THE IMPACT OF THE UNISA HIV/AIDS PROGRAMME ON LEARNERS AND THEIR COMMUNITY INVOLVEMENT

by

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SUMMARY

In this study the impact of the UNISA HIV/AIDS training programme on participants' learning and involvement in their respective communities was explored. The UNISA HIV/AIDS programme comprises Modules 1, 2 and 3. Module 1 focuses on orientation and background to HIV/AIDS Care and Counselling, Module 2 on HIV/AIDS counselling skills and Module 3 on train the trainer in HIV/AIDS education and counselling. This study focused only on Modules 1 and 2. Kirkpatrick's model of evaluating education and training programmes was used as a framework to evaluate the programme.

Participants for the study consisted of 116 students who attended the UNISA HIV/AIDS Module 2 workshops between December 2005 and December 2006. The study was conducted in two phases – the first phase during the workshops, where participants were asked to indicate both quantitatively and qualitatively how they experienced Module 1 and Module 2 as well as what they learnt in the two modules. The participants' involvement in HIV/AIDS work prior and post Module 2 training as well as the aspects of the programme that are being applied within their work in the community was assessed during the second phase of the study, which took place during 2007.

The results of the study indicate that the programme has successfully equipped participants with the necessary HIV/AIDS information and skills. The programme has further empowered participants to engage in HIV/AIDS education and counselling in their communities. Participants' attitudes towards the disease and towards those infected and affected by HIV/AIDS were challenged, resulting in less stigmatization and discrimination. The programme further challenged participants to start adopting health protective behaviours.

The present study concludes that for HIV/AIDS programmes to be effective, they need to include, amongst other things, a well-researched basic HIV/AIDS factual information section, a component on attitudes and one on skills (particularly linked to behaviour change). These should be presented in an interactive way, engaging the participants in active learning.

Key terms: UNISA HIV/AIDS training programme; Kirkpatrick's model of evaluating training programmes; HIV/AIDS knowledge; HIV/AIDS counselling skills; Attitudes on HIV/AIDS; Transferring HIV/AIDS knowledge and skills

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I declare that ***The impact of the UNISA HIV/AIDS programme on learners and their community involvement*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. I also declare that the raw data upon which the results of this study are based is obtainable from the author upon request.

_____ _____

SIGNATURE DATE

(M Matoane)

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To You, Oh! Lord, be the glory, the honour and praises! You were my Strength when I was weak, You were the Light that lit up my misty and foggy path at times, and were my Wisdom when I wove everything together.

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DEDICATION

I dedicate this thesis to all HIV/AIDS educators and counsellors who are engaged in the fight against HIV/AIDS, especially those who participated in this study. Let's keep the light burning. *Aluta continua!*

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CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 A PERSONAL ACCOUNT

My involvement in the field of HIV/AIDS started in 1993 when I was enrolled to study for a Master's degree in clinical psychology at one of the universities in South Africa. As part of our degree requirements, we were expected to conduct research on a topic of our choice. At that stage I knew very little about research and as such, struggled to come up with a research topic. Our lecturers were involved in research and often had research topics from which students could choose. I was drawn to a topic on HIV/AIDS as I had always had a passion for Health Psychology. At that time the topic seemed the most obvious choice as research in the field of HIV/AIDS was gaining momentum in South Africa. My research focus was on investigating motivations for or against HIV testing. I used the Health Belief Model as a theoretical framework. During those times, it was rare for individuals to voluntarily undertake an HIV/AIDS test, hence the study (Nefale, 1999).

During 1999 I became part of the team that developed the HIV/AIDS programme at UNISA. This was an opportunity for me to not only be involved in research in the field, but to also contribute towards empowering others to participate in understanding and combating the spread of the epidemic. My present involvement in the programme includes lecturing the distance learning component of the programme (referred to as Module 1) which focuses on equipping learners with factual information on HIV/AIDS care and counselling. I am also involved in the practical component of the programme that entails pre- and post-test HIV counselling. This second aspect of the programme (referred to as Module 2) is offered in the form of a workshop where I form part of the facilitation team. At other times I oversee the overall running of the workshop.

During one of the Module 2 workshops an 18 year old girl, who I will refer to as Princess, stood in front of the participants and related her story of being HIV positive as a result of having been raped. Princess told how she had been diagnosed with the virus; and how she had been living with it since the diagnosis two years before. She related how her social life had disintegrated following the rape- when her very own source of support, her family, rejected her. She saw her future collapse.

I sat there silently, listening to Princess' story. I found myself moving beyond the moment and going ahead in time, wondering what Princess' story was saying to us as HIV/AIDS researchers. Are we answering the needs of potential and HIV infected/affected people? Are we engaged in a process of continual reflection about the complex issues that this epidemic is presenting with?

I found Princess' story unpacking some of the complexities presented by the epidemic. On the one level, it points to the vulnerability of our young girls in society, or perhaps even extending to women in general, and their lack of power as compared to their male counterparts. On another level, it reflects the impact that the epidemic has on both the infected and affected. In her story, Princess relates how her family almost disowned her because of their own fear of society's reaction towards them (as a family) because of a family member who is HIV positive. The family's spontaneous reaction and manner of managing the disclosure reveals an unsaid subtext that points to society's attitude toward those who are infected and affected by the disease, hence the family's rejection of their daughter and possible disowning of her. From the infected person's point of view, there is a sense of isolation, discrimination and ostracization – feelings described by Princess. It was sad and unfortunate for Princess' family to react in the manner they did, but yet again, they probably reacted the best way they knew how given the perceptions most probably held about the disease in their community. This act of contemplating to reject their daughter ironically happened at a time when she needed them the most – a time where she needed them to accept, reassure and embrace her with love and support. Princess' story illustrates the cruelty of this epidemic: metaphorically it came looking for

her, and on top of that it made sure she remained alone without the support of people that were most important in her life. It sought to completely destroy her!

This story and many others that I have heard, either in training sessions or in my capacity as a psychotherapist, made me to continuously reflect on the various ways in which HIV/AIDS is dealt with. Due to the various roles that I fulfil as an academic, a researcher and a psychotherapist, I am repeatedly confronted with the complexity and challenges brought on by the epidemic. It is for this reason that I am motivated to evaluate the UNISA HIV/AIDS programme in order to establish to what extent it contributes towards the effective management of the epidemic in the country.

1.2 BACKGROUND TO THE UNISA HIV/AIDS PROGRAMME

According to the 2006 joint UNAIDS/WHO report, an estimated 39.5 million people worldwide were living with HIV by the end of 2006, 4.3 million of whom were newly infected. 63% of these infections were in sub-Saharan Africa, a region that continues to be hit the hardest by the epidemic; with 32% from Southern Africa. The UNAIDS (2006) statistics show 5.5 million people, including 240 000 children who are younger than 15 years, to have been living with HIV in 2005 in South Africa.

Although there seem to be some indications of a decline in HIV prevalence in some countries in sub-Saharan Africa, the decline does not seem to be strong nor spread wide enough to impact on the overall decline of the epidemic in the region (UNAIDS/WHO, 2006).

An increasing number of people are currently dying of AIDS in South Africa. This is attributed to the fact that the epidemic emerged a little later in South Africa in comparison to other regions (UNAIDS/WHO, 2006). Reports by the Actuarial Society of South Africa (2006) and Dorrington *et al*. (2001) (cited in UNAIDS/WHO, 2006) contend that the AIDS epidemic has led to a dramatic increase in the death toll in South Africa. The Actuarial Society of South Africa (2005) further indicates a decrease in life

expectancy to below the age of 50 years in the South African provinces of the Eastern Cape, the Free State and KwaZulu Natal.

The above information indicates that there is no cause for complacency. Instead, this poses a challenge on the effectiveness of prevention programmes and the provision of anti-retroviral drugs. HIV/AIDS clearly continues to ravage societies in a manner no any other disease has. Not only does it threaten the health of individuals who are infected with the virus, it also affects those close to the individual, such as the family, friends and colleagues thereby breaking down societal structures within which the individual lives. The epidemic has further challenged various sectors within the society to participate in making contributions towards its management. For example, the health sector has been challenged to find ways of controlling and preventing the spread of the disease, the legal sector is challenged to introduce legislation that provides guidelines on how to treat individuals who are HIV positive, while the labour department is charged with the mandate to secure laws that ensure fair labour practices concerning HIV-infected employees within the workplace. The education sector is also challenged to design and facilitate intervention programmes that will effectively address the management of the epidemic.

In response to this challenge, the Department of Health established a strategic plan for managing the AIDS epidemic. The aim of the strategic plan is to reduce the number of new HIV infections (especially amongst the youth) as well as to reduce the impact of HIV/AIDS on individuals, families and communities (HIV/AIDS/STD Strategic Plan for S.A. 2000). The Education sector through structures such as The Committee for Technikon Principals (CTP) and the South African Universities Vice Chancellors Association (SAUVCA) also rose to the challenge. Universities were not only challenged to conduct research within the field of HIV/AIDS, but were also requested to consider providing HIV/AIDS programmes that would cater for the country's needs. This led to the formation of the Centre for the Study of Aids at the University of Pretoria in 1999 (www.afroaidsinfo.org, 28.09.2005) and the HIV-AIDS Centre under the auspices of the Unit for Health Service at the Port Elizabeth Technikon, launched in

November 2001 (www.petech.ac.za, 28.09.2005). Another initiative that arose as a need to address HIV/AIDS within universities was the establishment of the Centre for HIV/AIDS Networking at the University of Natal in 2001 (www.afroaidsinfo.org, 28.09.2005). The Unit for Social Behavioural Studies in HIV/AIDS and Health was also established at the then Vista University – Mamelodi campus – and has now been incorporated into the (new) University of South Africa (www.unisa.ac.za, 28.09.2005).

The institutions mentioned above utilize a diversity of programmes to address HIV/AIDS issues. These incorporate academic teaching programmes, community outreach programmes, programmes that focus on research, prevention and education programmes on campus. Universities that offer certificates, diplomas and degree courses specifically in HIV/AIDS are few in South Africa. Those that could be identified include the University of Stellenbosch, which offers a postgraduate diploma in the management of HIV/AIDS (PDM) in conjunction with the Medical University of Southern Africa (MEDUNSA). The University of South Africa (UNISA) also offers a pre-graduate module as well as certificate courses in HIV/AIDS Care and Counselling, which will be referred to in this study as the UNISA HIV/AIDS programme. A BA (Hons) Social Behaviour Studies in HIV/AIDS, a MA Social Behaviour Studies in HIV/AIDS and a MA in Psychology with specialization in HIV/AIDS research are also offered at UNISA. The present study will specifically focus on the evaluation of the pre-graduate certificate courses offered at the University of South Africa on HIV/AIDS Care and Counselling.

The Department of Psychology at UNISA, in conjunction with the UNISA Centre for Applied Psychology (UCAP) developed the UNISA HIV/AIDS programme in an attempt to respond to the challenges brought about by the epidemic. Around the same time the programme was developed, there were attempts, at national level, to re-structure the education system, including the re-structuring of the curriculum. These re-structuring initiatives included the formation of the National Qualifications Framework (NQF), which became responsible for providing guidelines on the development of qualifications within the country. The South African Qualifications Authority (SAQA) was another governing body that was formed to oversee the development of these qualifications.

Another crucial sub-body of SAQA was the different standards generating bodies (SGB's), which were responsible for the actual development of standards governing qualifications across the country. There was also a move towards an outcomes-based education (OBE) approach, with an emphasis on life-long learning.

Within the field of Psychology in particular, some critics had already voiced issues of relevance and Africanization of the subject (Psychology). These critics argued that Psychology was dominated by Western thinking and yet it was applied within the African context. Another point raised in this regard was that Psychology was meant for the elite few within the society, and the majority of the people (who perhaps needed it most) could not gain access to it, because of the costs involved (Cooper, Nicholas, Seedat & Statman, 1990). Other points of criticism from proponents who argued for the re-structuring of the Psychology curriculum include the fact that undergraduate Psychology courses, in particular, were too academic (cognitive and facts-based), and did not equip students with the necessary skills for becoming employable thereafter.

UNISA also got involved in this national process of restructuring. In an attempt to do this, the institution restructured their undergraduate curriculum from a year-course system to a six-months-based, modular system. The department of Psychology also participated in these changes when it embarked on a process to determine new directions required for the training of Psychology students during 1997 – 1998. The HIV/AIDS programme formed part of these new course offerings. This programme was conceived to directly respond to requests from sectors in the community for knowledge and skills in the field of HIV/AIDS education and prevention.

It is evident from the above that the conception of the HIV/AIDS programme at UNISA was a result of two forces: the need to address the challenge brought on by the HIV/AIDS epidemic while the other was the national curriculum restructuring process.

HIV/AIDS prevention programmes tend to rely heavily on correct factual knowledge on HIV/AIDS, hence the necessity to design and implement training programmes that would

equip individuals with the necessary information to combat the spread of the epidemic. In recognition of this, one of UNESCO's aims was to give close attention to the dissemination of accurate information about methods of HIV transmission, safe sex practices and counselling services through formal and non-formal education and networks, in an attempt to reach students, institutions and communities (UNESCO, 2002). The challenge to provide accurate information on HIV/AIDS has been largely left upon the shoulders of researchers and academics in the field of HIV/AIDS. A partnership can however be formed between research institutions, institutions of higher learning, community-based organizations, non-governmental organizations and other relevant structures within the community. It is to this effect that UNESCO (2002) made it its mandate to promote scientific co-operation and to strengthen capacities of higher education institutes to produce and disseminate research and information related to HIV/AIDS. By conducting on-going research and assessment on HIV/AIDS training programmes, it becomes possible to improve the effectiveness of HIV/AIDS programmes. It is in the light of this that the present study is conducted.

1.3 THE OBJECTIVES OF THE PRESENT STUDY

The main objectives of the present study are to:

- Investigate the impact of the UNISA HIV/AIDS programme on participants' learning.

This study will examine the outcomes achieved by participants at the end of studying the programme. The manner in which the programme was delivered and aspects of the programme that participants found useful will also be investigated. Such an assessment will provide an indication of the value of the programme for the participants.

- Research the impact of the programme on participants' involvement in the community.

Another objective of this study is to assess how participants' involvement in their communities is influenced by the UNISA HIV/AIDS training. This will be done through investigating participants' involvement in the HIV/AIDS field prior to attending the programme and after attendance of the programme. The exact nature of their involvement with the community and specific skills that are utilized which related directly to the programme will be explored.

- Suggest improvements to the UNSA HIV/AIDS programme.

This objective involves suggestions made by participants through identifying themes/topics, teaching methods or skills taught that need further consideration to improve the quality of the presentation. This will be based on the participants' input resulting from their attendance of the programme as well as their involvement in actual HIV/AIDS work.

1.4 OUTLINE OF THE STUDY

The next chapter provides an in-depth discussion of the UNISA HIV/AIDS programme – how it is designed, the themes that are covered and the main objectives of the programme. The theoretical and/or philosophical assumptions upon which this programme is based as well as the method of tuition and assessment will be highlighted.

Chapter 3 deals with the research methodology for the study. A description of evaluation research is presented as background and Kirkpatrick's model of evaluating training programmes, with its various levels of evaluation is discussed. The research method that was used in this study is then described, as well as the sample, the data collection method and the data analysis techniques. The ethical considerations for the study are also presented.

Chapter 4 discusses the impact of the UNISA HIV/AIDS programme on participants' learning and involvement in their communities. The Reaction and Learning components of Kirkpatrick's model provide a basis for understanding the programme's impact on

participants' learning, thus addressing both formative and summative evaluations. The Behavioural component of Kirkpatrick's model assists in understanding the impact of the programme on participants' involvement in their communities, thereby addressing summative evaluation.

Chapter 5 presents the overall conclusions that can be drawn from the study, including suggestions for improving the UNISA HIV/AIDS programme. Limitations of the present study and suggestions for future research are also discussed.

CHAPTER 2

THE UNISA HIV/AIDS PROGRAMME

2.1 INTRODUCTION

The UNISA HIV/AIDS programme was conceived in 1999 by the Department of Psychology in collaboration with the UNISA Centre for Applied Psychology (UCAP). As already mentioned, the conception of this programme was a result of a national curriculum restructuring process in South Africa and a response to the challenge and explosion of the HIV/AIDS epidemic in the country.

The following three separate, but interrelated modules constitute the UNISA HIV/AIDS programme:

- Module 1: Orientation and background to HIV/AIDS Care and Counselling
- Module 2: Practical Workshop in HIV/AIDS Counselling Skills
- Module 3: Practical Workshop in Train the Trainer on HIV/AIDS Education and Counselling.

Even though the modules are separate, Module 1 is a pre-requisite for module 2 and Module 2 a pre-requisite for module 3. Module 1 is compulsory for all learners interested in pursuing an academic course in HIV/AIDS, whereas the other two modules are optional. Only learners who are interested in being involved in HIV/AIDS counselling and in facilitating HIV/AIDS workshops enroll for Module 2 and 3 respectively.

The need for the creation of partnerships and co-operation with other stakeholders in combating the spread of the epidemic was considered in the development of the UNISA HIV/AIDS programme. For this reason, the programme is seen as an attempt to constitute a "training chain" that is envisaged to work together with a well-functioning network of interwoven service providers. This system can only become functional when there is proper co-ordination, monitoring and effective use of these networks.

The programme is multi-disciplinary and its student base includes psychologists, counsellors (professional and lay), ministers of faith, nurses, social workers and educators.

The full programme is designed to enable learners to acquire knowledge and skills in the following:

- Counselling
- Developing education and prevention programmes
- Facilitating group processes
- Organizing multi-disciplinary teams to manage the AIDS epidemic
- Presenting HIV/AIDS education and prevention workshops

The programme is further aimed at equipping learners with the skills necessary to deal with HIV/AIDS issues across a diversity of settings within the multi-cultural South African context. The programme, therefore, equips learners with the skills to:

- Disseminate correct and relevant information on HIV/AIDS in the community
- Facilitate the breakdown of negative attitudes, stereotypes and misconceptions about HIV/AIDS
- Promote HIV/AIDS prevention strategies in the community
- Counsel clients on various HIV/AIDS aspects
- Provide pre- and post- HIV test counseling
- Deal with cultural and sexual diversity
- Apply basic legal and ethical issues in various contexts
- Understand the basic principles of home-based care
- Use relevant resources and be able to participate in networking
- Develop and facilitate educational programmes

The section that follows takes a closer look at the UNISA HIV/AIDS programme. For the purpose of this study, only Modules 1 and 2 of the UNISA HIV/AIDS programme will be focused on.

2.2 MODULE 1: THEORETICAL ORIENTATION AND BACKGROUND TO HIV/AIDS CARE AND COUNSELLING

In Module 1 learners are given the necessary and correct factual information on HIV/AIDS. This includes the technical description of the virus, how the virus is transmitted, how the spread of the virus can be prevented and how infection with the virus can be managed. In the absence of a cure for HIV/AIDS, prevention and treatment become the only answer to counter the spread of the epidemic. An integral aspect in the promotion of educational prevention messages is the dissemination of correct factual information in the form of HIV/AIDS awareness programmes. The Department of Health in South Africa illustrates the importance of this approach in the guidelines developed for providing minimum standards in training HIV/AIDS counsellors by including this component as an essential aspect of a training programme (DoH national guidelines, 1999). The UNAIDS (2006) underscores the role played by clear, factual HIV prevention information when they recommend that this be made a legal right in many countries in an attempt to strengthen AIDS prevention efforts. In Zimbabwe, AIDS awareness campaigns are reported to be amongst factors that have contributed to the decline in HIV prevalence (UNAIDS/WHO, 2006).

The module further covers transmission, prevention and management of the virus within the multicultural context of the South African population, embracing the legal and ethical issues that govern HIV/AIDS. According to the UNAIDS/WHO (2005) report, the noted variance in HIV prevalence among pregnant women highlights the epidemic's adaptability and sensitivity to contextual factors. For this reason, it makes sense to recognize the context within which the epidemic broods, and then build programmes that incorporate and address these factors. When a fit between an intervention and the cultural context within which it is applied exist, cultural competence has been achieved. Bok and Morales (1998) consider cultural competence to be a core concept in HIV prevention/education.

The following specific themes are covered in Module 1 (Van Dyk, 2005):

- Part 1: Fundamental facts about HIV/AIDS
    - HIV and the immune system
    - The transmission of HIV
    - HIV/AIDS related symptoms and diseases (including T.B. and S.T.I.'s)
    - Diagnosis of HIV infection and AIDS
    - Management of HIV infection (e.g. anti-retroviral therapy, treatment of opportunistic diseases, boosting of the immune system)
- Part 2: Prevention and Empowerment in the HIV/AIDS context
    - Principles and strategies for prevention
    - Prevention in traditional Africa
    - Changing unsafe behaviour and practices
    - HIV education and life skills training
- Part 3: HIV/AIDS Counselling
    - Basic counselling principles and skills
    - Pre- and post- HIV test counselling
    - Counselling in various contexts
    - Bereavement and spiritual counselling
- Part 4: Care and Support
    - Home-based care
    - Support for orphans and other vulnerable children
    - Infection control
    - Care and nursing principles
    - Care for the caregiver
- Part 5: Legal, Ethical and Policy Issues
    - Legal, ethical and policy issues

2.2.1 Fundamental facts about HIV/AIDS

The syllabus

Part 1 of Module 1 concentrates on basic virology, immunology, the history of HIV as well as theories of origin, and the latest development in vaccine research. It further highlights all the modes of transmission of HIV, and gives attention to poverty and depressed socio-economic conditions, as well as factors contributing to the spread of HIV infection. Myths about the transmission of HIV and prevention of the infection that exist in Southern African communities are explored and discussed in relation to scientific facts. In the discussion on symptoms and diseases associated with HIV/AIDS, special attention is given to co-infection with tuberculosis, and other sexually transmitted diseases. Included in the syllabus are (i) the latest technology in diagnosing HIV infection, and (ii) the most recent information on the management of HIV infection, with special reference to South African protocols on antiretroviral medications. The development of drug-resistant viruses and ways to promote adherence to medications, especially in poorly-resourced communities, get special attention.

The underlying theory and/or philosophy

The fundamental facts about HIV/AIDS are based on the latest bio-medical research on HIV/AIDS as published in various scientific sources, including publications from WHO, UNAIDS, CDC, SA HIV Clinicians Society and the SA TB Control Programme (Evian, 2000, 2003; Gray & McIntyre, 2002; Hooper, 1999; Jaret, 1986; Korber, 2000; SA HIV Clinicians Society, 2002; SA TB Control Programme, 2000; Schoub, 1997, 1999; UNAIDS, 2000, 2004 and WHO, 2000).

Learning Outcomes

After studying this section, learners are expected to be able to develop and present an HIV awareness programme that shows clarity on the following (Van Dyk, 2005):

- How the normal immune system functions
- How HIV affects the immune system
- How HIV is transmitted

- The clinical symptoms of HIV infection and AIDS
- The relationship between CD4 cells, the HI virus and phases of infection
- How HIV infection is diagnosed
- The management and treatment of HIV, including the use of antiretroviral therapy in the South African context.

2.2.2 Prevention and Empowerment in the HIV/AIDS context

The syllabus

Part 2 of Module 1 focuses on ways in which the spread of HIV can be effectively prevented. This starts by considering behaviours and situations that contribute to the spread of the epidemic. Psychological theories that explain and predict behaviour especially related to HIV infection are presented. This addresses the problem that HIV/AIDS programmes are often not based on a theoretical framework (Bok & Morales, 1999). We believe that an understanding of the theory of behaviour change will lead to a better understanding of the trends in sexual behaviour and the spread of the epidemic. This approach concurs with the idea that: "the future course of the world's HIV epidemic hinges in many respects on behaviour that young people adopt or maintain and the contextual factors that affect those choices" (UNAIDS/WHO, 2006, p.8). The section further discusses voluntary HIV counselling and testing (VCT) as a strategy for preventing HIV. This is particularly important to highlight as voluntary HIV counselling and testing has become a major HIV/AIDS prevention strategy in Africa. Research has indicated the importance of knowing one's HIV status in effecting behaviour change and the adoption of safe sex practices (Allen, Meinzen-Derr, Kautzman, Zulu, Trask, Fideli, Musonda, Kasolo, Gao & Haworth, 2003; Chesney, 1993; Miller, Turner & Moses, 1990; UNAIDS/WHO, 2006; Zapka, Stoddard, Zorn, McCluster & Mayer, 1991). The importance of acknowledging the role of culture in influencing the spread of the epidemic is also highlighted (UNAIDS/WHO, 2005). This is addressed through presenting the implications of various traditional African beliefs and practices on HIV prevention. The section focusing on "safer sex practices" entails the discussion of safe, safer and unsafe sexual practices. Furthermore, various tips and ideas on practising safer sex are given in

that section. The effects of safer sex practices are reflected in the observed decline in national adult HIV prevalence in Zimbabwe, which has been linked to a reduction in casual sex relations with non-regular partners and increased condom use (UNAIDS/WHO, 2006). Part 2 of Module 1 ends with a section on principles and methods that promote adult learning. It also includes the factors that need to be taken into consideration when assisting both adults and children learn new skills and attitudes, especially about HIV/AIDS. The importance of considering the impact of the various developmental phases of children and adolescents on their understanding of HIV/AIDS and their implications for developing suitable prevention programmes is discussed. The cognitive, emotional, social, moral, sexual and self-concept areas of development are explored and considered in developing appropriate HIV/AIDS education programmes. The theories that underlie prevention and empowerment in the HIV/AIDS context are discussed below.

2.2.2.1 Theories of behaviour change

Amongst some of the most widely used theories of health behaviour are the Theory of Reasoned Action (TRA), the Health Belief Model (HBM), the Theory of Planned Behaviour (TPB), the Social Cognitive Theory (SCT) and the Transtheoretical Model (TTM).

The Theory of Reasoned Action was advanced in the mid 1960's by Fishbein and Ajzen and is based on the assumption that humans are rational beings, who make systematic use of the information available to them to engage in specific behaviours (King, 1999). For the theory to apply the individual must have the intention to change behaviour and this intention will be influenced by two major factors (Fishbein & Ajzen, 1975):

- Attitudes towards the behaviour: here the belief in engaging in the behaviour is based on negative or positive outcomes, and there is also an evaluation of the consequences of engaging in the behaviour.
- Subjective norms about the behaviour: here it becomes important to know what significant others think about engaging in the behaviour as well as assessing the motivation to do so, based on subjective norms.

Ajzen and Madden (1986) recognise perceived behavioural control as an additional construct that could be used, together with the TRA constructs, to predict health behaviour; hence the Theory of Planned Behaviour (TPB). By adding perceived behavioural control, factors such as the absence of resources or skills and impediments to performing behaviour could be accounted for (Elder, Ayala & Harries, 1999).

According to Dennison (1996) TRA provides a framework that links individual beliefs, attitudes, intentions and behaviour. From this framework, behavioural and normative beliefs, also referred to as cognitive structures, influence individual attitudes and subjective norms, respectively. In turn, attitudes and norms shape a person's intention to perform behaviour. Finally, a person's intention, according to this theory, remains the best indicator that the desired behaviour will occur. King (1999) emphasizes the central role played by normative beliefs in the theory as reflected by focus on the individual's beliefs regarding influential people's expectations of the individual's behaviour in a given situation. For example, an individual's decision to start using condoms will be affected by whether his/her peers use condoms or not.

The Health Belief Model was developed in the early 1950's by a group of social psychologists at the U.S. Public Health Service in an attempt to understand the widespread failure of people to accept disease preventives or screening tests for the early detection of asymptomatic disease (Janz & Becker, 1984). According to Noar and Zimmerman (2005) the model is specifically aimed at explaining and predicting health behaviours by focussing on the attitudes and beliefs of individuals. The key HBM variables as described by Dennison (1996) are:

- Perceived susceptibility: one's subjective perception of the risk of contracting a health condition, in this case HIV/AIDS.
- Perceived severity: feelings concerning the seriousness of contracting an illness or of leaving it untreated, in this case the seriousness of contracting HIV/AIDS.
- Perceived benefits: believed effectiveness of strategies designed to reduce the threat of the illness, in this case either the use of condoms, abstinence or a cure for HIV/AIDS.

- Perceived barriers: potential negative consequences that may result from taking particular health actions, including physical, psychological and financial demands. In the case of this study, this could be the negative consequences associated with using a condom, abstaining from sexual activities or undertaking an HIV test.
- Cues to action: events, either bodily (e.g. physical symptoms of a health condition) or environmental (e.g. media publicity), that motivate people to take action. In this case, witnessing close friends and relatives dying from AIDS or developing symptoms related to HIV/AIDS might lead individuals to go for an HIV test or engage in behaviour that will prevent the risk of infection.

The Social Cognitive Theory (SCT), also known as the Social Learning Theory was proposed by Bandura around the 1970's and proposes that behaviour is learned either through modelling behaviour from others, or through direct experience (Bandura, 1999). The theory further acknowledges the important role that vicarious, symbolic and self-regulatory processes play in psychological functioning, as well as the dynamic interaction between cognitive, behavioural and environmental determinants on health behaviour (Elder, Ayala, & Harries, 1999; King, 1999).

According to King (1999), the following are the central tenets of the theory:

- Self-efficacy: this is a belief in the ability to implement the necessary behaviour. For example, one might feel they have the ability to insist on using a condom with a sexual partner.
- Outcome expectations: these are beliefs held with regard to certain outcomes. For example, the belief that using a condom correctly will lead to HIV prevention.

