

Health Care Providers' Perspectives on Voluntary HIV Counseling and Testing in Health Clinics in Tanzania - A Qualitative Study

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Abstract The aim of this study was to explore the perspectives of health care providers on voluntary counseling and testing (VCT) patients for human immunodeficiency virus (HIV) or counseling those living with the virus. Semi-structured interviews were conducted with 12 Tanzanian HIV counselors in different health service clinics in Dar es Salaam, Tanzania. The interviews were analyzed using a qualitative method. Three themes emerged from the interviews: a person-centered approach is necessary to build trusting relationships to negotiate for behavioral change; challenges in the variations in counseling sessions as well as the maintenance of confidentiality; and the Confidentiality requirement for privacy and disclosure only with the patient/client's consent. The health care providers, who all had considerably long experiences of VCT, showed confidence in the counseling situation and were aware of the many challenges and barriers they encountered at work as a counselor. They stressed that the basis for creating a trusting relationship between a counselor and a patient was a person-centered approach. Patient confidentiality was an important factor in the counseling work, but confidentiality could also be a challenge and dilemma to protect both the patient and sexual partners at risk, and this should be taken into consideration in counseling guidelines.

Keywords HIV/AIDS Counseling and testing, Person-Centered approach, Variation in counseling session, Confidentiality, Tanzania

1. Introduction

Most people who live in low- and middle-income countries with a high prevalence of HIV do not know if they are HIV positive or not. A survey from sub-Saharan Africa showed that only 12% of men and 10% of women had been tested for HIV and received their test results [1]. The UNAIDS action plan to scale up HIV/AIDS prevention,

particularly in low- and middle-income countries throughout the world is of great concern. To intensify HIV prevention, improved knowledge and counseling skills of health care providers need to be integral components of prevention [1,2].

Counseling is one of several important tools to prevent the spread of HIV. To make it possible to scale-up HIV prevention, trained health care providers of all kinds are very much in need. Nurses in many countries are in the majority among professional groups working with health care and the group most suited for the task of working as HIV counselors. To meet the goal endorsed by the UN for universal access to treatment and care, all nurses need special training in HIV counseling [1].

Counseling should always be a part of testing and diagnosing for HIV/AIDS. It helps the patients/clients understand the causes of the problems and guides them through the process of making decisions on how to improve or cope with their life [3]. According to McLeod [4] counseling can therefore be defined as an activity that takes place when someone in trouble invites and allows another person to enter into a particular kind of relationship. Counselors therefore need to be highly knowledgeable and aware of patients'/clients' different situations. A counselor is specifically trained to help patients/clients gain insight into their own problems and to cooperate in seeking a joint solution [1]. Counseling can only succeed if the people seeking help want to be helped, which is a central aspect of any type of counseling [4].

A test for HIV usually starts with *pre-test counseling* to ensure that the patient/client is informed about the HIV test procedure and what is meant by informed consent. All patients/clients who undergo HIV testing should be informed that their identity is secure and that all health care providers are required to follow strict rules of confidentiality. The counseling content should also inform patients/clients about transmission and prevention of HIV, as well as what will happen if the patient tests positive for HIV [5]. *Post-test counseling* should be in person. For patients testing HIV negative, information about risk reduction is essential.

Patients testing HIV positive need time to adjust to their diagnosis and follow-up counseling support should be available for them [6,7].

In order to scale-up HIV prevention, health care settings need to increase and invite people for HIV counseling and testing (HCT) [2]. In 2001, Tanzania had 92 voluntary counseling and testing (VCT) sites, which reached 4% of the entire population. In 2007, the VCT sites had increased to 128 in the Dar es Salaam region only [8]. In 2007, 36% of the Tanzanian population of both sexes were tested for HIV and had received their test results [9]. Two years later, the VCT sites had increased to 2,134 with 1,970,324 people being tested and counseled for HIV [10].

A study of Tanzanian high-school students showed positive attitudes towards VCT. Their awareness of and willingness to be tested were high, and all students (n=309) had knowledge about the benefits of VCT, but their perceptions of risk behaviors were low [11].

Grinstead & van der Straten [3] found that counselors learn much from work in the clinical field and find their work rewarding when patients/clients show behavioral change. They conclude that good knowledge and deeper understanding of counseling are essential in improving and implementing counseling for scaling up HIV prevention [3].

