

# “They should know where they stand”: attitudes to HIV Voluntary Counselling and Testing amongst a group of out-of-school youth

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*This article draws on a larger study that examined the ways in which out-of-school youth responded to a context of HIV/AIDS and how they themselves can be active participants in HIV/AIDS prevention. In addition, four out-of-school youths, trained as fieldworkers, interviewed 32 other out-of-school youths in the Shongweni area of KwaZulu-Natal about their attitudes towards VCT. The out-of-school youth displayed a very positive attitude towards VCT and 91% stated their intentions of getting tested. However this attitude was contradicted by the facts that only nine (28%) had been for testing and that participants evidenced high levels of fear and stigma surrounding VCT. Of the participants, 43% stated a preference for a VCT site or hospital far from home, or, if they could afford it, a private doctor, to minimise the likelihood of being seen by someone they knew. This factor made it more difficult and costlier for out-of-school youth to access VCT. For some, the fear of HIV infection is caught up with their existing social exclusion. In contrast, one reason for wanting to test amongst girls was the health of future children. While out-of-school youth understood the role of VCT in maintaining a healthy lifestyle, the obstacles to acting on those intentions included the context of poverty, gender inequalities, stigma and the fear of gossip. Campaigns have succeeded in raising awareness, but translating awareness into action remains a central problem.*

**Keywords:** HIV/AIDS; out-of-school youth; South Africa; VCT

## Introduction and background

How does a group of out-of-school youth in a peri-urban South African township perceive Voluntary Counselling and Testing (VCT)? This study aims to examine perceptions that support such testing, and those that oppose it. Through identifying typical themes in these perceptions, the study also aims to provide some insight into what would be needed if such young people are to be more willing to undergo testing. Before reporting on the research strategy, the paper explores the literature on VCT. It then proceeds to the findings from the data, and to a discussions section.

VCT services are widely recognised as having an effective role to play in the fight against HIV/AIDS, by providing contact centres where information, guidance and referral to medical treatment can be sought (Hutchinson & Mahlalela, 2006; Horizons, 2001). Information, counselling and testing also go hand-in-hand with promoting and reaffirming safer sex practices for those who test negative (Sherr *et al.*, 2007; Arthur *et al.*, 2007). However, these services cannot be effective if they are not accessed by community members and young people (15–24 years) in particular.

In South Africa there has been a roll out of VCT and related services such as access to ARV and other medical treatment, rapid testing, psychological support and hospice care (Hutchinson & Mahlalela, 2006). VCT remains an important entry point to these services. Yet despite awareness of HIV/AIDS, and high prevalence rates in communities in South Africa, a Nelson Mandela Foundation/HSRC study (Nelson Mandela Foundation, 2005) found that only 19% of adults over the age of 15 had been tested for HIV — often only women during pregnancy.

This lack of use of VCT is particularly noticeable amongst young people, even though new HIV infections are greatest amongst the group aged 15–24 years — they tend to be aware of VCT, yet few have accessed these services and know their HIV status (MacPhail *et al.*; 2008, Bell *et al.*, 2007; Boswell & Baggaley, 2002). Perceptions of both HIV/AIDS and VCT are still shrouded in stigma and mistrust, creating barriers to accessing VCT services at individual, interpersonal and community or cultural levels (Bell *et al.*, 2007; Skinner & Mfecane, 2004).

Out-of-school youth have been included as part of the sample in studies investigating youth-friendly VCT services in Kenya and Uganda (Horizons, 2001) and discussed as part of VCT strategies that reach marginalised groups (Boswell & Baggaley, 2002; Wyss *et al.*, 2007). Examining such studies on youth can provide a base towards understanding what out-of-school youths' perceptions of VCT are. Boswell and Baggaley (2002) point out that much diversity exists among youth, which needs to be taken into account when designing and delivering effective VCT. For a vulnerable group such as out-of-school youth who have little education, there is a need to adapt counselling, HIV awareness and prevention campaigns, and testing to their particular needs. VCT services may provide not only important information, but also an interactive opportunity for discussion, support and guidance that such youth may lack through being outside of formal education.