The Transtheoretical Model, also known as the Stages of Change Model (SOC), was developed by psychologists in 1982 in an effort to understand smoking cessation in individuals (Dennison, 1999). Behaviour change, according to this model, is not a single event, but a gradual, continuous, recyclic stage process (Zimmerman, Olsen & Bosworth, 2000), though at the initial conception of the theory, behaviour was believed to progress

in a linear fashion across four stages (Dennison, 1999). The fifth stage has since been added and processes to assist in predicting and motivating individual movement across stages were also developed (*ibid.*). Dennison (1999) discusses these stages with reference to Prochaska, DiClemente & Norcross (1992) as follows:

- Precontemplation: the individual has a problem (whether he/she recognizes it or not) and has no intention of changing.
    - Processes: consciousness-raising.
- Contemplation: the individual recognizes the problem and is seriously thinking about changing.
    - Processes: self-reevaluation (assessing one's feelings regarding the behaviour).
- Preparation for action: the individual recognizes the problem and intends to change the behaviour within the next month. Some behaviour change efforts may be reported, though the defined behaviour change criteria have not been reached.
    - Processes: self-liberation (commitment or belief in ability to change).
- Action: the individual has enacted consistent behaviour change for less than six months.
    - Processes: reinforcement management (overt and covert rewards), helping relationships (social support, self-help groups), counter-conditioning (alternatives for behaviour), stimulus control (avoid high-risk cues).
- Maintenance: the individual maintains the new behaviour for six months or more.

Freeman (1999) and Zimmerman, *et al*. (2000) add the sixth and last stage referred to as:

- Relapse: maintenance strategies break down and previous unhealthy behaviours are resumed. According to Zimmerman, *et al*. (2000, p. 1410), "relapses are almost inevitable and become part of the process of working toward life-long change". Patients may return to the contemplation stage and progress quickly through the preparation stage to the action stage (Freeman, 1999).

The above theories attempt to understand both the determinants of health behaviour and the processes of health behaviour change (Noar & Zimmerman, 2005).

2.2.2.2 Traditional African cultural and contextual factors

The section in the syllabus that deals with the role that culture plays in the spread of the epidemic is based on philosophical assumptions and theories that are discussed in detail in this section.

African traditional perceptions of illness, sexuality, children, community life and condom use and their implications for HIV prevention in Africa are also discussed. Amongst some of the reasons cited for the rapid spread of HIV/AIDS in Africa are poor economic conditions (Buseh, Glass, & McElmurry, 2002; Lindegger & Wood, 1995), and certain cultural practices, traditions and belief systems (Buseh *et al*., 2002; Sithole, 2001; Van Dyk, 1999). Patriarchal structures in certain cultures extend to men being allowed to have multiple wives as is the case with polygamy. In South Africa, the Venda and Tsonga cultures are examples of communities where polygamy is predominantly practised. In Swaziland, polygamy is a way of life amongst the Swazi males (Buseh, *et al*., 2002). Sithole (2001) confirms that within the Swazi culture, multiplicity of sexual partners for men is strongly supported; hence a man who engages in multiple sexual encounters is called "Ingwanwa", a positive term which is widely accepted, while the female equivalent, the "Ingwandla" is a derogatory term. In certain traditions, young girls are given over to older men with several wives by their own parents in exchange for money. Where these exchanges happen in the young girls' lives, they run the risk of contracting HIV/AIDS, especially in cases where multiple partners are involved (Sithole, 2001).

Communities in which polygamy is supported often generate proverbs that embody and encourage the practice. For instance, within the Northern Sotho culture in South Africa proverbs such as "*monna ke selepe o lala a adimilwe*" (a man is like an axe which is borrowed at night) and "*monna ke phoka o wa boshego"* (a man is like dew that falls at night). The gender inequalities as defined by men's sexuality that affords males greater power over women, both in public spheres and within families and sexual relationships are reflected in these proverbs (Weeks, Schensul, Williams, Singer & Grier, 1995). Since these proverbs are sanctioned by society, they not only encourage men to engage in

multiple relationships, but also disempower women and subject them to abuse; and thus increase the risk of HIV infection and the spread of the epidemic (Nefale, 2001). If there is no guaranteed faithfulness amongst all parties in a polygamous relationship, increased risk of HIV infection is inevitable (Van Dyk, 1999).

According to Sithole (2001), "widow inheritance" is still prevalent in some southern African countries. This practice entails that the younger brother or a relative of the deceased husband "remarries" the surviving wife. If this does not take place, it is believed that the spirit of the dead man will visit the living to make certain demands. In Zambia, this practice is still observed (UNAIDS, 2003). However, community-based approaches to counter this practice are emerging. While the practice of "widow inheritance" might seem innocent as it attempts to provide support for the widow and her children, which is a reflection of the communalistic nature of African culture; it might, however, prove harmful in the context of HIV/AIDS. If one of the partners within the new relationship is infected with the virus, this will increase the spread of the epidemic.

Another cultural practice that is re-emerging amongst many South African communities is that of virginity testing. Young girls are tested for virginity by a group of older women at a big ceremony attended by many women from the community (Nefale, 2001). A girl who is tested positive for virginity carries with her a sense of great pride and dignity. According to McGeary (2001) this practice is regaining popularity amongst certain communities in South Africa, and mothers are anxious for their children to remain virgins so as to avoid contracting HIV/AIDS. In neighbouring countries like Swaziland, a ceremony called the "Reed Dance for Maidens" maintains support for virginity and abstinence, with the male counterpart for this being the picking of the *Lusekwana* (holy tree) (Sithole, 2001). Most of these practices no doubt have the potential to facilitate the spread or the prevention of HIV infection. Some of these practices, however, have the potential to infringe human rights. For instance, the practice of virginity testing infringes the girls' right to human dignity. Another implication of virginity testing is the potential harm that can befall the identified virgins as reflected in the myth on "virgin cleansing".

2.2.2.3 Safer sex practices

Principles of practising safer sex as discussed in part 2 of Module 1 are based on strategies for preventing sexually transmitted HIV, general safer sex rules and practices, as well as drug-using behaviour (CDC, 2000; McIntosh, 2004; Siecus Fact Sheet, 2002, UNAIDS, 2000, 2004; Van Dyk, 2005 and WHO, 2000).

2.2.2.4 Principles of adult learning and education

The principles of how adults learn are based on the theory of adult learning (*andragogy*). Based on the assumptions of this theory, characteristics of adult learners include (Noe, 1999 and Leberman, McDonald & Doyle, 2006):

- The tendency to move from being other-directed to being self-directed as a result of being matured.
- A wealth of prior experiences and learning, which result from ageing, providing a possible rich source for learning.
- A sense of self, relating to ageing, which is connected specifically to the individual's experiences.
- An individual's readiness to learn is linked closely to his/her social roles.
- As an individual ages his/her perspective on time shifts from one with a future orientation to one which emphasizes immediate application.
- As individuals mature, they tend to prefer learning which is problem-centred, rather than theoretical or content-centred.

These characteristics of adult learning have implications for the methods used for facilitating adult learning. "To facilitate means to help people discover how much they already know; to enable them to explore their own potential; to build upon their experience; and to generate their own further learning" (Van Dyk, 2005, p. 112). This is a skill that is often used in workshops where group participation is encouraged.

Strategies that promote dialogue such as group discussions, role-plays, seminars and games have been found useful in HIV/AIDS educational programmes that integrate knowledge, attitude and skills (Eagle & Brouard, 1995; Swain & McNamara, 1997; Williams, Wang, Burgess, Wu, Gong & Li, 2006 and Wu, Detels, Ji, Xu, Rou, Ding & Li, 2002).

2.2.2.5 HIV/AIDS education and life-skills training

The underlying philosophy and theoretical framework upon which the principles and methods that promote adult learning are based are discussed in this section. This includes a discussion of the theory that informs factors that need to be considered when assisting both adults and children learn new skills and attitudes, especially about HIV/AIDS.

According to Van Dyk (2005) for HIV/AIDS education programmes to be successful, they need to strike a balance between knowledge, life-skills, values and attitudes. This is supported by Dorr and Lynch (1990) in their assertion that a mere imparting of information, while necessary, seems insufficient as it results in a gap between information and action which can best be filled through the exploration of feelings, attitudes, values, choices and responsibility. Kirby and DiClemente (1994) have noted five-generation curricula of sex and HIV/AIDS that involve:

- 1st generation: imparting knowledge
- 2nd generation: adding emphasis on communication and decision making skills and non-directive values clarification
- 3rd generation: moralistic reaction to the first two generations and emphasizing abstinence
- 4th generation: focusing on HIV but not particularly considering the successes and/or failures of the previous generations. Focusing more on the reduction in misinformation and fear around HIV/AIDS and on changes in risky behaviours
- 5th generation: curricula based on theoretical approaches used in other areas of health education such as the cognitive-behavioural approach or the social learning theory.

These five-generation curricula clearly indicate a shift from merely imparting HIV/AIDS knowledge to impacting on, and challenging people's attitudes and skills with regard to HIV prevention. It is important to adapt the knowledge, values, attitudes and skills to the age and developmental phases of individuals - both children and adults (Davidson, 1988; Edwards & Louw, 1998; Pilot Project on Life-skills, 1999). Piaget's theory of cognitive development, Kohlberg's theory of moral development, Erik Erickson's psychosocial stages of development and the emotional, social, sexual and self-concept development of individuals are discussed in relation to how these affect the development of age-appropriate HIV/AIDS education and prevention programmes (Baldwin & Baldwin, 1998; Elkind, 1978; Erikson, 1968; Gillis, 1994; Kohlberg, 1978; Louw, Van Ede, & Ferns, 1998; Meyer & Van Ede, 1998; Montauk & Scoggin, 1989; Norton & Dawson, 2000; Piaget, 1972; Piaget & Inhelder, 1969; Thom, Louw, Van Ede & Ferns, 1998; Williams, 1972 and Wong, Hockenberry-Eaton, Wilson, Winkelstein, Ahmann & DiVito-Thomas, 1999).

Learning Outcomes

The following are the learning outcomes for part 2 of Module 1 (Van Dyk, 2005):

- The ability to develop HIV/AIDS education and prevention programmes that are based on sound theoretical principles of behaviour change and appropriate methods of learning.
- The ability to explain the traditional African perceptions of illness, sexuality, condom use and community life, and develop an education and prevention programme that incorporates these beliefs.
- The ability to demonstrate the correct use of the male and female condom.
- The ability to develop an HIV/AIDS education and life-skills training programme for school children that takes the age and the developmental characteristics of the children concerned into account.

2.2.3 HIV/AIDS counselling

The syllabus

Part 3 of Module 1 prepares learners for basic HIV counselling work. The Health Professions Council of South Africa (HPCSA) and the South African Qualifications Authority (SAQA) stress the need for the training of counsellors at entry levels such as lay counsellors and registered counsellors.

Due to the nature of HIV/AIDS and the resultant stigmatization and ostracism following a positive diagnosis, those infected and affected often need counselling in order to continue living healthy lives (Kalichman & Simbayi, 2003; Ostrom, Serovich, Lim & Mason, 2004 and Rankin, Brennan, Schell, Laviwa & Rankin, 2005;). We therefore explore basic communication and counselling skills in this section by discussing the values that underlie the counselling process as well as the principles of counselling, including counselling across a diversity of cultural settings. Pre- and post-HIV test counselling is given particular attention. Hints on how to ask questions, provide information and deal with issues of informed consent and confidentiality during testing are also covered. Special HIV/AIDS related issues with regard to those who are HIV infected, such as disclosure, anxiety, depression, and suicidal feelings are also discussed. Counselling of special populations such as children, families and couples are given attention. The last sub-section deals with specialized counselling, especially bereavement and spiritual counselling.

The underlying theory and/or philosophy

I will discuss the underlying theory and/or philosophy of part 3 of Module 1 in detail under module 2, in section 2.3 of this chapter, where the practical application of counselling skills is imparted to learners.

Learning Outcomes

After studying this section learners should be able to understand the following, on a theoretical level (Van Dyk, 2005):

- The application of basic communication skills in interviewing a client.
- The requirements of counselling a client who wants to be tested for HIV (pre-HIV test counselling).
- The requirements of counselling a client who has tested HIV positive.
- The requirements of counselling a client who has tested HIV negative.
- The requirements of conducting basic counselling to help people living with HIV/ADS and their significant others to help them cope with the day-to-day demands of the illness.
- The requirements of conducting crisis counselling.
- Referring clients who might need professional help by learning how to recognize serious problems such as severe depression and suicidal tendencies.
- The requirements of conducting bereavement and spiritual counselling.

2.2.4 Care and support

The syllabus

The main focus of part 4 of Module 1 is on how to care for people who are living with HIV/AIDS in a variety of contexts; for example, hospitals, hospices, clinics and at people's own homes. Reference to caring for people in settings where there is a lack of resources and facilities, which are common in rural clinics and homes, is made. A discussion of the importance of family and community involvement in the care and support of people living with HIV/AIDS is also given.

AIDS orphans and other vulnerable children form part of the discussion in this theme, with the strategies and/or models for their care presented. According to the UNAIDS report, approximately 9% of children under the age of 15 in sub-Saharan Africa have at least lost one parent due to AIDS and one in six households with children are caring for at least one orphan (UNAIDS, 2006). It is therefore necessary to include this aspect in the programme.

Guidelines on infection control in hospitals, clinics, hospices and homes caring for HIV infected people are also discussed. Promoting general health, nutrition and nursing care for opportunistic infections and other problems, including the strengthening of the immune system also receives special attention. Lastly, focus on caring for the caregiver is made. Signs and symptoms of burnout are given for caregivers to use in evaluating their own functioning; and ways to care for themselves are proposed to prevent burnout.

The underlying theory and/or philosophy

In this section the philosophical assumptions and underlying theory of the part of the syllabus that deals with the care and support of people living with HIV/AIDS in a variety of contexts is discussed.

The development of home-based care programmes are based on the integrated home-based care model and the principles of home-based care teams (Frohlich, 1999; Marston, 2003; Muchiru & Frohlich, 2001; Uys, 2003 and WHO, 1993, 2000). Orphan care is based on the theoretical principles of safisfiers of needs (Kluckow, 2004; Max-Neef, Elizalde, & Hopenhayn, 1991 and Smart, 2003). According to Max-Neef, *et al*., (1991) the choice of orphan care should be based on whether it satisfies children's basic needs. These needs can be classified into ten categories, namely, subsistence, protection, affection, understanding, participation, leisure, creation, identity, freedom and transcendence category (Kluckow, 2004; Max-Neef, *et al*., 1991).

The following have been identified as satisfiers for human needs (Max-Neef, *et al*., 1999):

- Destroyers – satisfiers that address one need but end up destroying that need and others as well.
- Pseudo-satisfiers – satisfiers that seem appealing and promise to fulfill needs, but do not. They generate a false sense of satisfaction.
- Inhibitors – satisfiers that satisfy one need but inhibit another.
- Singular satisfiers – they satisfy one need in a child's life while ignoring others.

- Synergistic satisfiers – they satisfy a given need; stimulate and contribute to the fulfilment of others. These satisfiers meet several different needs at once.

Based on the above-mentioned needs of children and their accompanying satisfiers, it is therefore important to choose a model of orphan care that will sustain the provision of the needs of children who are orphaned or made vulnerable by HIV/AIDS. It is for this reason that a cautionary note is given on the use of orphanages as they are not regarded as the most appropriate form of intervention as most of the time they cannot provide for all of the children's needs. It is advisable to explore other forms of orphan care first and render them either unavailable or inappropriate before making use of orphanages (Van Dyk, 2005).

Infection control is based on guidelines drawn by CDC (1989) Department of National Health and Population Development (1989), Hauman (1990), Lusby (1988), Pearse (1997), WHO (1988, 1990, 1993) and Ziady (2003). Care and nursing principles, including principles of palliative care are based on best-practices that are advanced through international research and procedures (Canadian Palliative Care Association, 1995; Dickinson ,1988; Evian, 2000, 2003; Fahrner, 1998; Gwyther & Marson, 2003; Muchiru & Frohlich, 2001; Reno & Walker, 1988; Ungvarski, 1989; Van Dyk, 1999 and WHO, 2000) . The underlying theory and/or philosophy of caring for the caregiver are discussed in detail under module 2 where the practical aspects of these are dealt with.

Learning Outcomes

At the end of studying this section, learners should be able to (Van Dyk, 2005):

- Develop a home-based care programme for the community in which they live.
- Devise a practical model for orphan care that will work in their community.
- Prepare and present a lecture to primary caregivers (involved in home-based care) about the basic principles of infection control at home.
- Prepare and present a lecture to professional nurses about universal precautions and infection control in the hospital.

- Advise HIV-positive individuals about a healthy diet and sound nutritious practices (remembering to take their personal circumstances into account).
- Advise HIV-positive individuals on how to take care of their immune system by living a healthy life.
- Teach volunteers the basic principles of caring for a patient with AIDS in his or her home.
- Apply basic (or advanced) nursing principles in caring for patients with AIDS who present with fever, diarrhea, skin infections, problems with the mucous membranes, nausea and vomiting, genital problems, pain, weakness and mental confusion.
- Understand the principles of palliative care.
- Develop a programme to help caregivers who work in the HIV/AIDS field care for themselves in such a way that they can prevent burnout.

2.2.5 Legal, ethical and policy issues

The syllabus

Part 5 of Module 1 focuses on the rights of people living with HIV and the application of the laws to protect them within various contexts such as the workplace, medical settings and educational institutions. A summary of some of the legislation governing the rights of HIV-positive people is discussed. The section further provides recommendations on how to develop effective management and policy plans that embrace the needs of HIV-positive people.

The underlying theory and/or philosophy

The syllabus covered in this section of Module 1 is based on the following legislation, policies, proposal and common-law rights (Barret-Grant, Fine, Heywood & Strode, 2003; Van Wyk, 2000 and White-side & Sunter, 2000):

- The Employment Equity Act 55 of 1998
- The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
- The Labour Relations Act 66 of 1995

- The Occupational Health and Safety Act 58 of 1993
- The Mines Health and Safety Act 29 of 1996
- The Compensation for Occupational Injuries and Diseases Act 130 of 1993
- The Basic Conditions of Employment Act 75 of 1997
- The National Education Policy Act 27 of 1996
- The National Policy on HIV/AIDS for Learners and Educators in Public Schools and Students and Educators in Further Education and Training Institutions (Notice 1926 of 1999, *Government Gazette* 410 of 10 August 1999)
- The Medical Schemes Act 131 of 1998
- The National Policy on Testing for HIV (Department of Health, August 2000)
- The Health Professions Council Guidelines on the Management of Patients with HIV infection or AIDS
- Common-law protection of the right to privacy and dignity

Learning Outcomes

Learners are expected to be able to achieve the following at the end of studying this section (Van Dyk, 2005):

- Understand what basic rights the South African Constitution (Act 108 of 1996) guarantees to people living with HIV/AIDS.
- Be able to give informed and considered answers to the legal and ethical questions that they might encounter in their work as caregivers or counsellors.
- Be able to contribute to the development and evaluation of HIV/AIDS policies in the workplace, hospitals, schools or tertiary institutions.
- Be able to develop a personal ethical credo that will guide them in their work with people who live with HIV or who have AIDS.

The section that follows discusses the tuition methodology for this module.

2.2.6 Method of tuition and assessment

Module 1 forms part of the undergraduate modules that are offered in the Department of Psychology, within the School of Humanities, Social Sciences and Theology, and can therefore be taken as part of a degree package. However, the module can also be taken on its own for non-degree purposes. The module is also offered through the Unisa Centre for Applied Psychology (UCAP) to cater specifically for those learners who do not have matric. This makes the module accessible to anyone who would like to enroll for the HIV/AIDS programme, irrespective of their level of education.

Module 1 is offered through distance education over a period of six months. Learners receive a study package consisting of study guides and tutorial letters upon registration. They are required to purchase a prescribed textbook. During their course of study, learners are expected to submit one multiple choice assignment. At the end of the six months, they write an examination, which also consists of multiple choice items. Upon successful completion of the module, they receive certificates.

The UCAP module is also offered through distance education, but this is done over a period of four months. Learners also receive a study package upon registration, which includes the prescribed text book and study guides. Learners are expected to compile and submit a portfolio during the course of their study, upon which they are assessed. Upon satisfactorily meeting the requirements for passing the module, learners are also awarded a certificate.

2.3 MODULE 2: PRACTICAL WORKSHOP IN HIV/AIDS COUNSELLING SKILLS

For participants to enrol for the module in counselling skills they must have passed Module 1. The aim of Module 2 is to provide workshop participants with the practical skills needed to conduct HIV/AIDS counselling. In this module, learners move beyond

the theory of counselling that they were presented with in Module 1, to the actual practical application.

2.3.1 Themes covered in Module 2

The syllabus

The following are the main themes that are covered in the module:

- Attitudes and self-awareness
- Understanding counselling
- Basic counselling skills
- HIV testing
- Pre- test counselling
- Post- test counselling
- On-going counselling
- Crisis intervention
- Death, dying and bereavement counselling
- Legal and ethical issues
- Sexuality and safer sex
- Stress and burnout
- Care for the caregiver
- Supervision and mentoring
- Resources and networking
- Practical training

Module 2 discusses and provides a context within which to practise the basic conditions of conducting general counselling. Specific counselling skills needed for preparing someone to undertake an HIV test are also dealt with, including counselling skills needed to present both a negative and a positive test result to a client. Equally important and also covered in this module are the ethics governing counsellors in general and those specific to HIV/AIDS. Counselling skills required for supporting people living with the virus and

also faced with issues of death and dying are also covered. In this module, participants are especially cautioned about the fact that a week is not enough to make them competent counselors; and that it is important for them to realise the value of extensive practice in the field, under the guidance and/or support of an experienced counsellor. The main aim of the workshop is to introduce participants to the field of counselling, and to sensitize them to the importance of self-awareness and self-reflection. This is crucial for them to become effective counsellors. Participants are also shown the importance of referring cases they deem operating outside their scope of practice, and are equipped with the necessary skills to do this. Another aim of the module is to enable participants to work with other professionals in areas related to HIV/AIDS. They are thus expected to be able to identify these professionals and work co-operatively and collaboratively with them. The module also covers a section that deals with skills needed to assist clients in engaging in behaviours that prevent the spread of the epidemic. Another important aspect covered in this module is that of exposing participants to the skills necessary to take care of themselves, as caregivers, in order to avoid experiencing burnout.

Learning Outcomes

At the end of the workshop, participants are expected to be able to:

- Initiate and maintain a counselling relationship with a client.
- Counsel a client who wants to be tested for HIV (pre-HIV test counselling).
- Counsel a client who has tested HIV positive.
- Counsel a client who has tested HIV negative.
- Conduct basic counselling to help people living with HIV/AIDS and their significant others to cope with the day-to-day demands of the illness.
- Conduct crisis counselling.
- Conduct bereavement counselling.
- Recognize serious problems such as severe depression and suicidal ideation and refer such clients for professional assistance.
- Establish a good networking and referral system.
- Care for themselves as caregivers.
- Recognize the importance, of and effectively utilize, mentors and supervisors.

The section that follows covers the above topics in detail. This is done in the form of a day-to-day exploration of the workshop. The underlying theory and/or philosophy upon which the themes covered in this section are based are discussed in greater detail in the sections that follow.

2.3.2 Method of tuition and assessment

Module 2 is offered in the form of a five-day workshop that is attended at the Unisa Centre for Applied Psychology (UCAP) in Pretoria. The presenters of the workshop have varied expertise within their fields of operation; and most of them are UNISA lecturers from the departments of Psychology and Theology, while the rest are guest presenters from outside the institution. In addition to being the researcher for the present study, I also form part of the team of presenters from the Psychology department. This has implications for objectivity and subjectivity issues in terms of research. Since this study mainly adopts a qualitative stance, the researcher acknowledges the subjective nature of the research as influenced by her being part of the tuition team of this programme.

The workshop is run in the form of experiential learning, small group discussions, practical exercises, role plays and to a very limited extent, mini-presentations. These approaches to teaching and learning have been supported by research findings that indicate their value in HIV/AIDS programmes that aim to impart knowledge, attitude and skills in learners (Swain, *et al*., 1997, Williams, *et al*., 2006; Wu, *et al*., 2002).

What follows is a detailed discussion of the five days of the programme.

Day 1: Orientation and self-awareness

After registration the formal workshop starts with the facilitator welcoming the participants and introducing them to the programme and to the other facilitators of the day. Participants are then paired and asked to introduce themselves to one another.

After this, those participants who were paired introduce each other to the rest of the big group of participants, giving all the participants and the facilitator an opportunity to get to know one another. During this session, expectations about the programme are discussed and a final programme agreed upon. The participants contract on how the workshop is going to be run to ensure effective use of time and resources. This phase in the workshop is critical in the formation of the group and determines the dynamics of the group. According to Yalom (1985) a group passes through three stages in its formation, namely *orientation, hesitant and participants' search for meaning and dependency; conflict, dominance and rebellion; and development of cohesiveness.* It is important for the participants to feel comfortable with one another because the nature of the process demands some element of self-disclosure and this cannot easily happen if the participants do not trust one another. This phase lasts for two hours and usually happens with relative ease. The principles used in this session are in line with the principles of group work. This session is meant to facilitate the last stage in group formation (i.e. the development of cohesiveness) so as to facilitate an effective working relationship for each participant to get the most out of the workshop. It is only when all affects are expressed and constructively worked through that a group becomes mature to begin working effectively (Yalom, 1985).

The next session in the day's programme is spent with the facilitator encouraging the participants to re-cap on their knowledge regarding basic facts about HIV/AIDS. Another aim of this session is to update participants on new developments in the field of HIV/AIDS. This is another essential step in the process because whatever the participants are going to be exposed to in this module, hinges on their knowledge of correct facts about HIV/AIDS.

The first session after lunch is spent with an invited guest speaker, who is usually HIV positive. The purpose of this session is to allow the speaker to share his/her experience of "living positively" with the participants. The effect of this is that the participants are also given an opportunity to interact with an HIV-positive person. Apart from this being an educational session, it is also meant to sensitize and attempt to break any stereotypes

participants might have on HIV positive people. The session that follows ties in closely, and deals, with attitudes and self-awareness. The same facilitator takes charge of both sessions in order to provide a swift transition between the sessions. In this session participants are exposed to and even allowed to challenge attitudes and stereotypes that people have, which have the potential to harm someone who comes from a different background to the person holding the attitude or stereotype, including HIV-positive people. Participants are compelled to examine their own attitudes and stereotypes and to reflect on how these can influence their effectiveness as HIV/AIDS counsellors. According to Williams *et al*. (2006), for HIV/AIDS professional educational programmes to be effective, they have to encourage participants to identify and verbalize personal fears, assumptions and prejudices. This supports one of the main aims of the 4th and 5th generation of HIV/AIDS curricula, which is to eliminate discrimination and promote tolerance and empathy towards those who are HIV/AIDS infected and affected (Swain & McNaman, 1997). By engaging participants actively through the use of case studies and small group discussions, as used in these sessions, participants are able to effectively confront and deal with these prejudices. As Williams, *et al*. (2006, p.710) assert, "multifaceted and participatory AIDS education has been found to not only enhance participants' knowledge, but to also improve their attitudes towards patients with AIDS and increase their willingness to care for them". At the end of the session, participants realize the importance of embracing diversity in its various forms; be it in terms of race, culture, religion or sexual orientation. They are also equipped with the skills to recognize lack of tolerance in diversity issues and how to handle diversity in their roles as HIV/AIDS counsellors.

The facilitator ends the day by reflecting on participants' experiences for the day.

Day 2: Introduction to counselling skills

From the second up to the fourth day, participants are exposed to the actual counselling skills. During this period they deal with a specific main facilitator and a co-facilitator. The co-facilitator's role is to assist the main facilitator during role-play sessions used to

evaluate participants on their counselling skills. It would be difficult for one facilitator to effectively handle a large group, which is on average twenty participants (normally between fifteen and twenty five), and still manage to give each participant quality feedback. This session usually starts with the facilitators introducing themselves to the group as well as getting to know the participants themselves as it will be their first time with the group. The facilitators also provide a brief overview of the counselling programme.

In the next session the facilitator spends some time defining counselling. This is an important starting point since it is important for participants to understand and clearly differentiate counselling from any other kind of relationship. According to Gillis (1994), and Sikkema and Bisset (1997) counselling is defined as a facilitative process that uses specialized skills to assist clients to develop self knowledge, emotional acceptance, emotional growth and personal resources. It becomes clear from this definition that the aim of counselling is to assist clients to deal more effectively with their problems or life challenges both at the time of consultation (for assistance) as well as in the future. In the case of HIV infection, clients usually need support at the emotional, cognitive, social and spiritual level. Counselling may focus on any or all of these dimensions depending on the client's needs. For example, counselling might involve assisting the client to come to terms with a positive HIV test result, facilitating disclosure of this to his/her significant others, as well as dealing with the impact of symptoms at a later stage on the client's life. According to Van Dyk (2005) the role of the counsellor is to assist the client to improve his/her lifestyle as well as to assist him/her to cope better with current and future challenges. This session provides a basis for participants to conceptualize and understand counselling before they embark on practising it. Participants are given exercises or activities aimed at expanding their understanding of counselling to discuss in small groups.

After the discussion, they are exposed to a chosen model of conducting counselling. The model used is Egan's (1998), which maintains that for any kind of counselling to be successful it has to address the following questions:

- What are the problems (issues, concerns, undeveloped opportunities) that the client is facing or dealing with?

It is the role of the counsellor to assist the client to understand his/her problems, concerns or undeveloped opportunities by allowing him/her to tell his/her story. This is referred to as exploring or establishing the client's *current scenario*.

- What does the client need as opposed to what does he/she have at the moment?

This question explores the client's *preferred scenario*. The role of the counsellor is to assist the client to discover what is best for him/her or what works well for his/her situation or circumstances.

- What should the client do in order to achieve his/her need?

Counsellors assist clients to find *strategies* for getting to their preferred scenario through making them realize that there are different ways of achieving their goals and they have to choose the one that suits them better. Part of the role of the counsellor, in dealing with this question, is to assist clients to organize their actions into coherent, simple achievable plans for carrying out their goals.

- How does the client enact his/her need?

