

**THE SATISFACTION OF HIV/AIDS COUNSELLORS IN THE eTHEKWINI
METROPOLITAN AREA WITH REGARD TO THEIR COUNSELLOR TRAINING**

by

MIMONA HENDRICKS

submitted in fulfilment of the requirements for
the degree of

MASTER OF ARTS IN SOCIAL SCIENCE

in the subject

SOCIAL WORK

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: MRS A PETTY

FEBRUARY 2008

Student number: **3528- 426-9**

“I declare that ‘The satisfaction of HIV/AIDS counsellors in the eThekweni metropolitan area with regard to their counsellor training’ 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.”

SIGNATURE
MRS MIMONA HENDRICKS

DATE

ACKNOWLEDGEMENT

Accomplishments in life are achieved in partnership with others. So, on completion of this study I express tremendous gratitude to several role-players.

Firstly, to Almighty God. “Thank you for the gift of life and the countless bounties that inspires, nourishes and sustains me.”

To all the counsellors who will remain anonymous. “Thank you for allowing me into your space and for sharing your views and insights amidst your hectic schedules in service to humanity.”

My academic supervisor, Mrs Ann Petty, was a beacon of light. “Your scholarly mentoring and caring ways most cordially guided and strengthened me throughout this journey. Thank you.”

Family support was unqualified and forthcoming. My husband Fuad, ensured much needed time off on the home front. He literally edged me on when the going was tough. So did my daughters Fatima and Sumaya, sons Qutb and Towfiq, my daughter - and- son-in- law Fatima and Tayo. Loving thoughts also to my darling grandchildren, Ilhaam, Iman and Ammaar. “All of you are very special. Thank you for giving me the space to grow.”

Professor van Delft encouraged me along the way. “Thank you for your interest Professor. It meant a lot.”

My dear colleagues, especially my Director Mrs Chiluvane and Senior Manager Mrs Ngidi, supported me throughout this journey. “All of you helped to bring this project to fruition. I thank you most sincerely.”

My friends were accommodating. So also, were the employers who gave their counsellors time off to participate in this research. “I appreciate you.”

I wish to acknowledge the scholars and researchers from whose library of knowledge and available works into the growing and nascent discipline of HIV and AIDS counsellor research, I literally

tapped into. In addition, a hearty thanks to the UNISA library staff whose unstinting back-up provided relevant literature, which made my task so much more manageable. “All of you helped to make this project attainable. Thank you very much.”

This study was funded in part by:

UNISA Financial Aid Bureau.

ABSTRACT

Twenty four eThekweni HIV/AIDS counsellors based in four different work settings and who received training from five different training providers, shared their HIV/AIDS counsellor training experiences. The qualitative, phenomenological study utilized a multi-methods approach. The purpose of HIV/AIDS counselling lacks uniformity. Participants reflected upon their distinction between training satisfaction and perceived competency to render HIV/AIDS counselling after training. Although they were satisfied and empowered by the useful information gained, many felt inadequate to counsel an HIV positive person on completion of training. Inadequate practical learning opportunities were evident. Participants identified the need for a more balanced theoretical and practical training program incorporating experiential and didactic training methods. Entrance criteria to HIV/AIDS counsellor training courses and eventual assessment procedures in the study were diverse. Participants suggested improvements for training methods and course content and proposed a tiered training model that will result in standardized and certified training modules.

KEY WORDS

- HIV/AIDS counsellors
- Counsellor training
- Counsellor skills
- Counsellor roles
- Counsellor motivation
- Training methods
- Purpose of counselling
- Coping mechanisms
- Likes and dislikes of counsellors
- Counsellor training model

ABBREVIATIONS

AIDS - Acquired Immune Deficiency Syndrome

HIV - Human Immunodeficiency Virus

STD's - Sexually transmitted diseases

STI's - Sexually transmitted infections

FBO - Faith – based organizations

KZN - KwaZulu Natal

NGO - Nongovernmental organization

NQF - National Qualifications Authority

PPC - Para- professional counsellor

SAQA - South African Qualifications Authority

SACSSP - South African Council for Social Service Professions

VCT - Voluntary Counselling & Testing

WHO - World Health Organization

TABLE OF CONTENTS

TITLE	PAGE
Declaration	i
Acknowledgement	ii
Abstract	iv
Key Words	v
Abbreviations	vi
Table of Contents	vii
CHAPTER 1: INTRODUCTION TO THE RESEARCH	1
Introduction	1
1.1 Researcher's academic background and experience in research	1
1.2 Formulation of the research idea or topic	1
1.3 Rationale for the study	2
1.4 The preliminary literature study	6
1.5 The aim, goals and objectives of the research	11
1.5.1 The goals of the research	11
1.5.2 The objectives of the study	12
1.6 Overview of data collection to answer the research questions	12
1.6.1 Design of the study	12
1.6.2 Aim of the research	12
1.6.3 Data and information sources	13
1.6.4 Validity and reliability of the research	14

1.7 Method of data collection	15
1.8 Data analysis	16
1.9 Ethical issues concerning research	17
1.10 Assumptions concerning the study	18
CHAPTER 2: ADDITIONAL LITERATURE THAT INFORMED THE STUDY	20
Introduction	20
2.1 Important definitions and key concepts	21
2.2 Counselling as a distinct professional activity	23
2.2.1 Brief historical background to counselling development	23
2.2.2 Example of a counselling model	24
2.2.3 HIV/AIDS counselling	25
2.2.3.1 Pre-HIV - test counselling	26
2.2.3.2 Post HIV-test counselling	27
2.2.3.3 Ongoing HIV/AIDS counselling	28
2.3 Gaps in the research indicating the relevance of the study	29
2.4 The purpose of HIV/AIDS counsellor training	31
2.5 Issues of HIV/AIDS counsellor identity	33
2.6 HIV/AIDS counselling service development in South Africa	35
2.6.1 Training HIV/AIDS counsellors in KwaZulu Natal	37
2.6.2 Minimum training standards for HIV/AIDS counsellor training	38

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

2.7	Service standards of HIV/AIDS counsellors in South Africa	40
2.7.1	Accreditation	40
2.7.2	Batho Pele Principles (putting people first)	41
2.8	HIV/AIDS counsellor training	42
2.8.1	Registered unit standard: conduct basic lay counseling in a structured environment	42
2.8.2	Nurse counsellors	44
2.9	Training needs of HIV/AIDS counsellors	44
2.9.1	Skills pertinent to HIV/AIDS counselling	54
2.9.2	Training techniques for HIV/AIDS counsellors	56
2.9.2.1	Summary of training methods	57
2.9.3	Implementation challenges	59
2.9.3.1	Results of National Audit on voluntary counselling and testing (VCT)	59
2.9.3.2	South African Health Care system (state and NGO's)	60
2.9.4	What tasks should HIV/AIDS counsellors be trained to perform?	61
2.9.5	Legal and policy issues	62
2.9.5.1	National (South Africa)	62
2.9.5.2	Provincial (KwaZulu Natal)	64
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY		65
Introduction		65
3.1	Overview of the research concerning HIV/AIDS counsellors	65
3.1.1	Identifying features of the research	66
3.1.2	Research questions	67
3.1.3	Research setting or sites	67

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

3.2 Ethical considerations of the research	68
3.3 Data collection method or strategy	69
3.4 Multi methods	71
3.5 Participants in the research sample	72
3.5.1 Sample sources	72
3.5.2 Screening and recruitment of participants in the sample	72
3.5.3 Reasons given by some HIV/AIDS counsellors for abstaining from the research	74
3.6 Data collection procedure	75
3.7. Data collection instruments	76
3.7.1 The researcher	76
3.7.2 Pilot semi- structured interviews and pilot focus-group	76
3.7.3 Semi -structured interviews and interview guide	77
3.7.4 Focus group and focus group discussion guide	78
3.8 Data capturing	79
3.9 Data analysis	80
CHAPTER 4: PRESENTATION AND DISCUSSION OF RESULTS	83
Introduction	83
4.1 The objectives of the research	84
4.2 Findings of the study	84
4.2.1 Profile of the research sample	85
4.2.2 Work bases of HIV/AIDS counsellors	89
4.2.2.1 Government work base	89

