education itself, which they regard as being “technical” and may not be easy to understand. These authors also attribute this gap to a lack of integration of HIV and AIDS into the sexual and reproductive health services that covers contraceptive use, planned or unplanned pregnancies as well as sexually transmitted infections. Bosmans (2006), on the other hand attributes the gap to the ABC (abstain, be faithful, condom use) approach’s tendency to ignore the impact of socio-cultural factors such poverty and gender norms which unfairly place females at risk. HIV and AIDS-related stigma and discrimination has also been blamed for the gap between knowledge and actual behaviour, as it is assumed that adolescents may not be willing to face the possibility of being stigmatised (Anderson *et al* 2007).

The above discussion emphasises the assumption of the IMB model that information alone is not sufficient to ensure the enactment of health-related behaviour. Instead, enactment of health-related behaviour is a complex state that results from a myriad of factors including motivation and behavioural skills.

### **2.11.2 Adolescents’ knowledge regarding the importance of VCT and factors that motivate them to seek VCT**

The IMB model proposes the importance of knowledge in facilitating health-related behaviour, but also emphasises that this alone is insufficient without motivation to enact the specific health-related behaviour (MacDowell *et al* 2006).

The role played by knowledge in VCT uptake was highlighted in a study conducted by Middelkoop, Myer, Smit, Wood and Bekker (2006:1). The purpose of this study was to establish the relationship between increased awareness about VCT and actual VCT uptake, using drama among adolescents in a poor, peri-urban township in South Africa. Findings were that, following the intervention, there was a 172% increase in VCT use in this community. In comparison, no increase was reported in non-intervention communities. It can be concluded therefore that increasing adolescents' knowledge about VCT leads to its increased uptake, although other factors, such as peer pressure may also have played a part.

Students participated in a debate held at the Humansdorp Cultural Centre in the Eastern Cape Province of South Africa as part of the VCT awareness week. This debate was organised by the Department of Health on the 9<sup>th</sup> July 2008 (Eastern Cape DOH 2008). Following the debate, it was established that some South African adolescents seem to have sufficient knowledge about what VCT is and what it entails. Students who argued in favour of VCT highlighted benefits such as being able to protect themselves and those they love from HIV infection and ensuring positive living if infected. In addition, voluntary counselling and testing was considered beneficial as it leads to the checking of one's CD 4 cell count, thus enabling timely access to treatment. The students who argued against VCT pointed out that discrimination, lack of confidentiality in clinics, as well as depression with a possibility of suicide, were issues that hindered their uptake of voluntary counselling and testing.

Focus group discussions conducted in Cape Town as part of a study to assess facilitators and obstacles to the involvement of adolescents in HIV vaccine trials also found that adolescents were knowledgeable about VCT and its advantages and disadvantages (Jaspan, Soka, Mathews, Mark, Flisher, Middelkoop, Wood & Bekker 2010). This study was conducted in a semi-urban informal community of Cape Town with high HIV prevalence.

Four focus group discussions were conducted with adolescents aged between 14 and 17. The adolescents highlighted various issues for and against VCT. Some of the reasons for testing were: the need to know one's status in order to rule out HIV if one fell sick, having engaged in unprotected sex and being a peer counsellor. National and international campaigns also seemed to play a role in influencing the decision to seek VCT as some adolescents mentioned that they tested because it was World AIDS day.

The negative attitudes of nurses and counsellors, sharing waiting areas and consulting rooms with the rest of the clients as well as concerns regarding lack of confidentiality at public clinics were mentioned as some of the issues that deterred adolescents from seeking VCT. Some adolescents also mentioned that they feared that their parents would access the test results while others said they could not test because the staff at the clinics knew their parents. In addition, there was also a feeling that it was not necessary for them to test as they "knew" that they were safe (*ibid*).

Despite this knowledge, however, some studies indicate limited experience of VCT among adolescents in South Africa. Focus group discussions conducted as part of a study in two South African townships found that adolescents had little experience of VCT, were afraid of knowing their status and felt that testing was for symptomatic people. Support from family members was regarded as important, as adolescents said they would disclose to those family members who were supportive (MacPhail, Pettifor, Coats & Rees 2008).

A study conducted in a rural community of Kwa-Zulu Natal, South Africa in 2008, also found that despite high levels of knowledge about VCT and its benefits, as well as a positive attitude towards it, testing rates among adolescents and other young people were very low (Francis 2010). According to this study, although 91% of the respondents indicated that

they would seek VCT, only 28% actually tested. Those who had tested mentioned that VCT was beneficial as it facilitated positive living for those who tested positive for HIV, while girls also mentioned the protection of their unborn babies from HIV infection as a reason for testing (Francis 2010).

Njagi and Maharaj (2006) conducted a study in which they sought to understand how students at tertiary educational institutions perceived HIV voluntary counselling and testing. This study found that there were generally high levels of knowledge about VCT among students although only 14% had actually had an HIV test. Fear of stigma and a lack of privacy and confidentiality were mentioned as some of the factors that prevented them from testing. However, this study also found that 47% of those who had never tested indicated that they had never heard of VCT.

Factors that motivate adolescents to seek VCT seem to be similar across countries. Mphaya (2006) cites studies conducted in Kenya and Uganda by the Horizons Programme which indicate high levels of interest to seek VCT among young people. In Kenya, 75% of research participants indicated a keen interest in seeking VCT, while in Uganda it was 90% who indicated an interest in VCT. Factors motivating these young people's support for VCT included the benefits of seeking appropriate medical check-ups as well as being able to plan their lives accordingly. Overall, these participants regarded VCT as an important step towards HIV prevention, as they perceived themselves to be at risk of HIV infection.

Friendly conditions in facilities, such as those proposed by NAFCI, are major motivating factors in seeking VCT. This was evident from the focus group discussions conducted as part of a study (cited earlier in this section) by Jaspan *et al* (2008). Adolescents who participated in the focus group discussions mentioned specific elements which they thought would make a clinic adolescent friendly. These included "warm and friendly staff and waiting rooms" as well as having their peers as counsellors. The

absence of these conditions acted as barriers to testing, such as combined waiting areas, judgemental staff and lack of confidentiality (Jaspan *et al* 2008). Similarly, in a study conducted by Njagi & Maharaj (2006), students who had had an HIV test mentioned positive attitudes of counsellors and their willingness to answer their questions as having motivated them to test.

Not only do motivating factors appear to be similar across African countries, but also the factors that prevent adolescents from seeking VCT. Fear of an HIV positive result and fear of losing a relationship (rejection) were cited as barriers to seeking VCT in a study in a Malawian study (Munthali, Chimbiri & Zulu 2004). In a study conducted in the Shongweni area of KwaZulu Natal South Africa by Francis (2010), fear of being stigmatised by family members and the community in general was mentioned as the reason why 43% of the participants indicated that they would rather get tested at a private doctor or at a facility far from home than at a local clinic or hospital. This points to the extent to which HIV and AIDS-related stigma and discrimination negatively impacts on efforts to control the epidemic. Stigma and discrimination have resulted in missed opportunities, as individuals shy away from being tested, and consequently lose out on accessing treatment and care services (Grant-Stuart, Livingston & Mngadi 2006). Van Dyk (2008:131) also argues that “stigma and concerns about discrimination are the main reasons why people do not come forward to have an HIV test...” On the contrary, where there is a reduction in the levels of stigma and discrimination, there has been an increase in the uptake of VCT, resulting in more people knowing their status. This is evident from the findings of a national household survey conducted in South Africa in 2008 (Shisana *et al* 2009). The objectives of this survey were, among others, to establish HIV incidence and prevalence in South Africa, as well as to collect data to monitor and evaluate the country’s progress towards the achievement of its National Strategic Plan. Questionnaires were administered to

households and those who consented to an HIV test were tested. It was found that there was an increase in the percentage of individuals who knew their status from 11.9% in 2005 to 30.3% in 2008. In addition, the 2008 survey found that there was an increase in the percentage of people who had had an HIV test in the past 12 months from 92.8% in 2005 to 96.2% in 2008. According to Shisana *et al* (2009), this increase may be attributed to reasons such as an increase in the availability of antiretrovirals and to the reduction on HIV-related stigma and discrimination, among others.

It is clear from the above discussion that actual HIV testing is a result of complex and interrelated factors. All the three constructs of the IMB model appear to play a significant role in influencing an individual's final decision to test for HIV.

## **2.12 CONCLUSION**

The purpose of the literature review presented in this chapter was to obtain information pertaining to adolescents' knowledge regarding HIV transmission and prevention, as well as their perceptions of their own susceptibility to HIV infection. Such knowledge, coupled with the necessary skills to make informed decisions, belief in one's ability to handle a positive HIV status and knowledge of the process of VCT and where and how it can be accessed, are some of the factors that appear to lay the foundation for adolescent VCT uptake. Also crucial in this action, is the actual or perceived support from significant others, hence the choice of the Information-Motivation-Behavioural-Skills Model as a theoretical framework that guided the study.

In the following chapter, the researcher presents a detailed discussion of the research methodology employed in this study.

## **CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY**

### **3.1 INTRODUCTION**

This chapter provides a detailed description of the research design and methodology employed by the researcher in an attempt to understand the factors that motivate South African adolescents aged 15 to 19 years to test for HIV. A research design, according to McMillan and Schumacher (2001) refers to the entire process of conducting research, from the pre-data collection stage right up to the data analysis stage. It therefore includes the choice of research site, seeking permission to conduct the fieldwork, the length of the study, sampling as well as sample size. Creswell (2003:5) adds that a research methodology “governs our choice and use of methods”. Kothari (2008) concurs, adding that one’s research design and methodology also clarifies the logic behind the different steps taken in conducting the research, providing a justification of why they are used. This author adds that this allows for the evaluability of the research results.

Included in this chapter is the description of the research design used for this study; the settings in which the study was conducted; the sampling procedures; data collection and analysis as well as a narration of how the trustworthiness of the data was ensured. The last two sections of this chapter describe the ethical considerations that guided the study as well as how the pilot study was conducted in order to test the research instruments.

### **3.2 RESEARCH DESIGN**

According to Babbie & Mouton (2009:29), a research design entails “designing a strategy for finding out something”. As indicated in Chapter 1, the purpose of this study was to explore the factors that motivate South African adolescents aged 15 to 19 years to voluntarily seek HIV



counselling and testing. A qualitative research design was chosen for this study. This decision was informed by, among others, the fact that “qualitative research involves broadly stated questions about human experiences and realities, studied through sustained contact with people in their natural environments, generating rich, descriptive data that helps us understand their experiences and attitudes” (Munhall 2001 cited in Morgan & Drury 2003:75). In addition, in a qualitative research design participants’ own words are used as evidence that explains their experiences and attitudes (Babbie & Mouton 2009). The use of participants’ words as evidence sets apart a qualitative research method from a quantitative one. The latter uses statistics to describe and often to explain the unit of analysis (Neuman 2003) and the findings are usually presented in the form of tables and graphs. Whereas qualitative research usually uses a small, non-random sample with no attempt to generalise the findings, quantitative research usually uses a large, randomly selected and representative sample allowing for generalizability of the research findings (Babbie & Mouton 2009).

Quantitative research methods were therefore deemed not suitable for this study. Instead, a qualitative research design was chosen as it allowed the researcher to gain a deeper understanding of adolescents’ subjective experiences.

### **3.3 RESEARCH SETTINGS**

This section provides a detailed description of the two Youth Friendly Services sites where the fieldwork was conducted as well as an explanation as to why and how the participants were selected.

The first research site was in Pretoria, in a predominantly “Coloured” and Indian low to middle class residential area. This YFS is located inside a 24-hour community health centre, which provides services ranging from family planning, antenatal clinic, delivery, as well as general clinical

services. HIV care and treatment services, including VCT, are also provided at this facility. The YFS itself, where the fieldwork was conducted, is situated inside a building behind the main clinic. It is managed by the Sister in Charge, the Sister in Charge who is also responsible for providing all clinical services. The services provided at the YFS include family planning, treatment of sexually transmitted infections (STIs), HIV counselling and testing, as well as general clinical services. Apart from these services, there are entertainment (music and games) and life skills education (e.g. how to cope with peer pressure). This facility does not only serve local residents, but also people who live in other parts of Pretoria. The latter fact surfaced during the interviews, as two of the participants did not reside in the neighbourhood and required transport to get to this facility.

In addition to three consulting rooms and a waiting area, there is a “chill room” where adolescents and other young people meet for entertainment and life skills education. The chill room is staffed by youth leaders also referred to as “groundBreakers” (gBs). The chill room has television sets, a music system, reading material as well as equipment for games.

The second research site was situated in the Ekurhuleni Metropolitan Municipality in a predominantly African area. This facility also serves a wide range of clients, including people from nearby suburbs. It is also a 24-hour community health centre. In addition to general clinical services, other services provided here include family planning, antenatal care and maternity services. HIV counselling and testing as well as HIV care and treatment services are also provided. Unlike at the first research site, youth friendly clinical services at the Ekurhuleni research site are integrated within the main clinic. The other components of the YFS, such as life skills education and recreational activities, are provided in a park home (donated by loveLife), which serves as a chill room. This is situated behind the main clinic. HIV counselling is also provided in the chill room,

although the actual testing is done in the main clinic. Similarly, the chill room is staffed by gBs.

The first research site (in Pretoria) was selected due its proximity to the area where the researcher worked at the time. In addition, the researcher had identified, during a work-related study, that it was one of the busiest Youth Friendly Service sites and therefore envisaged minimum challenges with the sampling of participants. The researcher then sought permission to conduct the study at this facility from the Department of Health, Pretoria Region C (see Appendix B). However, although it was generally busy when the Sister in Charge was present, the situation changed when she went on maternity leave. The rate and frequency of visits to this YFS were drastically reduced, as consultation for clinical services was moved to the main clinic. Visits to the chill room were also affected, and it became difficult for the researcher to ascertain the exact days during which there would be any visits. This posed a major challenge to the selection of research participants and she managed to interview only four participants from this research site. The researcher therefore identified the second research site in the Ekurhuleni Metropolitan Municipality. The researcher identified this site as one of the busiest in the area. Another reason for choosing this site was that the researcher resides in the Ekurhuleni Metropolitan Municipality and could therefore access the site easily. Again, permission to conduct the study was sought and granted by the Ekurhuleni Health District Ethics Committee (see Appendix E). The remaining eight participants were selected from this research site.

### **3.4 SAMPLING DESIGN AND PROCEDURES**

A non-probability sampling technique was chosen for this study. Non-probability sampling is defined as a sampling technique “where the samples are gathered in a process that does not give all the individuals in the population equal chances of being selected” (Experiment-Resources.com:1). In addition, in non-probability sampling the researcher

uses his or her personal judgement or experience to determine who should be selected for the study (Laerd Dissertation [sa]). Issues taken into consideration when deciding to use non-probability techniques include that non-probability sampling techniques are (*ibid*):

- Not costly;
- Allow easy access to participants;
- Not time consuming.

Non-probability sampling is also appropriate for in-depth studies (Bernard 2006), similar to the one at hand.

The specific non-probability sampling technique used in this study was convenience sampling, also referred to as availability, accidental or haphazard sampling. In this sampling technique, research participants' selection depends on their "availability" and "convenience" (Rubin & Babbie 2010). As a form of non-probability sampling, convenience sampling was chosen because it required minimal resources (financial and time) and it allowed the researcher easy selection of participants.

The study was conducted at a Youth Friendly Service sites, where a range of services were provided, ranging from contraception, HIV testing, general clinical management as well as recreation. As the researcher had no way of knowing in advance the adolescents who would present at the YFS, (except for the two minors who had to bring consent letters from their guardians) she therefore interviewed (individually) the most readily available adolescents (Fink 1995; Nachmias & Nachmias 1996).

As a non-probability sampling technique was used, the findings of this study cannot be generalised (Schutt 2006) to the entire adolescent population in South African. Generalising the findings of the study was not the researcher's aim, as she was interested in the adolescents' subjective experiences and perceptions, which by nature, differ according to individual circumstances.

### **3.4.1 Sampling criteria**

The following criteria were used to select participants for this study:

- The participants had to be males or females aged between 15 and 19 years. This criterion ensured that all participants were within the age bracket of adolescents as defined by the World Health Organisation (cited in Mavedzenge, Ross & Doyle 2010).
- The participants had to visit an YFS at the time of interviews. No specific consideration was given regarding the purpose of the participants' visit.

Although there was no pre-determined criterion in terms of gender, there were more female (eight) than male (four) participants in this study. This may be linked to the fact that more females than males present at the YFS sites and clinics in general (Erulka, Beksinska & Cebekhulu 2001). The age specification turned out to be a challenge, as the researcher could not interview participants who were below the age of 18 without parental consent. Only two out of five possible participants below the age of 18 returned consent forms signed by a parent and a guardian. This may possibly be attributed to lack of communication between adolescents and their parents, regarding issues of sexuality in general and HIV and AIDS in particular, which in turn might have resulted in the adolescents' reluctance in being known to visit an YFS site. This lack of communication was alluded to during the literature review (see Section 2.3.2) and was also reiterated during the actual interviews as is described in Chapter 4.

### **3.4.2 Gaining access to the research sites**

The researcher initially obtained ethical clearance and permission to do the fieldwork at an YFS from the Department of Health Pretoria Region C and later from the Ekurhuleni Health District. In both cases, the researcher had already identified the YFS site at which she intended to conduct the study. At both research sites, appointments (to discuss the researcher's

intentions to conduct the study at these facilities) were made telephonically with the facility managers concerned. This was followed by face-to-face meetings with the facility managers, during which a detailed account of the study was given. The ethical approval and permission letters were also presented during these meetings (Attached as Appendix A, C and E).

At the first research site in Pretoria, the facility manager then introduced the researcher to the Sister in Charge of the YFS. The latter subsequently played a key role in the selection of research participants at this site. Each time the researcher visited the YFS, the Sister in Charge introduced her to the adolescents as they waited in the queue (for their turn for clinical and reproductive health consultation). She briefly explained the purpose of the researcher's visit, adding that the study was for academic purposes. The Sister in Charge advised those adolescents who were willing to participate to present to the researcher either before or after clinical consultation, depending on their position on the queue. As some adolescents arrived at the YFS after these introductions had already been made, the Sister in Charge then explained the researcher's presence as the adolescents consulted (inside the consultation room), referring those who were willing to participate to the researcher.

Unlike at the Pretoria research site, the facility manager at the Ekurhuleni research site introduced the researcher to the youth leaders (gBs), who were responsible for the running of the chill room. Following the introduction, the researcher explained the purpose of the study to the gBs. The gBs were subsequently involved in the identification and selection of adolescents aged 15 to 19 years at this research setting as they introduced the researcher and briefly explained the purpose of her visit. This process was facilitated by the fact that at this facility, most adolescents visited the chill room after every medical consultation with the clinical staff, and a number of adolescents go there in order to access life

skills education and entertainment services such as music and games. The groundBreakers' involvement in the selection process was beneficial to the researcher as they were known and trusted by the adolescents. They were the gatekeepers at the chill room and a relationship of trust existed between them and the adolescents. The selection process began when the adolescents visited the chill room. The gBs briefly explained the researcher's presence. The adolescents who were willing to participate were referred to the researcher. As ethically required, the researcher explained in more detail the purpose of the study, including the adolescents' right to participate and withdraw from the study at any time. Also explained was how their identities would be protected. Adolescents aged 18 to 19 who were willing to participate then signed consent forms. The adolescents aged 15 to 17 were given parental consent forms (Appendix G), which they were required to return at a later date. On the agreed dates, the two who returned the parental consent forms signed assent forms (Appendix H).

Twelve participants were deemed sufficient for the study since, according to Bowen (2008), the focus of qualitative research is the saturation of information and not the number of participants. Similar themes were emerging during the interviews; therefore the researcher felt that it was not necessary to continue with the selection of more participants.

### **3.5 DATA COLLECTION**

#### **3.5.1 In-depth semi-structured interviews**

In-depth, individual, semi-structured interviews were chosen as the data-collection method for this study. In this type of interview, the interviewer asks "key questions in the same way each time" and solicits more information by probing accordingly (Ritchie & Lewis 2003:111). The choice of an interview type, according to Sarantakos (2005) is informed by various factors, including the type of information being sought and the

availability (to the researcher) of resources (both financial and time). In support of in-depth interviews, Thyer (2001:310) observes that a researcher's choice of this type of interviewing is also influenced by the assumption that the participants are the "vital source of information".

The EIA Training Resource Manual (2002:489) states that semi-structured, in-depth, individual interviews are structured by an interview guide, which focuses the discussion although the participants can raise information that they consider important to them during the interview. Another advantage of semi-structured interviews is that they enable the researcher to generate more questions over and above those on the interview schedule and allows the researcher to probe the responses of the participants in order to delve deeper into their subjective experiences and the meanings they attach to these (Ritchie & Lewis 2003). At the same time, semi-structured, in-depth interviews allow the researcher to follow up on responses that may provide a deeper understanding of the topic at hand (Rubin & Babbie, 2010).

All the above reasons applied in the case of this study. Since the researcher was interested in the adolescents' personal views and experiences and the meanings attached to these, individual, semi-structured, in-depth interviews were deemed most suitable. Interviewing the adolescents individually ensured that they did not influence each other's responses. The use of an interview schedule safeguarded against straying away from the key themes. As this is a low-cost method of gathering information, the researcher was able to conduct the study without financial sponsorship. In addition, the researcher found the ability to probe and follow-up on responses very beneficial as she gained a deeper understanding of the adolescents' experiences, challenges, fears, concerns and opportunities related to HIV and AIDS in general and VCT in particular. This also contributed to the richness of the data (Babbie & Mouton 2009).