The aim of this study was to explore health care providers' perspectives on voluntary counseling and testing people, for or living with HIV as a means of developing a deeper understanding of counseling in clinical practice.

2. Methods

2.1. Design

A qualitative descriptive design was chosen that was suitable for deepening the understanding of a complex subjected area of working with HIV prevention as a counselor [12,13].

2.2. Settings and Participants

The study was conducted in the regions of Dar es Salaam and Pwani, Tanzania from July to August 2010. A purposive sample of 12 health care providers who counseled patients/clients being tested for HIV were invited to participate in the study. The participants were recruited from five health care settings in the districts of Kinondoni and Kibaha: the Dar es Salaam office of a non-governmental organization (NGO) working with HIV/AIDS prevention; a private missionary hospital; one government district hospital; and an outpatient department for VCT at the regional hospital. Kibaha in the Pwani region of Tanzania was also a selected health care setting because of its rural character. All 12 health care providers were informed about the aim and method of the study, and gave their permission to participate in a tape-recorded interview and signed a consent form.

2.3. Data Collection

Two to three in-depth, semi-structured interviews took place at each of the five health care settings, either in the counselor's room or in any room that was available. With the assistance of the first author (GB), who took notes during the interviews, a research assistant and second author (FK) performed the interviews in Kiswahili using a pre-tested semi-structured interview guide. The use of open-ended questions allowed participants to discuss their practices while the structure of the interviews was maintained. The participants were first asked to narrate their perceptions and experiences of counseling patients/clients who had an appointment for HIV testing and counseling or for treatment. Some of the answers were further probed so that more could be learned about a particular issue: for example, do you have written policy documents or guidelines to follow during HIV counseling? What do you do to get the client/patient to speak more openly? Each interview lasted about 45-60 minutes.

2.4. Data Analysis and Credibility

The tape-recorded conversations in Kiswahili were transcribed verbatim and translated into English by the second author (FK). The first author did the final editing by listening to the audio recording to ensure correct transcription and translation. The text was then analyzed. An inductive analytical approach was used to obtain a deeper understanding of ongoing clinical counseling practices [14,15].

The first stage in the thematic analysis involved reading each participant's text as a means of gaining greater comprehension and establishing a whole picture. The second stage consisted of breaking down the text into discrete passages that described the thoughts and experiences of the participants as expressed during the interviews. This process is also called "coding" and was done with the support of a computer program (NVivo8) that connected words, sentences or paragraphs to a "label" that can be the beginning of a concept or theory. [The computer program NVivo8 was also a good support for sharing coded data between the authors 16].

The third stage was to synthesize and transform the text into a new structure reflecting the participants' perceptions and experiences of counseling when testing for HIV. The second author (FK) assessed the interpretive description of data for its consistency by maintaining a comprehensive audit trail that consisted of field notes and data transcription [14].

2.5. Ethics and Research Clearance

A clearance certificate to conduct medical research was granted by the National Institute for Medical Research and the Tanzania Commission for Science and Technology (COSTECH) in 2010.

3. Findings

The majority (n=7) of participants were nurses, two were social workers and three had other professions (medical doctor, clinical assistant and employee in accountancy) (Table 1). They all had special education and training in working as counselors and they had all worked as counselors for several years.

Table 1. Characteristics of the participants

Characteristics	Participants (n= 12)
Age	
35-44	4
45-54	7
55-64	1
Sex	
Men	3
Women	9
Profession	
Doctor	1
Nurse	7
Social worker	2
Clinical assistant	1
Accountant	1
Years as HIV counselor	
5 – 9	4
10 -15	2
16 – 20	3
> 20	3
Education as counselor*	
6 weeks training	4
3 months training	2
3-4 weeks training	2
1.5 weeks training	1
Several regular seminars	2
Missing data* 1 person	

From the transcribed and analyzed data, three major themes emerged that reflected the participants' perceptions and experiences in working with HIV counseling in Tanzania. The three themes were:

- 1) A person-centered approach is necessary to build a trusting relationship and negotiate for behavioral change
- 2) Challenges of variations in counseling sessions as well as maintenance of confidentiality and
- 3) Confidentiality requirement for privacy and disclosure only with the patient/client's consent

3.1. A Person-Centered Approach is Necessary to Build a Trusting Relationship and Negotiate for Behavioral Change

The participants in this study explained how they sought to make the patients/clients who came for HIV-testing to feel at ease by, for example, by being friendly and polite, and greeting them in a positive manner. Through facial expressions and words and by giving a detailed description of the examination procedure, the participants explained how to build trust and confidence. The participants meant that by showing interest in the patients/clients, by listening and

talking to them, allowed the patients/clients to talk about the issues they found important, as expressed here by one participant:

"First, you must introduce yourself, and tell them what you want to do. The relationship helps the clients to express their feelings and not to have fear".