The final question has to do with *action.* The counsellor instils an attitude of "working hard" in achieving what the client wants. Clients need to realize that they have the ability to enforce change in their own lives, and that if they do not actively participate in the process, things will remain the same.

The following phases are central to a counselling relationship: establishing a working relationship with your client, assisting the client to tell his/her story, developing an increased understanding of the problem and providing an intervention or action.

Establishing a working relationship

- This phase forms the cornerstone of counselling because without a proper connection between a counsellor and the client, there can never be a counselling relationship. Here the counsellor assists the client to establish trust in him/her and to feel safe enough to share his/her personal issues with him/her. The counsellor

can do this through defining the process, objectives and parameters of counselling.

Assisting the client to tell his/her story

Once the relationship has been established between a counsellor and a client, the client is now ready to tell the counsellor why he/she has come to see him/her. It is during this phase that the client's current and preferred scenarios can be explored and a common understanding of the problem(s) established. Possible intervention strategies can then be explored. Egan (1998) and Rogers (1980) cite the following as important pointers to assist counsellors to explore the client's story:

- Learn and adopt the client's language.
- Use facilitative, open questions rather than closed questions.
- Be sensitive to feedback about specific questions.
- Be respectful.
- Revisit topics if necessary.
- Avoid suggesting solutions and giving advice.
- Deal with multiple levels of understanding – content/experience, behaviour, feelings and cognition.
- Involve context in your enquiry.
- Focus on process, which is not an event, but often takes place over time.

Developing an increased understanding of the problem

For the counsellor to have a complete understanding of the client's problem, he/she must have done a thorough exploration of the problem. This means moving beyond the content of what the client says to the feelings that accompany the content as well as the client's context. The counsellor consolidates the client's scattered thoughts, identifies any prevalent themes and links the client's behaviour, feelings and thoughts as an attempt to reflect their understanding of the client's problem. The counsellor often communicates this in a tentative manner so as to give the client the opportunity to refute or confirm

his/her analysis. By adopting this approach, the counsellor displays an attitude of congruency, respect and confidence in the client.

Providing an intervention or action

During this phase, attempts to explore the various options available for the client in order to deal with their situation are made as well as the necessary actions taken to deal with their situation/problem. Van Dyk (2005) stresses the point that an intervention does not mean offering a solution, but it is a process wherein a client becomes involved in improving the quality of his/her life and circumstances. This can take various forms:

- Obtaining relief from pressing emotional discomfort by simply telling one's story to the counsellor.
- Adopting a specific management approach to problem solving.
- Altering specific interaction patterns in relation to others in their environment.
- Changing their attitudes and mindsets in approaching specific situations or issues.

The counsellor assists the client through providing supportive, client-centred counselling and also acts as a change agent by facilitating a process in which the client forecasts a better future, sets realistic goals and decides on methods of achieving these goals (Egan, 1998; Rogers, 1980).

At the end of the counselling process, the client should feel less confused, emotionally calm, empowered and more focused.

Participants, through engaging in role-plays, are given exercises to practise these various counselling phases, with the aim of answering the four central counselling questions mentioned earlier.

The session that follows assists participants to acquire skills needed to encourage clients to express themselves during counselling. Participants are also equipped with skills to handle the variety of emotions encountered in counselling. This is an important aspect of counselling as some clients find it difficult to get in touch with and express their feelings.

After all, counselling is about allowing the client to access and express his/her emotions in order to feel better about their situation. Some of these skills are (Egan, 1998):

- Listening
- Observation
- Sensitivity to non-verbal behaviour
- Tracking
- Responsiveness to the client's emotional tone
- Building of trust
- Empathy
- Genuineness
- Respect
- Concreteness
- Minimal verbal responses such as "mmm…" and "uh-huh"
- Questions and probes
- Summarizing
- Partialising
- Clarifying
- Feedback or challenging
- Immediacy
- Non-directive counseling
- A directive stance
- Problem-solving

In the next session participants attempt to apply various skills that are appropriate in eliciting a variety of responses from clients. Particular skills that are dealt with in this session are "probing", "the use of silence", "reflective commenting" and "summarising". The appropriate application of each skill is demonstrated and then practised by each participant during role-play sessions. The session concludes with an exploration of the problem-solving model, where participants are assisted to acquire skills to assist clients to solve problems. Most of these skills are practiced through the use of case studies.

Day 3: Pre- and post-test (negative result) HIV counselling skills

The session starts with a recapitulation of the previous day's activities, followed by a revision of benefits and drawbacks of HIV testing, as well as the various HIV tests. This is done to refresh participants' knowledge on these topics and to make sure everyone understands these issues as they prepare for the practical application of the skills that are

to follow. Before participants can learn how to conduct pre-test HIV counselling they need have sufficient information on HIV testing to appropriately practise these skills.

It is important to remember that pre-test HIV counselling is built on the skills that participants were exposed to the previous day. In pre-test counselling, the counsellor provides the client with all the necessary information needed for him/her to make an informed decision to take or not take the HIV test. The following are critical themes to be covered during pre-test counselling (Albers, 1990; Blom, 2001 and Van Dyk, 2005):

- Explaining the reason for pre-test counselling, the implications the test might have, the fact that the client has a choice whether to be tested or not.
- Ensuring the client of confidentiality and their right not to disclose his/her status
- Exploring why clients want to be tested.
- Assessing the client's level of risk – this includes exploring the client's sexual history and exposure to possible contaminated blood.
- Exploring the client's beliefs and knowledge about HIV infection and safer sex
- Providing the client with information about the test – this includes the testing procedures and their reliability, the role of a confirmatory test, rapid testing, differences between being seropositive and having AIDS, the presence of HIV antibodies in the blood, the meaning of a positive and negative test result and the meaning of the *window period*.
- Discussing the implications of an HIV test result – this includes providing access to treatment, adjusting one's lifestyle to stay healthy, possible discrimination and rejection resulting from a positive test result, increased emotional stress and relationship difficulties.
- Anticipating the test result and discussing them with the client – the client's reaction to both a positive and a negative test result. Some of the questions that the counsellor can ask the client include:
    - How would you feel if you tested positive/negative?
    - Do you intend telling anyone about your results? If so, who?
    - How would you tell your sex partner in the event of a positive test result?

    - How would a positive test result change your relationships and the circumstances of your family?
    - Who could provide emotional and social support?
    - How did you cope with previous crises?
- Explaining to the client when, how and who will be giving out the test results
- Exploring the client's support network
    - Find out who the client might contact for moral support while waiting for the results
    - Encourage clients to contact you or a colleague if they have questions
    - Counsel clients on how to protect sex partners in the interim period
    - Explore infection control measures if necessary
    - Encourage clients to do something enjoyable to keep occupied while waiting for the results.

Pre-HIV test counselling is important as it not only prepares the client for an HIV test, but also provides the opportunity to educate a client about HIV/AIDS and safe sex. Again, participants are given the opportunity to practise pre-HIV test counselling skills through role-plays.

In the next session participants are introduced to key principles involved in conducting post-HIV test counselling. Ideally, both pre- and post-test HIV counselling should be done by the same counsellor so that he/she is better prepared to give out the test results, given the background information obtained during the pre-test counselling session. According to Van Dyk (2005) the following are ways in which the counsellor can prepare himself/herself for giving out HIV test results, be they negative or positive, by making sure they:

- Have the right results.
- Understand what the results mean.
- Have enough time to spend with the client.
- Are emotionally ready to give the results to the client.

In giving out the results, counsellors should remember the following:

- Give the client the results *personally.*
- The results should be given in a quiet, private environment.

The last session for the day is spent exposing participants to giving a client negative HIV test results. What is of importance to note in this session is that although a negative test result can be a relief to both the client and the counsellor, it is still important to provide counselling to a client who tested negative. This can provide the opportunity to encourage the client to reduce their chances for future infection. In this respect, the counsellor can revisit risk reduction and safer sex practices that were studied in Module 1. Another aspect of counselling a client who tested negative to the HIV test involves reminding the client of the "window period" that was discussed during the pre-test counselling session and encouraging them to re-test after 3 – 6 months. The possibility of a false negative result should also be discussed with the client.

The day closes with participants being given homework to recap on the principles of behaviour change. They are given a handout to assist them to this effect.

Day 4: Post-test (positive result) HIV counselling and counselling in a variety of contexts

The session starts with an exploration of key issues to be considered when giving someone a positive HIV test result. The following are the key issues that counselors should take into consideration (Albers, 1990; Blom, 2001; Brouard, 2002; Estaugh, 1997 and Van Dyk, 1999):

- Prepare themselves before giving the results.
- Share the results with the clients – it is important to note a few don'ts in this respect.
- Anticipate and be prepared for clients' reactions to a positive test result.

In general, the counsellor should respond to any need a client might have following a positive test notification. The counsellor should also explore the client's plans after leaving their consulting room, say in the next 24 hours. The counsellor may, for example, explore the client's support base and possibilities for suicidal intentions and behaviour, which should be managed accordingly. A follow-up session with the client should be scheduled in order to allow the client to ask any questions he/she may have following the results, especially after he/she has calmed down and internalized the results.

The session that follows is spent with participants exploring ways in which they can encourage clients to lead a healthy lifestyle, despite being HIV positive. Participants are reminded of the sections covered in Module 1 on this aspect. These are discussed in relation to a counselling context.

In the session that deals with assisting clients to disclose their HIV status to their significant others, participants are drawn to the importance of exploring both the benefits and drawbacks of disclosure with their clients. Partial versus full disclosure should be fully discussed with the client and the ultimate choice as to the kind of disclosure be left to the client.

The last session is spent on exploring and discussing disclosure of HIV-positive results when working with children. Studies have indicated the difficulties inherent in disclosing HIV positive test results to children due to their age and the need to protect these children (Stein, 2004). The implications and challenges of disclosure when working with this group are explored and the legal implications also discussed. Guidelines to facilitate disclosure when working with children are also provided (Paediatric HIV working group, 1997 and Stein, 2004). Reference to HIV in relation to stress, depression and suicide is made, especially the ability for counsellors to identify the symptoms associated with the latter and how to deal with them in counselling (Brouard, 2002; Sherr, 1995; Sue & Sue, 1999).

The day ends with the evaluation of the three days' counseling skills work and participants' experiences regarding a way forward on counseling. This is the last contact between the facilitator, the co-facilitator and the group.

Day 5: Counselling skills within specific HIV related contexts and closure

Participants are welcomed by a new facilitator who also introduces them to the day's programme. This specific facilitator will be present the rest of the day; and will also introduce participants to the facilitator of the next session, who is a different person.

In the first formal session for the day, participants are exposed to prevention and safer sex practices. The facilitator is an expert in sexuality issues. In this session a video is used to expose participants to methods of promoting HIV/AIDS prevention within a variety of contexts. Participants are given practical tasks to do which illustrate safe sex practices, especially with regard to the use of male as well as female condoms. They are also given group exercises with various scenarios in which they have to determine which scenarios depict safe sex practices. The session is mainly dominated by group activity. The principles of safer sex practices referred to in section 2.2.2.3 form the basis of discussion for this session.

The session that follows explores bereavement counselling in the context of HIV/AIDS and is done by the facilitator for the day. Participants are made to confront their own experiences of grief and to assess the level at which each one of them has successfully dealt with it. This is done through the use of an experiential exercise. This is important because if they, as counselors, have not fully resolved their grief, there is a potential they might not become effective counsellors as their own grief will affect and contaminate their clients' grief. The following are some of the issues related to the counsellor's own grief within a counseling relationship as adapted from Worden (1991, in Nefale, 2000):

- Working with the bereaved may make the counsellor aware, sometimes painfully so, of their own losses. This is particularly true if the loss experienced by the bereaved is similar to losses a counsellor has sustained in their own lives. If this

loss is not adequately resolved in the counsellor's life, it can be an impediment to a meaningful and helpful intervention.

- The counsellor may have his/her own feared losses. Most counsellors have sustained various losses in their lifetime; however they also enter counselling situations with apprehension over pending losses – e.g. parents, children, partners, etc. Usually this apprehension is at a low level of awareness. However, if the loss their client is experiencing is similar to the one they fear most, their apprehension can get in the way of effective counselling.
- When a client comes for grief counselling, the counsellor is put in touch with the inevitability of death and with the extent to which he/she is uncomfortable with this inevitability. This situation is especially difficult when the person who is being grieved for is similar to the counsellor in terms of age, sex or professional status, all of which can greatly increase the anxiety of the counsellor.

Ways in which counsellors' effectiveness is enhanced by their exploration of their own grief are also discussed. The session also covers the manifestations as well as the determinants of grief. The session further deals with the various tasks of grief, including some useful techniques that are used in grief counselling. The theory underlying the themes in this section is based on Gillis (1994), Johnson (2000), Nefale (2000), Sunderland and Shelp (1987) and Worden (1982). The facilitator reiterates to participants that the same skills learnt in the last three days on conducting counselling form the basis for bereavement counselling.

In the next session participants deal with how to care for themselves as caregivers. They explore various stressors in their environment and ways of recognizing their own stress. This is discussed in the context of their work as HIV/AIDS counsellors, which is often combined with other responsibilities. The stressful nature of this work is particularly highlighted, given the resultant deaths. The session ends with a discussion on how to prevent stress and burnout in a practical and realistic manner, including tips to assist counsellors take care of themselves. The session takes mainly the form of small group discussions. The theory and principles used in this session are based on the works of

Brouard (2002), Miller (2000), Oosthuizen (2002), Skovholt (2001), UNAIDS (2000) and Van Dyk (1991).

The session that follows focuses on supervision, networking and resources. This session links very well with the previous session as the participants see the value of supervision as a way of dealing with some of the stressful and difficult cases in their workload. Skills of how to identify and compile a list of resources are discussed. Networking skills are also discussed (Nel, 2000). The session also takes the form of small group discussions. At this point participants should be ready to go back to their communities to implement the knowledge and skills acquired in the programme.

The assessment of Module 2 is based on feedback that takes place during role-plays of the counselling skills taught. This is not a formal assessment as it is aimed at developing counseling skills as opposed to assessing competence. From 2006 onwards, learners would be formally assessed for competence through the use of a practical counselling skills assignment.

The day ends with participants filling in evaluation forms from UCAP regarding their impressions of the workshop, after which they are handed certificates. This marks the end of the workshop.

2.4 CONCLUSION

In this chapter I discussed in detail the syllabus that is covered in the programme for Modules 1 and 2. In so doing I reflected on the theoretical and philosophical assumptions upon which the syllabus is based and the learning outcomes for the various aspects of the two modules. The methods used for tuition and assessment in the two modules were also discussed.

In the chapter that follows I will discuss the methodology that has been adopted for evaluating the impact of the programme on participants. This will be in line with the themes that have been outlined in the present chapter.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The aim of this study is to evaluate the impact of the UNISA HIV/AIDS programme on participants' learning and their involvement in the community. Apart from providing a guide on the value of the programme, the results of the study will also assist in improving the quality of the UNISA programme, where necessary. This will, at a broader level, contribute towards the effective management of the epidemic in South Africa.

This chapter focuses on the methodology adopted for the study in general, and more specifically the methodology adopted to evaluate the impact of the UNISA HIV/AIDS programme. The chapter also focuses on the study's research design; its sample; and the methods of collecting and analysing the data.

3.2 THE RESEARCH APPROACH

3.2.1 Evaluation research

The overall approach adopted for this study is that of evaluative research. Weiss (1998, p.4) defines evaluation as the "systematic assessment of the operation and/or the outcomes of a programme or policy, compared to a set of explicit or implicit standards, as a means of contributing to the improvement of the programme or policy". Rossi and Freeman (1989, p.18) define evaluation research as, "the systematic application of social research procedures for assessing the conceptualization, design, implementation and utility of social intervention programmes". From these definitions it is clear that evaluation comprises a research element which is reflected in the use of systematic and social research procedures for conducting an investigation. Another aspect implicit in

these definitions is the fact that evaluation is an activity with a purpose. According to Weiss (1998, p.15), "principles and methods that apply in other types of research also apply in evaluation research - what distinguishes evaluation research is not method but intent". He outlines the following as the main distinguishing features:

- *Utility* – evaluation is intended for use. In its simplest form, evaluation is conducted for a client who has decisions to make and who looks to the evaluation for information on which to base his/her decisions. In this case the results will be used to measure the value of the UNISA HIV/AIDS programme as well as to decide whether it needs to be revised or not.
- *Program-derived questions* – the questions that evaluation considers derive from the concerns of the programme communities, i.e. the array of people involved with, or affected, by the programme. This research was motivated by my interest in assessing whether the programme addressed the needs of those that it is meant to serve. By being able to determine whether the programme is being transferred into participants' communities, these needs will be addressed.
- *Judgemental quality* – evaluation tends to compare "what is" with "what should be". Although the investigator usually tries to remain objective, he/she is typically concerned with phenomena that demonstrate how well the programme functions and whether it achieves its intended purposes. By assessing aspects of the programme that are most, or least used by participants will assist the programme deliverers to reinforce/improve the relevant aspects of the programme.
- *Action setting* – evaluation takes place in an action setting where the most important thing that is going on is the programme. In this study the HIV/AIDS programme was evaluated during the workshop.
- *Role conflicts* – interpersonal frictions are not uncommon between evaluators and practitioners. There is often a perception from practitioners that the merit of their activities is being weighed through an evaluation process. In this study, however, this friction might perhaps be somewhat lessened since the evaluator is part of the practitioner team.

- *Publication* – in evaluation, the majority of study reports probably go unpublished. Given this situation, I am determined that the results of this study be published.
- *Allegiance* – the evaluation researcher has a dual, perhaps triple, allegiance. The evaluator has obligations to the organization that funds the study, as well as responsibilities to contribute to the improvement of the programme in the field being studied. As a social scientist, the evaluator seeks to advance the frontiers of knowledge about how intervention affects human lives and institutions. This aspect is reflected in the previous comment wherein I acknowledge the fact that I occupy multiple roles; namely, that of researcher and of practitioner.

The advantages of evaluation are implied in the following (Noe, 1999; web.amnesty.org):

- Evaluation is a chance for practitioners to test for themselves that their efforts are working and are worthwhile as well as identifying weaknesses to be remedied.
- It is an essential step towards improving effectiveness.
- It gives the programme credibility in the eyes of those directly and indirectly involved. It is essential for good planning and goal setting.
- It can raise morale, motivate people and increase awareness of the importance of the work being carried out. Or it can help solve internal disputes in an objective and professional way.
- It allows others engaged in similar work, locally and internationally, to benefit from previous experience.

Evaluation therefore plays a central role in providing direction and credibility to the services being provided through a particular activity or programme.

3.2.2 Types of evaluation

Rossi and Freeman's definition of evaluation indicated above, implies different kinds of evaluation; namely, needs assessment, evaluability studies, programme monitoring, impact studies, cost-effectiveness studies and utilization assessment (De Vos, 2002). There are, however, two main broad categories of programme evaluation: formative and summative evaluations. Formative evaluation refers to evaluation that is usually conducted in order to improve the process of delivering a programme (De Vos, 2002; Knox, 1986 and Noe, 1999). Its purpose is to validate or ensure that programme goals are achieved as well as to improve the method(s) of delivering the programme (Weston, Mcalpine & Bordonaro, 1995). To improve methods of delivering a programme requires that problematic aspects of programme delivery, quality of implementation and assessment of the organizational context, personnel, and inputs be identified and rectified. Programme monitoring, sometimes referred to as process evaluation, is a form of formative evaluation in which an assessment of what the programme is doing and for whom the services are provided is done (WHO, 2000). Process evaluation is concerned with the following questions (Weiss, 1998):

- What is going on in the programme?
- What kinds of services are participants being given?
- Is the service following the prescriptions of the programme developer?
- Are clients happy with the programme?

Summative evaluation, on the other hand, is concerned with assessing a programme's effectiveness and utility by determining the extent to which participants have changed as a result of participating in a particular training programme (De Vos, 2002 and Noe, 1999). Summative evaluation usually addresses the following (Noe, 1999):

- Answers the question of whether trainees acquired knowledge, skills, attitudes, behaviour or other outcomes identified in the training objectives.
- Measures the monetary benefits that a company or organization receives from the programme.

The different forms of summative evaluation are outcome and impact evaluations. Outcome evaluation assesses expectations about how the programme will change participants' knowledge, attitudes, behaviour or awareness (Weiss, 1998; www.acf.hhs.gov). Weiss (1998) further distinguishes between anticipated and unexpected outcomes that result from the implementation of a particular programme. Sometimes outcome evaluation is used interchangeably with impact evaluation which refers to the net or long-term effects of a programme on participants (Weiss, 1998). Other forms of summative evaluation include cost-effectiveness and cost-benefit analysis, secondary analysis and meta-analysis (www.introduction).

This study focuses on both formative and summative evaluation. The form of formative evaluation to be addressed in this study is process evaluation, while the forms of summative evaluation to be addressed in this study are both outcome and impact evaluation, as reflected in the discussion below.

3.2.3 Kirkpatrick's model of evaluation

Kirkpatrick's model of evaluating learning and training provides the overall framework for assessing the impact of the UNISA HIV/AIDS programme as it has been widely utilized in the evaluation of training programmes in a variety of contexts (Albernathy, 1999; Alliger & Janak, 1989; Kaufman, Keller & Watkins, 1995; Naugle, Naugle, & Naugle, 2000 and Watkins, Leigh, Foshay & Kaufman, 1998). The model comprises four levels: Reaction, Learning, Behaviour and Results (Kirkpatrick, 1996) (See Figure 4.1 on p.71).

The **Reaction Level** deals with how participants feel about the various aspects of a training programme (Kirkpatrick, 1996). In assessing this level, the following questions are asked (www.business.balls.com):

- Did trainees like and enjoy the training?
- Did they consider the training relevant?
- Was it a good use of their time?
- Did they like the venue, style, timing, etc?

- What was their level of participation?
- Was their experience easy and comfortable?
- What was the level of effort required to make the most of learning?
- What is the perceived practicability and potential for applying the learning?

In the present study, participants' reactions to the training; that is, the methods used for tuition and the various components of the training in both Modules 1 and 2 are assessed. This is in line with process evaluation, a form of formative evaluation that was discussed in section 3.2.2.

The **Learning Level** assesses the extent to which participants had a change in attitude, knowledge and/or skills as a result of having participated in a particular programme (Kirkpatrick, 1996). In assessing this level, the following questions are asked (www.business.balls.com):

- Did the trainees learn what was intended to be taught?
- Did the trainees experience what was intended for them to experience?
- What is the extent of advancement or change in the trainees after the training, in the direction or area that was intended?

In this study, participants who studied the UNISA HIV/AIDS programme are asked to indicate whether the programme has assisted them in gaining entry into the field of HIV/AIDS counselling or not. This, to some extent, assesses the impact of the programme on participants; be it knowledge, attitude or skills. Participants' level of knowledge, attitude and/or skill will be compared to the learning outcomes outlined for the various themes covered in the programme. This forms part of summative evaluation (see section 3.2.2).

The **Behaviour Level** assesses whether participants use their newly acquired knowledge and/or skills that result from training, on their jobs (Kirkpatrick, 1996). This is also referred to as *"transfer of training"* (Noe, 1999). In assessing this level, the following questions are asked (www.business.balls.com):

- Did the trainees put their learning into effect when back on the job?
- Were the relevant skills and knowledge used?
- Was there noticeable and measurable change in the activity and performance of the trainees when back in their roles?
- Would the trainee be able to transfer their learning to another person?
- Is the trainee aware of his/her change in behaviour, knowledge or skill level?

In this study participants' ability to develop and conduct HIV/AIDS prevention programmes utilizing the information obtained in the programme is assessed. Their ability to transfer this information to their work contexts will be assessed. Firstly, by determining whether participants were able to get involved in HIV/AIDS work as a result of having undergone the training; secondly, by asking participants to indicate which specific aspects of the programme do they use to enable them to provide HIV/AIDS education and prevention. This forms part of summative evaluation.

The **Results Level** assesses the final results that emanate from the training; that is, the effect of training on the business or environment resulting from the trainee's performance (Kirkpatrick, 1996). The assessment of this level of training usually entails key performance indicators such as volumes, values, percentages, timescales, return on investments and other quantifiable aspects of organizational performance (www.business.balls.com). While this is easier to measure within a business context, it might be difficult within the context of HIV/AIDS. In the field of HIV/AIDS, measures of this level might include the national reduction in the prevalence of HIV/AIDS, increased usage of condoms or general engagement in safer sex practices and increased education on HIV prevention within the country. It will not be easy to assess the impact of the UNISA HIV/AIDS programme on these measures due to the fact that there are various models of training on HIV//AIDS which participants are often exposed to, in addition to the UNISA programme. Therefore, this aspect was not particularly measured in the present study as it requires, for example, an observation of national trends over a long period under very controlled environments; and this falls outside the scope of this study.

The **Reaction and Learning Levels** of evaluating training is usually assessed during the actual delivery of the programme, before participants return to their job settings (Kirkpatrick, 1996; Noe, 1999). In the present study these two levels were evaluated during the training, although Module 1 was assessed during Module 2 training. The Behaviour and Results levels of assessing training measure the degree to which trainees use the training content on the job; and thus implying that evaluation takes place after trainees have completed their training (Kirkpatrick, 1996; Noe, 1999). This kind of evaluation is usually conducted from at least 3 months and up to a year after training has occurred (Kirkpatrick, 1996; Naugle, *et al*., 2000). As already stated in section 1.3 above, one of the aims of this study is to assess the impact of the programme on participants' involvement in their communities. This suggests that we have to assess how the programme impacts on their work in their various communities. Participants were therefore asked to assess their application of Module 1 after they had spent, from as little as 3 months to as much as one and a half years, in their communities. For Module 2, participants were asked a year after they had undergone training (during 2007) to indicate whether they were involved in HIV/AIDS counselling or not.

3.3 THE RESEARCH METHOD

The present study adopted both a quantitative and a qualitative approach to evaluating the UNISA HIV/AIDS programme. Fouché and Delport (2005, p.74) define a quantitative study as "an inquiry into a social or human problem based on testing a theory composed of variables, measured with numbers and analysed with statistical procedures in order to determine whether the predictive generalisations of the theory hold true". On the other hand, a qualitative researcher is "concerned with understanding (*verstehen*), rather than explanation; naturalistic observation rather than controlled measurement; and the subjective exploration of reality from the perspective of an insider, as opposed to the outsider perspective that is predominant in the quantitative paradigm" (Fouché & Delport, 2005, p. 74).

In this study, the quantitative approach will mostly entail descriptive statistics to describe the sample, to quantify the participants' responses on aspects of the HIV/AIDS programme that had an impact on them, and on aspects they are able to apply when engaged in work within their various contexts. The qualitative aspect of the study will explore the participants' experiences while undergoing training of the UNISA HIV/AIDS programme. This will assess any changes in attitudes, knowledge, skills and behaviour resulting from having undergone training.

It is not uncommon in research to combine research methodologies in studying a single phenomenon. The most common rationale for the use of a combination of methodologies in a single study is triangulation. According to Creswell (1998), triangulation is often used to neutralise any bias that might result from a particular data source, or a researcher or a specific method by making use of other data sources, researchers or methods. Methodological triangulation and triangulation of measures are the main forms of triangulation used in this study. Padgett (in De Vos, 2005, p. 362) defines methodological triangulation as "the use of multiple methods to study a single topic, for example combining quantitative and qualitative methods in a single study". According to De Vos (2005) researchers utilize triangulation of measures when they take multiple measures of the same phenomenon. "By measuring something in more than one way, researchers are more likely to see all aspects of it" (De Vos, 2005, p.362). In this study, the impact of the UNISA HIV/AIDS programme with regards to change in attitudes, knowledge, skills and behaviour will be measured both quantitatively and qualitatively, reflecting the use of triangulation of measures. Apart from addressing the bias of measures inherent in the use of one methodology, one investigator or a single data source, triangulation also has the following "opportunities" or advantages (Jick, 1983, pp145 - 147):

- It allows researchers to be more confident in their results.
- It may also help to uncover the deviant or off-quadrant dimension of a phenomenon. Moreover, divergent results from multi-methods can lead to an enriched explanation of the research problem.

- The use of multi-methods can also lead to a synthesis or integration of theories. In this sense, methodological triangulation closely parallels theoretical triangulation, i.e. efforts to bring diverse theories to bear on a common problem.
- Triangulation may also serve as the critical test, by virtue of its comprehensiveness, of competing theories.

3.4 THE SAMPLE FOR THE STUDY

The sample used for this study was selected through the use of a non-probability sampling procedure and specifically purposive sampling. This is in line with Strydom and Delport's (2005) assertion that qualitative studies tend to utilize non-probability sampling, particularly theoretical or purposive sampling. Denzin and Lincoln (2000) believe that qualitative researchers seek out individuals, groups and settings where specific processes that are under investigation are most likely to occur. In this study, the sample that was chosen was seen as the most likely and suitable group that would provide the most relevant information on the UNISA HIV/AIDS programme as the group had undergone and was still undergoing training on HIV/AIDS at UNISA. Therefore, the sample for the study comprised students who undertook both module 1 and module 2 of the UNISA HIV/AIDS programme.

The study comprised a total of 116 participants (82% female and 18% male) for phase 1, while phase 2 of the study comprised 8 participants. Participants were aged from 20 years to 60 years, with an average age of 39 years.

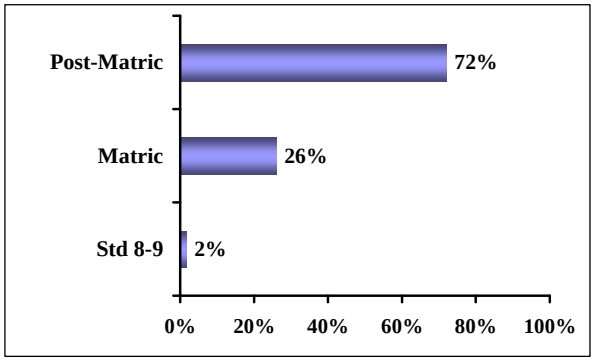

Figure 3.1: Highest level of education (n=112)

Most participants' ages fell in the 30-to-48-years age category (within one standard deviation which is 9.4 years). The sample comprised mainly Blacks (79%), with 12% of participants being Whites, 6% Coloured and 3% Asian. The highest education level of participants is presented in Figure 3.1. From this table, it is apparent that most participants have a post-matric qualification.