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

4.2.2.2 NGO work base	89
4.2.2.3 FBO work base	89
4.2.2.4 Tertiary work base	89
4.2.3 Nature of practical training	90
4.2.3.1 Duration and nature of training	92
4.2.3.2 Employment status at time of training	93
4.2.4 Levels of confidence on completion of training	94
4.2.5 Training providers	95
4.2.5.1 Levels of satisfaction with training	96
4.3 Counsellors' perception about HIV/AIDS counselling	104
4.3.1 Perceptions of motivation to become HIV/AIDS counsellors	104
4.3.2 Perception of the importance of HIV/AIDS counsellors	111
4.3.3 Perceptions of HIV/AIDS counsellors about their roles	113
4.3.4 The role of nurses versus HIV/AIDS counsellors	115
4.3.5 Perceptions of HIV/AIDS counsellors about their expanded roles	116
4.3.6 Counsellors' perceptions of core skills and competencies required of HIV/AIDS counsellors	118
4.4 Nature of training HIV/AIDS counsellors were exposed to	120
4.4.1 Structure of training courses	120
4.4.1.1 Entrance criteria	120
4.4.1.2 Size of the class	121
4.5 Training methods	121

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

4.5.1 Participatory experiential training methods	121
4.5.2 Didactic training methods	122
4.5.2.1 Formal didactic training methods that counsellors regarded as positive	122
4.5.2.2 Didactic learning methods learners were dissatisfied with	123
4.5.3 Evaluation and certification counsellors were exposed to	123
4.5.4 Counsellors' likes and dislikes of training	124
4.5.4.1 What counsellors liked about their training	124
4.5.4.2 What HIV/AIDS counsellors did not like about their training	125
4.5.5 Training content	125
4.5.6 Skills acquired	126
4.6 eThekweni counsellors' description of their primary roles as HIV/AIDS counsellors	128
4.6.1 Coping mechanisms used by counsellors in the study	130
4.6.1.1 Spiritual practices	130
4.6.1.2 Supervision	130
4.6.1.3 Clearly defined job descriptions	130
4.6.1.4 Other coping mechanisms	130
4.7 Focus group	131
4.7.1 Programme of the focus group	132
4.7.1.1 Introduction and setting group norms	132
4.7.1.2 Ice breaker	133
4.7.1.3 Addressing the objectives of the focus group	133
4.7.1.4 Focus group members' perception of core skills and competencies required of HIV/AIDS counsellors	134

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

4.7.2 Focus group members' views on how to improve counsellor training	135
4.7.2.1 Practical skills transfer	135
4.7.2.2 Personal growth and introspection sessions	135
4.7.2.3 Volunteering	135
4.7.2.4 In-service training based on in-service training manuals	135
4.7.2.5 Knowledge-based ongoing counselling skills training	136
4.7.2.6 Certification and recognition	136
4.7.2.7 Training content	136
4.7.3 Summary of focus group	137
4.8 Counsellors' suggestions for the enhancement of counsellor training	137
4.8.1 Selection criteria	137
4.8.2 Duration of the training	138
4.8.3 Creating a conducive environment for learning	138
4.8.4 Evaluation of trainees and issuing of certificates	138
4.8.5 Suggested content	139
4.8.6 Experiential learning and the balance between theory and practice	140
4.8.7 Facilitators	141
4.9 Summary	142
CHAPTER 5: CONCLUSIONS, SUMMARY AND RECOMMENDATIONS	145
Introduction	145
5.1 Rationale and content	145
5.2 Theoretical framework	146
5.3 Research approach	147
5.4 The objectives of the research	147

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

5.5	Conclusions of the study	148
5.5.1	Objective 1: To investigate what training counsellors in the eThekweni metropolitan area had received to prepare them as HIV/AIDS counsellors	148
5.5.2	Objective 2: To explore what these counsellors perceived to be the core skills and competencies of HIV/AIDS counsellors	149
5.5.3	Objective 3: To explore the extent to which counsellors in the eThekweni metropolitan area felt that the training they received had covered these core skills and competencies	150
5.5.4	Objective 4: To explore what these counsellors regarded as focus areas for the improvement of HIV/AIDS counsellor training	151
5.6	Summary	153
5.7	Recommendations	155
5.7.1	Recommendations for practice	155
5.7.1.1	An integrated learning model	156
5.7.1.2	Benchmarking	158
5.7.1.3	Mentoring, in-service training and ongoing support	158
5.7.1.4	Effective inter-sectoral collaboration	159
5.7.1.5	Minimum standards and SAQA accredited counsellor training	159
5.7.2	Policy recommendations	159
5.7.3	Research recommendations	160
5.8	Limitations of the study	160
5.9	Final note	161
	BIBLIOGRAPHY	163

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

APPENDIXES

Appendix A: Request and consent form to participate in semi-structured interview	173
Appendix B: Request and consent form to participate in a focus group	174
Appendix C: Demographic details	175
Appendix D: Discussion guide for semi-structured interview	176
Appendix E: Focus group discussion guide	177
Appendix F: Rating scale	178

TABLES

TABLE 1: Relevant studies pertaining to the research	45
TABLE 2: Gender of the HIV/AIDS counsellors	86
TABLE 3: Ages of HIV/AIDS counsellors	86
TABLE 4: Base level education of HIV/AIDS counsellors	87
TABLE 5: Work and training information of HIV/AIDS counsellors	88
TABLE 6: Duration of HIV/AIDS counsellor training	93
TABLE 7: Rating scale	96
TABLE 8: Philanthropic reasons	105
TABLE 9: Personal encounter with HIV	105
TABLE 10: Religious reasons	106
TABLE 11: Commitment to empowering the community	107
TABLE 12: Self-actualization	108
TABLE 13: A need to help others deal with the psychosocial aspects of HIV/AIDS	109
TABLE 14: Compromise	110

GRAPHS

GRAPH 1: Government training provider	97
GRAPH 2: NGO training provider	98
GRAPH 3: Faith - based organizations	99
GRAPH 4: College/ technikon training provider	100

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

GRAPH 5: University training provider	101
GRAPH 6: Mean satisfaction ratings of HIV/AIDS counsellors concerning their training	102
GRAPH 7: Satisfaction ratings of HIV/AIDS counsellor training on a scale of 1 to 10	103
PIE CHARTS	
PIE CHART 1: Nature of HIV/AIDS counsellor training	92
PIE CHART 2: Training providers of HIV/AIDS counsellors	95
TRAINING MODEL: Hendricks Progressive Training Model	156

CHAPTER 1

INTRODUCTION TO THE RESEARCH

INTRODUCTION

Mouton (2001:122) suggested that the first chapter of a dissertation should highlight the researcher's academic and research background and the factors that influenced the choice of the research idea, topic and the rationale or background to the study undertaken. This chapter outlines how the researcher derived the research topic from preliminary reading and her own work experience and goes on to the identification of the research questions and problem statement; the design and research methodology that were utilized and the chapter concludes with a brief about ethical issues and assumptions that arose concerning the study. In summary, the chapter maps out a rough overview of how the remainder of the study unfolded in keeping with Saunders, Lewis & Thornhill's recommendations for research reports (2003:420).

1.1 RESEARCHER'S ACADEMIC BACKGROUND AND EXPERIENCE IN RESEARCH

The researcher obtained Bachelor of Arts Degree in Social Work at the University of Western Cape in 1970, and worked as a social worker in the field for many years. As a prelude to entering the Masters Programme at the University of South Africa (UNISA), the fourth level of the Social Work Degree was completed for Non-Degree Purposes in 2004. A research exercise at a faith-based organization (Hendricks 2004) was submitted as part of the academic requirements, and thus laid the foundation for the current research project.

1.2 FORMULATION OF THE RESEARCH IDEA OR TOPIC

Previously cited Saunders et al (2003:13), said that before undertaking research, one needs to have at least some idea of what you want to do, and that this aspect was probably the most difficult and yet the most important part of the research project. The researcher's subsequent clarification towards the motivation for the study was therefore deemed necessary.

