HIV counselling – a luxury or necessity?

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WHO and UNAIDS have consistently promoted HIV counselling as a routine part of HIV testing in developing countries. Nevertheless, in many countries counselling is not considered a crucial accompaniment of testing services, and patients are tested without access to counselling during and after testing. Thus, information on the need for and results of counselling is needed to convince policy-makers and service managers to give greater priority to the development of counselling services.

This qualitative study describes informational, social and emotional needs and problems of newly diagnosed seropositive patients attending public health services in Zimbabwe. Their basic factual information on HIV/AIDS was reasonable, but many patients equated HIV to AIDS and conceptualized their infection as ‘social and physical death’. This seriously impeded their capacity to use knowledge of their test results in a constructive way, and stimulated coping by denial and/or secrecy about their HIV status. These avoidant coping strategies discouraged clients from using condoms, seeking social support and taking measures to protect their vulnerable health.

The complex and changing nature of clients’ needs indicates that common short-cuts in counselling (e.g. giving brief information before and after the HIV test) are seriously flawed as a strategy to prepare clients for effective coping. Comprehensive pre- and post-test counselling are an essential preparation for coping effectively during and immediately after testing. Availability of supportive counselling beyond this first phase is essential to assist clients with needs and problems which will appear over time. Development of counselling interventions should be guided by research into their effectiveness and by national policy guidelines. Replacing fear-inducing HIV campaigns with interactive, constructive information about HIV prevention and care will increase the preparedness of the community as a whole for effective living with HIV.

Introduction

The main goal of pre- and post-test counselling is to enable the individual to make good use of the test results: to assist those with negative test results to remain uninfected, and those who are positive to minimize the medical, social and emotional impact of HIV on their own and others’ lives. Despite a gradual accumulation of evidence that such counselling can, indeed, increase condom use (Kamenga et al. 1991; Allen et al. 1992; Sangiwa et al. 1998) and enable seropositive persons to gain social support and cope better (Woudenberg 1994; Lie and Biswalo 1996), some policy-makers, doctors and service managers in developing and industrialized countries remain skeptical about the need for such time-consuming interventions (Nkowane 1993; Jordan and Haworth 1995; Louw et al. 1995; UNAIDS 1997). Despite WHO’s concerted efforts to introduce counselling as a routine part of the testing procedure (Schopper et al. 1996), large numbers of patients in developing countries continue to be tested with little or no counselling – even in countries where counselling training has been conducted for several years (see, Zimbabwe: Woudenberg 1994; South Africa: Allwood et al. 1992; Louw et al. 1995; Tanzania: Lie and Biswalo 1994).

The question ‘what does counselling contribute to testing and HIV care’ is all the more urgent in developing countries where health services are often under-funded and understaffed, and already strained by heavy work loads. This includes Africa, Asia and the Pacific, where counselling and support services are now urgently being developed in order to cope with increasing numbers of seropositives. New services currently becoming available in developing countries, such as AZT for pregnant women, voluntary counselling and testing (VCT) centres, rapid HIV tests and preventive therapies, further raise the importance of a better understanding of the role and effectiveness of HIV counselling.

This article examines the value of pre- and post-test counselling by describing the informational, emotional and social needs of 96 seropositive patients attending HIV counselling in a Zimbabwean public hospital during the years 1991–93. During these years, AIDS was becoming the main cause of death of infants and young adults in the country. By means of a qualitative analysis of transcripts of counselling sessions, key aspects of pre- and post test counselling are highlighted: clients’ knowledge and conceptualization of HIV; their initial emotional reaction to the news that they are infected with HIV; acceptance of the diagnosis; intentions to disclose test
Responses to HIV in Zimbabwe

The first cases of AIDS in Zimbabwe were diagnosed in 1985. As in other countries, international blame and counter-blame caused government attitudes towards HIV to become increasingly ambivalent and secretive. Although the National AIDS Control Program, established in 1987, made concerted efforts to initiate responses to HIV, its effectiveness was limited by lack of support from other government departments and community leaders. The number of AIDS cases reported through national authorities to WHO were unrealistically low; on death certificates the word ‘AIDS’ was not mentioned, and seroprevalence figures were not published until the early 1990s.