Negative perceptions or barriers to seeking VCT services can be organised around three levels (MacPhail *et al.*, 2008): firstly the individual level, secondly the small group level consisting of family, peers and friends, and thirdly, the broader organisational and community level. This approach allows for the recognition that behaviour change is facilitated, constrained and influenced by the social and cultural context in which individuals live out their lives (MacPhail *et al.*, 2008).

At the individual level, barriers to VCT included fear of “what might happen” if HIV positive youth associated VCT with visible symptoms of AIDS and went to VCT in order to confirm the diagnosis. VCT was not associated with healthy individuals (MacPhail *et al.*; 2008, Bell *et al.*, 2007). MacPhail *et al.* state, “the perception that VCT is for people who are ill may be a manifestation of the inability of young people to accurately assess their risk of HIV infection” (2008). Other studies have linked this perception to an absence of treatment options associated with VCT, such as access to ARVs (Hutchinson & Mahlalela, 2006). Post-test stress was another barrier. Adolescents in the

focus group study by MacPhail *et al.* (2008) expressed the view that knowing one's HIV positive status might bring on sickness or drive one to suicide. This was also associated with a lack of hope and a collapse of dreams for the future. Clearly youth had little appreciation of post-test support in the event of an HIV positive diagnosis.

Despite concerns regarding confidentiality and youth's fear of being gossiped about, studies have found that most youth were comfortable with the idea of disclosing their HIV status to family members who they felt would be supportive (Horizons, 2001; Denison *et al.*, 2008; Denison *et al.*, 2006). Family and friends who were supportive and understanding provided motivation to access VCT services and many studies have reported that these relationships need to be strengthened as a source of support that encourages youth to access VCT (see for example Denison *et al.*, 2008; Denison *et al.*, 2006). However, friends were a source of concern, due to the fear of gossip, while disclosing to a sexual partner was the most problematic, as the potential loss of the relationship, of marriage and of the prospect of children was seen as a great risk. An added risk for women was the potential for a violent reaction when disclosing to their male partners (Bell *et al.*, 2007; MacPhail *et al.*, 2008).

The Nelson Mandela/HSRC survey (Nelson Mandela Foundation, 2005) found that education, household resources, knowledge about HIV/AIDS, discussions with family members and sexual partners, and condom use were positive factors that decreased stigma related to testing. These can be considered motivating factors which encourage an open, positive attitude towards VCT.

MacPhail *et al.* (2008) found that at organisational and community levels, perceptions of VCT were the most negative, presenting barriers to youth uptake of these services. Perceived negative and judgemental attitudes by service staff and poor training were mentioned as reasons not to go for testing. For youth a further concern was the issue of confidentiality and fear of gossiping among nursing staff, leading to parents and neighbours finding out, which would at best indicate that they were sexually active and at worst, indicate that they were already HIV positive. Youth also spoke of concerns regarding the quality of services, particularly pre- and post-test counselling.

Wider community stigma and discriminations towards those seeking VCT and testing positive are considerable barriers to youth seeking testing and treatment. This context had a direct influence on individual behaviour and decision-making regarding testing. Community care and support were not mentioned at all in the study by MacPhail *et al.* (2008), indicating a fear of discrimination and stigma. HIV/AIDS related stigma and discrimination present a very real barrier, as has been found in numerous studies (Francis, 2004; Wyss *et al.*, 2007; Bell *et al.*, 2007; Rule & John, 2008; Skinner & Mfecane, 2004). Possibly through increased public access to ARVs, this stigma surrounding people living with HIV could be reduced.

Boswell and Baggaley (2002) state that VCT services need to be sensitive to contextual factors as well as targeting specific groups of youth. For exam-

ple, integrating VCT services in educational settings would not reach out-of-school youth, who might be better served by mobile clinics. In order to roll out an effective programme, it is therefore important to understand where youth go for health services, who they speak to, and what levels of stigma and secrecy exist amongst the community.