At the research site in Pretoria, the interviews were conducted in a vacant consulting room. As these rooms had doors, it ensured that the participants' privacy was safeguarded and that there were no interruptions during the interviews. In addition, the conversations could not be overheard by anyone outside the room, thereby ensuring confidentiality.

Unlike at the Pretoria site, interviews at the second research site in Ekurhuleni were conducted in the gBs' offices. These offices also had doors which ensured the confidentiality and the privacy of the interviews. However, as this was a park home, it had minimal levels of insulation from outside noise. As a result, noise from barking dogs and cars driving past at times interfered with the quality of the tape recordings of the interviews. To deal with this, the researcher briefly halted the interview, paused the recording and resumed when the noise had subsided. Despite this, the researcher is confident that the interviews were not overheard by other occupants of the chill room as these offices were far removed from the area in which the other adolescents congregated.

### **3.5.2 The interview schedule**

An interview schedule (Appendix I) was developed with the purpose and research objectives of the study in mind, which was to explore the factors that motivate South African adolescents, aged 15 to 19, to seek voluntary counselling and testing.

The first part of the interview schedule (background and biographical information) solicited information relating to the participants' ages and gender, whether they worked or were still at school, their marital or relationship status, where they lived, as well as with whom they socialised (such as friends or neighbours). In addition, the participants were also asked questions regarding their family set-up as well as whether or not they had children. According to the literature reviewed in Chapter 2, various factors influence an individual's decision to have an HIV test,

including the social environment in which they exist and perceived or actual negative and positive influences from the community, family, neighbours and friends. Exploring this theme gave insight to the researcher with regard to how the adolescents' background and social context influenced or were likely to influence their decisions to test or not to test for HIV.

The purpose of the interview schedule was to explore the following:

### **3.5.2.1 The extent of the adolescents' knowledge about HIV and AIDS and their own susceptibility to contracting HIV**

The literature reviewed for this study in chapter 2 clearly indicates that although there are also other factors at play, knowledge about HIV and AIDS in general and about one's own susceptibility to HIV infection in particular is essential for adolescents to acknowledge the relevance of the epidemic to their lives, and ultimately are likely to influence their decisions on whether or not to test for HIV. Against this background, the adolescents were asked as to when and where they first heard of HIV and AIDS, including information on its symptoms. The adolescents were also asked to explain their initial reaction to the information received. Questions also sought to explore adolescents' knowledge regarding the modes of HIV transmission and protection against HIV infection. As a follow-up to their responses on their knowledge of transmission and protection against HIV infection, they were asked if they and their peers actually took precautions against HIV infection.

### **3.5.2.2 Adolescents' knowledge about voluntary counselling and testing and its benefits**

Linked to knowledge about HIV and AIDS, is knowledge about voluntary counselling and testing. It was important for the researcher to explore the extent to which the adolescents were knowledgeable about VCT; what it

is, where they can access it, as well as the advantages and disadvantages of knowing one's HIV status. The participants were asked if they had ever heard of VCT, where one could access this service and whether or not they knew what VCT entailed. In line with the theoretical framework of this study, the IMB model that is discussed in chapter 2, the researcher sought to understand whom the adolescents confided in (or would confide in) if they ever decided to seek VCT. In an attempt to understand who they would confide in, the researcher asked questions that aimed at getting an understanding of the families or communities' attitudes towards people living with HIV and how these attitudes would impact on the adolescents' own decisions to test for HIV. Participants were also asked as to what they thought were the benefits of VCT, and whether they would recommend VCT to their current or future sexual partners. Considering that in South Africa the focus has recently shifted from VCT to HCT, the researcher also asked the participants their opinions regarding the two scenarios, i.e. whether they prefer initiating HIV counselling and testing themselves or whether prefer this to be done by the health provider, as stipulated in the HCT policy.

### **3.5.2.3 Adolescents' support system and ability to make own decisions and act on them**

It was highlighted in Chapter 2 that the existence or nonexistence of a social support system plays a major role in final decisions to enact a health-related behaviour, including testing for HIV. It was therefore crucial to find out from the adolescents who they relied on for emotional support and the extent to which these people influenced the decisions they took in life, specifically decisions relating to HIV testing. As mentioned above, the participants were asked during the interviews as to whom they would talk if they were planning to have an HIV test. They were also asked about the attitudes of their communities towards people living with HIV and the kind of relationship they had with their neighbours and other community

members in general. Exploring adolescents' relationships with their neighbours and community was essential as it could shed light into the existence or non-existence of HIV-related stigma and support systems (outside the immediate family).

The questions in this section were also designed to help the researcher understand the adolescents' opinions regarding gender in relationships, whom they perceived to be the decision-maker in a relationship; the man, the woman, or both. Their own ability to make decisions in their relationships was also discussed. The researcher deemed these themes important because, according to literature reviewed, gender, coupled with social norms of masculinity and femininity place women at a disadvantaged position when it comes to safer sexual practices, including use of condoms and timing of sex.

#### **3.5.2.4 Adolescents' ability to handle a positive HIV result**

One of the factors that can motivate an individual to test for HIV is his or her own ability to handle an HIV positive result regardless of what he or she knows about the effects of HIV and AIDS on one's health and the stigma associated with an HIV positive result. Questions in this section were therefore designed to help the researcher explore the relationship between the adolescents' actual or perceived ability to handle testing positive for HIV and their intended or actual testing for HIV.

#### **3.5.3 Tape recording of interviews**

The face-to-face, in-depth interviews were tape-recorded with the participants' permission. The tape recorder was placed on a table or desk, in such a way that it could clearly capture the conversation. The researcher found the tape recordings to be beneficial, and as Seal (2004) asserts, it enabled more flexibility to interact with the participants, instead of having to write continuously on a note pad, thereby losing eye contact.

In addition, the researcher found the recording of the interviews to be beneficial as the responses were detailed and could be re-played for clarity during the transcription of interviews. This assisted in the analysis of the interviews, as the researcher was able to identify specific quotations from the participants' responses. Furthermore, while transcribing, the researcher had the opportunity to adjust questions for subsequent interviews, as well as identify themes that guided the final analysis of the gathered data. In instances where the participants used a Zulu word this was transcribed as it was (not translated into English). However, not all interviews were transcribed immediately due to time constraints.

The tape recording of the interviews had some disadvantages, however. As highlighted above, some responses had background noise from barking dogs and cars driving past. In addition, some participants became excited and often strayed away from the topic. Possible reasons for this excitement may have been the fact that the adolescents had found the opportunity to express themselves on a topic of interest, on which they had not before had an opportunity to freely discuss. In such instances, the researcher politely redirected the conversation.

During the interviews, the researcher also jotted brief notes on a note pad. The researcher's observations, such as unease with certain questions were noted during the interviews. This assisted in subsequent interviews as the researcher re-phrased the questions.

### **3.6 DATA ANALYSIS**

Thematic content analysis was used for the analysis of the data gathered during the fieldwork phase, guided by the steps proposed by Pope, Zielbland and Mays (2000:116). These authors propose five steps for conducting qualitative data analysis: familiarisation, identification of a thematic framework, indexing, mapping and interpretation.

In line with the five steps listed above, the researcher listened to the tape recordings, replaying when necessary, while transcribing the interviews verbatim. In this way she became familiar with the content of the interviews and identified existing and emerging themes. The existing themes were initially identified through the literature review and had informed the design of the interview schedule. The researcher also gave each participant a pseudonym, in order to link a response to a participant while protecting their identify.

As themes and sub-themes were identified, they were assigned a number for easy identification and use.

### **3.7 TRUSTWORTHINESS OF THE DATA**

According to Holloway & Wheeler (2002:254) trustworthiness in qualitative research refers to its “methodological soundness”. The following are the ways in which the trustworthiness of a study may be judged: authenticity, credibility, reliability/ dependability and validity.

#### **3.7.1 Authenticity**

According to Holloway & Wheeler (2002:254), for a study to be authentic, it must, among other things, be fair to the participants. One way in which the researcher can ensure this is by obtaining informed consent from the research participants, and another is to take into account the social context in which they work and live. This is important as individuals differ from one social context to the other, in terms of their religious beliefs, and sensitivity and openness to certain topics, among other factors.

The research participants signed informed consent or assent forms, to indicate their willingness to be interviewed. Throughout the interviews, the researcher remained sensitive to the participants’ experience of the interviews by observing body language in order to identify questions that made them feel uncomfortable in order to modify those questions.

Fossey, Harvey and McDermott (2002:725) add that other ways in which the authenticity of a study may be judged is through ensuring that the participants' perceptions have been accurately represented, "in their own voices [by] verbatim quotes". To meet this condition, the researcher used direct quotes from the participants as evidence of their views and reported these in Chapter 4.

### **3.7.2 Credibility**

Credibility refers to the study's ability to represent a true reflection of reality as the participants see it. There are different ways in which credibility can be ensured, including remaining in the field long enough to reach saturation (Babbie & Mouton 2009). Another way is "referential adequacy", which can be achieved by using a good recorder for interviews (*ibid*). To achieve credibility, the researcher ensured that saturation was reached, as she conducted the interviews until no significant new information was generated. In addition, a reliable recorder was used, and this helped to capture the exact words that were spoken by the interviewees.

### **3.7.3 Reliability/dependability**

According to Babbie & Mouton (2009:278), dependability refers to a study's ability to be replicated "with same (or similar) respondents (subjects) in the same (or similar) context" and yielding similar results. A study is also said to be dependable if it is not influenced by the researcher's bias (Sarantakos 2005). Throughout the data collection, analysis and interpretation stages, the researcher remained aware of her personal views that threatened to interfere with her interpretation towards the data. Shank (2006) recommends other ways in which reliability in qualitative research may be ensured. According to this author, it is the responsibility of the researcher to seek explanations when information supplied is unclear. During the study, the researcher asked the

participants for clarity, in cases where she was unsure of what the participants meant. In further efforts to ensure the dependability of this study, the researcher described in detail the research methodology, including both research sites and also the unexpected change of sites, including how this may have affected the research process. This is in accordance with Shenton (2004:73) who proposes that the researcher should provide an “in-depth methodological description”.

#### **3.7.4 Confirmability**

Confirmability refers to the extent to which the findings of the study can be traced back to or verified against the sources (such as tape recorded interviews) (Babbie & Mouton 2009). Babbie and Mouton (2009) cite Lincoln and Guba (1985), who proposes an audit trail, whereby raw data (recordings) and notes taken during the interviews can be accessible to an auditor who will in turn determine whether or not the findings were not fabricated by the researcher. To meet this requirement, the transcribed interviews and the coding frame were submitted to the supervisor for review. The recordings of the interviews can be made available on request.

### **3.8 ETHICAL CONSIDERATIONS**

There were a number of ethical issues to be addressed before and during this study. The first step was to seek ethical clearance from the University, followed by seeking permission to gain access to research participants from the relevant authorities. The researcher also ensured that each participant made an informed choice (see Appendix F) to be interviewed and ensured that their confidentiality was safeguarded. In addition, the researcher made every effort that the interviews did not cause discomfort or harm to the participants. Finally, the researcher made provisions for



debriefing, in case participants felt they needed counselling. Each of these procedures is discussed below.

### **3.8.1 Permission to conduct research**

De Vos (2002) emphasises the importance of seeking permission to conduct research at a selected field. This is reiterated by Babbie & Mouton (2009:528) who state that a study involving human subjects must first be approved by an ethics committee, which safeguards against the violation of the subjects' "rights and interests". Before this study was conducted, ethical clearance was obtained from the UNISA Research Ethics Committee (see Appendix A), following submission of the research proposal. With the ethical clearance from UNISA in hand, permission to conduct research at a Youth Friendly Service (YFS) in Pretoria was sought from the Department of Health Pretoria Region C (see Appendix B). However, due to the reasons highlighted in section 3.3 above, the researcher could not interview all the participants as required in terms of the sample size, or reach saturation on the identified themes at this research site. Therefore there was a need to find another research site. Permission was therefore sought from the Ekurhuleni Health District (see Appendix D). The ethical clearance letter from UNISA was also presented to the Ekurhuleni Health District Ethics Committee.

At both research sites, facility managers played a role in introducing the researcher to the relevant gatekeepers, who later assisted the researcher in the convenient sampling of the research participants. Despite the role played by these individuals in the identification of potential interviewees, the decision to participate lay entirely with the participants themselves.

### **3.8.2 Informed consent**

According to Silverman (2010:155), it is the research participants' right to be "given as much information as possible about the research so that

[they] can make an informed decision” on whether or not to take part. He further suggests that this should be given in a written format, and participants should sign the consent form to indicate their willingness to participate in the research.

Prior to interviewing the research participants, the researcher furnished each one of them with complete and accurate information regarding the purpose of the study and how the findings would be used. This information was given verbally as well as in a form of an informed consent letter which they could keep. Also included in this were the researcher and her academic institution’s contact details. The researcher also verbally explained to the participants how they and their YFs sites were chosen as research sites and research participants for this study. As a result, all the participants were fully aware of what their participation entailed and they signed consent forms (see Appendix F) and those participants who were below the age of 18 signed assent forms (see Appendix H). The consent forms were locked away, and only the researcher has access to them. These can be made available to the researcher’s supervisor if requested.

### **3.8.2 Voluntary participation**

Babbie & Mouton (2009:521) observe that the nature of social research is such that it “intrudes into people’s lives ... [and] requires people to reveal personal information”. In light of this, participants’ right to refuse to take part in a research project or to withdraw at any time should be clarified from the onset (*ibid*).

In the study at hand, participants were assured that they were not compelled in any way to participate and that they could withdraw at any point during the interview for any reason whatsoever and that there would not be any negative consequences for withdrawing. In addition, they could refuse to answer any questions if they felt uncomfortable answering them.

It was also explained to them that there were no rewards for participating in the study. Permission to record the interviews was also sought from the participants, and it was emphasised that the tape recordings and transcripts would be kept safe in a locked cupboard and destroyed at the end of the study. To the advantage of the researcher, all the participants agreed that their interviews may be recorded.

### **3.8.3 Confidentiality and anonymity**

According to Wiles, Crow, Heath and Charles (2006), confidentiality and anonymity are two 'related but distinct concepts'. These authors further argue that although confidentiality means that the participants' responses must be kept secret, this is not possible in social research as the findings usually are published. To ensure confidentiality, it is therefore the researcher's duty to eliminate any information that would link a specific response to particular participant. Babbie and Mouton (2009) also state that confidentiality also refers to the researcher's obligation to safeguard the research participants' identity, including not linking a specific response to a specific identifiable participant. This is done in order to ensure that the outcome of the research project does not cause harm to the participants (*ibid*). Steps to ensure this include the use of pseudonyms and ensuring that the interviews are conducted in a private and secure location, as well as minimising outside interruption. In light of this observation, at both locations where the study was conducted, the researcher made efforts to request a location that would safeguard the confidentiality of the interviewees.

Each interview was therefore conducted in a comfortable setting, behind closed doors. These places varied from an vacant consulting room to the youth leader's (gBs) office.

Participants were informed that they did not have to reveal their names. However, some did, and even wrote them on the consent form. However, their names as well as names of the facilities where the interviews took place are withheld in this report. In addition, as promised to the participants, all recorded interviews were safely locked away and only the researcher had access to them. The transcribed interviews were, however made available to the supervisor as she guided the whole study.

#### **3.8.4 No harm to participants**

According to Babbie (2007), protecting the research participants from harm is one of the most important ethical considerations to be adhered to by social researchers. Research participants can be harmed emotionally, psychologically or physically (*ibid*).

Harm to participants, specifically emotional harm, is more common in studies on human sexuality, as participants may feel that the issues raised by the interview questions relate to them (*ibid*). The current study had the potential to provoke such feelings, considering that sexual contact with a person living with HIV is the primary mode of transmission of the HI virus. The researcher was therefore careful and sensitive in the way she phrased the questions.

#### **3.8.5 Provision of debriefing, counselling and additional information**

According to Babbie (2007), the researcher must provide debriefing to the research participants, during which they are provided with information regarding the true purpose of the research, particularly to counter possible negative effects of participating in a study. Breakwell, Hammond, Fife-Schaw (2000) suggest that this should be done before the participants leave the research site. As one of the ways to meet this ethical requirement, the researcher made prior arrangements with the Sister in Charge (at the first research site) and the facility manager (at the second

research site) that should a need for counselling arise, those needing it would be referred accordingly, either to the Sister in Charge or to the counsellors, respectively. One participant who indicated that she wanted to be tested for HIV after the interview (at the first research site) was referred to the Sister in Charge.

### **3.9 PILOT STUDY**

A pilot study is described as a “pre-study... a miniature version of [a] project” (Woken [sa]:1). Different authorities have argued that piloting is a pre-requisite for any study. According to Rothman & Thomas (1994 in De Vos 1998, pre-testing the research instrument helps identify elements of the study that need to be revised. More reasons for conducting a pilot study have been cited, including the following from an article by van Teijlingen and Hundley (2001:1):

- Developing and testing the adequacy of the research instrument;
- Assessing the feasibility of a full scale study;
- Assessing whether the research protocol is realistic and workable;
- Assessing the likely success of the proposed recruitment approaches;
- Assessing the proposed data analysis techniques to uncover potential problems.

In the current study, piloting was conducted for all the above reasons. The researcher modified the interview schedule as a result of the pilot study. Specifically, questions that were not clear to the participants, due to phrasing or terminology used were modified. For example, on the original interview schedule one question was phrased in the following manner: “*As a girl, if you fell pregnant, would you opt for VCT?*” The pilot participants could not understand what the word *opt* meant. In addition, this question could have resulted in a ‘yes’ or ‘no’ answer.

Strydom (cited in De Vos 2005) proposes that a pilot study should be done on a small number of people with characteristics that are similar to those of the target group. Two adolescents were therefore selected for this process. They were identified at the first research site and were within the age group of 15 to 19 years. These two adolescents did not form part of the main study. In addition, the pilot study did not form part of the analysis of the research findings.

### **3.10 CONCLUSION**

This chapter presented a discussion of the chosen research design and methodology for the study, as well as a justification for such a choice. The two research settings have also been described. In addition, an explanation as to why this study was conducted in two settings has also been provided. Other themes covered in this chapter are the sampling procedure, the instruments used to collect data, how the data was analysed as well as how the trustworthiness of the data was ensured. A detailed description of the ethical considerations that guided the study was given. Finally, the pre-testing of the research instrument was explained.

In the following chapter the findings of the study will be presented, and the reader will be introduced to the study participants.

## **CHAPTER 4: DATA ANALYSIS AND INTERPRETATION**

### **4.1 INTRODUCTION**

The purpose of this study was to explore the factors that motivate South African adolescents aged 15 to 19 years to seek VCT. The study was conducted in two youth friendly services, one in Pretoria and the other in Ekurhuleni, among adolescents aged 15 to 19. The objectives of the study were:

- Explore 15 to 19 year old adolescents' perceptions of their own susceptibility to HIV infection.
- Explore 15 to 19 year old adolescents' knowledge about HIV, AIDS and VCT.
- Explore and describe the reasons why 15 to 19 year old adolescents would or would not voluntarily seek VCT.

As discussed in Chapter 3, this study employed a qualitative research design and methodology in which twelve participants were conveniently selected as they visited the two selected Youth Friendly Services for various reasons.

The data for this study was collected through in-depth, semi-structured, one-on-one interviews. Thematic content analysis was used to analyse the data. Table 3 below presents the themes and sub-themes that emerged during the analysis of the study.

**Table 3: Themes and sub-themes**

<b>Theme</b>	<b>Sub-theme</b>
Knowledge	Sources of HIV and AIDS information
	Initial response to HIV and AIDS information
	Knowledge about modes of HIV transmission
	Knowledge about severity of HIV and AIDS
	Knowledge about protection from HIV infection
	Knowledge about VCT
	Sources of information about VCT
	Knowledge about benefits of VCT
Motivation	Perception of own risk
	Engagement in high risk behaviour
	Attitudes towards VCT
	Significant others
	Marriage
	Own and partner's protection
	Fear of a positive result
	Knowing someone living with HIV
Behavioural skills	Ability to make decisions independently from significant others' opinions
	Visiting a VCT site
	Ability to negotiate VCT with a partner
	Inconsistent condom use
	Initiating condom use: gender

## **4.2 BIOGRAPHICAL INFORMATION**

### **4.2.1 Age and gender**

In this study, twelve adolescents between 15 and 19 years were interviewed. Their distribution, according to age and gender is presented in Table 4 below. As indicated in this table, the majority of the participants were females aged 18 to19, and only two were younger than 18 years old.