Secretiveness also affected the quality of AIDS information provided to the public. As in many other countries, the AIDS campaign relied heavily on one-way education methods and factual information about HIV summarized in slogans such as ‘AIDS kills and has no cure’ and simplistic behavioural advice (‘Stick to one partner!’). These did not take into account the complexities of the social, economic and cultural context of sexual behaviour, such as women’s lack of power in sexual decision-making, male norms with regards to sexual behaviour, and alcohol use (Njovana and Watts 1996; Ray et al. 1996). Public models demonstrating adequate coping by speaking openly of personal risk behaviour or of being HIV-positive remained extremely rare. Though numerous KAP studies showed the HIV campaign’s success in disseminating the basic facts about HIV, at a personal level HIV/AIDS remained surrounded by secrecy and denial. And as the general public was as yet unable to recognize symptoms of HIV-related disease (except, perhaps, ‘slimming’ or extreme emaciation in late-stage disease), the reality of a rapidly expanding AIDS epidemic remained largely hidden. Though anxiety about HIV was common, changes in sexual behaviour remained insufficient to curb the epidemic, and HIV became highly stigmatized.

From the early 1990s, political openness grew and a wide range of non-governmental organizations and businesses became involved and vocal about HIV. However, by that time the problem had grown so immense that even these concerted and increasingly sophisticated responses remained ‘too little, too late’ (Wilson et al. 1993). While in 1991 seroprevalence levels among sexually active adults varied between 7–22%, in 1997 similar studies revealed prevalence levels in excess of 40% (Zhuwau, in Tarantola and Schwartlander 1997).

Context of the study

This study was conducted in an HIV counselling clinic, held twice-weekly in the outpatient department of Mpilo Hospital, a large tertiary hospital in Bulawayo, Zimbabwe’s second largest town. This clinic provided pre/post-test and supportive counselling in preparation for an HIV test. The aim of pre- and post-test counselling was to prepare clients to make an informed decision about being tested, and to deal with the results in a constructive manner. Pre-test counselling included assessment and improvement of knowledge and understanding of HIV, a discussion of the advantages and disadvantages of having a test, and a brief inventory of the client’s social background and risk behaviour. Post-test counselling consisted of communicating test results, emotional support, and a discussion of short- and longer-term strategies for living with HIV in the spirit of ‘living positively with HIV’, including disclosure to carefully selected others and prevention of spread. The clinic provided a relatively high standard of counselling in the busy hospital where 2357 in- and out-patients were diagnosed seropositive in 1991. Ward-based pre-test counselling was often limited to brief, basic information about nature of the test, and post-test counselling to conveyance of test results and some advice.

Methodology

This study was carried by the Ministry of Health of Zimbabwe and the Matabeleland AIDS Council (MAC), a community-based AIDS service organization. The authors combined the role of counsellor and researcher.

Study participants were recruited from Mpilo Hospital’s outpatient HIV counselling clinic. Ninety-six consecutive clients who were found to be seropositive were asked to participate in a special study programme. This programme consisted of ongoing counselling and support either at home, at MAC or at the hospital (see Meursing 1997). Self-referrals to this clinic were rare and only 2 of the 96 patients had themselves requested an HIV test. All others were referred by doctors because of symptoms suggesting HIV infection.

Eighty of the 96 patients had undergone pre- and/or post-test counselling by the research team; 16 others had been referred for further counselling after diagnosis elsewhere. Criteria for selection in the study were: age > 15 years, living no more than 25 km from town, and being symptomatically seropositive short of having full-blown AIDS. This sample can be considered to be reasonably representative for seropositives attending urban public health services in Zimbabwe. Clients were assured that their identity would be protected, and names and identifying personal details in this report have been altered.