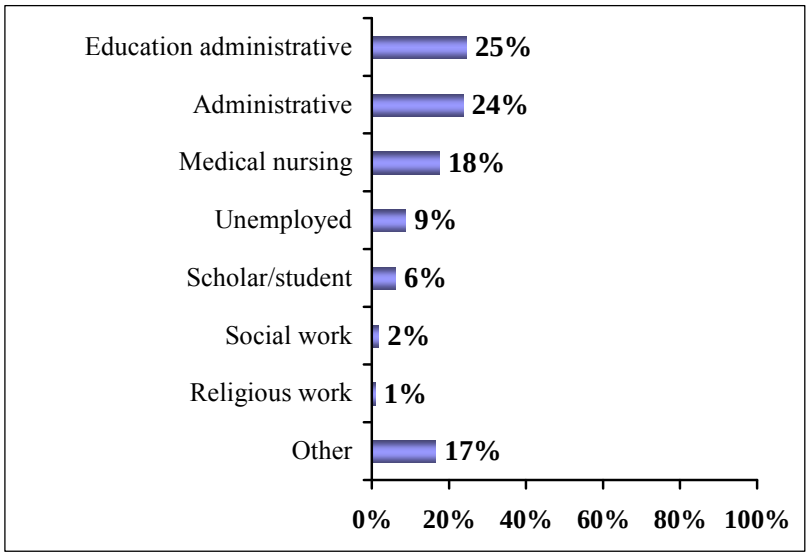

Figure 3.2: Occupation (n=112)

Figure 3.2 provides the various occupations represented in the sample. Almost half of the participants work in administration, either general (24%) or education (25%) administrations. A very limited percentage of participants was involved in religious work and social work, while 18% came from the medical nursing field. A small number of the participants (6%) was students, while 9% was unemployed.

Most participants were not involved in HIV/AIDS work prior to enrolling for the UNISA HIV/AIDS programme. However, they reported that their involvement increased after they had done the UNISA HIV/AIDS Module 1. These results are reflected in the next chapter. Most of the participants (84%) claimed that the module had assisted them to gain entry into the field of HIV/AIDS while only 16% stated that it did not.

3.5 DATA COLLECTION

Data for this study was collected through the use of a combination of group-administered and self-administered questionnaires. A semi-structured interview schedule was compiled, which consisted of both open- and close-ended questions, thus allowing for structure, while at the same time giving the participants the opportunity to respond freely (the questionnaires are provided in Appendix A). With group administered questionnaires "respondents who are present in a group, each complete a questionnaire or questionnaires on their own" without discussing it with other participants (Delport, 2005, p. 169). Since participants in this study were all students who were attending the HIV/AIDS Module 2 workshops, they were all given two sets of questionnaires to complete; one for Module 1 and another for Module 2. The questionnaires comprised sections which addressed the following themes:

- Biographical information
- Involvement in HIV/AIDS work pre- and post-training
- Experiences of the themes covered and methods of tuition and assessment during training
- Usefulness of aspects covered in the Modules and their applicability
- Suggestions for improving the programme

Data for assessing the impact of the UNISA HIV/AIDS programme on participants' learning for both Modules 1 and 2 was collected during November 2004 and December 2005. This constituted the first phase of data collection. In addition, data to assess the impact of the programme on participants' involvement in their respective communities for Module 1 was also collected during this period. The group-administered-questionnaire method was used with regard to Module 1 as participants were given a time slot to complete this questionnaire prior to the commencement of the Module 2 programme.

The self-administered questionnaire, according to Delport (2005), is a method of collecting data in which the questionnaire is given to the respondent to complete on

his/her own, with the guidance of the researcher or field worker. This method was used in this study to collect data for Module 2. Since the questionnaire was too long to complete in a single session, it was divided into sections according to the five days of the workshop, with each day's activities being evaluated at the end of that day. This was done to assist in getting reliable and quality responses. Participants were encouraged to complete the questionnaire at their own time, but to return it by the end of day 5, which would mark the end of the workshop. Appendix A provides the questionnaires that were used for the two modules, including the questionnaire for assessing the impact of the programme on participants' work in their work contexts.

Data for assessing the impact of Module 2 on participants' HIV/AIDS involvement in their respective communities was collected during 2007. This constituted the second phase of data collection. Participants were sent a semi-structured questionnaire asking them to share their experiences of how the UNISA HIV/AIDS programme is assisting them in their work in the community. They were asked to submit their responses in the form of a life story.

3.6 DATA ANALYSIS

3.6.1 Quantitative data analysis

The quantitative aspect of the study will use quantitative data analysis techniques. This will mainly take the form of descriptive data analysis where the aspects of the HIV/AIDS programme that were most useful to participants and are being applied within their community will be provided. These will be presented in the form of frequency distributions.

3.6.2 Qualitative data analysis

"Qualitative analysis involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for

communicating the essence of what the data reveal" (De Vos, 2005, p. 333). This implies a systematic information-organising process that follows a specific pattern or procedure. De Vos (2005) integrated Creswell and Marshall and Rossman's processes of data analysis and interpretation and presents it as follows:

- Planning for recording of data

The investigator in this study planned, prior to collecting the data, for how the data was going to be recorded in line with what the process requires. The questionnaires that were used for data gathering ensured that all information would be safely captured on the questionnaire itself as part of data recording.

- Data collection and preliminary analyses

Data analysis in qualitative research involves a process of analysing data at the research site during data collection as well as analysing the data away from the research site, after the data collection process has been completed (De Vos, 2005). The rationale for this inseparable process between data collection and data analysis, according to De Vos (2005), is to ensure effective collection of rich data that generate alternative hypotheses and provide the basis for shared constructions of reality. In this study, this process was done through the pilot study that was conducted at the initial phase of the data collection process. The preliminary analysis of the results influenced alternative ways of gathering the data, thereby enriching the data collected from the study. Another way this simultaneous process was done in the study was through the follow-up research that was conducted a year later (2006) to assess the impact of the UNISA HIV/AIDS programme on participants' work within their communities. As data was preliminarily analysed from the collection process in the workshops, any necessary refinements were taken care of during this follow-up research.

Creswell (1998, p.142) maintains that, "the researcher engages in the process of moving in analytical circles rather than use a fixed linear approach. One enters with data and exits with a narrative, in-between, the researcher touches on several facets of analysis and circles around and around". This has been my experience and process in analysing the data. I started analysing the data at the point when I started collecting it. Through the

process of data collection, I simultaneously categorised the information into themes to form a coherent story. As Cresswell (1994, p.153) notes, "in qualitative analysis several *simultaneous* activities engage the attention of the researcher: collecting information from the field, sorting the information into categories, formatting the information into a story or picture and actually writing the qualitative text".

- Managing or organising the data

Data in this process is organised in such a manner that it will facilitate proper analysis of the data as this is the first formal step in the process of analysing data away from the research site. In this study computer files were created as a step in organising and managing the data. Crucial questions that need consideration in this process of organising the data according to De Vos (2005) include:

  - Are the field notes complete?
  - Are there any parts that you put off to write later and never got to but need to be finished, even at this late date, before beginning analysis?
  - Are there any glaring holes in the data that can still be filled by collecting additional data before the analysis begins?
  - Are all the data properly labelled with a notation system that will make retrieval manageable? (dates, places, interviewee identifying information, etc).
  - Are interview transcripts complete?

In terms of the present study, part of this process involved clearly marking all the questionnaires according to the dates on which they were collected, and the total number of participants that attended the workshop. These were bound together to ensure identification during the process of analysis.

- Reading and writing memos

Qualitative analysis often entails immersing oneself in the data and this can be done through repeated reading in order to get a deeper understanding and provides the opportunity to extract themes. In this regard, Creswell (in De Vos, 2005) believes that reading the transcripts in their entirety several times enables the investigator to immerse

himself/herself in the details and get a sense of the results as a whole before breaking them into parts. As one reads the data several times, one is able to come up with ideas or key concepts which are then written down in the margins for use during the process of analysis.

- Generating categories, themes and patterns

A reason advanced for choosing the qualitative method of inquiry is the willingness to "engage in the complex, time-consuming process of data analysis – the ambitious task of sorting through large amounts of data, reducing them to a few themes or categories" (Creswell, 1998, p.16). In the terms of Marshall and Rossman (1999) I engaged in a process of reducing and interpreting the chunk of information at my disposal into categories and themes and then interpreting the information to reflect the emergence of a larger, consolidated picture. According to De Vos (2005, p. 338) this process "demands a heightened awareness of the data, a focussed attention to the data and an openness to the subtle, tacit undercurrents of social life".

- Coding the data

Coding of data in qualitative research can take the form of abbreviations of key words, coloured dots or numbers (De Vos, 2005, p. 338) to facilitate the process of understanding data that has been generated. Coolican (2004) distinguishes between initial line-by-line coding in which a code is assigned for each line of text read. This is then followed by what he refers to as focused coding, which combines early simple codes into larger constructs that will eventually combine into explanatory categories. In my process of analysing the data, I used both numbers (for differentiating quantitative from qualitative information) and key words (for assisting with classification of themes) to code the data in order to lay a foundation for the analysis.

- Testing the emergent understandings

After categories, themes and codes have been developed an assessment of the plausibility of emerging understanding of the data follows which is then explored through the data (De Vos, 2005). "This entails a search through the data during which the researcher

challenges the understanding, searches for negative instances of the patterns and incorporates these into the larger constructs, as necessary. Part of this phase involves evaluating the data for its usefulness and centrality (De Vos, 2005, p. 338 – 339).

- Searching for alternative explanations

As the investigator analyses the data, he/she must search for alternative explanations to the data as well as possible linkages between them. Part of this process involves challenging some of the patterns or categories that seem apparent (De Vos, 2005). This formed part of my analysis process and culminated in the present final themes as presented in my research findings.

- Representing, visualising (i.e. writing the report)

The final phase of the process of analysis entails presenting the data in a formalised, presentable format. In this study this entails the use of tables, graphs and descriptions of themes and categories in line with the quantitative and qualitative nature of the study.

The above steps in the process of analysing qualitative data have been presented in a linear fashion. However, but De Vos (2005) points out that these steps move in circles and should not be followed rigidly like a recipe. Creswell (1998) believes in a data analysis spiral that allows the researcher the flexibility to move in analytic circles which is more preferred than a fixed linear approach. Indeed, this has been my experience when I worked through the analysis of my data as at times I would be forced to move back and forth coding, categorising themes, testing the emergent understandings and searching for alternative explanations as I was finalising the themes and finally presenting the results. This is an essential process as it assists in providing integrated, coherent research results.

3.7 DATA VERIFICATION

In quantitative research, it is important to determine the accuracy of any research results by discussing issues of reliability and validity in relation to those results. In contrast, qualitative researchers have no single stance or consensus on addressing traditional topics

such as validity and reliability in qualitative studies. Instead, Lincoln and Guba (1985) point out that the researcher, in qualitative research, is mostly concerned with issues of credibility, transferability, dependability and conformability. These can be achieved through being involved in a prolonged engagement in the field and through the use of triangulation of data sources and methods of investigation (Creswell, 1998). In this study, being engaged in data collection for a period of a year and being part of the workshop team of presenters was an attempt at achieving the data verification process. Again, the use of triangulation ensured this process was sustained. De Vos (2005) outlines and describes Guba and Lincoln's verification process below:

- ***Credibility*** ensures that the enquiry was conducted in such a manner that the subject was accurately identified and described. By providing an in-depth description of the complexities of variables and interactions, a reflection of how embedded the data is from the setting from which it was derived will be so obvious that its validity cannot be questioned. In this study, the detailed description of the programme together with the manner in which the results are presented will provide the credibility needed with regards to the research findings. The fact that both a quantitative and qualitative analysis of data was adopted, triangulation will also account for this.
- ***Transferability*** entails the use of theory to show how it guides the process of data collection and analysis as an alternative to external validity or generalizability of research findings as found in quantitative data. The use of triangulation is seen as one way of enhancing a study's generalizability; and the present study is no exception as it also involved the use of triangulation. The link between the various levels of Kirkpatrick's model of evaluating training programmes and the aims of the present study, as well as the manner in which the research results are presented account for transferability.
- ***Dependability*** is the alternative of reliability. In this respect, the researcher attempts to account for the changing conditions in the phenomenon chosen for the study as well as changes in the design created by increasingly refined understanding of the setting. The assumption of an unchanging social world is in

direct contrast to the qualitative assumption that the social world is always being constructed, and the concept of replicability is itself problematic. A study such as this one addresses a topic that reflects the ever-changing social world, specifically as it relates to HIV/AIDS and the associated prevention methods.

- ***Conformability*** relates to the traditional concept of objectivity, which in qualitative research is a concept that is highly challenged as the researcher's influence on the study is acknowledged. I have indicated my involvement in the programme I am evaluating in the present study, thereby acknowledging the inherent subjective element that I bring into the study.

3.8 ETHICAL ISSUES

One of the important ethical considerations for this study has been obtaining informed consent from the participants. This implies that all possible or adequate information on the goal of the investigation and the procedures to be followed during the investigation are given to the potential subjects. According to Strydom (2005), the researcher should place emphasis on accurate and complete information for participants to fully comprehend the investigation and consequently make voluntary decisions regarding their possible participation in the study. This is particularly important in this study because the researcher holds *"power"* over the participants by virtue of the fact that she is also a facilitator in the programme. Evaluative research is often characterised by "conflict of interest" (which was alluded to in section 3.2.1 of this chapter) which needs to be dealt with openly and honestly to avoid compromising the evaluation process and the results (Weiss, 1998). That is why obtaining informed consent is a crucial ethical consideration in this study.

An equally important and linked ethical consideration is that of guarding against deceiving research participants by withholding information or offering incorrect information to ensure participation of subjects when they would otherwise refuse to do so (Strydom, 2005). These two ethical considerations were dealt with by thoroughly explaining the research and its purpose to the participants, especially that they were not

forced to participate in the research if they did not want to. Indeed, some participants did not take part in the study.

In evaluative research, the evaluator has a professional and ethical responsibility to fully and honestly report on the results of the study (Weiss, 1998). This is a challenge, especially when considering the tension that might exist as a result of the obligation to protect the interest of the people in the programme and the responsibility to report the results honestly. I was mindful of this tension and ethical consideration as I reported the findings of this study.

3.9 CONCLUSION

In this chapter I presented the methodology used in my research. I did this through discussing the overall research approach, the research design, the methods used for data collection and analysis. I then concluded by focussing on the authentication of my findings and endeavoured to show that I followed an ethical course of action.

In the next chapter I will present the results of the study.

CHAPTER 4

THE IMPACT OF THE UNISA HIV/AIDS PROGRAMME ON PARTICIPANTS' LEARNING AND INVOLVEMENT IN THE COMMUNITY

4.1 INTRODUCTION

This chapter presents the results of the study in which the impact of the UNISA HIV/AIDS programme on participants' learning and involvement in the community was assessed. Kirkpatrick's model of evaluating training programmes was used and comprises the Reaction, Learning and Behaviour levels. The assessment covered both formative and summative evaluation. A schematic representation of Kirkpatrick's different levels of evaluation, which includes the corresponding types of evaluation, is presented in Figure 4.1.

4.2 KIRKPATRICK'S MODEL: REACTION LEVEL

Kirkpatrick's Reaction Level (see Figure 4.1) assesses how participants react to the training by asking, amongst others, the following questions (Kirkpatrick, 1996; www.business.balls.com):

- Did trainees like and enjoy the training?
- Did they consider the training relevant?
- Was it a good use of their time?
- Did they like the venue, style, timing, etc?
- What was their level of participation?
- Did training provide ease and comfort of experience?
- What was the level of effort required to make the most of learning?
- What was the perceived practicability and potential for applying the learning?

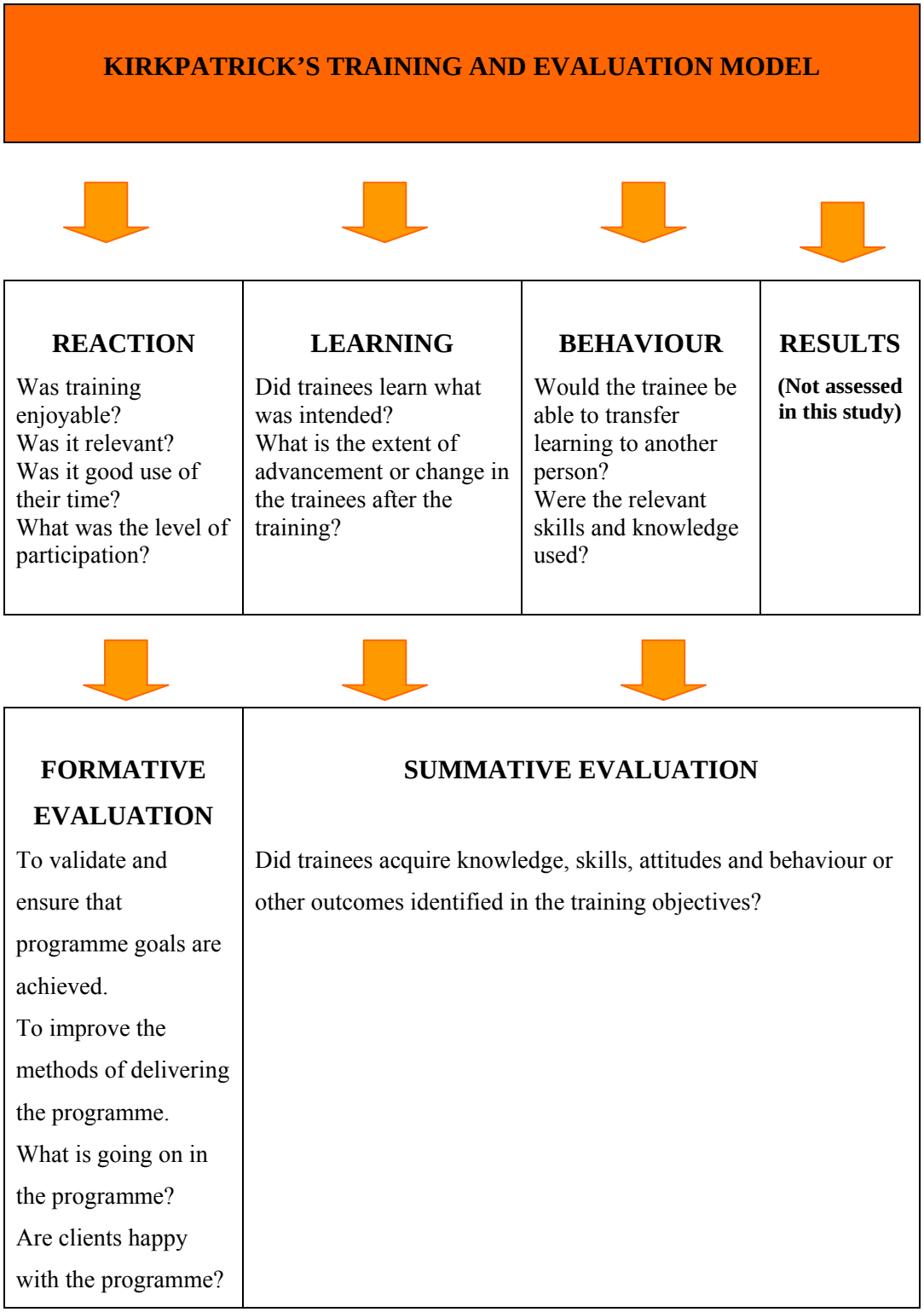

Figure 4.1: Kirkpatrick's levels for evaluating training programmes (Based on Kirkpatrick, 1996)

In answering the questions posed to assess the Reaction Level of Kirkpatrick's model we are engaging in formative evaluation, which aims to validate or ensure that programme goals are achieved and to improve the process of delivering a set programme (De Vos, 2002; Knox, 1986; Noe, 1999; Weston, Mcalpine & Bordonaro, 1995;). In this study the methods used for delivering the UNISA HIV/AIDS programme were assessed using Kirkpatrick's Reaction Level, thereby engaging in formative evaluation. The sections that follow present the results of the study that focused on evaluating the methods used for tuition and assessment in the UNISA HIV/AIDS programme.

4.2.1 The method of tuition

Participants were asked an open-ended question to report their general experiences of the methods that were used for tuition during the programme. The method used for tuition in Module 1 is mainly distance education while the method used for tuition in Module 2 is contact teaching in the form of a workshop.

With regard to Module 1, participants indicated that the method that was used for tuition presented them with certain challenges. Responses varied from satisfaction with the method used for tuition to indicating how this method of tuition influenced their learning. In their responses, participants also made reference to the manner in which the method of tuition was conducted and the extent to which it covered the learning material. Suggestions for improving the method of tuition were also advanced. In total, 73 participants responded to this question, with the possibility of making a choice in more than one category.

Most participants (51%) seem to be satisfied with being taught through distance teaching. This is reflected in some of their responses as indicated in these excerpts *"not bad"*, *"satisfied", "good" "excellent"*. Almost all their ratings of this method of tuition are positive. Twenty nine percent (29%) of the participants also found the manner in which tuition was offered clear, simple, well structured, illustrative, user-friendly, self-explanatory and understandable. They felt that it was well organized to the effect that it

simplified their learning and made it easy for them to understand the content. There was only one participant who did not find the method of tuition desirable. Table 4.1 presents the themes that describe participants' responses to this question.

Table 4.1: Themes describing participants' responses to the method of tuition (n = 73)

	Frequency	Percentage
Their level of satisfaction with the method of tuition	37	51%
The effect it had on their learning	23	32%
The extent to which it was comprehensible	21	29%
The challenges it posed	9	12%
The extent to which it was comprehensive	2	3%
Suggested improvements to this method of tuition	5	7%

The assertion by some that the method of tuition enabled them to understand what they were taught is supported by other participants (32%) who indicated that through this method of tuition, they were able to gain understanding of and to appropriately engage in the learning material. This seems to have instilled confidence in some participants to share their acquired knowledge with others.

Some of the challenges that this method of tuition presented for other participants (12%) include having to work hard and discover things by themselves, difficulties with concentrating at night while studying, being easily distracted and memorizing the work prior to writing a test. Most of the participants, as reflected in the sample for the study, are engaged in full-time jobs. Some of them might also be engaged in multiple roles of also being parents (although this was not established in the study). It then follows that occupying dual roles will result in challenges for the student as well as require the student to work hard. By virtue of the method of tuition being distant learning, self-discovery is implied as students are expected to gain understanding on their own, albeit with the help of the study materials that are provided. This proved to be hard and challenging for some students. It is therefore not uncommon for some of the participants to find the time allocated to studying the module insufficient, resulting in some of them memorizing the

work instead of attempting to understand it. Other participants, however, found this method suitable for their context as it provided them with the flexibility to study at their own time and pace. As a result, this group of participants was satisfied with the time that was allocated for studying the module. There were those amongst the participants who indicated that they were used to studying through correspondence, implying that they did not experience any difficulties with this method of tuition.

Some participants (3%) expressed satisfaction with the amount and depth of work that was covered through this method of tuition.

There were some participants (7%) who made suggestions with regard to how the method of tuition could be improved. Responses ranged from time allocation, the method of tuition, to content of what needed to be taught. With regard to time allocation, participants varied in their responses. For some there was a need to increase the time allocated for studying the module while for others there were suggestions that it be reduced to four months. This seems in line with the responses given earlier wherein some participants were satisfied with the time that was allocated for studying while others felt it was too short. With regards to the method of tuition, some participants suggest an increase in the number of contact sessions that are afforded to students. Others feel that teaching should cover everyday questions and should focus on African situations.

The evaluation of participants' reactions to Module 2 focused on the various methods that were used for presenting the HIV/AIDS Counselling Skills workshop. These methods include experiential learning, role plays, video presentations, mini-lectures and small group discussions. Participants were asked whether the various methods were found helpful and were also encouraged to provide elaborate answers.

In general, participants seem to have appreciated the variation in presentation techniques that they were exposed to throughout the week of the workshop. This combination of methods seems to have instilled confidence in the participants and also resulted in the workshop producing good outcomes. For instance, participants indicated that the use of

role plays and experiential learning heightened their awareness to the reality of counselling, provided them with the opportunity to practise counselling skills and assisted some to clarify and perfect their existing counselling skills. These outcomes seem consistent with the purpose of facilitation, which is to enable people to explore their own potential, build upon their experience and to generate their own further learning (Van Dyk, 2005). Through engaging in this process, participants seem to have been assisted in imprinting what they have learnt for later use. Video presentations were also found to be bringing out the reality of counselling for participants, stimulating and also assisting in preparing them for later learning in the course of the workshop. Small group discussions were commended for providing everyone with an opportunity to participate in the workshop, thus allowing participants to learn from each other.

Participants' experiences of the methods used for facilitating the workshop seem consistent with the characteristics of adult learning which indicate that because of their level of maturity, adult learners bring with them a wealth of prior experiences and tend to prefer self-directed learning as opposed to other-directed learning (Leberman, McDonald & Doyle, 2006; Noe, 1999).

The methods that were used to facilitate Module 2 workshops have been found useful in HIV/AIDS educational programmes that integrate knowledge, attitudes and skills (Eagle & Brouard, 1995; Swain & McNamara, 1997; Williams, Wang, Burgess, Wu, Gong & Li, 2006; Wu, Detels, Ji, Xu, Rou, Ding & Li, 2002).

The only criticism that was advanced against Module 2 tuition was the amount of time that was allocated for doing the workshop. Participants indicated that although a topic was important for the workshop, not sufficient time was allocated to explore it in detail, and sometimes they would have little time to get through an entire video presentation.

Participants' experiences of working through each theme that was covered in the workshop were also assessed. They were asked whether each theme was clearly explained and whether they understood what was taught.

From their responses, it seems as if participants found the workshop to be an informative, simple, clear, interesting, stimulating, good and enjoyable experience. The manner in which the introductory part of the workshop was done seems to have validated some participants' cultural norms of welcoming and conducting introductions. Other participants appreciated the fact that this section facilitated group cohesion. In fact, this was the main objective of this section (Yalom, 1985).

The sections on *information recapitulation, pre- and post-test counselling skills, positive living and bereavement counselling* seem to have been particularly informative for the participants. HIV/AIDS is a field that is rapidly growing and therefore regular updated information in this regard is essential. Perhaps this is the reason why participants found the section on information recapitulation informative. Another reason for this section to be found informative by the participants could be as a result of having found explanations to questions they had prior to attending the workshop, perhaps as a result of their engagement in HIV/AID education in their communities. Providing post-test counselling, especially with a positive test result can be a challenge to HIV counsellors, particularly those that have just entered the field. This could be one of the reasons why participants found this section informative as it equipped them with skills on how to break the news while at the same time containing the client's emotions. In the same manner, they might find encouraging clients to live positively with the virus a challenging experience, hence this section being also found to be informative. One of the reasons why bereavement counselling was also found to be informative could be the fact that the devastating effect of the AIDS pandemic is beginning to take root in the increasing number of AIDS deaths, particularly in South Africa (McGeary, 2001; UNAIDS, 2006).

Participants found the sections on *attitudes and self-awareness, and post-test counselling with a positive result* to be most challenging. Williams *et al*. (2006) provide evidence which indicates that effective HIV/AIDS professional programmes encourage participants to identify and verbalize fears, assumptions and prejudices. This explains why participants found this section challenging.

Post-test counselling with a positive result and bereavement counselling were experienced as highly emotional. The realization of the intensity of emotions that are most likely to be expressed by clients in these sections have most probably resulted in these sections described as emotional. For the section on post-test counselling, participants are shown a video that models such a counselling session and, as participants have already indicated, this brings out the reality of counselling. In the section on bereavement counselling, participants are made to confront their own grief and to understand the importance of this in bereavement counselling (Worden, 1991). This tends to be a highly emotional session for the participants, as evidenced by the description of their experiences.

The *counselling skills* were, in general, found by some participants to be difficult, tricky and scary. Others said that they struggled with fully grasping *the introduction to counselling skills* section. Given the fact that most of the participants were being exposed to counselling skills for the first time, it is therefore not surprising that they would feel this way about them. The section on *prevention, sexuality and behaviour change* were regarded by some as a bit confusing, with others stating that it was not well structured. Perhaps this is an area that might need to be improved on in the programme. Table 4.2 presents participants' experiences of going through the workshop themes.

Conclusion

The methods that were used for tuition in the UNISA HIV/AIDS programme were found by the participants to be simple, clear, interesting, stimulating and enjoyable, with most satisfied with them. There were some who were challenged by the manner in which they were taught, either in terms of time, studying and practising that which was presented before them. Most participants found the methods used for tuition informative and actively engaging with the study material.

Table 4.2: Participants' experiences of the workshop themes

Theme	Experience
Welcome and Introduction	• Enhanced group cohesion • Validated cultural norms • Well done and exciting
Information Recap	• Necessary • Unnecessary • Helpful
HIV-positive speaker	• Eye-opener • Motivated change in personal behaviour • Informative
Attitudes and self-awareness	• Challenged personal attitudes and stereotypes towards others
Counselling skills – introduction	• simple and clear • enlightening • not fully grasped • understood
Skills for responding to feelings	• interesting and stimulating • useful
Skills for problem solving	• Eye-opener • Challenging • Scary
Pre-test counseling	• Informative • Difficult, tricky and intriguing • Interesting • Challenging
Post-test counselling – negative result	• Informative • Easy to understand
Post-test counselling – positive result	• More challenging • Emotional • Empowering • Well-presented/excellent
Crisis counseling	• well-understood • scary • challenging
Positive Living	• well understood • informative
Prevention, sexuality and behaviour change	• well-understood • a bit confusing • not well-structured
Bereavement counseling	• difficult • emotional • informative
Care-for the-caregiver	• good
Resources, networking and referrals	• interesting • eye-opener

4.2.2 The method of assessment

This section presents participants' reactions to the methods used for assessing their work in the UNISA HIV/AIDS programme. The results will only focus on Module 1 as there is no formal assessment in Module 2.