### **Research strategy**

#### The broader study

This article draws on a larger research project that examined the ways in which out-of-school youth living in the Shongweni and Lamontville areas of Durban responded to a context of HIV/AIDS, and how they themselves can be active participants in HIV/AIDS prevention (see Francis & Rimmensberger, 2008; Francis & Hemson, 2009). The project worked from the premise that it is important to situate youth as agents in the production and consumption of knowledge about HIV prevention so as to allow for more engaged discussion with them on such issues. Unlike much educational work on HIV/AIDS, which consists of directing messages at young people with the intention that this translates into behaviour change, our project framed the issues differently. In order to obtain data which revealed how out-of-school youth talked to each other about the topics of HIV/AIDS, love, sex and friendships, eight out-of-school youths were trained in basic research skills to carry out interviews with other out-of-school youth in their communities (Francis & Hemson, 2009).

The selection of fieldworkers began simply through asking contacts to identify youngsters living in these two areas, in the age category, who were out-of-school and interested to take part in the research. We located four from each area, of whom five were girls, and provided transport to the university campus for the five days of training, as well as subsequent reviews.

Participation in this research project provided some form of employment and an opportunity to gain skills. Providing training and payment to these young people can be seen as a way for academic research to provide a more direct feedback loop to the (often disadvantaged) communities it researches (Francis & Hemson, 2009).

The eight out-of school youth researchers underwent a comprehensive training programme including sessions on such topics as the purpose of the research, confidentiality, the rights to privacy when generating data, ethical considerations in research, time management, and how to use tape recorders for data collection .

There were limitations in this approach. As inexperienced researchers, they did not always pick up on critical moments in interviews and follow them up, for example, by asking why respondents had acted in a certain way or why they held a particular opinion. Probably due to a lack of confidence they stuck rigidly to the questionnaire, often resulting in data that lacked depth. A further challenge was the issue of trust. The researchers reported that they were sometimes accused of wanting to “spread news” and were not welcome

in the homes of their respondents' families. The fear of being gossiped about inhibited some of the interviewees from talking openly about their own experiences regarding sensitive issues, such as HIV/AIDS.

#### This study: research site and design

We report on an extension of the study in the Shongweni area, an area about 50 km from the city centre. There is an industrial zone that was established in terms of the apartheid government's homelands policy, and that has been hard hit through the collapse of the textile and clothing industry. Around it are residential townships and shack settlements, and then rural settlements. Unemployment is very high. The area experienced intense violence in the political conflicts between ANC and Inkatha supporters in the 1980s, with many hundreds of deaths in the area.

The parameters were largely set by the design of the broader research project. The project is within an interpretivist perspective, in which the focus rests on the social construction of the meanings explored (Cresswell, 2009). Within such a study, the tendency is to use open-ended questions and to rely on limited numbers of respondents. However, in this section of the research there were two deviations from this approach.

A single method of data collection, structured interviews, was used. The structured interview is one in which the content and procedures are organised in advance (Cohen *et al.*, 2000). For the young fieldworkers, the sequence and wording of the questions were determined by means of a schedule and they had little leeway to make modifications. The reason for this was the limitation reported above in going beyond the initial comments of respondents — they would simply accept the first answer and not probe in depth. The interview schedule was thus constructed so as to generate as much data as possible without expecting the fieldworker to probe further.

Secondly, the number of respondents was relatively high for such a study, at 32. This has made it possible to quantify some of the responses. Given the limitations of using a qualitative approach, with the lack of further depth in the data collection, this offered a way forward. This is thus a mixed-methods design (Cresswell, 2009). The issue here is 'fitness of purpose'; the more one wishes to gain comparable data — across people — the more standardised and quantitative one's interview becomes (Cohen *et al.*, 2000).

#### Data collection

This part of the study was conducted by the four fieldworkers in Shongweni — two young women, aged 18 years, and two young men, aged 17 years. Selection of respondents was on a convenience basis — each fieldworker was asked to identify eight other youths aged between 16 and 19, and out of school. Table 1 provides an overview of the number of boys and girls interviewed by each fieldworker.