Counselling sessions were transcribed, coded and analyzed according to a wide range of variables related to coping, including emotional status, knowledge of HIV, acceptance of the diagnosis, and intention to disclose and to use condoms. In addition, client knowledge of HIV was measured before and after the first counselling session by means of a short, structured questionnaire on HIV knowledge and attitudes.

Characteristics of the sample

As in most public health facilities, individuals with low socioeconomic status predominated in the sample. Women outnumbered men and were considerably younger (see Table 1). This distribution reflects the actual sex-age distribution of HIV infection in the Zimbabwean population (Jackson 1992).
HIV counselling in Zimbabwe

Table 1. Age, sex and marital status of study sample

<table>
<thead>
<tr>
<th></th>
<th>&lt;21 years</th>
<th>21–30 years</th>
<th>&gt;30 years</th>
<th>Total</th>
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<td>14</td>
<td>6</td>
<td>34</td>
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<td>16</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Single men</td>
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<tr>
<td>Total</td>
<td>18</td>
<td>42</td>
<td>36</td>
<td>96</td>
</tr>
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Educational level of men and women was approximately equal, but women were more often poor and/or dependent on partners or family members for financial support. All study participants were symptomatic or the parent of an ill HIV-positive child.

Results

Superficially seen, the persons living with HIV (PLHA) in the study group seemed to possess a reasonable amount of factual knowledge of HIV already, before counselling. Almost half (43%) of the individuals who were pre-test counselled in the study knew the correct answer to the eight items used for assessing HIV knowledge, while one-third knew the answer to less than four items. The great majority of PLHA had retained the main messages of the AIDS information campaign: that HIV is transmitted sexually, that condoms are protective, and that AIDS is fatal and incurable. One-fifth of PLHA initially had misconceptions about HIV transmission (for example, transmission by mosquitoes and handshakes).

Imagination of their basic factual information did not present great problems: after pre- and post-test counselling most knew the right answer to the eight basic knowledge items. However, a more in-depth analysis of counselling transcripts revealed the existence of more subtle problems in patients' conceptualization and understanding of HIV, which had far-reaching consequences for their preparedness to deal with their test results.

Reactions of patients at post-test counselling

Patients' initial reactions to the news that their test results were positive varied widely. Some derived from pre-test counselling a basic plan of how to cope if the test was positive, and gained some emotional comfort from these plans.

Vusa, a divorced man of 35 years, reacted to his positive test results by saying: 'If it [the diagnosis] is so, it is so – I must accept it'. He asked his counsellor a lot of questions about the disease and discussed his plans for the future. He did not intend to disclose to his family at this time, but he would confide in his doctor, with whom he had a good relationship. Otherwise, he wanted to continue with his life much as it had been; but he would take special measures to protect his health.

However, it was more common to find reactions which contained a strong sense of helplessness. This helplessness had its roots in two dominant aspects of patients' views of HIV: the conceptualization of AIDS as a 'killer' and as a 'dirty disease' which necessarily evokes massive social stigma and rejection.

'AIDS kills'

Because the AIDS information campaign had focused on 'preventive scaring' and lacked models of successful living with HIV, virtually no one among the PLHA or their relatives had any idea prior to counselling on what to do once the HIV diagnosis was a reality. Even stronger, there seemed to be a quiet consensus that after a diagnosis of HIV, the individual's life would be 'over'. Many PLHA found the distinction between 'having HIV' (the virus) and 'having AIDS' (the final stage of the disease) difficult. They were most familiar with the concept of 'AIDS', which was viewed as a terminal disease, which could not be cured. This caused over-estimation of the chance that death would be imminent, and thus increased the sense of distress and helplessness that came with the diagnosis.

When John (24 years) heard he was HIV-positive, he was immensely shocked. As he had only suffered from minor symptoms (such as chronic tonsillitis and skin rashes), he had felt certain the test results would be negative. For a long time, he remained doubtful the test had been right.