**Table 4: Age and gender distribution of research participants**

<b>Age category</b>	<b>Male</b>	<b>Female</b>	<b>Total</b>
<b>15-17</b>	2	0	2
<b>18-19</b>	3	7	10
<b>Total</b>	<b>5</b>	<b>7</b>	<b>12</b>

#### **4.2.2 Level of education**

Half of the participants indicated that they were no longer at school (see Table 5 below), and were unemployed despite having matriculated. Three of those who were still at school were in grade 11 and another three were in grade 12. Most of those still at school enjoyed it, and had clear ideas of the career paths they were interested in pursuing. The careers they hoped to pursue ranged from nursing and social work to zoology. Only one participant sounded negative about school. When asked how she found school, Mandy responded by saying:

*“Boring ... teachers get on my nerves”*

**Table 5: Participants’ level of education**

	<b>Level of education</b>		
<b>Gender</b>	<b>Grade 11</b>	<b>Grade 12</b>	<b>Matriculated</b>
<b>Male</b>	1	1	3
<b>Female</b>	2	2	3
<b>Total</b>	<b>3</b>	<b>3</b>	<b>9</b>

### 4.2.3 Living arrangements

The participants' living arrangements varied, with the majority indicating that they lived with their mothers, grandparents or siblings. Mandy said her living arrangements were complicated as she lived with her boyfriend, but sometimes also lived with her mother. Sandy, on the other hand, said she lived with a distant relative, an in-law whom she called aunt, as she had come to Johannesburg specifically to attend school. Table 6 below indicates the participants' living arrangements.

**Table 6: Participants' living arrangements**

	Living with						
	Both parents	Mother	Grand parents	Siblings	Friends	Aunt	Boyfriend
Number of participants	1	3	2	3	1	1	1

### 4.2.4 Relationship and marital status

Most participants were involved in a relationship and sexually active. The only participants who were not sexually active were the two who were below the age of 18 (although they also had girlfriends) and one 18 year old girl who said she was "*still a virgin*". None of the participants had children or was married.

## 4.3 THEMES EMERGING FROM THE INTERVIEWS

### 4.3.1 KNOWLEDGE

#### 4.3.1.1 Sources of HIV and AIDS knowledge

Based on the interview responses, it is clear that HIV and AIDS information is provided as early as primary school at both rural and urban schools in South Africa. Most participants mention Life Orientation (LO) and General Science as subjects during which they were taught about HIV and AIDS.

When asked when she first heard about HIV and AIDS, Busi, an 18 year old girl said:

*“I think I was in junior school. I was in the rural area.”*

When asked a similar question, Erica, a 19 year old girl, replied by saying:

*“It was the year 2002 I do remember I was doing grade 7...people from loveLife came to our area to tell us about it.”*

When probed further, Erica explained that she first heard about HIV and AIDS during a Science lesson:

*“The subject that I was doing was general science. Natural science was then called general science. They were teaching us, telling us about antiretrovirals.”*

Paul also first heard about the epidemic during an LO school lesson, as indicated in his response:

*“I think it was in primary, I was in primary ... It was a school lesson. Like it was... it was LO then some people came. It wasn't people from the school. It was people from outside.”*

Like Busi, Erica and Paul, Mandla also first heard about HIV and AIDS at school:

*“Normally we hear this from school that there is a disease called HIV and AIDS. The LO teachers brief us that you get infected by doing this.”*

Sam, also mentioned LO as the subject during which he first heard about the epidemic:

*“I was in grade 6... during LO.”*

Jon, Sandy and Gugu mentioned that they also first heard about HIV and AIDS at school, through loveLife:

*“...loveLife people used to come and like, notify us about this.” (Jon)*

*“Through loveLife of course. They used to come to school and teach us about these things that HIV does exist you know.” (Sandy)*

*“It must have been in 2003. Ya it was in 2003... It was at school. There were people from loveLife” (Gugu).*

Busi, who first heard about HIV and AIDS at a rural primary school, also mentioned external people, (who were not part of the school) who came to teach them about the disease, although no specific names were mentioned:

*“There were people who came to teach us about this disease, about this AIDS.”*

Unlike the other participants who had first heard about HIV and AIDS at primary school, Peter first heard about HIV and AIDS when he went to high school. He mentioned that his friends were his initial source of information:

*“I was in standard 6. It was 2005, when I went to high school. When I heard about it, we were just talking with my friends but I didn’t even take notice of it. You see some things when you just talk with your friends you don’t really take any notice of them. I then heard about it in peer education at school. They had chosen us in class for motivational speaking. They said peer what what must come to school on Saturdays. They told us about HIV, the way it is.”*

Although Mandy remembered that she first heard about the AIDS epidemic in primary school when she was about 9 years old, she did not remember what was said on that day.

What was also deduced from the interview responses is that at school, children are given age appropriate HIV and AIDS information, as Gugu indicated in her response:

*“They give you tips on how you can protect yourself. As you grow they tell you that you must abstain if you are able to and use a condom...”*

Apart from school and loveLife, television and friends were also mentioned as initial sources of HIV and AIDS information. Although for most participants, the school and loveLife were the first sources of information, for Yusuf, television was his first source of HIV and AIDS information:

*“Around 13 years – 6 years ago... My friends were talking about it and I also heard about it on TV.”*

Family was not mentioned as the first source of HIV and AIDS information, although some participants said they would tell one family member if they were to test for HIV or discuss related issues with them. Sandy, Paul and Peter’s responses indicated a complete lack of HIV and AIDS-related communication between them and their parents or guardians. When asked

if she ever talked about HIV and AIDS with her family members, including her mother, Sandy's response was:

*"No (sighs) no, we don't talk about it just because I've got these sensitive elders you know. They don't talk about it even if they see that ... coz in my family we've got a few people who passed away because of it but then they just ignore that like, OK it does exist, it does kill. They got this thing like it doesn't kill dogs it kills people, you know."*

Paul indicated that there was no open communication about HIV and AIDS between himself and his grandmother, although he would tell her of his intentions to test, if given the opportunity. This is evident in his response:

*"My granny is not someone you can talk to. She is strict. You can laugh together. She has her own moments. You can't just go to her and say, granny, there is this chick I want to sleep with. No. But if I had a chance I was gonna tell her that I will be going to the clinic for an HIV test."*

Like Sandy and Paul, Peter also said his mother had never spoken to him about HIV and AIDS prior to his suspected TB infection, during which he was advised to test for HIV by healthcare workers at the clinic. His words were:

*"Have just heard her talking to her friends...talking to me, no. She sometimes tells me that I don't want you to have girlfriends. You must finish school before you bring a woman to my house. But regarding HIV I think she is not informed, you see... Eish, when I'm at home I don't even talk. It's my mom who talks. I don't know... I listen to her. She likes talking, she is always busy. Some of the things, no, no I don't talk."*

For Jon, the first time that his mother ever spoke to him about the epidemic was when she became terminally ill. When asked if they had ever spoken about HIV and AIDS, he responded by saying:

*“No. My mother was like, you are a child. We didn’t talk about anything, but when it comes to serious things, like when she was seriously ill she opened up and she told me about this. We understood each other, like this is happening, this is life. This is a real disease that is killing people.”*

Sam’s response indicated mixed feelings, as he said that although his mother talks to him about HIV and AIDS-related issues, he would not talk her if he decided to have an HIV test as he thought she “*would be suspicious and think that maybe I am having sex*”. Instead, he said he would talk to his friends:

*“We do talk about things like sexual intercourse and parties. Ya she [my mother] does tell me about them ... I would talk to my friends. My friends and I motivate each other...”*

Yusuf simply said:

*“No I have never discussed with my parents.”*

Mandla, on the other hand said he talked openly to his mother about relationships and practising safer sex, as they have a very close relationship, having lost a brother to an AIDS-disease. When the researcher asked if he ever talks to his mother about HIV and AIDS he said:

*“Yes. I normally discuss everything coz she is the person that I feel I’m left with in the world so I tell her everything... even when I’m here, she’ll ask me how was your day and I’ll say my day was like this. And I say mom can I tell you something, I met someone like*

*this and she would say you like to meet girls and advise me ...I'm not saying you shouldn't meet girls but make sure whatever you do you use protection."*

When asked if she and her mother ever talk about HIV and AIDS Mandy said they did, although her mother was scared of the disease. Her words were:

*"Ya...She is also a bit of scary cat. So hers is stay a virgin till you get married."*

When the researcher asked if Busi and her friends ever talked about HIV and AIDS, Busi said they did, adding that she also has open discussions with her sister about the disease:

*"Ya we do talk. Even at home. When my sister advises me about good things and bad things, like she advises me and I must be able to see the difference between something that is right and something that is bad. AIDS is a common disease and she always tells me that you must do this and mustn't do that."*

#### **4.3.1.2 Initial response to HIV and AIDS information**

Most participants mentioned that their initial response was to dismiss the existence and seriousness of HIV and AIDS. According to Jon although loveLife came his to school, he was sceptical about what he heard:

*"But then I was still young, you know, and taking things for granted, saying anyway, it's just a lie. People just come here and tell us whatever, so ... it's like any disease that comes across."*

Thembi's response to a similar question was:

*"People never believed this thing is real. It's only now that they realise that HIV is here and that it kills people."*



Another reason why some participants did not take HIV and AIDS seriously from the onset has to do with the nature of adolescence, as Mandla observes that:

*“Sometimes we children ... we don't take things seriously. We just want to maybe learn or take from experience. My mother said there is HIV and AIDS.”*

For Paul the new information resulted in confusion:

*“At first I was confused, like, what are they talking about...”*

On a positive note, at the time of the interviews, participants acknowledged that HIV and AIDS does exist, although for some, it took a tragedy for that to happen, as in Jon Mandla's cases. When asked whether he had changed his mind about the existence of HIV and AIDS he said:

*“Ya! I really knew when my mother was sick. I started to realise that this is happening coz like, she had like TB. Then I understood the situation as it came across. It happened that she opened up to me and she told me that she had the disease.” (Jon).*

Mandla also admitted that it took the death of his brother to convince him that HIV and AIDS actually exists:

*“...one of my brothers had it and then he passed away in 2007. That's when I took this thing seriously that there is something like this.”*

Sandy, on the other hand took HIV and AIDS seriously from the onset. She mentioned that she wrote a poem about the disease. Some of the words that she could still remember were:

*“HIV/AIDS is a disease that kills people and it is there...where do you come from, where are you going to and where do you end, something like that.”*

#### **4.3.1.3 Knowledge about modes of HIV transmission**

The participants not only demonstrated sufficient levels of knowledge about the existence of HIV and AIDS as well as its deadliness if untreated, they also understood the different ways in which HIV is transmitted. Of all modes of transmission mentioned, sexual transmission was high up on the list. As is apparent in Mandla’s response, both adolescents and the community consider this as the most common way in which adolescents get infected:

*“You get HIV infection whereby you try and help your friend and you have a little cut and that person is HIV positive and the blood gets in contact you get it. And the most enjoyable thing to us people in adolescent stage is sexual intercourse...if I can test and find out that I am HIV positive, there’s only one thing that’s gonna come to mind, to my mother it’s only sexual intercourse...”*

Like Mandla, Busi also mentioned sexual intercourse, in addition to other ways in which one can get HIV infected:

*“Like, if you have sex without protection, like, you can also get it if you use the same toothbrush with someone who is bleeding from the teeth and in accidents.”*

Peter also said:

*“Boys and girls can get it through unprotected sex.”*

Sandy also listed a number of ways in which HIV is transmitted:

*“You can get HIV through anal, oral and vaginal sexual intercourse. You can get from cuts; like if you have a cut and you touch someone who is infected without gloves, you can get infected....STIs you know they can cause you to get HIV.”*

Jon also acknowledged that sexual intercourse is not the only way in which HIV is transmitted. He explained that there are:

*“So many ways. It’s like when you use the same needle or maybe someone is, like bleeding and you not using your gloves properly, then you can get it. Not that it’s sexually only. There are so many ways you can get it.”*

Mandy’s response to a similar question was:

*“Sexually transmitted, it could be a needle or an accident, a blood transfusion ... the prick of a needle by mistake, blood on an open cut, when they touch other people’s blood that are sick...they could be very cautious, see where they sit before they sit, see they don’t have open cuts before they help a stranger”*

Yusuf mentioned *“having sex without a condom, I mean having unprotected sex, or sharing needles”* while Gugu’s response echoed earlier responses on sexual transmission as she said HIV could be transmitted through *“unprotected sex, without using a condom.”*

As evident from these quotes, contracting HIV through accidents also featured prominently in the participants’ responses, with Paul also mentioning sexual abuse:

*“Sometimes you can get it from accidents, car accidents, like maybe I have a scratch and you have a scratch and the other person has a scratch and we are leaning on each other, or someone who’s bleeding and you are trying to help and if you have*

*some wounds...Then obviously going, like having unprotected sex. Others are being raped..."*

Sam's response to a question related to modes of HIV transmission concurs with the above responses. He sends out a warning to other adolescents that perceiving HIV solely as a sexually transmitted disease, instead of considering many other ways in which it can be transmitted is itself risky. This is evident in his response below:

*"...they only view it sexually only. They must stop looking at it that way. They protect themselves during sex, using condoms. They must protect themselves even when they help people. In accidents it's difficult to help themselves because, you see, they will get hurt and I don't know how they can help themselves in those cases."*

Mother-to-child transmission of HIV was also mentioned as one of the ways in which HIV could be transmitted. This was linked to marriage, which is one of the factors that would motivate them to test for HIV, so as to protect their unborn babies. The following are some of the responses:

*"The third way in which you can get it is from breastfeeding from your mom."* (Mandla)

*"Just because we will be getting married, we both need to know our status. And if we have children, then they won't be positive."* (Thembi)

*"So many people are dying every day, every second and new babies are born with it."* (Jon)

#### **4.3.1.4 Knowledge about severity of HIV and AIDS**

All participants indicated that they were aware of the severity of HIV and AIDS, with some of them having had personal contacts with people who were living with HIV in their families. As a result, when asked what the symptoms of HIV were, Thembi said:

*“I know that the person becomes sick and the body...it depends if you are looking after yourself. If you don't look after yourself properly you become thin.”*

Mandla also had this to say about the severity of HIV and AIDS:

*“They have a lot of symptoms. But sometimes most of them don't live for long because some people maybe they hear that they are HIV positive they think that their life is over the they don't accept it and keep on stressing about it and whereby it eats you up until maybe you get weak.”*

Jon told of an emotional time when his mother, who passed away in 2006, was dying of AIDS-related illnesses:

*“...my mother was sick. I started to realise that this was happening coz like she had like TB.”*

#### **4.3.1.5 Knowledge about protection against HIV infection**

Participants in this study displayed sufficient knowledge about how they can protect themselves from HIV infection. Their responses in this regard were also linked to their understanding of the different ways in which HIV can be transmitted. It is interesting to note that those who were not sexually active were the ones who believed that abstaining was the best way for adolescents to protect themselves against HIV infection, although they also mentioned being faithful to one partner and using condoms

during sexual intercourse as ways to protect themselves. Apart from using a condom if sexually active, or abstaining, Busi, who also mentioned that HIV can be spread through contact with infected blood, said:

*“If the skin in your fingers is splitting and you help someone who is injured you must wear gloves.”*

Erica also thought that abstaining was one of the ways in which protection can be ensured. However, since it was not easy to do so, she suggested that *“they just use condoms”*.

In addition to abstaining and using a condom, Sam suggested:

*“Talk to your partner and be faithful and abstain.”*

Sandy also agreed that using condoms was one of the ways in which protection from HIV infection could be ensured and emphasised abstinence, but unlike Erica, thought this was “easy”:

*“Abstain! Abstain! That’s the only thing I can say. It’s easy...from me, you know, from my own perspective it is easy to abstain.”*

As a follow-up to their knowledge about the modes of protection against HIV infection, the researcher asked the participants if they thought that boys and girls in their age group actually protected themselves from HIV infection. Mandy’s response was:

*“No, not really. They live for today. They don’t worry about tomorrow.”*

This response is in line with Mandla’s:

*“A-a-m, some of them do, some of them don’t because when you are in adolescents stage its whereby you are controlled by peer*

*pressure, maybe using drugs and alcohol. Whereby if you go to a party you are drunk, suddenly you think that a condom is bad thin and maybe your friends say this is just a plastic...don't use it, don't use a condom."*

#### **4.3.1.6 Knowledge about VCT**

The interview questions were designed to explore, among other issues, whether the participants knew what VCT entailed. This is crucial, as knowledge of what VCT entails and its benefits are some of the factors that influence one's decision to test for HIV. Although all the participants knew that it was only through a blood test that one could know his or her HIV status, some were not familiar with the acronym "VCT" and even "voluntary counselling and testing". As a result, the researcher had to repeat the acronym a few times and at times explain what the acronym stood for and what *voluntary counselling and testing* entailed before the question could be answered. For example when the researcher asked Erica if she had ever heard about VCT or voluntary counselling and testing, her response was:

*"I have never heard about it."*

However, when the researcher explained that it was the testing of blood for HIV, she indicated that she had "*heard about it a lot of times*" and had previously had an HIV test herself. The researcher got a similar response from Jon, who, like Erica, had also previously had an HIV test. When asked if he had ever heard of VCT his response was:

*"No. I have never heard about it."*

He only understood what was being referred to when the researcher asked him if he had ever heard about testing for HIV. Like Erica and Jon, Yusuf was also initially confused by the acronym VCT. When the researcher asked him as to when he first heard about VCT, he said:

*“It’s the first time I’m hearing this. What is this?”*

The researcher then explained what VCT meant, including what the term “voluntary” meant. Following this explanation he then said *“I have heard.”*

#### **4.3.1.6.1 Sources of VCT information**

Participants mentioned various sources through which they first heard about VCT, including at school and on the television. Like HIV and AIDS information, Paul first heard about VCT at school, although he explains that it was confusing at first:

*“I first heard about it in primary school but we didn’t yet understand enough...you go and test, but before you get your results they will tell you that if you are positive it’s not like you are going to die. They counsel you and tell you how your lifestyle should be; how your diet should be. Things like that, not to say because you have HIV you must give it to someone else since someone else gave it to me.”*

Like Paul, Busi also first heard about VCT at school:

*“At school they told us that if you want to know your status you must go and test so that you know whether you are sick or not, so that if you are sick you must get treatment according to the rules that you get from the clinic.”*

Erica and Peter also mentioned that they first heard about VCT at school. Erica also mentioned the local clinic and loveLife:

*“I have heard from a school that I attended and also from the clinic, even the people from loveLife do come to our area and tell us about it.”* (Erica)

*“It was the same year when I heard about HIV, that if you want to know your results you must go and test.”* (Peter)



Sam first heard about VCT during a school project, where he was required to conduct research at a clinic. In the following quote, he demonstrates a detailed understanding of what VCT is and what it entails:

*“I heard when I was doing research at the clinic...they take your blood, like they prick you with a needle and put it on something like, I don’t know what it is, and they put your blood there and wait for about, like 30 minutes. But before that they counsel you, they talk to you and tell you all about HIV.”*

Thembi is the only participant who said she first heard about VCT on television:

*“I have seen it on TV....I see other young people on TV encouraging us to go and test.”*

#### **4.3.1.6.2 Knowledge about benefits of VCT**

All interviewees acknowledged that knowing one’s HIV status was beneficial. The benefits highlighted included living positively, getting timely treatment, and behaviour change (such as to engage in less risky behaviour). Part of this reduction of risk included protecting one’s marital partner and one’s unborn baby from HIV infection.

When Busi, who first heard about VCT at school was asked as to what exactly she had heard, she replied by saying:

*“At school they told us that if you want to know your status you must go and test so that you know whether you are sick or not, so that if you are sick you must get treatment according to the rules that you get from the clinic.”*

Like Busi, Gugu also mentioned access to timely treatment as one of the benefits of VCT:

*"It is important because I don't want to see myself getting sick until I drop dead. I must know what is happening coz sometimes, when someone is using ARVs it happens that there need to be changes [in the regimen] because they don't go well with her [develops side effects]. So if you are already sick that is too much."*

Gugu also emphasised the fact that knowing one's HIV status assists in determining appropriate treatment, including timely initiation on ARVs:

*"Firstly it is important to know your status it is easy that when you are sick, like you can go to hospital and say you have a headache and you have not tested. What happens is that HIV uses an existing illness that you have, so if you know your status you can get ARVs in time and get better."*

Similarly, Paul finds VCT to be beneficial. The following words indicate what he perceives to be the benefits of VCT:

*"It helps to know because if you know that you are HIV positive and you have the right attitude about that you do as they tell you. You take your tablets, you exercise and eat right. But if you say I'm not going to test yet you have HIV, you live your life, you smoke, you drink and you will end up being sick."*

Another participant, Erica, responded by saying:

*"I think that the benefit is that if you don't know your HIV status you are putting your life at risk and other people's lives at risk."*

When probed further, she explained what she meant by "risk":

*"Because if I get married now and I don't know my HIV status and my partner doesn't know his HIV status and we want to start a family then we start having unprotected sex. You know those kinds of things. I will infect him."*

Peter demonstrated a sound understanding of how beneficial VCT was, specifically referring to the role played by pre-and post-test counselling in enabling acceptance of one's status; living positively and in preventing the intentional spread of the virus. His words were:

*"You go and test, but before you get your results they will tell you that if you are positive it's not like you are going to die. They counsel you and tell you how your lifestyle should be; how you diet should be. Things like that, not to say because you have HIV, then you must give it to someone else since someone else gave it to me."*

Making a decision to live positively is one of the benefits of VCT that was mentioned by Mandla.