The participants reported that their purpose was to follow basic rules and principles concerning the relationship between themselves as counselors and the patients/clients. Even if some of the patients/clients did not want to talk, their silence was accepted and considered to be an important element of the counseling process. Some of the participants described this approach as a common model in counseling, referring to it as a person-centered or client-centered practice.

A challenging counseling situation could have arisen if patients/clients told the counselor that they used to be engaged in activities that put them (and others) at risk of becoming HIV-infected. The participant then tried to guide the person to understand the serious nature of the situation, including the urgency of being tested for HIV and being treated accordingly. The participants stressed that during counseling sessions no one should be blamed if the HIV results were positive.

Another demanding counseling situation was when for example, disclosure of HIV status to one's partner was discussed. All participants seemed to be well aware of this problem, and so they talked of "beneficial disclosure" only. For instance, if the patient feared that her husband or partner might use violence against her, the recommendation was not to disclose her condition. One participant expressed concerns about the difficulties in reaching all of her patients:

"Every person you care for has his or her own background and culture, and therefore you cannot speak easily to all of them. Some of the clients are short-tempered. If, for example, the person is given a positive result, you become that person's 'enemy'".

Another difficulty as expressed by one participant was to communicate with young people. Young people's view of "reality" differs from that of adults. The participant said:

"No significant changes occurs even if you talk to young people about risk behavior".

When a question about HIV prevention rose during the interviews, generally the participant's answer was that the best tool was to educate people about HIV. Education has been done at various levels, i.e. at schools and at the individual level when individuals come for testing. Campaigns were mentioned as one good example of how to increase voluntary testing and counseling, as well as to provide good opportunities for education.

Several participants stressed that there a basic need for every person who had tested HIV positive to have a social support network. The health care settings with little or no social support resources could refer people to other health care settings. A network of organizations, to which most of

the participants had access, made it possible to provide emotional and social support.

3.2. Challenges of Variations in Counseling Sessions as Well as Maintenance of Confidentiality

Various forms of counseling were used in the different health care settings, and the form chosen depended on both the individual counselor as well as the nature and complexity of the patients/client problems under discussion. Regardless of the settings and problems, the participants had to be prepared to talk, to listen and to educate individuals, couples and different types of groups about coping strategies.

Counseling could also consist of visiting a patient/client's home to assist in various matters depending on the problem. Sometimes the whole family or groups in the community were involved. It was more common that a counselor in the rural health care setting visited clients in their homes. This situation arose in cases of severe illness and in the belief that it protected confidentiality, which the patients/clients appreciated greatly.

The health-care counseling approach of provider-initiated HIV testing and counseling (PITC) was mentioned by some of the study participants to be a positive way to offer counseling. One participant emphasized that after several sessions of counseling, most of the patients/clients agreed to be tested and were offered further help if needed. This approach made it possible for the patients/clients to decide what to do in order to make the best choice to suit their individual needs. As one participant said:

"... and to direct the way, I am not the one who talks much or judges somebody but who advises somebody. It is his/her decision".

PITC had helped the participants to find those individuals who needed support and treatment but who had not dared to ask for a test. Some health care settings had not yet introduced PITC, although it was well established in other settings.

One participant, a nurse, described her work in the following way:

"I am used to talking with patients who are admitted to the wards for the purpose of reaching a decision about testing for HIV. Patients can have many signs and symptoms but do not know what health problem they have. Therefore, I start by explaining what will happen during a test and try to find out what causes the trouble. Not all patients accept the situation and some say they need more time for reflection".

One nurse explained that the PITC method had been productive because patients are often afraid to speak about their condition, and thus they need to be encouraged to speak up. She also said that patients later came to thank her and very much appreciated her help. PITC worked particularly well in such situations as those mentioned above. The patient had been ill for quite some time and did not know the reason

for his/her suffering. Further, informed consent was not violated because testing was not carried out against the patient/client's will.