All interviews were taped and transcribed. Interviews conducted in isiZulu were translated into English by the four trained out-of-school youth researchers. This approach also meant that skills were imparted to a group margi-

nalised from formal education and training, and meant that the research process was less “top down” (from researchers to the researched) and more participatory.

The schedule began by establishing the respondents’ level of understanding about the topic, by asking whether the respondent could explain what VCT is. This functioned both to test the extent of accurate knowledge around VCT as well as to allow the interviewer to explain and clear up confusion. Further questions addressed behaviour and perceptions related to VCT.

### Data analysis

Analysis of the data made use of both qualitative and quantitative methods to respond to the specific needs and complications that arose from the data. Data were collated by the one author into two spreadsheets that responded to the two general research questions. This provided an overview of general trends and patterns in the data. In addition, qualitative responses were taken from transcriptions to add depth and colour to the picture. Analysis was qualitative in that the transcribed dialogues between out-of-school youth were examined for wider discourses and “ways of speaking” about VCT.

This approach used Merriam’s (1998) two stages of analysis: (1) within case analysis and (2) cross case analysis. Within case analysis focused on the responses of the participants individually, addressing their attitudes and perceptions etc. Cross case analysis consisted of an analysis of the trends and patterns across the cases after a reading of the individual responses. The focus was on differences and similarities in attitudes and perceptions. The data from the transcripts of the interviews, conversations with the youth researchers and literature were triangulated and used to confirm the results emerging from the studies (Merriam, 1998). The data were then transformed into a logical and manageable structure that attempted to address the research agenda posed by this paper.

While the sample size does make a quantitative analysis possible, it is not sufficient to enable the analysis to go beyond the production of descriptive statistics.

### Ethics

The study was approved by the Ethics Committee at the College of Humanities, University of KwaZulu-Natal (HSS/06075A). Consent was obtained from all participants. Confidentiality and anonymity were stressed and maintained throughout the study. At each briefing of fieldworkers these issues were raised. Our judgement was that the minimum age of 16 and the concern for confidentiality that was being expressed in the broader study meant that it was not appropriate to ask for parental consent, and this was accepted in the ethical clearance.

### Limitations

Some of the limitations, such as the lack of in-depth interviewing, have already been noted. Despite the relatively large sample size, there is no claim that the findings are generalisable to any specific population, given the nature of the sampling procedures. It is acknowledged that the restriction of the interviews to a more structured format does limit the depth of the responses that might be gathered.

In one respect the lack of greater depth makes it harder for us to address an aspect of the interpretation. Where attitudes are positive to VCT, it could be that respondents simply knew what responses were expected of them, as a result of the effectiveness of the local HIV/AIDS campaigns in communicating their messages. This issue is commented on below.

### Trustworthiness

To ensure an acceptable degree of trustworthiness (Cresswell, 2009; Whitbeck, 2006), checking was done between the quantitative and the qualitative data to establish whether these were consistent with each other. There was allocation of different tasks to the two authors, to enable some degree of independence within the study. For example, the one researcher worked with the data analysis while the other worked independently in reviewing and interrogating the data to establish the credibility of the findings.

In addition, focus group discussions were held with the fieldworkers, to establish in what ways their handling of selection of respondents and of the interview process might influence the data collected. They also served as 'peer debriefers' (Cresswell, 2009) who could comment on the interpretation of the findings. These findings were then reviewed against the findings from the broader study.

The following section will present the findings of the study under three key themes, namely, (1) being informed about VCT, (2) general attitudes towards VCT and (3) VCT, results and changing behaviour.

### Findings

To enable checking in greater detail, each respondent was numbered, as indicated in Table 1. The relevant number is given in brackets.

#### "Something to do with HIV/AIDS": being informed about VCT

As can be seen from Table 1, more girls than boys were interviewed .