*"I would just accept it that I got this thing so... I can live a long life as long as if I do what the doctor tells me .Whereby I don't like vegetables there is a time where I have to force myself to be in shape and be healthy."*

Erica, who had come for her second HIV test also highlighted the benefits of the counselling received as part of the process of VCT. According to her, she was pleased with the counselling she received since, despite an HIV negative result, she received information on how to protect herself from contracting the virus. Her response was:

*"Yes I was happy because they first gave me counselling before I went to test. Even though I was negative they did counsel me. They told me that since I am HIV negative I have to play it safe."*

Thembi's response highlighted her understanding of VCT as a way in which they, as young people, can be protected from HIV infection:

*“I understand that these people want us young people to get help so that we don’t get infected with HIV and AIDS. That you need to test so that you know your status, where you stand so you don’t remain in the dark. Maybe you will be positive and not know it.”*

According to Sam, VCT is also beneficial as it enables one to know his or her HIV status, considering the multiple ways in which HIV can be contracted. When asked if he would consider testing for HIV he responded by saying:

*“I would do it, I will do it coz you won’t know when somebody got hurt and you get hurt at the same place, or something like that. So I will take it.”*

In addition to knowing the benefits of being aware of one’s HIV status, some participants highlighted the importance of testing every three months, indicating their awareness of the window period in HIV infection. When asked why one should test every three months, Jon said:

*“...most of the time it’s like after 3 months you have to have a test or after 6 months...you have to trust your partner, but when it comes to other issues you don’t know, when you leave him or her, you don’t know what she is doing. You just need help to be up to date.”*

When asked if she would consider having another HIV test in the future, Gugu said she would, after three months. The researcher then asked for the reasons why she would have to test specifically after that period, to which her response was:

*“Sometimes it is possible that the virus is still hiding in the blood...They say it happens that sometimes when you test the virus is not yet showing in your blood even if it is there, and after 3 months it can show.”*

### **4.3.2 MOTIVATION**

According to the literature reviewed for this study, knowing and acknowledging one's own susceptibility to HIV infection is one of the ways that can motivate a person to have an HIV test. Participants were therefore also asked questions that related to whether they perceived themselves to be at risk of HIV infection or not. Questions to tease out this information made mention of whether they had ever known anyone who is living with HIV; discussed HIV and AIDS with parents, partners or friends as well as which population category they thought was most at risk of contracting HIV.

Participants mentioned a number of factors that would influence their final decision to take an HIV test. These included support from friends and family; ensuring their partners' and their own protection: living positively; having engaged in risky behaviour, as well as getting married. It is interesting to note that they specifically associated getting married with starting a family and therefore protecting their unborn babies from HIV infection. This sub-section presents the factors that were mentioned as the ones that would motivate them to test for HIV.

#### **4.3.2.1 Knowing someone who is living with HIV**

Knowledge of someone who is living with HIV was raised, during the interviews as one of the factors that motivate an individual to seek VCT. Yusuf who has never tested for HIV explained what would make him decide to test:

*"Maybe if I see my close friends having AIDS would make me decide to be tested. To be honest, just hearing about other people I don't know doesn't catch my attention. Not people I don't know. If your friends do something and get caught, you learn from it*

*because you see it's real. It's just an example of how I understand it."*

#### **4.3.2.2 Perception of own risk**

In her response, Busi does not only acknowledge that adolescents are the most at risk population category, she also cautioned fellow adolescents:

*"Mostly, it is teenagers. We are at risk as teenagers. So whatever we do we must think of the consequences. Don't say I want to see it through me because as teenagers we are under peer pressure and we don't want to listen. We just say I want to see it through me."*

Like Busi, Yusuf also thought adolescents were faced with high risks of contracting HIV:

*"Yes – we are more risky to it - we want to have sex".*

In explaining the risks they face as adolescents, Paul gave an example of what was happening at his school:

*"... there's this thing that if you don't have a girlfriend or you don't have sex you have nothing... like you have no future, you have nothing ... some people at school ...they smoke."*

Erica also agrees that teenagers are at high risk of contracting HIV, adding that this is because they like *"sleeping around."* When asked a similar question, Sandy responded by saying:

*"Of course, if they are sexually active and uhm like, changing partners and not using sexual, what do you call it, protection."*

There are many other reasons which, according to the participants, place them at higher risk of HIV infection. These include poverty, which forces some of them into transactional relationships with "sugar daddies";

unemployment and peer pressure. These factors undermine the wealth of information they possess, to practise safer sex, as Busi indicates in the following words:

*“We have information on this... we are always taught about it and we see it when people are sick... when they have AIDS”*

However, despite having the information, it is not easy to put it into practice, because of different reasons. Erica mentions poverty and peer pressure as some of the issues that expose adolescents to HIV:

*“... the youth of today ...like sleeping around ...because of maybe poverty you know these kinds of things, unemployment. Maybe others just do it for their friends.”*

A similar response was given by Jon:

*“They are just doing things just to please their friends, not necessarily for themselves. Just to be, like please my friend that OK my friend is doing this then I must do it.”*

#### **4.3.2.3 Engagement in high risk behaviour**

Having engaged in risky behaviour is one of the factors that would influence a decision to seek VCT, according to some participants. Mandla said before deciding to test:

*“I will firstly look at things that I have done, maybe if I went to a party and that mistake happened, I would feel guilty!”*

There is also a tendency among the participants to associate the need to have an HIV test with having engaged in a risky sexual behaviour. Paul said he had come to the clinic to test for HIV. When asked why he chose that particular time, since he had known about HIV since primary school,

he said it was because his friend's condom burst and they had therefore come together with to do the test:

*"Well, the whole point of us coming here for an HIV test is that this new friend of ours...he's b-a-d this one coz on Friday he had sex with some chick so he says the condom burst. So we told him to go for an HIV test."*

Although the participants were aware that they faced high risks of HIV infection, their responses indicate that they persistently engage in high risk behaviour. A number of male interviewees support the idea and practice of having multiple relationships. According to Yusuf, although he would not want to share a girlfriend, he believed in having more than one girlfriend at a time:

*"...if you like someone else when you are with someone I think you must go for her."*

Peer pressure played a role in adolescents' decisions to be involved in multiple relationships. Peter indicated that his friends had many girlfriends while he had two, despite the fact that he would not like it if his girlfriends also had other boyfriends. He is quoted as saying:

*"For my side it's cool to have many girlfriends...You become popular. Most people will like your style you see, rather than if you have one girlfriend. You become a "sishimane". They say you are stupid. You go out with one person for so long. Don't they get bored of each other? But if you have many girlfriends and one dumps you, you know that you have another girlfriend somewhere."*

Yet another interviewee alluded to the influence peers have in decisions to have more than one partner at a time. When the researcher asked what he thought about having one partner Jon responded by saying this does



not only make one an object of ridicule but that, according to him, it is “like laziness”. He went on to say:

*“Most people now they think if you having one partner...they think you are mad...It’s like if you having one partner they ask you, like what are you doing. But if you have more than one they say you should have more, as much as you can.”*

Although a few females indicated that they have been involved in more than one relationship at a time, they do not support this. Gugu indicated that she was opposed to multiple relationships, although she herself was at one time involved in such a relationship:

*“It is wrong...Firstly if I am in love with 3 people, I sleep with this one today, I don’t know how many people he has. He also has someone else and he doesn’t know how many that person has. In this way, what happens, HIV is being spread... Uhm, I once had 2. My boyfriend is in Maritzburg, then I had another one here.”*

#### **4.3.2.4 Significant others**

According to Fisher & Fisher (2000), cited in MacDowell *et al* (2006), significant others (such as family and friends) play an important role in motivating an individual into enacting health-related behaviour. For adolescents, support from this source, whether positive or negative, can either encourage or dissuade them from seeking an HIV test. Jon mentioned that although handling a positive result would be hard for him, knowing that he has support would be important and would make him stronger. He was quoted as saying:

*“...it would be hard coz if you don’t have support it can be hard but if you have support...support from your friends, from your family, maybe your colleagues. Everyone who is around you. But if there is*

*no one it is difficult...if it comes to the push, your friends are important.”*

For most participants, it is very important to trust someone before they can talk to them about having an HIV test. Erica, who had already had an HIV test before, had told her sister that she was going to test. When the researcher probed for the reasons why she chose to tell her, and not any other person, she said:

*“Because I trust her, you know I trust her.”*

Thembi’s response to a similar question also highlighted the importance of trust before one could share plans to test for HIV. When asked why she would choose to talk to her cousin if she decided to have an HIV test, Thembi said:

*“I trust her. Most of the time she is the one I tell if I have a problem.”*

Some participants said they would tell their mothers as they had a close and open relationship with them. These participants’ mothers also knew that they were involved in relationships. When asked who else she would tell if she were to test for HIV, Thembi said:

*“My mom... It’s because I am open with her. I talk to her about everything. If I have a problem I tell her.”*

Mandy also said she would confide in her mother if she were to test:

*“Because I trust my mom with my life.”*

Mandla mentioned that his mother actually encouraged him to go and test for HIV, following the death of his brother:

*“I have heard about it that you have to go and test... I was so close to my brother in such a way that I would do anything ... after he passed away then my mother said I must go and test to find out if I am HIV negative... I normally discuss everything because she is the person that I feel I’m left with in the world so I tell her everything.”*

Apart from his mother, Mandla also said he would talk to his girlfriend about his decision to test.

However, not all participants said they would tell their mothers if they decided to have an HIV test. Busi said that she has had an HIV test before and was about to have a second one. She emphasised that on both occasions telling her parents was not an option. According to her, she would rather live in the street if she tested positive for HIV than tell them her status as she thought they “would kill her”. When asked why they would do that to her since they previously supported a family friend living with HIV, she said:

*“Ya he was an old man. Now I’m a kid. I’m a young girl you see. Now I’m gonna go there, umm, umm, parents, I’m HIV positive. Eeyo! They wouldn’t understand it. Eeyo! Because I’ve always been decent.”*

Thembi said although there were individuals within the community who spoke to young people about VCT, she had never spoken to her mother about it:

*“... in our area there are people who come and tell us about testing. But with my mother, we have never set down and talk about it.”*

Sandy also said she would not talk to her mother if she were to take an HIV test. Instead, she said she would talk to the counsellor. The reasons for not talking to her mother were:

*"... if I tell her that I'm going to test, well, the first thing that she will think of, OK she is pregnant. My God she is having sex!"*

Gugu, whose parents are both living with HIV, said she would tell her mother about her plans if she decided to test as she trusted her although she knew her mother would also tell her father. When asked what she thought her reaction would be she replied:

*"She wouldn't have a problem...coz they have also been through that."*

The following responses show that although some participants mentioned mothers and grandmothers as being some of the most important people in their lives, they were least likely to tell them about their plans for an HIV test. In line with these responses, Sam said:

*"No! She would be suspicious and think that I am having sex."*

In response to a similar question about his grandmother, Paul said:

*"My granny is not someone you can talk to... But if I had a chance I was gonna tell her that I will be going to the clinic for an HIV test."*

Lack of communication between the two generations is widening the divide between adolescents and their elders. Discontinuing the dialogues during which issues affecting the youth (early sex, lack of respect for adults) were discussed has worsened the situation as Sandy observed that:

*"They also used to, in 2006, do what do they call it... dialogues, born fire dialogues where there are adults and youth. The youth of '76 and the youth of today, whereby they debate on certain things."*

When the researcher asked her if she thought the discussions still existed in the absence of dialogues her response was:

*“I don’t think so because many parents don’t want to talk about such things.”*

However, although Busi’s mother and her neighbours did not talk about HIV and AIDS and VCT, she mentions a certain woman who teaches young people in the community about the disease:

*“Those people don’t talk about AIDS. But there is another Venda lady who likes educating kids. That lady, she will tell you from start to end. She is not like my mom. She will tell you what AIDS is and what it can do to you. You know. She goes into detail.”*

The role played by friends in the participants’ lives came out very clearly during the interviews. Most participants, particularly boys, were more likely to confide in their friends than anyone else as they had a close and supportive relationship with them. This was clear in Paul’s case. According to him, he would not discuss his intentions to test with his grandmother but he was sure he could count on his friends’ support. When the researcher probed further, on whether he would be brave enough to test for HIV, his response was:

*“No, no, no. But my friends would have forced me. They were going to make me come. Like they are like a family to me. We talk, we do things together. If one of us says mate, I have to go somewhere, you see, like he doesn’t have money – we give him money to go.”*

Like Paul, Sam also mentioned that his friends were his pillar of strength:

*“I would tell my friends. My friends and I motivate each other I’ll go to my friends for advice. They are the ones who motivate me*

*more...My friends support me in everything I do. I'm definitely sure that they'll say let's go and take it together."*

Jon also mentioned the importance of friends at difficult times in one's life:

*"...if it comes to a push, your friends are important."*

The following words highlight the role played by Mandela's friends in his life, as his mother also solicits their support when she cannot get through to him:

*"If my mother tells me something and I don't agree with her she will go to my friends ...can you please convince Mandela that he must do this and that..."*

Mandy also indicated how much she trusted her friends. Her words were:

*"The two friends that I do have would support me unconditionally."*

However, Gugu did not show as much enthusiasm about her friends. When asked a question relating to her friends' attitudes towards HIV and AIDS, Gugu responded by saying:

*"My friends, I keep them out of my home. They don't enter my home coz, I don't think they are the kinds of people, like if they see something... they are the kinds of people who think they are better than everyone. That's why."*

Upon further probing for reasons why she would not tell her friends, Gugu's response was:

*"I know them. I know them. I know who I can talk to about certain things, and this one I can't. But I really think my best friend is my sister."*

Most participants did not seem to have amicable relationships with, or even trust their neighbours. When asked how they related to their neighbours, most said they do not talk to them, and associated them with gossiping. When asked how her neighbours would treat a person who is living with HIV, Busi said:

*“It’s like they like being nasty, you know. They say you should have that disease because you were doing this and this. They don’t encourage you. OK they tell you before you become that way but when you are like that they don’t support you...they say you deserve it because you don’t listen, you see.”*

When asked how he thinks his neighbours would treat him if he was living with HIV and they knew about it, Jon said:

*“They would reject me. They would push me away. They would treat me like trash. Obviously you would die, and ...there would be no life anymore. They would just neglect you.”*

Mandy also did not have a positive view about her neighbours:

*“They like to judge and live on their own and live for themselves. They don’t care about anybody else...that’s how they are.”*

Instead of his neighbours, Jon preferred spending time with his friends as indicated in the following words:

*“Normally uum I only know my friend. We stay in a place where it is racism...When you Black, you Black. Why stay in Palm Ridge, you know.”*

Paul mentioned that his neighbours liked to gossip:

*“...when you walk on the street and they are standing there talking, as you walk past them they keep quiet, and when you have passed*

*they talk. Things like that. They would do that... neighbours, what they do is that they make tea, sit in the house and talk.”*

Yusuf’s neighbourhood was characterised by violence. When asked as to what his neighbours’ attitudes were towards people living with HIV he replied:

*“They are violent, they like fights with people – and they don’t care about things like this. It’s the least of their concerns.”*

Like the above respondents, Mandy who also came from the same neighbourhood as Yusuf, also did not like her neighbours:

*“They like to judge and live on their own and live for themselves. They don’t care about anybody else.”*

Mandla on the other hand, had a good relationship with his neighbours. His words were:

*“We have a very good relationship because they take me as a brother and the moms of my neighbours take me as a son.”*

#### **4.3.2.5 Marriage**

Most participants mentioned that they would go for an HIV test before they get married. They also associated this with having children, and the need to protect the children from being infected with the HI virus. The following response from Thembi supports this conclusion:

*“Just because we will be getting married, we both need to know our status. And if we have children then they won’t be positive.”*



Erica also considered it important to test for HIV before getting married because during this time, the couple does not use protection as they want children:

*“Because if I get married now and I don’t know my HIV status and my partner doesn’t know his HIV status and we want to start a family then we start having unprotected sex. You know those kinds of things. I will infect him.”*

According to Busi, testing before marriage would make sure that the unborn baby is protected through the PMTCT program. Her words were:

*“It’s about the two of us coz maybe it would be me having it. Both of us must test coz in marriage you also have children. If like we are HIV positive we would then protect the baby...there is medicine that they give in the clinics.”*

Asked a similar question, regarding VCT and marriage, Sandy emphasised the element of trust:

*“...if you trust your partner and he trusts you back I think that won’t be a problem to do that ... if you trust each other ... because having an HIV test is not about ...you sleep around or a previous relationship or what. You just say OK you trust me I trust you so let’s just do this.”*

For Mandla VCT was important, not only when getting married but also to ensure that there is openness in the relationship. When the researcher enquired if he would ask his current girlfriend to have an HIV test if they were to get married, he said he would, emphasising that a positive result would not in any way make him cancel the wedding plans:

*“I think we must do it together so there are no secrets. I wouldn’t say, if we go and test, then maybe we have planned the date*

*already, then I find that that she is HIV positive and I say let's cut off the wedding, no."*

When probed further regarding the need to "do it together" at this stage of the relationship, as opposed to while still dating, his response was:

*"...at the moment you get the feeling that she's not mine forever, we just having this thing coz we still in adolescence whereby we change and meet other people...but when you decided to get married is whereby you get this thing that this person I'm willing to spend the rest of my life with..."*

Paul's response also hinted at the importance of VCT in ensuring that there is complete trust before the commitment of marriage:

*"...sometimes you say this person we are engaged and we are getting married next week ... You can find that this person knows is getting married next week and then on Sunday decides that they want to be with someone else for the last time. So from there she can bring something."*

According to Thembi, refusal to test for HIV is equivalent to a lack of trust between the two partners:

*"It will mean that we don't trust each other, if he doesn't want to go."*

Gugu mentioned that she would ask her fiancé to test prior to getting married to ensure transparency, adding that if he refused to test, she would call off the wedding:

*"I must tell him so that I can know his status and he knows mine. I shouldn't be at risk or him be at risk. Or maybe he will be using*

*ARVs without my knowledge... Marry him, without testing? No I will never."*

Busi had a similar perspective:

*"No no no I must first force him to do it, then we can get married."*

Busi added that if her partner refused to join her for an HIV test she would end the relationship, as she has to be sure of his HIV status considering that she would not know "where he had previously been". According to her, if he refused to test:

*"He must go because this is my future and it is also his future. He must go coz maybe there will be someone else who will listen to me."*

Unlike the girls, who sounded sure of what exactly they would do if their fiancés refused to test, the boys were not as sure. Although Sam mentioned that he would suggest an HIV test to his fiancé, he said he would take the test alone and go ahead with the marriage if she refused, regardless of the fiancé's HIV status. The following are his words:

*"Then I will just have to take it on my own... I wouldn't want to force her; she'll say that I think she's cheating on me or stuff like that... I will have to live with it. If you love somebody you have to live with it."*

Like Sam, Mandla said he would go ahead with the marriage, adding that they would practice safer sex, as there would be no trust between them. However, when starting a family they would then stop using condoms, thereby risk contracting the HIV virus:

*"If she refuses, then ...there is nothing I can do coz I love her. I'll go ahead and get married If she hasn't tested I think I would continue*

*using a condom, but it means I won't trust that person. But maybe there will be a time when I will say let me just take a risk and see what's going to happen, and when you are in a marriage you want to start a family. I will take it from there and if she is positive then there is nothing I could do."*

#### **4.3.2.6 Own and partner's protection**

Some participants mentioned that they would go for VCT so that they know their partner's, as well as their own HIV status in order for both to be protected. Although Mandy said she would not have an HIV test herself, as she was too scared to do so, she mentioned that she would encourage her partner to have one:

*"I guess just to be safe myself. I wouldn't get tested though because I would be scared. But I would let him get tested coz I know that I'm faithful."*

Ensuring her own protection was also mentioned as one of the reasons that would motivate Gugu to test for HIV. When the researcher probed for reasons behind this she replied:

*"It would help me know his status and him to know mine so that I don't get myself into a situation I will not be able to stand."*

Busi's response was similar to Mandy and Gugu's. According to her, testing for HIV was necessary before taking the relationship further in order to ensure protection for both she and her partner:

*"For sure we must both go and test because I wouldn't know what he was doing. He wasn't staying with me so we are forced to go and test."*

Erica had a similar perspective:

*“... sometimes maybe if I tell him that we have to go and test and he doesn't agree and tells me that we will use a condom, sometimes it can happen that we don't use a condom.”*

#### **4.3.2.7 Fear of a positive HIV test result**

Despite all the known benefits of VCT as highlighted above in section 4.3.2.2, there was still hesitation to test for HIV among the participants. Fear of testing positive for HIV was the main reason why there was hesitation to test. When asked why her boyfriend initially resisted her suggestions for him to go and test, Gugu said:

*“He said he does not want to go and test because he can kill himself straight away.”*

#### **4.3.2.8 Attitudes towards VCT**

Considering that since the 1<sup>st</sup> of April 2011 the South African Department of Health has been promoting provider initiated HIV counselling and testing (PITCT) through the HIV Counselling and Testing (HCT) campaign, the researcher also asked the participants for their general views on, or preferences between VCT and PITCT. There were mixed responses to this. However, as only two interviews were conducted after the implementation of the HCT policy, only Mandla and Sandy's responses are presented.

Mandla expressed his disapproval of PITCT as he argued that it meant testing people before a person is ready, and considering that there is a general fear of testing for HIV, he preferred VCT. The following were his words:

*“I'll never do that coz if I want to go and find out about blood pressure and they tell me about HIV and AIDS – that's too much to*

*handle, then maybe I'll commit suicide. Voluntary counselling and testing means you are ready to do it and that one comes as a shock... I would faint!"*

Sandy, on the other hand felt that PITCT was the best way through which stigma against HIV and AIDS could be addressed. In addition, she felt that in this way, more teenagers would get tested as they “do not take things seriously” and would therefore test if constantly reminded to do so:

*“I prefer the one that the president did ...uhm, implement coz, you know people... I think it's a very, very great idea, you know, just to take out that stigma from people. They take HIV as like “t-h-e disease” while there are other “t-h-e diseases” that could kill you, like meningitis. People don't take it seriously but it does kill, it does kill! There are other diseases. But I think it's very, very great.”*

### **4.3.3 BEHAVIOURAL SKILLS**

The ability to independently make decisions and follow through on them is considered an important behavioural skill necessary for the enactment of health-related behaviour such as VCT. Interview questions were also designed to establish whether or not the participants were able to make these types of decisions.