At one of the health care settings, counseling was the primary treatment approach. The length of a session for counseling differed depending on the type of counseling. A pre-test could last 60 minutes and a post-test about 30 minutes in well-staffed health settings, whereas in hospital settings with large numbers of patients/clients, sessions were often brief (e.g. 10 minutes).

In some of the health care settings, it was necessary to counsel patients/clients in-group sessions because there were too few counselors to deal with the large number of patients/clients. Those who had already been diagnosed as HIV positive were asked to attend group sessions. The group sessions were useful in helping newly diagnosed people to cope better and to meet those who had more experience of living with the virus. Certain health care settings did not offer group counseling because it interfered with the principles of confidentiality. Thus, the only counseling that could be in groups was if couples, families or a group of close friends expressed the desire to be together.

Certain health care settings offered pre- and post-counseling only, while pre-counseling was given in groups. At one health care setting with sufficient resources, pre-testing was done individually. This individual testing made it possible to make a risk assessment with a risk reduction plan and at the same time check people's willingness to test for HIV.

Post-testing was always done individually, since the test results were delivered during the post-test session and demanded absolute confidentiality. In fact, counseling was given even before the test results were delivered to ensure that what was discussed in the pre-testing session had not been forgotten.

3.3. Confidentiality Requirement for Privacy and Disclosure Only with the Patient/Client's Consent

Almost all participants had written guidelines to follow when counseling about HIV infection and disease. The first important principle when counseling is to insure patient/client confidentiality, i.e. not to reveal the patient/client's identity. A queue system (with numbers) was used when patients/clients were waiting for their turn to be counseled and tested for HIV in the laboratory. Such a procedure was followed in almost all of the health care settings studied. One participant exclaimed that if the rules and regulations about confidentiality were not followed,

"It will cost you your job."

Another participant, a social worker, said,

"What is important is to ensure secrecy ... what we are talking about, nobody else will hear."

The participants expressed two major concerns in the clinic: one was that there were too many clients/patients and

the other was a lack of privacy, which could lead to problems with confidentiality. One solution was to offer pre-counseling in groups, followed by patients/clients having private access to a counselor with an assurance of confidentiality when test results were delivered. Even those who came with relatives were assured that no information would be revealed to the relatives without patient/client consent. In-group sessions, the patients/clients sat in an open space and were instructed not to talk to outsiders about what took place during the sessions.

Ethics in counseling was another issue that arose during the interviews, and it was broadly felt that ethics must also be considered when planning and conducting counseling sessions. Counselors must be trustworthy and be able to show genuine openness. Moreover, they should not reveal information about the patients/clients. Finally, counselors must show a positive, unconditional regard for the wellbeing of the patients/clients. One participant, a nurse, said:

"I think we are trying our best to follow ethics because in this unit confidentiality is maintained, although the patients may become anxious in the beginning, showing rather harsh and unjustified beliefs about themselves, which others easily notice."

The participant in this study showed a strong awareness of the many ethical issues that could arise regarding the patient's point of view and rights to integrity. The counselors were thus aware of the dilemma it could cause if disclosure to partner was not a regular habit. The most important thing was to maintain confidentiality in the careful work with HIV patients/clients.

4. Discussion

Being a counselor and working with HIV prevention meant meeting people face-to-face every day. Most of the participants had a long history of counseling patients/clients testing or living with HIV, and they were fully aware of that each patient/client had individual needs and rights. They were sensitive to the fact that they should greet the patient/client in a positive, friendly manner and show the patient/client respect. These attitudes have been shown to be important, especially in patients/clients demonstrating risky behavior. Guidelines and policy documents for human rights and work strategies outlined by UNAIDS and WHO for scaling up prevention work to combat HIV/AIDS have proved to be helpful in counseling work. [6,17,18]

A person-centered approach helped to create a trusting relationship, implying that the counselor had understood the purpose of the counseling work by encouraging a change in behavior and showing empathy and respect, so that individuals could preserve their personal integrity. A person-centered approach, as outlined by Carl Rogers, is well known within psychotherapy [20] and has proven to be an effective tool for the counseling of individuals who are to undergo HIV testing [21]. It corresponds well with the WHO's global program on AIDS (GPA), which emphasizes

that a unified theory should also include practical skills that are person-centered and that meet the needs of the HIV/AIDS population [22]. The participants in this study expressed the fact that a person-centered approach worked well in the standardization of the counseling. The approach was also helpful in discussions with the patients/clients regarding their progress and in situations where the patient/client did not respond as expected or did not show signs of changed behavior.