Most respondents simply answered "no" when asked if they knew what VCT was. Seven girls and two boys answered that they could explain what VCT is and attempted a definition. Mostly these were accurate indicating a basic understanding of what VCT involves, although, some confusion did still exist. One girl (5) thought VCT was, "when people go around asking people questions. It is a survey to know about HIV/AIDS." One boy (21), although stating he knew what it was, could only explain it as "something to do with HIV/AIDS."

**Table 1** Overview of out-of-school youth interviewers and interviewees

Researcher	Respondent number	Girls interviewed	Boys interviewed
Female 18 yrs	1	18 yrs	
	2		18 yrs
	3		18 yrs
	4	18 yrs	
	5	16 yrs	
	6	17 yrs	
	7	17 yrs	
	8	16 yrs	
Male 17 yrs	9		19 yrs
	10	18 yrs	
	11		18 yrs
	12	17 yrs	
	13		18 yrs
	14	17 yrs	
	15	16 yrs	
Male 17 yrs	16	16 yrs	
	17	18 yrs	
	18	17 yrs	
	19	17 yrs	
	20	18 yrs	
	21		19 yrs
	22	18 yrs	
	23		17 yrs
Female 18 yrs	24		18 yrs
	25	16 yrs	
	26		17 yrs
	27		18 yrs
	28		16 yrs
	29		18 yrs
	30	16 yrs	
	31		18 yrs
Total	32		17 yrs
		19 girls	14 boys
		Average age 17.1 yrs	Average age 17.8 yrs

Another seemed to understand VCT, but interestingly put an emphasis that is seldom made, on the counselling rather than on the testing:

*It is to do with... if you want to test you will need counselling to get an understanding of HIV.* Girl (12).

Thus only seven out-of-school youth from a total of 32 could give an accurate explanation, showing that out-of-school youth are not well-informed about VCT in particular, although high levels of general "HIV/AIDS literacy" did exist. This became evident in their later responses, for example all except two girls and one boy thought it was important for youth to know their HIV status.



This was reflected in their repetition of the HIV/AIDS prevention campaign slogan “know your status” as well as in comments that indicated knowledge about other HIV/AIDS messages about making lifestyle changes to stay healthy:

*Yes, [it's important for youth to know their status] so that they can change the wrong things they do. Things like sleeping around and having unprotected sex. Girl (5).*

The three who felt that it was not important to know one's HIV status gave reasons such as that knowing one's status would not make a difference to behaviour change, that going for testing would compromise their privacy leading to gossip, and that knowing one's positive status would lead to depression and suicide.

“They need to know where they stand”: general attitudes towards VCT

Of the 32, seven girls and two boys had been for VCT, five in 2007 and four in 2006, and all reported a satisfactory experience. The youth participants were then asked whether they would go for VCT or another VCT in the future. This meant that responses could be divided into two categories: “actual” for those who had been for VCT and “prospective” for those who had intentions of going in the future.

Data were collated into two tables that responded to the two research areas of the study. Table 2 presents reasons out-of-school youth gave for going for VCT. These were grouped into general categories and then examined for frequency in all participant responses. More than one entry was possible per respondent. Table 2 allows for comparison between reasons why respondents had gone, and reasons they give for going in the future.

**Table 2** Reasons for going for VCT

	Reasons for having gone for VCT	Reasons for wanting to go in the future
Pregnant	4	0
Family member	1	0
Partner	1	4
Wanted to know status/want to know if status has changed	6	22
Be healthy	0	7
Want to start family in future	0	3
Total	12 (9 respondents)	36 (29 respondents)

The results indicate that 29, or 91%, of all respondents, expressed an intention of going for VCT in future.

Wanting to know their status is significantly the most frequent category for boys and girls combined, amongst those who had been tested and those who planned to. However, for girls who had been tested, being pregnant was the driving reason for going. This result indicates a positive attitude towards VCT which is also confirmed by responses which describe youth wanting to take charge of their health and their future:

*As a mother, I need to be healthy for the sake of my child. I want to set an example by making good decisions.* Girl (12).

