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THE PERCEPTIONS AND EXPERIENCES OF HIV TESTING SERVICE COUNSELLORS WITH PROVIDING HIV COUNSELLING AND TESTING AT THREE COMMUNITY SITES IN SOUTH AFRICA

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A research report submitted to the Faculty of Health Sciences (School of Public Health), University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master in Public Health in the field of Social and Behaviour Change Communication

4 June 2019, Johannesburg

Declaration

I, **Zuzelle Changuion Pretorius**, declare that this research report is my original work. Any work done by other persons has been properly acknowledged in the text. The report is submitted in partial fulfilment of the requirements for the Degree of Masters in Public Health (MPH) at the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted for any other degree or examination in this or any other University.

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Date: 4 June 2019

Abstract

Introduction

HIV Testing Services (HTS) represents a critical entry point for reducing HIV risk through personalised counselling and testing (Colpin, 2006, Denison et al., 2008; Fonner, 2014). Despite the significant uptake of HTS since 2010, personal risk perception among South Africans remains low, with individuals continuing to engage in risky sexual behaviour (Statistics South Africa, 2017). This raises concerns about the quality and effectiveness of HTS in reducing HIV risk among HTS clients. In seeking to understand how best to strengthen HTS, lay counsellors who work at the forefront of HTS provision are primary targets for inquiry. This study sought to explore the experiences and perceptions of community-based HTS lay counsellors of providing HTS, the strategies they use to reduce HIV risk among diverse clients, and their perceptions of HTS training and supervision.

Methods

Qualitative semi-structured interviews were conducted with 12 community-based HTS counsellors at three government-accredited HTS sites in Gauteng and North West provinces. Ethical clearance was obtained in April 2015 and the interviews were conducted from July-October 2015. Interviews were audio-recorded, professionally transcribed, and coded using MaxQDA. Inductive and deductive thematic analysis was used to meet the study objectives.

Results

The HTS lay counsellors came from diverse personal and educational backgrounds. Their HTS training was not standardised, differing in scope, depth, and duration. Their sector influenced their scope of practice, remuneration and relationship with the Department of Health. HTS Counsellors tended to follow a client-centred approach to HIV counselling; balancing general HIV education with more tailored prevention counselling. Gender norms appeared to influence risk-reduction counselling, in which counsellors advised men to use condoms and women to be faithful to their partners. Counsellors resisted the notion of differential risk among HTS clients, and offered generic, simplified prevention messages tailored to clients' age and gender. Counsellors seldom explored known risk factors for HIV infection, such as alcohol and drug

abuse, anal sex, and gender-based violence with clients. They prioritised post-test counselling for HIV-positive clients and tended to neglect post-test counselling for HIV-negative clients. . Counsellors recommended regular in-service training, enhanced supervision and debriefing, and formal recognition of the field through establishing standardised guidelines, career paths and a professional body.

Discussion

This study confirms previous research on the sub-optimal quality of risk-reduction counselling, which varies between sites and counsellors. Although HTS counsellors follow the nationally prescribed, client-centred approach, there is limited evidence that this approach effectively reduces HIV risk (Peltzer et al., 2013). In contrast, theory-based approaches, such as Motivational Behavioural Interviewing, which has effectively reduced unprotected sex, alcohol use before sex, number of sexual partners, and transactional sex among high risk groups globally and in South Africa (Petersen et al., 2014, Simbayi et al., 2004).were largely absent in HTS programmes covered in this study.

The HTS lay counsellors in this study are among those who have contributed significantly to the rapid scale up of HTS in South Africa. However, they identified structural challenges detrimental to their work performance and motivation. HTS counsellors are not formally recognised or included within national human resources for health plans, and their job profiles and remuneration are not standardised. The inconsistent management and unfair treatment described by counsellors in this study has been reported across the country (Medecins Sans Frontieres, 2015).

Conclusions

The major recommendations that emerged from this study include the need for the government to create a supportive legal and policy framework to guide the integration of HTS counsellors into the formal health care system. This could happen by establishing a professional body for HTS counsellors and updating the minimum standards for HTS. Quality could be improved by training counsellors on use of individual and social theories of behaviour change (Petersen et al., 2014) and standardising HTS training curricula at national levels. Strengthening HTS

supervision to ensure quality HTS counselling and testing nationally is also needed. Overall, this study confirmed that further research is needed to improve the quality of risk reduction interventions in HTS and develop a coherent framework for the integration of lay counsellors into the South African health and social service sectors.

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List of acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CB-HCT	Community-Based HIV Counselling and Testing
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CSO	Civil Society Organisation
CYCW	Child and Youth Care Worker
DOH	Department of Health
FETC	Further Education and Training Certificate
FPD	Foundation for Professional Development
GBV	Gender-Based Violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HTS	HIV Testing Services
IDI	In-Depth Interview
KZN	KwaZulu-Natal
LTC	Linkage to Care
MCP	Multiple Concurrent Partnerships
MSM	Men who have Sex with Men
NACCW	National Association of Child and Youth Care Work
NBCRFLI	National Bargaining Council for the Road Freight and Logistics Industry

NCD	Non-Communicable Diseases
NGO	Non-Governmental Organisation
NQF	National Qualifications Framework
NSP	National Strategic Plan for HIV, Sexually Transmitted Infection (STIs) and Tuberculosis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
QA	Quality Assurance
RCT	Randomised Control Trials
SA	South Africa
SADC	Southern African Development Community
SAMA	South African Medical Association
SANAC	South African National AIDS Council
SAQA	South African Qualifications Authority
SBC	Social Behaviour Change
SOW	Scope of Work
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex workers
TASO	The AIDS Support Organisation
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development

VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Chapter 1: Introduction

1.1 Overview

This chapter provides a background to the study covered in this report. In the background, I give an overview of the HIV (human immunodeficiency virus) epidemic in South Africa and review progress in national efforts to scale up HIV counselling and testing (HCT) services in South Africa (SA). It defines the problem this study tackles and explains the rationale, aims, and objectives of the research. The chapter also includes a literature review, which provides an analysis of available scholarly evidence around the effectiveness of HCT in changing sexual risk behaviour and highlights gaps in current HCT research and practice both globally and within SA. Further, it describes how behaviour change theory may be used to enhance academic and practical understanding of the psychosocial factors that affect individual behaviour, including HIV risk and how resulting insights may be used to design appropriate interventions to reduce HIV risk among HCT clients in South Africa and the broader sub-Saharan African region.

1.2 Background

Thirty years into the global AIDS (acquired immunodeficiency syndrome) pandemic, HIV prevention continues to be a top priority within South Africa. East and southern Africa remain the world regions most affected by HIV and account for more than half (53%) of the world's 36.9 million [31.1–43.9 million] people living with HIV (PLHIV) (UNAIDS, 2018). In South Africa, 7.9 million people (nearly one in five adults) are HIV positive, and there were an estimated 231,100 new infections in 2017—down from 500,000 at the country's peak incidence in 2005 (UNAIDS, 2017b). South Africa also has the sixth highest tuberculosis (TB) burden in the world; nearly 60% of HIV-positive patients are also diagnosed with TB (UNAIDS, 2017b). The AIDS epidemic is concentrated in a number of provinces and districts in the country, and HIV prevalence ranges from 27.0% in KwaZulu-Natal to 12.6% in the Western Cape (HSRC, 2018).

HIV affects some populations more than others. Since 2004, HIV prevalence among pregnant women has stabilised at 29%, and adolescent girls and young women (AGYW) are currently the population group most affected (South African National AIDS Council (SANAC), 2015). In 2016, HIV prevalence among AGYW ages 15 to 24 years was nearly four times greater than that of men the same age and comprised 37% of all new infections in SA, despite AGYW representing only 13% of the adult population (UNAIDS, 2017a). Concentrated sub-epidemics

have also been observed among populations such as sex workers (SW), men who have sex with men (MSM), injecting drug users (IDU), and migrants (UNAIDS, 2017b). For example, national HIV prevalence is 58% among SW and 27% among MSM (UNAIDS, 2017b, Scheibe et al., 2011). Although national data are unavailable, small scale, bio-behavioural surveys have estimated HIV prevalence rates of 3% to 35% for IDU in urban areas, and 28% to 39% among cross-border migrant farm labourers in Limpopo and Mpumalanga provinces (International Organisation for Migration, 2010). HIV risk among these sub-populations is compounded by stigma and discrimination, as well as by limited access to essential HIV prevention, treatment, and care services (Scheibe et al., 2011, UNAIDS, 2014b, International Organisation for Migration, 2010).

South Africa's epidemic is largely driven by heterosexual sexual transmission and is exacerbated by underlying behavioural, socio-cultural, economic, and structural factors that influence HIV transmission (Bekker et al., 2012, Shisana et al., 2014). Such factors include early sexual debut, lack of knowledge of HIV status, inconsistent condom use (especially in longer-term relationships and during pregnancy/post-partum), intergenerational sex, multiple and concurrent sexual partnerships, low prevalence of male circumcision, alcohol and drug use, sexual and gender-based violence (GBV), population mobility and migration, economic and educational status, discrimination and stigmatisation, and additional gender dynamics (e.g. unequal power relations between men and women) (PEPFAR, 2018).

The latest statistics show high levels of HIV risk behaviours. Male respondents aged 15 to 49 reported having had 14.7 (mean) lifetime sexual partners; with 72 % of males in the study having had two or more sexual partners (17%) or intercourse with a person who was not their spouse or primary partner in the past year (55%), with approximately two thirds using condoms in these sexual encounters (Statistics South Africa, 2017). Even though reported risk behaviours were slightly lower among women in the same study, 50% of women reported having had more than two sexual partners (5%) or had sex with someone who were not their main partner (45%) in the past year with 59% using condoms in these relationships (Statistics South Africa, 2017).

HIV counselling and testing (HCT) is an integral part of HIV prevention globally and serve as an entry point to treatment, care and support for people living with HIV.[1]. HCT gained particular

[1] HCT is an umbrella term used globally and in SA prior to 2016. It describes services that combine both HIV counselling and testing. HCT can be client- or provider initiated. It should be voluntary, requires informed consent,

prominence in 2014 with the launch of the UNAIDS Global 90-90-90 strategy, which introduced fast-track treatment targets to end the global AIDS pandemic by 2030. According to this strategy, certain goals should be reached by 2020: 90% of all PLHIV would know their HIV status, 90% of people diagnosed with HIV would receive ART, and 90% of those taking ART would be virally suppressed (UNAIDS, 2014a). Increasing the number of PLHIV who know their HIV status is a key priority in both the 2012-2016 and the 2017-2022 *South African National Strategic Plans (NSP) for HIV, Sexually Transmitted Infections (STIs), and TB* (Republic of South Africa, 2012, South African National AIDS Council (SANAC), 2016). The NSP advocates a comprehensive response to HIV prevention and treatment.

HCT contributes directly to the 2017-2022 NSP's goal to reduce new infections of HIV, TB, and STIs by increasing the general population's knowledge of their individual HIV statuses and acting as a critical entry point for HIV prevention and HIV, TB, and STI treatment and care services. For the first time, the 2017-2022 NSP also prioritises services to key populations, such as SW and MSM, given their role in current epidemic dynamics (South African National AIDS Council (SANAC), 2016). According to the NSP, the government aims to test more than 10 million people annually to ensure 85% of PLHIV know their status and all HIV-positive clients immediately enrol in ART (South African National AIDS Council (SANAC), 2016). To achieve this, the government has committed to ensuring universal access to HCT at clinics, homes, workplaces, schools, prisons, and local communities (Republic of South Africa, 2012). Regardless of whether HCT is client- or provider-initiated, the National Department of Health (DOH) (2016c) notes HCT should be voluntary and require pre- and post-test counselling, informed consent, and respect for client confidentiality.

HIV Testing Service (HTS) pre- and post-test counselling provide an unique opportunity to educate clients about HIV, engage them in meaningful dialogue about their sexual and other risk behaviours, assess their personal risk of HIV infection, and help them make informed choices that may prevent the acquisition or onward transmission of the virus (Colpin, 2006). HCT has

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counselling and respect for client confidentiality. In 2016, the South African Department of Health broadened the term to HIV Testing Services (HTS) to reflect the full range of services that should be provided alongside HIV testing. These include counselling (pre-test information and post-test counselling); linkage to HIV prevention, treatment, care, and other clinical services; and coordinating with laboratory services for quality assurance and the delivery of accurate testing results. This study was conducted in 2015. In this study the term HCT will be used to describe the process of HIV pre-test counselling, HIV testing to know your HIV status and tailored post test counselling) as counselling is a primary factor in determining whether or not risk reduction will occur post HCT.

been shown to reduce an individual's risk of contracting HIV by motivating individuals to decrease their number of sexual partners and consistently and correctly use condoms (Denison et al., 2008, Fonner et al., 2014). HTS programmes may further reduce risk by promoting access to biomedical HIV prevention interventions, for example voluntary medical male circumcision (VMMC), prevention of mother-to-child transmission (PMTCT), Pre-Exposure prophylaxis (PrEP), sexual and reproductive health (SRH) services, and medical treatment of TB and STIs (Colpin, 2006, Auvert B et al., 2013, Chang et al., 2013). In case of an HIV-positive diagnosis, HTS post-test counselling aims to provide HIV-positive clients with tools to help them accept their diagnosis and manage its consequences (Haffejee et al., 2010). Post-test counselling thus focuses on coping strategies, disclosure, prevention of onward transmission of the virus, and accessing ART, PMTCT, TB treatment, and mental health or psychosocial support services (Haffejee et al., 2010, Chang et al., 2013).

Across the country, HCT is available at approximately 7,900 health facilities and government-accredited, community-based HTS sites (Department of Health, 2018).. The majority of HTS services are provided by nurses and HTS lay counsellors—a cadre of community health workers trained specifically for counselling and testing tasks without acquiring a professional or para-professional degree or certificate (Medecins Sans Frontieres, 2015). HTS lay counsellors are contracted by the Department of Health or non-governmental organisations (NGOs) on short-term contracts or as volunteers on stipends, funded by government or international donors (Medecins Sans Frontieres, 2015).

1.3 Problem statement

Despite the successful scale up HTS and the large number of South Africans who participated in HTS (82% of women and 69% of men), individuals' risk perception remains low, with people continuing to engage in high risk sexual behaviours (Statistics South Africa, 2017). This raises concern about the quality and effectiveness of HIV counselling in HTS in increasing individual risk perception and reducing HIV risk among HTS clients (Denison, et. al., 2008, Fonner, et.al.,2014).

Explanations about why HTS is not sufficient are varied, but not comprehensive. According to Kok et al. (2014), inappropriate training and poor supervision can negatively affect the quality of care provided by community health workers (CHW). Research by Peltzer et al. (2013), Mohlabane (2015), and Mwisongo (2015) also found that HTS in routine care is sub-optimal;

HTS counsellors often inconsistently adhere to national counselling and testing protocols. In addition, HTS training is not standardised across provinces, with the duration, content, and depth of training varying between provinces and service providers. Quality-assurance systems for HTS also appear to be inadequate and include only limited supervision of HTS lay counsellors due to human resource constraints, strictures on funding, and competing health priorities (Department of Health, 2014, Medecins Sans Frontieres, 2015). These studies have largely focused on health systems factors.

Examples of successful HTS have also been noted. Research shows that HCT, as one component of a comprehensive HIV prevention programme, can reduce individual HIV risk through personalised counselling, increasing knowledge about HIV, encouraging HIV testing, increasing condom use, and reducing the number of sexual partners among HCT clients compared to people who did not receive HCT (Denison et al., 2008; Fonner et al., 2014). A systematic review by Petersen et al. (2014) demonstrated that lay counsellor lead risk reduction counselling based on the Information, Motivation, and Behavioural (IMB) Skills Model effectively reduced HIV risk behaviours (e.g. unprotected sex, alcohol use before sex, number of sexual partners, and transactional sex) among high-risk groups. These counsellors were supported by rigorous training and regular supervision.

Given the above, scholars and practitioners have struggled to understand the disconnect between HTS, risk perception and health behaviours. Some scholars have identified inefficiencies within HTS as a potential culprit—particularly insufficiencies around HTS counsellor training and supervision. In this study, I take HTS as a critical site of investigation and interrogate the perceptions and experiences of HTS lay counsellors as they go about their daily intervention practice.

1.4 Justification for study

HTS lay counsellors are at the forefront of HIV service delivery in South Africa (Dlamini, 2011, Visser and Mabota, 2015). They engage clients on a daily basis, educate them about HIV and AIDS, assist clients with learning their HIV sero-status, promote sexual risk reduction, help those infected and affected by HIV cope with the emotional and social impacts of an HIV positive diagnosis, and promote the uptake of HIV prevention, treatment, and care services (Dlamini, 2011, Visser and Mabota, 2015). A qualitative , exploratory study using semi structured in-depth interviews was conducted to enable HTS counsellors to provide an “insider” view of what

actually happens during HIV pre and post test counselling and identify opportunities for strengthening the quality of counselling within HTS programmes.

Public health literature in southern Africa has focussed primarily on strategies to increase HTS uptake, with less attention given to the quality of HTS counselling (Mohlabane et al., 2015). Although a number of qualitative studies explored counsellors' perceptions of and experiences with HCT, their work contexts, and the emotional impact of their work, it has concentrated mostly on lay counsellors in the public sector (Mohlabane et al., 2015, Mwisongo et al., 2015, Peltzer and Davids, 2011, Dlamini, 2011, Visser and Mabota, 2015). Few studies have been conducted in SA with community-based HTS counsellors who provide door-to-door HTS, mobile HTS and outreach to high-risk groups in high-prevalence communities and focussed on lay counsellors approaches to reducing HIV risk behaviour among clients, as articulated by lay counsellors themselves (Magasana et al., 2016, Doherty et al., 2013, Knight et al., 2015). Given the significant scale up of community-based HTS in recent years and the quality concerns raised by Peltzer et al. (2013), Mohlabane et al. (2015), and Mwisongo et al. (2015), there is a need to explore community-based HTS counsellors' perceptions of, experiences with, and thoughts about providing HCT to diverse clients in everyday practice.

This study was designed to provide a qualitative understanding of how community-based HTS is delivered on the ground. This included what specific information is given to clients; what approaches HTS counsellors use to assess clients' risk and facilitate risk reduction among diverse clients, how they link clients to HIV prevention, treatment, and care services; and what HTS counsellors think about the quality of training and supervision they received to equip them for HTS programming. In doing this, the research sought to identify gaps in and opportunities for strengthening HTS policy, training, supervision, and counselling practice. The study therefore has the potential to contribute to improving the quality and effectiveness of HTS programmes in South Africa.

1.5 Research question

How do HTS counsellors' perceptions and experiences influence provision of HIV counselling and testing services to diverse clients at government accredited community-based HTS sites in South Africa?

1.6 Study aim and objectives

The aim of this study was to explore HTS counsellors' perceptions of and experiences with providing HIV counselling at three NGO-managed community-based HTS sites in two provinces of South Africa (Gauteng and North West) in 2015.

Specific objectives of the study include the following:

1. To describe HTS counsellors' background, motivations for becoming counsellors, and personal experiences with and views on providing HIV counselling and testing to HIV-positive and HIV-negative clients at three NGOs in Gauteng and North West provinces in 2015.
2. To describe HTS counsellors' approaches to counselling clients, including specific tactics they use to reduce HIV risk behaviour among different types of HTS clients (e.g. youth, long-distance truck drivers, sex workers) at three NGOs in Gauteng and North West provinces in 2015.
3. To describe HTS counsellors' experiences with and opinions of HIV counselling and testing training and supervision at three NGOs in Gauteng and North West provinces from their initial employment through 2015.
4. To elicit HTS counsellors' recommendations for strengthening HTS policy, training, and counselling practice.

1.7 Literature review

1.7.1 Overview

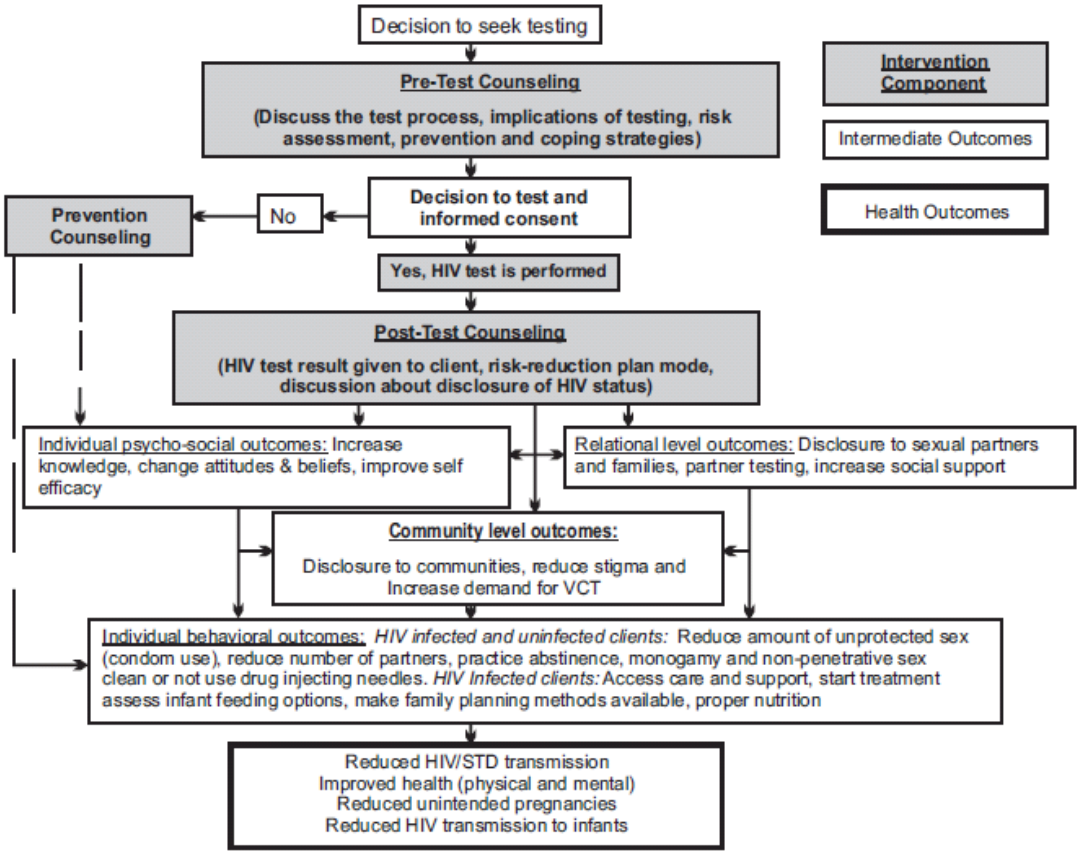
The literature review presents a brief analysis of available scholarly evidence around the effectiveness of HCT in changing sexual risk behaviour and highlights gaps in current HCT research and practice both globally and within SA, with a particular focus on the role of lay counsellors. The review describes how behaviour change theory can potentially enhance our understanding of the psycho-social factors that affect individual behaviour and how these insights may be used to design appropriate risk reduction interventions for HCT clients in South Africa and the broader sub-Saharan African region. It further reviews current HTS practice, including HIV counselling, HTS counsellor training and supervision in an effort to understand the disconnect between HTS, risk perception and actual real life behaviours.

1.7.2 HTS and HIV risk behaviour

Systematic reviews and meta-analyses by Weinhardt et al. (1999), Denison et al. (2008), and Fonner et al. (2014) have investigated the effects of HIV counselling and testing (knowing your status) in HTS on behavioural risk reduction in developed and developing countries. These reviews confirmed that HCT is not only an important gateway to HIV prevention, treatment, and care, but directly contributes to HIV prevention outcomes (Denison et al., 2008, Fonner et al., 2014).

HCT in particular appears to be more effective at secondary prevention than primary prevention. Weinhardt's (1999) meta-analysis of 27 HCT studies, published in developed countries from 1985 to 1997, found that after participating in HCT, HIV-positive participants and sero-discordant couples decreased their risk of infecting others through increasing their condom use (Weinhardt et al., 1999). However, participants who received an HIV-negative test result did not modify their sexual risk behaviour any more than people who had not received HCT (Weinhardt et al., 1999). HCT thus appears to be an effective secondary HIV prevention strategy through reducing risk behaviour among HIV-positive clients, but not among HIV- negative clients (Weinhardt et al., 1999).