When WHO made the decision to scale up HIV prevention in 2005, PITC in health facilities was one of many preventive strategies. [23]. PITC has been accepted by health care providers in general since it has been proven that a person who knows his or her HIV status when being tested for HIV will then access prevention and treatment [24]. Several studies show an increase in HIV counseling and testing (HCT) performed by PITC, and patients have reported a positive response towards this kind of test [25, 26]. In present study, one participant mentioned that PITC was a useful tool when patients showed sickness without knowing the cause. If a counselor can suggest HIV testing it will mean that a patient/client with an unknown disease will be diagnosed and will hopefully be treated and have a chance to improve his/her health.

Two of the participants suggested that violence and abuse from patients/clients could create a problematic counseling situation. Such situations bring with them a sense of unease and extra strain that require good conduct from the health care provider. Professional ethics and policy regulations for health care personnel may provide support because they clearly state the codes of conduct [27, 28]. However, according to Hayter [28], the definition of confidentiality allows exceptions in the application of the law; clearer guidance must be offered by professional bodies [28].

Critics argue that ethical guidelines regarding confidentiality, which are a legacy of Western medicine, can cause problems and lead to consequences such as stigmatization of people living with HIV/AIDS [29]. Family members of people living with HIV felt isolated and rejected because they were prevented from participating in the care of their sick relatives. In southern Africa, family unity is very important and the family is expected to help solving problems with a family member with HIV. Privacy can inadvertently cause rumors and suspicion that can damage family relationships [30]. The strict use of secrecy creates a barrier between the person with HIV and their family members. The Western model of counseling has been followed too strictly according to Angotti [31].

A successful counseling session and a trusting relationship could however be both a challenge and dilemma for the counselor in respect of the maintenance of confidentiality if disclosure to a partner has not been dealt with as part of the information before the test. On the one hand if clients cannot trust the staff at the clinic, many will avoid going there to be tested for HIV and may even go somewhere else and get the wrong information [32]. On the other hand, actions have to be taken to avoid the spread of the virus, especially as there is

not yet a cure for or safe prevention of the spread of the virus (HIV). If confidentiality requires privacy and disclosure only with the patient/client's consent, the counseling session can thus cause conflict between the client and the counselor as to how to deal with informing the partner or other family members. A recent study by Njosing et al. stressed that by adopting a human rights perspective in HIV counseling programs the interests of both patients and their partners can be achieved [33]. Assurance of confidentiality during testing procedures and adapting to the circumstances that prevail in different health care settings are essential factors, especially in health care settings with limited recourses where counseling in groups is one option that is practiced if the patient/clients agree.

The participants in this study had learnt that negotiation and maintenance of confidentiality in the health care setting were important aspects of counseling. The participants emphasized the importance of having the patients/clients disclose their HIV status. The only exception was the potential risk of violence. Only a few of the participants did not entirely support confidentiality, reasoning that it might cause new infections, because not all patients/clients disclose their HIV status to their partners for fear of violence or of being abandoned [34]. In antenatal clinics in Dar es Salaam, divorce and abandonment in marriage were major problems in relation to HIV. Therefore, the counselors suggested that couples should be counseled and tested together to maintain good relationships between sero-discordant partners [35].

A study from the Kagera region in Northwest Tanzania confirms that social relationships are vital in helping to combat an HIV epidemic. In the villages, the people organized and created new norms, values, and confidence essential in the prevention of HIV/AIDS [36]. HIV incidence in the Kagera region decreased from 13.7% in year 1993 [37] to 3.4% in year 2007 [38].

4. 1. Limitations of the Study

The study was conducted in five health care settings in an area in Dar es Salaam with a population consisting of people mainly from the middle-class economic standard and one health center in a rural area representing people with low income and education. This meant that the health care providers working as the HIV counselors interviewed for this study had not worked in all possible HCT services, for example "stand alone settings". Maximum variation sampling of data cannot therefore be absolutely guaranteed.