The multiple choice assignment

An open-ended question on participants' experiences about being assessed through a multiple-choice assignment was posed to the participants. Table 4.3 gives a summary of the themes categorizing participants' responses. Participants could give more than one response.

Table 4.3: Themes indicating participants' responses to the multiple choice assignment (n = 57)

	Frequency	Percentage
Its ability to facilitate learning	18	32%
Participants' level of satisfaction with the method of assessment	47	82%
Suggestions for improving this method of assessment	12	21%

The multiple-choice assignment, as a form of assessment, seems to have had both a positive and a negative effect on the majority of participants. Those that experienced it as positive (70%) responded by indicating that it was *"excellent", "good", "not bad", "easy to comprehend", "interesting", "intensive" and "challenging"*. Twelve percent (12%) of participants experienced it as negative, and described it as *"too difficult" and "confusing"*. Others were dissatisfied with the fact that the assignment did not expand their understanding as it tested only one way of thinking. For others this form of assessment seems to have encouraged memorizing the module content rather than understanding it.

A proportion of participants (32%) said that the multiple choice assignment facilitated their process of learning the contents of the module. Within this category of responses, participants indicated that the multiple choice assignment, in some way, forced them to consult the textbook and the study guide in order to answer the questions. It seems as if they would find it difficult to respond to the questions correctly if they did not have a thorough knowledge and understanding of their subject matter. For this reason, participants were encouraged to broaden their knowledge and to commit themselves to studying. One participant said: "*the multiple choice assignment made us smarter"*. The fact that the multiple choice assignment covered the whole syllabus was regarded as a good exercise for preparing participants for the examination. Some participants said that some of the case studies were related to reality, thus suggesting that this made their understanding of the subject matter easier. Others said that the assignment *"forced optimism"*, which is a bit difficult to understand and interpret but could perhaps refer to the fact that it gave them hope to pass the examination.

A few participants (21%) felt that feedback on the assignments should be delayed, without necessarily indicating their reasons for this suggestion. Other participants felt that the multiple choice assignment was the same as that of the previous year. It seems as if they would like it to be different. There were some responses that were difficult to explain; such as the fact that the multiple choice assignment needs to be compulsory, and the fact that they needed to see the results. The way the assessment is presently structured is such that the multiple choice assignment is compulsory and students are given back their results. Due to the fact that only 21% of participants have suggested that some improvements to this method of assessment be made and the fact that inadequate motivation for such a suggestion was advanced, it becomes difficult to adjust the module accordingly. Within this group of participants, there were those who were happy with the way the multiple choice assignment was presently structured and suggested that it be retained as it is in the future. Their responses include the following: *"a good way of assessing"*, "*negative marking was an excellent way of eliminating wild guessing"*, and *"both tracks are important for the assignment"*.

The portfolio (the multiple choice section)

Participants were asked an open-ended question with regards to their experiences of the multiple choice aspect of the portfolio. Their responses fell into two main themes: (i) how useful this form of assessment was, and (ii) the emotional and cognitive reactions it evoked in the participants. The results are reflected in Table 4.4. Participants could give more than one response.

Table 4.4: Themes reflecting participants' responses to the portfolio – multiple choice section (n = 26)

	Frequency	Percentage
The emotional and cognitive responses evoked in participants	20	77%
The method of assessment facilitated participants' learning	18	70%

Most participants (77%) found this aspect of the portfolio easy, good, interesting and enjoyable. Others, within this category, felt that they were challenged to know their work in order to answer the questions as the answers looked similar, otherwise they would find this method of assessment tricky.

Many of the participants (70%) felt that the manner in which the portfolio was structured enabled them to study with understanding in order to correctly answer the questions asked. Other participants therefore felt that it was impossible to respond to the questions without consulting their book. In this regard, the portfolio is said to have broadened the participants' understanding of their work and increased or upgraded their knowledge. An example of specific knowledge gained was reported by some as: *"learnt not to use vaseline with condom"*. It seems as if participants were not only able to study for the tests through this method of tuition, but were equally equipped to prepare for the examination. This made them to commend the method of assessment for covering most of the module topics, and thereby offering them a wide scope to respond to the questions.

The portfolio (the written/experiential tasks)

Again, participants were asked an open-ended question with regard to their experiences of the written/experiential aspect of the portfolio. Table 4.5 presents a summary of the themes categorizing participants' responses. Their responses, as reflected in the table, ranged from reference to the usefulness of this method of assessment, the level of satisfaction or rating of it, to the comprehensive nature of the written/experiential tasks. Participants could give more than one response.

Table 4.5: Themes reflecting participants' responses to the portfolio – written/experiential tasks (n = 23)

	Frequency	Percent
Participants' level of satisfaction or rating of this method of assessment	19	83%
Its usefulness	6	26%
Its comprehensive nature	1	4%

This method of assessment seems to have impacted on participants both negatively and positively. Those participants on whom this method of assessment impacted positively (66%) described it as: *"OK"*, *"not difficult"*, *"good"*, *"excellent"*, *"exciting"*, *"enjoyable"*, *"interesting"*, *"challenging" and "thought-provoking"*. Those on whom the method had a negative impact (17%) said it was time consuming and that it demanded intensive research. Others found some parts of this method of assessment difficult.

A proportion of participants (26%) found this section of the portfolio informative, as it required them to read and closely observe what they had studied. Others, within this category, indicated that they got an opportunity to share with others what they had learnt and this sharing enabled them to understand specific aspects of the module, such as the *African context/belief* system on HIV/AIDS.

A very small percentage (4%) of participants found this section of the portfolio to have covered most of the topics that they were expected to study in the module, and were satisfied that it enabled them to cover the entire syllabus.

Conclusion

The methods that were used to assess participants' knowledge in Module 1 were found by most to be good, easy to comprehend, interesting, enjoyable and challenging, while a few experienced them as difficult, confusing and time consuming. Participants indicated that they were encouraged to actively engage with the learning material and as such were able to gain a deeper understanding of their work as well as to transfer their learning to their community context. Others, however, felt that some of the methods used for assessment did not expand their thinking, and instead encouraged them to memorize their work. The changes that were suggested for this part of the evaluation were ambiguous, and further made the process for improving the programme difficult.

4.2.3 Suggestions for improving students' experiences of learning

Participants were given an opportunity to indicate whether they had any suggestions for improving the quality of the training that was provided in the programme. Table 4.6 presents a summary of the themes that categorize participants' responses with regard to Module 1. The participants' responses include suggestions with regard to tuition, qualifications, a practical component to tuition, and the venue used for aspects of the tuition method. Participants could provide an answer in more than one category.

Table 4.6: Summary of themes on suggestions to improve the method of delivery for the module 1 (n = 70)

	Frequency	Percentage
Tuition	26	37%
Qualifications	1	1%
Venue	1	1%
Nothing suggested	47	67%

The above results indicate that 67% of participants did not see the need for any improvements to be made on the module; which means they were satisfied with the manner in which the UNISA HIV/AIDS programme was presented to them.

The results that are presented here are suggestions made by 33% of the participants. Thirty seven percent (37%) of participants suggested a need for both contact teaching and learning. Workshops (to enable participants to gain better understanding of the knowledge acquired), classes, exposure and contact with other students (even if it is through e-mail or telephone), and site visits are some of the suggestions made by participants to increasing contact between them and their lecturers and with one another.

Proposed changes with regard to the methods used for assessment related to participants' dissatisfaction with the multiple-choice forms of assessments. They indicated that they were more in favour of answering questions that would challenge them to express themselves in writing. Others proposed that the multiple-choice assignment needs to be made compulsory, with the questions being altered on a yearly basis. Another group of participants expressed their preference for assessment that takes the form of a formal examination at the end of the module (these are probably participants who enrolled for the module through UCAP as its assessment does not entail a formal examination). Some participants suggested that the time that is allocated to teaching the module needs to be increased. Another sub-group of participants suggested the addition of a practical component to the module. A need to integrate theory with practice, to use challenging scenarios to better understand theory, and reference to the skills that are needed to assist people become realistic about HIV/AIDS were other suggestions that were made by the participants. A further need for more relevance in the material that was covered in the course, such as updated progress on treatment issues, was expressed. Some simply said, *"add real issues in HIV"*; implying that the issues they dealt with seemed far removed from them.

Suggestions with regard to obtaining some form of recognized formal qualification, such as a diploma, were also advanced. Others supported this suggestion from the perspective

that it would strengthen the status of the module if participants were to gain recognition at their workplaces through a form of promotion after completing the module.

A very small percentage of participants (1%) expressed dissatisfaction with the venues used for group discussions.

Suggested improvements to Module 2 also include issues relating to the method of tuition and the integration of theory with real-life experiences such as site-visits. In addition, participants added suggestions with regard to the cost of the module and the catering that is provided during the workshops.

The majority of participants (79%) felt that the duration of five days was not sufficient to cover all the activities of the workshop. Due to the fact that a lot of work had to be covered during one week, participants experienced the five days as too tiring. Participants therefore suggested that the duration of the workshop be extended to two weeks in which participants can enjoy a break in between the sessions. Another rationale for extending the workshop period to two weeks is to split theory and practice, thereby spending the first week on theory, and the second week solely on practising the counselling skills.

The impact of time constraints on participants' learning is reflected in the themes that participants identified where learning was compromised as a result of having either rushed through or dealt with these themes at a superficial level. It is clear that participants would have liked to have gone deeper into the themes in order for them to feel completely competent in dealing with the issues back in their work contexts. "*Care for the caregiver", "issues pertaining to treatment", "dealing with children in counselling", "crisis intervention" and "silence"* were some of the issues which participants felt were not adequately discussed during the workshop. Some of the excerpts from participants' responses are: "*Spend more time on Care of the care-giver", "because of time constraints we had to do much in one day", "Dealing with Children, the time was up! Time should be managed in future"* Crisis intervention: *"Although this*

was covered, I would have liked to spend more time on it" Silence: *"Mentioned but not discussed".*

Participants made suggestions relating to specific tuition matters to enhance their level of competence with counselling skills. These include the following:

- Increased opportunity to practise counselling skills

Participants suggested that regular workshops be held in order to assist them to improve their newly gained skills. This is an excerpt from one of the responses: *"Regular workshops need to be held on a number of occasions to equip counsellors to enable them to be competent." "I propose that students who complete module 2 be exposed to actual counselling sessions, preferably at the UNISA campus in order to practise our skills in an actual counselling session." "Formal presentation of a real-life situation like bringing a HIV positive patient or two and we take turns counselling them".*

- Inclusion of site-visits

Other participants expressed a need for greater exposure within the field of HIV/AIDS during Module 2 training. This is evident in this excerpt: *"Module 2 as a workshop should be completed with site visits to places involved with HIV/AIDS care giving and counselling"*

Other suggestions related to the study package which participants were given during the workshop. The majority of participants were, nevertheless, satisfied with the study package, referring to it as user-friendly and well structured. Excerpts from these participants' responses include: *"Easy to read", "Very detailed", "Was good source of reference to recap on information presented during the session", "Some of the information is very learner friendly and comprehensive. I can deal with the more difficult stuff in a more relaxed way at home", "It was everything I need to start counselling"* and *"*[*I]n the sense that one will always open and refer".* Those who were not entirely satisfied with the study package mainly made reference to the lack of references at the end of each theme or set of notes on particular themes. They felt that it would be helpful

to have such a list so that they could be able to make their own follow-up consultation with the relevant literature. These participants, however, were very few. Excerpts from their responses in this regard include: "…*The only problem I have with the file, although the content were spot on and relevant, was that there are no sources or references, except on one section i.e. HIV AIDS bereavement and referral"*

There was a general feeling that the workshop was expensive and therefore deterred most participants from enrolling for subsequent modules. They therefore suggested that a reduction in the cost of the workshop be considered. Excerpts from participants' responses in this respect include: *"Reduce the cost and make food choices not only one choice of the meal of the day", "It also seems to be expensive, especially when one has to travel from the other provinces".* Others felt that the choice of meals offered could be widened.

In summary, participants seem to be generally satisfied with the methods that were used for delivering Module 1 of the UNISA HIV/AIDS programme. Few of the participants who suggested some changes in the method of delivering the programme focused on the inclusion of interactive and practical learning. Others felt that improving the qualification of the programme will result in added value for the programme.

Time constraints seem to have disadvantaged participants' learning during Module 2; hence their suggestion that the duration of the module be extended to two weeks. In this manner, participants would be enabled to feel comfortable with their acquired skills. By further increasing participants' level of exposure to counselling, post the workshops will result in increasing participants' level of competency in counselling.

4.2.4 Conclusion

The above results indicate that participants found the UNISA HIV/AIDS training enjoyable. Most of the participants were satisfied with the methods that were used for delivering the programme. They also seem to have been afforded a good opportunity to

make the most of the learning. This is evident in their responses that reflect an active engagement with the study material and their appreciation of the practical component of the training. These responses address Kirkpatrick's questions with regard to assessing the Reaction Level of the programme (Kirkpatrick, 1996; www.business.balls.com).

In general, it seems as if the majority of participants are satisfied with the manner in which the training was conducted. This is reflected in the low percentage of participants (33% for Module 1) who indicated a need for improving the method of delivering Module 1. Participants were also generally satisfied with the methods used for delivering Module 2 as reflected in their experiences of taking part in the workshop.

Most of the participants' suggestions for Module 2 involve increasing the duration of the workshop in order to feel confident with their acquired skills (79%). This suggestion is shared by a few of the participants with regard to Module 1. Specific suggestions for Module 1 involve increasing the number of contact teaching sessions.

Perhaps, areas for consideration in improving the methods used for delivering the UNISA HIV/AIDS programme are: extending the duration of Module 2 and allowing for more interactive sessions in Module 1. This therefore addresses formative evaluation in which an attempt was made to determine whether a need to improve the process of delivering the UNISA HIV/AIDS programme exists (De Vos, 2002; Knox, 1986; Noe, 1999).

These results have addressed an aspect of the first objective of this study which is to investigate the impact of the UNISA HIV/AIDS progamme on participants' learning. The results have also addressed an aspect of the third aim of the study which is to suggest improvements to the UNISA HIV/AIDS.

4.3 KIRKPATRICK'S MODEL: LEARNING LEVEL

This section focuses on evaluating the UNISA HIV/AIDS training programme through the use of Kirkpatrick's Learning Level of evaluating training programmes. This level

evaluates the extent to which participants experienced a change in knowledge, attitude and/or skills as a result of having undergone the training (Kirkpatrick, 1996) (see Figure 4.1). An assessment of this component could cover the following questions:

- Did the trainees learn what was intended to be taught?
- Did the trainees experience what was intended for them to experience?
- What is the extent of advancement or change in the trainees after the training, in the direction or area that was intended?

By addressing the above questions, we are engaging in summative evaluation which is also the extent to which participants change as a result of participating in a particular programme (De Vos, 2002; Noe, 1999). The results of this study with regard to whether participants gained any change in knowledge, attitude and skills from participating in the UNISA HIV/AIDS programme are presented.

4.3.1 The impact of the programme on participants' knowledge

In order to ascertain the value of the programme, participants were asked why they thought they were able to gain entry into the field of HIV/AIDS post training (most of them indicated they were able to gain entry into the field). Their responses to the latter question are presented in Table 4.7.

From the themes presented in Table 4.7 it is clear that participants gained both knowledge and skills which seem to have impacted on their personal lives and their involvement in the community. This section only focuses on the knowledge theme while the other themes that are reflected in Table 4.7 will be discussed under the Kirkpatrick's Behaviour Level (section 4.4).

Most participants (89%) claim to have gained a better understanding of HIV/AIDS in terms of its nature, the method through which it is transmitted and how it is treated. It seems as if the module has particularly assisted participants to deal with the misconceptions that they might have had about the disease prior to the training.

Table 4.7: Themes indicating what participants acquired knowledge and skills from Module 1 (n = 108)

	Frequency	Percentage
They were equipped to provide HIV/AIDS-related services	22	20%
They acquired knowledge and skills in HIV/AIDS	96	89%
They were empowered to change personal circumstances	6	6%

They have also become enlightened about the fact that being infected with HIV does not necessarily imply a *"death sentence"* and that *"HIV/AIDS is a disease like any other disease"*. These changes in participants' knowledge on HIV/AIDS seem to emphasize the importance of equipping people with the correct facts and knowledge regarding the disease in order to bring about an impact in the way it is managed (DoH, 1999; UNAIDS, 2006 and UNAIDS/WHO, 2006). Excerpts from participants' responses in this respect include: "*Nobody is immune", "Realized more the disease/helped understand it better", "HIV is a disease like any other", "Realized you can live positive/its not a death sentence/can live normal live", "Realized it is treatable and fragile", "Not a sin/curse", "Show seriousness of epidemic"* and *"Aids is every bodies business"*.

In order to assess the impact of Module 2 on participants' knowledge, they were asked an open-ended question regarding how they experienced each theme that was presented in the Module and what they had learnt. In this section the knowledge gained by participants is presented in table 4.8, according to either the correction of perceptions about HIV/AIDS or the skills-related-knowledge that the participants have acquired.

Most of the participants' changes in their perceptions about HIV/AIDS-related knowledge happened during the session where an HIV-positive person was invited to share his/her experiences with the participants. The experience of just seeing an HIV-positive person seems to have been, in itself, a powerful experience that impacted on participants' perceptions regarding HIV-positive people.

Table 4.8: Impact of module on participants' knowledge

Clarification of knowledge	Skill-related knowledge
Realized an HIV diagnosis is not a death sentence	Counselling is difficult but with practice you will master it
Realized getting tested is not scary	Felt like I still have a lot to learn with counselling
Realized infected can be married and have children	Learnt systematic approach to counselling/counselling process
Realized that testing and counselling can save lives	When counselling a client, you wait for client to respond and then take it from there
Disclosure helps people to accept and heal	Must be able to read body language during counselling
Must be aware of own values and attitude in dealing with clients	Must stay with client until they break silence or stop crying
Taught to handle stress and burnout	Learnt that in counselling you help client consider options and make plans
Be calm and relaxed/don't get emotionally involved	Learnt not to push people to test
Learnt certain responsibilities with negative results, like safe sex education and window period	

Some of the excerpts of these responses include: *"thought they were thin and sickly"*, *"helpful – touched by the way the person handles her situation, how she told people"*, *"spoke freely and openly, with confidence"* and *"saw that they have a positive attitude"*. Some of the factual pieces of information that participants learnt during the workshop include knowledge about an HIV diagnosis not being the same thing as death, as exemplified by: "*that one can still get married and have children"*. They also realized the importance of disclosure on people's mental health. Participants seem to have also acquired knowledge that is related to their own values and attitudes towards HIV/AIDS-infected people. They were also exposed to important information that needs to be communicated to a client who tests negative to an HIV-test during post-test counselling.

Participants' skills related knowledge was mainly acquired during the pre- and post-test counselling sessions that they were exposed to, correcting the misconceptions they held

about the disease and those who are infected. The aspects that were learnt most from these sessions include the realization that counselling is more about the needs of the client than those of the counsellor. They also realized that counselling is a skill that needs more practice for one to feel confident and competent about.

In summary, the programme seems to have equipped participants with correct factual information about HIV/AIDS, particularly debunking the HIV/AIDS-related myths that they previously held. Participants also report that they have acquired knowledge about basic counselling skills, the processes that need to be followed during counselling and the manner in which they need to contain their clients' emotions.

4.3.2 The impact of the programme on participants' attitudes

Participants were asked to indicate, through an open-ended question, whether Module 1 had affected their attitudes in any way. Participants' responses were categorized into themes and are presented in Table 4.9 according to the three main areas of focus.

The majority of participants feel that studying the module has affected their attitude towards HIV/AIDS in general, towards those who are infected and affected by HIV/AIDS and has also challenged their own personal reactions to HIV/AIDS as a disease. There are those who indicated that going through the module did not affect their attitudes in any way. The following are the themes which cover participants' responses.

From the results, it is clear that the majority of participants' attitude toward those who are infected and affected by HIV/AIDS had been greatly influenced by studying the module. Studying the module seems to have challenged participants to treat those who are infected and affected by the epidemic with respect and not to judge or discriminate against them (66%). This change in attitude will facilitate the destigmatization of the disease.

Table 4.9: Themes of the module's impact on participants' attitudes (n = 99)

	Frequency	Percent
Better understanding of the disease and its impact on the infected	36	36%
Non-discriminatory behaviour towards the infected and the affected	65	66%
Displaying positive feelings towards the infected	45	45%
No change in attitude	8	8%

It seems as if some participants' myths about infection were also debunked in the sense that where participants had held incorrect information regarding the transmission of HIV/AIDS, which led to discriminatory behaviour against the infected, studying the module seems to have corrected these misconceptions, thus leading to non-discriminatory behaviour.

Module 1 seems to have affected participants' unpleasant and negative feelings that were held towards those who are both infected and affected by HIV/AIDS (45%). Whereas participants used to feel scared, ignorant, fearful and insensitive towards those infected, they express change towards being more confident in dealing with both the infected and the affected as well as being tolerant towards them.

With regard to the impact of Module 2 on participants' attitudes, participants indicated that the workshop seems to have positively impacted on their attitude towards those who are infected with the HI-Virus. This change in attitude seems to have resulted from exposure to the various themes of the workshop, particularly the one that dealt with an HIV-positive speaker and the one on attitudes and self-awareness. Below are some of the responses:

- Changed view of infected/ More positive attitude towards infected.
- Will now not ever be shocked again but will give attention and support.
- Reduce discrimination/give respect and rights to infected.
- Encourage acceptance.

- Changed stereotyped attitude/learnt not to be prejudiced and not to judge people.
- Helped to think before acting.

The responses of participants for both Module 1 and Module 2 are similar and reflect the positive impact that the programme has had on the participants with regard to their attitude towards those who are infected as indicated in Table 4.10. It seems as if the more participants possess correct factual information about HIV/AIDS, the more positive their attitude towards those who are infected and affected by the epidemic becomes. Through this newly-acquired information about HIV/AIDS, participants seem to have been further challenged to gain a deeper understanding of the epidemic and to begin to engage in HIV prevention work.

4.3.3 The impact of the programme on participants' skills

Participants were asked whether the programme had enabled them to acquire any skills. Their responses in relation to the impact of Module 1 on their skills acquisition ranged from learning communication and interpersonal skills, learning skills to assist the HIV-infected and affected, research skills, to personal empowerment. Some participants however, indicated that they did not learn any skills from this module. Table 4.11 presents the themes from participants' responses.

An overwhelming majority of participants (91%) indicated that they had learnt skills that were related to managing HIV/AIDS. Given that the module was intended to provide basic knowledge regarding HIV/AIDS care and counselling, perhaps the results reflect the success of the module. An examination of the responses given under this theme indicates that the skills learnt by the participants include those that are needed to interact with those who are infected, in a spirit of acceptance and respect. They also learnt how to care for and assist those who are infected and affected by the disease. The module seems to have also equipped them with the skills to recognize and utilize opportunities within their communities for HIV/AIDS education.

Table 4.10: Detailed descriptions of the impact of Module 1 on participants' attitudes

Towards the infected and affected	Towards the self	Towards the disease
Changed attitude towards stigma of HIV-infected people	More challenging than I thought	Changed attitude towards HIV
Respect people who are affected more/view of infected people changed/respect and care for infected/compassion/accept infected/should not discriminate	More cautious	Gave more interest in learning about the disease
Realized not just a disease for sinners	More tolerant	Aids is everybody's business
Realized there is more to the reaction of infected people	Scared before but confident now/removed fear	Realized it is treatable and fragile
Realized major effect it has on individuals Developed love and support for infected/must give advice/help them	Want to further studies on HIV	
Realized to maintain friendships of infected/can work with infected	Needed to have more info/have more knowledge about disease/understand facts/more exposure	
Accept infected because they can't infect me/not afraid of them any more	Can make a difference to those infected/also affected because colleagues are infected	
Learnt to treat and deal with infected	Enable to be more involved in community around HIV	
Understand situation of people infected and affected	Was ignorant and insensitive	
Understand how people feel	Feel you are also infected	
How to approach people when they gossip	Began to think more deeply about it	
	Must take care of yourself/be aware and careful	
	A lot still to be learnt	
	Do not judge people	
	Take responsibility	

Table 4.11: Themes of Module 1's impact on participants' skills (n = 96)

	Frequency	Percentage
Communication and interpersonal skills	52	54%
Skills related to managing HIV/AIDS	87	91%
Personal empowerment	6	6%
Research skills	2	2%
No skills learnt	1	1%

Other skills learnt involve how to prevent HIV infection through the correct use of condoms and living positively. These skills will contribute towards eradicating discrimination against, and stigmatization of, those who are infected and affected by HIV/AIDS. They will also contribute towards providing appropriate care and support for both the infected and affected.

The module seems to have also equipped participants with communication and interpersonal skills (54%). In this regard, some participants indicate that they learnt basic skills such as reading and writing. Perhaps, this was a skill that was acquired through participants having to study on their own; through the distance mode of learning and through having to submit the portfolios for assessment. For others, it seems as if the module has enabled them to effectively interact with others in the community, especially those who are infected and affected by the disease. Studying Module 1 seems to have encouraged participants to self-reflect on their attitude towards the infected and affected, challenging these attitudes in order to enable them to effectively interact with the infected and affected. The module seems to have further equipped participants with skills to openly talk about their feelings, to listen, to guide and to assist with problem solving. All these skills are essential to make the infected and affected people feel accepted and part of the community, again contributing towards eliminating discrimination and ostracism.

A small percentage of participants (6%) acquired skills to empower themselves. They say that they have learnt how to be confident in sharing their problems, opinions and viewpoints with others, in seeking help timeously and how to disclose their HIV status.

Other skills mentioned include life skills and skills to personally use protection to prevent HIV infection. The module seems to have not only equipped participants with skills to assist with combating the spread of the epidemic in the community, but it also made them realize that they too have personal responsibility towards ensuring that they behave in a manner that does not put them at risk of infection.

A very small percentage of the participants acquired research skills (2%) and only 1% felt they did not acquire any skill from the module. Although research skills did not form part of the main outcomes for this module, some participants might have indeed learnt from the experience of engaging in the small research component of the module. I presume that those who did not acquire any skill in this respect fall under the category of those who mentioned earlier that they did not learn anything from the module as they already had the knowledge. Some responses did not seem to fit in with the question asked and seemed to relate more to knowledge that participants acquired studying the module. These responses are included under "other skills". Table 4.12 illustrates a detailed description of participants' acquired skills.

Participants' responses on the impact of Module 2 on their skills acquisition are more related to HIV/AIDS counselling skills, an outcome which is in line with the main objectives of the module. These are presented in Table 4.13.

The skills that participants have acquired during Module 2 relate to the skills that are needed to form the basis of a counselling relationship and those that are specific to pre- and post-test HIV counselling. It seems as if participants' emphasis is more on basic counselling skills. This is not a surprising finding since most of them became exposed to a counseling relationship for the first time in the workshop. Therefore, counselling is a new experience to them as they are still grappling with the basics. It is, however, encouraging that there are other participants whose responses were more focused on HIV counselling. There were a few responses that acknowledged the fact that counselling is a process which one only masters through more practice.

Table 4.12: Detailed descriptions of the impact of Module 1 on participants' skills

Manage HIV/AIDS	Communicate	Personal empowerment	Other
To understand patient situation/sympathy/treat them as humans/accept them	Listening skills	Disclosure	Research
How to deal with suffering people/how to approach and assist infected/affected	Learn to guide	To seek help timely and be open about a problem	Life beyond HIV infection
How to care and nurture suffering people/help sick/advise on how to eat/caring	To be open and talk about things like feelings	Confidence in myself/to express point of view/open about questions	newborns can be tested
Counselling skills	Communication skills	To use personal protective equipment	Practical course is NB
Use situations to educate people/how to educate/explain to community essentials	Give advice correctly/advice	Life skills	different test types
Infected people trust-keeping their secrets	Interpersonal skills		Learnt terms/info
Pre- and post-testing skills/skills for telling clients results	Problem solving		
Treatment	Interact in discussions		
Prevention	Do away with blame and be truthful to self		
Comfort infected/affected	Facilitating		
Set up and guide support groups	Reading and writing		
Management of infection			
Condom usage			
Positive living			
Empathy			

Table 4.13: Detailed descriptions of skills learnt from Module 2

Basic counselling skills	Specific to HIV counselling
Unpacking a problem	Presenting facts about HIV to client
Attending to a client	Immediate feedback giving results/try to convince not to go immediately after receiving results
Listening	Pre-test counseling
Questioning	
Not to talk too much/help person tell his/her story/let client do the talking	
What to do when first meeting a client	
Diagnosing skills/assessment skills	
Observing skills	
Feeling/empathy/managing emotions/was able to pick up the correct words about feelings of the client/learnt to reflect feelings	
Help direct/move client forward/help client consider options and make plans/empowered me with skills to explore options in counselling session	
Being non-judgmental	
Got practice in what to do and what not to do when solving problems/exposed to steps to follow when solving problems/got methods to try and help solve problems	
Confirmed skills I already had	
Had a chance to evaluate myself and counselling skills learnt	
Validated knowledge and enhanced skills through presentations and group inputs	
Listening skills learnt	
Practical part made you see pitfalls and so be able to change your way of counselling/can see where I make mistakes in counselling and fill gaps	

The skills that the UNISA HIV/AIDS programme has equipped the participants with seem to be a result of both anticipated and unexpected outcomes (Weiss, 1998). The outcomes that were expected from studying the programme relate to skills associated

with managing the epidemic, communication (in the context of HIV/AIDS education) and counselling skills. The outcomes that are unexpected and have resulted from the module in the present study relate to interpersonal skills, skills for empowering themselves and research skills.