In an effort to explain how HCT influences HIV risk behaviour, Denison et al. (2008) developed a model of HCT intervention components and outcomes (see Figure 1 below). They hypothesised that HCT components in pre- and post-test counselling (including prevention counselling), combined with HIV rapid testing and knowing one's HIV status, influence several intermediate outcomes, such as enhancing clients' HIV risk reduction knowledge, attitudes, beliefs, and behaviours. They also suggested that such services affected relationship (e.g. disclosure and social support) and community level outcomes (e.g. increased demand for HCT and reduced stigma). These altered outcomes, in turn, may reduce the risk of HIV infection and improve the physical and mental health status of HCT clients and their partners (Denison et al., 2008) (see Figure 1.1 below).



(Source: Denison et al., 2008)

Figure 1.1: HCT intervention components and outcomes

Notably, HCT appears to be more effective in reducing some HIV-related risk behaviours (e.g. condom use) than others. Denison and colleagues' (2008) meta-analysis of seven eligible studies from developing countries, published between 1990 and 2005, highlighted that participating in HCT and knowing one's HIV status had a moderate but statistically significant effect on reducing HIV risk behaviour. Compared to their behaviours prior to HCT, or to participants who did not receive HCT, HCT recipients, regardless of their HIV status, were significantly more likely to use condoms after receiving HCT (OR=1.69; 95% CI 1.25–2.31). However, HCT did not have a statistically significant effect on the number of sexual partners (OR=1.22; 95% CI 0.89–1.67) (Denison et al., 2008).

A follow-up systematic review and meta-analysis by Fonner et al. (2014) confirmed Denison and colleagues' (2008) findings: HIV-positive HCT clients were significantly more likely to increase

condom use with their sexual partners when compared to people who did not receive HCT (OR=3.24; 95% CI 2.29-4.58). However, Fonner et al. (2014) found a statistically insignificant increase in the odds of condom use/protected sex among all participants who received HCT, compared to those who did not receive HCT (OR=1.39; 95% CI 097-1.99). In contrast to Denison et al. (2008), Fonner et al. (2014) established that HCT clients (regardless of their HIV sero-status) were also more likely to reduce their number of sexual partners when compared to people who did not receive HCT at all (OR=0.69; 95% CI 0.53-0.90). Fonner et al. (2014) explained that the inclusion of additional studies in their meta-analysis may have enhanced the statistical power of their study. They added that, although HIV disclosure was less common among HIV-positive than HIV-negative clients, HCT did not significantly increase the risk of negative life events, such as violence or discrimination (Fonner et al., 2014).

More recent HCT studies have emphasised the importance of HCT being incorporated into a broader package of HIV prevention services to reduce HIV incidence. A systematic review by Rosenberg et al. (2016) on the effect of HCT on HIV acquisition among HIV-negative clients in sub-Saharan Africa concluded that despite intensive regional scale up of HCT over the past two decades, the simple, individual behavioural messaging of common HCT campaigns did not consistently or substantially prevent HIV acquisition among HIV-negative persons. In contrast, HCT efforts focussed on couples significantly reduced HIV risk (Rosenberg et al., 2016). When HIV-negative people tested together as a couple or HIV-negative women in sero-discordant relationships tested with their partners, both partners in the relationships learned their HIV status simultaneously and received tailored counselling based on their HIV statuses. In such instances, Rosenberg et al. (2016) found that couple HCT reduced HIV acquisition risk by approximately half through consistent condom use. Rosenberg et al. (2016) cautioned that the majority of studies included in their analysis were conducted in the late 1990s and early 2000s, prior to findings that voluntary medical male circumcision and pre-exposure prophylaxis (PrEP) reduce the risk of HIV acquisition among HIV-negative clients. They recommended that HCT scale up should serve as a platform for promoting and increasing referrals to biomedical prevention interventions and services such as VMMC and PrEP to reduce HIV incidence (Rosenberg et al., 2016).

Collectively, these studies demonstrate that HCT can potentially reduce the risk of HIV acquisition and transmission by affecting intermediate outcomes, such as condom use and the

reduction of sexual partner numbers, when compared to individuals who did not receive HCT. However, HCT interventions appear to be more effective for PLHIV and sero-discordant couples than people who test negative (Weinhardt et al., 1999, Rosenberg et al., 2016, Denison et al., 2008, Fonner et al., 2014).

Limitations in HCT research

The authors of the above systematic reviews and meta-analyses of the efficacy of HCT in reducing sexual risk behaviour highlight a number of limitations in HCT research that may affect the interpretation of results (Weinhardt et al., 1999, Rosenberg et al., 2016 , Denison et al., 2008, Fonner et al., 2014).

Denison et al. (2008) and Fonner et al. (2014) raise concerns about the quality of study designs. The majority of studies in their reviews were outcome studies and used cross-sectional surveys that relied on self-reported behaviour and did not control for co-founders (Denison et al., 2008, Fonner et al., 2014).The rigour score of studies analysed varied from one to six out of eight, with an average rigor score of three out of eight, which demonstrates the need for more rigorous behavioural research in countries most affected by the HIV epidemic (Denison et al., 2008, Fonner et al., 2014).

Rosenberg et al. (2016) also acknowledge that assessing the impact of HCT on HIV acquisition is methodologically challenging; it requires large cohorts to be followed for long periods, which is time consuming and costly. The effect of HCT cannot be determined through randomised control trials (RCT), since the deliberate withholding of HCT is unethical (Rosenberg et al., 2016). In addition, HCT studies tend to focus primarily on the measurement of behavioural outcomes with limited information about how intervention components were implemented, e.g. which counselling strategies were employed during pre- and post-test counselling and what methods were most effective in facilitating behaviour change (Denison et al., 2008). This type of information is required by policy makers, trainers, and HCT counsellors to improve the quality and effectiveness of HCT.

Finally, the majority of HCT studies included in these systematic reviews were not guided by theories of social and behaviour change (Weinhardt et al., 1999). This atheoretical approach contrasts with contemporary HIV prevention approaches, in which researchers examine the effects of an intervention on the theoretical determinants of risk behaviour (Weinhardt et al.,

1999). Some scholars have noted that understanding which psychological factors (e.g. HIV-related knowledge, attitudes, and skills; perceived social norms; and intentions for behaviour change) have the strongest influence on HIV risk behaviours, and how such factors may affect HIV testing, would help researchers understand the mechanisms behind behaviour change and guide the development and refinement of effective prevention interventions (Denison et al., 2008).

Although a number of quantitative and qualitative studies are available on HIV counselling and testing services by lay counsellors in South Africa, few national studies exist. The 2013 national assessment of HCT services in SA by the Human Science Research Council is the exception. The study was conducted at 67 Government accredited HCT sites in eight provinces (excluding North West). It included observational assessments at 46 government and 21 NGO and private sector/workplace sites in 8 provinces with derivative research based on data from the 2013 national assessment. Other studies focussed primarily on lay counsellors' perceptions of and experiences with HCT, their work contexts, and the emotional impact of their work (Mohlabane et al., 2015, Mwisongo et al., 2015, Peltzer and Davids, 2011, Dlamini, 2011, Visser and Mabota, 2015). Few studies explored the perspectives of community HTS counsellors with regard to their counselling approaches to reducing HIV risk among high-risk groups in high-prevalence communities as articulated by lay counsellors themselves (Magasana et al., 2016, Doherty et al., 2013, Knight et al., 2015). Given the significant scale up of community-based HTS in recent years and the quality concerns raised by Peltzer et al. (2013), Mohlabane et al. (2015), and Mwisongo et al. (2015), there is a need for qualitative research to provide a thick description of HTS counsellors' perceptions of, experiences with, and thoughts about providing HCT to diverse clients in everyday practice.

1.7.3 Theoretical support for HCT?

Human behaviours, including sexual behaviour, are complex; different meanings are ascribed to sex in different societies, cultures, and relationships (Colpin, 2006). As a result, individual HIV risk behaviour is influenced by multiple factors, including individual knowledge, attitudes, emotions, and risk perceptions at the individual level; power dynamics in relationships; social and cultural norms (e.g. around masculinity, multiple sexual partners, and condom use); and structural factors, such as the accessibility of services, economic and gender inequalities, and the marginalisation or criminalisation of vulnerable groups (Colpin, 2006). Understanding these

complexities and the context within which individual risk behaviours occur is critical for developing appropriate, effective, and evidence-based interventions to reduce HIV risk.

Theories of social and behaviour change can help to understand and predict behaviour change; in relation to HCT, these insights can influence how counsellors approach their role in reducing HIV risk among clients. Theories of social and behavioural change (SBC) offer health care practitioners and social scientists opportunities to understand these complexities and design appropriate prevention interventions. Theory presents a systematic way of understanding events, behaviours, and situations (Glanz and Rimer, 2005). According to Glanz and Rimer (2005), theory is a set of concepts, definitions, and propositions that explain or predict events, situations, or behaviours by specifying relationships among different variables. A theory becomes formalised after it has been carefully tested, the results are replicable in a number of different settings, and it can be generalised to various communities (Glanz and Rimer, 2005). Theory helps scholars understand why people engage in risky sexual behaviours and often provides the basis for designing HIV prevention interventions to reduce these risks (Noar, 2007). It can help practitioners to improve the efficacy and effectiveness of behaviour change interventions. SBC theories used in HIV prevention are drawn from several disciplines, including psychology, sociology, anthropology, consumer behaviour, and marketing (Glanz and Rimer, 2005).

Promoting healthy individual behaviours is a key element of HCT. Noar (2007) provides a useful overview of individual-level theories for understanding HIV risk behaviour. For example, he discusses stage theories, such as the Trans Theoretical Model (TTM), which describe the process of behaviour change and explain the stages through which an individual moves over time—from not contemplating change, through testing a new behaviour, and finally to engaging consistently in it (Noar, 2007). Other SBC theories are not as explicit about this change process, but rather focus on which psychosocial factors explain or predict individual behaviour (Noar, 2007). Although the conceptualisation of some variables (e.g. attitudes and social norms) differ between theories, the following constructs are common to most SBC theories: individual beliefs and attitudes towards the behaviour, skills, self-efficacy, perceptions of social norms, and behavioural intentions (Noar, 2007). Thus, the theories suggest that a person is more likely to engage in a health behaviour when he holds a positive attitude, is supported by positive social norms and have strong intentions towards engaging in a specific behaviour (Noar, 2007). Nearly all SBC theories emphasise the importance of an individual's beliefs and attitudes toward behaviours

socially construed as safer (e.g. does the person believe that adopting the behaviour will have benefits?).[2] Many also focus on the ideas of skills[3] (e.g. can the behaviour be successfully undertaken?); self-efficacy[4] (e.g. does the person feel confident in his or her ability to undertake the behaviour?); social norms[5] (e.g. does the person feel it is socially acceptable to adopt the behaviour?); and behavioural intentions,[6] a concept similar to "readiness to change" in the stages of change model (e.g. how much effort a person is willing to apply to implement a specific behaviour or achieve a goal).

The role of risk perception in risk reduction

HCT counsellors have a particular role to play in addressing HIV risk perceptions. A core construct for many public health behaviour change theories is the concept of risk perception. According to the Health Belief Model (HBM), people who believe that they are at risk of acquiring a disease or illness and that the consequences of doing so may be severe (perceived severity), will be more likely to engage in protective behaviours (Glanz and Rimer, 2005). Risk perception is also an important predictor of risk behaviour in other SBC theories, such as the Social Cognitive Theory (SCT), the Extended Parallel Process Model (EPPM), the Protection Motivation Theory (PMT), and the AIDS Risk Reduction Model (ARRM) (Noar, 2007). Although perceived risk alone is insufficient to motivate behaviour change, many models suggest it is a necessary component for behaviour change.

One dynamic HCT counsellors should contribute to is aligning personal risk perceptions with actual risk. Several researchers have found that individual HIV risk perception may be inaccurate or even at odds with an individual's actual risk of HIV infection (Maughan-Brown and Venkataramani, 2018, Corneli et al., 2014). For instance, when comparing individual longitudinal data from a Cape-area panel study, Maughan-Brown and Venkataramani (2018) found no association between risk perception among young black African women in Cape Town in 2005

[2] The Health Belief Model (HBM), Social Cognitive Theory (SCT), the Theory of Reasoned Action (TRA), Theory of Planned Behaviour (TPB), and the Protection Motivation Theory (PMT) share the assumption that attitudes and beliefs, as well as expectations of future events and outcomes, are major determinants of health-related behaviour.

[3] The Trans Theoretical Model (TRM), AIDS Risk Reduction Model (ARRM), Information-Motivation- Behavioural Skills model (IMB) and Theory of Gender and Power (TGP) models highlight the importance of sexual communication skills and assertiveness in behaviour change

[4] Self-efficacy is an essential component of behaviour change in the HBM, TRA, TPB, TTM, IMB and TGP.

[5] Social norms can influence individual behaviour according to the HBM, TRA, TPB, SCT, TTM, IMB, TGP, and PAPM.

[6] Behavioural intentions are relevant in the HBM, TRA, TPB, SCT, TTM, IMB, MDM, EPPM, PMT, TGP, and PAPM.

and their HIV test results four years later. While more than 60% of respondents in both the 2005 and 2009 studies perceived themselves to be at “no” or “small” risk of HIV infection, approximately a quarter of these women tested HIV positive (Maughan-Brown and Venkataramani, 2018). Even individuals at substantial risk of HIV infection may underestimate their risk. Corneli et al. (2014) found that 52% of the young women who sero-converted during a FEM-PrEP study in Pretoria, South Africa, and in Bondo, Kenya,[7] perceived themselves to be at "no risk" of acquiring HIV in the four weeks prior to sero-conversion (Corneli et al., 2014). These findings demonstrate that individuals' HIV risk perception can be inaccurate and may be driven by an incomplete understanding of epidemiological risks or be influenced by psychosocial factors unrelated to the individual's sexual behaviour.

Mechanisms that may influence a person’s risk perception have been identified. Corneli et al. (2014) identified a range of risk protection and risk rationalisation strategies that made participants feel invulnerable. These include partial adoption of HIV protective behaviours (e.g. using condoms inconsistently) and "protective reasoning" (e.g. acknowledging risk, but rationalising the need to worry by making assumptions about their partners' HIV status and fidelity). Such reasoning creates the false perception that a person is not at risk of HIV infection and that it is safe to discontinue protective behaviours, which then increases a person’s risk of HIV infection (Corneli et al., 2014). HCT potentially offers a space where these misperceptions could be explored and addressed.

Warren et al. (2018) also found that although HIV risk perception is key in explaining inconsistent or non-use of HIV prevention interventions, it is mediated by contextual factors beyond concerns about disease prevention. For example, the use of prevention methods, such as condoms, MMC, PrEP, and HTS, are also influenced by the type of relationship a person has, the symbolic meaning of a specific prevention intervention, and the personal, social, emotional, and economic costs or risks associated with adopting specific prevention methods (Warren et al., 2018). This finding is important because it acknowledges that:

> HIV prevention decisions thus occur in a context that can either restrain or enable individual choice, and that decisions about HIV and HIV prevention forms part of a much

[7] Inclusion criteria for participation in the FEM PrEP study included having had vaginal sex at least once in the past two weeks or having had sex with more than one sexual partner in the past month.

> larger, complex hierarchy of concerns extending beyond disease and entering into deeply personal domains of love, trust, economic security, and values. (Warren, 2018: 2)

This is important also in terms of acknowledging the limits of what HCT can address.

The Information-Motivation-Behavioural (IMB) Skills Model

One theoretical framework that has been successfully applied globally in HIV risk reduction interventions, as well as in South Africa, is the Information-Motivation-Behavioural (IMB) Skills Model. According to the IMB Skills Model, a person will be more likely to adopt HIV/STI preventative behaviours if he or she is well informed, motivated to act, and has the required skills to act effectively (Fisher and Fisher, 1992). Within the model, HIV risk reduction interventions are considered most effective when they are population-specific and address the specific information, motivational, and behavioural barriers that an individual faces in changing his or her risk behaviour (Fisher and Fisher, 1992). To reduce the risk of HIV infection, a person must: a) have relevant information about HIV transmission and HIV prevention methods; b) be motivated to reduce his or her HIV risk or adopt preventative behaviours; and c) have the necessary behavioural skills, tools, strategies, and self-efficacy to successfully negotiate condom use with a specific sexual partner before and during sex (Fisher and Fisher, 1992). All three components must be present for effective behaviour change; without behavioural skills, even well-informed and motivated individuals may find it difficult to modify their sexual risk behaviour (Fisher and Fisher, 1992). According to the IMB Skills Model, counsellors need to engage clients in a collaborative, client-centred discussion (using motivational interviewing techniques). In this engagement, they assist the client to assess his/her sexual risk behaviour and identify specific IMB barriers that may prevent the client from consistently engaging in safer sex; they explore possible strategies that the client could use to address unique and specific barriers, and then negotiate an individually tailored, achievable behaviour change goal with the client (Cornman et al., 2008).

While lay counsellors are critical in delivering this model, it does not reflect standard HCT. One of the most convincing studies of the potential of IMB-based counselling to reduce HIV risk was the 1998 United States' Centers for Disease Control and Prevention (CDC) Project RESPECT Randomised Control Trial (RCT). This study demonstrated that two 20-minute client-focussed HIV risk reduction counselling sessions and voluntary testing reduced STI infections by 30%

over six months and 20% at 12 months among STI clinic patients when compared to participants who received physician-led, didactic information messaging (Kamb et al., 1998). Multiple interactions with the same counsellor is not standard practice. However, HIV risk reduction counselling based on the IMB Skills Model has also been successfully piloted at selected STI and HCT sites in South Africa. The intervention, called Phaphama (meaning "Be Wise" or "To wisen up"), was adapted to South African cultural circumstances in 2003 and has proven effective in reducing HIV risk in multiple contexts. HCT programs based on the IMB skills model reduced HIV and STIs and alcohol abuse among STI clinic patients (Simbayi et al., 2004, Kalichman et al., 2011, Kalichman et al., 2007, Mathiti et al., 2005). A systematic review of 29 South African studies by Petersen et al. (2014) further demonstrated that lay counsellor-led behaviour change interventions based on adaptations of the IMB Skills Model was feasible and effectively reduced a range of HIV risk behaviours, such as unprotected sex, alcohol use before sex, number of sexual partners, and transactional sex (Petersen et al., 2014). Despite its effectiveness in reducing HIV risk in various pilot studies in SA and efforts by the HSRC to train DOH national, provincial, district, and local service providers, the national Department of Health has not officially adopted this model nor scaled up these strategies (van Rooyen et al., 2009).

1.7.4 Community-based HTS

In addition to exploring how counselling is delivered, South Africa has expanded where HTS can be accessed. In an effort to rapidly increase the number of people who know their HIV status, the South African government has scaled up community-based HTS since 2014 (South African National AIDS Council (SANAC), 2015). Community-based HTS is defined as HTS that is conducted outside health facilities (comprising clinics, hospitals, or fixed, stand-alone HTS sites). These include home-based testing and counselling (i.e. offering HTS door-to-door within a specific catchment area) and mobile testing and counselling (i.e. setting up a mobile van, container, or tent to provide HTS in a central area of a community). The government also supports short-term counselling and testing campaigns, generally one to two weeks of duration, which offer intensive community mobilisation followed by mobile testing in partnership with other health interventions. Additional non-clinical strategies include workplace counselling and testing; HTS that targets key populations (e.g. MSM, SW, and PWID), index partners or family testing (i.e. offering HTS to individuals who may have been exposed to HIV by a sexual partner or individuals who have an HIV-positive household member (Suthar et al., 2013).

Increasing access has increased testing and links to HIV testing. Systematic reviews and meta-analyses by Suthar et al. (2013) and Sharma et al. (2015) confirmed the benefits of community-based HTS. Across modalities, community-based HTS was more effective in reaching men, young adults, and first-time testers when compared to HTS delivered within health facilities (Suthar et al., 2013, Sharma et al., 2015). This indicates high acceptability of HTS outside health care facilities. Community-based HTS helps to identify HIV-positive individuals with higher CD4 counts (at earlier stages of HIV) and results in retention rates similar to clinic ART patients. This, combined with improved linkage to ART, could improve life expectancy and reduce the risk of HIV transmission associated with late- or non-initiation of ART (Suthar et al., 2013, Sharma et al., 2015). Although community-based HTS interventions in the systematic reviews studies tested a large number of HIV-negative individuals, they provided an opportunity to reduce risky sexual behaviour through counselling and linking uninfected persons to primary prevention strategies, such as VMMC and PrEP (Suthar et al., 2013, Sharma et al., 2015). Specific behavioural outcomes beyond linkages to biomedical prevention services were not assessed.

According to public health scholarship, some community-based HTS modalities were more effective in reaching specific sub-populations. For example, mobile HIV testing reached the highest proportion of men (50%), while home-based self-testing reached the highest proportion of young adults (66%) (Sharma et al., 2015). Mobile and campaign HTS efforts had generally high uptake (97%), and some scholars note that individuals at a mobile van or during a campaign likely sought out testing (Sharma et al., 2015). Home-based HTS also attained high population coverage, with 82% uptake among people who were offered testing at home (Sharma et al., 2015). However, home-based HTS was less likely to reach men and young adults. This may be because women are more likely to be at home during the day when door-to-door testing was conducted. Only a few studies evaluated HTS for key populations (SW and MSM), but these interventions yielded high HIV positivity rates (38%) and the highest proportion of first-time testers (78%), which indicates the need to expand HTS to these populations (Sharma, et al., 2015).

1.7.5 HTS practices in South Africa

National policy guidance

The implementation of HCT has been guided by the *2000 Minimum Standards for Counselling*, the *2010 National HIV Counselling and Testing Policy Guidelines*, and more recently, the *2016 South African National HIV Testing Services (HTS) Policy Guidelines* (Department of Health, 2010, Department of Health, 2016c). These policies have evolved based on emerging evidence around best practices in HIV intervention and international guidance by the World Health Organisation (WHO), the United States Centers for Disease Control and Prevention (CDC), and the Joint United Nations Programme on HIV and AIDS (UNAIDS). For example, in 2008, the South African government adopted international guidelines and introduced referral for VMMC as an intervention strategy, and since 2010, HTS lay counsellors have been allowed to conduct HIV rapid testing under the supervision of registered health care professionals. Similarly, referral requirements for ART have changed over time, based on global changes in the eligibility criteria for ART enrolment (Department of Health, 2014).

In 2016, the DOH issued updated policy guidance and formally changed the term "HCT" within national programming to "HTS" to reflect the full range of services that should be provided alongside HIV testing. These include counselling (pre-test information[8] and post-test counselling); strengthening the linkage to HIV prevention, treatment, care, and other clinical services; and coordinating with laboratory services to support quality assurance and the delivery of accurate testing results (Department of Health, 2016c). This updated policy guidance emphasised the importance of retaining HIV-positive clients in the HIV continuum of care—from initial diagnosis of HIV infection, through linkage to care and ART enrolment, to adherence to ART, and finally to achieving viral suppression. The updated guidelines also prioritise ongoing monitoring of individuals living with HIV and tracking the proportion of people engaged in care at each stage (Department of Health, 2016c). To remove barriers to treatment, the government adopted a universal "test and treat" approach in September 2016, which entailed offering HTS to the country's entire population and providing immediate ART to anyone who tested HIV positive, irrespective of clinical stage or CD4 count (Department of Health, 2016a).

[8] Since this national policy update in 2016, what used to be called "pre-test counselling" is now formally termed "pre-test information." However, since the research for this study was conducted in 2015, prior to these updates, I will refer to this type of counselling as "pre-test counselling" for consistency.

Variable quality of HIV counselling and testing

Having guidelines and standards for public health interventions does not necessarily translate into quality implementation. Despite HTS being a national strategic priority, a 2013 national assessment of 67 government-accredited HTS sites found that the implementation of HTS was not standardised, and the quality of services varied between provinces, as well as between government, NGO, and workplace HTS sites (Peltzer et al., 2013).[9] HTS lay counsellors saw an average of 11.5 patients a day and spent approximately 18 minutes (ranging from three to 45 minutes) on pre-test counselling, 12 minutes (zero to 30 minutes) on post-test counselling in case of a negative HIV test result, and 23 minutes (zero to 45 minutes) on post-test counselling in case of an HIV-positive diagnosis (Peltzer et al., 2013).

The quality and content of pre- and post-test counselling efforts have been identified as a particular concern in observational studies. In the 2013 national HTS assessment (described above) , Mohlabane et al. (2015) used observation assessments and checklists (based on the *2010 National HCT Policy and Guidelines*) to assess both the content and quality of HIV counselling and HIV rapid testing. This included direct observation of 140 individual and nine group HCT pre-test counselling sessions. They found that while HIV pre- and post-test counselling were provided at all sites, the quality of counselling varied considerably between sites and between counsellors; counsellors did not consistently follow national DOH HCT protocols, and some counsellors exhibited inadequate counselling skills (Mohlabane et al., 2015).