*My boyfriend and I say that if we love each other then we must be responsible. One way of doing this is to know our status and share this with each other, because my HIV status affects him and his HIV status affects me.* Girl (18).

*I would go for VCT because it's important to know my status. It will help me stay protected and also protect others.* Boy (26).

*They should know where they stand so that if they find out that they are positive they can get treatment on time and stay alive. If they are negative they can stay motivated to remain that way.* Girl (25).

Figure 1 shows where out-of-school youth would go for VCT and Figure 2 the reasons given for choosing a VCT site. In both cases data were drawn from the question where they would go in the future, a question answered by all participants.

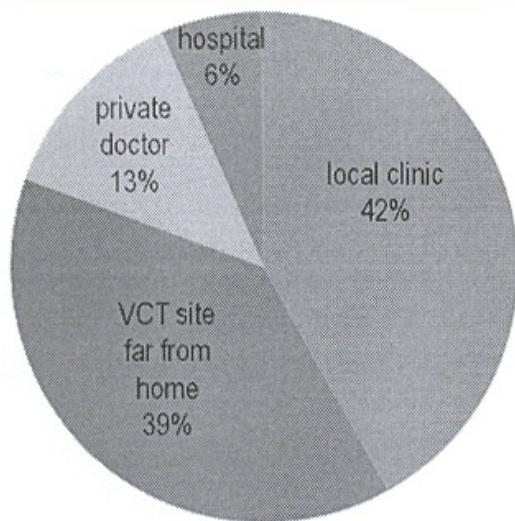


Figure 1 Where out-of-school youth would seek VCT

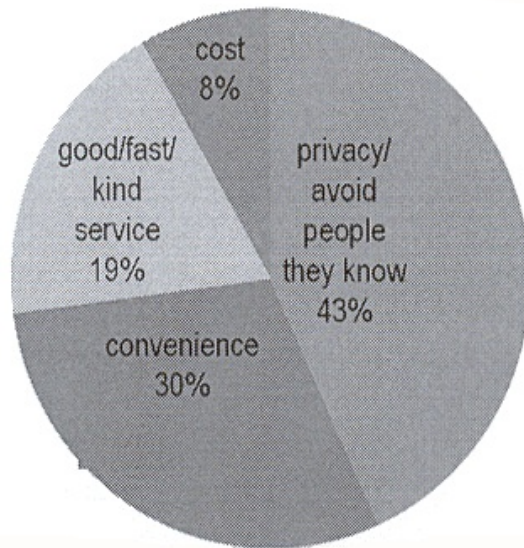


Figure 2 Reasons for choosing VCT site

One of the main concerns when choosing a VCT site was being seen by someone known to them or their families who might report seeing them being tested for HIV. This resulted in 43% stating that if they went for VCT they would select a site based on minimising this likelihood. In most cases this meant going to a VCT site or hospital far from home or, if they could afford it, a private doctor.

As a significant number of out-of-school youth feared being seen at a VCT site, this can be viewed as a sign of the still prevalent stigma and prejudice surrounding HIV testing, where testing is associated with sickness and AIDS (MacPhail *et al.*, 2008; Hutchinson & Mahlalela, 2006; Horizons, 2001). Further analysis of comments in Figure 1, responding to the question as to whom out-of-school youth would not tell about testing, reveals similar mistrust and stigma surrounding HIV/AIDS and related testing. Decisions regarding whom to tell about going for VCT and whom to disclose results to were dominated by fears that others would find out and the consequences of this.

This lies in contradiction with the positive outlook most out-of-school youth expressed initially about VCT in the interviews. Clearly, while the youth express strong intentions of going for VCT and understand its role in maintaining a healthy lifestyle, there is a large gap between this knowledge and

actual outcomes in the form of visits to VCT sites. As only nine had been tested, the only way to assess whether the positive attitude is a sign of positive decision making and action, would be through a follow-up interview to see how many had actually been for VCT. Despite high levels of “HIV/AIDS literacy” among these out-of-school youth, intention and knowledge do not necessarily lead to action and behaviour change, as has been noted in a number of other studies (Campbell & MacPhail, 2003; Morrell *et al.*, 2001, Harrison *et al.*, 2000).