The equation of HIV with AIDS also meant that PLHA diagnosed during a relatively minor illness episode often doubted the diagnosis – as did others who learnt about their HIV status. When Tametsi, a single woman of 28, told her mother she was HIV-positive, her mother reacted with disbelief. She reasoned that as 'AIDS kills' her daughter should be dead by now. Instead, she looked quite well.

Mary (33) did not dare to tell her sexual partner outright that she had been diagnosed HIV-positive, but she warned him very strongly about AIDS and encouraged him to use condoms, saying: 'either of us could have it!' However, her boyfriend refused, saying 'You look so healthy and beautiful, how could you have HIV?'

Expectations of imminent death could turn into a belief that the infection was cured when symptoms improved instead of growing worse. This could reduce patients' commitment to taking active steps to prevent secondary HIV spread.

When Thembi (16) was diagnosed with HIV, she was suffering from a variety of chronic infections and felt very miserable. Her knowledge of HIV was good already at the pre-test session, and improved further in subsequent sessions. With treatment most of her medical problems gradually disappeared, and she became far happier. Eight months after diagnosis, Thembi sought help with her counsellor because she was pregnant. Her boyfriend did not know about her HIV infection. With the pregnancy, Thembi's health deteriorated rapidly. When her counsellor discussed anew the risks of unprotected sex for her boyfriend, herself and the baby, Thembi said: 'I was feeling so much better, so I thought it [the HIV infection] was over'.
‘AIDS is a dirty disease’

A second set of problems was based on the common conceptualization of AIDS as a ‘dirty disease’ associated with ‘promiscuity’. The AIDS campaign had fed this misconception through publication of an early AIDS poster with the picture of a commercial sex worker. This emphasis on the connection between professional sex work and HIV caused intense confusion among newly diagnosed seropositives who had considered themselves to be ‘safe’, such as married monogamous women, persons who had been ‘serially monogamous’ or who had settled down with one partner after multiple partners in the past. Moreover, the definition of ‘promiscuous’ was very flexible. Some men did not consider having one new girlfriend per month as promiscuity, and therefore thought this was safe.

Finally, the misconception that HIV only affects promiscuous ‘sinful’ people caused seropositives to expect rejection and condemnation. In this expectation, PLHA seemed to make little distinction between loved ones and potential reaction of the general public. Though John (24, see above) was a well-adjusted young man with many brothers and sisters and a loving mother, he absolutely rejected the idea of disclosing his HIV status to any of them. He felt too ashamed and was certain they would ‘mock’ him.

Consequences of misconceptions for coping

Patients’ overestimation of the chance of dying soon and of total social rejection fuelled their distress at hearing they were infected with HIV. Some coped with these dire expectations by fatalistic acceptance.

(Man, 44) ‘Well, if that [the test results] is true, then I must accept it . . . I was born, so I know I must die’.

(Woman, 34) ‘God is my keeper and everything is in His hands. What comes, comes’.

A second, common way of coping with this high distress was denial of one’s HIV status. Josphat (23), a single young man belonging to a Christian sect, denied he could be HIV-positive, saying his beliefs prohibited him from having pre-marital sex. He was soon to be married, but did not plan to tell his fiancée about the doctor’s diagnosis; he felt certain that the Lord would take care of his health problems.

Maria (20) came to hear her test results protectively huddled in a big leather motor jacket. When she heard she and her baby were positive, she yelled at her counsellor that the diagnosis was ‘nonsense’, that she was well, and her baby had a traditional disease. She refused to discuss HIV further, and soon discharged herself and her baby from hospital.

Other clients did not deny their HIV status but strove to repress awareness of their test results as soon as possible. Daniella (24) exclaimed: ‘I don’t want to think about it [my diagnosis!] I want to live and not think about death, until I die’.

Women who accepted the diagnosis could still be overruled by a denying husband. Jenny (a married woman of 27) had been tested with her baby in a paediatric ward. Her husband had refused to be tested together with them. When she told him the test results were positive, he became aggressive. He refused to discuss the matter further, and forbade Jenny to go back to the hospital for medical care and counselling. From then on, she was only allowed to visit traditional healers.