For example, HTS counsellors discussed the voluntary nature of HTS and clients' right to refuse or postpone HIV testing in only 44% of government and 65% of observed NGO HTS sessions. Similarly, HTS counsellors discussed the importance of knowing your partner's HIV status in less than 67% of counselling sessions (Mohlabane et al., 2015). Of particular concern is that HTS counsellors at NGOs discussed disclosure and referral for medical care and support with only 66% of HIV-positive clients compared to 93% at government sites (Mohlabane et al., 2015). Mohlabane et al. (2015) further found that some HTS counsellors at government clinics tended to

[9] Few national studies are available on HIV counselling and testing services in South Africa. The 2013 national assessment of HCT services in SA by the Human Science Research Council is a majority study. The study was conducted at 67 Government accredited HCT sites in eight provinces (excluding North West). It included observational assessments at 46 government and 21 NGO and private sector/workplace sites in 8 provinces. Other works include derivative research based on data from the 2013 national assessment. Although I was able to locate studies on this topic from other Southern African countries, very little is written for SA specifically.

focus primarily on giving information about the HIV testing process and less on HIV prevention and opportunistic infections, such as TB and STIs, which resulted in missed opportunities for prevention.

HIV risk assessment and risk reduction counselling were also found to be inadequate (Mohlabane et al., 2015). For example, HTS counsellors at government sites conducted personalised risk assessments with clients in less than half (49%) of cases observed, compared to 63% at NGO sites (Mohlabane et al., 2015). While 82% of NGO counsellors versus 75% in government health sites reviewed risk reduction strategies with clients, most counsellors appeared to have difficulty facilitating the development of personalised risk reduction plans with clients and were more inclined to advise clients to adopt general, predefined prevention strategies (Mohlabane et al., 2015). The counselling skills of HTS counsellors in the review studies also appeared to be inadequate; some struggled to apply basic counselling skills, such as open and closed questions, summarising information, probing for information, and using silence to optimise client participation and empower clients, to reduce their risk of HIV (Mohlabane et al., 2015).

Studies about adherence to quality standards within HTS efforts have been mixed. The national HTS study by Peltzer et al. (2013) highlighted that there were limited formal quality-assurance systems in place in both the public and NGO sectors and insufficient guidance on who is responsible for quality assurance and how it should be done. A follow-up assessment by the DOH and WHO in 2014 confirmed that quality-assurance programmes for HIV rapid testing by lay counsellors at most facilities in SA were still inadequate, which increased the risk of misdiagnosing clients (Department of Health, 2014). In contrast, Magasane et al. (2016) reported high adherence to HTS counselling and testing protocols among home-based HTS counsellors in the Good Start Home based-HCT Randomized control trail (RCT) in rural KwaZulu-Natal province. HTS counsellors in that study obtained median compliance scores of 26.5 out of 29 for HIV counselling and 100% compliance for HIV testing. Magasane et al. (2016) ascribed the success of these programmes to rigorous training; both HTS lay counsellors and their supervisors in the study underwent two weeks of HTS classroom training with intensive supervision during in-service training over four months. This training included direct observation and follow-up assessments to verify HTS lay counsellors' proficiency in both HIV counselling and their ability to correctly apply testing procedures prior to being deployed in the field (Magasana et al., 2016). HTS supervisors also received specific training in quality assurance and supervision, including

how to conduct direct observations of counselling sessions and do exit interviews with randomly selected HTS clients to monitor the quality of services provided by HTS lay counsellors. These studies confirmed the feasibility of lay counsellor-led behaviour change interventions, but indicated that rigorous training, supportive supervision, and quality assurance are crucial for providing high quality HTS (Magasane et al., 2016).

HTS training in South Africa varies in depth and focus

HTS training in the country is not standardised and often does not comply with national minimum standards. According to the *2010 National HCT Policy and Guidelines* and the *2016 National HTS Policy*, all HTS counsellors should be adequately trained by accredited service providers to meet the *National Minimum Standards for Counselling* (first developed in 2000, but not yet updated) to ensure that quality counselling is conducted (Department of Health, 2010). However, a 2013 national study found that HTS training was not standardised and varied significantly in duration, topics covered, depth, and emphasis (Peltzer et al., 2013, Mohlabane et al., 2015, Mwisongo et al., 2015). Training for HTS lay counsellors ranged from three to ten days—the prescribed minimum in the *2000 National Minimum Standards for Counselling and Testing* (Peltzer et al., 2013). Most training programmes were didactic and included presentations and guest speakers who shared their work experiences (Peltzer et al., 2013). Training either focussed on teaching general HIV non-directive counselling skills, guided by Egan and The AIDS Support Organisation (TASO) counselling models, or focussed on HTS procedures; less attention was given to counselling skills or individual or social theories to understand and facilitate behaviour change among clients (Peltzer et al., 2013, Haffejee et al., 2010). Peltzer et al. (2013) identified the following gaps in HTS training: most training programmes did not include detailed guidance on how to facilitate in-depth, personalised risk assessments and risk reduction strategies among clients; did not cover quality assurance for HTS counselling; offered inadequate quality assurance for HIV rapid testing; lacked protocols for referral to treatment of opportunistic infections and psychological assistance; and their training efforts failed to address common practical challenges that counsellors encountered or how to deal with them (e.g. dealing with denial of an HIV-positive diagnosis, couples' counselling, or dealing with sero-discordant couples, youth, older clients, MSM, sex workers, immigrants and clients holding particular cultural values (Peltzer et al., 2013).

1.7.6 Conclusion

. The literature review confirms that personalized counselling combined with knowledge of one's HIV status, can reduce the risk of HIV acquisition and transmission by motivating people to use condoms and reduce their number of sexual partners (Denison et al., 2008, Fonner et al., 2014). Human behaviour, including sexual behaviour is complex and is influenced by a range of individual-, relationship-, socio-cultural- and structural factors. However, unlike other HIV prevention programmes, HCT practice globally and in South Africa are not informed by social and behaviour change theory and contain limited information about which counselling strategies are most effective in reducing the risk of HIV acquisition and transmission (Weinhardt et al., 1999, Denison et al., 2008, Fonner et al., 2014). Theories of behaviour change can help HCT counsellors better understand HIV risk and how psychosocial factors, such as knowledge attitudes, beliefs, skills and self-efficacy predict/influence individual behaviour and influence how they approach their role in reducing HIV risk among clients. It will also enable counsellors to appreciate that " ... decisions about HIV and HIV prevention forms part of a much larger, complex hierarchy of concerns, extending ... into deeply personal domains of love, trust, economic security, and values." (Warren, 2018, p 2). This, together with enhanced counselling skills, would enable counsellors to engage HTS clients in "... a collaborative, client-centred discussion .. "(Cornman et al. (2008,p 556) to ".. empower clients with relevant knowledge, behavioural skills and strategies to successfully negotiate safer sexual behaviours in specific relationships" (Fisher& Fisher,1992:p 464).

Despite the existence on national guidelines, the quality of HTS services in South Africa is routine care is variable with training and supervision often not complying with national minimum standards. A number of studies explored HTS lay counsellors' perceptions and experiences of providing HCT and the impact of their work, but few investigated the counselling approaches they use to reducing HIV risk among high-risk groups, as articulated by HTS lay counsellors themselves. There is therefore a need for qualitative research to provide a thick description of community-based HTS counsellors' perceptions of, experiences with, and thoughts about providing HCT to diverse clients in everyday practice.

The next chapter describes the research methodology applied to answer the study's primary research question: "How do HTS counsellors' perceptions and experiences influence provision of HIV counselling and testing services to diverse clients at government accredited community-

based HTS sites in South Africa?", as well as ethical considerations. The research results, discussion, key findings and conclusion will be presented in chapters 3 -5.

2 Chapter 2: Methods

2.1 Overview

This chapter describes the research methods used to answer the study's primary research question: What are community based HTS counsellors' experiences with and perceptions of providing HIV counselling and testing services to diverse clients at government accredited HTS sites in Gauteng and North West provinces, South Africa? The chapter describes the study design, study setting, and sampling methods. This is followed by a description of the data collection tools used and how they were administered, managed, and analysed. The chapter concludes with a discussion of the ethical considerations of this study.

2.2 Study design

A qualitative, descriptive, exploratory study, drawing on phenomenology, was conducted to explore HTS counsellors' experiences with and perceptions of providing HIV counselling to different HTS clients. I identified this approach as most appropriate, as it provides rich data for understanding complex phenomena from participants' perspectives, It offers an insider's view of HTS counsellors' lived experience and gives insight into the meaning HTS counsellors prescribe to events in their lives and to their behaviours (Hennink et al., 2011, De Vos et al., 2011). According to Hennink and colleagues, qualitative researchers ought to be "open-minded, curious, empathic, flexible and able to really listen to people telling their story in their own words" (2011: 9). When conducting this study, I interpreted what I saw, heard, and understood. However, since my interpretation cannot be separated from my personal background, history, and context, I have followed the recommendations of other scholars to reflect on and make explicit my potential influences on the research process (De Vos et al., 2011, Hennink et al., 2011).

2.3 Study sites and settings

This study was conducted at three different government-accredited, NGO-managed, community-based HTS sites in Gauteng and North West provinces between July and October 2015. Each of the NGOs provided community-based HTS services to specific target groups in high-prevalence communities and districts, which were identified as priorities by the national Department of Health. Study sites and settings included:

- A small, local NGO in the North West province, which provided home-based HTS services to migrant mine workers, their families, and the general population within informal settlements around the platinum mines in the Madibeng local municipality in the Bojanala district (Nkathalo Traders, 2010). Madibeng is located along the N4 highway in the northern part of the province. It has an estimated population of 477,381 people and a 32% HIV prevalence rate among women attending antenatal clinics (North West Provincial AIDS Council, 2017, Department of Health, 2015). The area has a high concentration of platinum mines with local and regional migrant workers, and several studies have documented high rates of TB, HIV, and silicosis among mineworkers in southern Africa (Wits Health Consortium, 2017). The DOH has identified the Bojanala district as one of six national priority districts for scaling up TB screening and treatment services (North West Provincial AIDS Council, 2017).

- A private sector-funded NGO in Gauteng province, which was established in 1999 by the National Bargaining Council for the Road Freight and Logistics Industry (NBCRFLI) to provide accessible and cost-effective health and wellness services to those employed in industry (National Bargaining Council for the Road Freight and Logistics Industry, 2017). The NGO provides HIV, STI, and HTS services to employees in the road freight and logistics industry, particularly long-distance truck drivers and sex workers, through a network of 22 roadside health and wellness centres (stand-alone clinics) situated along major transport routes in South Africa (National Bargaining Council for the Road Freight and Logistics Industry, 2017). Field data were collected at two of the NGO's service delivery sites in Gauteng—a workplace clinic at a trucking depot and a roadside wellness centre at a truck stop. Despite the unavailability of recent national data on HIV prevalence in the transport sector in South Africa, the sector employs truck drivers who are highly mobile and often spend some time away from home (National Bargaining Council for the Road Freight and Logistics Industry, 2017). This, combined with stressful working conditions, limited recreational opportunities, and restricted social conditions, creates flourishing commercial sexual networks along major transport corridors (Fourie and Schoeman, 2006, National Bargaining Council for the Road Freight and Logistics Industry, 2017).

- A large, local, donor-funded NGO based in Gauteng province, which was also an institute of higher education. It implemented a range of HIV, health, training, and technical assistance programmes in support of the government's strategic health objectives. This NGO was in the process of implementing a five-year, USAID-funded (United States Agency for International Development), high-yield, community-based mobile HIV counselling and testing (CB-HTS) services project in high-prevalence peri-urban communities in Gauteng, Mpumalanga, and North West provinces. The programme targeted young women and their sexual partners, as well as sex workers, men who have sex with men, people who inject drugs, and migrants with limited access to health care services. One of the core objectives of the NGO was to identify PLHIV and effectively link them to HIV and TB care and treatment services. For this particular study, IDIs were conducted with five HTS counsellors from the NGO's Tshwane office, which provided mobile HTS services on a rotational basis within under-serviced, high-prevalence, peri-urban communities in the Tshwane and Sedibeng districts of the Gauteng province.

The selection of these NGOs and study sites allowed for maximum variation in different settings (urban, peri-urban, and rural), testing modalities (home-based versus mobile HTS), and types of clients (young women and their male sex partners, migrant mine workers, long-distance truck drivers, sex workers, men who have sex with men, and people who inject drugs) within HTS programming.

2.4 Study population

The study population was the entire group of persons involved in community based HTS counselling, with the phenomena of interest being the pre- and post-test counselling encounters, from the perspective of the counsellors. For this research, the study population consisted of included HTS staff (lay counsellors), employed by three government accredited NGOs HTS across Gauteng and North West provinces, who provided community-based HTS to clients. Purposive sampling criteria for participation in the study included: HTS lay counsellors who were: a) 18 years or older; b) providing community-based HTS services to more than ten clients a week; c) knowledge of and experience with providing HTS counselling to specific target groups (young women and their male sex partners, migrant mine workers, long-distance truck drivers, sex workers, men who have sex with men, and people who inject drugs) in identified high-

prevalence communities and districts; d) being able to speak English and e) able to provide maximum and relevant information on the issue being investigated.

2.4.1 Sampling

For the research, I purposively sampled HTS counsellors who met the above criteria. I recruited 12 HTS counsellors from the three NGO study sites. NGO HTS managers and site coordinators informed eligible HTS counsellors of the aim and objectives of the study and forwarded the names of interested participants to me. I contacted HTS counsellors who were interested in participating and arranged formal interviews. Interviews were conducted at participants' places of work on dates set by the HTS counsellors and their management. The final sample was determined by participant availability and the quality of data collected. When no new data emerged from the in depth interviews about counselling experiences and approaches, we concluded that data saturation was sufficient and data collection ended. The final sample consisted of 12 participants.

2.5 Data collection

In this study, I conducted IDIs with 12 HTS counsellors using a semi-structured interview guide (see Appendix 1). The guide included qualitative probes to facilitate open discussion of issues raised by HTS counsellors. The interview guide was developed and piloted with three HTS counsellors who were not included in the study. I then refined it based on field testing and feedback from one of my academic supervisors. The interview guide was divided into three sections. The first contained biographic details of the HTS counsellors and questions about their NGO's approach to recruiting and providing HTS to their target group. The second section included in-depth questions and probes about what happens in individual HTS pre-testing counselling, HIV testing, and post-test counselling sessions with specific clients. The final section explored HTS counsellors' perceptions about their work, training, and supervision and elicited their recommendations for improving the quality and effectiveness of HIV counselling within HTS in South Africa.

IDIs were conducted at participants' workplaces between July 2015 and October 2015. Interviews were scheduled to minimise disruption of HTS services. However, HTS counsellors were not always available at the agreed times, which necessitated rescheduling some interviews. In addition, some interviews were conducted in the NGO boardroom or staff offices, which also served as storage facilities for HTS testing kits. Interviews were sometimes interrupted as staff

members collected equipment for the day. I managed these disruptions by pausing the interview and reassuring the counsellors of confidentiality before continuing. Interviews with HTS counsellors took approximately 70 to 90 minutes each and were conducted in English. Although English was not the first language of the participants, the majority of HTS counsellors interviewed had intermediate English language abilities.

The IDIs explored HTS counsellors' personal experiences and elicited their perceptions, observations, views, opinions, and insights about providing HIV counselling to diverse HTS clients. I opened each interview by establishing rapport with interviewees, conducting a consenting process for the interview and for audio recording (see Section 2.7), and collecting basic demographic data, such as the participant's age, gender, and HTS work history. I then requested that the participant describe in detail what happens in individual HIV pre- and post-test counselling sessions with a typical HTS client. This included asking questions about counsellors' strategies for establishing rapport with clients, the topics they cover during counselling, information they give to clients, counselling approaches they use to assess individual risk and reduce HIV risk behaviour among clients, and how they tailored their counselling to the unique circumstances and needs of different clients (e.g. youth, long-distance truck drivers, migrant mine workers, and sex workers).

Counsellors were invited to describe their successes and practical challenges in HIV counselling, as well as how they addressed these challenges. I then requested that counsellors reflect on the HTS training and supervision they had received since their appointment and to identify any strengths and weaknesses in HTS training and supervision practice. Finally, I elicited HTS counsellors' recommendations for strengthening prevention outcomes, policy, and practice within HTS. At the end of each interview, I explained the next steps in the research process and how data confidentiality would be ensured. Interviews were audio recorded, and I took supplementary field notes on relevant content and information about participants' behaviours and the contextual aspects of the interview (Mack et al., 2005).

2.6 Data management and analysis

2.6.1 Data management

The transcribing of audio recordings was outsourced to a professional transcription company. I verified the quality of the audio recordings prior to transcription and was able to use 11 of the 12

audio-recorded interviews. Once transcribing was complete, I compared the transcripts of the audio recordings to the raw data to verify the transcripts' accuracy and quality. One interview could not be fully used due to poor audio recording quality. Notes from the interview were used in the data analysis and discussion of results (without verbatim quotes). The original audio recordings and backup copies of electronic recordings were stored separately. Copies of these materials will be kept for two years after publication or six years if data are unpublished, after which these records will be destroyed.

2.6.2 Data analysis

The aim of data analysis for this study was to produce a detailed and systematic analysis of issues raised by HTS counsellors in the IDIs (Mack et al., 2005). Electronic data and interview transcripts were imported into and coded using MaxQDA, a qualitative data analysis software programme. Inductive and deductive thematic analysis was used to analyse the data. (Mack et al., 2005). I used Braun and Clarke's steps for thematic analysis to analyse the meaning and frequency of specific themes or codes that emerged from the data (Braun and Clarke, 2006, Clarke and Braun, 2013). I familiarised myself with interview content by repeatedly reading the transcripts and my field notes, documenting initial ideas triggered by the raw data/text, and identifying relevant themes and patterns that emerged from the data (Clarke and Braun, 2013). As part of this process, I generated an initial list of codes to organise data in a meaningful way (Clarke and Braun, 2013). These codes were deductively informed by theory, concepts, and global guidance and good practices on providing quality HTS services, which I identified in the project's literature review. In addition, the codes included themes that emerged from the data inductively (Clarke and Braun, 2013). After coding the text in MaxQDA, I grouped similar codes together to identify categories or higher level sub-themes. I documented clear definitions and names for each theme, sub-theme and code in a codebook (Clarke and Braun, 2013). Relevant text segments from the interviews were also extracted to illustrate key points. I then shared the codebook with one supervisor, who independently coded two of the interviews to compare codes with those I had identified. Where the interpretation of codes or themes differed, I discussed it with my supervisor, and we reached consensus on the codes prior to further analysis. I then reread and recoded transcripts where required to ensure all relevant text was properly coded and accurately reflected the data (Mack et al., 2005, Clarke and Braun, 2013). Codes were then summarised and analysed in line with study objectives, as presented in the results chapter. The findings were then compared with the broader literature in the discussion chapter of this report.

2.7 Ethical considerations

The Human Research Ethics Committee (HREC) of the University of the Witwatersrand gave ethical approval on 24 April 2015 (see Appendix 2). The relevant NGOs also gave permission to conduct the study (see Appendices 3 through 5).

All participants signed written informed-consent forms for the interview (see Appendix 6) and for audio recording (see Appendix 7) prior to data collection. Prior to all interviews, I explained the study aims and objectives to participants using an information sheet and provided participants with written information on the study. I emphasised that participation was voluntary and confidential and that participants were at liberty to choose to stop participating at any point without repercussions. This was also emphasised in the information sheet participants received (see Appendix 8). All participants gave written consent to participate in the study and to be audio recorded.

Interviews took take place at a private space at the health facility at a time and place convenient to participants. To ensure confidentiality, I also de-identified all transcripts prior to data analysis and kept physical data (e.g. notes, audio recordings, and transcripts) in a locked filing cabinet.

The goal of qualitative research is to accurately represent the participant's experiences. Lincon and Guba (1985:74) identified four criteria to indicate trustworthiness, namely, true value, (credibility); applicability (transferability); consistency (dependability), and neutrality (conformability) of the research. The researcher adopted various strategies to enhance/ensure trustworthiness of the results. Credibility and confirmability were ensured through triangulation of data collection methods. Field notes were captured and a voice recorder was used in all in depth interviews (Babbie & Mouton, 2001:276). The tape recordings of all the interview proceedings were captured by professional transcribers and the typed transcripts were compared with the original tape recordings to verify that participant narratives were accurately captured. The code book and transcripts were shared with and independently coded by my academic supervisor. Where the codes differed, we reviewed and reached consensus on the codes to ensure all relevant text was properly coded and accurately reflected the data (Mack et al., 2005, Clarke and Braun, 2013). Codes were then summarised, analysed, and discussed in the results and discussion chapters of this report.

2.7.1 Reflexivity statement

Social scientists are an integral part of the social contexts that they study (Hennink et al., 2011, De Vos et al., 2011). Researchers therefore need to acknowledge and "reflect on" how their cultural, political and social context, as well as their social position (gender, race, age, sexual orientation, personal values, ethics, and training affect) affect how you conduct research (De Vos et al., 2011). At the time of the study, I was employed as an HIV prevention advisor at a USAID-funded international organisation that provided grants to two of the NGOs one year prior to this study. Since I had a positive and prior working relationship with the management and HTS site managers of these NGOs, I was cognisant of the potential power dynamics as a representative of a donor organisation. Furthermore, as a white, privileged, South African female, I had to reflect critically on how my background and position affected power dynamics during interviews. I recognised that HTS lay counsellors were experts of their own lived experiences and tried to manage these dynamics by clarifying my role in the research. I explained that this study was conducted in my personal capacity as an MPH student, and was not in any way related to my professional position as an HIV prevention advisor. I emphasised that participation in the study was voluntary and carried no penalties for withdrawal. Finally, I had to reflect on how this influenced the areas I explored for analysis and my interpretations of HTS counsellors' narratives (Clarke and Braun, 2013). My background in HIV prevention and clinical psychology may have resulted in my decision to focus on HTS counsellors' motivations, their perceptions of the emotional impact of their work, and the psychosocial aspects of HIV counselling and behaviour change in HTS rather than on the biomedical components of HIV and AIDS.

3 Chapter 3: Results

3.1 Overview

This chapter presents key themes from the IDIs with research participants. In particular, it describes the backgrounds of the HTS counsellors, their work contexts, their experiences with and perceptions of HTS, and the counselling approaches they used to reduce HIV risk behaviour among different clients. It also covers the counsellors' recommendations for improving HTS training, supervision, and counselling practices in South Africa.

3.2 Counsellor profiles

When exploring the perceptions and experiences of lay counsellors who provide HTS in South Africa, it is useful to establish exactly who these counsellors are, including their backgrounds, motivations for becoming HTS counsellors, and approaches to counselling. This section aims to introduce the sample population and highlight some of the factors that facilitated HTS counsellors' entry into the field.

3.2.1 Demographic profile of HTS counsellors

The 12 HTS counsellors in this study came from diverse personal and educational backgrounds. They were employed as full-time contract staff or as volunteers at NGOs that provide HTS services in Gauteng and North West provinces in South Africa. The HTS counsellors in this study were predominantly female (8 of 12), Black (11 of 12), and ranged in age from 27 to 63 years. The majority of the counsellors completed Grade 12 (10 of 12), and three counsellors obtained post-matric qualifications, such as auxiliary health certificates, university degrees, or work towards a university degree. HTS counsellors entered the HIV-testing field through either the health or counselling fields and completed courses in auxiliary health care, HTS or general counselling courses offered by Lifeline, a provincial Department of Health-approved training service provider, which is accredited by the national Health and Welfare Sector Education and Training Authority (SETA).