The above research exercise (Hendricks 2004), focussed on the evaluation of the HIV/AIDS counselling service at a faith-based organization in KwaZulu Natal and directly influenced the idea and choice of topic for the study. Mouton (2001:27) stated that a first obvious source of ideas for a research topic was your own experience and reflections about the things around you. The research exercise was semi-qualitative and involved discourse with six HIV/AIDS counsellors at the organization and a random, non-purposive sample of 35 clients of the client-base of 100 HIV-positive persons who were registered with the organization. Amongst the findings, one of the pervasive outcomes was the identified need for ongoing HIV/AIDS counsellor training amongst counsellors. Their training varied from two to four and six to seven weeks, and only one was a qualified Social Worker. The exercise intrigued the researcher, especially in terms of training. Clearly, the participants in the research exercise felt that their training was inadequate. There appeared to be no standardization in terms of training content and expectations of what training should offer, was also not dealt with. The sample was small and focussed only on the views of the HIV/AIDS counsellors in the organization where the student was based.

Mouton (2001:39) pointed out that it was not uncommon for students to choose topics that relate directly to their immediate working environment, hence the researcher successfully submitted a research proposal (Hendricks 2006) to the University of South Africa (UNISA) to motivate for further research to focus on the satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their training as HIV/AIDS counsellors.

1.3 RATIONALE FOR THE STUDY

According to Mouton (2001:48) the first phase of any research project involves transforming an interesting research idea into a feasible, researchable research problem. Appropriate to this, the researcher intends to outline the research steps that were taken to transform her curiosity about how HIV/AIDS counsellors perceived their counsellor training, into empirical evidence. The chapter outlines the rationale or background for the study, preliminary reading that influenced the topic and the statement of the research problem. In particular, the phase referred to has been documented in

the dissertation in conformity with Mouton (2001:48), which related to the rationale or background for the study, the preliminary literature review and the statement of the research problem.

To clarify further, the reasons that lead the researcher to select the topic were empirical, theoretical and practically-based (Mouton 2001:122), as will be explained in the ensuing paragraphs. Raimond (in Saunders et al 2003:15) emphasised that for most research topics, it was important that the issues within the research were capable of being linked to theory, whilst Mouton (2001:53) clarified that an empirical question seeks to ask something about the world we live in and addresses a real life problem. The researcher conducted the study within the realm of social work practice and the information that was sought through the study, was needed in order to address practical problems (Rubin & Babbie 1992:99). As service providers, it is imperative that we familiarize ourselves with practical problems pertaining to the training of HIV/AIDS counsellors, in view of their strategic and important role within the arena of HIV and AIDS.

To begin with, the researcher wanted empirical evidence of the experiences of people, in this instance, HIV/AIDS counsellors, in keeping with Mouton's proposal of good research (2001:53). The focus would be a phenomenon of interest as proposed by Todres (Holloway 2005:107), in this instance, the counsellors' experiences of their HIV/AIDS counsellor training would be reviewed. The research needed to be preoccupied with the concrete life-worlds of these counsellors, namely, their experiences of their counsellor training programmes.

Coyle & Soodin (1992:218) stated that the training experiences of HIV/AIDS counsellors differ and this motivated the researcher to explore the views of several HIV/AIDS counsellors who worked in different settings within the eThekweni Metropolitan area. It was anticipated that they would have been exposed to varied training opportunities and review of their perceptions of their training would be regarded as invaluable. The researcher wanted to find out what they experienced to be positive or negative factors and uncover possible areas for the improvement of HIV/AIDS counsellor training. The research would be of significance, especially viewed against the strategic and significant role of HIV/AIDS counsellors in South Africa. Moreover, a key priority area according to the HIV and

AIDS and STI Strategic Plan (2007-2011:14) was to increase voluntary counselling and testing (VCT) coverage. The HIV/AIDS epidemic is a severe health crisis in South Africa and a challenge that goes far beyond the provision of medical treatment (Strand, Matlosa, Strode & Chirambo 2005:1). In this regard Hoffman (1996:179) said:

“The loss of a loved one or a person one has established a relationship with, has been acknowledged throughout history as one of the most profound life experiences; and during protracted, life-threatening illnesses, family members and counsellors need to accompany them on a journey through deterioration, multiple loss and dying.”

The researcher believes that the sustainability of counsellors in the HIV/AIDS arena is critical, as pointed out by Hoffman (1996:179). A supportive view by Lahav (2001:210) affirmed the crucial role of counsellors in addressing the enormous challenges posed to people whose lives had been affected by HIV/AIDS. As such, Lahav emphasised that it is essential that the training of counsellors should be prioritized as a multi-disciplinary collaboration and partnership between educational institutions and the community at large.

While the disease kept ravaging the bodies, lives and social networks of their patients (Hlalele 2004:6), committed HIV/AIDS counsellors were needed to continue their counselling work so as to help patients achieve more fulfilling lives. Counsellor involvement, viewed against the background of an estimated 5.54 million individuals living with HIV/AIDS in South Africa in 2005 (HIV and AIDS and STI Strategic Plan 2007-2011: 9), reflects the gravity of the challenges confronting counsellors in the HIV/AIDS arena (Bekker & Wood 2006:1235). One might conclude that it is more important than ever before, for the counsellors who have been appointed to counsel HIV infected people and their families, to feel that they are suitably qualified to manage their daily duties in the field.

Practical reasons in support of the study, related to the urgency of the sub-Saharan epidemic. Over the past decade the number of HIV/AIDS counsellors trained in South Africa, steadily grew. In an attempt to record local service provision in the sphere of HIV/AIDS in South Africa, one of the

databases for example, which archived approximately 1,300 organizations and individuals involved in HIV/AIDS work (HIVAN/KZNCAN DIRECTORY 2005:8), clearly reflected HIV/AIDS counselling as part of integral service-provision for the majority of the service-providers mentioned in the directory.

The magnitude of HIV/AIDS counsellors' involvement appeared to be escalating. Hence, the researcher believed that a concerted local effort was needed to support these dedicated counsellors by establishing whether they felt that they were adequately trained. Their participation and contribution are pivotal to the success in fighting the spread of the disease and providing support to infected and affected people. However, at the time of the study, it appeared to the researcher that there existed no standardization of HIV/AIDS counsellor training programmes at a local level. One might assume that in order for HIV/AIDS counsellors to deliver efficient and effective quality services, some standardization in their training is necessary. Society can ill afford to lose the critical services rendered by HIV/AIDS counsellors. The researcher's study sought to afford counsellors a voice and opportunity to express their views and possible concerns, or to make suggestions concerning their training. The researcher hoped that such insights can increase our understanding of where the strengths and opportunities for growth lie, in order to ensure that we will have suitably qualified people to address and manage HIV/AIDS counselling service-delivery.

The researcher formulated specific research questions in order to focus on and seek answers to the research study namely, HIV/AIDS counsellors' experiences pertaining to their training.

Specifically, the researcher addressed the following research questions:

- What training have counsellors received to prepare them as HIV/AIDS counsellors?
- What do counsellors perceive to be the core skills and competencies required of HIV/AIDS counsellors?
- To what extent do HIV/AIDS counsellors feel that the training they received covered these core skills and competencies?
- What do they regard as focus areas for the improvement of HIV/AIDS counsellor training?

Preliminary reading on the topic provided information concerning the research topic, which further helped to formulate the research problem statement. The researcher, who is a practicing Social Worker, was influenced by the national guidelines and ethical code of her professional association, to promote and facilitate towards evaluation and research and to contribute to the development of knowledge (SACSSP 5.1.4 (b):9). As a result, the researcher embarked upon a journey of exploration with a particular aim and ensuing goals in mind.

1.4 THE PRELIMINARY LITERATURE STUDY

AIDS differs from any other disease that has ever plagued the world because it challenges our deepest secrets and taboos about sex and death, whether as individuals or as a community (van Dyk 2005:91). Moreover, AIDS is the one acronym or abbreviation that requires no translation throughout the world as it has become the most deadly sexually transmitted disease to ever confront humanity (Amod 2006:21).