4.3.4 Suggestions for improving participants' learning

Participants were given an opportunity to suggest topics that could still be included in the UNISA HIV/AIDS programme which would enhance its value.

A vast majority of participants (83%) are satisfied with the themes that were covered in Module 1 and only a small percentage (17%) have expressed a need for the inclusion of other themes in the module. The responses on the suggested themes are presented in Table 4.13 (multiple responses are possible).

Of the 17% of this group of participants, 14 expressed the need for detailed specialized knowledge on HIV/AIDS issues and another 14 expressed the need for programme related issues.

Table 4.14: Themes to be covered in Module 1 (n =-34) – Multiple response possible

	Frequency	Percentage
Detailed, specialized knowledge	14	41%
Skills and a practical component	13	38%
Updated research and statistics	2	6%
Networking information	5	15%
Programme-related issues	14	41%

An analysis of the participants' profile and the reasons for enrolling for this module may, perhaps, shed some light on why participants have a need for this kind of information to be included in their training. Being in administrative positions requires that participants be able to implement HIV/AIDS programmes within their workplaces, the prerequisite of

which would be a comprehensive and thorough knowledge of HIV/AIDS related issues. Their positions might also require them to be competent in designing programmes and be familiar with the criteria for successful intervention programmes. There were some participants who wanted a chapter on psycho-immunology to be added to the syllabus, while another small group of participants wanted a clearer explanation of the nature of the disease. The group on psycho-immunology might be part of the small percentage of participants who felt that they did not learn anything from the module. This might be alluded to the fact that they already had the knowledge and they just wanted the certificate.

Thirteen participants out of the 17% expressed a need for a practical and skills component to Module 1. Again, given the nature of HIV/AIDS, it would not only be sufficient to impart HIV/AIDS knowledge, but at times the participants might be required to manage or facilitate the psychological consequences of HIV/AIDS infection. However, the main objective of Module 1 is to equip participants with a theoretical foundation of HIV/AIDS education, care and counselling.

Five participants in this group of participants expressed a need for networking with other sectors such as the government in combating the spread of HIV/AIDS. Given the multi-sectoral and multidisciplinary nature of HIV/AIDS, this need becomes inevitable. Perhaps the nature and ranks of the participants' jobs require that they not only focus on HIV/AIDS education, but also liaise with other relevant stakeholders, hence the need for such a skill.

The nature of work in the area of HIV/AIDS is such that a constant update on the spread of the epidemic and new developments in the field is necessary. There were some amongst the participants who were already involved in HIV/AIDS work prior to enrolling for Module 1 and perhaps the 2% of participants who requested this information are already aware of its necessity. With participants expected to be at the entry level as regards HIV/AIDS information and in line with the module's objectives, it is not expected for participants to already have such information. However, during training

participants are provided with updated information as a result of their prescribed textbook being updated on a regular basis.

The evaluation of the impact of the UNISA HIV/AIDS programme in relation to Module 2 was done twice: during and post-training. As a result, some of the responses to the participants' questions in this module will be presented twice.

4.3.4.1 Assessment during training

Participants outlined a number of themes which they felt needed some focus in Module 2. Some of the issues were already included in the Module, but participants reiterated their inclusion, perhaps more in terms of the amount of time that was needed to be allocated to the themes for a deeper understanding. The following are some of the suggested themes:

- Treatment issues
- Facts on HIV/AIDS
- Research on HIV/AIDS programmes
- HIV/AIDS programmes
- Counselling children
- Sexual trauma counselling
- Crisis intervention
- Facts on prevention
- Cultural issues and language barriers
- Spend more time on care for the care giver
- Silence

Detailed responses in which participants elaborated on why they suggested certain themes to be included in the module are presented below:

- The need for updated information on HIV/AIDS

It emerged from participants' responses that they required updated information with regard to research on HIV/AIDS treatment and developments in the AIDS field in general. Some of participants' excerpts in this regard include: *"a resources kit on status of research in the area is needed", "what are the latest results indicating?", "Medication: what are new on the market?", "who qualifies for free medication and to what extent?"* and "*thought some discussion the pattern of the disease/demographics of the pandemic would have been helpful".*

- HIV/AIDS programme-related themes

Other participants expressed particular interest in having some information on HIV/AIDS programmes included in the Module 2 syllabus. Although they acknowledged that this theme does not necessarily form part of this module, they nonetheless felt its inclusion will enrich the module. For example, in one participant's words, "*while this is not a course on programme, some tips of programme effectiveness could have enhanced the depth of the course".*

- Allocating more time to adequately address certain themes

Some of the themes that were suggested above for inclusion were already covered in the module but their inclusion was as a result of the dissatisfaction with the amount of time that was spent on them. Excerpts from participants' responses include: *"Spend time on care for the caregiver", "silence", "Treatment: Not enough was done regarding treatment. Many times informed clients want specific answers on treatment"* and *"Counselling children: Different emphases and information needs to be given to children that will not prevent them from living as 'normal' children do, without instilling fear or a sense of being different".* The module did cover the theme on counselling children. The fact that it emerges as one of the themes that need to be included in the module indicates that not much time was spent on dealing with all the essential issues. This idea supports the suggestion made in section 4.2.3 on extending the time for presenting Module 2.

- Improvement of themes that were covered

Some participants were not satisfied with the manner in which the theme on HIV prevention and safer sex practices was dealt with during Module 2 training. They therefore suggested the following with regard to the theme:

- *"How to use a condom males/female. Too much was said on actual sex, prostitutes than real facts!. Never use that pornographic cassette where the prostitute used her mouth to put condom on the client's penis. It is disgusting."*
- *"Prevention, sexual behaviour and behaviour change. No linkage of information"*
- *"Prevention in traditional Africa. Because they believe in traditional things they need to be taught about the facts and the differences between myth and fact. Maybe they can change".*

This is consistent with participants' earlier responses on their experiences with this aspect of the training. The section was reported to have been confusing and not well structured.

- Counselling specific issues

Suggestions for including themes that were specific to counselling were also made. Excerpts from participants' responses include: "*Sexual trauma counselling: e.g. rape. Rape and HIV counselling need to be done at the same time", "Cultural issues and language barriers: I find it difficult to counsel cross-cultural and especially language barriers."*

4.3.4.2 Assessment post-training

This section of the results will be presented in a different format from the one that was being used throughout the chapter as the assessment adopted a purely qualitative approach. Participants were asked to submit their experiences of being involved in HIV/AIDS work in their respective communities in the form of a life story.

In general, participants seemed satisfied with the contents of the UNISA HIV/AIDS programme except for very few things. One participant in particular expressed strong feelings related to the section on safer sex practices that is presented during the Module 2 workshop. An excerpt from her life story goes thus: *"The last session, presented by a sexologist, was the only part of the course that was a total waste of time. We learnt nothing, except to be exposed to the special talents of the therapist' children. Either it needs to be excluded from the course, or the content of that session needs to be revised".*

Another aspect that was suggested for consideration in the programme is the exposure to other alternative forms of managing HIV/AIDS given the diverse nature of the South African cultural landscape. This is evident in this excerpt: *"The HIV/AIDS course must say something about the contribution (whether bad or good) that can be made by our traditional healers in and outside the South Africa with specific reference to treatment of HIV/AIDS. Because HIV/AIDS infections are a big problem to every inhabitant of South Africa and Africa at large, let everyone be involved in an attempt to defeat this monster HIV/AIDS".*

One participant's suggestion for improving the present programme was related to the theme of infection control, with particular reference to the medical context. This is evident in the excerpt from her life story: *"Because of working in the field of HIV/AIDS method of discarding the used needle and syringes in the waste bin is emphasized. To discourage staff from trying to disconnect the needles from the surface because they can prick themselves".*

These participants' suggestions for improving Module 2, although not representative of the population of participants that studied the module, may be reflections based on observable and real needs within their communities. It would therefore be in the interest of improving this module to consider these suggestions.

4.3.5 Conclusion

The UNISA HIV/AIDS programme has resulted in a change in participants' knowledge, attitudes and skills with regard to HIV/AIDS and those who are infected and affected by it. Participants have learnt correct (factual) information about HIV/AIDS, and information relating to basic HIV/AIDS counselling skills. This has enabled them to dispel the myths that had influenced their feelings, behaviour and perceptions about the disease, and those that are infected and affected by it. By following the programme, they are better able to communicate with people in general, and appropriately disseminate HIV/AIDS prevention messages. Participants have been empowered to handle their challenges better since studying the programme and can conduct HIV/AIDS counselling.

Participants were generally satisfied with the themes that are covered in the UNISA HIV/AIDS programme. Most of the themes that were suggested for improving the programme are not in keeping with the objectives of the module. However, these suggestions are accommodated in other relevant modules within the programme. It is important to note that the suggestions relating to time constraints and the theme on HIV prevention and safer sex, support the suggestions which were made earlier with reference to these matters. Suggestions relating to the inclusion of cross-cultural counselling, sexual trauma counselling and multiple perspectives to managing the epidemic within the South African context, though advanced by a very small percentage of participants may be valid and therefore require further consideration.

The results that have been presented in this section indicate that participants seem to have learnt certain aspects of what the UNISA HIV/AIDS programme intended for them to learn and that the programme has also resulted in changing participants' knowledge, attitudes and skills as regards HIV/AIDS. The following aspects of the programe did not particularly draw much of the participants' interest: HIV and the immune system; HIV/AIDS-related symptoms; prevention in traditional Africa; support for orphans and other vulnerable children; as well as infection control and legal, ethical and policy issues. This is perhaps a reflection of the participants' needs, which seem to be the foundation

needed for engaging in HIV/AIDS work. Kirkpatrick's Learning Level of evaluating the UNISA HIV/AIDS programme has been adequately satisfied, thus addressing summative evaluation. This has addressed the first aim of the study, which was to assess the impact of the programme on particpants' HIV/AIDS knowledge, attitudes and skills.

These results have also addressed the second aspect of the first objective of this study, which is to investigate the impact of the UNISA HIV/AIDS progamme on participants' learning. They have also addressed an aspect of the third aim of this study, which is to suggest improvements to the UNISA HIV/AIDS programme.

The section that follows addresses Kirkpatrick's third level of evaluating training programmes, which is the Behaviour Level.

4.4 Kirkpatrick's model: Behaviour Level

The Behaviour level of Kirkpatrick's model assesses the extent to which a change in behaviour has occurred in the trainees as a result of having undergone training (Kirkpatrick, 1996) (see Figure 4.1). In order to assess this level, the following questions are asked:

- Did the trainees put their learning into effect when back on the job?
- Were the relevant skills and knowledge used?
- Was there noticeable and measurable change in the activity and performance of the trainees when back in their roles?
- Would the trainee be able to transfer his/her learning to another person?
- Is the trainee aware of his/her change in behaviour, knowledge or skills level?

Part of what this level measures is the participants' ability to transfer their training into their work environment (Noe, 1999). In the present study this level was assessed through investigating the impact of the UNISA HIV/AIDS programme on participants' involvement in HIV/AIDS work post-training. Firstly, participants were asked about their involvement in HIV/AIDS work prior and post to enrolling for the programme.

They were then asked to indicate which aspect(s) of the programme was (were) found most useful in their involvement in HIV/AIDS work in their communities. Participants had to further indicate the various community contexts within which they were able to apply these identified aspects. Thirdly, participants were asked if the training had, in any way, impacted on their own personal behaviour, thus noting HIV/AIDS related changes in behaviour as a result of having participated in the programme. The results are therefore presented according to these three aspects; that is, involvement and entry into the field of HIV/AIDS prior and post the training, aspects of the programme that were found useful to apply in the communities and the impact of the programme on their personal lives.

4.4.1 Involvement and entry into the field of HIV/AIDS

Since most of the participants (62%) had done Module 1 sometime before (5% during 2002, 57% during 2004 and 33% during 2005) they were also asked about their involvement in HIV/AIDS work post attendance of Module 1. Thirty eight percent (38%) said that they were involved prior to enrolment, while 58% said that they got involved only after enrolling for the module.

Participants were further asked if they believed that Module 1 assisted them to gain entry in the field of HIV/AIDS. A large percentage of participants (84%) said that Module 1 has assisted them in gaining entry into the field of HIV/AIDS.

A cross-tabulation was also performed with regard to participants' experience in the HIV/AIDS field and the degree to which Module 1 has assisted them to gain entry into the field of HIV/AIDS. Participants' results on this question are presented in Table 4.15.

From participants' responses it appears that the course facilitated their entry into the field of HIV/AIDS. A closer look at the cross-tabulation between experience in the field of HIV/AIDS and entry into the field of HIV/AIDS after completing the module reveals that

Table 4.15: Cross-tabulation between experience in HIV/AIDS and entry into the field (n = 108)

Prior experience in HIV		Gained entry into the field	
		Yes: helped	No: did not help
	Yes experience	27%	7%
	No experience	56%	9%

a large percentage of those with no HIV/AIDS experience prior to enrolling for the module gained entry into the field of HIV/AIDS after passing the module (56%). The reasons advanced for this were related to the fact that the module had equipped them with the necessary HIV/AIDS knowledge and skills to provide HIV/AIDS-related services. Excerpts from participants' responses include: *"got opportunity to counsel"*, *"involved in voluntary training and counseling volunteer at hospitals"*, *"put in specialist program in department"*, *"had a certificate"*, *"gained respect"*, *"feel more qualified"*, and *"gain respect of people who are infected"*. By virtue of the fact that they had completed Module 1, some felt this adequately enabled them to provide HIV/AIDS-related services within their respective communities. For others, merely having a certificate in HIV/AIDS care and counselling was sufficient to enable them to provide services in their communities. For others, being able to gain respect from their colleagues and the community as an HIV health worker provided what was needed.

Others stated that it was through having studied Module 1 that they were challenged to get more involved in HIV/AIDS work in the community.

In dealing with this particular aspect of the evaluation with regard to Module 2, data resulting from the analysis of the participants' life stories is presented in a qualitative format. As was the case in Module 1, some participants were involved in HIV/AIDS work prior to enrolling for Module 2 while others only got involved in HIV/AIDS work post the training. Those who were not involved in HIV/AIDS work before the training reported that they encountered various challenges in their efforts to gain entry into the field post training.

One participant (A) listed the following as some of the reasons that led to her devastation when she realized she could not get employed: *"I had to enroll to do in-house training at a cost", "Some government organizations did not employ volunteer workers", "I did not have experience".* Another participant (B) was also frustrated in her attempt to get involved in an Employee Assistance Programme (EAP) where she was hoping to implement her acquired knowledge and skills in HIV/AIDS. The following is an excerpt from her life story: *"I apply for a position in the bank as EAP, I thought I had all it takes to have the position. People who interview me were happy about me and the interview went so good, I supposed. But they never call me for an approval. That never discouraged me I keep on assisting people who need the support."* This second participant is now involved in an organization that caters, amongst others, for people who are infected with, and affected by, HIV/AIDS, although not directly. I will tell her story later. Another participant (G) also told about the challenges she encountered whilst seeking employment relating to HIV/AIDS matters. This is an excerpt from her life story: *"I haven't worked in the field of HIV, not because I am not interested. I've gone to many organizations to ask if I could volunteer, but I was rejected, maybe because I am studying because at one of these organizations I was told that we students only want experience, after that we go for greener pastures. They told me they wanted people who will stay with the organization for a long time".*

On the other hand, those participants who were already involved in some form of HIV/AIDS-related work prior to enrolling for Module 2 found themselves easily integrated into HIV/AIDS work post the training. For others, their level of involvement in HIV/AIDS work post enrolment increased. One participant (E) shared how his deficient knowledge in HIV/AIDS influenced his work responsibilities and how he, having undergone the UNISA training, was empowered to participate fully and meaningfully in his HIV/AIDS responsibilities. This is an excerpt from his life story: *"[S]omewhere in 2002, education department devoted its intention to take educators to inservice training based on lifeskills…the training was not up to scratch as they were not fully equipped and conversant with HIV/AIDS matters. I witnessed this as I was part and parcel of these educators…after being redeployed from one circuit to the other, I was*

requested to offer Life Orientation as one of the subjects in grade 5 – the grade 5 syllabus contained HIV/AIDS part". The same participant later shares how the UNISA HIV/AIDS programme upgraded his HIV/AIDS knowledge and subsequently influenced his career. *"As I was busy with HIV/AIDS module I at UNISA, I got background information to start teaching learners Life Orientation. In 2005 I was requested to teach Life Orientation in grades 6 and 7. It was hectic to me to teach these grades as I was having enough HIV/AIDS information…I enrolled for module 2 HIV/AIDS to increase my knowledge on HIV/AIDS…Learners enjoyed my HIV/AIDS lessons greatly. Studying the course on HIV/AIDS impacted positively on my teachings at school level…Even this year 2007 I devoted my intention to offer extra lessons on HIVAIDS after school. The principal even appreciated what I am doing".*

Another participant (F) who was already engaged in HIV/AIDS work prior to enrolling for the programme says the following: *"[I]t became easier for me to conduct the no apologies programmes for the Grade 7 learners. As I am a Life Orientation teacher in Grade 7 I am now able to solve the problems of most teachers."*

Participant (I) indicated that before she enrolled for the UNISA HIV/AIDS programme she was not concerned about certain HIV/AIDS related issues, but the programme later influenced her actions and attitude pertaining to the same issues. An excerpt from her life story goes thus: *"At my place of work it didn't have a meaning or make a difference to me when the patient did not take the niverapine before delivery or taking it an hour or six hours before delivery…"* The participant goes on to say that: *"After enrolling for the UNISA programme I was able to change and make the difference because I explain to staff that we need to check the results of the patients when goes into labour in order for us to give the niverapine if positive six hours before delivery and be able to give report to labour ward staff that niverapine given after how many hours for them to know how long must the baby get niverapine syrup".*

The above results show how much easier it was for those who were already engaged in HIV/AIDS work prior to enrolling for the UNISA programme to continue implementing

what they had learnt, as opposed to those who were not previously engaged in HIV/AIDS and had to struggle to find their way into the field. Most of the latter group are now involved in HIV/AIDS work as it will be evident later when I describe their kind of involvement in HIV/AIDS work. The manner in which they eventually found entry into the field of HIV/AIDS reflects the confidence that participants seem to have in the programme as also reported by participants with regard to Module 1.

4.4.2 Aspects of the UNISA HIV/AIDS programme which were found most useful and their applicability

To assess the aspects of Module 1 that were found useful by participants for use in the community, a quantitative approach was adopted where participants were given a list from which to tick the aspects of the programme found most useful in descending order. The following are the themes that are covered in module 1: *fundamental facts about HIV/AIDS, prevention and empowerment in the HIV/AIDS context, HIV/AIDS counselling, care and support for the person living with HIV/AIDS; and legal, ethical and policy issues*. Participants' responses in this respect are presented below, starting with the results for all the five different areas summarised and thereafter presenting a break-down of each theme in greater detail. Figure 4.2 presents the percentages reflecting participants' assessment of each theme's level of usefulness.

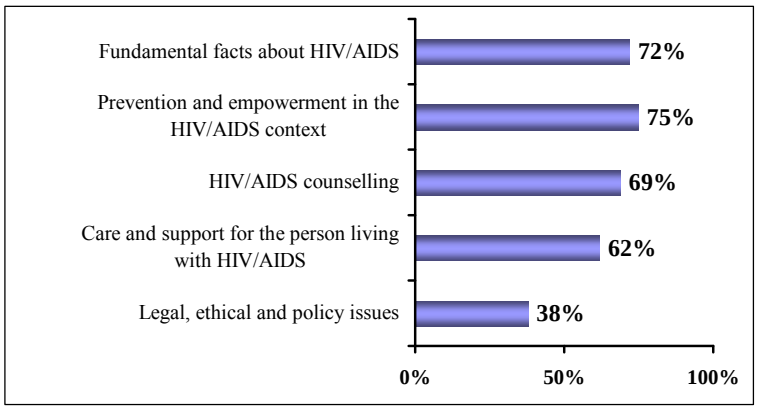

Figure 4.2: Percentage of aspects of Module 1 that were found most useful (n=116)

Most participants found the different aspects of Module 1 useful for use in their community, with the notable exception being, "legal, ethical and policy issues", where only 38% indicated that it was useful.

Of these five aspects of Module 1, "prevention and empowerment in the HIV/AIDS context" was the aspect found most useful (75%), followed by "fundamental facts about HIV/AIDS" (72%), followed by "HIV/AIDS counselling" (69%) and "care and support for the person living with HIV/AIDS" (62%). As indicated, the aspect rated least useful was the "legal, ethical and policy issues". Given the fact that the main aim of Module 1 is to provide orientation and background to HIV/AIDS care and counselling, these ratings somewhat make sense as they are related to aspects of HIV/AIDS that assist with managing HIV/AIDS, be it through education, prevention or counselling. This is consistent with the reasons that most participants advanced for enrolling for this module (see table 4. 16 below). Most indicated that they wanted to acquire knowledge and skills in HIV/AIDS (49%), while another 19% indicated the need to get involved in HIV/AIDS work.

Each of the five themes that are covered in the module was examined in detail, with participants identifying useful sub-themes within each main theme and the context within which it was most applicable. The contexts include work, community, social circle and personal life.

Table 4.16: Reasons for enrolling for Module 1 (n = 115)

	Frequency	Percentage
To acquire knowledge and skills on HIV AIDS	56	49%
To intervene in the field of HIV/AIDS	22	19%
Identified need at the workplace	15	13%
The high prevalence of HIV/AIDS	8	7%
Interest in HIV/AIDS and health issues	7	6%
To obtain a qualification	3	3%
Personally being infected and affected by HIV/AIDS	3	3%
Personal empowerment	1	1%

The results of the various sub-themes within each main theme are presented below, with each sub-theme being reported together with the context within which it is most applied.

4.4.2.1 Useful aspects of the fundamental facts about HIV/AIDS and their applicability

Fundamental facts about HIV/AIDS comprised five sub-themes, namely *HIV/AIDS origins and effects, transmission of HIV, HIV/AIDS-related symptoms and diseases, diagnosis of HIV infection and AIDS and management of HIV infection.* Figure 4.3 presents participants' responses to the aspects of this theme.

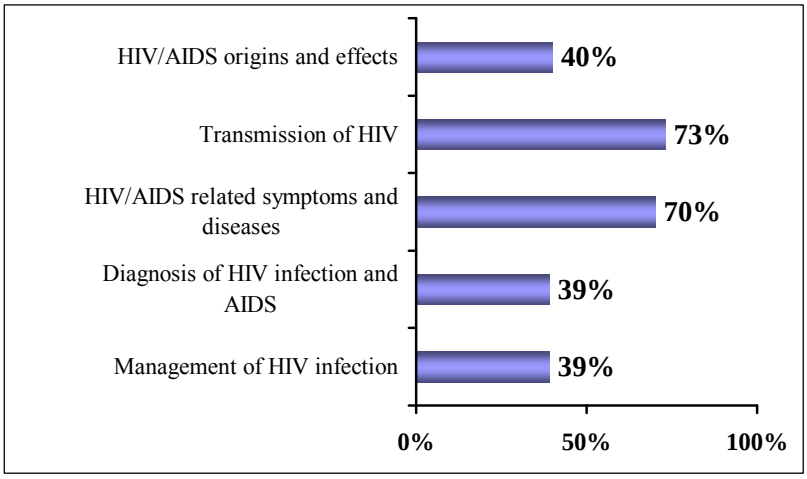

Figure 4.3: Percentage of useful sub-themes on *Fundamental Facts*

The majority of participants found the sections on the transmission of HIV (73%) and HIV/AIDS-related symptoms and diseases (70%) most useful as compared to the other sub-themes. The sub-themes that were found least useful are HIV/AIDS origins and effects (40%), diagnosis of HIV infection and AIDS (39%), and management of HIV infection (39%). Given participants' educational background and occupations, it makes sense that the majority find "transmission of HIV" and "HIV/AIDS related-symptoms and diseases" most useful as they related to basic information on HIV/AIDS. HIV/AIDS origins and effects, diagnosis of the infection and the management of HIV infection refer to the more technical aspects of the disease which might not be the main needs of the

participants at this stage. These technical aspects seem associated with health-related fields and might also be the reasons why this group of participants does not find them useful, given their occupations and educational background. These findings are consistent with participants' acquired knowledge as reflected in the previous section on HIV transmission.

In general, participants are able to apply the fundamental facts about HIV/AIDS within their various contexts. The majority of participants are able to apply this within their work (75%) and personal contexts (72%). The community context (65%) is another area where this information is applied, followed by the social circle (55%). These results might suggest that participants' work and personal life contexts require more information on basic facts as opposed to the technical and management aspects of the disease.

Figure 4.4 presents participants' responses on the various contexts within which they are able to apply the theme on fundamental facts.

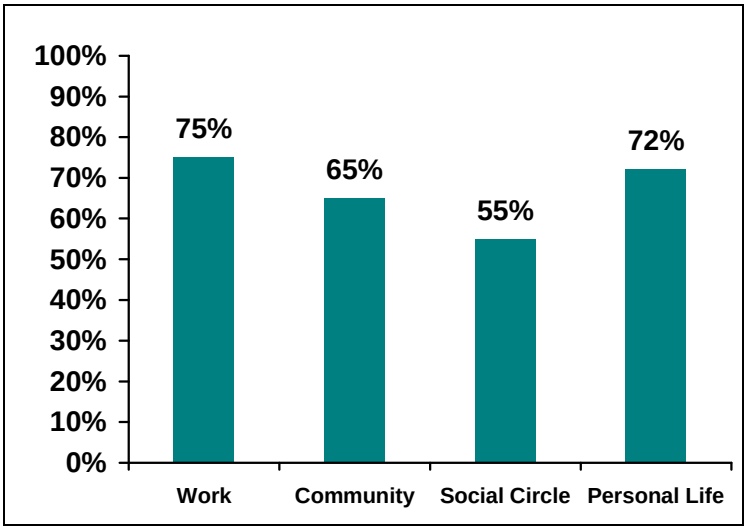

Figure 4.4: Application of *Fundamental Facts*

4.4.2.2 Usefulness of aspects of prevention and empowerment in the HIV/AIDS context and their applicability

This is the theme that was found most useful by the participants in Module 1. It also consisted of various sub-themes, whose usefulness and applicability were also assessed. Figure 4.5 presents participants' responses to this theme.

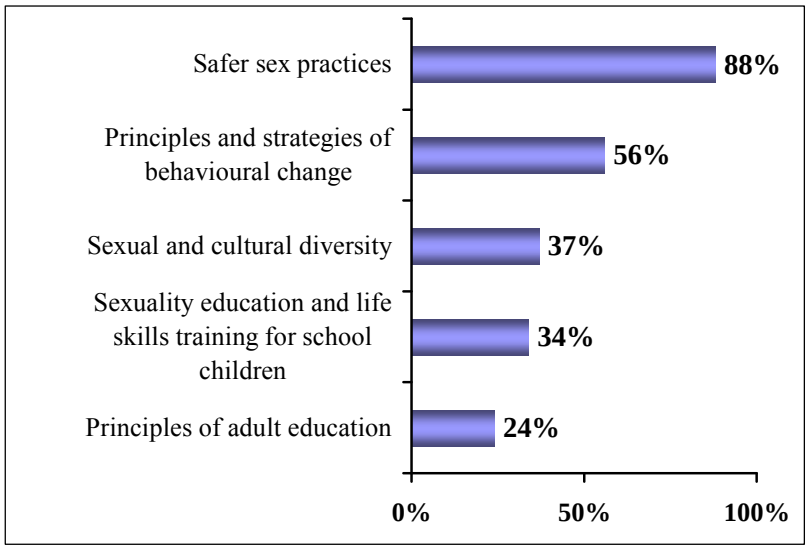

Figure 4.5: Percentage of useful sub-themes on *Prevention and Empowerment*

The sub-theme on safer sex practices was found to be the most useful (88%) under the prevention and empowerment theme, followed by principles and strategies of behavioural change (56%). The least useful sub-themes were sexual and cultural diversity (37%), sexuality education and life skills training for school children (34%) and principles of adult education (24%). The fact that sexuality education and life skills training for school children is an optional track in the training programme (which was not necessarily taken by all the participants), might account for this sub-theme being rated as less useful. Safer sex practices and principles and strategies of behavioural change are themes that are normally useful when dealing with HIV/AIDS education, perhaps accounting for their applicability within participants' environments. These aspects form part of basic information on HIV/AIDS and perhaps this further explains its usefulness to the participants. It is also possible that the applicability of these sub-themes reflect

HIV/AIDS needs or areas of emphasis in these participants' respective communities. With regard to the knowledge that was acquired during the module, participants did not identify this as one of the areas that was found most useful.

The theme on prevention and empowerment is applicable across all contexts: work, community, social circle and personal life. However, it seems as if the theme is mostly applied within participants' personal lives. This is indicative of the fact that the module has affected participants' behaviour. Again, this might reflect an emphasis of prevention efforts within participants' environments. Figure 4.6 presents the various contexts within which the theme of prevention and empowerment can be applied.

4.4.2.3 Usefulness of HIV/AIDS counselling and its applicability

HIV counselling was one of the most useful (69%) themes in Module 1. It also consisted of various sub-themes.