Table 3.1: Description of study sample

Gender	Age	Race	Primary Language	Highest educational qualification	Sector	HTS modality/ work context
Female	46	Black	Sotho	Grade 12	Civil society/ small local NGO	Home-based HTS
Female	30	Black	Sotho	Grade 12	Civil society/small local NGO	Home-based HTS
Female	30	Black	Tsonga	Grade 12	Civil society/small local NGO	Home-based HTS
Female	35	Black	Sotho	Grade 10	Civil society/small local NGO	Home-based HTS
Male	32	Black	Sotho	Grade 12	Civil society/small local NGO	Home-based HTS
Female	40	Black	Sotho	Grade 12	Civil society/large donor-funded NGO	Mobile HTS
Female	60	Coloured	Afrikaans	Grade 12	Civil society/large donor-funded NGO	Mobile HTS
Male	63	Black	Sotho	BA degree (Education & Psychology)	Civil society/large donor-funded NGO	Mobile HTS
Male	39	Black	Tsonga	BA degree (Social Work 3rd year)	Civil society/large donor-funded NGO	Mobile HTS
Female	29	Black	Sotho	Auxiliary nursing	Private transport sector	Workplace HTS roadside wellness centre
Female	27	Black	Sotho	Grade 12	Private transport sector	Workplace HTS roadside wellness centre
Male	29	Black	Sotho	Grade 11	Private transport sector	Workplace HTS roadside wellness centre

HTS counsellors' experience ranged from three to 12 years, and most had worked as HTS counsellors for five years or longer. Some counsellors had prior related experience, such as being Lifeline counsellors or ART-adherence counsellors in government and NGO sectors. The majority of the counsellors in this study spoke Sotho as their first language, and the interviews were conducted in English.

3.2.2 Motivation to become HTS counsellors

Participants provided valuable insights into their motivations for becoming HTS counsellors. These included personal experiences of loss and trauma (e.g. the diagnosis or death of a loved one due to AIDS) and altruistic motivations (e.g. the ambition to "*save lives*" and "*make a difference in other people's lives*"). As illustrated in the following quotation by one of the male counsellors, sometimes these motivations were interwoven:

> *The reason I got into counselling and do the things I am doing now is because I think it is working. I got into counselling after my oldest sister died of HIV, because I remember she didn't have information then and the person who tested my sister told her she has got "a touch" of HIV. Couldn't he have just been straight and said, 'You are HIV positive; this is what you need to do'? Because I remember at home, we were very supportive. We would have done everything. . . . So now, every day I give someone information and see that he is now equipped with knowledge—that makes me very happy.* (Male, home-based HTS counsellor, 32 years old)

In addition to altruism and personal experiences of loss, some counsellors spoke of what they gained from being an HTS counsellor. For example, as captured in the following quotation, some mentioned learning new skill sets:

> *. . . My sister's child is HIV positive—a boy of ten years, he is the one who is the reason why today I am here, because I was in the clinic taking him for his medication every month. . . so the sister said to me, 'Why can't you go so that you can become a HIV counsellor?' It (HTS) teaches me a lot, especially counselling, and every day I am learning a different thing about counselling, and you learn how to communicate with different people.* (Female, home-based HTS counsellor, 30 years old)

A common belief among the HTS counsellors in this study was that they play a valuable role in the national fight against HIV. Most perceived themselves to be at the forefront of the HIV response. Through HTS, they noted that they help save lives by educating people in their communities about HIV, combating myths about the epidemic, enabling people to know their HIV status, and helping HIV-positive clients access life-saving treatment and care. As one male counsellor noted:

> *Why is HTS important? The thing is South Africa has the highest HIV rate. In our community, people die—every week we go to the cemetery to bury young people. Old people die, too, but the rate that young people are dying is terrifying. I do believe HTS is important in the family. People who know their status, who have been put on the medication in time, it helps them. . . we will avoid many infections; we will avoid this many deaths we are having. It is very important for people to come in and test.* (Male, home-based HTS counsellor, 32 years old)

Another counsellor emphasised that knowing one's HIV status not only benefits an individual, but enables individuals to protect their families, including their partners and children, through making informed decisions about the future:

> *Testing is good, because you need to know your status. If you don't know your status, you don't know your life and where it's going. . . . So, it is very important to know your status to protect your partner, also your kids, so you can see them grow up. Ja, it's very important.* (Male, transport-sector HTS counsellor, 29 years old)

Together, such responses demonstrate that these HTS counsellors perceived their work as valuable, meaningful, and fulfilling. Counsellors appeared to derive a sense of personal satisfaction from "*making a difference and changing people's lives*" (Male, home-based HTS counsellor, 32 years old).

3.2.3 HTS counsellors' work contexts and responsibilities

The work context, remuneration, and scope of services provided by HTS counsellors differed depending on the sector and type of organisation in which they were employed. None of the NGOs participating in this study received government funding, even though they provided HTS in support of the government's National Strategic Plan (NSP) priorities. The HTS counsellors worked in the private and civil society sectors. Counsellors in the transport sector were employed full time and had medical aid and pension fund benefits. A second group of counsellors were employed as contract workers at a large, local NGO that was implementing a five-year, donor-funded, community-based HTS programme in high-prevalence communities in Gauteng. The final group worked as volunteers for a small, local NGO in a peri-urban platinum-mining community in the North West province. These counsellors received monthly stipends of R1,500 per month but no benefits. This last group experienced high levels of job insecurity. Despite the

fact that this NGO was based at a local government clinic, it did not receive government funding and was dependent on occasional grants from international donors or donations from private companies in the district.

HTS counsellors used different community-based HTS service-delivery models to reach priority, vulnerable, and at-risk groups. These groups were identified through South African sero-prevalence surveys as having a higher risk for contracting HIV and STIs and having limited access to HTS and other health care services. Special emphasis was placed on immediately enrolling newly-diagnosed HIV-positive clients on ART.

Table 3.2: Description of HTS target groups and services

NGO	Clientele	Services	Outreach
Home-based HTS in a high-prevalence peri-urban mining community in North West province	Migrant mine workers and their families; general population	• HIV pre- and post-test counselling and rapid HIV testing • TB, STI, and non-communicable diseases (NCD) screening and referral • Sputum collection • Directly observed treatment (TB-DOTS) • Trace TB suspects and TB patients who default on treatment • Referral to ART—follow-up home visit and accompanying clients to local clinics • Promotion and referral to HIV prevention services, MMC, and SRH	Community-based HIV education and awareness campaign; health talks at local clinic; door-to-door home visits
Mobile HTS in high-prevalence communities in Gauteng province	Young women and their sexual partners; sex workers; men who have sex with men; injecting drug users; general population	• HIV pre- and post-test counselling • TB, STI, and NCD screening and referral • HIV rapid testing • On-site CD4-testing • Referral to ART • Client follow up by local call centre	Community mobilisation and HIV education and awareness campaign; mobile HCT (tents)
Workplace HTS along major routes in the transport sector in Gauteng province	Transport sector employees, especially long-distance truck drivers and sex workers	• HIV pre- and post-test counselling • TB, STI, and NCD screening and referral to private doctor/clinic • HIV rapid testing • Audiology testing • Health education on NCDs under supervision of a professional nurse • On-site primary health care services, including STI treatment (professional nurse) • On-site CD4-testing • Referral to ART and client follow up via call centre	Community-based HIV education and awareness campaign; roadside wellness centres at truck stops

The sector in which HTS counsellors worked influenced their relationships with the national DOH and their access to information and training opportunities. Home-based HTS counsellors operating from the local government clinic reported daily to the manager, called the "sister on duty," before going out to the field. They also reported weekly and monthly data to her regarding the number of clients they tested and what the HIV results were. The following quotation illustrates these counsellors' close collaboration with the clinics in which they worked:

> *We do (HTS) everywhere, because on Mondays we are at the clinic helping the TB patients, checking if they are coming to the clinic, and we also check their files when he'd done HTS. If it was three months ago and he was negative, we re-test him. On Tuesday, Wednesdays, Thursday we are going out to the field, providing door-to-door testing. If they want to test at their home, we give them information about HIV and TB, STIs, and PMTCT, condom usage, and do condom distribution and condom demonstration, we also do that. On Friday, we are at the clinic doing our weekly stats.* (Male, home-based HTS counsellor, 32 years old)

The second group of counsellors, employed at a large, international donor-funded (PEPFAR) NGO, also reported relatively strong links with the DOH. These counsellors pointed out that although their mobile outreach teams worked in different communities in Gauteng, they linked HIV-positive clients with their closest public health facility for ART enrolment and care. They reported monthly data to DOH district offices, which covered the number of clients tested, HIV positivity rates, and the number of HIV-positive clients referred for ART. NGO managers also participated in monthly and quarterly DOH and donor coordination meetings, where the organisation received updates on emerging policies and accessed training opportunities.

In contrast, the HTS counsellors in the private transport sector reported very limited contact with the DOH, except for submitting quarterly HTS reports to the district. HIV-positive clients, including truck drivers, were referred to private hospitals for ART enrolment, which was paid by the transport company's medical aid. HIV-positive sex workers were referred to the closest government health facilities for ART. Private-sector HTS counsellors mentioned that they had never benefitted from government or donor-funded training opportunities and had limited access to national DOH policies or guidelines that affect their work.

3.3 HTS counsellors' experiences with different clients

HTS counsellors provided valuable insights into the nature of HTS and their personal experiences with counselling HIV-positive and HIV-negative clients. These include their reflections on what really happens in HTS counselling sessions—from the moment a client enters the venue. This section gives a broad overview of counsellors' stories of their experiences with and views on providing HTS to diverse clients. The recounted interactions were all self-reported; no counselling sessions were observed.

3.3.1 Gaining clients' trust in pre-test counselling

A strong theme that emerged in HTS counsellors' anecdotes about pre-test counselling, regardless of client type, was the importance of establishing rapport as a gateway for obtaining testing consent, educating clients about HIV, and preparing clients for HIV testing. HTS counsellors explained in detail the strategies they used to gain clients' trust prior to introducing sensitive topics such as sexual behaviour, discussion of which is still commonly considered taboo in South Africa. Several counsellors stressed the right of clients to refuse HIV testing during pre-test counselling without adverse consequences. As one female counsellor noted:

> *We start by introducing ourselves. We build a relationship with the client, to open up the client. . . so that the client can be open and trust you for what she/he is bringing to you. Because sometimes you think that the client is only coming for HTS, to find that there is another issue that you have to deal with—so you have to open the client to accommodate the client. . . . I explain to the patient this is not about me, this is about you, so everything that I am going to do, I need to get permission from you. . . . If there is something that you are uncomfortable with, you don't let me go ahead and sign the consent, as consent will give me permission to proceed.* (Female, home-based HTS counsellor, 40 years old)

Many counsellors emphasised the importance of confidentiality and often stated, "*What happens in counselling stays between us."* However, one counsellor acknowledged the limitations of client confidentiality and explained how she introduced the concept of "*shared confidentiality among health care professionals*" to clients:

> *We stopped saying to people 'This is between the two of us,' because (confidentiality) has to break—if I refer the client to another person for services, and I said 'This is between the two of us,' and then I tell the nurse this person is taking this medication or is HIV*

reactive. . . . I break confidentiality. So I tell him, his results will be handled under health confidentiality that is shared among service providers only. . . . I assure him it is not my stand (place) to tell other people (about his HIV status). . . . I tell them outside the facility, you are not my patient. (Female, home-based HTS counsellor, 46 years old)

The majority of counsellors highlighted the need for a person-centred approach to counselling and emphasised the importance of being non-judgemental and accepting and respecting clients, regardless of the client's background.

Counsellors also described how they determined a client's motivation for HIV testing on a particular day, explored the client's testing history, and assessed their knowledge about HIV in order to tailor their counselling approaches. As I discuss in Section 3.4, the pre-counselling stage was, for all counsellors, a critical time for general HIV education and tailored prevention messaging.

Finally, counsellors related how, as a concluding step in pre-test counselling, they explained HIV rapid testing procedures, the steps they follow, and how they interpret HIV test results. They also used this opportunity to help clients anticipate the outcome of the HIV test result by asking questions such as, "*What do you expect to see? What would you do if you are HIV positive or HIV negative?*" This helped them assess the clients' emotional states and identify potential coping mechanisms and resources in case of an HIV-positive diagnosis. Some counsellors mentioned that these discussions prompted clients to share previously undisclosed risk behaviours, including alcohol abuse, infidelity, or having multiple sexual partners.

3.3.2 HIV testing experiences

If the client consented to testing, HTS counsellors performed HIV rapid tests according to DOH HIV testing algorithms and protocols. Some HTS counsellors mentioned that they explained each step as it occurred to ensure clients felt comfortable and understood the rationale for procedures. When doing mobile testing and using tents in communities, HTS counsellors would, after completing HIV rapid testing, request that the client return for his or her results after 20 minutes. However, in home-based testing, counsellors noted they usually used the 15 minutes of waiting time, while the HIV rapid test developed, to engage clients in discussions of the potential test outcome and the implications of a positive or negative diagnosis. They also noted this time was useful for reinforcing prevention messages.

3.3.3 Post-test counselling experiences

The majority of counsellors emphasised the importance of post-test counselling, especially for HIV-positive clients, and described how they informed clients of their HIV test results and tailored post-test counselling to clients' diagnoses. In their discussions of post-test counselling, the four following major themes emerged from interviews.

Giving hope to HIV-positive clients

Counsellors emphasised that reassuring HIV-positive clients and giving them hope are key elements of post-test counselling. HTS counsellors were sensitive to the potentially devastating impact of an HIV-positive diagnosis on clients and their families, and some stated that they spent more time with HIV-positive clients to help them deal with the initial shock and consequences of an HIV-positive diagnosis. They helped clients think through the psychological, social, and practical consequences of being diagnosed with HIV and allowed clients to verbalise their fears and feelings. Counsellors also mobilised support systems to help their clients cope. One counsellor compared the shock of being diagnosed HIV positive to "*being hit by a car.*" She continued:

> *I give them the information that it will not be easy for them, being told you are HIV positive, it's like a hit and run so if the car hits you, you become injured. That injury will be there for many years, and you will be reminded that you were hit by the car, that's why you still have this pain. The same with HIV, every time you will be thinking that 'I am HIV positive,' you gonna have to deal with the HIV status of yours. It's for you to accept yourself, before other people can accept you.* (Female, home-based HTS counsellor, 46 years old)

During IDIs, the HTS counsellors explained how they tried to de-stigmatise HIV and give hope to HIV-positive clients through cognitive reframing techniques. A key strategy was to shift focus away from death and toward life or family responsibilities. For instance, counsellors noted, "*HIV is not a death sentence"* (Male, transport-sector HTS counsellor, 29 years old); "*HIV is a now a chronic disease, it can be managed"* (Female, mobile HTS counsellor, 60 years old); "*You can still have kids, live a good life, and achieve your dreams"* (Female, transport-sector HTS counsellor, 29 years old); "*You need to be forward thinking—you cannot change your status, but you have to think about your baby*" (Female, home-based HTS counsellor, 35 years old). However, some counsellors also emphasised the realities of living with HIV and the client's

responsibility to manage the disease. As one noted, "*HIV is the beginning of a journey—your journey. You are going to live with this (HIV) for the rest of your life. The virus is in your body, and it's your decision how to deal with the virus*" (Female, home-based HTS counsellor, 46 years old).

Promoting disclosure to significant others

Although most HTS counsellors encouraged clients to disclose their HIV status to their significant others [e.g. parents, trusted family members, or sexual partner(s)], they were not naive about the risks behind disclosure. They cautioned clients and noted disclosure may result in discrimination and rejection. They also helped clients weigh the benefits and disadvantages of disclosing their status to others and prepared clients for these discussions. As one male counsellor recounted:

> *I ask if the person got support. If she has support, especially at home, I will be asking 'What are you going to do? If you are HIV positive, who is the first person you are going to tell? Why are you going to tell this person? What do you expect from this person if you say you are going to tell them?'. . . . I do encourage them to disclose, but I also show them the disadvantages of disclosing. . . . We live in a very cruel world, and people are still lack information (about HIV) out there, this is why it is important to know before you disclose. . . . Ja, because you can still be stigmatised and alienated. You can say, my family have been loving me since birth, I have never seen them act otherwise, but tell them you are HIV positive, then you will see another people (a different side of people). . . People can surprise you sometimes. You will never know what you're gonna get.* (Male, home-based HTS counsellor, 32 years old)

However, only one HTS counsellor explicitly mentioned the longer-term mental health consequences of being diagnosed HIV positive. She described how she monitored clients' emotional reactions and advised HIV-positive clients about counselling and other support services in the community:

> *He must tell you who he is going to tell, what he is going to do on that day, because that day is going to be a hard day for him. So he must tell you, then you can see how is she (he) feeling, check if he becomes emotional or what. Then you can tell him, if you've got a problem, there is a (HIV) support group that you can go to, there is a helpline like*

LifeLine you can call and talk to them. There are people that you can talk to about your status if you can't accept it. So he will tell you, 'I am HIV positive, and I am worried,' and you must also pick up why he is worried. (Female, home-based HTS counsellor, 30 years old)

ART education and linking HIV-positive clients to treatment and care

Counsellors also educate HIV-positive clients about the benefits of ART and about viral loads, CD4 counts, and their implications for ART enrolment. The HTS counsellors in this study prioritised referrals and linking HIV-positive clients to treatment. The referral strategies they used depended on their contexts and resources. Well-resourced HTS programmes, such as the ones in the transport sector and in the donor-funded community, enable counsellors to perform on-site CD4 testing to determine a client's eligibility for immediate ART treatment, while home-based counsellors noted they accompanied HIV-positive clients to the government clinic for CD4 testing and ART enrolment. The counsellors at roadside wellness clinics and those doing mobile HTS forwarded HIV- positive clients' details to a call centre for follow-up counselling and linkage to treatment and care. Home-based counsellors in the North West province emphasised the importance of treating both TB and HIV, given the high rates of HIV/TB co-infection in the mining sector.

Congratulations, please stay HIV negative

By their own accounts, counsellors tended to spend less time with HIV-negative clients. HTS counsellors framed being HIV negative as "*lucky*" and "*being given a gift or a second chance*" and urged clients to stay negative—primarily by using condoms. One counsellor's narratives indicated the risk that counsellors may sound as though they are lecturing when they advise clients to take responsibility for protecting themselves against HIV:

If the person is negative, I tell them, 'You see that your result is negative.' . . . Then I say, 'Most of the people who are HIV positive, . . . those people they didn't listen to us when we talk to them. . . . So you are negative today, make sure you stay negative. Make sure that your life comes first. You protect yourself, you protect your life, so that you do not need to take medication. Maybe you can take medication for something else, but not for HIV, because you know with HIV, you can protect it by using a condom.' (Female, home-based HTS counsellor, 30 years old)

Counsellors also reminded HIV-negative clients about the window period and urged them to be re-tested after three months to confirm their negative status. As one female counsellor said:

> *When they are negative, I also tell them, 'That's okay, we've got this thing called a window period. So you must come after three months to test again. You must condomise for this three months so that you come and check again, because the virus, it can hide. So you must come after three months to check again.'* (Female, home-based HTS counsellor, 29 years old)

Education and referrals to other HIV prevention services, such as referrals to VMMC, SRH, PMTCT, and STI treatment, was not consistently done by most HTS counsellors interviewed for this study. Only home-based HTS counsellors prioritised referrals to both HIV-negative and HIV-positive clients. They also established partnerships with the local NGO VMMC service provider in their community and provided HTS during VMMC outreach campaigns. Several home-based counsellors described their referral responsibilities in ways similar to the following counsellor:

> *If clients are negative, . . . we refer them to VMMC. The HIV-positive ones must do pap smear once a year, the negative must also do the pap smear. We also introduced the implant for family planning, so we refer also for family planning. They must go and be checked if they do not have STIs. If they are found to have STIs, they must also involve their partners because treating STI for one partner is not gonna help them.* (Female, home-based HTS counsellor, 46 years old)

Other counsellors appeared to be unaware of these requirements and did not have a resource list or service level agreements with relevant clinics or NGOs to facilitate such referrals.

3.4 HTS counsellors' approaches to reducing HIV risk among clients

A key interest of this study was how perceptions of client risk influence HTS counselling interactions, given counsellors' different clientele. To explore this, I present key findings about counsellors' perceptions of HIV risk among different clients, their approaches to facilitating personalised risk assessments, what constituted the basis of their assessments, and how they sought to motivate clients to reduce their HIV risk behaviours.

3.4.1 Perceptions of clients' risk

The majority of HTS counsellors in the study resisted interview probes about identifying differential risks among clients, and some actively challenged the notion that some people are at higher risk of HIV infection than others. One counsellor articulated HIV risk in her community as follows:

> *I tell them that everyone is at risk, because sometimes, it might be one of your family members that you don't know his HIV status, who is injured. You might be in a taxi, and you might be involved in a car accident, you don't know who HIV positive in the car is—so we are all at risk. . . .* (Female, home-based HTS counsellor, 46 years old)

Several counsellors explained that anybody could be infected with HIV, either sexually or via contact with contaminated blood. They emphasised the random nature of HIV infection and stated that anybody can get HIV. They noted, counsellors had to be non-judgemental and treat all clients the same, regardless of their personal backgrounds or HIV status. A few counsellors acknowledged that stigma remained rife in their communities and explained, for example, that sex workers seen at their roadside wellness centre were often reluctant to disclose their profession. One counsellor noted:

> *The sex workers, they do not say, 'I'm a sex worker.' But when you're sitting with them, then they explain to you. . . I'm doing this and this and that . . . when we do their counselling, I explain to them you are, have got this, this disease of STIs. So then they will say. . . 'Ahm, actually this is the kind of job I'm doing.'* (Male, transport-sector HTS counsellor, 29 years old)

Despite early resistance, some counsellors addressed the research questions in further discussion. For example, one mentioned that the lifestyles of youth place them at risk:

> *For the youth especially, because of their lifestyle today, because you might go to the tavern or a party and there is some guy with a lot of money and you are at risk and he used you for one day and you can be at risk. So for the youth, we give them example about not trusting anyone. If you don't use condom, you might be infected by HIV, you might be pregnant, or you might be left with the STIs.* (Female, home-based HTS counsellor, 40 years old)

Another mentioned that they (counsellors) target pregnant women for HTS, since pregnancy is an indication that a client engaged in unprotected sex.

Although a few counsellors acknowledged that some groups (e.g. youth and pregnant women) may be more vulnerable to HIV infection, the majority were reluctant to acknowledge the notion of differential risk among clients for fear of blaming or stigmatising them. This reluctance to perceive or label some clients as at higher risk of HIV infection may stem from counsellors' personal experiences of stigma and discrimination against PLHIV in their communities, as well as their perceptions that they, as champions of PLHIV, should not discriminate against any client—a fact often emphasised in HTS training (Angotti, 2010). It appears that HTS counsellors considered it more important to counter such stigma and discrimination against PLHIV and preferred to characterise *"everyone as at risk*" rather than single out specific groups or individuals as at higher risk of contracting HIV. However, such practice may lead to counsellors neglecting known risk factors of HIV infection.

3.4.2 Strategies for assessing HIV risk among HTS clients

HTS counsellors explained that they did not conduct formal risk assessments of clients, but rather determined clients' risk for HIV and STIs by exploring their reasons for HIV testing and their HIV-testing history. For example, they enquired whether a client previously tested for HIV and whether s/he engaged in any risk behaviours, such as sex without a condom, or were in contact with blood since their previous test. One counsellor illustrated how a client's stated reason for testing guided her counselling approach:

> *. . . from the reason of testing, you hear what kind of person you are dealing with. Sometimes, a person is coming for testing because he has too many partners, or maybe she didn't use protection, or maybe the husband is cheating, or he or she has something to blame. . . that's how you gonna deal with the client.* (Female, home-based HTS counsellor, 46 years old)

Similarly, another counsellor said:

> *First of all, you need to think of their history. Firstly, we have to ask about the last test you took and after that, you assess and ask if during that time she been sexually active. If yes, you ask if it was maybe protected sex (used a condom), if she has been in contact with*

blood, maybe she has been using injections for whatever reason? Used needles and razors? So you take that history down, and then it will give you insight of what is happening in this person's life. (Male, home-based HTS counsellor, 32 years old)

3.4.3 Reducing HIV risk among clients

During pre- and post-test counselling, certain techniques and messages were described by the HTS counsellors, which could be categorised as risk-reduction counselling. These approaches included enquiring about the client's reasons for testing, providing general HIV education, and outlining HIV prevention methods to help the client reduce his or her risk of HIV infection. Although risk-reduction counselling should ideally be tailored to the client's specific risk profile and HIV diagnosis, a client's HIV status is not yet known in pre-test counselling. A finding of this study is that tension occurred between information counsellors considered directly relevant to a specific client and their provision of general HIV prevention education.