The HIV/AIDS pandemic remains a global disaster. The joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), estimated the number of people living with HIV to be 33.2 million (30.6 – 36.1 million) worldwide according to their AIDS epidemic update ((UNAIDS & WHO AIDS epidemic update 2007:3). According to the same report (p4) over 6,800 persons became infected with HIV every day and over 5,700 persons died from AIDS. While approximately 10% of the world's population live in sub-Saharan Africa, an enormous 64% of all people living with HIV live in this region, including 77% of all women living with HIV, according to South Africa's current HIV and AIDS and STI Strategic Plan (2007-2011:19). An estimated one in three adults in Swaziland was living with HIV in 2005, making this the most intense epidemic in the world. South Africa, in terms of numbers, has one of the world's largest HIV epidemics.

Prevalence in HIV/AIDS varied considerably throughout South Africa. Some provinces were more severely affected than others. The highest antenatal prevalence in 2005 was in KwaZulu Natal (39.1%), where the study unfolded (HIV and AIDS and STI Strategic Plan 2007 -2011: 27). Although southern Africa had less than 2% of the world's population (van Dyk 2005:7), reasonable estimates indicated that there were about 5.4 million people living with HIV or AIDS in 2006 (HIV and AIDS and STI Strategic Plan 2007-2011:24).

Professor Gita Ramjee of the Medical Research Council said:

“The figures we are finding are unbelievable, and when I present them at international meetings, people are shocked. These figures are not even found in the high risk areas of East Africa” (Carnie, The Mercury, 7 September 2006).

Researcher Nina Veenstra from HEARD (Health Economics and HIV/AIDS Research Division), who was involved in a study on the actual burden of HIV/AIDS on the KwaZulu-Natal Provincial Health Services at the time of the researcher's study, concurred that South Africa (and KwaZulu-Natal in particular) was experiencing a rising HIV prevalence rate. She said that the resulting impact of HIV/AIDS on health systems was a double edged sword and that demand for care was increasing at the same time as the capacity for delivery services was being eroded. Veenstra explained that if health systems were to be maintained and even strengthened in a context of HIV/AIDS, then it was important to plan appropriately for the economic impacts of the epidemic on these systems. Yet, this required information concerning the way that health systems were responding, which was limited (Veenstra 2004: 3). She continued that HIV patients could soon account for 60 to 70% percent of hospital expenditure in medical wards.

Veenstra (quoted in Palitza 2006) said that already about half of all patients could be admitted to hospitals in South Africa and seek care for HIV-related illnesses, while the numbers of HIV-positive paediatric wards were even higher.

Pembrey (2007) wrote that it was difficult to overstate the suffering that HIV has caused in South Africa, with almost one in five adults infected. For each person living with HIV in South Africa and elsewhere, not only does it impact on their lives, but also on those of their families, friends and the wider communities. <http://www.info.gov.za/otherdocs/2007/aidsplan07.pdf>

On the other hand, the AIDS pandemic presented an opportunity to forge a society that values caring and confronts healthcare costs. Such a society would orientate itself around the needs of the poor and vulnerable people and learn to talk with and listen to those who are marginalized. These are issues of social reconstruction and governance and not medical issues (Strand et al 2005: xi). Similarly, van Dyk (2005:174) said that HIV/AIDS forced us to think of caring rather than curing, because there is no cure for HIV and AIDS.

Evidently, the disease appears to infiltrate every conceivable area of life. By its very nature, HIV/AIDS has wide-ranging socio-economic implications for societies affected by the pandemic (Strand et al 2005:11). Nevertheless, although the HIV pandemic is devastating to the world, it is possible to manage the pandemic. One form of management is through the use of counselling. Green (1989 cited in Coyle & Soodin 1992: 217) was quick to recognize that the provision of counselling should be regarded as an indispensable part of the services offered to those who are concerned with HIV/AIDS or who have contracted the disease. Bor & Elford (1992: 435) concurred and said that there was clearly a need for training and skills development in HIV/AIDS counselling and that this could increase as the numbers affected by HIV/AIDS continued to grow. Similarly, and more recently, van Dyk (2005:173) postulated:

“There is a very great need for counselling and for skilled HIV/AIDS counsellors. Professional psychologists, counsellors and psychiatrists often cannot cope with the demand, and many people don’t have access to professional services. We must therefore train every helper in the HIV/AIDS field to give basic counselling. Counsellors should also be trained to recognise serious problems and to refer clients if they don’t know how to cope themselves.”

Amongst key strategic functions in this decade were for counsellors to communicate the issues faced by positive HIV persons, throughout the organisations they serve, share best practice and involve and consult people with HIV/AIDS on any plans of action.

In response to the pandemic, South Africa developed the HIV/AIDS/STD Strategic Plan for South Africa in 1999. The third and latest national HIV and AIDS and STI Strategic Plan (2007-2011) was launched on the 12th March 2007. The purpose of the National Strategic Plan was designed to guide South Africa's response to HIV & AIDS & STI's control in the next five years. This was influenced by the National Strategic Plan of 2000-2005 as well as the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment (HIV and AIDS and STI Strategic Plan 2007-2011: 53).

The South African HIV and AIDS and STI Strategic Plan (2007-2011) represented the country's multi sectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS (HIV and AIDS and STI Strategic Plan 2007-2011:8). In order to meet national targets specific key areas needed to be pursued, that included amongst others, to increase coverage of voluntary counselling and testing and promote regular HIV testing as a key priority area (p 14).

As the number of infected and affected persons escalates, a vital people resource in the struggle against HIV/AIDS was recognised. HIV/AIDS counsellors were needed to support those infected or affected. They were called on to intervene in the lives of people affected by HIV/AIDS in many capacities. Such services (Richter, van Rooyen, Solomon, Griesel & Durrheim 2001:153) were, home-based care and a range of preventative and supportive services in the form of negotiating access to health services on behalf of their HIV positive clients, liaising with landlords and employers to retain accommodation and work in the face of all forms of discrimination, providing support to the family and attempting to link the family to non-governmental sources of food, money and clothes, and so forth. Subsequently, a concerted effort is needed to support these dedicated counsellors. A good point of departure could be to explore whether or not they believed they were adequately trained to undertake the responsibilities we as communities, have allocated to them. In

addition, the South African HIV and AIDS and STI Strategic Plan (2007-2011:55) stated that all interventions should be subjected to monitoring and evaluation and HIV/AIDS counsellor intervention was one such crucial form of intervention. For example, at the time of the study it was found that a number of HIV/AIDS programmes throughout various sectors were all grappling with the effects of the disease. Moreover, HIV/AIDS counsellor trainees need continued training and support (Coovadia 2000:62) to be kept up to date with relevant skills on how to manage the disease.

Due to the shortage of trained professional counsellors in Africa, paraprofessional counselling was viewed as a feasible way to address the growing need for psychological assistance amongst people with HIV/AIDS (Vollmer & Valadez 1999:1558). However, Maclain (2003:2) cautioned that paraprofessional counsellors were typically trained over a period of weeks compared to the years of training that professional counsellors received. Lay counsellors are not formally schooled in the human sciences as psychologists and therefore cannot be considered to be professionals. According to van Dyk (2005:173) there existed a very great need for HIV/AIDS counsellors and that professional psychologists, counsellors as well as psychiatrists could not cope with the demand on their own. The latter author proposed that in the dearth of professional services, “We must therefore train every helper in the HIV/AIDS field to give basic counselling” (van Dyk 2005:173). By implication, this also puts the spotlight on society to ensure that HIV/AIDS counsellors receive the training that they need to be able to provide efficient and effective services.

Several authors stressed the need for further investigation into counsellor perceptions and experiences of their training, and subsequent relevant themes that emerged in the literature, included:

- Inadequate response to the reality that VCT training was unsatisfactory (Richards 2004:2).
- A need to examine factors that impact on the counselling process and outcome, and the experiences and perceptions of HIV/AIDS counsellors were critical for this (Richards 2004:2).
- Counsellor perceptions of their training were critical to the confidence of new counsellors (Maclain 2003:186).