Further, the attempts by out-of-school youth to avoid gossiping neighbours and relations are making access to VCT more difficult and costlier for themselves. Again, this undermines the work of key roleplayers to make access to VCT by youth easier, cheaper and friendlier (Horizons, 2001; Boswell & Baggaley, 2002). Stigma and gossip are key factors that work against those goals and drive youth to seek VCT far from home, making it less likely that they will actually go:

*I would go to the clinic far from home, There are so many people attending the local clinic who know me. I wouldn't want them to know when I get tested.* Girl (16).

*I'd go far from where I live. I wouldn't want people to see me check my HIV. They will spread the word that I am positive and then what? Everyone will know!* Boy (23).

Since the great majority of respondents expressed the intention of going for VCT, there were very few data on why they would not do so.

*I don't think I am at risk of being HIV. I have not had sex and so I don't think I am at risk.* Girl (15).

*I am scared. What if I am positive what will I do? I don't have a job and I want to go back to school. What will I do? My mother and father will tell me that I failed them and that I have let them down.* Boy (23).

*Because if I find out I am positive I would definitely kill myself. I would just throw myself in the river. Because what is going to happen if I know I am going to die with AIDS. I don't have job so who will look after me. I am not at school and then I will find out I have HIV. I will kill myself.* Boy (31).

These point to the intense feelings of desperation linked to a diagnosis of being positive. Interestingly, these are couched in terms of work and exclusion from schooling. The fears around being HIV positive are expressed in terms of social exclusion, whereas social inclusion would by implication mitigate the effects of the infection.

“I would ask my boyfriend to use a condom everytime we had sex”: VCT, results and changing behaviour

The interview schedule included questions about behaviour change in two different scenarios; one where results were HIV positive and one where the results were HIV negative. Youth were not asked to reveal their actual status if they knew it, but rather to imagine “what if”. Answers therefore can only indicate intention and knowledge rather than actual behaviour.

Of the respondents, 19 girls and 10 boys stated that they would change their behaviour if they found out they were HIV positive. Responses revealed knowledge about preventing infection of others, as well as reinfection of themselves, by abstaining from sex or using protection. Some also mentioned living a healthy lifestyle in terms of food, exercise and taking medication. One boy stated he wouldn't change, without giving a reason.

If the test was negative, nine girls and eight boys stated they would still change their behaviour in order to remain negative. This usually took two forms, either through attempting to gain control in relationships or through making an individual decision. Being involved in a relationship usually had a disempowering effect where responsibility for their health was taken out of their hands and rested with a partner, whose commitment and faithfulness could not be guaranteed. The following comments reveal little sense of real control either of self or a partner:

*[If results were negative] I will force my boyfriend to go for VCT so that we can start our life again. I will also force him to not have sex with other girls. Girl (16).*

*I believe that my boyfriend and I must talk more about our relationship and what we think about being unfaithful so that we remain faithful to each other. I also think that my boyfriend and I should talk about only having sex with each other. Girl (17).*

*[If results were negative] I would change the way I do things like using a condom and remaining faithful. I might stop seeing more than one girlfriend and maybe remain faithful to one. But it will be hard. If I want to remain negative then I will have to change. Boy (11).*

However, other responses such as the following revealed intentions to act on a basis not so dependent on others:

*I will abstain until I meet the right person and I will only have sex when I marry. Girl (15).*

### **Discussion and conclusion**

The broadly positive attitudes to VCT coexist with limited understanding of it and limited use of it. This study reveals a high general level of awareness of HIV/AIDS, certainly to the point that out-of-school youth can repeat many of the standard messages used in campaigns against the disease. First, they could be viewed as a sign of some success of HIV/AIDS campaigns aimed at destigmatising the disease and encouraging youth to know their status. Through this lens, out-of-school youth can be seen as having gained a greater sense of agency, allowing them to make informed decisions about their health.