Many HTS counsellors therefore attempted to provide comprehensive risk-reduction counselling. HTS counselling usually began with basic HIV education about the modes of HIV transmission, then moved to information about behavioural and biomedical prevention interventions to reduce the risk of HIV acquisition or transmission. HTS counsellors explained how they assessed a client's baseline knowledge regarding HIV and addressed myths and misconceptions about HIV. As one stated:

You give information to the client, and also ask the client what he/she knows about HIV and AIDS—that's how you know if the client have knowledge and who don't. . . . I myself have changed to not just give information but also ask questions, so that I can fit the (HIV) information to the client. So you do not just barge in and give information, but first find out what the client knows. And also, to make the counselling 'entertainful' because if the client has to come and only listens to you, sometimes, he/she can be bored. I also refer to (examples in) the media, what do they know about the Department of Health, then you will hear what is this people's knowledge so far. (Female, home-based HTS counsellor, 46 years old)

Another counsellor emphasised the value of counselling to address misconceptions about HIV:

> *The counselling, it's very important, because most of the people, they don't know—they don't have the right information. Some of them don't know about HIV and what to do if they are HIV positive. They (truck drivers) are getting the wrong information from others. When the guys are sitting in the trucks, some will say, 'Hau, me, I know myself—I'm negative. My woman did test for HIV last month, because she's pregnant. She was not pregnant, and she's was HIV negative. So, I'm negative.'* (Male, transport-sector HTS counsellor, 29 years old)

Beyond general messages, counsellors appeared to tailor their HIV education to the client's reasons for HIV testing and to counsellors' perceptions of the relevance of specific modes of transmission for a client. For example, the majority of counsellors emphasised sexual transmission of HIV, and some mentioned exposure to contaminated blood in the context of motor vehicle accidents. Mother-to-child transmission seemed to be discussed only with pregnant and young women. However, one female counsellor related how she educated both men and women regarding PMTCT, thereby acknowledging the need for comprehensive HIV education, the potential role a man plays in his partner's sexual reproductive health decisions, and the benefits of a man supporting his partner's adherence to PMTCT interventions. One counsellor said:

> *I teach them how people get infected. They must know it is not only about people having sex. . . . If we only focus on the people getting HIV from unprotected sex, then where did the baby get HIV from? So that is when they (men) will become interested to know how, then you explain the PMTCT and MTCT—that the mother who is HIV positive can infect the baby if she didn't take the treatment during pregnancy. Some, they take the treatment during pregnancy, but they took it late, so the mother infected the baby during delivery, they (men) must also know those kind of things.* (Female, home-based HTS counsellor, 46 years old)

The same counsellor also highlighted the risk of HIV transmission due to sharing beauty products, such as razor blades, which is a risk factor seldom mentioned in broader HIV education:

> *I teach them how people get infected, and they must know it is not only about people having sex. That you get HIV through unprotected sex, blood to blood, I also have to explain because most of the women, we tend to forget that they (men) use the blade for shaving, and we also tend to use it for eyebrows and if I use it for my friend, so we have to prevent that, as we can get infected.* (Female, home-based HTS counsellor, 46 years old)

The majority of the counsellors explained that they convey similar HIV prevention messages to all clients but tailor their language to clients' age and gender. As one counsellor noted:

> *I do believe every person is an individual, and everyone is unique. I believe when a guy my age comes in, I draw myself to his standard and talk to him in a language he will understand. And if it's an older man, maybe 50 years, I tend to address him with the respect which I would give to my father. I will use for example, and excuse me for this, a 'penis' for a 60-year-old, and I will just say a 'dick' on a young guy.* (Male, home-based HTS counsellor, 32 years old)

Several counsellors stressed the need to be respectful when counselling older clients, but also to challenge the common perception that older people are not at risk of acquiring HIV. One counsellor mentioned that "*older people can contract HIV though caring for their HIV-positive children*" (Female, home-based HTS counsellor, 40 years old). Another said, "*older people do not have access to relevant information or condoms to protect themselves, as HIV awareness campaigns are biased towards young people"* (Female, transport-sector HTS counsellor, 29 years old).

Furthermore, they emphasised the role of parents in educating and protecting their children against HIV infection. A female counsellor described how she appealed to parents to engage their children in discussions of HIV and condoms to prevent new HIV infections among youth:

> *You must explain to them (parents) that I am talking to you about HIV so that you can teach your children at home, because they teach children (about HIV) at school and the clinic, but when they ask (you) their mother what is HIV, you say, 'Hey, don't come and talk your nonsense here!'. . . . So we teach them, you must know what HIV is and that you can also be infected, even if your man died a long time ago. You must also know about condoms, because you will go into your son's room and get the condoms under the pillow, and you will think, 'He start to become naughty,' and you throw it away. You must know*

> *that when you do that, you throw your child's life away, because you don't go with him. . . . You don't know what he is doing. So when you get the condom under his pillow, you must know that this one, he has started sex.* (Female, home-based HTS counsellor, 29 years old)

Consistent condom use—without guidance

Regarding condoms, the study participants explained how they assisted clients with reducing their HIV risk by promoting consistent and correct condom use and by distributing condoms at wellness centres, community outreach campaigns, and home-based HTS. Counsellors voiced a simplistic approach to prevention by advising all clients "*to use condoms with all partners, every time they have sex.*" (Male, home-based HTS counsellor, 32 years old). Although they emphasised the multiple benefits of condom use, such as preventing unwanted pregnancies, STIs, and HIV, they tended to use fear-based messaging, especially for their young clients. For example, they cautioned young clients about the risks of becoming pregnant or HIV positive, but gave relatively limited attention to building skills to empower those clients to negotiate condom use in relationships. As one of the female counsellors noted:

> *For the youth, I tell them to rather have sex with a condom than nothing, because if you meet with a person and you sleep with that person you might become HIV positive and also be pregnant. The guy might not have interest anymore you might be left with responsibilities about the baby, HIV, and your life.* (Female, home-based HTS counsellor, 46 years old)

Another female counsellor noted something similar:

> *We tell men we know that sex is part of life, but please, now we have HIV, we have STI, we have a lot of diseases. Please just make sure that you use condoms, as condoms are the best solution. . . when we test teenagers, we will encourage them to use a condom for prevention, yes condom is the best, condom is the way of preventing all of the diseases that can come from other people. Ya, condom is the key.* (Female, home-based HTS, 30 years old)

The majority of the counsellors acknowledged that condom use is inconsistent in stable relationships. They also recognised that young women in particular often find it difficult to negotiate condom use in relationships, due to power dynamics, issues of trust, and infidelity.

However, most counsellors did not use these opportunities to explore barriers to condom use and increase clients' self-efficacy. Yet another female counsellor said:

> *Most of the people, like the married people, they don't see the reason of using condoms and in some cultures, people (women) believe they have to get consent from the husband. If the husband says no—even though they are both HIV positive, they still don't use condoms, because the husband might leave her as he doesn't like to use a condom. Some, they are afraid that when they ask their partners to use condom, they are identified as they are sleeping around.* (Female, home-based HTS counsellor, 40 years old)

HTS counsellors in the transport sector who worked with truck drivers (who are often away from home) and sex workers were more inclined to discuss condom use in the context of multiple, concurrent sexual partnerships and high levels of infidelity. Counsellors described how they stressed the importance of a person using condoms with casual sexual partners to protect his or her main partner from getting HIV. This demonstrated a more nuanced approach to condom education when compared to advising "*everybody to use condoms every time you have sex."* One of the male counsellors stated:

> *Most of the time, they (truck drivers) use condoms with outside partners. Those who are married, they use the condoms outside. In the house, most of them they didn't use it (condoms), because their partners will think why are you using rubber, because we didn't use it before. We never used the rubber before, why now?* (Male, transport-sector HTS counsellor, 29 years old)

Despite HTS counsellors playing a critical role in condom distribution and condom education to prevent HIV, STIs, and unwanted pregnancies, a finding of this study is that their overall approach to condom education appeared to be simplistic and insufficient to equip their clients with the relevant skills to negotiate condom use in casual or stable sexual relationships.

Limited promotion of partner reduction and abstinence

The majority of the HTS counsellors in the study mentioned that being faithful to partners or reducing the number of sexual partners is important for HIV prevention. However, only home-based HTS counsellors promoted abstinence among youth. From the interviews, there appeared to be an implicit acceptance of the practice of multiple or concurrent sexual partnerships, especially among men. Counsellors acknowledged that men often had multiple sexual partners

and tended to advise men to use condoms with *"outside partners" to protect their "main partner"* (Male, transport-sector HTS counsellor, 29 years old).

There was also an acceptance of serial, sequential sexual relationships among women. A 50-year-old female counsellor, who conducted mobile HTS in high-prevalence peri-urban communities in Gauteng, normalised serial sexual relationships among women when she said:

> *In human relationships, we are in and out of relationships. Supposing you start at 15 dating a guy, sooner or later sex will happen. . . and then you find out this guy is not the one that you want. He's not interested in school, he's maybe doing drugs or gangs. . . . So, you leave him and you move on. . . to boyfriend number two. . . . At that stage, you are 18 maybe, at university, and this guy starts abusing you or is cheating on you. Sex has occurred. So you leave this guy, and move over to boyfriend number three. Boyfriend number three dies in a car or motor vehicle accident; you have to move on, you are still young. So eventually, you end up with boyfriend number four. . . . Where is the badness in this?* (Female, mobile HTS counsellor, 60 years old)

Counsellors acknowledged that such sexual practices increase HIV risk but are the norm in their communities. To address this, most promoted consistent condom use as a more practical alternative to abstinence or monogamy. They also highlighted the benefits of condom use to protect oneself against other STIs and unwanted or unplanned pregnancies.

Repeat HIV testing in contexts of continued risk

An unexpected trend that emerged from interviews in this study was the counsellors' promotion of repeated HIV testing for HIV prevention. Many emphasised regular testing of oneself, as well as for new or existing sexual partners in the context of increased or simply continued risk. A male counsellor described how he advocated for regular HIV testing:

> *Then we suggest. . . . So why don't you and your partners test (for HIV) on a regular basis, the same as you are doing now? . . . Ja, have them tested on a regular basis; check for all those other diseases that may affect them, because sometimes you find out that it happened. Because there are two things that you are using condoms for—one is to prevent infections and then the other one is for pregnancy. Will you be able to handle that situation? You know you have got a steady wife. . . . So these are the kind of things that we normally tell them. Then they have to make a decision. . . whether to continue with*

multiple partners or stick to the one partner or continue and place their partner at risk. (Male, mobile HTS counsellor, 63 years old)

3.4.4 Overlooked risk factors: anal sex, substance abuse, and gender-based violence

Although several HTS organisations in this study specifically targeted mobile populations (e.g. truck drivers, migrants, sex workers, and MSM), most HTS counsellors only addressed HIV risks associated with heterosexual vaginal sexual intercourse. They seldom mentioned unprotected anal sex, drug and alcohol abuse, or gender-based violence as risk factors in HIV transmission.

Anal sex occurs in both heterosexual and same-sex male relationships; however, it was only mentioned by one male counsellor after a male client explicitly stated that he engaged in sexual intercourse with other men:

> *Ja. . . the other thing that maybe I didn't mention, we also try to find out about sexual orientation. Like what sexual preference do you have. . . do you love to sleep with men outside, because some men . . . then go home to sleep with their wives. . . without using condom. . . . But now it's for us now to say, 'Okay, why don't you use protection when you have sex with your partner—that's the male partner. And when you go home, or explain to your wife or your partner that you are this kind of a person?'* (Male, mobile HTS counsellor, 63 years old)

This was the only instance where a counsellor mentioned MSM. The counsellors in this study appeared to subscribe mainly to heterosexual notions of sexuality, and discussion of other sexual orientations was largely missing.

Even though alcohol abuse and gender-based violence are risk factors for HIV infection, counsellors noted they only addressed these issues if they emerged in the conversation with a client. Only one female counsellor stated that she asked all female clients about a history of sexual abuse or GBV. She said, *"Firstly, you just ask the client if she used a condom or what, and secondly, you gonna ask the client how many partners does she have and again if she has ever been raped or abused or something"* (Female, home-based HTS counsellor, 35 years old). Together, the examples from this section highlight that many counsellors appeared to be unaware of or failed to address some of the known risk factors for HIV in their counselling.

3.5 Counsellors' perceptions of and experiences with training and supervision

Counsellors provided insights into the training they received and shared their perceptions about the quality and relevance of HTS training and supervision.

3.5.1 Perceptions of and experiences with HTS training

During interviews, the counsellors made it clear that the duration, depth, and content of their training varied widely. For participants in this study, HTS training ranged from five to twenty days. Home-based HTS counsellors in the North West province completed a 20-day HIV counselling and testing course at LifeLine. This training was offered either full time over one month or part time over six months. The LifeLine course focussed on personal development, basic counselling skills, and HIV counselling and testing. Successful completion of the personal growth course was a prerequisite for acceptance into the HIV counselling course. The counselling training focussed on basic counselling skills (guided by Rogers and Egan's non-directive counselling approaches), active listening, questioning and reflection skills, and non-verbal behaviours (van Dyk, 2012). In addition, counsellors had to complete an HIV rapid testing course and perform 50 HIV tests under the supervision of a professional nurse in order to be accredited as HTS counsellors.

Counsellors in the donor-funded programme, in contrast, completed a five-day HTS training course offered by the Foundation for Professional Development (FPD), an accredited, private, higher education institution affiliated with the South African Medical Association (SAMA). The course comprised three-day training on HIV counselling, followed by a two-day HIV rapid testing course focussed on HIV testing procedures, finger pricking, quality assurance, and the interpretation of HIV test results. Counsellors also had to complete 50 HIV tests under the supervision of a professional nurse to be accredited.

The content of the LifeLine and FPD courses were similar but varied in duration and depth. Both covered basic HIV knowledge, modes of transmission, biomedical and behavioural HIV prevention methods, and government HIV testing and counselling protocols. However, the training by LifeLine focussed more on counselling skills, while the training by FPD emphasised the biomedical aspects of HIV, TB, and STIs, as well as HIV testing procedures outlined by national DOH HIV policy guidelines.

The HTS counsellors in the private transport sector were trained as part of their Ancillary Health Care qualifications, which are offered by private colleges. The duration of these courses varied from three to six months full time, and HIV comprised one module within a broader qualification. Notably, none of the counsellors mentioned any training to increase their understanding of human behaviour or facilitate risk reduction among clients, such as that provided by instruction on theories of behaviour change.

In addition to basic HTS training, some counsellors completed government- or donor-sponsored training in ART adherence counselling and the counselling of key populations and migrants; others completed part-time courses on couple's counselling and trauma management (over three months) at LifeLine at their own cost. The frequency of in-service training varied among the NGOs in this study and ranged from every six months to annually. However, training appeared to be ad hoc, based on perceived organisational needs, rather than regularly scheduled. Counsellors emphasised that in order to be effective, they needed both counselling skills and medical knowledge to provide accurate information to clients on HIV, STIs, HIV-TB co-infection, and ART and TB treatment. They also noted both types of skills were necessary to identify illness signs and symptoms and refer clients to clinics for follow up.

Despite its perceived importance, many counsellors identified several challenges in accessing skills-development opportunities. Importantly, these included a lack of resources and limited access to information about policy changes. Most counsellors rated the government's policy dissemination strategies as inadequate. As one said, *"[Ongoing personal development] is important, but I can't afford to go onto the internet every day and find the new information"* (Male, home-based HTS counsellor, 32 years old). The same counsellor noted that, despite being based at the local government clinic and reporting daily to the sister-on-duty, counsellors at NGOs were often excluded from DOH training opportunities:

> *They only involve their government counsellors when it comes to training. We (as counsellors at NGOs based at the clinic) must also be involved, because we are part of that. You will only hear about the (new) protocol maybe after a month. How are you gonna know it—if maybe you made a mistake as you were still implementing the old protocol and the protocol has changed?* (Male, home-based HTS counsellor, 32 years old)

Counsellors described themselves as passionate, committed individuals and mentioned they felt valued and respected in their communities, but they also felt undervalued in their professional environments. As verbalised by the same counsellor:

> *I don't believe counsellors are recognised. I am speaking for myself. You get into the clinic when you are a counsellor. Those nurses will make you feel like you are a mere counsellor. When there is a job to be done, they will call you. When there is food to be eaten, they won't be calling you. If there is money to be given away, we won't be seen.* (Male, home-based HTS counsellor, 32 years old)

3.5.2 Perceptions of and experiences with supervision: psychological support needed

The psychological impact of HTS work

The counsellors in this study noted they often have to confront complex situations during HTS counselling. For example, they described how they deal with suspected cases of child abuse (see below), conflict in sero-discordant couples, angry HIV-positive clients who refuse to accept their diagnoses, the burden of conveying HIV diagnoses to young people, and HTS counselling in cases of sexual assault. Many characterised these situations as overwhelming and involved counselling tasks they felt under-trained and ill-equipped to handle. For instance, one counsellor recounted his experience with a female client:

> *She told me she tested when she was pregnant (7 years ago) and that both she and the baby was HIV negative. . . and she wants to re-test. Then we do the counselling, and she tests negative. Then she asks me to do another test to verify. . . . I told her. . . you are HIV negative, two of these test kits showed you are negative. She is like. . . 'There is something going on. I took my child to the doctor, and my child is HIV positive. I and my partner are both HIV negative. So, I had to ask some very deep questions' . . . . Only then did she open up telling me her boy was sodomised. It was a difficult one for me. . . . I had to sit down with her and think what the way forward with this. The thing is, my main concern was the child, since he was HIV positive. . . so I tell her the main thing she should concentrate on now is the health of her child. She should take him to the clinic to make sure that she gives him his medication on time, that was my main concern. . . . And even with this thing of sodomy, I told her she can go to the police and talk to them about this,*

this thing should be reported. Abuse should not be left unreported. (Male, home-based HTS counsellor, 32 years old).

Another described the challenges of dealing with the impact of HIV diagnosis on trust in relationships:

> *HIV is not an isolated issue, it's an integral part of people's lives now. Ja . . . you are having sex, because you want to be satisfied, but there is trust that you have created between you and your partner—and that trust can be broken by people that bring something different (like HIV) into the relationship. So you break that trust. . . if somebody is HIV positive, you have to think how do you deal with that as a couple. . . and as an individual.* (Male, mobile HTS counsellor, 63 years old)

He noted that counsellors are not always equipped to deal effectively with complex situations, such as couples in sero-discordant relationships:

> *But now, with couple counselling, you look at their relationship. . . it has been there for many years. . . their relationship now, is it going to crumble, because one now have a different status. . . You have to come up with a ways to deal with it. . . though it's not your field. . . . Ja, you are not a social worker.* (Male, mobile HTS counsellor, 63 years old)

Counsellors also shared personal experiences of distress when dealing with HIV-positive clients:

> *Like actually when that person is positive. . . I pray every day when I am doing HIV testing, please, God, I don't need to find someone who is positive, because when they are positive, I also feel like I am positive. That feeling that you feel—I also feel. So, I am trying to hold myself that you won't see me that I'm. . . upset. Ja, I think counsellors, they need support. They need counselling also.* (Female, transport-sector HTS counsellor, 29 years old)

Others described feeling helpless when confronting situations they could not resolve. For example, when counsellors advise clients to eat healthy foods before taking ARV medication, their clients often said they could not afford to buy such food—or any food, sometimes. Others highlighted instances when they spent their own money to buy food for clients, especially for children in need. One counsellor shared his frustration at seeing HIV-positive clients or TB patients engaging in high-risk behaviours, such as smoking or drinking, and being unable to

intervene. Home-based HTS counsellors further shared their experiences of living in the same communities where people know them and seek help at all hours. The majority of the counsellors did not complain about this but rather indicated they felt valued and needed within their communities.

Supervision and the need for debriefing or psychosocial support

Despite the stressors mentioned, the majority of HTS counsellors indicated that they seldom received debriefing, supervision or emotional support to deal with the sometimes-traumatic impact of their work. Counsellors in this study did not distinguish between supervision for personal development and psychological debriefing to cope with the emotional consequences of their work. However, most counsellors revealed that they received limited supervision and support after completing basic training. Where staff meetings or supervision did occur, they focussed mainly on operational matters and less on the personal or professional development of counsellors. Some mentioned receiving informal support from their peers and occasionally from their immediate supervisors. One home-based HTS supervisor explained how she introduced weekly group debriefing sessions, while a counsellor in the transport sector stated that even though their company had an employee wellness programme for staff, they (HTS counsellors) had never made use of it. He concluded, "*So ja, also us, we do need the counselling, because we get stressed a lot of time here*" (Male, transport-sector HTS counsellor, 29 years old).

3.6 Counsellors' recommendations for strengthening HTS policy, training, and practice

Based on the interviews, HTS counsellors made specific recommendations for improving HTS training, supervision, and practice. This included introducing regular in-service training, giving greater recognition to counsellors in the workplace, enhancing career paths for counsellors, advocating for counsellors' professional interests, and enhancing accountability within HTS practice.

HTS counsellors rated their basic training as adequate. However, they called for restructuring training pedagogy, so it would be more practical and include sufficient role-play time and scenarios. They expressed this would better equip them with skills to deal more effectively with the real-life challenges they encounter while counselling diverse clients. As one counsellor said, "*The training is comprehensive and covers everything but really needs to be rebuilt. . . . The role*

plays, we need to do more role plays, because we are meeting different clients and must know how to deal with them" (Female, home-based HTS, 46 years old).

HTS counsellors emphasized the benefits of ongoing personal and professional development, stating that they should take personal responsibility for this, since HIV is an evolving field. One counsellor said, *"HIV isn't staying in one place. New information comes in every time"* (Female, transport-sector HTS counsellor, 35 years old). Another lamented, "*New protocols are being put out, and we don't know about those. It is very shameful if I come to test someone, and she tells me about the new protocol, and I didn't know about it"* (Male home-based counsellor, 32 years old). A third declared, "*Counsellors must also go the extra mile. We must also read, listen to the media, because some of the things you can use in counselling"* (Female, home-based counsellor, 46 years old).

Despite its perceived importance, counsellors mentioned that opportunities for personal and professional development were extremely limited and requested that the government introduce regular (e.g. quarterly) in-service training. They also called for more effective communication and dissemination of new government policies to ensure counsellors can incorporate policy changes into their counselling and HTS practice.

Counsellors highlighted that because they often deal with difficult cases, they need regular supervision and psychosocial support. They recommended that supervision include psychological debriefing, case management, and the personal development of counsellors. This, many suggested, would help them deal with the psychological impacts of their work and enhance the quality of their HTS provision.

As noted above, some counsellors mentioned they found their work meaningful and felt valued and respected in their communities but undervalued in their professional environments. One counsellor elaborated:

> *You know, when we go out there, people call us—they think we are doctors. Yes, they sometimes they think we are doing the work of the doctors or nurses. If, it's a woman, they call her a nurse. What does it says to you? . . . Yes. Respect. . . let's say, if the organisation or the government can give us that kind of recognition. . . .* (Male, mobile HTS counsellor, 63 years old)

They also spoke about their career aspirations and called on the government to invest in the professional development of HTS counsellors, so they may respond appropriately to the national AIDS epidemic. One male counsellor noted:

> *Equip people, train people. Some people wish they could be psychologists and social workers, but they can't because of finances. Maybe the government can equip these people. I do believe the counsellors are the hardest working people you can ever find in the health department. I know I sound biased, but if you can just give them (counsellors) proper training, that would change a lot of people.* (Male, home-based HTS counsellor, 32 years old)

Finally, HTS counsellors called on the government to formally recognise HTS counselling as a profession and establish a professional body to regulate the conduct of HTS counsellors and look after members' interests. They also proposed the development of a Code of Ethics to guide the conduct of counsellors and hold them professionally accountable. One of the counsellors articulated these needs as follows:

> *Nurses, they register every year, and they are recognised, then whenever any problem comes, there is somebody to stand up for them. The counsellors can be the same. Let them register somewhere and then from there on, if anything happens to them, they will be supported and recognised. . . they can have like official recognition for what they do, but they can also be held accountable. . . if a counsellor give wrong information to the client or do something you are not supposed to do. . . one can reprimand that person. As I said, formal recognition, there must formal recognition too for their skills and experience.* (Male, mobile HTS counsellor, 63 years old)

From the above examples and other interviews, a finding of this study is that HTS counsellors value and consider basic training adequate. However, they also express the need for regular in-service training, greater recognition of counsellors, and the professionalisation of HTS to enhance development opportunities and accountability within broader HTS provision.