Fear of rejection and denial or repression of the diagnosis all undermined motivation to disclose. Indeed, due to the social climate of stigma and secrecy surrounding HIV in the community, preservation of confidentiality was a main concern of virtually all seropositives.

Reluctance to disclose stood in the way of finding social and other support, and often aggravated clients’ sense of isolation and helplessness. When Chiku (a factory worker of 39 years) heard he was infected, he was quiet for a long time and then said ‘my life won’t be long’. He was very afraid of the disease. Though his health was only moderately impaired, he expected to die soon. Despite his immense sadness and worry, he did not want to confide in anybody; from some he feared rejection, while he wanted to spare others the pain of knowing he was infected.

Grace (20) had been initially very nervous about being tested for HIV. When she heard she was positive, she stood up abruptly and in an angry tone said: ‘OK, if this is it, then I’ll go’.

With difficulty, her counsellor persuaded her to stay and discuss her situation. She suspected she had been infected by her boyfriend, but did not want to confide in him: she strongly expected he would simply reject her. She did not want to tell her parents either as her father had always told her her boyfriend was ‘no good’. She later married her boyfriend without having disclosed her HIV status to him or her parents.

Secretiveness and denial both reduced clients’ capacity to take steps to protect others from HIV. In well-established relationships, non-disclosure could render the introduction of condoms impossible. Ephraim (a married policeman of 38 years with four children) did not intend to disclose his HIV status to his wife, as he feared her anger. ‘I would never hear the end of it’, he said. He also did not want to use condoms, as she might question him why. He rationalized his decision by saying she must be already infected.

However, clients in more casual relationships also often feared that proposing condom use would cause anger or embarrassing questions about their HIV status, and these expectations were often confirmed. Women especially found the introduction of condoms into non-marital relationships very difficult (see also Meursing and Sibindi 1995).

Secrecy could also compromise clients’ own health. Chronically ill individuals tended to consult a wide range of medical authorities, including private, traditional and spiritual healers. In these new consultations, clients often presented their physical complaints without mentioning that they had been diagnosed HIV-positive. This carried the risk of inappropriate treatment.
judgmental comments when watching an AIDS education movie on TV. ‘They all think people with HIV are prostitutes and lack self-control’, he told his counsellor bitterly. ‘They think they are too smart to get HIV’. When he finally told his sister, she proved to be understanding and supportive.

Sixty-two of the 72 PLHA who accepted ongoing counselling disclosed their HIV status to at least one other person. Twenty-five of 32 married PLHA in ongoing counselling took the difficult step of disclosing to their spouse. In contrast, more than half of PLHA who refused further counselling intended not to tell anyone of their diagnosis. Some were married or engaged to be married (see for example Josphat above).

With counselling, none of the clients who disclosed their HIV status to family members experienced total rejection, though some family members reacted with ambivalence. Similarly, divorce due to disclosure of the diagnosis was rare and occurred only in couples whose marriage had already been strained before diagnosis. Successful treatment of HIV-related illness also boosted clients’ confidence in counsellors’ message that HIV does not equal imminent death. Nevertheless, this confidence was fragile. Clients’ initial extremely negative conceptualizations of HIV proved to be tenacious, especially as they continued to be reinforced by their social environment and the media. Consequently, the option to escape the distress of HIV by denial or repression remained attractive, also among those who did accept counselling. Twelve of the 72 clients broke off contact with their counsellor when they began to deny or disbelieve the diagnosis during a period of protracted good health. This carried the risk of a return to unprotected sex.

Soon after her diagnosis, Daniella (see above) became very ill with pneumonia and tuberculosis. When her health improved, she became reluctant to see her counsellor. During a last phone call a year later, she said she had now managed to ‘forget’ her disease and was soon to be married.