#### **4.3.3.1 Ability to make decisions independently from significant others' opinions**

Interviewees were asked as to what they would do if their significant others were to oppose their decision to go and test for HIV. The responses were similar in the case of all the respondents. Despite the important influence of significant others pointed out in section 4.4.4 above, most

participants said the final decision to test rested with them, and no one would sway them. Mandla's response was:

*"Maybe sometimes it would depend on how I feel about it. If I'm willing to do it she won't ... maybe tell me what to do but I would still ask for her permission to do it. If she disagrees then I will say no that's what I want to do and I will go ahead and do it."*

Erica said:

*"I wouldn't have listened to her because it was my choice."*

Like Mandla and Erica, the following participants also said the final decision to test for HIV, was theirs, and not any of the people they would confide in. When asked as to what they would do if someone discouraged them, they responded by saying:

*"No, no one can ever tell me don't go. If I decide something I decide something and I'm gonna do it." (Busi)*

*"Because this thing is about me and my health, you know, and for my sake I will go, I will go." (Sandy)*

*"Well, I will go coz it's me who wants to have the test." (Paul)*

*"I won't go, but will think about it." (Yusuf)*

Unlike the above participants, Thembi sounded unsure of whether she would be able to stand by her decision to test despite being discouraged by her cousin:

*"I don't know. But if I really want to go, and I want to know my status I will explain to her that I want to know my status. But it's not easy."*

Sam who said he believed his friends would support his decision to test or even take the test with him, was unsure when the researcher asked what he would do if his friends unexpectedly opposed his decision to test. His words were:

*“I’ll ask somebody but I won’t say I want to take a test. I’ll just say ‘if you want to take an HIV test people keep discouraging you what you would do?’ If that person can make an idea then I would take it.”*

However, not all participants appear to be influenced by their friends to the same degree:

*“When it comes to making decisions, I make my own decisions because even if they are my friends they don’t live my life for me.”*  
(Gugu)

Although the participants said they can make their own decisions, specifically regarding testing for HIV, their peers play an influential role for most of them.

#### **4.3.3.2 Visiting a VCT site**

An individual’s ability to visit a VCT site is one of the important behavioural skills necessary for VCT uptake. In addition, testing as a couple has been proved to be more effective in the adoption of risk reduction behaviour, as highlighted in Chapter 2. Among the participants who had previously had an HIV test, none of them said they tested as a couple. As Erica indicates, she went alone for the test:

*“I told my boyfriend that I’m going to test. But, I did not tell him. I told him after.”*



When probed further, it became clear that this couple assumed that if one of them tested negative for HIV, the other would automatically be negative as well. When asked why she decided to tell her boyfriend about the test after she had already had one, Erica said:

*“It’s because I knew that if I went there, if I’m HIV negative we have to be faithful to each other...I encouraged him to go but he told me that if I went it means that he doesn’t have it.”*

Participants who had previously visited a VCT site and had an HIV test gave different reasons as to why they had it. These range from health related reasons, influence from relatives or seeing a loved one die due to AIDS-related illness. Peter explained that he had a test because he was sick, but said that it would have been difficult for him to go and test had it not been because of the illness:

*“I have tested before...I had gone to test for TB in fact. My results were OK. I did not have TB but I was very sick. They said it’s not TB. They said I should check HIV and AIDS cause they thought that I had even lost weight...they took my blood and put drops in that thing with 2 red lines. They said if there are 2 lines you are positive.”*

John, who previously had an HIV test had visited a friend suffering from and AIDS-related illness when he took a decision to go for VCT:

*“...it touched me to see someone who is sick like that. My friend’s condition motivated me.”*

Girls, as compared to boys, seem more likely to visit a VCT site or a healthcare facility and seek HIV testing, condom use, according to Jon:

*“Normally, girls make such decisions like, let’s do this. With men, it’s like they are bossy. They want to make decisions all the time.”*

*But when it comes to that, its girls who make decisions... Mostly girls like to learn more. They have information towards these things coz they go to clinics more often. They get, like more information than boys.”*

#### **4.3.3.3 Condom use**

From the interview responses, it is clear that girls are more conscious about protection than boys. Both male and female interviewees, when asked as to who decides whether to use condoms or not said it is the girls. When asked who makes decisions about using a condom in their relationship, Gugu said:

*“I make them. Firstly I don’t want a baby cause I’m not working. At home no one can take care of a baby. Maybe he can even run away.”*

##### **4.3.3.3.1 Inconsistent use of condoms**

The ability to influence one’s partner either to use a condom or to have an HIV test is an important behavioural skill in terms of health seeking behaviour and is linked to their ability to influence their partner to seek VCT. However, despite having extensive knowledge regarding the role played by condoms in preventing HIV infection, most participants mentioned that adolescents often do not use them.

Like most participants, Peter was aware that some adolescents “*protect themselves during sex using condoms*”. When the researcher asked if he thought adolescents actually protected themselves in this way, his response was:

*“I don’t think they do because most of the people I go to school with have children and some of them are pregnant. You can’t get*

*pregnant ... you can't get HIV if you use protection via condoms. Or maybe it bursts, eish, I really don't understand."*

A similar response came from Gugu, who mentioned that adolescents use condoms inconsistently. She also mentioned issues of trust and "tricks" played by boys:

*"It is possible that they don't use them all the time coz they have people that they trust more and love more. Like, most of them use them with people that they don't love at all. But with those that they love, they don't use them. Boys have a tendency to say they want a baby. Sometimes they tear them without your knowledge."*

Although Gugu mentioned that there was easy access to condoms as they were available "everywhere", including shopping malls and clinics, she mentioned that she and her boyfriend did not consistently use condoms as indicated in her response:

*"N-o-o, not all the time."*

Busi was also of the opinion that adolescents often do not use condoms when they engage in sexual activity. When the researcher asked if she thought that adolescents used condoms her response was:

*"Most of them don't."*

It appears that the use of condoms is determined by issues related to gender, pleasure-seeking, peer pressure, drug and alcohol abuse, as well as the quality of the condoms. When asked the same question, Mandla gave an explanation as to why he thought most adolescents do not use condoms. His exact words were:

*“Am-am-am, some of them do, some of them don’t because when you are in adolescent stage it’s whereby you are controlled by peer pressure, maybe using drugs and alcohol. Whereby if you go to a party and you are drunk, suddenly you think a condom is a bad thing and maybe your friends say this is just a plastic ... don’t use it, don’t use a condom. You go for it just to get the opportunity, not knowing your sexual partner, the history, like who she is and the status of that person.”*

Sandy, on the other hand thought adolescents do not use condoms because they choose to ignore the information they receive:

*“... if they were using condoms our statistics wouldn’t be so high you know. It’s showing that they are not using condoms and that’s due to lack of information...but I won’t say its lack of information coz they know about it but they are just ignorant. They ignore that information.”*

According to Busi for some adolescents, a person’s healthy physical appearance determines whether a condom is used or not, adding that the potential sexual partner may perceive a demand for condom use as a sign of mistrust. Her response was:

*“...some don’t use a condom because they look at the person’s appearance. They think that if the person is nice he or she can’t have a disease. Again, if someone says a condom must be used he will say you don’t trust him, all that.”*

Gugu asserts that boys complain that condoms also interfere with pleasure. Her response was as follows:

*“Some of them say is not nice with condoms and stuff...they don’t enjoy it with condoms.”*

The above response is similar to Peter's, who explained that most girls were parents despite the knowledge that condoms could have prevented this:

*"They do have that knowledge. I think they were ignorant. Some say a condom, protecting yourself... they don't, they don't, they don't get satisfaction when they are having sex as compared to when they don't use the protection."*

The quality of condoms, specifically those provided free by the government, deters some adolescents from using condoms. When asked a question relating to condom use, Yusuf responded by saying:

*"We don't use a condom...all my friends don't want to use them, especially the free ones CHOICE...those condoms will give you AIDS... They are weak. I have heard that they are not the same quality as those you buy from the chemist."*

#### **4.3.3.3.2 Initiating condom use: gender**

Whether a condom is used or not also appears to be gender-related, as observed by most participants. In answering questions regarding the initiation of condom use, most participants indicated that boys, as compared to girls, are less likely to initiate condom use. The researcher also sought to explore as to who makes decisions regarding the use of condoms or having sex at any given time in their relationships.

Mandla's response indicated that girls make these decisions:

*"I think when it comes to condoms, I think ... it's only a girl's decision ...I don't know, maybe we guys we don't care about HIV and AIDS. Every girl we meet we just want to have sexual intercourse without using a condom. So maybe those girls want to*

*protect themselves from getting pregnant. Then if you don't use a condom you don't have sex."*

When asked if there are any boys actually initiate condom use, he emphatically said "no".

Like Mandla, Jon also mentioned that girls were leaders in trying to practise safer sex. According to Jon, although men always want to control the relationship and are 'bossy', when it comes to issues of condom use, and even testing for HIV, it is girls who are on the forefront:

*"Normally girls make suggestions like, let's do this. With men, it's like, they are bossy. They want to make decisions all the time. But when it comes to that, its girls who make the decisions."*

Upon further probing, Jon explained why he thought girls were on the forefront of such decisions:

*"Mostly girls like to learn more. They have more information towards these things coz they go to clinics more. They get like, more information than boys."*

Erica's response to a question regarding condom use supports Jon's assertion about girls initiating use of condoms. According to Erica, she insists on using a condom each time she has sexual intercourse with her boyfriend, adding that if he refused to use it, she would not have sexual intercourse with him:

*"You'll just have to discuss with him. If he doesn't agree you just have to let go."*

According to Thembi, she also makes decisions on the use of condoms. Like Erica, Thembi said sexual intercourse would not take place if her boyfriend refused to use a condom:

*“I would refuse to do it. If he doesn’t understand it’s his problem. I try to protect myself. Maybe I will also be protecting him.”*

According to Peter, physiological differences between boys and girls also contribute to boys’ inability to consistently use condoms, or initiate condom use. Using himself as an example, he mentioned that although he always has condoms at home (where sex takes place), there are times when he cannot hold back even when condoms are unavailable:

*“I mean on my side, when I’m on I can’t control myself.”*

Like Mandla and Jon, Peter mentioned that girls always try to promote safer sex, in order to avoid HIV infection and unplanned pregnancies. However, despite this, girls tend to be shy to collect condoms, preferring instead to buy them from shops, according to Mandla. Thembi’s words also indicate that girls must make the decision to use condoms or else face the consequences:

*“But these days if you have sexual intercourse with someone you tell them that they must use this thing. If he doesn’t want then you don’t do it. If you, the girl doesn’t want to use a condom and sleep with that boy without a condom, you will see the consequences in the future.”*

Paul’s response, on the other hand, indicates that although there is tendency for inconsistent condom use among adolescents, some do use them. When the researcher asked if he and his girlfriend would use a condom if they engaged in sexual intercourse on her birthday as she had proposed, he said:

*“If we come and test, and on her birthday if we do anything it’s obvious we will use a condom.”*

Paul added that his friend, whom they had accompanied to test for HIV had, on that day, also used a condom although it burst.

#### **4.4 CONCLUSION**

This chapter presented the findings of the study. Common themes emerging from the interview responses were identified and discussed, guided by the theoretical framework of the study and the literature reviewed. Themes identified pertain to the information that the adolescents have regarding HIV in general and VCT in particular; what motivates or would motivate them to seek VCT as well as the kind of behavioural skills that would enable them to test for HIV and use condoms.



## **CHAPTER 5: CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS**

### **5.1 INTRODUCTION**

In this chapter, the researcher presents a summary of the research findings. In addition, the researcher offers suggestions for further research, based on the findings. Finally, also based on the findings, the researcher presents a set of recommendations for policy practice and practice and discusses the limitations of the study.

### **5.2 SUMMARY OF THE RESEARCH FINDINGS**

The purpose of this study was to understand and describe the factors that motivate South African adolescents aged 15 to 19 years to seek VCT. In the process, factors that deter adolescents from voluntarily seeking HIV tests were also explored. The specific objectives of the study were to:

- Explore 15 to 19 year old adolescents' perceptions of their own susceptibility to HIV infection.
- Explore 15 to 19 year old adolescents' knowledge about HIV, AIDS and VCT.
- Explore and describe the reasons why 15 to 19 year old adolescents would or would not voluntarily seek VCT.

Face-to-face individual interviews were conducted with twelve adolescents aged 15 to 19 to gain insight into their perceptions and experiences regarding HIV voluntary and testing, using the IMB model to guide this understanding. Conducting research on adolescents' VCT-related perceptions and experiences is essential in assisting policy makers and implementers to find ways to increase VCT uptake among this age group.

Analysis of the research findings indicates that adolescents' decisions to go for VCT are a result of a complex combination of factors. These include knowledge about the existence of HIV and AIDS – its modes of transmission and prevention, as well as its severity. Knowledge about VCT and its benefits were also identified as being a key in influencing adolescents' decisions to actively seek VCT. Furthermore social support from friends and family and getting married and having children are some of the factors identified in the findings of this study as being important motivational factors for VCT uptake among adolescents. Another key finding of this study, linked to behavioural skills, relates to the importance of the adolescents' ability to make own decisions and follow through on them. This chapter presents a summary of the research findings, indicating how the research was able to meet the objectives of the study as specified above.

The findings of the study will be summarised according to three main themes, namely knowledge, motivation and behavioural skill

## **5.2.1 Knowledge**

### **5.2.1.1 Knowledge related to HIV and AIDS**

#### **5.2.1.1.1 Sources of HIV and AIDS knowledge**

Knowledge about HIV and AIDS is the initial step required in order for one to consider going for VCT. This study therefore sought to establish as to where adolescents access this information. For most participants, the school, and specifically Life Orientation and General Science lessons, as well as loveLife (the “external people” invited by the schools) were the primary sources of HIV and AIDS information. This was the case regardless of whether the participants were in rural or urban schools. Television was also another source of HIV and AIDS information for some participants.

Similar to other studies, such as the study by Grant [sa], schools appear to play a central role in the dissemination of HIV and AIDS information. This is indicated in the findings of his study in which 45.6% of the adolescents who were at school as compared to only 25.6% of those who were not at school acknowledged that they had a “great chance” of contracting the HI virus. The family was not mentioned as a source of HIV and AIDS information by the participants of this study, as there were concerns regarding possibilities of being misunderstood (either as being sexually active or living with HIV). In the literature reviewed for this, study, sources of HIV and AIDS information for adolescents were not discussed, except in the aforementioned study by Grant [sa].

With regard to the participants’ initial response to the HIV and AIDS information they received, this study found that the participants did not initially believe that the epidemic existed. In addition, they mentioned that the information they received was initially confusing. This was expected as they had little knowledge about it at the time. In addition, the epidemic was fairly new and there is a possibility that the information provided was insufficient. Disbelief about the existence of the HIV and AIDS epidemic during its first decade was also common in other parts of the world. This is evident from the findings of a KAB survey cited by Mwale (2008), which found that 55% of the respondents indicated that they did not believe that HIV and AIDS actually existed.

#### **5.2.1.1.2 Knowledge about modes of HIV transmission and prevention**

Coupled with the extensive knowledge about HIV and AIDS and VCT is the participants’ knowledge about the modes of HIV transmission and prevention. This study found that the participants possessed extensive knowledge regarding HIV prevention and transmission. Sexual transmission of HIV was mentioned as the most common mode of HIV

transmission, particularly for adolescents as they tended to engage in unprotected sex. STIs were also mentioned as facilitators of HIV transmission in this study. Other modes of prominent modes transmission according to this study were mother to child (through breastfeeding); blood contact through car accidents and needle prick; as well as rape and sexual abuse.

This high level of knowledge about HIV and AIDS among adolescents is confirmed by findings of earlier studies conducted in the early 2000s. In South Africa, for example, knowledge about HIV prevention and transmission among young people aged 15 to 24 were as high as 95% among 15 to 24 year olds (loveLife 2006). Other studies that found high levels of HIV and AIDS knowledge among adolescents were conducted in South Africa by Pettifor *et al* (2005) and in Malawi by Mwale (2008). In addition, in earlier studies, sexual transmission of HIV was also considered the major mode of HIV transmission by adolescents (Shisana 2005).

#### **5.2.1.2 Knowledge related to VCT**

The findings of this study, like those of other studies cited in the literature reviewed in Chapter 2 and mentioned below, indicate that adolescents possess extensive knowledge about VCT, what it is, what it entails as well as what its benefits are. Participants in this study, like those who participated in a study by MacPhail *et al* (2008) acknowledged the role played by VCT in preventing the spread of HIV, facilitating timely access to antiretroviral treatment as well as enabling people living with HIV an opportunity to live positively, thereby prolonging their lives. In addition, protection of an unborn baby was mentioned as one of the major benefits of VCT (*ibid*, Eastern Cape Department of Health 2008; Mphaya 2006). In addition, participants, both in this and earlier studies, for example by Mphaya (2006) acknowledged that through VCT they could make decisions to protect themselves and their partners from HIV infection.

Mphaya (2006) cites findings of studies whereby the adolescent participants displayed a keen interest in VCT. They mentioned the following factors as being some of the reasons why they would consider going for VCT: access to treatment and being able to plan one's future.

However, like in earlier studies on adolescents and VCT, such as those conducted by Francis (2010), Mwale (2008) and Njagi & Maharaj (2006), this study found that the high levels of knowledge about VCT and its benefits did not translate to actual HIV testing. This supports the postulation by the Information, Motivation, Behavioural Skills model (MacDowell et al 2006). According to the IMB model, although information (knowledge) about a specific health-related behaviour is a prerequisite for behaviour change, it alone is not sufficient to enable an individual to enact the specific health-related behaviour. Instead, an individual should be adequately motivated and possess specific behavioural skills to be able to enact a specific health-related behaviour. The findings of this study that are related to the latter aspect will be discussed in more detail in section 5.2.2.2 below.

It is important to note that in this study parents were not mentioned as sources of information, either for HIV and AIDS in general or VCT. Instead, participants mentioned schools, loveLife, local clinics and the media as their primary and on-going sources of such information. It is important to highlight that in this study, the school was the most important source of information for adolescents as it was mentioned by all the research participants.

Parents were not mentioned as sources of VCT information by participants in this study. This is similar to findings of an earlier study conducted by Volkwyn (2010) where only a minority (21%) mentioned parents as a preferred source of information. In addition, most participants (both those who had previously gone for VCT and those who had not) were least likely

to confide in their parents in decisions related to VCT uptake for fear of being misjudged.

## **5.2.2 Motivation**

### **5.2.2.1 Adolescents' perception of own susceptibility to HIV infection**

Acknowledging one's own susceptibility to HIV infection is an important step towards the adoption of preventive behaviour, including actively seeking VCT. The findings of this study indicate that adolescents are aware of their own susceptibility to HIV infection. All participants mentioned that as adolescents, they are faced with significantly high risks of contracting HIV. This perception of own susceptibility to HIV infection can be attributed to the wealth of information they have about the epidemic, including general information on what HIV and AIDS are, how HIV is transmitted from one person to the other, as well as its symptoms. In addition, all participants acknowledged that adolescence is a phase that is characterised by risk-taking, which in turn increases their chances of contracting HIV.

Risky behaviour typical to this population category (according to the participants) includes early sexual debut, having multiple sexual partners, sex without a condom as well as transactional sex with older men. Peer pressure was also considered a major contributory factor for adolescents' high susceptibility to HIV infection as most adolescents tend to engage in risky behaviour in an effort to impress their friends. Participants also considered accidents to be another major HIV risk factor for them and other adolescents.

These findings are in line with the conclusions made by Shisana *et al* (2009); Hope (2007) and The Transition to Adulthood Study Team (2004). These authorities concluded that adolescents' risks to become infected with HIV resulted from a myriad of factors including transactional sex with

older men, poverty and engagement in multiple concurrent sexual relationships. Also in line with the assertions made by the participants of this study, the aforementioned authors state that the risky behaviours that adolescents engage in lead to unplanned pregnancies.

Despite the aforementioned similarities regarding factors that increase adolescents' risk to HIV infection, findings of the following previous studies cited in the literature review, present an interesting contrast to findings of the current study. The latter found that all participants fully acknowledged their own susceptibility to HIV infection.

In a study that was conducted by Grant ([sa]), the majority of participants, both at school at out of school, did not perceive themselves to be at risk of HIV infection. Only 45.6% of adolescents who were still at school and 25% of those who were no longer at school acknowledged their own susceptibility to HIV infection. Pettifor *et al* (2004) also found that only 14% of a survey participants acknowledged that they were at risk of HIV infection.

In another study (Anderson *et al* 2007) participants indicated low levels of perception of own risk as compared with those of the current study as only 7% of the total number of participants acknowledged their own susceptibility to HIV infection (Anderson *et al* 2007). However, similar to the findings of the current study, Anderson *et al* (2007) found that knowledge of a person living with HIV or who had died of an AIDS-related illness played influenced adolescents' acknowledgement of own susceptibility to HIV infection.