3.7 Conclusion

HTS counsellors came from diverse backgrounds and joined the field motivated by feelings of altruism, opportunities to learn new skills and sometimes personal experienced of loss and trauma, They perceive their work as valuable, and fulfilling and appeared to derive a sense of personal satisfaction from "making a difference and changing people's lives." Counsellors used workplace, community outreach, mobile-and door-to-door HTS to reach priority, vulnerable, and at-risk groups, e.g. sex workers, long distance truck drivers, MSM and adolescent girls and men in peri-urban and mining communities. Counsellors followed a client-centred approach to HCT, emphasising the need to establish rapport and be non-judgemental to gain client's trust prior to prior to discussing sensitive topics such as clients' sexual behaviours. They assessed clients risk by enquiring about their reason for testing and testing history and balanced general HIV education with more personalized risk reduction counselling tailored to clients age and gender. Counsellors promoted condom use with limited attention to skills building, promoted faithfulness among female clients and condom use by males as alternatives to partner reduction and abstinence, while advocating for regular HIV testing in the context of continued risk. They prioritised post counselling for HIV positive clients, using cognitive reframing to give clients hope, promote disclosure and educated and linked HIV positive clients to treatment and care. However, they spent limited time with HIV negative clients and inconsistently referred clients to biomedical prevention services such as VMMC and PreP

Despite counsellors perceptions of client risk influenced their interactions given their different clientele being a key focus of the study, HTS counsellors resisted the notion of differential risk. Instead, they emphasised the need to be. non-judgemental and not stigmatize clients, preferring to view HIV infection as a random event. This resulted in counsellors addressing HIV risks associated with heterosexual vaginal sexual intercourse, while seldom addressing known risk factors such as unprotected anal sex, drug and alcohol abuse, or gender-based violence. Finally, counsellors highlighted that the duration, depth, and content of HTS training varied widely and that ongoing training and supervision of counsellors are limited. Although they recognised the need for ongoing professional development, lack of resources and limited access to information about policy changes were identified as barriers.

4 Chapter 4: Discussion

4.1 Overview

In this chapter, I compare HTS counsellors in this study to others in South Africa and further afield. I relate HTS counsellors' experiences with providing HIV counselling and testing to HIV-positive and HIV-negative clients to broader literature on HTS, and I focus specifically on how counsellors evaluate HIV risk and establish strategies to reduce it. The limitations of this study are also discussed.

4.2 HTS counsellor profiles

Presenting a profile of HTS counsellors is important, since it provides insight into their backgrounds, professional preparation, and motivations for entering and remaining in the field. Given the qualitative nature of this study, the broader transferability of some of the observed perspectives may be considered by examining the sample in relation to national contexts for HTS counsellors.

South Africa has approximately 10,000 HTS lay counsellors out of a cadre of 72,000 community health workers (Medecins Sans Frontieres, 2015). HTS counsellors are employed by the government at public health facilities or by NGOs and private sector companies that implement HTS to priority target groups and to the general population within high-prevalence communities. As characterised in this study, HTS counsellors are not a homogenous group. Depending on their backgrounds and the sectors in which they are employed, counsellors differ along the axes of personal and educational backgrounds, scope of work, skill sets, remuneration, career paths, and skill development needs. HTS counsellors also differ in their motivations, as will be discussed in 4.3..

Although it is not possible to make broad inferential claims based on the study's sample size, nor was this the intention of the study, it appears that the demographic profile of HTS counsellors in this study is similar to other HTS counsellors in South Africa. A 2013 national evaluation of HTS services in the government, NGO, and private sectors found that the bulk of national HTS services are delivered by nurses (41%) and HTS lay counsellors (40%) (Peltzer et al., 2013). When comparing the profiles of HTS lay counsellors in Peltzer and colleagues' (2013) study with this one, the gender profiles and age ranges of lay counsellors were similar, although HTS counsellors in this study appeared to be better qualified and more experienced. Females made up

the majority of counsellors in both studies [85% in Peltzer et al. (2013) versus 89% in this study] with a mean age of 35 years (Peltzer et al., 2013) versus 38 years (this study). However, 83% of counsellors in the current study completed Grade 12, with 25% obtaining tertiary level degrees or diplomas, compared to 53% completing Grade 12 and none obtaining tertiary level qualifications in the Peltzer et al. (2013) study. In addition, HTS counsellors in this study completed short courses in ART adherence-, general-, and trauma counselling, which were provided by the government, FPD, and LifeLine. The majority of HTS counsellors in this study, (58%), had worked as HTS counsellors for five years or longer, compared to 22% in the study by Peltzer et al. (2013). This suggests high levels of tenure, experience, and commitment among this study's participant group.

The findings of this study disrupted the perception that all HTS counsellors are poor and unemployed (Topp et al., 2015); HTS counsellors in the private sector were full-time employees with pensions and medical aid benefits. Nevertheless, they represent only a small percentage of HTS lay counsellors in South Africa. Counsellors in this study employed by NGOs faced similar challenges as those in the public sector (see Section 4.4). This study's results are aligned with those of scholars who call on government to design sustainable service delivery models that balance the need to strengthen the national health and social service system with the job-creation needs of poor, under-resourced communities and the career aspirations of CHWs and HTS lay counsellors (Akintola and Chikoko, 2016, Medicin Sans Frontiers,).

4.3 Motivation to become HTS counsellors

HTS counsellors do not use mechanistic tools in counselling; accounting for their personal motivations is one important tools to explain variation in both the quality and outcome of counselling (Goldberg, 2004, Beatty, 2012). Ideally, HTS counsellors' motivations for becoming counsellors should therefore be explored in recruitment and should be addressed in training and supervision to ensure they do not compromise the quality of counselling (Peltzer et al., 2013, Haffejee et al., 2010). Orlinsky and Ronnestad state, "To optimally develop as counsellors, we need to not only to understand who we are, what we do, and how well we do it; but also why we do it and what keeps us doing it" (Orlinsky and Rønnestad, 2005:4). In this study, we explored both motivations to enter the profession as well as ongoing motivations.

The motivations of HTS counsellors to enter the profession are diverse. In this study they ranged from altruism to opportunities to learn new skills and make sense of personal experiences of trauma or loss. Similar reasons were identified by Akintola (2011) and Topp et al. (2015) that revealed the complex motivations underlying volunteerism in AIDS care. In these studies, volunteer home-based caregivers and community health workers in SA and Zambia cited similar motives, in addition to religious and moral obligations, community recognition, and meeting social needs (Akintola, 2011, Topp et al., 2015). In the study by Topp et al. (2015), more than 50% of participants also cited economic motivations, such as improving their prospects for paid employment. Given high unemployment rates in South Africa, primarily due to people lacking employable skills, it is unsurprising that unemployed individuals view community health work and HTS as potential opportunities for skills development, which may enhance their employment prospects (Topp et al., 2015, Akintola, 2011, Times Live, 2018). Some scholars have raised ethical questions about the sustainability of relying on community members with limited training and poor or no remuneration to carry the burden of community health care in low- and middle-income countries (Topp et al., 2015).

For counsellors motivated by career aspirations, Akintola and Chikoko (2016) argue that the government should support CHWs who dream of becoming nurses, social workers, or community developers, in their attempts to achieve these ambitions, since their quests for career advancement may not end with promotion to paid supervisory positions within their organisations. Rather, they argue that the government should provide CHWs with a platform to access opportunities for further training and professional development, thus enabling CHWs to become professionals in the health care or social sectors (Akintola and Chikoko, 2016).

Another motivation for entry into the field was personal experiences of loss or trauma associated with the HIV diagnoses and deaths of loved ones. Similar motivations were identified in qualitative studies by Goldberg (2004), Beatty (2011), and Topp et al. (2015), all of which found instances where HTS counsellors (and psychotherapists) entered their professions because of previous experiences of loss or trauma. Goldberg (2004) argues that having a loved one diagnosed with or passing away as a result of HIV and AIDS can be a powerful motivator for entering the counselling field. This phenomenon may be understood in relation to psychological concepts such as “coping through meaning-making," a process of constructing, understanding, or making sense of life events, relationships, and the self (Park, 2010). Another relevant concept

is “post traumatic growth,” that describes the process where individuals who have experienced difficult or traumatic events re-evaluate their assumptions about life, the world, and others in an effort to find meaning and then later become motivated to help others (Hernandez-Wolfe et al., 2010, Park, 2010).

Exposure to previous trauma can make counsellors more empathetic to clients’ needs (Goldberg, 2004, Hernandez-Wolfe et al., 2010). However, supervision is important, since unresolved trauma may lead to over-identification with certain clients and may compromise the quality of counselling (Goldberg, 2004, Hernandez-Wolfe et al., 2010).

4.4 Work contexts and legal positions of HTS counsellors

The sector in which HTS counsellors are employed determines their scope of work, remuneration, job security, career paths, and access to government-related information and skills development opportunities. Most of the national HTS literature focuses on HTS counsellors employed by the government. This study found that counsellors in the private sector experienced higher levels of job security and career possibilities, since they were appointed as full-time employees with medical aid and pension benefits. In contrast, counsellors employed by civil society NGOs (funded by government, private, or international donors) were appointed as short-term contract workers or volunteers on stipends. These groups received different levels of remuneration, had limited or no benefits, experienced higher levels of job insecurity, and had limited career options, despite high levels of commitment and many years of HTS experience.

HTS lay counsellors’ motivations and approaches (described in 4.5), are compromised by structural factors in South Africa. Medecins Sans Frontieres (2015) compared the position of CHW (which includes HTS lay counsellors) in eight SADC (Southern African Development Community) countries and found that, despite being perceived as a valuable resource in the fight against HIV and TB, this cadre of health workers faced numerous challenges that affected both their motivation and work performance. These include a lack of formal recognition, the absence of supportive legal and policy frameworks, the lack of sustainable financing, and inadequate supervision and investment in their professional development. Combined, these limit the career progression opportunities for lay counsellors (Medecins Sans Frontieres, 2015). As a result, these health workers have not yet been integrated into most countries’ national health care systems or human resources for health plans, and their programmes lack adequate budgets (Medecins Sans Frontieres, 2015).

Despite that national policies (e.g. the *2010 HIV Counselling and Testing Policy and Guidelines* and the *2016 South African National HIV Testing Services Policy*) prescribe the use of HTS counsellors, their scope of their work (SOW) and remuneration are not standardised across provinces (Medecins Sans Frontieres, 2015, The Labour Court of South Africa, 2016). For example, in KZN, lay counsellors are only allowed to provide HTS, while in the Eastern and Western Cape, they may provide both HTS and ART adherence counselling (Medecins Sans Frontieres, 2015). Additionally, HTS counsellors' remuneration is poor and inconsistent across provinces. Despite performing similar duties, HTS counsellors in Mpumalanga are paid 90 USD (ZAR 1,170) per month, compared to 200 USD (ZAR 2,400) in Gauteng and 335 USD (ZAR 4,020) in the Western Cape (Medecins Sans Frontieres, 2015).

HTS lay counsellors' legal position in SA is also unclear, which seemed to complicate the management of this cadre of health care workers. Though this was not raised in this study, in a 2016 court case, legal counsel for the Gauteng DOH argued that HTS lay counsellors, contracted by the provincial DOH, are not protected by South African labour legislation, since they are not appointed as DOH employees but rather as independent contractors or volunteers on stipends (The Labour Court of South Africa, 2016). However, the court dismissed this argument and ruled that SA labour law applies to all employees, regardless of whether they are appointed as permanent, fixed-term (contract), part-time, or temporary employees, and this entitles them to certain rights. The court further found that since the HTS counsellors' scope of work was prescribed by the Gauteng DOH, and they reported directly to health supervisors at government clinics, HTS counsellors should be regarded as DOH employees and are entitled to same rights and protection under the law (The Labour Court of South Africa, 2016).

According to SA labour law, a permanent employee is someone employed for an undetermined period of time and whose contract has no agreed date of termination (Legal Wise, 2017). Such contracts can be terminated by either the employer (dismissal) or the employee (resignation) by giving formal notice (Legal Wise, 2017). In contrast, fixed-term/contract employees are employed for a pre-determined period of time with an agreed start and end date. However, if a fixed term/contract employee, or an employee contracted through a labour broker, earns less than R205,000 annually and is employed for longer than three months, the employee should be considered permanent and receive the same remuneration and benefits (e.g. medical aid, pension fund) as permanent employees doing the same or similar work (Legal Wise, 2017, Cabe, 2018).

Such an employee is also entitled to the same work and professional development opportunities as permanent employees (Legal Wise, 2017, Cabe, 2018). As home-based HTS counsellors are employed on open-ended contracts as volunteers, and mobile HTS counsellors are employed on fixed-term contracts for longer than three months, they should be entitled to the same rights and benefits as permanent employees in these organisations.

These examples illustrate how the absence of clear legal and policy frameworks results in the inconsistent and unfair treatment of HTS lay counsellors. It clearly demonstrates the need for urgent reform to empower this cadre of health workers to optimally support the government in achieving its national health objectives. Despite the labour court judgement being delivered in March 2016, the government has not yet complied with its recommendations. However, the national DOH is in the process of finalising the *National Policy Framework for Ward-based Primary Health Care Outreach teams, 2018/9-2023/4* to standardise the management of CHWs as part of the re-engineering of the primary health care system. It is envisaged that this policy will serve as a blueprint for the integration of HTS counsellors into the national health care system (personal communication, Director of HIV Prevention, Department of Health, 2018).

4.5 Counsellors' experiences with providing HIV counselling to clients

4.5.1 Counselling approaches

HTS counsellors in South Africa (including participants in this study) are trained in and follow a client-centred counselling approach, pioneered by Carl Rodgers and Gerard Egan (Peltzer et al., 2013). This approach was adopted by the national DOH to counter the tendency of HTS counsellors to give advice (van Dyk, 2012). It is based on the premise that clients who voluntarily seek HTS are more likely to be motivated to change their risk behaviour, and it requires counsellors to focus primarily on the client's needs—as expressed by the client (van Dyk, 2012, Peltzer et al., 2013). It does not account for the developments of South Africa's testing strategies to test everyone. According to this approach, the main tasks of HTS counsellors are therefore to establish open and trusting relationships with clients, help clients tell their stories or explore problems (e.g. HIV risk, reason for HIV testing); based on these conversations, counsellors assist clients with identifying personalised alternatives to risk behaviours and developing an action plan to manage identified problems (Department of Health, 2010, Mohlabane et al., 2015, van Dyk, 2012).

Based on this study's participant narratives about their interactions with clients, the counsellors appeared to subscribe to and value the core principles of respect, empathy, and acceptance of clients, which a client-centred approach advocates. They also appeared to successfully apply other core counselling skills, such as active listening, questioning, and non-verbal skills, to gain clients' trust and thus created safe spaces for clients to share intimate details about their sexual behaviour—a topic still taboo in many cultures (Mudhovozi et al., 2012).

HTS counsellors tailored their counselling to a client's reason for testing, prior HIV knowledge, and testing history. As an HTS client's HIV status is not initially known during pre-test counselling, the counsellors in this study tried to balance comprehensive, general HIV prevention education with more tailored prevention counselling. They reported that they adhered to DOH protocols regarding HIV pre-test counselling and emphasised the voluntary nature of counselling and client confidentiality. This contrasts with counsellors in a study by Mohlabane et al. (2015), in which researchers physically observed counselling sessions, and some counsellors did not consistently follow a client-centred approach or were prone to dispensing didactic advice. One counsellor in my study acknowledged the limitations of client confidentiality and introduced the concept of "shared confidentiality" to explain the need for health care providers to share information regarding clients—a concept that was only recently introduced in the *2016 National HTS Policy and Guidelines*. This policy states that "shared confidentiality, including disclosure of a client's HIV status by a health worker to other health workers involved in the client's care, is inevitable" (DOH, 2016: 22). It also notes:

> Clients and patients who test positive must be informed that their diagnosis may be shared with other healthcare providers to ensure appropriate medical care from the different healthcare workers. Such disclosure should respect clients' basic right to privacy and confidentiality of all medical information. (DOH, 2016: 22)

4.5.2 Giving hope to HIV-positive clients

HTS counsellors appeared well aware of the psychological impacts of an HIV-positive diagnosis on individuals, their families, and trust within intimate relationships. They devoted more counselling time to HIV-positive clients and to creating a safe space for clients to deal with common, immediate emotional reactions: shock, denial, and guilt. Van Dyk (2012) and Haffejee et al. (2010) highlight that although clients' reactions vary, most HIV-positive clients go through a stage of denial (an important defence mechanism that temporarily helps individuals reduce

emotional distress) and may experience fear about stigma, rejection, and death. People who receive an HIV-positive diagnosis also often feel anger or guilt about being infected and about the potential impact of the diagnosis on their loved ones. Counsellors therefore need to help clients express these feelings and accept their HIV-positive diagnoses (van Dyk, 2012).

Hope emerged as a central theme in this study. HTS counsellors provided emotional support and reassured HIV-positive clients using reframing techniques to shift clients' focus away from death and toward life or family responsibilities. One stated, for example, that "*HIV is not a death sentence, but a chronic disease that can be managed*" and that "*you can still have a positive life and see their children grow up if you adhere to treatment*." Casale et al. (2013) demonstrated how social support (including emotional, instrumental/practical, informational, and appraisal/feedback support) helped HIV-positive caregivers foster a sense of hope for survival, living a relatively normal life, and for a better future, despite their circumstances. Social support thus seems to enable HIV-positive clients to regain a sense of self-control and may facilitate more active problem-solving and coping strategies, as opposed to remuneration—a form of coping through negative avoidance, where individuals remain preoccupied with the causes and consequences of their illness and imminent death (Casale et al., 2013).

One way HTS counsellors in this study mobilised social support for clients was by promoting disclosure to trusted significant others. Disclosure of an HIV status can have important health and social benefits for PLHIV; in particular, it may reduce stigma and increase social support for PLHIV if family and friends react positively to the diagnosis. Disclosure may also improve the uptake of health services (e.g. ART initiation and adherence) and reduce the risk of onward transmission of the virus, since PLHIV who know and disclose their statuses to sexual partners are more likely to engage in protective behaviours and safer sex (Maman et al., 2014, Casale et al., 2013, Bott and Obermeyer, 2013). However, HIV disclosure is not a one-time event; it is a process that occurs repeatedly over time as HIV-positive individuals disclose to different people in their networks (Bott and Obermeyer, 2013).

Counsellors in this study prioritised disclosure to trusted family members. They highlighted both the benefits and risks of disclosure and prepared clients for these discussions by exploring with whom, when, where, and how a client would disclose his or her HIV status to significant others, and they even role-played disclosure scenarios with clients if required. Such activities enabled clients to make informed decisions about to whom they should disclose and how. Although

governmental HTS policy encourages disclosure of a person's HIV status to sexual partners, family members, or friends (Department of Health, 2016c), counsellors confirmed that HIV-positive clients were more likely to disclose their status to trusted family members (e.g. parents and trusted relatives), who in turn act as intermediaries to facilitate disclosure to others. Similar patterns of disclosure were found by Maman et al. (2014) when HIV-positive participants in both South Africa and Nigerian studies first revealed their HIV statuses to trusted family members but only months later told their spouses or sexual partners. Maman et al. (2014) concluded that fears of stigma, discrimination, abandonment, and violence remain significant barriers for women and delay or prevent their disclosure to spouses or sexual partners, which thus reduces its prevention benefits.

A systematic review by Mayston et al. (2012) confirmed the high prevalence of depression among PLHIV when compared to HIV-negative clients and highlighted that both depression and alcohol consumption are associated with reduced ART adherence. Although HTS counsellors in my study appeared to be sensitive to the immediate emotional needs of HIV-positive clients, only one counsellor identified the need for longer-term psychosocial support. She explained how she monitored clients' initial reactions and informed them about counselling and support groups for PLHIV in the community. Further, a baseline study in 2010 found that mental health services for PLHIV in Gauteng were inadequate and that HTS counsellors had limited knowledge about the psychiatric and psychological challenges faced by PLHIV and were therefore unable to address these needs (Haffejee et al., 2010). Although the *2016 National HTS Policy and Guidelines* recognised these needs and stated that HTS counsellors "must assess the risk of suicide, depression and other mental health consequences of being diagnosed and provide relevant referrals," these issues have not yet been incorporated into national HTS training (Department of Health, 2016c).

This study confirmed the critical role of HTS counsellors in providing emotional support to and mobilising psychosocial support for HIV-positive clients. As such, greater emphasis should be placed on these aspects in HIV post-test counselling practice. HTS counsellors should also be sensitised to the potential mental health needs of PLHIV in order to identify and refer clients who are at risk of depression, suicide, and substance abuse for follow-up counselling and support services, given the detrimental impact of poor mental health on PLHIV's quality of life and for ART adherence (Mayston et al., 2012, Haffejee et al., 2010).

4.5.3 Linkage to HIV prevention, treatment, and care services

Linkage to care (LTC) is a critical component of HTS services and represents an important bridge between HIV testing, diagnosis, and the start of ART—three important aspects of the UNAIDS global HIV treatment fast track targets (Knight et al., 2015). HIV testing without linkage to treatment has few benefits for PLHIV (Department of Health, 2016c). Individual HIV testing experiences can also influence HTS clients' future engagement with the health care system (Wringe et al., 2017). Modelling studies conducted by Johnson et al. (2017) projected that by the middle of 2015, South Africa would have achieved high levels of HIV diagnosis, with an estimated 85.5% of adult PLHIV diagnosed. However, of those diagnosed, only 56.9% were on ART (Johnson et al., 2017). This ranged from 50.8% in the North West province to 72.7% in the Northern Cape (Johnson et al., 2017). Improving linkage to ART treatment and care is therefore critical to ensuring that PLHIV access life-saving ART. In August 2016, after this study was conducted, the national Department of Health adopted a universal test-and-treat policy where all clients testing HIV positive would immediately be enrolled on ART, thus removing the final barriers to treatment (Department of Health, 2016a).

HTS counsellors in this study prioritised linking HIV-positive clients to ART treatment and care. They educated clients about the benefits of ART, TB, and viral load and CD4 counts, as well as their implications for ART enrolment. LTC strategies depended on the contexts and resources of NGOs. For example, NGOs that provided HTS via mobile clinics or roadside wellness centres forwarded the details of HIV-positive clients to a call centre for follow-up counselling and LTC, while home-based counsellors accompanied clients to a local clinic for ART enrolment. Sharma et al. (2015) confirmed that home-based HTS, combined with facilitated linkage interventions (e.g. lay counsellor follow-up visits to encourage clinic visits or lay counsellor accompaniment to an HIV clinic), enhanced clients' understandings of ART initiation and improved LTC; such activities helped clients overcome the social barriers, such as stigma and discrimination, sometimes associated with ART (Sharma et al., 2015). Home-based HTS counsellors in this study confirmed these benefits and stated that their proximity to their local communities enabled them to provide services beyond HTS. For example, some conducted follow-up home visits, accompanied clients to the clinic, provided TB treatment support, and re-linked people who had defaulted on TB or ART treatment to a local clinic.

HTS may also reduce HIV risk among HIV-negative clients by linking them to biomedical prevention interventions (e.g. MMC and PrEP), STI and TB treatment, and SRH services (Department of Health, 2016c). However, referrals to HIV prevention and related health services appeared to be a weak link in HTS (Barnabas et al., 2016). In spite of the *2016 National HTS Policy and Guidelines* obliging HTS counsellors to ensure all HIV-negative clients access HIV prevention and SRH services, only home-based HTS counsellors promoted VMMC and SRH and referred HIV-negative clients to these services. The counsellors at this NGO established a referral partnership with a local VMMC service provider and offered HTS as part of VMMC outreach services. While counsellors in the transport sector screened clients for STIs and provided on-site STI treatment, they did not actively promote VMMC and SRH, which indicates they were unaware of this requirement or did not have relationships with service providers to facilitate such referrals. Given the nature of their services, counsellors providing mobile HTS also described difficulties in tracking clients to verify their use of prevention referrals.

4.5.4 Neglected post-test counselling for HIV-negative clients

Despite the importance of primary prevention in ensuring that HIV-negative clients remain so, HTS counsellors in this study tended to spend limited time on post-test counselling for HIV-negative clients. Counsellors congratulated clients on their HIV-negative status, framed being HIV-negative as lucky, and then educated clients about the window period and the need to retest within three months to verify their HIV-negative status. They urged HIV-negative clients to stay negative primarily through using condoms. Colpin (2006) and Corneli et al. (2014) both cautioned that an HIV-negative result or repeated HIV-negative results may decrease the perceived threat of HIV infection, thereby inhibiting changes toward safer sex. They also noted that a large number of people who test HIV positive had previous negative test results (Colpin, 2016; Corneli et al., 2014). Given the continued low-risk perception among South Africans in the context of sustained high-risk behaviour (Shisana et al., 2014, Statistics South Africa, 2017), research showing that individual HCT does not consistently or substantially decrease HIV acquisition risks (Rosenberg et al., 2016), and the fact that receiving repeated HIV-negative test results may create a false sense of security among HIV-negative clients (Plattner, 2010, Colpin, 2006 , Corneli et al., 2014)), further research is urgently needed on how to effectively reduce HIV risk among HIV-negative clients.