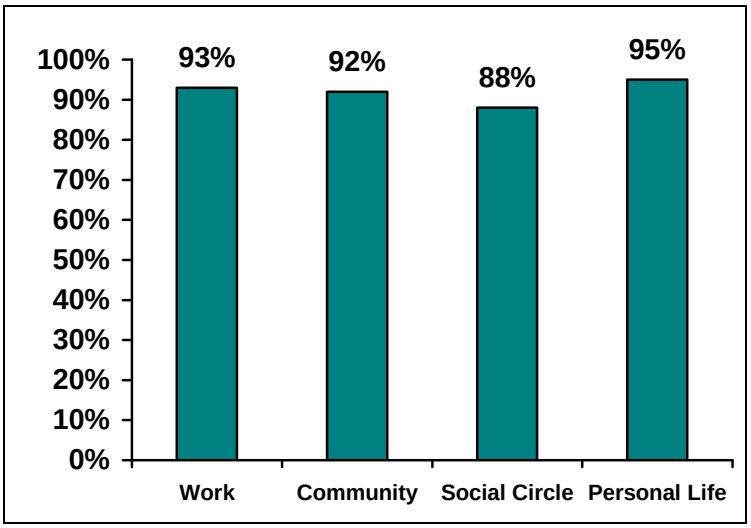

Figure 4.6: Application of *Prevention and empowerment*

Figure 4.7 below, presents the results of participants' responses to the usefulness of the HIV/AIDS counselling theme.

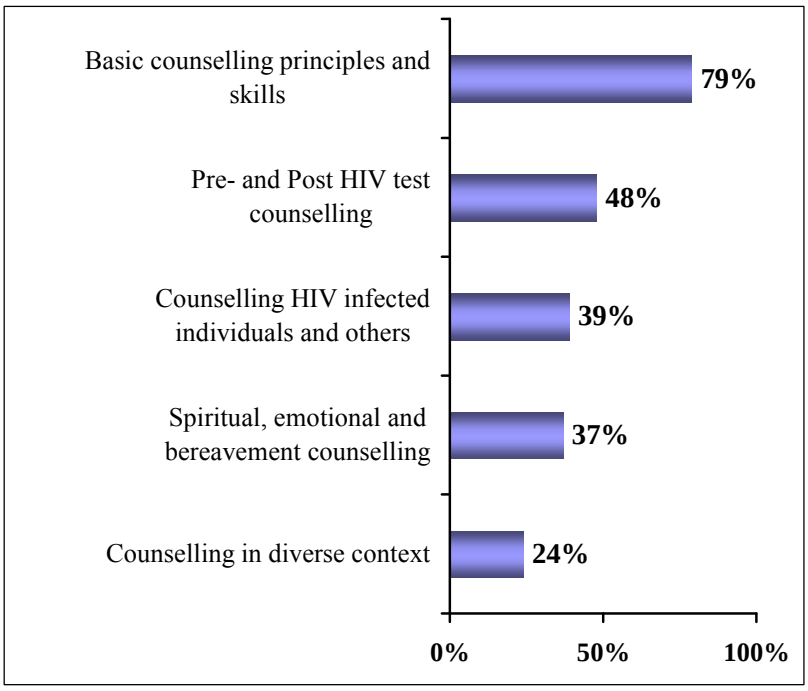

Figure 4.7: Percentage of useful sub-themes on HIV/AIDS Counselling

Participants found the basic counselling principles and skills sub-theme to be the most useful (79%) in the HIV/AIDS counselling theme. Almost half of the participants (48%) found the sub-themes on pre- and post-test counselling useful. The sub-themes rated least useful in this aspect of the module were counselling HIV-infected individuals (39%), spiritual, emotional and bereavement counselling (37%) and counselling in diverse contexts (24%). The results seem to suggest that the most basic forms of HIV/AIDS counselling are found most useful compared to more specialized forms of HIV/AIDS counselling. This makes sense, given that only a few of the participants (38%) were already involved in HIV/AIDS work prior to enrolling for the module. Most of them (49%) have expressed a need to be equipped with knowledge and skills on HIV/AIDS. The results might therefore imply that participants at this stage are more concerned with basic HIV/AIDS skills-related knowledge, as opposed to complex HIV/AIDS skills-related knowledge.

Again, almost all the participants indicated that they are able to apply this theme in various contexts of their lives, including their work, community, social and personal

contexts (see Figure 4.8). These results might suggest that there is a need within their environments to provide counselling to those infected and perhaps, to a larger degree, those affected by the epidemic. The application of more specialized skills tends to be required mostly by those who are infected with the epidemic as opposed to those affected by it.

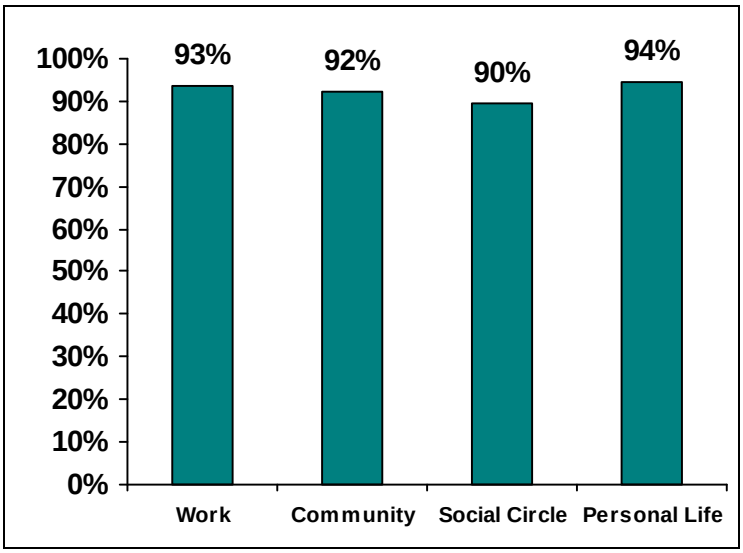

Figure 4.8: Applicability of the HIV/AIDS Counselling aspect

4.4.2.4 Usefulness of care and support for the person living with HIV/AIDS and its applicability

This theme was rated at the bottom end of the most useful themes in Module 1. The aspect comprises four sub-themes and the results of its assessment are presented in Figure 4.9.

Participants found "positive living" to be the most useful (73%) sub-theme in Care and Support of people living with HIV/AIDS. Almost half of the participants (49%) found the sub-theme on family and community involvement useful. The sub-themes that were found least useful were "infection control" (41%) and "care and nursing principles" (23%).

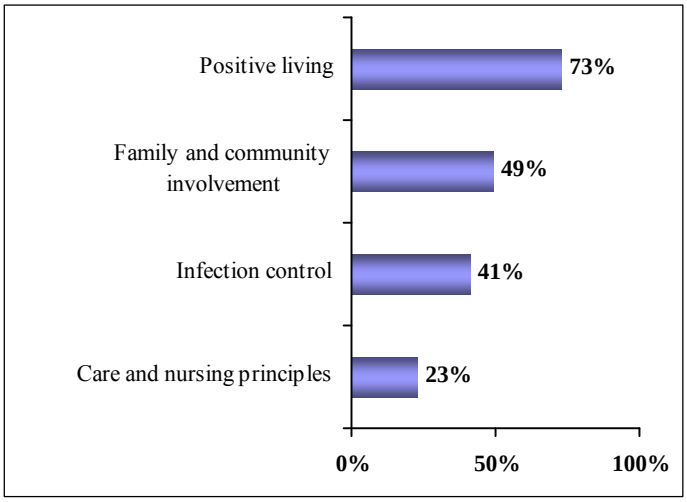

Figure 4.9: Percentage of useful sub-themes on *Care and support*

With the high prevalence of HIV/AIDS in sub-Saharan Africa, it makes sense for participants to find the theme on positive living most useful (UNAIDS, 2006). This then leads to greater emphasis on positive living within participants' environments and occupations as opposed to other sub-themes. "Positive living" links with "safer sex practices", which is one of the sub-themes which were found to be most useful by participants, perhaps accounting for the present results. The sub-theme on care and nursing principles was optional (taken by only some of the students) and may account for it being found least useful.

This theme can also be applied to participants' work, community, social and personal contexts. The nature of positive living makes it applicable to all interactional spheres of life. Figure 4.10 presents participants' responses on their ability to apply the theme on care and support for people living with HIV/AIDS.

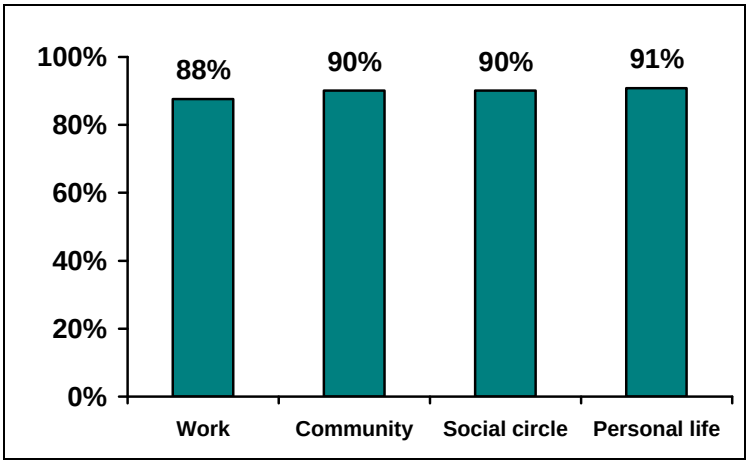

Figure 4.10: Applicability of the care and support aspect

4.4.2.5 Usefulness of legal, ethical and policy issues and their applicability

This theme is the only one that was found least useful in Module 1. It is the last theme that is covered during Module 1. The theme comprises only two sub-themes: *legal, ethical and management issues; and guidelines on confidentiality, informed consent and disclosure.* Participants' responses on the sub-themes within this theme are presented in Figure 4.11.

Guidelines on confidentiality, informed consent and disclosure was found to be the most useful sub-theme (74%) as compared to the legal, ethical and management sub-theme (52%). In comparison to each other, these sub-themes are found useful by participants unlike when this theme was compared to the rest of the themes within the module.

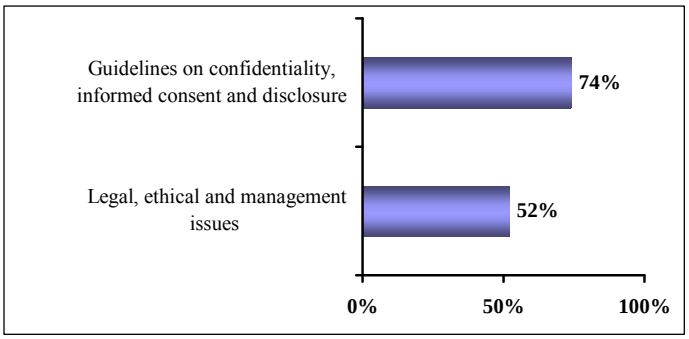

Figure 4.11: Percentage of useful sub-themes on the legal, ethical and policy section

Again, participants' occupations most probably contribute to why this theme is found least useful in general. The legal, ethical and management sub-theme is most likely related to how management ensures that the workplace promotes an HIV/AIDS-friendly and safe environment. However, the theme, "guidelines on confidentiality, informed consent and disclosure" seems more related to participants' interactions with the group of employees, community, friends or family. Perhaps most participants, due to their inexperience in HIV/AIDS work at management level, are more involved with aspects relating to guidelines on confidentiality, informed consent and disclosure as opposed to legal, ethical and management issues.

The legal, ethical and policy issues can again be applied in participants' work (93%), community (89%), personal (87%) and social circle (82%). Again, these results might be a reflection of the needs and areas of emphasis in participants' contexts. Figure 4.12 presents participants' ability to apply the legal, ethical and policy theme.

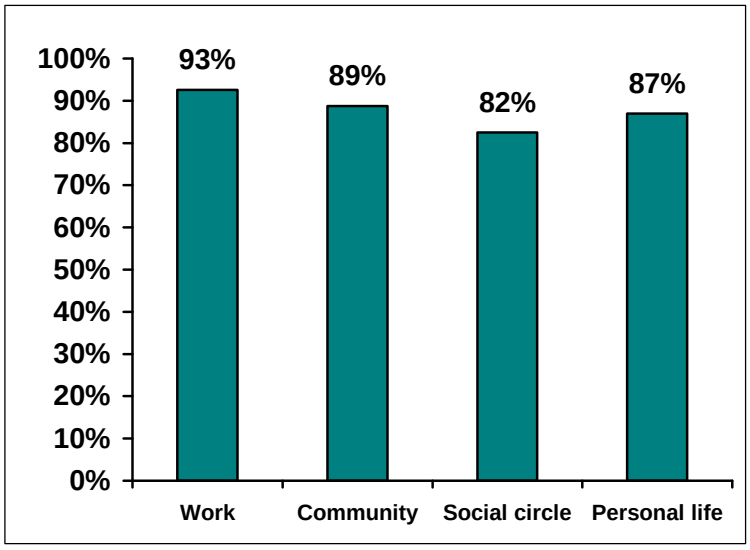

Figure 4.12: Application of *legal, ethical and policy*

Module 2 participants were also asked to indicate the specific themes that they found useful in this module. Participants were asked to answer this question in the form of the life stories that they submitted. Data generated from their responses is therefore presented in a qualitative format.

The themes that participants identified as most useful in Module 2 are: *fundamental facts about HIV/AIDS, prevention and empowerment in the HIV/AIDS context and HIV/AIDS counselling*.

Excerpts from participants' responses with regard to *fundamental facts about HIV/AIDS* include: "*symptoms of HIV/AIDS, concepts of TB, fluids that can transmit/cannot transmit HIV"* (participant E), "*I had wrong ideas about it. For example, I used to think that when someone share a toilet with someone who is living with HIV/AIDS, she/he will be infected"* (participant G) and "*There were a few things that I thought were true and after doing the course I noticed that they were just myths"* (participant D).

Only one participant found the theme on prevention and empowerment in the HIV/AIDS context useful, and an excerpt from her response reads thus: "*safer sex practices"* (participant E).

The following are excerpts from participants' responses with regard to *the usefulness of HIV/AIDS counselling*: "*pre- and post- test counseling"* (participant E), "*the aspects that were useful in changing my life was to have respect for other people as well as to have time when giving somebody results or when counselling that somebody because if not so if that individual is having questions or shocked after getting the results it might result in that somebody committing suicide"* (participant I), and "*The practical application of what I had learnt (in theory) during my studies for my degree, was the most valuable part of my studies, without that, I would not be capable of doing what I am doing now"* (participant A).

Even though the following aspect of the programme was not explicitly mentioned as useful, from one participant' life story, it is apparent that the legal, ethical and policy theme was useful (participant I) as reflected in this excerpt: "*to continue to be patient, advocacy where doctors are forcing patients to sign consent to be tested for HIV…to maintain confidentiality and privacy for the patient*".

The themes that have just been mentioned are somewhat consistent with the results indicated by participants for Module 1 where the themes on fundamental facts about HIV/AIDS; prevention and empowerment in the HIV/AIDS context; HIV/AIDS counseling; and the legal, ethical and policy issues were found useful by the participants. Even though the responses for Module 2 are based on a very small sample, they nonetheless confirm the applicability of these themes in participants' environments, even though the responses were given in different time frames. It would therefore be advisable to increase the sample size for Module 2 in order to make more reliable generalizations about this.

Participants' involvement in HIV/AIDS work varies from context to context. There are those who work in the education context (participants E & F), the medical context (participants A, I & H), a non-governmental organization (participant B), and a retail outlet (participant D). One participant's work was done in the family or personal life context (participant G).

It is interesting to note that the participants who found it difficult to gain entry into the HIV/AIDS field post training did not get discouraged when they couldn't find jobs, their level of persistence seems to have eventually enabled them to get some form of employment within the field. This is reflected in some of what they said in their life stories: *"Eventually I started networking, just spreading the word regarding the course I've done and that I was looking to do voluntary counselling…Two months down the line I had an interview with the psychologist in charge at the Harriet Shezi Clinic (paediatric HIV/AIDS clinic) at Baragwanath hospital…I was employed immediately, as a volunteering counsellor, to do in-depth individual counselling, once a week"* (participant A). Another participant says the following: *"But fortunately I was called two weeks ago by one of the organizations I asked to do volunteering at. I am starting on the 11th of June".*

The participants are engaged in various kinds of work, which include: HIV/AIDS education, counselling, administration, advocacy and treatment. Excerpts relating to

participants' involvement in the education sector include: *"After the completion of module 1 and 2 at UNISA I was able to counsel my learners and parents who are affected and infected with HIV/AIDS and those with other problems"* (participant F) and, *"As I was busy with HIV/AIDS module 1 at UNISA, I got background information to start teaching learners Life Orientation"* (participant E).

Participants' responses with regard to involvement in the medical context are: *"[I]t was an eye opener because first thing when I go back to work I was able to give lectures on HIV/AIDS to staff and patients…I continued to be patient's advocacy where doctors are forcing patients to sign consent to be tested for HIV…to maintain confidentiality and privacy for the patient…because of basic counseling that I receive from the course it helped me so much where it made me to have listening ear and to think for the other people but to let them think and come up with the solution"* (participant I). *"I was employed immediately, as a volunteer counselor, to do in-depth individual counseling, once a week"* (participant A). *"During drug literacy we emphasise the use of ART with family planning and condoms…we encourage them not to default or stop taking ARV's always when we meet with them, we encourage them to share whatever they feel after taking medication with the person they feel like to talk to"* (participant H).

One participant is engaged in HIV/AIDS work within a Non-Governmental Organization. This is an excerpt from the participant's life story: *"Presently I have a project that we are running in Meadowlands is called Mokone Maruping Care Giving project. I work as a secretary in the project. My responsibility is to write letters for donor assistance, I have to make sure that we have food to cook for the community. We have orphans children that we give support to…we are assisting the needy by giving them food parcels…we supply school children with food and clothes…we have HIV/AIDS people that we give them support and care…"* (participant B).

There is another participant who shared her life story about applying her learnt knowledge and skills in her social life within her family. *"After I finish the course, I went through many challenges. One of them was when I was looking after my cousin who*

was dying from AIDS. She was rejected by all members of the family except her daughter and me. They were blaming her and telling her that she deserves to be sick. I was always telling them to be supportive to her and not to judge her" (participant G).

This excerpt from one participant indicates how she was able to apply her knowledge and skills in a retail outlet: *"I did the course and there is a book at Pick n Pay that they issue every month. It's the staff magazine and it's free of charge. I use to write articles on it so that it can reach the staff in the whole South Africa and it did and I'm glad it did…when I was doing presentations at Pick n Pay, I would answer the general questions that they had and explain to them how the condom is used"*(participant D).

From participants' involvement within the various contexts, it is apparent that most of them are able to apply the themes that they found useful in Module 2 in the work context and the social circle. Generalizations with regards to the various contexts within which Module 2 can be applied cannot be made as the sample size for this module is very small.

4.4.3 The impact of the programme on participants' personal lives

Another way in which this study assessed participants' ability to transfer the training into their life contexts was to assess the impact of the programme on participants' personal lives. When participants become conscious about adopting certain HIV/AIDS-related behaviours as a result of having undergone training, then there is some indication that the programme has impacted on participants' lives in some way.

Module 1 has impacted on participants' personal lives in the sense that it has challenged or encouraged them to start engaging in behaviour that would prevent them from being infected with the HIV virus. Module 1 appears to have also influenced participants to behave in a less discriminatory way and become less judgmental against those who are infected with, and affected by, HIV/AIDS. As a result of studying the module, participants claim to have become more inclined to be involved in HIV/AIDS prevention work. There were some who indicated that the module did not have any impact on their

personal lives. Table 4.17 provides a summary of the themes that categorized participants' responses in this regard.

Forty three percent (43%) of participants report to have had a change in attitude towards those who are infected with, and affected by the disease. They claim to have become more respectful, sympathetic, compassionate and sensitive towards those who are infected and affected. They also became more willing to help and reach out to those who are infected and affected without being judgmental.

Table 4.17: Themes of the module's impact on participants' behaviour (n = 96)

	Frequency	Percentage
To begin engaging in self-protective behaviour	28	31%
Started interacting with those who are infected with and affected by HIV in a positive way	39	43%
Started engaging in HIV/AIDS prevention work	29	32%
No impact	6	7%

This change in attitude contributes towards embracing the infected and affected in our communities without discriminating against or ostracizing them. These results are consistent with participants' earlier assertion that the programme impacted on their attitudes.

Thirty two percent (32%) of the participants say that after studying Module 1 they became motivated to reach out and help the infected and affected. Studying the module seems to have made them want to be more involved in helping with combating the spread of the epidemic, worry more about the youth and realize the magnitude of their responsibility in this field. They indicated that they also felt empowered to talk openly about the disease and to counsel people. These results are supported by the results that were presented earlier, indicating participants' involvement in HIV/AIDS work post training, and the various ways in which they are involved.

Module 1 seems to have also challenged participants to begin engaging in behaviour that will minimize the likelihood of being infected with the HI- Virus (31%). Participants said that after studying Module 1 they have become more aware of the need to take care of themselves, to take responsibility for their own lives; and to be more cautious and careful. This is indicated by their assertions that they have become more health conscious, are empowered to say "no", consistently use condoms and test for HIV on a regular basis. They also indicated that there is better communication between themselves and their sexual partners, and thus leading to increased faithfulness. As a result of studying the module, participants claim to be now able to live comfortably with those who are infected, sharing everything with them without fear of being infected. This theme seems to have contributed to removing stereotypes and dispelling the myths that participants had about the disease, the infected and affected. This will also contribute towards destigmatization of those who are infected with, and affected, by the virus.

Twenty nine percent (29%) of participants claim that the module has changed their attitude towards the disease and towards life in general. Participants say that studying Module 1 has challenged them to think more deeply about the epidemic and to also have an interest in further understanding the disease. It seems as if studying the module has enabled them to realize that HIV/AIDS affects everyone, and therefore needs to be dealt with in a positive way (without being shocked). On another level participants have become more aware of the disease and the misconceptions around it, including understanding the impact of attitudes and cultural differences on the disease. For some, the module has been an enabling factor in accepting their personal situations. This theme, yet again, reflects on the module's role in dealing with issues of stigma and discrimination regarding the HIV/AIDS infected and affected. Only a few (7%) of the participants felt that the module did not have an impact on their personal lives. Perhaps this last percentage of participants was already engaged in behaviour that reduces the likelihood of contracting HIV/AIDS and were, in general, already exposed to the field of HIV/AIDS, and therefore explains why the module did not have any impact on them.

Table 4.18 presents detailed descriptions of the impact of Module 1 on participants' personal lives.

The assessment of the impact of the UNISA HIV/AIDS programme on participants' behaviour in Module 2 was assessed twice: during training and post-training. Participants' responses, that were given during training, with regard to their change in behaviour as a result of Module 2 should be interpreted with caution since changes in behaviour are usually noticeable after a period of time, say six to 12 months.

Table 4.18: Detailed descriptions of the impact of Module 1 on participants' personal lives

Self-protective behaviour	Interaction with infected/affected	Engagement in HIV prevention
Now use condoms/gained knowledge of how to protect self/be careful/be health conscious	More willing to help infected/can now reach out and assist/guide/advice/teach	Want to be more involved
Now test every year/get tested	Love and respect individuals/treat all with respect/empathy/compassion	Talk openly
Learnt to say no	Be sympathetic and understand feelings	Positive impact
Can live with patients/share everything with them	Counsel without being judgemental	Manage to counsel people
Focus on influencing others to live positively	Reserve more time for infected/affected	Realized own responsibility/have to contribute/help
Partner and self more faithful/better communication with life partner	Deal with HIV people	Worry more about young people
	Be more sensitive towards attitudes	Gained confidence in counselling

In this study, questionnaires that were used to assess this variable were given to participants immediately after they had been exposed to the programme (that is, on the last day of the workshop), it would therefore be difficult to ascertain a true measure for this aspect of the study. The results that are presented below should therefore be

understood in the context of participants' motivation and/or intention to change their behaviour as a result of having been exposed to the module. The following themes emerged from participants' responses:

- Engaging in HIV/AIDS education and prevention work

  Some participants expressed a sense of confidence in going back into their communities and engaging in HIV/AIDS work as a result of the training.

- Confidence to conduct HIV/AIDS counselling

There were a few participants who felt empowered to conduct HIV/AIDS counselling after the training. They now felt brave enough to provide counselling.

- Personal growth

  Other participants acknowledged having attained some level of personal growth as a result of having undergone training.

- Ability to engage in self-protective behaviour

Some participants felt motivated to engage in behaviour that would minimize the likelihood of HIV infection.

These themes are, however, similar to those that were presented by participants for the impact of Module 1 on their personal lives. Detailed themes on participants' responses are given in Table 4.19.

Post-training, participants' life stories revealed that Module 1 affected their personal lives. One participant (D) indicated that *"there were a few things that I thought were true and after doing the course I noticed that they were just myths…I am now glad that I was able to change before it was too late and start using protection"*. Another participant wrote: *"If I can sum up the advantages of doing Module 2 HIV/AIDS, it would be 'EMPOWERMENT'. I soon realized that I had learnt skills which a lot of qualified psychologists did not have. I was at a definite advantage in the field, & I was sure that putting my knowledge & skills to use would be easy"* (participant A). Drawing from her personal life, participant (G) says the following: *"I was always there for my cousin. Bathing her, cooking [for] and feeding her. I really accepted her unconditionally.*

Table 4.19: Detailed description of the impact of Module 2 on participants' personal lives

HIV prevention work in the community	Conducting HIV/AIDS counselling	Personal growth	Engaging in self-protective behaviour
Can encourage others to be positive	Feel brave enough to be counselling now	Help manage and deal with diversity	Encouraged to go for own test
Gave confidence to go and do best I can	Gave me more confidence to provide counselling	Helped me realize who I am	Empowered with ways to look after myself
Can pass info to client	Reducing fears in myself in giving positive results	Changed way of dealing with people	Helped me to make personal decisions
Passing information to other people	Can use counseling skills learnt	Made me see what I was doing wrong	Helped me check my own view on sexual issues
Assisted me in knowing I can help others to live with the virus		Motivated me to be close to my family	
		Know where and when to seek help	
		Get in touch with own emotions	
		Self-awareness of needs	

I was told that I will also be infected, but I didn't listen to anyone because I knew what I was doing. That was when I realized that this course really empowered me because maybe it wasn't by it, I was also going to behave like other members of the family". Another participant wrote: *"Because of basic counseling that I receive from the course it helped me so much where it made me to have listening ear and to think for other people but to let think and come up with the solution"* (participant I). The following was said by another participant: *"My life changed drastically after enrolling for this course…I am now able to advise uninfected people to be watchful when they see somebody's blood…I am now able to advise infected people how to behave or live to prevent/avoid re-infection…I am bold enough to give post-counseling to people who have lost their loved*

ones – learners who have lost their parents and learners who have lost their friends at school…I turned to be self-assertive when coming to HIV/AIDS matters – I align myself with the saying: Abstain, Be faithful and Condomise…" (participant E). Lastly, one participant stated, *"After attending the workshop for caring and counseling I became interested in knowing more about HIV and AIDS…I was able to counsel my learners and parents who are affected and infected with HIV and AIDS and those with other problems"* (participant F).

The above responses support participants' earlier claims about Module 2 motivating them to change their behaviour as assessed during training. This, therefore, supports participants' responses that were made during training. However, due to the small number of participants who were willing to submit their life stories on Module 2, it might be useful to extend the sample size to substantially corroborate these findings.

4.4.4 Conclusion

After studying through the UNISA HIV/AIDS programme, participants have since been challenged and motivated to engage in HIV/AIDS-related work and to engage in behaviour that would prevent them from being infected with the HI-Virus. The programme, through imparting the appropriate HIV/AIDS knowledge and skills, has enabled participants to become involved in HIV/AIDS work.

Participants are able to apply the knowledge and skills that they have acquired from the programme in their work and community contexts, their social circles and their personal lives. The themes that are mainly useful to participants within these contexts are: the fundamental facts about HIV/AIDS (particularly transmission of HIV and HIV/AIDS related symptoms and diseases), prevention and empowerment in HIV/AIDS (particularly safer sex practices and principles and strategies of behaviour change), HIV/AIDS counselling (particularly basic counselling principles and skills), care and support for the person living with HIV/AIDS (particularly positive living) and to a small extent, the legal, ethical and policy issues.

The results presented in this section have shown that trainees have managed to put their learning into effect. They have also applied the relevant knowledge and skills, and were aware of their change in behaviour, knowledge and skills (Kirkpatrick, 1996; www.business.balls.com). The participants have thus demonstrated the ability to transfer the UNISA HIV/AIDS training to their environments (Noe, 1999). This has thus addressed Kirkpatrick's Behaviour Level, and also engaged in summative evaluation (De Vos, 2002; Noe, 1999; Weiss, 1998). It has also succeeded in investigating the third aim of this study, which is to investigate the impact of the UNISA HIV/AIDS programme on participants' involvement in the community.

4.5 CHAPTER CONCLUSIONS

In this chapter the results of the evaluation of the UNISA HIV/AIDS programme through the use of Kirkpatrick's model were presented. It was shown how the various Levels of Kirkpatrick's model addressed both formative and summative evaluation, linking to the three aims of the study. The results indicate that participants found the UNISA HIV/AIDS programme an exciting and valuable experience which has led to increased knowledge and skills on HIV/AIDS. The programme has also engendered positive attitudes in the participants towards those who are infected and affected by HIV/AIDS. Participants were further enabled to participate in HIV/AIDS prevention initiatives, which gave them the opportunity to apply their knowledge and skills.

In the chapter that follows, the strengths and weaknesses of the UNISA HIV/AIDS programme, the recommendations of the study, as well as limitations and suggestions for further research will be presented.

CHAPTER 5

(RE) POSITIONING THE UNISA HIV/AIDS TRAINING PROGRAMME

5.1 INTRODUCTION

In this chapter I will focus on the conclusions of the study. I will also point out some of the limitations of the study's results and make suggestions for future research.