#### **5.2.2.2 Factors that motivate adolescents to seek VCT**

The IMB model asserts that information alone is insufficient to result in adolescents making a decision to go for VCT. Instead, this model

proposes that information should be accompanied by sufficient motivation to enact the specific health-related behaviour. This assertion is supported by this study's findings as well as findings of earlier studies. Adolescents who participated in the current study displayed extensive understanding of VCT and its benefits, although the majority had never had an HIV test. However, both the adolescents who had never had an HIV test and those who had had it mentioned a number of factors that motivated or would motivate them to make that final decision to test for HIV. Support from parents (specifically mothers), sisters, cousins guardians and friends ranked high on the list of factors that would motivate the participants to go for VCT. Equally important for the participants of this study was the need to protect themselves and their partners against HIV infection. This need was considered important, particularly when deciding to get married. Also linked to the issue of marriage was the need to test due to uncertainty about a partner's previous behaviour, a factor associated with trust. It is interesting to note that female adolescents mentioned that they would end a relationship if a partner refused to test for HIV whereas male adolescents had mixed reactions, as they were unsure of how they would handle a partner's refusal to test.

In addition, testing for HIV during pregnancy (through the PMTCT programme) was considered important as this would enable the pregnant woman to protect her unborn baby against HIV infection. Furthermore, being able to benefit from timely access to treatment in the event of a positive HIV result as well as being able to live a positive lifestyle were also mentioned as motivational factors for VCT uptake.

Apart from the positive factors such as those highlighted above, knowing a loved one (including other adolescents) who was living with HIV or who had died of AIDS-related diseases were among the factors that led (or would) lead to the actual uptake of VCT for some participants in this study.



A similar conclusion was made by a study conducted by Anderson *et al* (2007).

The factors that motivate for VCT as mentioned above were also identified in other earlier studies, such as ones conducted by Eastern Cape DOH (2008); Francis (2010); MacPhail *et al* (2008) and those cited by Mphaya (2006). These studies found that support from family, opportunity to live positively and the need to protect unborn babies played a major role in decisions to actively seek VCT. However, participants in the earlier studies (cited above) did not mention marriage as a motivation factor for VCT uptake.

Factors that were mentioned as barriers to VCT uptake by participants of this study were fear of a positive HIV result and fear of stigmatisation by family and community (neighbours). These barriers were also mentioned in a debate in by adolescents in Humansdorp (Eastern Cape DOH 2008). Frances (2010); Shisana (2009); Munthali *et al* (2004) and Njagi and Maharaj (2006) also found that fear of stigma, lack of support from significant others as well as fear of a positive HIV result were barriers to VCT uptake. In addition, having engaged in risky, behaviour was also mentioned as one of the reasons why adolescents would seek VCT. Similar finding were made by Jaspan *et al* (2010).

### **5.2.3 Behavioural skills**

As the IMB model postulates, complex behavioural change such as VCT uptake is a result of a complex relationship between information, motivation and behavioural skills, and although an individual may possess sufficient information about a specific health-related behaviour, lack of motivation may prevent its enactment. However, even with sufficient motivation, an individual's ability to enact a complex health-related behaviour such as VCT is also dependent on whether he or she has the behavioural skills to make decisions and follow through on them despite

the possible negative influence from significant others like family, friends and the community. In addition, an individual's ability to handle an HIV positive result is another important behavioural skill necessary for an individual to be able to actively seek VCT.

In this regard, there were mixed responses from the participants of this study. The majority indicated that they possessed the necessary behavioural skills to enable them to take that final step of going for VCT, as they emphasised that neither their friends nor family could influence their final decision to test for HIV. However, some specifically male participants were hesitant as to whether they would test, if opposed by their friends. This finding emphasises the important role played by friends in male adolescents' lives. The differences between male and female views expressed above confirm conclusions made from a study conducted by Donenberg *et al* (2005). According to Donenberg *et al* (2005), gender plays a significant role in taking health-related decisions. In addition, these authors mentioned an individual's level of intellectual maturity as one of the necessary preconditions for the enactment of health-related behaviour.

Yet another important behavioural skill necessary for VCT uptake is the ability to negotiate VCT with a partner. In this study, although there was an emphasis of testing as a couple, especially when planning to get married, male participants were not confident that they would be able to enforce VCT to their partners or even end a relationship in case the partners refused to test. On the contrary, female participants emphasized that they could not only influence their partners to test, but would actually end the relationship if the partner refused to test. In addition, female adolescents were more likely to seek VCT and enforce condom use.

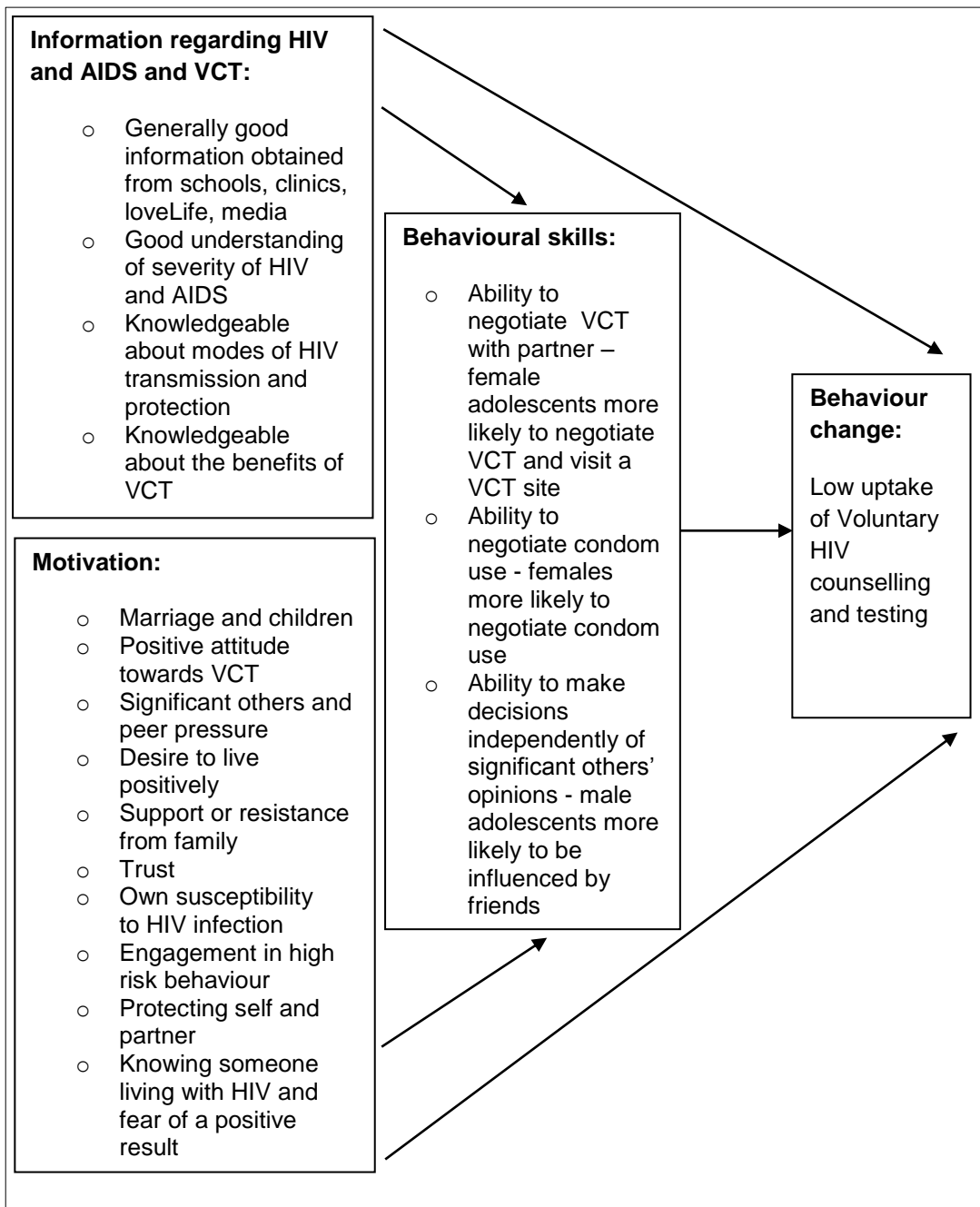
Similar to the findings of this study, earlier studies found that adolescents did not use condoms consistently (Phorano *et al* (2005); Mwale (2008) and Bosmans (2006). However, in this study girls were found to be more likely than boys to initiate condom use as well as influence a partner to test for

HIV. However, this in contrast to an earlier study done by Hope (2007) who found that girls did not possess skills to negotiate condom use with their partners.

In addition, this study found that there were high levels of fear of an HIV positive result and discrimination by family and the community, similar to findings by Anderson *et al* (2007).

The findings of this study can be summarised in Figure 4 below.

**Figure 4: IMB model as it relates to the findings of the study**



**Adapted by the researcher from:** Fisher & Fisher in DiClemente *et al* (2002:52)

### **5.3 RECOMMENDATIONS FOR FUTURE RESEARCH**

Although the adolescents interviewed as part of this study demonstrated extensive knowledge about the benefits of VCT and acknowledged their high risk to HIV infection, this seems not sufficient to convince them to take up VCT. There were still high levels of fear of an HIV positive result and a fear of being stigmatised by the community. Based on the findings of this study, the researcher suggests that further research should be conducted to investigate the persistence of HIV and AIDS-related stigma and discrimination within communities, followed by well-informed strategies to address these factors. In addition, further qualitative studies should investigate ways in which parental capacity to openly communicate about HIV and AIDS with their children could be strengthened.

As accidents present an increased threat to HIV infections, research should be conducted at health care facilities to establish ways in which accident victims can be given the opportunity to take ARV prophylaxis.

Following the introduction of provider initiated testing and counselling (PITC) or HIV counselling and testing (HCT) in South Africa, mixed method studies (using both qualitative and quantitative methods) should be conducted to measure and compare HCT with VCT among adolescents aged 15 to 19 in order to inform the implementation of the new policy.

### **5.4 RECOMMENDATIONS FOR POLICY AND PRACTICE**

Based on the findings of this study, the researcher recommends that the following should be considered in policy formulation and program development and implementation.

#### **5.4.1 Scaling up of interventions that facilitate communication within families and communities**

Based on participants' responses, there seems to be very limited communication between adolescents and their parents on issues related to HIV and AIDS, and specifically VCT. Parents and guardians were not mentioned as primary sources of VCT or even of HIV and AIDS information. In addition, adolescents were reluctant to involve their parents and guardians in their decisions to go for VCT for fear of being misinterpreted and felt that some parents would assume that they are sexually active or are living with HIV.

In this regard, the researcher recommends that:

- I. Parents and other adults need to be empowered with skills to communicate sexuality- and HIV and AIDS-related information to their children. This can be achieved through the rapid scaling-up of the provision of parent-specific information, education and communication (IEC) material within communities, health care facilities and places of interest where adults congregate during their free time.
- II. On-going campaigns and community dialogues designed to encourage communication between the two generations (adults and adolescents) about HIV and AIDS-related stigma should be conducted in communities by non-governmental and civil society organisations.

#### **5.4.2 Involving adolescents who have previously been tested for HIV in influencing behaviour change**

The importance of peer education in influencing behaviour change, especially with regards to issues related to HIV and AIDS and sexuality cannot be underestimated. Involving both uninfected adolescents and

adolescents living with HIV (who previously took up VCT) to encourage VCT uptake among adolescents who have never tested for HIV can be an effective way of improving VCT uptake among this age group.

#### **5.4.3 Scaling up involvement of male adolescents in health-related decision making**

Both male and female participants indicated that boys are less likely than girls to initiate health seeking behaviour such as condom use and VCT services. Considering the gender imbalance favouring male dominance, it is imperative that targeted interventions should be scaled up in order to address the negative health seeking behaviour among male adolescents. Some of the ways in which this can be achieved include:

- I. Scaling up of tailor-made VCT promotion messages that target male adolescents' understanding of masculinity (that masculinity should not mean dominance and control over their girlfriends) and positive health-seeking behaviour. This should be coupled with the involvement of adult males as role models as well as readily available clinical personnel at facilities in order to ensure continuity of services at all times.
- II. Sources that provide VCT awareness messages, including schools and the media, should promote couple counselling among adolescents as it is argued that couple counselling facilitates disclosure and adoption of risk-reduction behaviour. These messages should also dispel the adolescents' tendency to believe that one partner's HIV negative status is a proxy for the other's HIV negative status.

## **5.5 LIMITATIONS OF THE STUDY**

In this section, the researcher discusses the limitations identified during the course of the study. The researcher acknowledges that taking into consideration that the nature of qualitative research is such that it generates information based on participants' subjective experiences and perceptions, this study cannot be generalised to the entire population of South African adolescents aged 15 to 19 years. However generalising the findings of the study was not the researcher's aim.

The researcher managed to interview only two adolescents younger than 18, although she initially intended to have an equal distribution in terms of the research participants younger and older than 18. This limitation is likely to have resulted from the fact that other possible interviewees who were aged between 15 and 17 years did not return signed consent forms from their parents or guardians as per ethical requirements. This may therefore present a skewed picture, due to the unequal distribution of participants in terms of age groups.

The researcher had also originally planned to interview an equal number of male and female participants. However, as more female than male adolescents presented at the YFS, the sample consequently consisted of more females participants.

The age difference between the researcher and the research participants could have had a negative effect on the extent to which the adolescents freely expressed themselves, considering the sensitivity of the subject of HIV and AIDS and its link to sexuality. To minimise the effect of this factor, the researcher did not immediately ask sensitive questions during the interviews but started off with a general discussion of the participants' background, during which rapport was established.



## 5.6 CONCLUSION

As the findings of this study indicate, adolescents test for or would consider testing for HIV based on a myriad of interrelated factors. It was apparent however that information about the benefits of VCT alone was not sufficient to translate into actual testing. There was a need for a stimulus for VCT uptake to take place, either negative (such as loss of a loved one and for having engaged in risky behaviour) or positive (such as pregnancy and getting married). At the same time, adolescents who did not possess the necessary behavioural skills such as the ability to make their own decisions and follow through on those or the ability to influence condom use and one's partner to test for HIV) were not likely to test for HIV, despite having high levels of knowledge of the benefits of knowing one's HIV status.

The implementation of the new HCT policy in South Africa, although provider initiated, should therefore take cognisance of the complexity surrounding HIV testing, particularly for adolescents. In addition, the "voluntariness" of the procedure should be preserved. It is encouraging to note, however, that adolescents remain one of the South African government's priority groups that should be targeted through "a package of combination prevention" which includes HCT, medical male circumcision, the promotion of health-seeking behaviour and TB screening (NSP 2012-2016:22), among other key strategies. The findings of this study illustrate and suggest that the importance and the benefits of VCT cannot be overstated.

## LIST OF SOURCES

Adedimeji, A. 2010. To tell or not to tell: managing HIV/AIDS disclosure in a low-prevalence context . *Journal of Social Aspects of HIV/AIDS*. 7(1):16-23

Adolescent HIV Care and Treatment Module 9-1. Module 9 Positive living for adolescents Adolescent HIV care and treatment in Zambia. Available on [www.columbia-icap.org/resources/supporttools/Zambia%adolescent%20care%20and%reatment%20Participant%20Manual/PM%20PDFs/Module\\_9-PM.pdf](http://www.columbia-icap.org/resources/supporttools/Zambia%adolescent%20care%20and%reatment%20Participant%20Manual/PM%20PDFs/Module_9-PM.pdf)  
(Accessed on 30/01/2012)

Allen and Nesta Ferguson Trust 2007. *Dstance education program. Integrated HIV/AIDS prevention, treatment and care unit 3: Counselling and Psychological support in HIV/AIDS*. Kenya: AMREF

Anderson, KG, Beutel, AM, Maughan-Brown, B. 2007. *HIV Risk Perceptions and First Sexual Intercourse among Youth in Cape Town. South Africa. International Family Planning Perspectives*. 33(3):98-105

Aral, L. Puskur, R, Mengesh, A, Tesema, E, Ali, Z. 2009. *Gender and HIV/AIDS mainstreaming in a market context: training manual for frontline staff* Adis Ababa: International Livestock Research Institute

Aral, SO, Douglas, JM, Handsfield, HH. 2008. *Behavioural interventions for prevention and control of sexually transmitted diseases*. Springer

Arthur, G, Nduba, V, Forsyth, S, Mutemi, R, Odhlambo, J, Gilk, C. 2007. Behaviour change in clients of health centre-based voluntary counselling and testing services in Kenya. *Sexually Transmitted Infections* 83(7):541-546

Ashton, J, Dickson, K, Pleaner, M. 2008. *The evolution of the National Adolescent-Friendly Clinic Initiative in South Africa*. World Health Organisation

Auzina, I, Kelle, I, Lapina, S, Lazdina, S, Potosova, A. 2003. *Youth friendly services: reproductive health and HIV prevention. Manual for healthcare providers*. Riga Latvia. UNAIDS, UNDP, UNFPA, WHO

Babbie, E. 2007. *The practice of social research. (9<sup>th</sup> ed)*. California: Wadsworth

Babbie, E, Mouton, J. 2009. *The practice of social research*. London: Wadsworth. Cengage Learning

Bernard, HR. 2006. *Research methods in anthropology: qualitative and quantitative approaches*. California: Altamira Press

Bowen, GA. 2008. Naturalistic inquiry and the saturation concept: a research note. *Qualitative Research*, 8 (1):137-152

Berry, L, Hall, K. [sa]. *Age at sexual debut. HIV and AIDS and STI National Strategic Plan 2007-2011*. Available at [www.childrencount.ci.org.za/uploads/NSP-age-at-sexual-debut.pdf](http://www.childrencount.ci.org.za/uploads/NSP-age-at-sexual-debut.pdf). (Accessed on 30/01/2012)

Bhana, J. 2006. VCT in Mozambique: which is the most effective? *The Southern African Journal of epidemiology and Infection* 21(3):70-147

Bock, ME. 2009. Factors influencing the uptake of HIV voluntary counselling and testing in Namibia. Masters dissertation. KIT (Royal Tropical Institutes). Development Policy and Practice. Vrije Universiteit, Amsterdam

Bosmans (2006). The potential of sports as a toll for a rights-based approach to HIV/AIDS. *Ghent University International Centre for*

*Reproductive Health.* Available at [www.toolkitssportdevelopment.org/html/resources/..Bosmans.doc](http://www.toolkitssportdevelopment.org/html/resources/..Bosmans.doc)  
(Accessed on 25/10/2011)

Boswell, D, Baggaley, R. 2002. Voluntary counselling and testing and young people: a summary overview. *Family Health International/USAID.*

Bourne, P. 2005. Sexual behaviour of the Jamaican adolescents. Available at [www.forums.joeuser.com/74861](http://www.forums.joeuser.com/74861) (Accessed 15/08/2011)

Botswana (Republic). *National Strategic Framework for HIV/AIDS 2003-2009.* Botswana

Bradely, H, Tsui, A, Kidanu, A Gillespie, D. 2010. HIV infection and contraceptive need among female Ethiopian voluntary HIV counselling and testing clients. *AIDS Care.* 22(10):1295-1304

Breakwell, G, Hammond, S, Fife-Schaw, S. 2000. *Research methods in psychology.* (3<sup>rd</sup> ed). London: Sage.