- Self-efficacy was linked to counsellors' perceptions of the effectiveness of their counsellor training course in terms of skills enhancement (Ortlepp 1998 in Maclain 2003:177).
- Counsellors felt that their training was inadequate (Green 1989: ii).
- The process of exploring and describing perceptions and experiences of counsellors involved in training programmes should continue (Lahav 2001:209 & Hlalele 2004:110).
- There existed positive results with regard to counsellor training but it was not clear what made training effective (Britton, Rak, Cimini & Shepherd 1999:63-64).

1.5 THE AIM, GOALS AND OBJECTIVES OF THE RESEARCH

The aim of the study was to uncover possible factors linked to the improvement of locally specific HIV/AIDS counsellors' training programmes that could impact positively on counsellor performance in the arena of HIV and AIDS. Subsequently, the researcher formulated specific goals to address the research aim and to guide the study.

1.5.1 THE GOALS OF THE RESEARCH

The goals of the study were:

- To engage HIV/AIDS counsellors in discourse about their experiences.
- To identify patterns and themes in their experiences and to come up with suggestions about what counsellors regard as relevant with regard to their training needs.
- To identify any locally specific issues that might be prevalent in the eThekweni Metropolitan area that could be used as a guide to shape training programmes for HIV/AIDS counsellors in this region.
- To utilize feedback from the study in the interest of HIV/AIDS counsellors and service providers, social work practice as a whole and to possibly influence policy issues with regard to the national training of HIV/AIDS counsellors.

1.5.2 THE OBJECTIVES OF THE STUDY

The objectives of the study were:

- To investigate what training counsellors in the eThekweni Metropolitan area received to prepare them as HIV/AIDS counsellors.
- To explore what these counsellors perceived to be the core skills and competencies of HIV/AIDS counsellors.
- To probe to what extent counsellors in the eThekweni Metropolitan area felt that the training they received covered these core skills and competencies.
- To explore what these counsellors regarded as focus areas for the improvement of HIV/AIDS counsellors.

Saunders et al (2003:25) said that objectives were more generally acceptable to the research community as evidence of the researcher's clear sense of purpose and direction with regard to undertaking the study.

1.6 OVERVIEW OF DATA COLLECTION TO ANSWER THE RESEARCH QUESTIONS

1.6.1 DESIGN OF THE STUDY

The purpose and objectives of the research directly influenced the way the study was designed. A research design is actually a plan of how the researcher decides to go about seeking answers pertaining to the research problem. As advised by Mouton & Marais (1994:193) the researcher understood that three aspects were usually discussed with reference to the design of the research, namely, the aim of the research, data or information sources and considerations of validity and reliability of the study.

1.6.2 AIM OF THE RESEARCH

Since the aim or purpose of the research was to develop an understanding of how counsellors in the eThekweni Metropolitan area with more than one year practicing experience as HIV/AIDS counsellors, experienced the training they received, the researcher chose to do so by means of an

exploratory research design. Such a design afforded the researcher the opportunity to enter into a journey of exploration with the counsellors in order to identify strengths and shortcomings based on their training experiences. The researcher thought that such an exploration with the counsellors on a personal level was deemed necessary, since they were an integral part of service delivery in a geographical area characterized by extremely high prevalence of the HIV pandemic.

Furthermore, the researcher adopted a phenomenological approach because the researcher was preoccupied with gaining an understanding of the meaning that the HIV/AIDS counsellors ascribed to various phenomena (Saunders et al 2003:250), which in this particular instance related to their training experiences. Sometimes the more philosophical term phenomenology was used to emphasize a focus on people's subjective experiences and interpretations of the world and this type of focus tended to apply to all qualitative enquiries (Rubin & Babbie 1992:362). Therefore, such an approach was very useful for a qualitative study of this nature. The research was also a case study, which was defined as a strategy for doing research that involves an empirical investigation of a particular contemporary phenomenon (HIV/AIDS counsellors training experience at a local level), using multiple sources of evidence (semi structured interviews and a focus group), as explained by Robson (in Saunders et al 2003:93).

1.6.3 DATA AND INFORMATION SOURCES

The research design integrated empirical research that was undertaken with the sample of twenty four counsellors who were drawn from faith - based organizations (FBO's), non-governmental organizations (NGO's) and government organizations. An additional category was added to include HIV/AIDS counsellors from tertiary institutions. It was felt that such a sample would be fairly representative of the HIV/AIDS counsellor population and provide a collective voice of the counsellors in the eThekweni Metropolitan area. However, the researcher was well aware that there were many other counsellors in the same geographical area who were actively engaged in the HIV/AIDS arena. Every effort was made to include counsellors with diverse ethnic and racial backgrounds and counsellors of both genders, although this was not a requirement of the study.

The sampling was intentionally purposive which enabled the researcher to use her judgement and select only HIV/AIDS counsellors from eThekweni Metropolitan area who fitted the sample profile that was outlined earlier. Such a purposive sample was best suited to assist the researcher to uncover the issues specifically related to satisfaction levels of HIV/AIDS counsellor training at a local level, as advised by Saunders et al (2003:175).

1.6.4 VALIDITY AND RELIABILITY OF THE RESEARCH

Prior to the commencement of the study the researcher was aware that internal validity required her to represent the reality and feedback obtained from the counsellors in a truthful way as advised by Holloway (2005:277). The information gained from the counsellors was tape-recorded and transcribed, but was not given back to the counsellors for review or member check. Bryman (2001 in Holloway 2005:277) wrote that many research colleagues argued against member check as this was problematic for a variety of reasons. Furthermore, phenomenologists in particular, rejected the notion of member check because the researcher would have transformed the data in the process of analysis and writing (Holloway 2005:277). However, Saunders et al (2003:252- 253) cautioned about concerns of data quality issues related to semi-structured or in-depth interviews. As such, he was referring to reliability due to the lack of standardization within the interviews as well as interviewer bias that might impact on the flow and response of the respondent and in the way that the responses were interpreted by the researcher. The same authors explained that there was likely to be an issue about generalisation of the findings from qualitative-based interviews, although validity of such studies was not raised as an issue.

The researcher made use of triangulation by means of recalling some of the counsellors in the sample to participate in a focus group discussion to engage the counsellors yet again, as advised by Saunders et al (2003:99), in order to promote reliability of the research findings.

1.7 METHOD OF DATA COLLECTION

The approach that was used to collect data was qualitative as it sought to firstly explore issues surrounding HIV/AIDS counsellor training. Saunders et al (2003:250) informed that in the event of undertaking an exploratory study such as the researcher's one, it was likely that qualitative research interviews would be included in the research approach. Based on the literature study, major themes for discussion were developed for semi-structured interviews and a focus group discussion with the participants for the purpose of triangulation. These themes formed the basis for the formulation of the semi-structured interview guide which was used for individual interviews with the counsellor respondents.

The semi-structured interviews were the primary data collection method. In an exploratory study in-depth interviews can be very helpful to find out what was happening and to seek new insights (Robinson in Saunders et al 2003:248). Open-ended questions, allowed participants the freedom to express themselves. In addition, face to face contact between the researcher and the individual counsellors during semi-structured interviews in a non-threatening environment created the opportunity to observe both verbal and non-verbal responses. Such a data collection method had the potential to facilitate deep insights into the perceptions and critical issues experienced by the HIV/AIDS counsellors. It also assisted in providing a contextual framework for the study. Saunders et al (2003: 248) said that semi-structured and in-depth interviews were used in qualitative research in order to conduct discussions to not only reveal and understand the 'what' and the 'how,' but also to place more emphasis on exploring the 'why.'

The purpose of the focus group as a data collecting tool of the study was to further explore the perceptions of the HIV/AIDS counsellors by means of triangulation. The group comprised of a mix of the counsellors who participated in the individual interviews. The focus group that was held with six of the participants sought to establish and verify the information that had already been acquired through the semi-structured individual interviews with twenty four counsellor participants. Since each method had its own effect, using different methods cancelled out the 'method effect' thus

giving more reliable conclusions. Hence, although the study was qualitative, reliability was increased by the use of more than one research tool or method that included the individual semi-structured interviews and the focus group discussions. Saunders et al (2000:100) stated that reliability can be determined by the question whether similar observations can be made by different researchers on different occasions and whether the study will yield the same results on different occasions. The issue of reliability was therefore based on whether the findings were really what they appeared to be about as ascertained through the semi-structured interviews and the focus group discussions.