**Role of counselling over time**

The fact that 72 of the 96 (75%) seropositive persons invited to continue counselling accepted suggests this service meets a demand. Over time, the needs of the PLHA and their families changed with fluctuations in their health and social situation, and counsellors’ role requirements shifted concurrently. Thus, counsellors were involved in assisting PLHA to gain social support from family, partners and employers by correcting misconceptions and defusing irrational fears, blame and anger. In both marital and family relationships the presence of a counsellor facilitated the discussion of ‘shameful’ sexual subjects, and to broach the difficult subject of planning for a future with more advanced HIV-related disease. Apart from social and emotional problems, counsellors also were often asked for help in medical, practical and economic problems. Therefore, counsellors often functioned as a ‘relay station’ in organizing comprehensive care adjusted to clients’ changing needs, by bringing PLHA and their families in contact with appropriate sources of support in the community and health care system.

Continued counselling support allowed PLHA to gradually face and deal with issues arising from their diagnosis in a constructive manner. It took John (see above) two years of counselling and living with HIV, before he felt confident enough to share his secret with his favourite sister. His fear of rejection had deepened when he heard some of his siblings make harsh, judgmental comments when watching an AIDS education program on TV. ‘They all think people with HIV are prostitutes and lack self-control’, he told his counsellor bitterly. ‘They think they are too smart to get HIV’. When he finally told his sister, she proved to be understanding and supportive.

Finally, community conceptualizations of HIV as ‘social and physical death’ reduced the motivation of newly diagnosed seropositives to seek or accept counselling and other HIV support services. Not rarely, clients were uncertain that anything could still be achieved to improve their predicament, and on the contrary feared that attending specialized HIV services could alert others to their HIV status. Coping strategies discussed during pre- and post-test counselling sessions – such as disclosure to carefully selected others and condom use – often raised clients’ anxiety, as they contradicted the community norm to ignore and/or hide HIV, and conflicted with the desire for ‘safety in secrecy’.

Thus, fear of becoming ‘known’ as a seropositive fuelled denial and reduced clients’ willingness to accept counselling support. Twenty-four of the 96 PLHA who were offered participation in the study support programme after pre- and post-test counselling did not accept, even though 15 were highly distressed and seemingly in acute need of support (see the example of Maria above). In 18, denial and fear of social rejection played a major role in this refusal.

**Conclusions and discussion**

Analysis of transcripts of pre/post-test and further counselling sessions revealed that newly diagnosed seropositive PLHA had a host of social, emotional, and informational needs, which often seriously impeded their capacity to make constructive use of the knowledge of their HIV status. Misinformation and an extremely negative conceptualization of HIV/AIDS as ‘social and physical death’ increased feelings of distress and helplessness, and fostered denial and secrecy – which in turn posed grave risk to the health and well being of seropositives and others. Similar views of HIV have been reported from Tanzania, Uganda, other areas of Zimbabwe, and more recently South Africa (Ankrah 1991; Dautzenberg 1992; Woudenberg 1994; Coleman 1996).

During pre- and post-test counselling, counsellors and clients laid the foundation for making use of the test results in an active and pro-active manner. This included correction of misconceptions, exploration of sources of potential social support, and most importantly the introduction of a positive framework for thinking about and coping with HIV.
first and subsequent sessions, counselling helped clients and their families to find ways of coping with HIV together, by assisting in disclosure and mediating in social and emotional problems. Over time, counsellors functioned as a relay station between families, hospital services, community-based AIDS organizations, self-help groups and other sources of practical, emotional and social support. Pre- and post-test counselling also allowed the counsellor to identify clients in need for crisis intervention.

The multiple, complex and long-term needs and problems of these relatively well-supported seropositives suggest that lower standards of ‘counselling’ (consisting perhaps only of communicating test results with health advice and condoms) are woefully inadequate in helping patients to deal constructively with the news that they are HIV-positive. Similarly, a study in Kenya found that single-session post-test counselling in women tested in pregnancy had little effect on partner notification or subsequent condom use (Temmerman et al. 1990).