Cavaiola, AA, Colford, IE. 2011. *Crisis intervention case book.* Belmont: Brooks Cole Cengage

Centre for Disease Control 2011. School health programs. Improving the health of our nation. (Available on [www.dcd.gov/..dash.html](http://www.dcd.gov/..dash.html)). (Accessed on 03/01/2012)

Chilufya, AC. 2009. The impact of HIV and AIDS on education for orphans and vulnerable children in Zambia. *Oxfam Discussion Document.* Available at [www.oxfam.org](http://www.oxfam.org) (Accessed on 05/12/2011)

Collini, P & Obasi, A. 2006. Interventions to reduce HIV sexual transmission within discordant couples. *BMJ Publishing Group*

- Conelly, D, Veriava, Y, Roberts, S, Tsotetsi, J, Jordan, A, DeSilva, E, Rosen, S, DeSilva, MB. 2007. Prevalence of HIV infection and median CD4 count among care workers in South Africa. *South African Medical Journal*. 97(2):115-120
- Cresswell, JW. 2003. *Research design. Qualitative and quantitative and mixed methods approaches*. Thousand Oaks CA: Sage
- De Koker, P, Lefevre, P, Matthys, F, van der Stuyft, P, Delva, W. 2010. Barriers to VCT despite 13 years of community-based awareness campaigns in a peri-urban township in Northern Limpopo. *South African Medical Journal*. 100(6)
- De Graft-Johnson, J, Paz-Soldan, V, Kasote, A, Tsui, A. 2005. *Voluntary counselling and testing services preferences in a rural Malawi population*. *AIDS and Behaviour* 9(4):475-484
- De Haan, M, Dennhill, K, Vasuthevan, S. 2005. *The health of Southern Africa*. Juta
- De Vos, AS. 2005. *Research at grassroots for the social sciences and human services professions*. Pretoria: Van Schaik
- De Vos, AS. 2000. *Research at grassroots: a primer for caring professionals*. Pretoria: Van Schaik
- De Vos, AS. 1998. *Research at grassroots. A primer for the caring professionals*. Pretoria: Van Schaik
- Dickson-Teteh, K, Ashton, J, Silimperi, D, Moleko, W, Ladha, S. 2000. *Going for gold. A clinic guide to the National Adolescent Friendly Clinic Initiative*. Johannesburg: Reproductive Health Research Unit
- DiClemente, RJ, Crosby, RA, Kegler, M. 2009. *Emerging theories in health promotion practice and research*. San Francisco: John Wiley & Sons

DiClemente, RJ. 1992. *Adolescents and AIDS. A Generation in Jeopardy*. Sage Publications

DiClemente, RJ, Crosby, RA, Kegler, MC, Jossey-Bass, A. 2002. *Emerging theories in health promotion practice and research. Strategies for improving public health*. A Wiley

Donenberg, GR, Schwartz, RM, Emerson, E, Wilson, HW, Bryant, FB, Coleman, G. 2005. Applying a Cognitive-Behavioural Model of HIV Risk to Youths in Psychiatric Care. *AIDS Educ Prev*.17(3):200-216

EIA Training Resource Manual. 2002. (2<sup>nd</sup> ed). Social impact assessment tools and methods. (Available on [www.unep.ch/./EIA\\_E\\_top13\\_hd1.PDF](http://www.unep.ch/./EIA_E_top13_hd1.PDF)). (semi structured interviews low cost – social impact assessment tools and methods)

Elrulka, SA, Beksinska, M, Cebekhulu, Q. 2001. *An assessment of youth centres in South Africa*. (Available on [www.popcouncil.org/pdfs/frontiers/F...](http://www.popcouncil.org/pdfs/frontiers/F...)) (Accessed on 20/03/2009)

Experiment-Resources.com [sa]. (Available on [www.experiment-resources.com](http://www.experiment-resources.com)) (Accessed 2/04/2009)

Family Health International (2005). Service delivery models for HIV counselling and testing. FHI. Available on [www.fhi.org/NR/rdonlyres/ModelsofCTpager122706.pdf](http://www.fhi.org/NR/rdonlyres/ModelsofCTpager122706.pdf) (Accessed on 30/07/2009)

Fennie, T. 2011. An exploration of HIV/AIDS and risky sexual behaviour of first year psychology students at the University of the Western Cape. Masters Dissertation, University of Stellenbosch, Cape Town

Ferrand RA, Bandason T, Musvaire P, Larke N, Nathoo K, Mujuru H, Ndhlovu CE, Munyathi S, Cowan F, Gibb DM & Corbett EL (2010).

Causes of Acute Hospitalisation in Adolescence: burden and spectrum of HIV-related morbidity in a country with an early onset and severe HIV epidemic: a prospective survey. *PLoS Med* 7(2): e1000178

Fink, A. 1995. *How to sample in surveys*. New Delhi: Sage Publications

Francis 2010. They should know where they stand: attitudes to HIV voluntary counselling and testing amongst a group of out-of-school youth. *South African Journal of Education* 30(3):327-342

From Theory to Practice in Peer Education. Section 1[sa]. (Available on [www.cfsc.trunky.net/downloads.asp](http://www.cfsc.trunky.net/downloads.asp)) (Accessed on 20/052008)

Fossey, E, Harvey, C, McDermott, F. 2002. Understanding and evaluating qualitative resaech. *Australian and New Zealand Journal of Psychiatry*. 36:717-732

Global Business coalition on HIV/AIDS. *Leading business fight against HIV/AIDS*. (Available on [www.data.unaids.org/Topics/Partnerships-Menus/gbc\\_brochure\\_2003\\_en.pfd](http://www.data.unaids.org/Topics/Partnerships-Menus/gbc_brochure_2003_en.pfd)). Accessed on 30/09/2010

Grant, MJ. [sa]. HIV risk perception and the timing of adolescent sexual debut in Southern Malawi. (Available on [www.ppa2009.princeton.edu/download.aspx](http://www.ppa2009.princeton.edu/download.aspx)). (Accessed 16/03/2011)

Grant-Stuart, L, Livingston, J, Mngadi, B. 2006. Voluntary counselling and testing. *University KwaZulu Natal Medical Student Counselling Centre*. Available at: [www.scc.ukzn.ac.za/Libraries/med\\_school/VCT\\_-\\_Aug\\_Topic.sflb.ashx](http://www.scc.ukzn.ac.za/Libraries/med_school/VCT_-_Aug_Topic.sflb.ashx) (Accessed on 21/06/2011)

Harrison, A, Cleland, J, Gous, E, Frohlich, J. 2005. Early sexual debut among young men in rural South Africa: heightened vulnerability to sexual risk? *Sexually Transmitted Infections* 81(3):259-261

Health24. HIV and AIDS. (Available on [www.health24.com/medical/Condition\\_centres/777\\_792-1758,22170.asp](http://www.health24.com/medical/Condition_centres/777_792-1758,22170.asp)).

(Accessed on 21/08/2009)

*HIV/AIDS and TB Newsletter*. Newsletter from the National HIV/AIDS Programme. Pretoria. No. 20, 19. April 2002

Holden, S. 2004. *Mainstreaming HIV/AIDS into development and humanitarian programs*. Oxfam

Holloway, I, Wheeler, S. 2000. *Qualitative research in nursing (2<sup>nd</sup> ed)*. San Oxford: Blackwell

Hope, R. 2007. *Addressing cross-generational sex. A desk review of research and programs*. Population Reference Bureau. (Available on [www.prb.org/Reports/2007/addressingcrossgenerationalsex.aspx](http://www.prb.org/Reports/2007/addressingcrossgenerationalsex.aspx)).

(Accessed on 15/05/2009)

Huson, M. 2009. Managing HIV and AIDS on another level. Promotion of voluntary counselling and testing and stigma reduction through HIV/AIDS workplace policies in Ugandan NGOs. Masters Dissertation. University of Amsterdam. Amsterdam

Hutchinson PL & Mahlalela X. 2006. Utilization of Voluntary Counselling and Testing Services in the Eastern Cape, South Africa. *AIDS Care*, 18:446-455

India Ministry of Health and Family Welfare. 2004. *Voluntary counselling and testing operational guidelines 2004*. National AIDS Control Organisation



International Centre for Research on Women. 2012. *The issue: Women and HIV and AIDS*. Available on [www.icrw.org/what-we-do/hiv-aids](http://www.icrw.org/what-we-do/hiv-aids) (Accessed 13/02/2012)

Itech. [sa]. Available on [www.go2itech.org/HTML/CM08/toolkit/tools/...HIVART\\_2.ppt](http://www.go2itech.org/HTML/CM08/toolkit/tools/...HIVART_2.ppt). (Accessed on 126/072011)

Izumi, K. 2006. *Reclaiming our lives. HIV and AIDS, women's land and property rights and livelihoods in Southern and East Africa. Narratives and responses*. Human Sciences Research Council

Jaspan, HB, Soka, NF, Mathews, C, Flisher, Mark, D, Middelkoop, K, Wood Bekker, LG. 2010. A qualitative assessment of perspective on the inclusion of adolescents in HIV clinical trials in South Africa. *International Journal STD AIDS*. 21(3):172-176

Kaiser Family Foundation. 2008. HIV/AIDS Policy Fact Sheet. The HIV/AIDS epidemic in South Africa. October 2008. Available on [www.kff.org/./7365-065.pdf](http://www.kff.org/./7365-065.pdf) (Accessed on 26/07/2011)

Kaiser Family Foundation. 2006. HIV/AIDS Policy Fact Sheet. The global HIV/AIDS epidemic. May 2006. Available on [www.kff.org/hivaids/upload/3030-07.pdf](http://www.kff.org/hivaids/upload/3030-07.pdf) (Accessed on 26/07/2011)

Karim SS, Karim, QA. 2005. *HIV/AIDS in South Africa*. Cambridge: Cambridge University Press

Karim, SS, Churdhyard, G, Karim, QA, Lawn, SD. 2009. HIV infection and tuberculosis in South Africa: an urgent need to escalate the public health response. *The Lancet*. 374(9693):921-933

Kartikeyan, S, Bhamal, RN, Tiwari, RP, Bisen PS. 2005. *HIV and AIDS: basic elements and priorities*. Netherlands: Springer

Key Global Statistics on Young People. Available on [www.unpan1.un.org/intradoc/groups/public/documents/cafrad/unpan011375.pdf](http://www.unpan1.un.org/intradoc/groups/public/documents/cafrad/unpan011375.pdf) (Accessed on 28/12/2011)

Kothari, CR. 2008. *Research methodology: methods and techniques*. New Delhi: New Age International.

Laerd Dissertation [sa]. (Available on <http://dissertaion.laerd.com/articles/nonprobabilitysampling> (Accessed On 2/04/2009)

Lawoyin, OO & Kanthula, RM 2010. *Factors that influence attitudes and sexual behaviour among constituency youth workers in Oshama region, Namibia*. African Journal of Reproductive Health, Vol. 14 No. 1 2010

Lee-Rife, SM. *The educational trajectories of pregnant adolescents in South Africa*. [sa]. Department of Sociology and Population Studies Centre. University of Michigan. USA

LoveLife. 2006. *Report on Activities and Progress*. [SA]

LoveLife 2009. *Report on activities and progress 2009*. LoveLife 2009 Annual monitoring report

MacDowell, W., Bonell, C., & Davies, M.2006. *Health Promotion Practice: Understanding Public Health*. London: McGraw-Hill International

Macintyre, K, Rutenberg, N, Brown L, Karim, A. 2004. The perceptions of HIV risk among adolescents in KwaZulu Natal. *AIDS Behaviour*. 8(3):237-250

MacPhail, CL, Pettifor, A, Coats, T, Rees , H. 2008. You must do the test to know your status: attitudes to HIV VCT for adolescents among South African youth and parents. *Health Education and Behaviour*. 35(1):87-1-4

Madise, N, Zulu, E & Ciera, J. 2007. Is Poverty a driver for risky sexual behaviour? Evidence from national surveys of adolescents in four African countries. *African Journal of Reproductive Health*. 11:3 December 2007

Makabarasi, T, Kamenga, C, Murray, D, Micomyiza, P, Ngabonziza, M, Price J, Ndabamenye P. 2006. The effect of VCT on primary and secondary prevention of HIV/AIDS: presentation of data from Rwanda. Paper presented at International AIDS Conference 13-14 August

March, AL. 2006. Adolescent sexual debut, risk factors, protective factors, and health risk behaviours: rural, suburban, and urban differences. PHD thesis, State University of New York at Birmingham

Mason, J. 2002. *Qualitative researching*. (2<sup>nd</sup> ed). London:Sage

Mathinti, V, Simbayi, LC, Jooste, S, Kekana, Q, Nibe, XP, Shasha, L, Bidla, P, Magubane, P, Cain, D, Cherry, C, Kalichman, CS. 2005. Development of an HIV risk reduction counselling intervention for use in South African sexually transmitted clinics. *SAHARA* 2(2):267-276

Matubatuba, C. 2002. Defining an adolescent-friendly health reproductive service: and investigation among adolescents in Winterveld. Masters Dissertation. University of South Africa, Pretoria

Mavedzenge, SN, Doyle, A, Ross, D. 2010. HIV prevention in young people in sub-Saharan Africa: a systemic review. *SRG* 2(26). (Available on [www.schoolsandhealth.org/Documents/...](http://www.schoolsandhealth.org/Documents/...))

McCauley, AP. 2004. Equitable access to HIV counselling and testing for youth in developing countries. A review of current practice. *Horizons report*. Washington DC: Population Council

McMillan, JH, Schumacher, S. (2001). *Research in education: A conceptual introduction*. New York: Longman

Mengistu, AA, Kibret, MA, Nouga, A. 2011. Addressing the missed opportunity in family planning services through FP/HIV integration: the experience of Pathfinder International Ethiopia

Michael, B, Alexandria, V, Donald APB. 2004. (eds). *Education and HIV/AIDS. A source book of HIV/AIDS prevention programs*. Washington DC: World Bank

Middelkoop, K, Myer, L, Smit, J, Wood, R Bekker, LG. 2006. Design and evaluation of a drama-based intervention to promote voluntary counselling and testing in a South African community. *Sexually transmitted diseases*. 33(8):524-526

Millstein, SG, Halpern-Felsher BL (2002). Perceptions of risk and vulnerability. *Journal of Adolescent Health* 31(1):10-27

Mokabane, ME. 2010. Process evaluation of the Odi Youth Centre. Master of Public Health Dissertation, MEDUNSA, University of Limpopo

Morgan, AK, Drury, VB. 2003. Legitimising the subjectivity of human reality through qualitative research method. *The Qualitative Report* 8(1):70-80

Morin, SF, Khumalo-Sakutukwa, G, Charlebois, E, Vaki, T, Fiamma, A, Coates, TJ. 2006. Removing barriers to knowing HIV status. Same-day mobile HIV testing in Zimbabwe. *Journal of Acquired Immuno Deficiency Syndrome*. 41:218-224

Mphaya, JC. 2006. *Factors that motivate young people aged 14-25 years to go for voluntary counselling and testing for HIV in Malawi*. Masters Dissertation. University of South Africa, Pretoria

Mphuru, L Perchal, P, Barone, M, Luiola, G. [sa]. *Integration of voluntary counselling and testing for HIV into family planning and reproductive*

*health services in Arusha Region Tanzania*. USAID. (Available on [www.ihsph.nts.jhu.edu/..Mphuru\\_addis.pdf](http://www.ihsph.nts.jhu.edu/..Mphuru_addis.pdf)). (Accessed on 27/08/2011)

Mukabarasi, T, Kamenga, C, Murray, D, Ngabonziza, J, Price, J, Ndabameye, P. 2006. *AIDS 2006. XVI International AIDS Conference. Abstract No. THPE0336*

Munthali, A, Chimbiri, A, Zulu, E. 2004. *Adolescent Sexual and Reproductive Health in Malawi. A Synthesis of Research Evidence. Occasional Report No. 15*. Washington. The Allan Guttmacher Institute

Musemwa, S. 2011. *Factors influencing university students' use of HIV counselling and testing services: an analysis using the health belief model*. Masters dissertation, Nelson Mandela Metropolitan University, Port Elizabeth

Mutale, W, Michelo, C, Jurgensen, M, Fylkesnes, K. 2010. Home-based voluntary HIV counselling and testing found highly acceptable and able to reduce inequalities. *BMC Public Health* 10:347

Mwale, M. 2008. Behavioural change vis-à-vis HIV/AIDS knowledge mismatch among adolescents: the case of selected schools in Zomba. *Nordic Journal of African Studies*. 17(4):228-229

Nachmias, CF, Nachmias, D. 1996. *Research methods in the social sciences*. (5<sup>th</sup> ed). London: Arnold

National Health Department Cluster HIV/AIDS and TB. 2002. *Voluntary Counselling and Testing for HIV: An entry point to prevention and care interventions in South Africa*

Negin, J, Wariero, J, Mutuo, P, Jan, S, Proryk, P. 2009. Feasibility, acceptability and cost of home-based HIV testing in rural Kenya. *Tropical Medicine and International Health* 14(8):849-855

- Neuman, WL. 2003. *Social research methods: qualitative and quantitative approaches*. (4<sup>th</sup> ed). Boston: Allyn & Bacon
- Njagi, F, Maharaj, P. 2006. Access to voluntary counselling and testing services: perspectives of young people. *South African Review of Sociology* 37(20:111-127
- Nelson Mandela Foundation/HSRC. (2005). South African National HIV Prevalence, HIV incidence, behaviour and communication survey
- Nsabagasani , X, Yoder, S. 2006. Social dynamics of VCT and disclosure in Uganda. *Measure Demographic and Health Surveys*
- Obiajulu, AC. 2010. Knowledge, attitude and practice of voluntary counselling and testing (VCT) for HIV/AIDS amongst the health professionals in Umpumulo Hospital, Mapumulo, Ilembe district, KwaZulu Natal province. Masters dissertation, University of Limpopo
- Patterson, J, Watson, C. 2003. Healthy generation. Children in their early years: many get a poor start. *School of Public Health and Epidemiology*. University of Minnesota. Minneapolis
- Peacock, D, Redpath, J, Weston, M, Evans, K, Daub, A & Greig, A. 2008. *Literature review on men, gender, health and HIV and AIDS in South Africa*. Johannesburg: Sonke Gender Justice Network
- Pettifor, A E, Rees H V, Steffenson, A, Hlongwa-Madikizela, L, MacPhail, C, Vermaak, K & Kleinschmidt I. 2004. *HIV and Sexual Behaviour Among Young South Africans: a national survey of 15-24 year olds*. Johannesburg Reproductive Health Unit, University of the Witwatersrand
- Phorano, OD, Nthomang, K, Ntseane, D. 2005. *Alcohol abuse, gender-based violence and HIV/AIDS in Botswana: establishing the link on empirical evidence*. Journal of Social Aspects of HIV/AIDS (2) 1:188-202

Pope, C, Zielbland, S, Mays, N. 2000. Qualitative research in healthcare. Analysing qualitative data. *BMJ* 320:114-116

Reach Out. 2010. *Accepting my HIV status*. Reach Out Newsletter. Issue No. 39 April-July 2010

Rew, L. 2005. *Adolescent Health. A multidisciplinary approach to theory, research and intervention*. Sage Publications. California

Rinke de Wit, TF, Van der Borght, S, Schim-vander Loef, M, Clevenbergh, P, van Cranenburg, K, Rijckborst, H. 2006. Determinants of VCT uptake in 5-year Heineken HAART programme in Africa. *International AIDS Society. 16<sup>th</sup> International AIDS Conference. Toronto, Canada. August 13-18 2006*

Ritchie, J, Lewis, J. 2003. *Qualitative research practice: a guide for social science students and researchers*. California: Sage

Rohleder, P, Swartz, L, Kalichman, CS, Simbayi, LC, Cameroon, E. 2009. HIV/AIDS in South Africa 25 years on: psychosocial perspectives. London: Springer

Rubin, A, Babbie, ER. 2010. *Research methods for social work*. London: Cengage Learning

Rural Centre for AIDS/STD Prevention. *Behaviour Change Models for Reducing HIV/STD Risk*. Fact Sheet No. 3, 1995

Sarantakos, S. 2005. *Social Research. (3<sup>rd</sup> ed)*. Palgrave MacMillan

Schoster, B, Callahan, LF, Meier, A, Mielenz T DiMartino, L. 2005. The people with arthritis can exercise (PACE) program: a qualitative evaluation of participant satisfaction. *Preventing Chronic Disease Public Health, Research, Practice and Policy*. 2(3)

Schutt, RK. 2006. *Investigating the social world. The process and practice of research.* 5<sup>th</sup> ed. California: Pine Forge Press

Seal, C. (ed). 2004. *Researching society and culture.* London: Sage

Sefularo, M. August 2002. Speech at the launch of the National Adolescent Friendly Clinic Initiative. Makapanstad. (Available on [www.info.gov.za/./02080210461004.htm](http://www.info.gov.za/./02080210461004.htm)). Accessed on 3/03/2008

Setswe, G. 2009. *Models of HIV counselling and testing in SADC.* HSRC

Shank, GD. 2006. *Qualitative research: a personal skills approach. (2nd ed).* Upper Saddle River, NJ: Pearson

Shenton, KA. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Infomation.* 22:63-75

Shisana, O., Rehle, T., Simbayi, LC., Zuma, K., Jooste, S., Pillay-Van-Wyk, V., Mbelle, N., Van Zyl, J., Parker, W., Zungu, NP., Pezi S., & the SABSSM III *Implementing Partners.* 2009. *South African national HIV prevalence, incidence, behaviour and communication survey 2008: A turning tide among teenagers?* Cape Town: HSRC Press

Shisana, O, Rehle, T, Simbayi, LC, Parker, W, Zuma, K, Bhana, A, Connoly, C, Jooste, S, Pillay, V. (eds). 2005. *National HIV/AIDS prevalence, incidence, behaviour and communication survey.* Cape Town: Human Sciences Research Council Press

Silverman, D. 2010. *Doing qualitative research.* London: Sage Publications

Solomons V, Van Rooyen, H, Griesel, R, Gray, D, Stein, J, Nott, V. 2004. *Report. Critical Review and Analysis of Voluntary Counselling and Testing Literature in Africa.* Durban: Health Systems Trust



South Africa (Republic) Department of Health, 2010. National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009

South Africa (Republic) Department of Health. 2001. *Policy guidelines for youth and adolescent health*. Pretoria: Department of Health

South Africa (Republic). Department of Social Development & Mabitsela, O. [sa]. *Adolescent health services in South Africa NAFCI – The National Adolescent Friendly Clinic Initiative*. South Africa Good Practice

South Africa (Republic). Department of Health. *HIV & AIDS and STI Strategic Plan for South Africa (NSP2000-2005)*.Pretoria: Department of Health

South Africa (Republic). Department of Health. *HIV & AIDS and STI Strategic Plan for South Africa (NSP2007-2011)*: Pretoria Department of Health

South Africa (Republic). Department of Health. 2010. *National HIV Counselling and testing (HCT) guidelines*. Pretoria. Department of Health

South Africa (Republic). Department of Health. *National Strategic Plan on HIV, STI & TB 2012-2016*: Pretoria Department of Health

South Africa (Republic). Department of Basic Education 2010. *Integrated Strategy on HIV and AIDS 2011-2015. Summary Report*. Pretoria: Department of Basic Education

Statistics South Africa 2010. *Mid-year population estimates 2010*. Pretoria:Statistics South Africa

StopTB[sa]. Available on [www.stoptb.org/wg/tb\\_hiv/assets/doc](http://www.stoptb.org/wg/tb_hiv/assets/doc) (Accessed on 21/06/2011)