The present study evaluated the impact of the UNISA HIV/AIDS training programme on participants' learning and involvement in the community. The evaluation focussed on both formative and outcome evaluation; that is, evaluating participants' experiences of undergoing the training (both in terms of the process and the outcome) as well as the impact of the training on their involvement in HIV/AIDS work in their respective communities. These forms of evaluation were assessed through the use of Kirkpatrick's model of evaluating training programmes. According to this model, formative evaluation is carried out through assessing participants' feelings towards training (or their learning experiences), constituting the Reaction Level of the model. The Learning Level of Kirkpatrick's model assesses participants' change in knowledge, attitudes and skills post the training, thereby embarking on outcome evaluation. The third level of Kirkpatrick's model, called the Results Level assesses the extent to which participants are able to apply what they learnt from the programme to their community contexts. This also engages in outcome evaluation.

In line with the above, the main objectives of the present study were:

- Assessing the impact of the UNISA HIV/AIDS progamme on the participants' learning.

- Assessing the impact of the UNISA HIV/AIDS programme on the participants' involvement in the community.

- Providing suggestions for improving the UNISA HIV/AIDS programme.

5.2 THE IMPACT OF THE PROGRAMME ON PARTICIPANTS' LEARNING

It is clear that the programme has equipped participants with factual information about HIV/AIDS and the related HIV/AIDS counselling skills. The programme has managed to dispel the myths that participants had about the disease. Participants' feelings, behaviour and perceptions about the disease and those that are infected with and affected by it, were influenced positively.

5.2.1 Participants' HIV/AIDS knowledge

The results of this study have shown how participants acquired and broadened their knowledge of HIV/AIDS, and dispelled the myths that they previously had about HIV/AIDS. From the UNAIDS (2005, p. 18) report, the following is highlighted:

> Generally, women are less well-informed about HIV than are men; this is also true of rural areas compared with those living in cities and towns. This is the case even in the ten countries where more than one out of ten adults is infected. In 24 sub-Saharan countries (including Cameroon, Côte d'Ivoire, Kenya, Nigeria, Senegal and Uganda), two thirds or more of young women (aged 15–24 years) lacked comprehensive knowledge of HIV transmission (various surveys, 2000–2004). Data from 35 of the 48 countries in sub-Saharan Africa show that, on average, young men were 20% more likely to have correct knowledge of HIV than young women.

The above extract indicates that most countries in sub-Saharan Africa lack correct knowledge on HIV/AIDS, resulting in difficulties for initiatives to curb the spread of the epidemic. It has been argued that accurate information on HIV/AIDS is a bare minimum in any attempts to prevent the spread of the epidemic (Eaton & Flisher, 2000). From the results of the study, it was shown that participants' knowledge of HIV/AIDS was both increased and broadened. Research indicates the prevalence of HIV/AIDS-related myths

across the globe and the UNISA HIV/AIDS programme was shown to have succeeded in challenging participants' previously held myths and replacing them with correct factual information (Eaton & Flisher, 2000). In line with the 4th generation of sex and HIV/AIDS curricula, the UNISA HIV/AIDS programme has contributed towards reducing misinformation and fear around HIV/AIDS (Kirby & DiClemente, 1994).

5.2.2 Participants' HIV/AIDS attitudes

Another success of the UNISA HIV/AIDS programme is its contribution towards reducing participants' stigma and discrimination associated with HIV/AIDS. The stigma attached to HIV/AIDS and the resultant actual or feared discrimination have proved to be the most difficult obstacles in effectively preventing HIV/AIDS (UNAIDS, 2005). As a result of having undergone the UNISA HIV/AIDS programme, participants reported that they have since started interacting with both those who are infected with, and those affected by the disease in a respectful and non-judgemental way. HIV/AIDS stigma results from both associating HIV with forbidden, immoral or illegal acts, and lack of awareness and knowledge on HIV/AIDS (UNAIDS, 2005). The latter has been clearly shown in the results of this study, wherein participants acknowledged that they discriminated against HIV infected/affected people as a result of the myths that they held about the disease. The UNISA HIV/AIDS programme seems consistent with the aims of the 4th and 5th generation curricula of sex and HIV/AIDS education, which are to eliminate discrimination and to promote tolerance and empathy towards those who are HIV/AIDS infected and affected (Swain & McNamara, 1997).

Assisting with dealing with stigma and discrimination is an important aspect in the field of HIV/AIDS prevention, as some of the consequences of stigma have been linked to people being afraid of testing and disclosing their HIV status, preventing people from negotiating safer sex and seeking treatment (Molefe, 2005; Skinner & Mfecane, 2004; UNAIDS/WHO, 2005; Van Dyk, 2001)

5.2.3 Participants' HIV/AIDS-related skills

Exploring feelings, attitudes, values, choices and responsibility bridges the gap that usually exists between the mere imparting of HIV/AIDS information and translation into HIV/AIDS prevention action (Coughlan, Coughlan & Jameson, 1996; Dorr & Lynch, 1990; Eaton & Flisher, 2000; Thomson, Currie, Todd & Elton, 1999). By integrating HIV/AIDS information with values, attitudes and skills, the UNISA HIV/AIDS programme has empowered participants with the necessary skills to engage in HIV/AIDS prevention.

This is evident in the study's ability to positively impact on behaviour that is related to HIV/AIDS prevention. According to Thomson *et al*. (1999), HIV can only be prevented through protective behaviour and behaviour change. This makes changing one's behaviour and adopting safe sex practices an important aspect of HIV prevention. Changes in sexual behaviour appear to have contributed to the declines in HIV prevalence in Zimbabwe (UNAIDS, 2005), and other countries across the globe (Fishbein, 2000; Fisher & Fisher, 1992; Perez & Dabis, 2003).

HIV/AIDS is mainly transmitted through sexual intercourse and blood transfusion, making it a life-style disease which is characterized by "risky behaviours". Pre- and extra-marital sex, commercial sex work, injection drug use and unprotected sex are some of the identified "risky behaviours" (Bettencourt, Hodgins, Hubes & Pickett, 1998; Coyle & Loveless, 1995; Murphy *et al*., 1998; Perez & Dabis, 2003; UNAIDS, 2005; UNESCO, 1999). From these studies, it follows that HIV can be prevented through engaging in behaviour that does not put one at risk of infection. Studies also confirm that sexual health risks, including those related to HIV/AIDS transmission can be reduced through adopting appropriate health behaviour (Eaton & Flisher, 2000; Thomson, Currie, Todd & Elton, 1999).

According to the social-cognitive theory and the information-motivation-behavioural-skills model, when individuals possess the relevant HIV/AIDS knowledge and the accompanying skills to prevent HIV infection, they are more likely to engage in

behaviour that protects them against HIV infection (Bandura, 1994; Fisher & Fisher, 1992). By being able to challenge participants to begin engaging in behaviour that reduces their chances of HIV infection the UNISA HIV/AIDS programme contributes towards curbing the spread of the epidemic. Participants in the present study reported that after studying the programme, they started testing for HIV on a regular basis, became more faithful towards their partners and used condoms regularly during sexual intercourse. It is through increasing the behavioural skills component of HIV prevention programmes that HIV/AIDS programmes become most successful (Fisher & Fisher, 1992).

5.2.4 Methods used for facilitating learning

Research has indicated the value played by discussions and role-plays in HIV/AIDS educational programmes where knowledge, attitudes and skills are integrated (Eagle *et al*., 1995; Swan, *et al.*, *1997*; Williams, *et al*., 2006; Wu *et al*., 2002). Participants in this study reported to having since adopted a positive attitude towards those infected with, and those affected by, HIV/AIDS as well as engaging in behaviours that prevent them from being infected with the HI-Virus as a result of the interactive nature of the methods used to facilitate the UNISA HIV/AIDS programme. According to Williams *et al*., (2006), participants' attitudes towards AIDS patients and their willingness to care for them improved after they were exposed to participatory AIDS education. Active interventions (that is, those that required activities by the recipients) were found to result in the faithful implementation of programmes as opposed to passive interventions (Ahmed, Flisher, Mathwes, Jansen, Mukoma & Schaalma, 2006; Albarracin, Durantini & Earl, 2006). The facilitation of discussions on feelings, beliefs and attitudes amongst participants in HIV/AIDS programmes has proved most useful in achieving later implementation within participants' work context (Ahmed, *et al*., 2006; Williams *et al*., 2006).

The findings of this study have shown how useful the methods that were adopted in the UNISA HIV/AIDS programme have been, thereby providing guidance on how HIV/AIDS programmes need to be presented in order to produce effective results.

5.3 THE IMPACT OF THE PROGRAMME ON PARTICIPANTS' COMMUNITY INVOLVEMENT

The UNISA HIV/AIDS programme has not only challenged and motivated participants to engage in HIV/AIDS related work and behaviour that prevents them from being infected with the HI-Virus, but it has also facilitated their entry into the HIV/AIDS field.

Participants' involvement in HIV/AIDS work includes their communities in general, their social circles and personal lives. The themes from the programme that participants are able to apply in these contexts are fundamental facts about HIV/AIDS (particularly transmission of HIV and HIV/AIDS-related symptoms and diseases), prevention and empowerment in HIV/AIDS (particularly safer sex practices and principles and strategies of behaviour change), HIV/AIDS counselling (particularly basic counselling principles and skills), care and support for the person living with HIV/AIDS (particularly positive living) and to a small extent, the legal, ethical and policy issues.

These results show aspects of the UNISA HIV/AIDS programme that have proved useful for use in participants' respective communities.

5.4 THE STRENGHTS OF THE UNISA HIV/AIDS PROGRAMME

According to Noe (1999) evaluating a programme has some positive implications and the following can be observed from the evaluation of the UNISA HIV/AIDS programme:

- The credibility of the programme has been achieved.
- The evaluation has rendered the programme's efforts worthwhile.

- The programme qualifies to serve as an example from which other related programmes can learn.

Based on the above points, the following strengths of the UNISA HIV/AIDS programme are identified:

- It has instilled correct or factual knowledge and skills on HIV/AIDS.
- It has positively impacted on participants' HIV/AIDS-related behaviour, their attitudes towards the disease, and to those infected with and affected by the disease.
- It has empowered participants to positively contribute towards managing the epidemic in their respective communities; including their work contexts, social circles and personal lives.
- It has facilitated participants' understanding of HIV/AIDS through the
    - methods that were used for tuition.
    - methods that were used for assessment.
    - study materials that were provided.

5.5 THE LIMITATIONS OF THE UNISA HIV/AIDS PROGRAMME

The following are the limitations of the UNISA HIV/AIDS training programme that are identifiable from participants' responses:

- Insufficient physical contact between learners and their lecturers and between learners themselves especially with regard to Module 1 (which was a distance education course).
- Limited time for studying Module 2.
- Unclear presentation of the HIV prevention and safer sex theme in Module 2.
- Limited focus on specialized themes in counselling, particularly within the multicultural context of South Africa. These include cross-cultural counselling,

multiple perspectives to managing HIV, embracing the role of traditional healing and sexual trauma counselling.

5.6 SUGGESTIONS FOR IMPROVING THE UNISA HIV/AIDS PROGRAMME

Participants were generally satisfied with the themes that the UNISA HIV/AIDS programme covers, with notable few exceptions.

Increasing the time allocated for the teaching of Module 2 could perhaps be one of the areas that can be considered to improve the UNISA HIV/AIDS programme. In line with the suggestions by the participants in the study, the time could be extended to two weeks in order to increase students' exposure to practising the acquired counselling skills. This will also allow for all themes to be adequately addressed during the workshop, with each of them getting the necessary attention. This suggestion might, however, increase the costs of taking the Module, thereby adding extra expenses for the participants.

HIV prevention and safer sex practice is an important theme in the area of HIV prevention. It is therefore strongly recommended that the theme be presented in a manner that captures the participants' attention, while at the same time impacting appropriately on participants' knowledge and skills in this regard.

Given the fact that South Africa is a multicultural society, it would be a good idea to consider including the role of traditional healers in managing HIV/AIDS. This can be an opportunity to highlight some of the advantages of involving traditional healers in the fight against HIV/AIDS, given the fact that 80% of the South African population consult traditional healers at one point or the other (Madu, 1997). This combination will strengthen the multi-disciplinary approach that is adopted in the UNISA HIV/AIDS programme. The approach can also serve as a platform to raise awareness on how traditional healers manage the epidemic. Furthermore, this approach will also assist researchers to explore both the useful and potentially harmful practices that are carried out by traditional healers. The inclusion of traditional healers in the management of

HIV/AIDS will also be in line with the efforts by the National Department of Health (South Africa) to integrate traditional healers into the health system.

Another aspect that is worth considering for further strengthening of the UNISA HIV/AIDS programme is to focus on cross-cultural counselling. The break-down in percentages of the number of psychologists according to race in South Africa indicates that there are 80% white psychologists, as opposed to 20% black psychologists (Canham, Kiguwa & Kometsi, 2007). The South African population consists of a high percentage of blacks in relation other race groups, and therefore cross-cultural or racial dyadic counselling relationships are inevitable. In the light of the disproportionate percentage of counsellors to clients, the B. (Psychology) programme was introduced to cater for the much needed pool of counsellors in the country. Perhaps this further strengthens the need for particular focus on cross-cultural counselling in the UNISA HIV/AIDS programme.

There is an increasing exposure to trauma that is related to HIV/AIDS, rape, crime and many other social ills in South Africa. This creates an increased need for trauma counselling, thereby requiring counsellors to be better equipped for this task. By including an aspect of trauma counselling, especially in the context of HIV/AIDS, participants would be empowered to competently deal with this aspect in their work in the community. It is acknowledged that trauma counselling is a specialized field which can constitute an independent programme. However, the UNISA HIV/AIDS programme can expose participants to the basic skills required to manage clients who present with trauma related issues.

5.7 LIMITATIONS OF THE PRESENT STUDY

The sample used for evaluating the impact of Module 2 on participants comprised eight (8) participants. This is against the hundred and sixteen (116) participants who took part

in the evaluation of the entire UNISA HIV/AIDS programme (that is both Module 1 and most aspects of Module 2). Although the aim of the study was to obtain an in-depth understanding of how useful the module is in participants' community contexts, this relatively small sample size has the potential to limit the generalization of the findings.

The present study focused on evaluating the impact of the UNISA HIV/AIDS programme on participants' HIV/AIDS knowledge, attitudes and skills. Although this was a starting point in ascertaining the effect that HIV/AIDS programmes have on programme participants, focussing on just the one programme does not provide insight into the broader HIV/AIDS programmes that are being utilized, at least, within the country.

The results of the study have indicated the impact of the programme on participants' behaviour. Albarracin, Durantini and Earl (2006) have identified a difference between intention to engage in behaviour and the actual adoption of the changed behaviour following an intervention. This therefore questions participants' ability to enact their intentions to change their behaviours (especially in relation to assessment conducted during training on Module 2) and the ability to sustain such behaviours over time. The time-frames within which the present study was conducted does not necessarily provide a full picture in this regard.

5.8 SUGGESTIONS FOR FUTURE RESEARCH

It is suggested that for future research, Module 3 of the UNISA HIV/AIDS programme be evaluated so as to obtain a complete insight of the programme.

Another aspect that needs further investigation is the Results Level of Kirkpatrick's model of evaluating training programmes with regard to the UNISA HIV/AIDS programme. This can be conducted, for example, after a period of 5 years following this study, in order to obtain meaningful results. Combined with this aspect is the further investigation of the Behaviour Level, assessing for sustained behaviour changes.

Literature indicates that intention to change behaviour and the changes effected in one's behaviour take place over a period of time, with some behaviours not being sustained (Albarracin, *et* a*l*., 2006).

Future research could also consider increasing the sample size for particularly evaluating the impact of Module 2 on participants' involvement in the community. To further strengthen the quality of the data, focus group discussions could be utilized as a method for collecting the data.

The UNISA HIV/AIDS programme could be evaluated against the Department of Health's guidelines on developing HIV/AIDS programmes to assess how it compares with national standards.

5.9 CONCLUSION

The ability of the UNISA HIV/AIDS programme to contribute towards managing the spread of the epidemic has been illustrated in this study. It was revealed, through the results of the study, that the programme has successfully equipped participants with the necessary HIV/AIDS information and skills. The programme has further managed to empower participants to engage in HIV/AIDS education and counselling in their communities. Participants' attitudes towards the disease, to people infected with, and to those affected by it were furthermore challenged; resulting in less stigmatization and discrimination.

It has also been shown how the UNISA HIV/AIDS programme can assist in designing effective HIV/AIDS programmes, reducing stigma and discrimination, and preventing the spread of the epidemic through engaging in health-protective behaviour. The limitations of the study were discussed and suggestions for future research made.

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APPENDIX A

QUESTIONNAIRE TO EVALUATE THE UNISA HIV/AIDS PROGRAMME - MODULE 1

- Thank you for completing this questionnaire. Your contribution will assist us to improve the quality of the UNISA training in HIV/AIDS. It will also help us to provide effective interventions within the field of HIV/AIDS in general.
- Please note that there are no right and wrong answers. What is of interest is your own personal view.
- Please **do not** write your name on the completed questionnaire.

BIOGRAPHICAL INFORMATION

1. Age

2. Sex

1	2
Male	Female

3. Ethnic group

1	2	3	4	5
Asian	Black	Coloured	White	Other…….

4. Highest academic qualification

1	2	3	4	5	5
No formal schooling	Grade 1 – Std 3	Std 4 - 7	Std 8 - 9	Matric	Post-Matric (diploma or degree)

5. Occupation

1	2	3	4
Education	Medical/nursing	Social work	Religious work
Administrative	Scholar/student	Unemployed	Other ……..
5	6	7	8

MODULE 1 QUESTIONS

6. In which year did you pass module 1? …….

7. What motivated you to enroll for module 1?

……

8. Did you enroll for module 1 through

1	2
PYC 206-B	Unisa Centre for Applied Psychology (UCAP)

9. Were you involved in HIV/AIDS work before enrolling for the module?

1	2
Yes	No

10. Were you able to get involved in HIV/AIDS work after you had passed the module?

1	2
Yes	No

11. Do you think the module assisted you in gaining entry into the HIV/AIDS field?

1	2
Yes	No

If yes, how?

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12. Which of the following area (s) covered in module 1 did you find useful? **(you may choose more than one option)**

1	2	3	4	5
Fundamental facts about HIV/AIDS	Prevention and empowerment in the HIV/AIDS context	HIV/AIDS counseling	Care and support for the Person Living with HIV/AIDS	Legal, Ethical and Policy Issues

13. Within the section on fundamental facts about HIV/AIDS, which of the following are you able to use?

1	2	3	4	5
HIV/AIDS origins and effects	Transmission of HIV	HIV/AIDS related symptoms and diseases (incl. T.B. and S.T.I.'s)	Diagnosis of HIV infection and AIDS	Management of HIV infection (anti-retroviral therapy)

13.1 Are you able to use this in your:

Context	**Yes**	**No**
Work		
Community		
Social circle		
Personal life		

14. Within the section on HIV/AIDS prevention, which of the following are you able to use?

1	2	3	4	5
Principles and strategies of behavioural change	Principles of adult education	Safer sex practices	Sexuality education and life skills training for school children (optional)	Sexual and cultural diversity

14.1 Are you able to use this in your:

Context	**Yes**	**No**
Work		
Community		
Social circle		
Personal life		

15. Within the section on HIV/AIDS counseling, which of the following are you able to use?

1	2	3	4	5
Basic counseling principles and skills	Counseling in diverse contexts	Pre- and post- HIV test counseling	Counseling HIV infected individuals, their caregivers and significant others	Spiritual, emotional and bereavement counseling

15.1 Are you able to use this in your:

Context	**Yes**	**No**
Work		
Community		
Social circle		
Personal life		

16. Within the section on care and support for the person living with HIV/AIDS, which of the following are you able to use?

1	2	3	4
Family and community involvement (home-based care, orphans care	Infection control	Care and nursing principles (optional)	Positive living

16.1 Are you able to use this in your:

Context	**Yes**	**No**
Work		
Community		
Social circle		
Personal life		

17. Within the section on legal, ethical, human rights and management issues, which of the following are you able to use?

1	2
Legal, ethical and management issues (hospitals, workplace, schools)	Guidelines on confidentiality, informed consent and disclosure

17.1 Are you able to use this in your:

Context	**Yes**	**No**
Work		
Community		
Social circle		
Personal life		

18. Do you feel that there are any areas/themes that have not been dealt with in this module that you feel should be covered?

1	2
Yes	No

18.1 If Yes,
What are the areas? And the reasons why they should be included in module 1?

1.…….

Reason……

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2.…….

Reason……

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3…….

Reason……

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4.....

Reason……

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IF YOU ENROLLED FOR PYC 206-B AND WROTE THE FORMAL UNISA EXAMINATION, PLEASE ANSWER QUESTIONS 19 – 24. IF YOU ENROLLED FOR MODULE 1 THROUGH THE CENTRE FOR APPLIED PSYCHOLOGY, WHERE YOU COMPILED AND SUBMITTED A PORTFOLIO, THEN ANSWER QUESTIONS 25 – 30.

19. What were your experiences during your course of study? How did you find the method of tuition – the multiple choice assignment, research assignment and examination as well as the study guide and textbook?

Method of tuition

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Multiple choice assignment

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Multiple choice examination

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Mini-research project

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Study guide

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textbook

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20. Did the course in any way change your attitudes towards HIV/AIDS? (Perhaps your attitudes towards HIV/AIDS as a disease, towards HIV positive people, etc) Please explain.

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21. If through studying this course you learnt certain skills, what are those skills and how useful are they to you?

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22. Has this course, in any way, had an impact on your own personal life? If so, how did it impact on your life?

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23. Is there any comment that you would like to make to improve this module?

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QUESTIONS 25 – 30 ARE FOR THOSE WHO ENROLLED FOR MODULE 1 THROUGH THE Unisa Centre for Applied Psychology (UCAP)

24. What were your experiences during your course of study? How did you find the method of tuition – compiling the portfolio, the study guide, as well as the textbook?

The method of tuition

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the portfolio

(a) The multiple choice section:

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(b) The written/experiential tasks:

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the study guide

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the textbook

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25. Did the course in any way change your attitudes towards HIV/AIDS? (Perhaps your attitudes towards HIV/AIDS as a disease, towards HIV positive people, etc) Please explain.

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26. If through studying this course you learnt certain skills, what are those skills and how useful are they to you?

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27. Has this course, in any way, had an impact on your own personal life? If so, how did it impact on your life?

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28. Is there any comment that you would like to make which will result in the improvement of this module?

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THANK YOU FOR YOUR PARTICIPATION

QUESTIONNAIRE TO EVALUATE THE UNISA HIV/AIDS PROGRAMME - MODULE 2

- Thank you for completing this questionnaire. Your contribution will assist us to improve the quality of the UNISA training in HIV/AIDS. It will also help us to provide effective interventions within the field of HIV/AIDS in general.
- Please note that there are no right and wrong answers. What is of interest is your own personal view.
- Please **do not** write your name on the completed questionnaire.

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1. What motivated you to enroll for module 2?

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2. Were you involved in HIV/AIDS work before enrolling for the module?

1	2
Yes	No

3. Do you think the module will assist you in gaining entry into the HIV/AIDS field?

1	2
Yes	No

   a. If yes, why do you think so?

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b. If no, why do you think so?

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4. Whilst undergoing training for module 2, how did you experience the training in each of the following areas covered in the module?
    a. The **welcome and introduction section** – did you find it necessary? What about the way it was done?

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    b. Did you find the section in which **"a recap on the information on the virus that changed our world"** was done useful? Do you think it was necessary? In which way was it helpful for the module?

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    c. A guest presenter who was HIV positive shared his/her experiences of living with HIV with you. Did you find this session helpful? If so, in which way was it helpful?

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d. There was a session that dealt with **attitudes and self-awareness**, where you were exposed to stereotypes and "postponing your own frame of reference" when dealing with clients. Did you find this session helpful? If so, in which way was it helpful?

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End of Day 1

DAY 2 TO DAY 4

THE FOLLOWING QUESTIONS REFER TO THE **COUNSELLING SKILLS SESSIONS** THAT YOU PARTICIPATED IN. PLEASE REFLECT ON YOUR **LEARNING, FEELINGS AND EXPERIENCES** ON EACH OF THE SECTIONS MENTIONED BELOW.

e. During the session in which **counseling was defined** – did you understand the way counseling was defined?

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How did you feel about the way it was introduced to you?

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Any specific skill(s) that you learnt, if so which ones?

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f. There was a section in which **the model of counseling** was presented to you – was this clearly presented and well understood?

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How did you feel about the way it was presented to you?

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Any specific skill(s) that you learnt, if so which ones?

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g. With regards to the session in which **the key counseling skills were defined** – were they defined in a manner that you were able to understand?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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h. There was a session in which you were exposed to **skills on how to respond to feelings within a counseling context** – how did you find this session? Was it useful, if so, how?

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Any specific skill(s) that you learnt, if so which ones?

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i. You were also exposed to a **problem-solving model** during your training, in which you practiced how to assist clients to solve problems in a counseling relationship. Did you understand this session? How did you experience it?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?
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j. There was session in which you explored the **benefits and drawbacks of HIV testing** – did you understand this session? How did you experience it?

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Did you find this session helpful? Motivate your answer.
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Any specific skill(s) that you learnt, if so which ones?
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End of Day 2

DAY 3

k. How did you experience the session that focused on **pre- HIV test counseling**? Did you understand what you were supposed to learn?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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l. Did you understand the session that dealt with the **key principles: post-test counseling**? What was your general experience of this session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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m. There was a session in which you covered **post-HIV test counseling, focusing specifically on a negative test result** – did you understand this session? What was your general experience of the session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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End of day 3

DAY 4

n. There was a session in which you covered **post-HIV test counseling, focusing specifically on a positive test result** – did you understand this session? What was your general experience of the session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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o. There was a session in which you were exposed to the **skills of conducting crisis counseling** – did you understand what you had to do in this session? What was your general experience of this session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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p. A session on how to encourage clients to **live positively** formed part of the workshop – did you understand what you had to do in this session? What was your general experience of this session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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q. There was a session in which you were exposed to **skills on assisting clients to disclose a positive result** – did you understand this session? What was your general experience of the session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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End of Day 4

DAY 5

r. A session on **prevention, sexuality issues and behaviour change** was done with you – did you understand this session? What was your general experience of the session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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s. A session on **bereavement counseling** was done with you – did you understand what this session was all about? What was your general experience of the session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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t. Did you understand the session on how to **care for yourselves as caregivers**? What was your general experience of this session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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u. There was a session that dealt with **referrals, networking and resources** – did you understand what is entailed in this session? What was your general experience of this session?

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Did you find this session helpful? Motivate your answer.

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Any specific skill(s) that you learnt, if so which ones?

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5. Are there any areas/themes that were not covered in this module, which you feel need to be covered? If so, what are they and why?

1……..

Reason……

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2……..

Reason……

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3.…….

Reason……

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4……..

Reason……

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6. Were the following method(s) of running the workshop helpful to you? Motivate your answer.

   a. Experiential learning

1	2
Yes	No

Reason……

……

……

……

   b. Role plays

1	2
Yes	No

Reason……

……

c. Video presentations

1	2
Yes	No

Reason……

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……

……

d. Lecture presentations

1	2
Yes	No

Reason……

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……

……

e. Small group discussions

1	2
Yes	No

Reason……

……

……

……

f. A combination of all of the above methods

1	2
Yes	No

Reason……

……

7. Are there other methods of facilitation that you feel the presenters could incorporate in the running of the workshop? If so, what are the methods and how useful will they be?

1……..

Reason……

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……

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2……..

Reason……

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……

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3…….

Reason……

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……

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4……..

Reason……

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8. Did you feel 5 days were sufficient for you to learn basic counseling skills?

1	2
Yes	No

Why? ……

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9. Do you find the study package (file) handed out at the workshop useful? In which way?

1	2
Yes	No

Reason……

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……

10. What did this module on counseling skills mean to you:

(a) In your work context?

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(b) In your personal life?

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11. How equipped do you feel after this 5 day workshop, on a scale of 1 to 5, to conduct HIV counseling? Please circle most appropriate response.

Not equipped	1
Less equipped	2
Moderately equipped	3
Enough equipped	4
Well equipped	5

12. Any other comments that you feel will improve the quality of module 2?

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THANK YOU FOR YOUR PARTICIPATION

QUESTIONNAIRE TO EVALUATE THE IMPACT OF MODULE 2 ON PARTICIPANTS' INVOLVEMENT IN THEIR COMMUNITIES

Dear past workshop attendant

My name is Matshepo Nefale. I am from the Department of Psychology at UNISA. In 2005 you were kind enough to participate in my research study which required your views on the HIV/AIDS programme that you enrolled for at UNISA.

This is a follow-up on that research project. The purpose of this research is to find an answer to the following question: **"How did studying both module 1 and module 2 of the HIV/AIDS Care and Counseling course at UNISA empower you (personally/at work/your community) to do the kind of HIV/AIDS related work that you do? If the modules empowered you in any way, *how* did they empower you?"**
If you found no benefit from the course, please also indicate this.

You can answer the question in the form of a life story or in the best way that will enable you to express yourself. Your life stories or answers should include, but are not limited to:

- **Your life/circumstances before enrolling for this course**
- **Your current involvement in HIV/AIDS work – when it started, what exactly you are doing and how studying the course facilitated this process.**
- **Your life/circumstances after enrolling for this course**
- **Aspects of the course that were most useful in changing your life and how they did that**
- **Limitations of the course and suggested changes based on your exposure, now that you are working in the field of HIV/AIDS.**

Your assistance in submitting your life stories will assist not only my study, but the management of HIV/AIDS in the country and beyond.

I will appreciate it if you could try to send your life stories to me at the following address by **31 May 2007** – Department of Psychology, P.O. Box 392, UNISA, 0003.

Thank you for your co-operation and assistance.

Yours faithfully

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Matshepo Nefale – Chief Researcher

Prof. JM Nieuwoudt – Supervisor
Prof. AC van Dyk – Co-supervisor