5. Conclusions

The health care providers, who all had considerably long experience of VCT showed confidence in the counseling situation and were aware of the many challenges and barriers they encountered at work as counselor. The study found that if the health care providers used a person-centered approach it helped the patient/client to communicate more easily. The approach encouraged the patient/client to open up and talk

about sexuality and intimacy and accept the importance of changing sexual behavior. The counselors also emphasized that confidentiality during counseling was shown to have a significant impact on people seeking care and those to be tested for HIV. Patients'/client's confidentiality was an important factor in the counseling work, but it could also be a challenge and dilemma protecting both the patient and sexual partners at risk and should be taken into consideration in counseling guidelines. More research should focus on the process of disclosing the HIV status to partner and other close family member in HIV counseling and prevention.

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REFERENCES

- [1] UNAIDS. Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition. Geneva, CHE: 2006.
- [2] WHO, UNAIDS, UNICEF. Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector. 2009.
- [3] Grinstead, O. A., & van der Straten, A. Counsellors' perspectives on the experience of providing HIV counselling in Kenya and Tanzania: the Voluntary HIV-1 Counselling and Testing Efficacy Study. *AIDS Care*. 2000; 12, 5, 625-642.
- [4] McLeod, J. *Counselling Skill* (1 ed.). Milton Keynes: Open University Press, 2007.
- [5] Chippindale, S., & French, L. HIV counselling and the psychosocial management of patients with HIV or AIDS. *BMJ*, 2001; 322:1533.
- [6] UNAIDS. UNAIDS/WHO Policy Statement on HIV Testing. Geneva CHE, 2004. Online Available <http://www.unaids.org>
- [7] WHO. Operations manual for delivery of HIV prevention, care and treatment at primary health centers in high-prevalence, resource-constrained settings. 392, 2008. Online Available from <http://www.who.int/hiv/pub/>
- [8] Lugalla, J., Madihi, C. M., Sigalla, H. L., & Mrutu, N. E. Social Context of Disclosing HIV Test Results: HIV Testing in Tanzania, Dar es Salaam, Tanzania and Centre for Strategic Research and development and Calverton Maryland, USA Macro International Inc. 2008.
- [9] UNAIDS. The Global AIDS report Geneva, CHE. 2010. Online available from <http://www.unaids.org/>
- [10] UNAIDS. Getting to Zero: 2011-2015 Strategy Joint United Nations Programme on HIV/AIDS Geneva. 64. 2010.
- [11] Charles, M. P., Kweka, E. J., Mahande, A. M., Barongo, L. R., Shekalaghe, S., Nkya, H. M., Mahande, M. J. Evaluation