Tanzania Ministry of Health and Social Welfare (2008). *HIV and AIDS voluntary counselling and testing. Module 5: Counselling, care and treatment*. Tanzania

The Manager's Electronic Resource Centre: Management Sciences for Health. Managing integrated services. (Available on [http://erc.msh.org/staticpages\\_printerfriendly/2.2.5\\_health\\_English\\_.htm](http://erc.msh.org/staticpages_printerfriendly/2.2.5_health_English_.htm)). (Accessed on 16/09/2010)

The Stephen Lewis Foundation. 2012. *HIV/AIDS: Key statistics*. (Available on [www.stephenlewisfoundation.org/assets](http://www.stephenlewisfoundation.org/assets))

The Transitions to Adulthood Study Team. 2004. *Transitions to adulthood in the context of AIDS in Africa: The Impact of Exposure to Life Skills Education on Adolescent Knowledge, Skills, and Behaviour*. Horizons Final Report. Washington DC: Population Council

Thyer, BA. 2001. *The handbook of social work research methods*. California: Sage

Uganda (Republic). Ministry of Health 2005. *HIV counselling and testing. A national counsellor training manual*. Kampala

United Nations. 2011. High level meeting on youth. General Assembly. 25-26 July 2011

United Nations Entity for Gender Equality and Empowerment of Women. *Latest data and statistics. Gender equality, women and HIV/AIDS*. Available on [www.unwomen.org/wp-content/uploads](http://www.unwomen.org/wp-content/uploads) (Accessed on 01/02/2012)

U.S Global Health Policy 2011. *The global HIV/ AIDS epidemic*. Fact sheet November 2011. Available on [www.kff.org](http://www.kff.org) (Accessed on 02/01/2012)

USAID. 2009. *HIV/AIDS. Prevention across the spectrum*. (Available on [www.usaid.gov/our\\_work/global\\_health/aids/TechAreas/prevention/youth/youthfactsheet.html](http://www.usaid.gov/our_work/global_health/aids/TechAreas/prevention/youth/youthfactsheet.html)). (Accessed on 30/09/2010)

UNAIDS 2010. *Global report. UNAIDS report on the global AIDS epidemic*

UNAIDS 2010. *Fact Sheet: Women, girls and HIV*. (Available on [www.data.unaids.org/pub/Fact Sheet/2010](http://www.data.unaids.org/pub/Fact Sheet/2010)). (Accessed on 11/09/2009)

US Global Health Policy 2011. *The global hiv/AIDS epidemic. The Fact Sheet*. (Available on [www.kff.org](http://www.kff.org)). (Accessed on 10/01/2012)

Van Dyk, AC. 2008. *HIV/AIDS care and counselling*. Cape Town: Maskew Miller Longman

Van Teijlingen, ER, Hundley, V. (2001). The importance of pilot studies. *Social Research Update. Sociology of Surrey*. Issue 35. (Available on [www.sru.soc.surrey.ac.uk/SRU35.html](http://www.sru.soc.surrey.ac.uk/SRU35.html)). (Accessed on 2/02/2008)

Welope, I & Owino, P (eds). 2007. *The Intersection of Human Capital, Gender and HIV/AIDS in the African Context*. Frankfurt: Peter Lang. [www.unaids.org](http://www.unaids.org) (Accessed on 11/09/2009)

Woken, MD. [sa]. Advantages of a pilot study. (Available on [www.uis.edu/./ctlths7.pdf](http://www.uis.edu/./ctlths7.pdf)). Accessed on 02/02/2008)

Volkwyn, S. 2010. The knowledge, attitudes, beliefs and reported sexual behaviour in relation to HIV/AIDS amongst adolescents in a general practise population in Port Elizabeth. *African Journal of Primary Health Care and Family Medicine*. Available on <http://www.phcfm.org/index.php/phcfm/thesis/view/40> (Accessed on 21/06/2011)

WHO 2006.HIV/AIDS program. Strengthening health services to fight HIV/AIDS. Antiretroviral therapy for HIV infection in adults and adolescents: recommendations for public health approach

WHO 2007. *HIV/AIDS program. Strengthening health services to fight HIV/AIDS. Guidance on provider-initiated testing and counselling in health facilities*. Switzerland: World Health Organisation

Wiles, R, Crow, G, Heath, S, Charles, V. 2006. Anonymity and confidentiality: setting the scene. (Available on [www.ccsr.uk/./wiles.ppt](http://www.ccsr.uk/./wiles.ppt)). (Accesses on 11/09/2009). Confidentiality and anonymity 'related but distinct concepts' – page number

Wodi, BE. (2005). HIV/AIDS knowledge, attitudes and opinions among adolescents in the River States of Nigeria. *International Electronic Journal of Health Education*. 8:86-94

Women Deliver: Fact Sheets on Young People. [sa]. *Young People Worldwide*. Deliver for Youth. Youth Working Group

World Health Organisation. 2008. *Making health systems work. Integrated health services. What and why*. Technical Brief No.1. 2008

World Health Organisation. 2003. *Annexes*. [www.who.int/./adherence\\_annexes.pdf](http://www.who.int/./adherence_annexes.pdf) (Accessed on 20/04/2011)

World Health Organisation. 2005. *Alcohol use and sexual risk behaviour: a cross sectional study in eight countries*. Geneva: World Health Organisation

Wusu, O, Okoukoni, S. 2009. The role of HIV counselling and testing in sexual health behaviour change among undergraduate students in Lagos, Nigeria. *Tanzania Journal of Health Research* 13(1):32-39

Zambuko, O, Mturi, AJ. 2005. Sexual risk behaviour among the youth in the era of HIV/AIDS in South Africa. *Journal of Biosocial Science*. 37(5)569-584

Zuma, K, Setswe, G, Ketye, T, Mzolo, T, Rehle, T Mbelle N. 2010. Age at sexual debut: a determinant of multiple partners among South African youth. *African Journal of Reproductive Health*. 14(2):47-54

[http://www.unicef.org/russia/youth\\_health\\_development\\_10747.html](http://www.unicef.org/russia/youth_health_development_10747.html)

[http://www.unicef.org/russia/youth\\_health\\_development\\_10747.html](http://www.unicef.org/russia/youth_health_development_10747.html)

[www.globalhealth.org](http://www.globalhealth.org) (Accessed 2/02/2008)

[www.care.co.za/..HIVtestedit.pdf](http://www.care.co.za/..HIVtestedit.pdf) (Accessed 14/08/2011)

[www.ecdoh.gov.za/press\\_releases.asp](http://www.ecdoh.gov.za/press_releases.asp). (Accessed on 20/03/2009)

[www.emro.who.int/GFATM/guide/vct/vct1.html](http://www.emro.who.int/GFATM/guide/vct/vct1.html) (Accessed on 2/04/2009)

[www.hsrc.ac.za/HSRC\\_Review\\_Article](http://www.hsrc.ac.za/HSRC_Review_Article). (Accessed on 15/09/2009)

[www.starfishcharity.org/general-content.aspx?id\\_Content=193](http://www.starfishcharity.org/general-content.aspx?id_Content=193). (Accessed on 2/4/2009)

[www.mediaclubsouthafrica.com](http://www.mediaclubsouthafrica.com) (Accessed on 12/04/2009)

[www.unicef.org/programme/breastfeeding/hiv.htm](http://www.unicef.org/programme/breastfeeding/hiv.htm) (Accessed on 2/04/2009)

## **APPENDICES**

Appendix A: UNISA ethical clearance letter

Appendix B: Letter requesting access - Pretoria

Appendix C: Letter approving research - Pretoria

Appendix D: Letter requesting access - Ekurhuleni

Appendix E: Letter approving research – Ekurhuleni

Appendix F: Participant consent form

Appendix G: Parental consent form

Appendix H: Assent form

Appendix I: Interview schedule

## APPENDIX A

Department of Sociology  
College of Human Sciences  
13 March 2008

**Proposed title:** *The uptake of voluntary counselling and testing by adolescents aged 15- to 19-years at an integrated adolescent-friendly clinic in Pretoria, South Africa*

**Principal investigator:** Lindelwa Ndzombane, (student no.4360 3610)

**Reviewed and processed as:** Class approval (see paragraph 10.7 of the UNISA Guidelines for Ethics Review)

**Approval status recommended by reviewers:** Approved

The Ethics Subcommittee of the College of Human Sciences has reviewed your proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines:

- To only start this research study after obtaining informed consent from your research participants
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To work in close collaboration with your supervisor(s) and to record the way in which the ethical guidelines as suggested in your proposal has been implemented in your research
- To notify the Ethics Subcommittee in writing immediately if any change to the study is proposed and await approval before proceeding with the proposed change
- To notify the Ethics Subcommittee in writing immediately if any adverse event occurs.

Approvals are valid for ONE academic year after which a request for a continuation of the approval must be submitted to your supervisor(s).

Kind regards

G E Du Plessis (Dr)  
M & DPhil Coordinator  
Department of Sociology  
Tel + 27 12 429 6507

## **APPENDIX B**

7 Coral Street  
Mayberry Park  
Alberton, 1448

26 August 2008

The Director  
Department of Health  
Pretoria Region C  
PO Box 9514  
Pretoria 0001

### **RE: Permission to conduct research at an adolescent friendly clinic**

My name is Lindelwa Ndzombane a student at UNISA, studying towards a Masters degree in Social Behaviour Studies in HIV/AIDS. As part of the degree, I am required to conduct a research project. The title of my research project is "An investigation of the uptake of voluntary counselling and testing by adolescents aged 15-19 at an integrated adolescent friendly clinic in Pretoria, South Africa". I would like to request permission to conduct this study at an adolescent friendly clinic in Pretoria.

Attached to this letter is the research proposal.

Yours sincerely

Lindelwa Ndzombane



# APPENDIX C



DEPARTMENT OF HEALTH  
PRETORIA REGION C  
P.O.BOX 9514  
PRETORIA  
0001

Enquiries: M van Nickerk  
Tel: 303-9038 / 9003

27 April 2009

ATTENTION : Ms OL Volkwyn  
Director - Tshwane Metro

CC : Dr. S Oosthuizen

FROM : Mrs. M van Nickerk  
Assistant Director: HRD

Re : Permission for L.Ndzombane to do research in an adolescent friendly clinic

Could you please look at the above mentioned request and consider for permission?  
Ethical approval has been given. I am waiting for a signed copy.

  
M van Nickerk  
AD: Training

  
Ms. OL Volkwyn / Dr. Oosthuizen

Permission granted / 004-granted

## APPENDIX D

7 Coral Street  
Mayberry Park  
Alberton, 1448

19 May 2009

Manager, Epidemiology  
Ekurhuleni Health Department  
PO Box 4  
Alberton 1450

### **RE: Permission to conduct research at an adolescent friendly clinic**

I am a student at UNISA, studying towards a Masters degree in Social Behaviour Studies in HIV/AIDS. As part of the degree, I am required to conduct a research project. The title of my research project is "An investigation of the uptake of voluntary counselling and testing by adolescents aged 15-19 at two integrated youth friendly clinics in Gauteng, South Africa". This study was initiated at an adolescent friendly clinic in Pretoria but was interrupted due to logistical problems. I am therefore requesting permission to conduct this study in Ekurhuleni District.

Attached to this letter is the research proposal guiding the study.

Yours sincerely

Lindelwa Ndzombane

# APPENDIX E



## RESEARCH ETHICS CLEARANCE CERTIFICATE



**Research Project Title:** Investigation of the uptake of VCT by adolescents aged 15-19 years at an integrated youth-friendly clinic in the Ekurhuleni Health District  
**Research Project Number:** 012/2009

**Name of Researcher(s):** Ms L. Ndzombane

**Division/Institution/Company:** UNISA

**Co-Researcher(s):** None

**DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT ETHICS PANEL (HEDEP)**  
THIS DOCUMENT CERTIFIES THAT THE ABOVE RESEARCH PROJECT HAS BEEN FULLY APPROVED BY THE ETHICS PANEL (RESEARCHERS) MAY THEREFORE COMMENCE WITH THE INTENDED RESEARCH PROJECT

NOTE THAT THE RESEARCHER WILL BE EXPECTED TO PRESENT THE RESEARCH FINDINGS OF THE PROPOSED RESEARCH PROJECT AT THE ANNUAL EKURHULENI RESEARCH CONFERENCE HELD IN JULY/AUGUST

- THE ETHICS PANEL WISHES THE RESEARCHER(S) THE BEST OF SUCCESS

**CHAIRPERSON, EKURHULENI HEALTH DISTRICT ETHICS PANEL**  
*Boyd (Dr S. Sepuya)*  
Dated: 09/04/2010

**RESEARCH COORDINATOR, EKURHULENI METROPOLITAN MUNICIPALITY**  
*Boyd (Dr S. Sepuya)*  
Dated: 07/04/2010

**RESEARCH COORDINATOR, GAUTENG DEPARTMENT OF HEALTH (REGION B)**  
*P. R. Kellerman*  
Dated: 07/04/2010

## APPENDIX F

Dear participant

My name is Lindelwa Ndzombane. I am studying towards a Masters degree in Social Behaviour Studies in HIV/AIDS at the University of South Africa. As part of my studies, I am conducting a research project entitled "*An investigation of the uptake of voluntary counselling and testing by adolescents ages 15-19 at an adolescent friendly clinic in Gauteng, South Africa*". The purpose of this research project is to understand the factors that motivate adolescents aged 15-19 to seek voluntary counselling and testing.

I am requesting that you participate in this study. The interview will last approximately 45 minutes. Participants will be asked some questions, and in order to ensure accuracy and avoid misrepresenting the information given, the researcher will tape record and take notes of the interview. Participants have an option to refuse being tape recorded.

Confidentiality will be ensured and transcripts and tape recorded interviews will be accessible only to the researcher and her supervisor and will be destroyed on completion of the study. No names will be used in the final report.

There are no direct benefits in participating in this study but the information you give will be used in a research report. It will also contribute to policy and program design. Participation in this interview is voluntary and the participants have a right to withdraw any time before or during the interview. If you choose to participate, please sign the attached consent form and keep this letter for your records.

If you have any questions please contact Ms E Koen at the University of South Africa on 0124296600 or myself on 0728933149.

**Consent to participate in a research project**

I have read the attached informed consent letter and agree that my child take part in the research entitled *“An investigation of the uptake of voluntary counselling and testing by adolescents ages 15-19 at an adolescent friendly clinic in Gauteng, South Africa”*

Child’s name (please print) .....

Parent/ guardian’s name (please print).....

Parent/ guardian’s signature .....

Date .....

## APPENDIX G

Dear parent/ guardian

My name is Lindelwa Ndzombane. I am studying towards a Masters degree in Social Behaviour Studies in HIV/AIDS at the University of South Africa. As part of my studies, I am conducting a research project entitled *“An investigation of the uptake of voluntary counselling and testing by adolescents ages 15-19 at an adolescent friendly clinic in Gauteng, South Africa”*. The purpose of this research project is to understand the factors that motivate adolescents aged 15-19 to seek voluntary counselling and testing.

I am requesting that you allow your child to participate in this study. The interview will last approximately 45 minutes. Participants will be asked some questions, and in order to ensure accuracy and avoid misrepresenting the information given, the researcher will tape record and take notes of the interview. Participants have an option to refuse being tape recorded.

Confidentiality will be ensured and transcripts and tape recorded interviews will be accessible only to the researcher and her supervisor and will be destroyed on completion of the study. No names will be used in the final report.

There are no direct benefits in participating in this study but the information you give will be used in a research report. It will also contribute to policy and program design. Your name will not be included in the report. Participation in this interview is voluntary and the participants have a right to withdraw any time before or during the interview. If you choose to allow your child to participate, please sign the attached consent form and keep this letter for your records.

If you have any questions please contact Ms E Koen at the University of South Africa on 0124296600 or myself on 0728933149.

**Consent to participate in a research project**

I have read the attached informed consent letter and agree that my child take part in the research entitled *“An investigation of the uptake of voluntary counselling and testing by adolescents ages 15-19 at an adolescent friendly clinic in Gauteng, South Africa”*

Child’s name (please print) .....

Parent/ guardian’s name (please print) .....

Parent/ guardian’s signature.....

Date .....

## APPENDIX H

My name is Lindelwa Ndzombane. I am studying towards a Masters degree in Social Behaviour Studies in HIV/AIDS at the University of South Africa. I am conducting research that aims to understand the factors that motivate people in your age group to seek voluntary counselling and testing. If you decide to participate in this study, you will be asked a few questions and the interview will last approximately 45 minutes and will be recorded. You can refuse to be recorded.

Your parents/ guardian are aware that you are taking part in this study. There are no direct benefits in participating in this study but the information you give will be used in a research report. It will also contribute to policy and program design. Your name will not be included in the report.

You are not forced to take part in this study, therefore, if you want to stop before or during the interview, we will do so. If you have any questions feel free to contact Ms Elize Koen on 0214296600.

I .....give  
assent to be interviewed as part of this research project.

Signature .....

Date .....



## **APPENDIX I**

My name is Lindelwa Ndzombane. I am a Masters student at University of South Africa. This research follows the university's requirements. Any information you will supply will be treated with absolute confidentiality.

The interview will take approximately 20 minutes.

### **A. Background and biographical information**

1. Tell me about yourself
  - 1.1. How old are you?
  - 1.2. Are you still at school?
  - 1.3. Do you work?
  - 1.4. Where do you live?
  - 1.5. Are you married?
  - 1.6. Are you in a relationship?
  - 1.7. Who do you live with?
2. Do you have children?
3. Please tell me about your social life
  - 3.1. Do you have friends?
  - 3.2. What do you do in your spare time?
  - 3.3. Do you talk to your neighbours?
4. Who are the most important people in your life?
  - 4.1. Please explain

### **B. Adolescents' knowledge about HIV and AIDS**

1. Have you ever heard about HIV/AIDS?
  - 1.1. What is it?
  - 1.2. When was the first time you heard about it?
  - 1.3. Who told you about it?

- 1.4. What did they say about it?
- 1.5. What came to your mind when you first heard about it?
- 1.6. How can one get HIV?
- 1.7. What does HIV do to a person?
2. Who can get HIV?
  - 2.1. Can boys and girls get it?
  - 2.2. How can they get it?
  - 2.3. What can they do to make sure they do not get it?
3. Have you ever talked about HIV and AIDS with your parents/ guardian/partner?
  - 3.1. If not – please tell me what are the reasons why you do not talk about it
  - 3.2. If yes – please tell me what you talk about regarding HIV and AIDS.
4. Have you ever discussed about HIV and ADS with your friends?
  - 4.1. If yes, please tell me what you discuss regarding HIV and AIDS
5. Have you ever talked about HIV and AIDS with your neighbours?
  - 5.1. What do you and your neighbours talk about regarding HIV and AIDS?
6. Have you ever known anyone who is living with HIV?
  - 6.1. If yes, please tell me more about how you felt about that person?

**C. Adolescents' knowledge about VCT and its benefits**

1. Have you ever heard about VCT?
  - 1.1. What is it?
  - 1.2. When was the first time you heard about VCT?
  - 1.3. How did you hear about VCT (please tell me the occasion)
2. Since you know about VCT, have you ever discussed about VCT with your parents/ guardian?
  - 2.1. If not – what are the reasons the reasons for not discussing VCT with your parents?

- 2.2. If yes – please tell me what it is about VCT that you discuss with your parents?
- 2.3. Have you and your friends ever discussed about VCT?
- 2.4. If in a relationship, do you and your partner ever talk about VCT?
- 2.5. If yes, please tell me what you talk about?
- 3. Probe according to responses

**D. Adolescents' support system, ability to make own decisions and factors that motivate VCT uptake**

- 1. Please tell me, have you ever tested for HIV?
  - 1.1. If yes – what made you decide to test?
  - 1.2. How long ago did you test?
  - 1.3. Who did you talk to before you went to test for HIV?
  - 1.4. What were the reasons for telling this person?
  - 1.5. If no - would you like to know your HIV status?
  - 1.6. If you would like to know your HIV status – please explain why you would like to know your status
  - 1.7. If you would not like to know your HIV status – please explain why this is so
- 2. Please tell me who you would talk to if you decided to test for HIV?
  - 2.1. What are the reasons for choosing this person?
  - 2.2. What do you think this person would say if you told them you were going for and HIV test?
  - 2.3. What would you do if this person told you not to test for HIV?
  - 2.4. In general, what do you think are the reasons why young people your age test for HIV?
  - 2.5. Do you know where one can get an HIV test?
  - 2.6. How did you know this?
- 3. (If you are in a relationship), who makes decisions in your relationship?
  - 3.1. Generally, in a relationship between a man and a woman, who makes decisions about sex – condoms – VCT

- 3.2. Please tell me what you think is the reason for this?
- 3.3. Would you suggest VCT to your partner – when?
- 4. Please describe the relationship between you and your friends/ parents/ guardians/ neighbours

**E. General information on risky behaviour**

- 1. Do you think girls and boys should have more than one partner at a time?
  - 1.1. Please explain
  - 1.2. What do your friends think about having more than one partner at a time?
- 2. What do you think about girls and boys who use drugs and drink alcohol?
  - 2.1. Do you sometimes use them?
- 3. What is your opinion regarding using condoms?

**F. Closure**

Is there anything that you would like to say in connection with what we have discussed today?

**G. Word of thanks**

Thank you for taking your time to participate in this study. You have been very helpful. Let me remind you once again that everything you said will remain confidential.