4.5.5 Quality of HTS counselling

Quality is defined as "the consistent delivery of a product or service, according to expected standards" (FHI/Impact, 2001: 44). HTS research in southern Africa has focussed primarily on service delivery approaches to increasing the uptake of HTS, but less attention has been paid to the content and quality of counselling in HTS sessions (Mohlabane et al., 2015). However, the quality of counselling is critical; it affects the likelihood of clients reducing their HIV risk through adopting protective behaviours and adhering to prevention guidance. It also affects how PLHIV cope with an HIV diagnosis and may even influence clients' future engagement in ART treatment and care (van Dyk, 2012, Wringe et al., 2017).

Home-based HTS counsellors in this study used checklists to ensure relevant topics were covered and thereby complied with DOH HTS guidelines. They also appeared to be more proficient in counselling when compared to their counterparts in the private transport sector and to HTS counsellors in the national study by Peltzer et al. (2013), which highlighted that some HTS counsellors had difficulty applying even basic counselling skills. This difference may be due to the fact that HTS counsellors in this study were better qualified and more experienced than their counterparts—the majority had five or more years of HTS experience with ten out of 12 (84%) completing Grade 12 and three (25%) obtaining tertiary qualifications. In addition, home-based HTS counsellors were trained primarily by LifeLine in the North West province, where it was compulsory to complete both the LifeLine personal growth course and a ten-day general counselling course before being allowed to apply for the HTS training course.

Reviews of the quality of lay counsellor-led behaviour change interventions in South Africa are mixed. Dewing et al. (2013) and Mohlabane et al. (2015) expressed concern about the quality and fidelity of HCT and adherence counselling in routine care, while Doherty et al. (2013), Petersen et al. (2014), and Magasana et al. (2016) demonstrated that lay counsellor-led interventions are feasible, effective, and can be of high quality if supported by rigorous training and effective supervision. For example, Magasana et al. (2016) found high adherence to HTS counselling and testing protocols among counsellors in the Good Start RCT HB-HCT trial in rural KwaZulu-Natal. Counsellors achieved median scores of 26.5 out of 29 for HCT counselling and 100% adherence to testing protocols. The researchers ascribed the success of these interventions to intensive training (two weeks) attended by both HTS counsellors and their supervisors, combined with rigorous supervision and follow-up assessments (direct observation of counselling sessions)

during the subsequent four-month in-service training (Magasana et al., 2016). This ensured that HTS counsellors were competent and confident in counselling and correctly applied testing procedures when deployed to the field (Magasana et al., 2016). In addition, HTS supervisors also received specific training in quality assurance, supervision, and monitoring and evaluation skills to enhance their capacity to support counsellors and effectively monitor their quality of services (Magasana et al., 2016).

Petersen et al. (2014) suggest that concerns about quality and low fidelity to training models in routine care indicate a need for refresher or in-service training, as well as intensified supervision. Lay counsellors in this study [and previous HCT studies by Peltzer and Davids (2011), Visser and Mabota (2015), and Malema et al. (2010)] confirmed that they received limited supervision and support beyond basic training. This places counsellors at a disadvantage in providing quality HIV counselling and testing services. As such, I ascribe the current gaps in the quality of HTS counselling within routine care to an overburdened health care system with competing priorities and limited investment in the supervision and ongoing professional development of HTS lay counsellors.

Quality assurance, combined with regular supervision, will enhance the quality of HTS counselling nationally. Based on their personal experience supervising lay counsellors who provided risk reduction counselling for HIV PrEP in clinical settings, Malotte et al. (2013) emphasised the importance of both clinical supervision and quality assurance in ensuring fidelity in counselling. They also proposed other quality-assurance mechanisms that have been shown to enhance the quality and consistency of counselling—all of which could be adopted in SA. These include the direct observation of counselling sessions followed by feedback to counsellors; regular case-conferencing, where counsellors and supervisors discuss particularly difficult or rewarding cases or scenarios; the use of cue cards, checklists, or job aids that cover key topics in HCT through open-ended questions, which may counter drift by counsellors; client exit interviews; and self-reflection by counsellors and clinicians (Malotte, 2013). However, they also stress that quality assurance should be accompanied by supportive supervision and psychological debriefing, which enhances lay counsellors' personal and professional competencies and motivations, to improve the quality of counselling (Malotte, 2013).

4.6 Approaches to reducing risk behaviour among clients

One of the core objectives of HTS is to reduce individual risk of HIV acquisition or transmission (Denison et al., 2008, Department of Health, 2010, Department of Health, 2016c). Systematic reviews have confirmed that HCT can increase condom use and reduce the number of sexual partners among HTS clients (Fonner et al., 2014, Denison et al., 2008, Weinhardt et al., 1999).

HTS counsellors in SA (including in this study) follow a client-centred, individualised approach to HTS counselling. However, there is limited evidence that this approach is effective in reducing HIV risk among HTS clients (Peltzer et al., 2013). In contrast, theory-based strategies, such as brief and structured risk-reduction counselling (based on the IMB Skills model), combined with HIV testing, have proven effective in reducing unprotected sex, alcohol use before sex, the number of sexual partners, and transactional sex among high-risk groups globally and in South Africa (Petersen et al., 2014, Simbayi et al., 2004).

The IMB Skills model provides a comprehensive yet simple framework for understanding and addressing the social and psychological factors that influence individual HIV risk behaviour (Fisher et al., 2003). This model can assist HTS counsellors with identifying the specific client, relationship, and contextual IMB gaps and barriers that clients must overcome to adopt safer sex behaviours and set and reach concrete, achievable risk-reduction goals relevant to their unique circumstances. This specificity may help counsellors tailor their risk-reduction counselling strategies to the specific contexts, risk factors, and prevention needs of individual clients, instead of providing general prevention messages. The IMB Skills model has also been culturally adapted to South African circumstances and successfully piloted by lay counsellors in a range of contexts (Petersen et al., 2014). Given its potential and the fact that behaviour change is central to reducing HIV risk, creasing the uptake of and adhering to biomedical interventions such as VMMC, PrEP and sustaining clients on ART, the feasibility of scaling up theory-based counselling approaches should be further investigated.

4.6.1 Risk assessment and risk-reduction counselling

Risk assessment is a process where the counsellor assists a client with identifying, understanding, and acknowledging the behaviours and circumstances that put them at increased risk of HIV infection (FHI 360, 2016). HTS counsellors in this study did not conduct such risk assessments with clients in the formalised process described by FHI 360 (2016) but rather determined clients' risk by exploring their reasons for testing, their testing histories, and whether they had recently

engaged in any risk behaviours. As stated by one counsellor, it "*helps to determine the type of person you are dealing with*." However, Mohlabane et al. (2015) identified risk assessment and risk-reduction counselling as weak—and half of the time missing—points in current HTS, which was also found in this study. Despite the centrality of risk reduction in HTS, Peltzer et al. (2013) identified the lack of detailed guidance for conducting risk assessments and facilitating risk-reduction counselling among clients as a gap in HTS policy and training. This situation was also reflected in the findings of this study.

HTS counsellors' strategies for reducing the number of sexual partners among HTS clients also appeared to be points of disconnect within counselling sessions. Kenyon et al. (2016) and Mah (2012) explored the prevalence and social dynamics of partner concurrency and HIV using data from the *2008 South African National HIV Behaviour Survey*. They found a significant positive relationship between male partner concurrency (having multiple concurrent partners) and HIV prevalence among young, black, African women. They found that male partner concurrency not only expanded the sexual networks of these women, but it also increased the probability that women came into contact with HIV-infected members of these network (Kenyon et al., 2016). Despite these risks, the approach of HTS counsellors in this study to partner reduction appeared to be shaped by socio-cultural and gender norms; there was greater acceptance of MCP among men than among women. Both male and female counsellors tended to encourage men to use condoms with all sexual partners and particularly with external partners but encouraged women to be faithful to their partners. One counsellor also advised men engaging in MCP to have regular HIV tests and to take their partner(s) to clinics for HIV and STI testing. Although females also engage in MCP, they were less likely to admit engaging in such behaviours; MCP among women is culturally discouraged (Kenyon et al., 2016, Maughan-Brown et al., 2014, Mah, 2010, Mah and Maughan-Brown, 2012).

The gaps in risk-reduction counselling identified in this study may be due to a variety of factors, including an inadequate understanding of differential HIV risk among clients (Richter et al., 2013, Bernard, 2010); insufficient training and inadequate national guidance on how to conduct comprehensive HIV risk assessments or facilitate risk-reduction counselling among clients (Peltzer et al., 2013); and limited exposure to psychosocial theories of behaviour and behaviour change (Weinhardt, 1999). Peltzer et al. (2013) found that most HTS training programmes did not include specific guidance on how to facilitate in-depth personal-risk assessments or risk-

reduction counselling. The current study confirmed this finding; none of the counsellors mentioned specific guidance or training in this regard.

Additionally, HTS counsellors in this study had limited exposure to individual or social theories of behaviour change. However, such theories may improve counsellors' understandings of how individual, relationship factors and higher-level social, cultural, economic, environmental, and structural factors influence individual risk (Baral et al., 2013). Counsellors' increased understandings of these factors could provide a framework for assessing individual HIV risk and vulnerability or help identify comprehensive packages of HIV prevention services for individual clients (Department of Health, 2016b, Baral et al., 2013). HTS counsellors could also apply insights to the identification of IMB-related barriers to behaviour change, assist clients with overcoming such barriers to reduce their risk of HIV infection, and refer them to appropriate HIV prevention, treatment, and care services (FHI 360, 2016, Bekker et al., 2012).

Finally, research has shown that 30 years into the global AIDS epidemic, no single prevention method is sufficiently effective or feasible to control the AIDS epidemic (Chang et al., 2013, Alsallaq et al., 2013). However, a growing number of interventions (e.g. ART, MMC, condom use, and PrEP) have been shown to partially reduce HIV risk (Alsallaq et al., 2013). Combining these interventions with structural interventions to enhance gender equality, respect for human rights, and improve socioeconomic conditions has proven effective in reducing population-level HIV incidence in four studies in eastern and southern Africa (UNAIDS, 2018). In recognition of this complexity, the national Department of Health adopted a combination prevention approach in 2016, which entails the strategic use of tailored combinations of behavioural, biomedical, and structural interventions to reduce HIV vulnerability and risk (Alsallaq et al., 2013, Department of Health, 2016b). Although this study focussed primarily on lay counsellor experiences with and strategies for reducing HIV risk, HTS is not intended to be implemented as a single, stand-alone intervention. Rather, it should form part of a comprehensive package of HIV prevention services that should be tailored to the risk profiles and prevention needs of specific populations and clients to effectively reduce HIV risk.

4.7 HTS training and supervision

The training of HTS counsellors emerged as an area of concern in this study and has also been highlighted as a quality concern nationally. Both the 2010 and 2016 *South African National HIV Testing and Counselling Policies* emphasised that HTS counsellors should be adequately trained

by accredited service providers and that HIV counselling should comply with the *National Standards for Counselling*, published in 2000 (Peltzer et al., 2013, Department of Health, 2010, Department of Health, 2016c). HTS counsellors in this study confirmed the lack of standardisation within training identified by Peltzer et al. (2013). In that study, training was provided by NGOs or the government, and provinces used different training curricula, with some containing irrelevant or outdated content (Peltzer et al., 2013). Against a prescribed minimum of ten days, HTS training ranged from five to 20 days in my study and three to ten days in the study by Peltzer et al. (2013). Mohlabane et al, (2015) found that 75% of HTS lay counsellors interviewed as part of the national HTS study completed the required ten days or more of training, while 25% received less than the minimum. The prescribed duration of HTS training in SA is shorter than in other SADC countries, where pre-service training ranges from two to three weeks (ten to 15 days) in Lesotho, Swaziland, Zimbabwe, and Malawi, with most countries requiring a compulsory, supervised, practical component of six weeks to six months to ensure counsellors' proficiency in both HIV counselling and rapid testing (Medecins Sans Frontieres, 2015).

HTS training also differed in content, depth, emphasis, and pedagogic approach, depending on the training organisation (Peltzer et al., 2013), which was also found to be the case among counsellors and organisations in this study. HTS managers in a study by Peltzer et al. (2013) raised concerns about training programmes and have recommended that HTS training be standardised at the national level and annually updated and that all training service providers be accredited by the Health and Welfare Sector Education and Training Authority (SETA) to ensure consistency in training. Despite HTS managers raising these concerns in 2013, updated standards for HTS training and nationally standardised curricula for HTS service provision are not yet available. The national Department of Health is, however, in process of finalising a national *Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams*, which will serve as a blueprint for the standardisation of HTS training, recruitment, and services by lay counsellors (personal communication, HIV Prevention Director, Department of Health, 27 March 2018).

According to Hannula (2014), the standardisation of business processes has the potential to ensure quality and consistency of procedures and reduce the risk of mistakes. HTS training can be standardised by developing an easily-referenced, standard training documents and standard

training approaches, but training methodologies need to be robust to take into account principles of adult learning and accommodate different learning styles (Hannula, 2014). In addition, minimum standards for HTS training—with clear training aims and objectives—should also provide an indication of the intended end result of training; specify the desired knowledge, attitudes, and behaviour or skill levels required; indicate the conditions under which these behaviours need to occur; and set the benchmarks against which progress would be measured. Well-defined and clearly articulated learning objectives would also direct learners' efforts and provide guidance to HTS trainers around appropriate instructional activities and assessment strategies (Hannula, 2014). Updating or setting minimum standards for HTS training and the accreditation of training service providers would enhance the national quality and consistency of HTS training and practice.

The motivation and retention of HTS counsellors also emerged as a potential challenge. Counsellors highlighted a number of physical and psychological stressors they encountered in everyday practice and in supporting PLHIV within their communities. These included dealing with cases of child abuse, denial among HIV-positive clients, conflict between couples in cases of sero-discordant diagnoses, and feelings of frustration at being unable to assist destitute clients. Similar stressors were experienced by HTS lay counsellors in the Eastern Cape, Limpopo, Gauteng, and Mpumalanga provinces, who reported medium to high levels of stress due to the emotional burdens of informing the parents of children and young adults of their child's HIV-positive diagnosis (especially if the client's age was similar to the counsellor's own children); dealing with loss and death; and having to watch as PLHIV were sometimes rejected by their families (Peltzer and Davids, 2011, Visser and Mabota, 2015, Malema et al., 2010, Goldberg, 2004)).

Some counsellors in this study mentioned being motivated to enter the HTS field by personal experiences of loss or trauma, such as the HIV-related death of a loved one. In addition, HTS counsellors often went beyond the call of duty, assisted clients after working hours, and incurred out-of-pocket expenses to help destitute clients. These counsellors appeared unaware of the need for HTS counsellors to set and maintain psychological and professional boundaries to reduce the risk of secondary traumatisation and to prevent burn-out. Goldberg (2004) and Visser and Mabota (2015) cautioned that these tendencies, if not addressed, may negatively affect counsellors' mental and physical health, increase the risk of burn-out and high dropout rates, and

compromise the quality of HTS counselling. These issues, coupled with high levels of job insecurity, poor remuneration, limited opportunities for career advancement, and the negative attitudes of many health care workers toward HTS counsellors, may also de-motivate HTS counsellors and negatively affect their work performance (Petersen et al., 2014, Peltzer and Davids, 2011). This confirms the need for both psychological debriefing and supportive supervision for counsellors to sustain the quality HTS counselling (Goldberg, 2004).

Peterson et al. (2014) and Goldberg (2004) argued that supervision should be an integral, rather than peripheral, part of HTS counsellors' training and practice. Supportive supervision is the process of guiding, monitoring, and coaching workers to promote compliance with standards of practice and to ensure the delivery of quality services (Crigler et al., 2014). It enables supervisors and supervisees the opportunity to work as a team to meet common goals and objectives (Crigler et al., 2014). Despite both the 2010 and 2016 *National HTS Policies and Guidelines* stating that regular supervision and training, including observation of actual counselling sessions with feedback to counsellors, are essential to ensure quality counselling and testing in HTS, supervision remains a weak area of HTS programmes (Department of Health, 2014, Department of Health, 2010, Department of Health, 2016c). The majority of HTS counsellors in this study highlighted that supervision and support were limited and irregular due to competing priorities and that staff meetings focussed mainly on operational matters rather than on the personal or professional development of counsellors. Similar concerns were raised by HTS counsellors in studies by Dlamini (2011), Malema et al. (2010), and Peltzer and Davids (2011). This is in contrast to Mwizongo's (2015) findings that 86.1% of the 32 lay counsellors interviewed as part of the national HTS study reported receiving some kind of formal counselling supervision at work. Although 53.1% of those counsellors reported satisfaction with their supervision, 46.9% requested emotional support and debriefing as they felt de-motivated and undermined by other health professionals due to their lack of health-related education (Mwizongo, 2015).

According to Peterson et al. (2014), supervision contributes to the development and maintenance of professional competence for new and experienced counsellors and enables them to provide quality care to clients. Supportive supervision, combined with debriefing, may also help counsellors cope better with the emotional impacts of their work and reduce the risks of burn-out and high staff turnover (Petersen et al., 2014, Goldberg, 2004, Visser and Mabota, 2015). Quality-assurance mechanisms that may easily be incorporated into existing national HTS

practice include routine, periodic site visits, observation during HTS counselling sessions, and feedback to counsellors (Petersen et al., 2014). While trained supervisors may not always available to perform such functions, senior HTS counsellors could fulfil these roles, with follow up support by supervisors (Petersen et al., 2014). However, this requires performance standards that clearly define the content and quality HTS counselling to guide both the implementation and assessment of counselling practice. Clients' permission should also be obtained prior to observation of HTS sessions (Petersen et al., 2014).

Many of the HTS counsellors in this study desired formal recognition or accreditation for their work. They stated that, while they felt accepted and respected in communities and found their work meaningful and fulfilling, they also felt marginalised within the broader health care system. They called on the government to formally recognise their role by providing uniforms to increase their visibility in communities; doing away with stipends and instead appointing HTS counsellors as full-time employees; investing in the professional development of HTS counsellors; and establishing a professional body for HTS to advocate for counsellors' rights and to regulate members' conduct. Similar desires were expressed by community health workers in South Africa and other SADC countries (Medecins Sans Frontieres, 2015, Peltzer and Davids, 2011). However, the pace of transformation has been slow; only one country, Zambia, has established a professional council for lay counsellors to date (Medecins Sans Frontieres, 2015).

Despite this, good practice examples exist in South Africa. For example, the National Department of Social Development committed to professionalising child and youth care work through partnering with the National Council of Child and Youth Care Work (NACCW) to recruit and train 10,000 unemployed youth as child and youth care workers (CYCW). This was intended to improve the quality of care for orphans and vulnerable children (Dlamini, 2012). The NACCW is registered with the Health and Welfare SETA and offers a Further Education and Training Certificate (FETC) in Child and Youth Care Work at the NQF Level 4 (National Council for Child and Youth Care Work, 2018). In addition, two South African universities now offer CYCW degrees, and more than 6,000 CYCWs have been qualified and are formally registered with the South African Council for Social Service Professions under a new statutory legislation championed by the NACCW (National Council for Child and Youth Care Work, 2018). SAQA also developed qualifications in community development, counselling, auxiliary health care, and auxiliary social work, which may provide potential career paths for HTS counsellors and

community health care workers. However, further research is needed to establish a coherent framework for the professional development and career progression of lay counsellors in South Africa. Given the high HIV burden in SA, the need to further scale up HTS, and the need to sustain approximately 7.9 million PLHIV on lifelong ART treatment, investment in the supervision of HTS lay counsellors remains a critical priority.

4.8 Study limitations

This study had some design limitations. First, as a small, qualitative study, findings may not be transferrable beyond the study context. The use of thick description and discussion with the broader literature has sought to address this. By selecting multiple sites and HTS modalities (i.e. home-based, mobile, and outreach), the study uncovered contextual differences that influence HTS counselling approaches and strategies for linking clients to prevention, treatment, and care services. While we noted some of these in the results, this sampling strategy could have been better leveraged using a clear phenomenological approach from the onset and by presenting the findings in a more clearly patterned way in analysis. There were also limitations in terms of data collection. A majority of counsellors in this study spoke Sotho as a first language, and interviews were conducted in English. Participants' language proficiency varied, which may have affected the information gained from the interviews. They may have omitted some information due to language differences. In addition, the study focussed on HTS counsellors only. No direct observations were made of counselling encounters to verify their accounts and the perspectives of HTS clients were beyond the scope of the study. HTS clients could have provided valuable feedback on their HTS experiences, their thoughts about HIV risk, how and whether HTS influenced their perception of risk, and their adoption of HIV prevention methods and protective behaviours.

5 Chapter 5: Conclusion and recommendations

5.1 Overview

The final section of this report synthesises key findings of the study with its conclusions. It also presents a synthesis of policy recommendations, programmatic considerations, and recommendations for future research.

5.2 Conclusion

This study explored the perceptions and experiences of HTS lay counsellors with regard to the HIV counselling and testing of diverse clients. It interrogated their counselling approaches with both HIV-positive and HIV-negative clients and the strategies they used to reduce HIV risk among HTS clients. The study further elicited counsellors' perceptions of and experiences with HTS training and supervision and their recommendations for improving HTS policy, training, and counselling practice. Key findings that emerged from the study are covered below.

HTS lay counsellors, as professionals, do not feel they receive the support they need. They also recognise they are at the forefront of national HIV intervention and have played a critical role in scaling up HTS in poor and under-resourced communities in South Africa (Medecins Sans Frontieres, 2015). The roles they describe include educating clients about HIV; providing HTS pre- and post-test counselling and testing; countering stigma and discrimination; mobilising social support for HIV-positive clients; and linking clients to prevention, treatment, and care services in line with the global UNAIDS 90-90-90 targets. However, they face a number of structural challenges that impede their work performance and motivation; this has also been noted in other studies (Medecins Sans Frontieres, 2015). HTS counsellors are not formally, nationally, and professionally recognised or included in national human resources for health plans. They also lack standard scopes of work, job profiles, and consistent salaries, which results in inconsistent management and unfair treatment.

This research confirms previous findings that the quality of HTS counselling, especially risk-reduction counselling in routine care, is sub-optimal and varies between sites and counsellors. HTS counsellors were trained in and follow a client-centred approach to counselling, which has been adopted by the national DOH. Because clients’ HIV status are unknown in pre-test

counselling, lay counsellors tended to balance general HIV education with more tailored HIV prevention counselling for individuals. However, counsellors did not conduct formal risk assessments; rather, they educated clients about HIV and risk-reduction methods based on the client's reasons for testing, testing history, and risk behaviour since their previous test. Risk-reduction counselling covered behaviour change, such as condoms and the reduction of sexual partners, as well as STI screening and treatment, ART, and referrals to VMMC and SRH. However, risk-reduction counselling tended to be general, and counsellors tailored their language to the age and gender of clients. Counsellors appeared to neglect exploring the client's specific risk factors and informational, motivational, and skills-related barriers that may prevent the adoption of protective behaviours (Fisher et al., 2003). Additionally, HTS counsellors did not appear to accept the notion of "differential risk" among clients—the idea that some individuals may be at higher risk of HIV infection due to biological, structural, social, cultural, and behavioural factors (Richter et al., 2013). The counsellors in this study preferred to consider everyone at risk for HIV infection rather than to ascribe HIV-related risk to specific circumstances or behaviours. This reluctance to label clients as “at risk” may be due to counsellors’ first-hand experiences with stigma and discrimination against PLHIV in their communities, their interpretations of interview questions (due to language difficulties), or their perceptions that such a distinction may appear discriminatory. However, their approach to the notion of risk increased the perception that HIV infection is unavoidable, and it resulted in counsellors failing to address known risk factors, such as alcohol abuse, anal sex, and gender-based violence, during HTS counselling.

Counsellors prioritised post-test counselling for HIV-positive clients, as well as creating a safe space for clients to express their fears and feelings. They also used reframing techniques to give clients hope and to focus on life and social responsibilities versus death. They further mobilised social support for PLHIV by promoting disclosure to trusted significant others and by linking HIV-positive clients to treatment and care services through referrals. Home-based HTS counsellors conducted follow-up counselling and site visits and accompanied clients to clinics to overcome treatment barriers.

Although research demonstrates that lay counsellor-led risk-reduction interventions (based on adaptations of the IMB Skills model), coupled with sufficient training and supervision, can be effective in reducing risk behaviour (e.g. unprotected sex, alcohol use before sex, number of

sexual partners, and transactional sex among high-risk groups) (Petersen et al., 2014), risk-reduction counselling alone appeared to be inadequate for the reduction of HIV risk. This could be mitigated through improved HTS training, the use of individual and social theories of behaviour change within interventions, and a greater investment in supervision and professional development opportunities for HTS counsellors.