- of uptake and attitude to voluntary counseling and testing among health care professional students in Kilimanjaro region, Tanzania. *BMC Public Health*, 2009; 9, 128.
- [12] Dahlgren L, Emmelin M, &Winkvist A. Qualitative Methodology for international public Health. Umeå: Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine, Umeå University; 2004.
- [13] Sandelowski, M. Focus on research methods. Whatever happened to qualitative description? *Research in Nursing & Health*, 2000; 23, 4, 334–340.
- [14] Kvale, S., &Brinkmann, S. *InterViews: learning the craft of qualitative research interviewing*. (2.ed) Los Angeles: Sage Publications. 2009.
- [15] Thorne, S., Reimer Kirkham, S., &O'Flynn-Magee, K. The Analytic Challenge in Interpretive Description. *International Journal of Qualitative Methods*, 2004; 3, 1, 1-21.
- [16] QRS International. NVivo 8. Get Started. London, GBR: QRS International Pty Ltd. 47, 2008. Online Available from <http://www.qsrinternational.com/>
- [17] TACAIDS. National Policy on HIV/AIDS. Prime Minister's Office. The United Republic of Tanzania. 2001. Online Available from <http://www.tacaids.go.tz>.
- [18] WHO. WHO Global health sector strategy on HIV/AIDS 2011-2015. 2011. <http://www.who.int/>
- [19] Ministry of Health and Social Welfare. Standard operating procedures for HIV testing and counseling (HTC) service. Ministry of Health and Social Welfare, Tanzania. 48 2009. Online Available from: <http://ihi.eprints.org/>
- [20] Patterson, C. H. *Carl Rogers and Humanistic Education Foundations for a theory of instruction and educational psychology* New York: Harper & Row. 1977.
- [21] Commonwealth Regional Health Community, S. HIV/AIDS voluntary counselling and testing: review of policies, programmes and guidelines in east, central and southern Africa. Arusha, Tanzania: Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa. 2002.
- [22] Balmer, D. H. (1993). The evaluation of a unified theory for HIV/AIDS counselling. *International Journal for the Advancement of Counselling*, 1993; 16, 4, 269-280.
- [23] WHO. Guidance on provider-initiated HIV testing and counseling in health facilities [Internet]. Geneva, CHE: Department of HIV/AIDS; 2007. Online Available from: <http://www.who.int/hiv/pub/vct/pitc/en/>
- [24] Baggaley, R., Hensen, B., Ajose, O., Grabbe, KL., Wong, V., Schilsky, A., ... Hargreaves, J. From caution to urgency: the evolution of HIV testing and counselling in Africa. *Bulletin of the World Health Organization*, 2012; 90, 652–658.
- [25] Dalal, S., Lee, C., Farirai, T., Schilsky, A., Goldman, T., Moore, J., & Bock, N. N. Provider-Initiated HIV Testing and Counseling: Increased Uptake in Two Public Community Health Centers in South Africa and Implications for Scale-Up. 2011; 11: 2011.
- [26] Kennedy, C. E., Fonner, V. A., Sweat, M. D., Okero, F. A., Baggaley, R., & O'Reilly, K. R. Provider-initiated HIV testing and counseling in low- and middle-income countries: a systematic review. *AIDS And Behavior*, 2013; 17, 1571-1590.
- [27] International Council for Nurses. Code of Ethics for Nurses. International Councils for Nurses. Online Available from <http://www.icn.ch/about-icn/code-of-ethics-for-nurses/> 2006
- [28] Hayter, M. Confidentiality and the acquired immune deficiency syndrome (AIDS): an analysis of the legal and professional issues. *Journal of Advanced Nursing*. 1997; 25: 6: 1162-1166.
- [29] Ndebele, P., Mfutso-Bengo, J., &Masiye, F. HIV/AIDS reduces the relevance of the principle of individual medical confidentiality among the Bantu people of Southern Africa. *Theoretical Medicine And Bioethics*, 2008; 29:5: 331-340.
- [30] Uys, L. R. Confidentiality and HIV/AIDS in South Africa. *Nursing Ethics*, 2000; 7, 2, 158-166.
- [31] Angotti, N. Working outside of the box: how HIV counselors in Sub-Saharan Africa adapt Western HIV testing norms. *Social Science & Medicine* 2010; 71, 5, 986-993.
- [32] Van Dyk AC. Client-Initiated, Provider-Initiated, or Self-Testing for HIV: What do South Africans Prefer? *JANAC: Journal of the Association of Nurses in AIDS Care*. november 2013;24(6):e45–56.
- [33] Njosing BN, Edin KE, Sebastián MS, Hurtig A-K. "If the patients decide not to tell what can we do?"- TB/HIV counsellors' dilemma on partner notification for HIV. *BMC Int Health Hum Rights*. 01 december 2011;11(1):1–11.
- [34] Balaile G, Laisser R, Ransjö-Arvidson A-B, Höjer B. Poverty and devastation of intimate relations: Tanzanian women's experience of living with HIV/AIDS. *J Assoc Nurses AIDS Care*. 2007; 18, 5, 6-16.
- [35] Mlay, R., Lugina, H., & Becker, S. Couple counselling and testing for HIV at antenatal clinics: views from men, women and counsellors. *AIDS Care*, 2008; 20, 3, 356-360.
- [36] Frumence, G., Killewo, J., Kwesigabo, G., Nystrom, L., Eriksson, M., &Emmelin, M. Social capital and the decline in HIV transmission - A case study in three villages in the Kagera region of Tanzania. *SAHARA J: Journal Of Social Aspects Of HIV/AIDS Research Alliance/SAHARA, Human Sciences Research Council*, 2010; 7, 3, 9-20.
- [37] Killewo, J. Z., Sandstrom, A., Bredberg Raden, U., Mhalu, F. S., Biberfeld, G., & Wall, S. Incidence of HIV-1 infection among adults in the Kagera region of Tanzania. *Int J Epidemiol*, 2010; 3, 528-536.
- [38] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc. *Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08*. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc. 296. 2008. Online Available from <http://www.tacaids.go.tz/>