1.8 DATA ANALYSIS

The tape recordings from the semi-structured interviews were transcribed by the researcher and content analysis from transcripts was carried out. Themes were extracted and a model framework was developed that guided the formulation of the focus group discussion guide. The same method of content analysis from transcripts were used to analyse the data from the focus group discussions. Data analysis included identification of statements relevant to the topic, grouping into meaningful units, searching for divergent perspectives and composite construction.

Overall, by using content analysis the researcher analyzed the transcripts utilising pattern seeking analysis from the transcribed audio recordings of the semi-structured interviews and the information obtained in the focus group discussions. Since qualitative inquiry was fundamentally interpretative, a data analysis spiral, was suggested. In other words data was organised into units such as stories, words or categories. The entire data was perused several times and general themes were identified to begin to make sense of the similarities and differences in the text based on break characteristics and finally integrating and summarizing the data. This process was carried out manually and no computer databases were utilised. However, the different themes were captured electronically by means of power point since it was found to be an effective and practical method. The supervisor verified the themes which emerged from the data, thereby ensuring synchronic reliability of the coding procedure. In addition, the written demographic details obtained from the counsellors prior to the commencement of the respective semi-structured interviews, were recorded through Excel in order to reflect some background information about the counsellors who participated in the study.

The researcher utilised a non-probability sampling technique which meant that the researcher might be able to generalize from the non-probability sample included in this study, but not on statistical grounds. With reference to explaining the nature of non-probability samples, Saunders et al (2003:152) mentioned that the probability of each respondent selected from the population was not known and in the case of this study, it would therefore not be possible for the writer to answer research questions or to address objectives in the study that requires statistical inferences about the characteristics of the HIV/AIDS counsellor population.

The sampling frame was primarily a directory consisting of 1,300 HIV/AIDS service providers in KwaZulu Natal. Nevertheless, it was very challenging to find counsellors to take part in the study for a variety of reasons that will be further discussed in the third chapter of the dissertation.

1.9 ETHICAL ISSUES CONCERNING RESEARCH

The researcher was aware that whilst she sought to engage HIV/AIDS counsellors in the study, she was ethically bound to do so according to certain research guidelines. According to Mouton (2001:238), ethics in research was preoccupied with what was considered to be right or wrong with regard to research and generally arose from accepted research norms and values that govern the researcher and the research process.

The study was conducted from a social work platform, therefore the researcher was interested in the writings of Rubin and Babbie (1992:57) who cautioned that social work research often, though not always, represents an intrusion into people's lives. Moreover, social work research often requires that people reveal personal information about themselves that might not be known to their friends and associates (Rubin and Babbie 1992:57).

The researcher strictly adhered to the professional values of respect, individualization, self-determination and confidentiality during the research process. Moreover, the researcher was aware that she should under no circumstances cause harm to respondents in any way, either by inciting them pain or discomfort or subjecting them to humiliation of any kind. Each respondent was presented with a consent form by the researcher prior to his or her engagement in the study.

The researcher was guided by research ethics that necessitated obtaining written consent from the counsellors, and was aware that their participation in the study had to be of a voluntary nature and that their rights to privacy and anonymity had to be respected. The following statement was included in the consent form for the protection of participants:

“... I know that I may withdraw from the research if I choose to or become uncomfortable.”

The researcher took heed of Raemer’s words of caution (2001:432) that ethical issues related to research and evaluation could arise at every stage of the evolution of a project and research activity. The same author mentioned that some ethical issues could emerge at various stages of the study. Such ethical issues could occur at the beginning stages when Social Workers formulated their research questions and basic methodology; whilst the research and evaluation were being conducted or at the conclusion of the research and evaluation, particularly in relation to data analysis and the reporting of results. The research process was carefully supervised by the promoter and second promoter.

1.10 ASSUMPTIONS CONCERNING THE STUDY

In pursuit of the above-mentioned goals and objectives of the current study, the researcher set out with certain assumptions.

- Firstly, the researcher assumed that the information gained from the study could add to the existing body of knowledge of social work and research in healthcare.
- Secondly, that the research findings would stimulate the involvement of other scholars to build on the information and further grow and explore it by conducting their own research projects.
- The researcher assumed that the findings would have direct implications on the training and development of HIV/AIDS counsellors in the eThekweni Metropolitan area. Ideally, a locally specific training module could be developed based on the findings of this study.

- It was assumed that when counsellors were satisfied with their training and felt that they were suitably equipped to do their work properly, they would be more motivated to work in the sphere of HIV and AIDS. Their retention as a proactive workforce would then be maximized.

The central issues of concern in this study were explained in the aforementioned chapter, which detailed why the researcher engaged in the study concerning the levels of satisfaction of HIV/AIDS counsellors in eThekweni with regard to the counsellor training they received. The second chapter highlights what is commonly referred to as the 'literature review,' which the researcher undertook in order to obtain pertinent information from other scholars in this field. Thereafter, the third chapter of the dissertation describes the methodological process that was followed during the study and sheds light on the HIV/AIDS counsellors in the sample. The subsequent findings of this study are presented and discussed in chapter four and the fifth and final chapter contains the conclusions, summary and related recommendations of the study.

CHAPTER 2

ADDITIONAL LITERATURE THAT INFORMED THE STUDY

INTRODUCTION

Knowledge does not exist in a vacuum and the main purpose of the literature presented throughout the second chapter as informed by Saunders et al (2003:420), was basically to set the researcher's study within a wider context. It was hoped that this could illustrate how this research could augment existing work in this field of service. Mouton (2001:86) stated that the term 'literature review,' did not in fact embody all that it was intended to convey. Similarly, Saunders et al (2003:420) recommended that the chapter should not simply be entitled 'literature review,' because literature should be reviewed in more than one chapter. Mouton (2001:87) explained that the term 'scholarly review' was more accurate since the researcher's interest was to learn from other scholars. It was therefore very useful for the researcher to scan the literature and to ascertain what answers already existed with regard to the research problem. Saunders et al (2003:420) advised that such an exercise could inform the researcher about avenues that had been pursued by other research scholars and could promote further insight into promising new directions.

The researcher set out to meet the following objectives in this particular chapter, namely:

- To present important definitions and key concepts for the purpose of clarification.
- To present significant pieces of research conducted to date in order to shed more light on the study and to provide more understanding of the research undertaken in this field of service.
- To highlight some identified gaps located within the field of research in order to indicate the relevance for the researcher's study.
- To ground the study within the researcher's theoretical paradigm.
- To establish the context of the research problem by learning from the valued works of other scholars and the existing policy issues that affect the research in this field.

The researcher integrated literature in this chapter that was sought from other studies such as theses, dissertations, surveys as well as journal and peer reviewed articles linked to the research topic.

Relevant books, reports, interviews, newspaper articles, magazines and conference papers were scanned. Although a preliminary review of the literature was done in the previous chapter by way of introducing the study, the researcher was guided by Yegidis & Weinbach (in Thyer 2001: 402) to find more available information in order to provide a deepened understanding about the research topic, its history, origin and scope. The researcher initially intended to include literature from 1995 to date, however, when the researcher found limited resources about the topic, the search was subsequently broadened to include earlier related references. Thyer (2001:410) advised that qualitative research should preferably incorporate the results of qualitative studies such as the researcher's study, however this could not exclusively be followed due to the scarcity of relevant studies within this scope of study.

2.1 IMPORTANT DEFINITIONS AND KEY CONCEPTS

All research involved particular key concepts around which they unfold and Mouton (2001:123) advised that clarification of such terminology should be defined as soon as possible. Hence the motivation for this particular section was to clarify relevant concepts concerning the study:

Asymptomatic - infected by a disease agent, but exhibiting no medical symptoms (Department of Labour HIV/AIDS Technical Assistance Guidelines: 1999: vii).

Confidentiality - the right of every person, employee or job applicant to have their medical information including HIV/AIDS status, kept private (Department of Labour HIV/AIDS Technical Assistance Guidelines: 1999: vii).

Disease - although we use the term 'disease' when we talk about it, AIDS is not a specific illness. It is really a collection of many different conditions that manifest in the body (van Dyk 2005:4).