5.3 Recommendations

Based on the results and conclusions of this study, the following key considerations are recommended to enhance the experience and performance of HTS lay counsellors through policy, programmatic changes and further research.

5.3.1 Create a supportive legal and policy framework to guide the integration of HTS lay counsellors into the formal health care system

Job insecurity and lack of recognition impact the experience and performance of lay counsellors. To optimise the role of lay counsellors and to ensure sustained support by this cadre of health workers, this study recommends that the government develop a supportive legal and policy framework to guide the integration of HTS lay counsellors into the formal health care system. Medecins Sans Frontieres (2015) called for the formal recognition of CHWs and cautioned that the ability of SADC countries (including SA) to effectively scale up HTS and sustain HIV-positive patients on ART, in line with the global UNAIDS 90-90-90 targets, would be compromised by the lack of supportive national policy and legal frameworks and by an over-reliance on shrinking donor funding. This type of formal recognition should be preceded by a human resource skills audit to identify existing skills and gaps among HTS providers, as well as skills development needs (Akintola and Chikoko, 2016). The national DOH should also update its health information systems to include data on CHW and HTS counsellors to inform human resource planning and the appropriate allocation of finances and resources (Medecins Sans Frontieres, 2015). In addition, the government should clarify the legal position of HTS lay counsellors as per the labour court judgement of 2016 to ensure equitable treatment of HTS lay counsellors as employees (The Labour Court of South Africa, 2016, Cabe, 2018). The national DOH, in consultation with relevant departments and organisations (e.g. the Department of Social Development, provincial Departments of Health, the Health and Welfare SETA, and civil society organisations), must update the *2000 National HTS Minimum Standards* and harmonise HTS

counsellors' scope of work, job profiles, education entry criteria, basic and ongoing training, remuneration, career paths, and supervision and debriefing requirements.

Establish a professional body for HTS lay counsellors

HTS lay counsellors expressed the need to professionalise HTS services by establishing a formal body (similar to a nursing council) to protect their rights, oversee their work practices, and hold them accountable. This was also recommended by Peltzer and Davids (2011) based on their study with HTS lay counsellors in the Eastern Cape. Good practices related to the professionalization of lay counsellors exist in South Africa and regionally. For example, Zambia established a council for lay counsellors, while the South African NACCW worked with the Department of Social Development and the Social Work Council to professionalise child and youth care work in SA. The recommended council could be affiliated with or established under the auspices of an existing council, such as the Health Professions Council of SA, the Board for Psychology, the Social Work Council, or an equivalent, to enhance the recognition and accountability of HTS counsellors and facilitate their integration into the formal work force.

Improving motivation and retention of HTS lay counsellors

The motivation and retention of HTS counsellors emerged as a potential challenge. HTS counsellors enter the profession motivated by altruism, opportunities to learn new skills or find employment and sometimes in an effort to make sense of personal experiences of loss and trauma (Akintola, 2011, Topp et al., 2015, Goldberg, 2004 and Beatty, 2011). These motivations should be acknowledged and addressed in both recruitment, training and supervision as unresolved trauma may lead to over-identification with certain clients, compromise the quality of counselling and increase the risk of secondary traumatisation and burn-out among counsellors (Goldberg, 2004, Hernandez-Wolfe et al., 2010, Visser and Mabota,).

5.3.2 Recommendations for improving HTS counsellors approaches and skills

Update the minimum standards for HTS training, and standardise HTS training curricula at the national level

Standardised HTS training would enhance the relevance and consistency of HTS and address the quality concerns raised by Peltzer et al. (2013) and Mohlabane et al. (2015). HTS training should include clearly defined training aims, objectives, outcomes, and assessment criteria for determining the achievement of skills and competencies (Hannula, 2014). It should include easily

referenced, nationally standardised facilitator- and participant-training materials and a standard training approach with experiential, participatory training methodologies that are in line with the principles of adult learning (Hannula, 2014). HTS training should be aligned with the qualifications of auxiliary health, nursing, auxiliary social work, social work, counselling, psychology, and community development and be accredited with the Health and Welfare SETA to create career paths and enhance the career progression of CHW and lay counsellors. HTS training should focus on skills development and knowledge around counselling, mental health, individual and social theories of behaviour change, risk reduction, medical knowledge, HTS procedures, and the biomedical aspects of HIV prevention, ART, and TB treatment (Peltzer et al., 2013). Additionally, given the dynamic nature of the country's AIDS epidemic, training materials should be reviewed and updated annually based on emerging evidence and policy changes (Thurling and Harris, 2012).

Develop theory-based counselling approaches, such as the IMB Skills model to enhance the quality of risk reduction counselling in HTS

Theory-based approaches, such as brief-structured risk-reduction counselling (based on the IMB Skills model), combined with HIV testing, have proven to be effective in reducing unprotected sex, alcohol use before sex, number of sexual partners, and transactional sex among HIV high-risk groups globally and in South Africa (Petersen et al., 2014, Simbayi et al., 2004). The IMB Skills model has been culturally adapted to South African circumstances through job aids and has been successfully piloted by lay counsellors in a range of contexts (Petersen et al., 2014). The IMB Skills model provides a comprehensive yet simple framework for understanding and addressing the social and psychological factors that influence individual HIV risk behaviour (Fisher et al., 2003). This type of model could assist HTS counsellors with identifying the specific client, relationship, and contextual IMB barriers that clients must overcome when adopting safer sex behaviours. It could also help HTS clients set and reach concrete, achievable risk-reduction goals relevant to their unique circumstances. Given the potential of this approach and the fact that behaviour change remains core to HIV risk reduction and to biomedical intervention adherence, the feasibility of scaling up theory-based counselling approaches should be further investigated.

Strengthen HTS supervision to improve the quality of HTS counselling and testing

Given the critical role of supervision to ensuring quality HTS provision, the national DOH should develop supervision and quality-assurance standards and guidelines that specify HTS supervision

objectives, responsibilities, frequency, outcomes, and tools (Crigler et al., 2014). In addition, the HTS supervisors and senior HTS counsellors should be trained in supportive supervision and mentorship skills, problem solving, quality improvement, and psychological debriefing to enhance HTS lay counsellors' professional competencies and to help them cope with work-associated stress (Peltzer and Davids, 2011, Petersen et al., 2014). Intensive, practical supervision should be provided during in-service training on both HIV counselling and rapid testing prior to accreditation and deployment as HTS counsellors. This would ensure that counsellors are competent and confident in applying their HTS skills. The government should also investigate the feasibility of partnering with local NGOs (e.g. Lifeline and FAMSA) to facilitate monthly psychological debriefing sessions for counsellors in order to monitor and reduce the risk of compassion fatigue and burn-out among HTS counsellors (Goldberg, 2004, Visser and Mabota, 2015).

5.3.3 Recommendations for further research

Given the following, further research is urgently needed around how to effectively reduce HIV risk among HIV-negative clients: the continued low-risk perception of HIV acquisition among South Africans in the context of sustained high-risk behaviour (Shisana et al., 2014, Statistics South Africa, 2017), research that shows that individual HCT does not consistently or substantially decrease HIV acquisition risk (Rosenberg et al., 2016), and evidence that receiving repeated HIV-negative test results may create a false sense of security among HIV-negative clients (Plattner, 2010, Colpin, 2006 , Corneli et al., 2014).

This study explored the perceptions and experiences of HTS lay counsellors with providing HTS to diverse clients, including risk-reduction strategies, and elicited their insights into current training and supervision practices. However, no direct observations were made of HTS counselling encounters to verify these accounts. Further, the inclusion of HTS clients would have been helpful for triangulation purposes and for the observations of counselling encounters. HTS clients could provide valuable feedback on their HTS experiences, their thoughts about HIV risk, how and whether HTS has influenced their perceptions of risk, and their adoption of HIV prevention methods and protective behaviours.

Much research on the effectiveness of HCT in reducing sexual risk behaviour has focussed only on HCT as a stand-alone intervention (Denison et al., 2008, Fonner et al., 2014). More research is

needed to assess the synergistic effects of HCT when implemented in combination with other biomedical and structural interventions, such as VMMC, SRH, PrEP, and ART.

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Appendices

Appendix 1: Plagiarism Declaration



PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I ___Zuzelle C Pretorius____ (Student number: 745746) am a student

registered for the degree of _Masters in Public Health in the academic year _2019_.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.



Signature: _____ Date: _2019/06/04_____

Appendix 2: In-depth interview guide

IN DEPTH INTERVIEW GUIDE

1. Personal details	Number/Code: Organisation: Position: Age: Sex: Education:
	Date: Time: Place:
2. Introduction and informed consent	Obtain written consent for participation in study and separate consent for audio-recording.
3. Questions:	– How is HIV Counselling and Testing provided to clients at your clinic/organisation? – Now I want us to explore more in depth what happens in a counselling session with specific clients. Tell me exactly what happens in a counselling session with a client from the moment the person steps into the door? Probe: o How do you establish rapport? Inform the client about confidentiality? o How do you assess the client's current level of knowledge about HIV and AIDS?

	○ What information do you give to a client? (HIV, modes of transmission, dispel common myths, STIs, TB, & HIV, window period, retesting) ○ How do you obtain informed consent and explain procedures for HIV testing? ○ How do you assist a client to assess their HIV risk? (sexual activities with multiple partners, or while infected with STIs, low condom use, transactional sex, excessive alcohol use, migration, early sexual debut, or the sharing of needles among IDUs) ○ How do you help a client to reduce their risk of contracting HIV? ○ What counselling approaches and techniques do you use to achieve this? ○ How does your counselling approach differ with different types of clients? E.g. men, women, youth, sex workers, long distance truck drivers ○ How do you prepare a client to deal with the potential outcome of the HIV test – HIV positive or negative test result? – After HIV testing, the client returns for post-test counselling. What happens in the post-test counselling session, from the moment the person steps in the door? Probe: ○ How do you inform the client of the outcome of the HIV test? ○ How does your approach or the content differ based on their HIV result? ○ What do you discuss with the client in case of an HIV negative or positive result? ○ What do you discuss in case of an HIV positive result? ○ How do you help a client to cope with the HIV positive diagnosis? (implications of being infected, accessing emotional support, disclosure, viral load and ART, susceptibility to TB, life style changes, how to reduce risk of onward transmission)

	– How do you refer clients for different services? o What information do you give to HIV positive and negative clients about available HIV prevention, TB and STI treatment, and care services? o What support do you provide to enable clients to access these services? – What do you see as some of the strengths/successes in HIV- counselling in HCT services? – What are some of the challenges you encounter in counselling? o How do you deal with these challenges? – Tell me more about the HIV and counselling training that you have received to become an HCT counsellor? Probes: o Who presented the training? What topics were covered? What was the duration of the training? o What counselling approaches or individual and social theories did it cover to help understand individual behaviour? o Did the training focus on risk reduction counselling? o How did the training help to develop your counselling skills? o Have you attended any follow up or refresher training courses since becoming an HCT counsellor? What topics did it cover? o Are there specific topics that you feel should be included in the training of new HCT counsellors? Please describe. o Are there any topics that you feel should be included in follow up training of counsellors? Please describe. – How do you feel about your work as an HCT counsellor? – Probes: o What kind of supervision and other support do you receive to deal with the emotional consequences/stress of your work?

	○ What support would you like to receive? How often? – How can HCT counsellors best use their time with HCT clients to enhance HIV prevention outcomes? – What could HCT counsellors do to help improve the uptake of other HIV prevention treatment and care services? – How can government strengthen HCT policy, training, and supervision to improve the quality and effectiveness of HIV counselling in HCT?
Closing • Additional comments • Next steps • Thank you	– Is there anything more you would like to add? – I'll be documenting and analysing the information you and others gave me and submitting a draft report to the organization in one month. I'll be happy to send you a copy to review at that time, if you are interested. – Thank you for your time.

Appendix 3: HREC approval

R14/49 Mrs Zuzelle C Pretorius

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M150359

NAME: (Principal Investigator)	Mrs Zuzelle C Pretorius
DEPARTMENT:	Public Health HCT Sites in Gauteng and One Site in Zeerust, North West; HCT Sites in Madibeng Sub-District, North West HCT Sites in Tshwane Metropolitan Municipality Area
PROJECT TITLE:	Perceptions and Experiences of HCT Counsellors of Providing HIV Counselling at Three NGO HCT Sites in South Africa
DATE CONSIDERED:	27/03/2015
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Sara Nieuwoudt
APPROVED BY:	Professor P Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	03/06/2015

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.
I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned

contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**.

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 4: NGO permission to conduct study

Trucking Wellness
Driving the well-being of the industry.

Unit 7, Colgray Business Park, 32/33 Christopher Street, Boksburg
PO Box 1188, Boksburg 1459
Tel: 011 914 1611 Fax: 011 914 3463
Fax2Email: 086 693 3997
www.truckingwellness.co.za

2015-03-05

Ref: ZC Pretorius 745746

To whom it may concern

PERMISSION TO CONDUCT QUALITATIVE RESEARCH WITH HCT COUNSELLORS

CEP is a non-profit organisation established in 2006, that provides essential Healthcare services to Long Distance Truck drivers and Commercial sex workers through a national network of 22 Wellness Centres. The Trucking Wellness Programme is an initiative of the National Bargaining Council is for the Road Freight and Logistics Industry (NBCRFLI) in South Africa.

Permission is herewith granted to Zuzelle Pretorius, a student pursuing a Master's in Public Health through the School of Public Health at the University of Witwatersrand to conduct in depth interviews with HIV counselling and testing counsellors at HCT sites in Gauteng province. The actual sites will be confirmed in consultation with CEP management.

The aim of the study is to explore the perceptions and experiences of HCT counsellors of providing HIV counselling at three NGOs in Gauteng and North West provinces in South Africa in 2015. Specific objectives of the study are:

- To describe HCT counsellors' experiences and views of providing HIV counselling to HIV positive and HIV negative clients at three NGOs in Gauteng and North West provinces in 2015
- To describe HCT counsellors' approaches to reduce sexual risk behaviour among different types of HCT clients (e.g. youth, long distance truck drivers, sex workers) at three NGOs in Gauteng and North West provinces in 2015
- To describe HCT counsellors' experiences and their opinions of HIV counselling training and supervision at three NGOs in Gauteng and North West provinces from their initial employment until present
- To elicit HCT counsellors' recommendations for strengthening HCT policy, training and counselling practice.

It would be appreciated if the student could share the final report/present the results to Trucking Wellness, to identify potential areas for strengthening HCT counselling practice.

Regards

Tertius Wessels
Managing Director
CEP

Executive Directors: *Tertius Wessels, Nelson Themba Mthombeni, Michelle Steyn, Ryan Goosen*
Non Executive Directors: Dr Clifford Panter, Louis Hollander

Corridor Empowerment Section 21 CK No.: 2006/016165/08
Non Profit Organization: 069-592-NPO



Physical Address:
283 Rotsvvgie Street
La Montagne
Pretoria
0184

Tel: -2712 803 1985
Fax: +2712 803 5360

NKATHALO WELLNESS

Reg No.:2010/005974/08 SECTION 21 COMPANY

16/03/2015

Ref: ZC Pretorius 745746

To whom it may concern

PERMISSION TO CONDUCT QUALITIATVE RESEARCH WITH HCT COUNSELLORS

Nkathalo Wellness is a section 21 non-profit company registered in 2010 in the Republic of South Africa. The NGO through funding, has been providing health care services to communities assisting the Department of Health in areas of HIV prevention, TB treatment support and Intensified case finding. Nkathalo Wellness operations are in the North West Province in the district of Bojanala.

In 2014 Nkathalo Wellness received funding from USAID through MSH to provide HIV prevention services to Migrant Corridor Communities. Under this funding Nkathalo Wellness provides HCT,TB screening, treatment support and community awareness services to Migrants in the communities of the North West Province in the Madineng sub-district along the N4 route.

Permission is herewith granted to Zuzelle Pretorius, a student pursuing a Master's in Public Health through the School of Public Health at the University of Witwatersrand to conduct in depth interviews with HIV counselling and testing counsellors at Bapong and Majakaneng communities.

The aim of the study is to explore the perceptions and experiences of HCT counsellors of providing HIV counselling at three NGOs in Gauteng and North West provinces in South Africa in 2015. Specific objectives of the study are:

- To describe HCT counsellors' experiences and views of providing HIV counselling to HIV positive and HIV negative clients at three NGOs in Gauteng and North West provinces in 2015.
- To describe HCT counsellors' approaches to reduce sexual risk behaviour among different types of HCT clients (e.g. youth, long distance truck drivers, sex workers) at three NGOs in Gauteng and North West provinces in 2015.
- To describe HCT counsellors' experiences and their opinions of HIV counselling training and supervision at three NGOs in Gauteng and North West provinces from their initial employment until present.
- To elicit HCT counsellors' recommendations for strengthening HCT policy, training and counselling practice.

It would be appreciated if the student could share the final report/present the results to Nkathalo Wellness, present key findings of the study to Wellness management to identify potential areas for strengthening HCT counselling practice.

Regards

D. NDIWALANA

Signed by Director

FPD
www.foundation.co.za

30 March 2015

Ref: ZC Pretorius 745746

To whom it may concern

PERMISSION TO CONDUCT QUALITIATVE RESEARCH WITH HCT COUNSELLORS

The Foundation for Professional Development (FPD) is a non profit organisation established in 1997 by the South African Medical Association (SAMA)

The Community Based Counselling and Testing (CBCT) program, a USAID funded initiative, implemented by Foundation for Professional Development (FPD) in partnership with Society for Family Health, FHI360 and Humana People to People South Africa. This initiative aims to contribute to reduced HIV incidence by linking key populations (KP) and high incident communities to HIV and TB prevention, care and support services. The goal of the program is to expand high quality community-based HIV Counselling and Testing (CBCT) models supported with innovative and effective referral systems.

Permission is herewith granted to Zuzelle Pretorius, a student pursuing a Master's in Public Health through the School of Public Health at the University of Witwatersrand to conduct in depth interviews with HIV counselling and testing counsellors at Tshwane, Sub-district 1

The aim of the study is to explore the perceptions and experiences of HCT counsellors of providing HIV counselling at three NGOs in Gauteng and North West provinces in South Africa in 2015. Specific objectives of the study are:

To describe HCT counsellors' experiences and views of providing HIV counselling to HIV positive and HIV negative clients at three NGOs in Gauteng and North West provinces in 2015.

To describe HCT counsellors' approaches to reduce sexual risk behaviour among different types of HCT clients (e.g. youth, long distance truck drivers, sex workers) at three NGOs in Gauteng and North West provinces in 2015.

To describe HCT counsellors' experiences and their opinions of HIV counselling training and supervision at three NGOs in Gauteng and North West provinces from their initial employment until present.

To elicit HCT counsellors' recommendations for strengthening HCT policy, training and counselling practice.

Tel: +27-12-816 9900 | Fax: +27-12-807 7165 | e-mail: foundation@foundation.co.za | PO Box 75524, Lynnwood Ridge 0040, Student Office Park, East Block, 123 Riley Road, The Willows, 0184, South Africa
External Directors: P. van der Walt (Chairperson), M.L. Bourbouse, I. Adw, G. Faulkenson | Executive Directors: G.J. Wehmeyer (Managing Director), V.D. Pillay | Company Secretary: A. Rasmus
Registered with the Department of Education as a Private Higher Education Institution under the Higher Education Act 1997. Registration certificate number 2000/HE07/013
Trading as the Foundation for Professional Development | Registration number 2001/ 022178/08

(If relevant) It would be appreciated if the student could share the final report/present the results to the CBCT department to present key findings of the study to identify potential areas for strengthening HCT counselling practice.

Regards

Approved
Hanlie Kapp
Head Of Department: TAP

Signature: .....

Date: 2015-03-30

Hanlie Kapp
Head of Department
Technical Assistance: Prevention
Community Based Counselling and Testing

Appendix 5: Participant information sheet

University of the Witwatersrand
School of Public Health
27 St. Andrews Road
Parktown, 2193
South Africa

PARTICIPANT INFORMATION SHEET

Hello, my name is xxx and I am a student at the University of the Witwatersrand. I am pursuing a Masters in Public Health through the School of Public Health.

As part of the course requirement, I will be conducting a study to learn more about the experiences of nurses and lay counsellors of providing HIV counselling to HIV Counselling and Testing (HCT) clients.

I would like to invite you to participate in this study.

Why are we doing the study?

HIV prevalence in South Africa is high, with a large number of HIV-positive people not knowing their HIV sero-status. HIV Counselling and Testing (HCT) is an important gateway to accessing HIV prevention, treatment, and care services. HCT also provides an opportunity to engage clients to assess their personal risk of HIV infection and develop strategies to reduce their risk of acquiring or transmitting HIV.

The aim of this study is to explore the perceptions and experiences of HCT counsellors of providing HIV counselling at three NGOs in Gauteng and North West provinces in South Africa in 2015. Specific objectives of the study are:

- To describe your experiences and views of providing HIV counselling to HIV-positive and HIV-negative clients.
- To describe how you help to reduce sexual risk behaviour among different types of HCT clients, for example, men, women, youth, long distance truck drivers, or sex workers.

- To describe your experiences and views of HIV counselling training and supervision from your initial employment until present.
- To elicit your perceptions of current HIV counselling practices and your recommendations for strengthening HCT policy, training and counselling practice.

What is involved in the study?

During the course of the research process/study, I will visit your offices to conduct a single in depth interview with you as an HCT counsellor to better understand your experiences and perceptions of providing HIV counselling to clients.

The interview will be no more than ninety minutes and will be conducted at a time that is convenient for you. The interview will be conducted in English. It will be audio recorded, with your permission, so that I do not miss anything that you say.

Confidentiality

Confidentiality will be maintained throughout the study. Information you provide will be kept confidential, and your name will not appear on any material/reports that will be produced as part of the study. A unique number or code will be allocated to each participant, instead of names on all results.

I will ensure that no clues to your identity appear in the report. Any extracts from what you say that are quoted in the report will be entirely anonymous.

Risks

There are no risks in your participation in the study. Answering questions will be voluntary, and you do not have to answer any questions you feel uncomfortable with.

Benefits

There will be no personal benefits in participating in the study. However, as an HCT counsellor, you are at the forefront of HIV service delivery in South Africa. Sharing your experiences and perceptions as an HCT counsellor will provide valuable insights into current HIV counselling practice, its strengths and weaknesses, and help to identify areas where one can strengthen HCT

counselling. The final research report will be shared with the National Department of Health to potentially inform the strengthening of HCT policy, training, and counselling services in South Africa.

Voluntary participation

Participation in this study is voluntary, and you can refuse to participate or decide to discontinue participation at any time without any penalty.

Ethical Approval

This study protocol has been submitted to the University of the Witwatersrand, Human Research Ethics Committee (HREC), and written approval has been granted by that committee (Certificate M150359 dated 25 April 2015).

I will preserve the records of your participation for two years after the study results have been published or six years if there is no publication.

Contact details of Wits Human Research Ethics Committee

If you would like to report any complaints about the study, or if you experience any problems, you may contact the HREC Chairman, Prof. Peter Cleaton-Jones at 011 717 2301.

You are welcome to call me on XX or XX if you have any questions.

Appendix 6: Consent form

CONSENT FORM

I hereby confirm that the researcher, Zuzelle C. Pretorius, has informed me about the nature, purpose, benefits, and risks of participating in this study.

I have also received, read, and understood the written information in the Participant Information leaflet regarding the study.

I am aware that the results of the study, including personal details regarding my sex, age, and date of birth will be kept confidential and will be anonymously processed in the study report.

In view of the requirements of the research, I agree that data collected through the study will be analysed through a computer program by the researcher and her supervisor.

I may at any stage, without prejudice, withdraw my consent and participation in the study.

I had sufficient opportunity to ask questions and agree to voluntarily participate in this study.

PARTICIPANT:

_____ _____

Printed Name Signature

_____

Date and Time

Appendix 7: Consent form—audio recording interview

CONSENT FORM - AUDIO RECORDING INTERVIEW

Permission to audio record the interview

I am aware that the interview will be tape recorded and transcribed for data analysis purposes.

I understand that these recordings will be preserved for two years after the study results have been published or six years if there is no publication, after which they will be destroyed.

I give permission for my interview with Zuzelle C. Pretorius to be audio recorded.

PARTICIPANT:	
_____	_____
Printed Name	Signature
_____	
Date and Time	