Thus, pre- and post-test counselling should be seen as a beginning and a necessary minimum of services, rather than a ‘luxury’. This importance should be acknowledged at policy level. National AIDS programmes should assess shortcomings in existing counselling services, and investigate creative ways to close the gap between these needs and staff/time shortages. One such option used in this study, and for example also in New Delhi, is for hospitals to share counselling responsibilities with community-based organizations. This approach reduces the hospital workload and enables community-based counsellors to contact and support PLHA from the moment of diagnosis. Close cooperation between hospital and community services will, most importantly, aid the provision of comprehensive, ongoing home- and community-based services for PLHA, a task for which hospitals are not best placed (Osborne et al. 1997). Group information and discussion sessions on how and why to have an HIV test may be another way to make pre-test counselling more time-efficient.

Furthermore, the study results amply illustrate the long-term negative consequences of fear-based HIV prevention campaigns for infected and at-risk persons. Public conceptualization of AIDS as ‘social and physical death’ fuels the trauma of a positive test result, reduces access to social support, and engenders secretiveness and denial. A view of AIDS as a disease ‘one can do nothing about’ is also likely to discourage the use of voluntary counselling and testing services. In this study, only two of 96 patients had approached medical staff with an explicit request for an HIV test. Medical personnel had initiated all other tests. Similar low interest in knowing one’s HIV status has been reported by Nnko et al. (1998) and Temmerman et al. (1995). Study results suggest that once such beliefs have been induced, it can be well nigh impossible to change them by counselling alone. Rather, media and information campaigns should encourage the community as a whole to accept and understand what it takes to ‘live positively with HIV’, and aim to make such constructive thinking part of community discourse on HIV. Very importantly, such information should be reinforced by respected community members who demonstrate in word and deed that despite the ultimately fatal outcome of HIV, people with HIV remain part of the community and are neither helpless nor vile.

Study results also point to some of the challenges to counselling. In order to develop ‘counselling that works’ culturally sensitive strategies to deal with avoidant coping should be devised and carefully evaluated. A particularly worrying finding was that high psychological distress may cause individuals to avoid disclosure to family and friends and refuse professional support. The difficulty of disclosure may be eased by encouraging persons about to be tested to confide in a significant other at the pre-test counselling stage. Such challenging issues need to be addressed in counselling training and supervision, evaluated in research and supported by national policy guidelines.

Finally, study findings point to the necessity of improving services for people with HIV in developing countries. A positive, constructive attitude to living with HIV – including taking action to prevent spread – is not built merely on adequate information and social support, but also needs access to drugs, care and assistance in urgent economic needs. Such tangible material measures will be essential to convince PLHA in developing countries that they are not helpless against HIV, but can take steps to minimize the impact of HIV and AIDS on their own lives, and the lives of their family and loved ones.

Endnotes

1 Only in 1996 the Vice-President of Zimbabwe, Joshua Nkomo, broke the mould by speaking about his son’s death from AIDS.

2 This philosophy underlies most support and care for PLHA. See, for example, the TASO booklet (Strategies for Hope, No. 2, 1990) and Woudenberg 1994.

3 HIV subcommittee report, Mpilo Hospital, 1991.

4 Four of 24 clients who did not accept counselling did so for practical reasons unrelated to denial. In two cases reasons for non-acceptance remained unknown.

5 Five of 7 couples where disclosure did not occur had separated before diagnosis.

6 Three of 24 who did not accept further counselling were married and refused to disclose; five more ‘refusers’ did not want to disclose to partners they intended to marry.

7 Similar needs have been identified for the South African situation by Coleman 1996.

8 In the STD clinic of Safdarjung Hospital in New Delhi, HIV counselling is provided by staff members from six community-based NGOs working with street children, women, IVDU’s and prisoners. This increased interest in HIV testing in these community groups, and greatly benefited the quality of services at the STD clinic.

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Biographies
Flora Sibindi is by background a senior psychiatric nurse and worked for many years in the mental health services of the Zimbabwean Ministry of Health. She then became involved in AIDS work and functioned as a counsellor, trainer, supervisor and researcher. She is currently working with people suffering post-traumatic stress disorders.

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