Early Intervention Consultants - staff who had been hired as early intervention consultants had the responsibility to provide training to HIV/AIDS 501 trainers in accordance with the Minimum Standards (Department of Health Technical Assistance: HIV/AIDS 1999:5).

Minimum Standards - policy guidelines applicable to all Department of Health staff in South Africa who performed HIV/AIDS testing for clients, training of HIV/AIDS counsellors and trainers (Department of Health Technical Assistance: HIV/AIDS 1999:1).

HIV/AIDS Test - refers to any form of testing designed to identify the HIV status of a person, including blood tests, saliva tests or medical questionnaires (Department of Labour HIV/AIDS Technical Assistance Guidelines: 1999: vii).

Informed Consent to an HIV test - means when an individual gives expressed agreement to do an HIV/AIDS test, without coercion. The individual should feel equally free to grant or withhold consent (van Dyk 2005:338).

Opportunistic infections - infections that occurred because a person's immune system was so weak that it cannot fight the infection (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999: vii - viii).

Pandemic - an epidemic occurring simultaneously in many countries (Department of Labour HIV/AIDS Technical assistance Guidelines 1999: viii).

Counselling - a confidential dialogue between a client and a trained counsellor aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. Counselling may be provided by a professional or lay person (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999: vii).

Pre-test counselling - refers to counselling given to an individual before an HIV antibody test, to ensure that the individual had sufficient information to enable him or her to make an informed decision about whether to have an HIV anti-body test (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999:58).

Post test counselling - is counselling provided when an individual receives his or her HIV test results. Preferably it should involve one or more sessions (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999:58).

Positive living - a way of living with HIV and AIDS which enable people to cope with difficulties and challenges they might face and to live a long and fulfilling life (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999: viii).

Seroconversion - this refers to the point at which the immune system produces antibodies and the point in time when the antibody test registers HIV infection (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999: viii).

Care - refers to steps taken to promote a person's well-being through medical, psychosocial and other means (Department of Labour HIV/AIDS Technical Assistance Guidelines 1999: vii).

2.2 COUNSELLING AS A DISTINCT PROFESSIONAL ACTIVITY

This section describes how counselling developed as a professional entity. In addition, counselling as a model and an explanation about HIV/AIDS counselling, is discussed in this section.

2.2.1 BRIEF HISTORICAL BACKGROUND TO COUNSELLING DEVELOPMENT

There have always been 'counsellors' or people who listen to others and help them to resolve life challenges, explained Gladding (2007:3-7), a professor of counsellor education and the Director of the Counsellor Education Program at Wake Forest University in North Carolina. He informed that the word 'counsellor' had been associated with numerous descriptive adjectives to promote products and services, such as financial counsellors, pest control counsellors, and so forth. The author highlighted that counselling as a profession grew out of the guidance movement, which was in opposition to traditional psychotherapy, and yet current professional counselling encompasses clinicians who focus on both growth and wellness together with the remediation of mental disorders. Gladding said that the term 'counselling,' had eluded definition for many years. The Governing Council of the American Counselling Association (ACA), which is the largest professional organization representing counsellors, accepted a definition of the practice of professional counselling in 1997.

The definition is as follows:

“The application of mental health, psychological or human development principles, through cognitive, effective, behavioural or systemic interventions, strategies that address wellness, personal growth, or career development, as well as pathology.”

The above-mentioned definition contains a number of implicit and explicit points that were important for counsellors as well as consumers to realize, namely:

- Counselling deals with wellness, personal growth, career as well as pathological concerns.
- Counselling is conducted with persons who were considered to be well functioning and those who were having serious problems.

- Counselling is theory-based and
- Counselling is a process that might be developmental or intervening.

In addition to the general counselling definition, the ACA defined a professional counselling speciality within counselling such as marriage guidance counselling, mental health counselling, and so forth. Some definitions related to HIV/AIDS counselling will be discussed later in this dissertation.

2.2.2 EXAMPLE OF A COUNSELLING MODEL

The researcher was trained in the use of the model discussed here as part of her under-graduate training. She favoured using this as an example of a counselling model because it had been empirically validated. It was an eclectic model that had successfully been used in many countries and contexts of helping, including South Africa.

Gerard Egan (1994) developed a problem-management approach with regard to helping others at a professional level. In his book entitled 'The Skilled Helper: A problem-management approach to helping,' Egan described his model of counselling. He said that historically there had been a deeply embedded conviction that some people were capable of helping others under the proper conditions. This conviction had evolved and had been institutionalized in a variety of formal helping professions such as counsellors, psychiatrists, psychologists and social workers. He said that clients sought help because they experienced crisis, troubles, doubts, difficulties, frustrations or concerns. Often their emotions ran high and there were no clear-cut solutions. Egan advocated that the needs of the clients were the starting point in helping rather than the models and methods of the helper or counsellor. The helping process should be kept on a professional level and should be goal directed. Egan recognized two basic counselling goals. The first related to problem management and opportunity development and the other, to helping clients to become more effective at managing their own lives. The author divided counselling into three stages within his helping model, which firstly entailed exploration with the client about the current scenario, then established the imagined preferred scenarios and thirdly, developing strategies towards attainment of that preferred scenario.

The model guides and orientates the counsellor at any given time during the counselling process to gain understanding and to direct the helping process, in much the same way as a road map does. The stages might overlap and interact with one another and the model is not truly a linear one. Helpers or counsellors require specific skills and counselling techniques that are grounded in theory, to enable them to facilitate the counselling process. Egan's Helper Model includes three stages, namely:

Stage one - deals with the client's current scenario. The counsellor helps the client to identify, clarify and understand the existing state of affairs, which are unacceptable to them or to those who referred them for help. Egan operated from the assumption that problems only occur because life situations were not managed properly and opportunities were overlooked or not properly developed.

Stage two - is where the counsellor helps the client to develop a preferred scenario. Clients are helped to identify what they want in terms of their goals and objectives. This can only be based on a clear understanding of their unique problem situations and opportunities.

Stage three - deals with the activities required to change the client's situation. Clients are assisted to translate the identified strategies into viable accomplishing actions.

2.2.3 HIV/AIDS COUNSELLING

Much is written about HIV/AIDS counselling. The researcher favoured the work of South African author, Alta van Dyk, an academic, whose book on HIV/AIDS Care and Counselling (2005) was used in the ensuing discussion on HIV/AIDS counselling. The book provides comprehensive input into the process of HIV/AIDS counselling. The author stressed that the HIV test promotes unique psychosocial reactions and has enormous emotional, psychological, social and practical implications for the client.

Whilst basic counselling principles, together with values and communication skills continue to be relevant and applicable, there are other factors involved in the provision of HIV testing, which will briefly be highlighted.

It was generally accepted that HIV counselling needed to be plotted on a continuum of care. At the lowest point of the range was pre-test counselling, followed by post-test counselling and finally, ongoing HIV/AIDS counselling.

2.2.3.1 Pre - test HIV counselling

Pre-test HIV counselling focuses on the provision of all the necessary information in a supportive environment, to someone considering to take an antibody test. Reasons for testing as well as identification of high-risk behaviour and the implications of possible results of the test, usually form part of pre-test counselling. Specific guidelines formed for this process, emphasise relationship building, especially because very intimate details are discussed since HIV is primarily associated with sexual activity. A trusting relationship is facilitated by a discussion regarding confidentiality and ethical requirements within an atmosphere of privacy and safety. The client's reasons for wanting to take the test are explored.

The counsellor and client then do a preliminary assessment in HIV risk behaviours, amongst others: exposure to sexual risk history in terms of frequency and type of sexual behaviour, possible history of sexual abuse or sexually transmitted diseases, possible involvement in drugs or sharing of needles or non-sterile invasive procedures such as traditional circumcision, tattooing, whether the client was ever a prisoner, migrant worker or sexually involved without the use of condoms, and so forth. The client's knowledge of HIV/AIDS is also explored to find out if the client is aware of how HIV is transmitted. The counsellor prepares the client for the result of the anti-body test, which might be positive, negative or indeterminate, which means that the result was not clear either way. The test should then be repeated after a few weeks. Clients should also be informed about the window period, which is the time between infection and the appearance of detectable HIV anti-bodies in the blood stream. The different testing procedures and the way the test will be interpreted, is then explained. It is imperative for the counsellor to help the client to focus on what his or her motivation for the test was. The counsellor also assists the client to identify potential sources of support that he or she can turn to if the test renders an unfavourable result.