Secondly, this result could be viewed as a sign of well-informed intentions, where "HIV/AIDS literate" youth understand the importance and role of knowing their status, but fail to carry the intention through, through social, gender and cultural pressures in a context of poverty, and through lack of confidence in transforming knowledge into action. From this viewpoint, the positive responses to VCT are answers that they know are "right".

Yet, while there are generally positive comments about the value of VCT,

there is also considerable vagueness as to what exactly it entails. This indicates the need for publicity to explain more clearly what it involves.

The gap between positive intentions in terms of VCT and the practices of youth points to the same findings as other studies, which reveal the 'right' messages but the weight of factors that impede action on the basis of these messages (Rassjo *et al.*, 2007; Bell *et al.*, 2007, Boswell & Baggaley, 2002; MacPhail *et al.*, 2008).

While the data related to reasons for not testing are limited, it is striking the extent to which two respondents responded with such a sense of desperation, a desperation communicated in terms of social exclusion. This sense of exclusion might reflect the specific circumstances of people in Shongweni, but similar expressions, related also to their exclusion from schooling and work, were voiced by out-of-school youth in Lamontville in response to a different question (see Francis & Rimmensberger, 2008b; Francis & Rimmensberger, 2008a). Lamontville, a centrally situated Durban township, was the other area in the broader study. While working class, it does not experience the same degree of economic marginalisation as Shongweni.

The finding regarding pregnancy is promising. Young mothers, who may fail to act decisively to protect themselves, are prepared to overcome their own resistance in the interests of their children. This indicates a tussle between blocking and impelling factors related to VCT.

The responses regarding behaviour after an HIV test indicate the intention to change (or an intention to try to change a partner who poses a threat to their continued health), they also indicate a lack of any real power and an implicit acceptance of this role. For example the 18 year old girl states she "will also force him [her boyfriend] to not have sex with other girls", a task she has little say over in reality, in contrast to a decision to leave her unfaithful partner.

The desire to use VCT is linked in pregnant girls to health concerns for their children, and more generally amongst respondents is associated with action to care for one's health. This suggests a valuable line of publicity worth following in campaigns to promote the use of VCT. It may be that such messages should in the case of boys and girls who are not pregnant be linked to general images of health, fitness and sporting prowess. Given that such findings reveal the contestation between fear of stigma and other constraining factors on the one side, and a commitment to one's own health (and that of one's children) on the other, it may be worth exploring the possibility of making VCT services less clearly identified with HIV/AIDS specifically, and more part of general health awareness and counselling services.

The study confirms the findings of other studies (Bell *et al.*, 2007; MacPhail *et al.*, 2008; Rassjo *et al.*, 2007) regarding the obstacles posed to VCT by inequitable gender relations, by the stigmatization of those infected with HIV, and by poverty.

That the fear of testing HIV positive was expressed in relation to existing social exclusion, in two cases, argues for further research on this issue. Should such research find that this relationship to be widespread, the

implication would be that focusing primarily on issues of health may not sufficiently address the burden experienced by those who face the disease and stigma while simultaneously face a broader social exclusion based on class and race. Campaigns should then be framed to groups such as these in ways that communicate their resilience and ability to manage their lives effectively.

Possibly VCT services could be made integral to the provision of health services to young people, rather than having them organised and advertised separately. However feasible it is to have specific youth health centres with an emphasis on fitness, well-being, and even physical training is beyond the scope of this paper, but the findings do suggest that VCT services need to be located in ways that would attract young people who fear stigma and do not want to be seen visibly using VCT.

The study is a reminder to researchers of the gap between awareness and action. Our title is a declaration by an out-of-school youth about what out-of-school youths should be doing. Its indirectness gives a sense of the gap between attitude and action. Positive attitudes towards VCT may lead to action, or may not. The hope here is that greater understanding of these attitudes may reveal points at which young people can be guided towards greater and more effective use of VCT.

### Acknowledgement

I acknowledge financial support from the South African Medical Research Council.

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