The client's earlier coping strategies are identified and the pre-test counselling process then concludes by the signing of the consent form.

2.2.3.2 Post HIV-test counselling

The content of the pre-test counselling interview is inextricably linked to post-test counselling, since this is when the results of the anti-body test will be revealed. van Dyk (2005:208) commented that "Not many things in life could be as stressful as waiting for HIV test results."

The counsellor's role is critical. There is no perfect or ideal way to inform someone of a positive result, except to let the client be consoled by a supportive presence. van Dyk (2005:209) cited useful guidelines developed by several authors. In the first instance, the counsellor should be certain about the correctness of the results and be emotionally ready to counsel in the event of a positive result. The counsellor must have a plan of how he or she will break the news and deal with the client's responses and needs, especially when the results confirm positive HIV status. The counsellor should assist the client by trying to simplify his or her identified options and if possible, to help with the immediate and most pressing concerns. The counsellor should check the client's plan for feasibility, including time-lines and although it is better for the client not to be alone, some people prefer some time alone first to work through the crisis by themselves.

Plans need to be formulated for the first 24 hours after receiving the results, followed by arrangements for follow-up visits as soon as possible. The client should also be given appropriate contact numbers and the counsellor should assess if the client presents a suicide risk and then respond in a more active manner in the form of crisis intervention.

On the other hand, a client can become very anxious when an inconclusive result is obtained, which prolongs the agony for a few more weeks because the test will have to be repeated. In the event of a negative result, it will no doubt be a welcome relief for both the client and counsellor. However, it could also give someone with high-risk behaviour a false sense of security. The possibility that the client might be in the window period should also be pointed out if the results are negative. It is

therefore extremely important that the client receive counselling in order to reduce the chances of future infection and to facilitate behaviour change.

2.2.3.3 Ongoing HIV/AIDS counselling

An HIV/AIDS positive result makes a tremendous and irreversible impact on a person's life and calls for important decision-making. In this regard, van Dyk cites Watts (2005:214) who said

“Aids is the stuff of nightmares, triggering many of our deepest fears.”

When people hear that they are HIV positive, they usually experience so much stress that they absorb very little information and follow-up visits and ongoing counselling are essential. The client then has the opportunity to ask questions and talk about personal fears and various life challenges.

Counsellors can help people to live beyond a diagnosis by paying attention to their psychological experiences and the impact of HIV infection on the significant people in their lives, as well as specific issues that clients tend to grapple with. Clients often grapple with the challenge of who to tell and important decisions and changes have to be made by the clients and their significant others to live within the constraints of the virus.

Counsellor training should prepare counsellors to do pre-and post-test counselling as well as ongoing counselling, bearing in mind that the medical and psychological symptoms of HIV and AIDS can affect the counselling process in a number of ways (Johnson cited in van Dyk: 2005:230). As such, training should prepare counsellors to counsel clients at any given point on this continuum of care.

The South African author cited in this section (van Dyk 2005:40) noted that although HIV was theoretically divided into different phases, in practice the phases were not separate and distinct with easily identifiable boundaries. van Dyk said that it was nevertheless helpful to divide HIV infection into phases. However, HIV-positive persons do not necessarily move in a distinct order from phase one to phase five of infection. In practice they are not separated and can move back and forth depending on the wellness of the infected person.

The author cited that at different phases on the continuum of care one should expect different levels of intervention and noted the different phases of HIV infection, namely:

- the primary HIV infection phase (or acute seroconversion illness)
- the asymptomatic latent phase
- the minor symptomatic phase
- the major symptomatic phase and
- the severe symptomatic phase or Aids-defining conditions.

HIV/AIDS counsellors should be trained to offer counselling services to HIV positive persons, irrespective of their so-called HIV infection phase.

2.3 GAPS IN THE RESEARCH INDICATING THE RELEVANCE OF THE STUDY

Hlalele (2004) said that there existed a striking lack of literature about counsellors' experiences in working with HIV/AIDS patients and that most of the readings cited were of a quantitative and semi-qualitative level. Furthermore, the majority of the research studies or reviews about HIV/AIDS counsellor training were done outside of South Africa, which points to the relevance of the researcher's local qualitative study.

According to the United Nations Programme on AIDS (UNAIDS 2006 -2007:7), one of the stated principles of Effective Prevention was that HIV/AIDS programmes must be differentiated and locally adapted to the relevant epidemiological, economic, social and cultural context in which they were implemented. Moreover, Grinstead & van der Straten, members of the Voluntary HIV Counselling and Testing Efficacy Study Group (2000:626) said that there was a need to improve counsellor training and counsellors who were actually providing the services were an important source of information about the process of counselling, the impact of being a counsellor and information about their training and support needs. For this reason, the researcher chose to focus on HIV/AIDS counsellors who were practically engaged in the field. Some authors in this field stressed the need to explore the counsellors' experiences of training and even encourage us to

explore counsellors' experiences of the selection criteria involved in their appointments (Britton Rak, Cimini & Shepherd 1999 & Coyle & Soodin 1992).

HIV/AIDS counsellors at a FBO in eThekweni where the researcher conducted a research exercise in 2004 for academic purposes in Social Work, Level Four, strongly indicated that they needed more training. However, due to the limited nature of that particular research exercise, the specificity of the training required was not determined (Hendricks 2004). Clearly, a qualitative study using a phenomenological approach, inviting counsellors to freely express themselves about their training needs, was indicated in these findings. In addition, authors Howard, Inman & Altman (2006) said that there was a need for more consideration for research if the epidemic was to be contained and more specifically, several studies underline the importance of cultural context (Grinstead et al 2000). The researcher thus chose to do a study at a local level in an attempt to address the identified gap in the research. Howard et al (2006) suggested that future research could ask trainees what their belief was about counselling and why counselling worked. Their responses could shed light on preferences, concerns and suggestions regarding training, based on the practical counselling experiences of the counsellors. Their suggestions for change should influence the development and implementation of future programmes for HIV/AIDS counsellors at a local level as indicated by Lahav (2001). No standardization of training packages for HIV/AIDS counsellors exist. There is also no standardization of lay-counsellor training offered in South Africa (Lindegger & Wood: 1995). Professional development is needed for counsellors (Howard et al 2006) together with ethical or professional guidelines to protect members of the public from inadequate counselling services (Lindegger & Wood 1995).

Emphasis was given in the literature to the importance of including basic counselling skills in different fields such as medicine, psychology and social work. Pressure was being placed on educators to integrate HIV education in all courses, even HIV basic counselling, because it is anticipated that people from all disciplines would encounter HIV/AIDS in the workplace. Britton et al (1999) supported this point of view, advising that there had been a strong motivation for the

inclusion of basic counselling skills for medical and paramedical personnel because they would all probably encounter clients with HIV/AIDS. With regard to most of the studies quoted above, focus was specific to one type of training programme in the form of quantitative or semi-qualitative studies and case studies, but the researcher's concern was that many of these studies were not locally specific. Mouton (2001:123) cautioned that researchers should be fair in the treatment of other authors. The inclusion in the study of HIV/AIDS counsellors with diverse backgrounds, was therefore regarded as valuable and this research project was therefore the researcher's choice.

2.4 THE PURPOSE OF HIV/AIDS COUNSELLOR TRAINING

In order to explore the appropriate provision of training opportunities for HIV/AIDS counsellors and their training experiences or needs, the researcher was interested in first gaining more insight into what HIV/AIDS interventions counsellors (and by implication, HIV/AIDS counsellors), are expected to actually perform since that should directly influence the content of their training. To begin with, Solomon, Van Rooyen, Griesel, Gray, Stein, & Nott (2004) whose research consisted of an audit of voluntary counselling and testing services in South Africa, said that there appeared to be a mismatch in the anticipated goals and outcomes of counselling intervention in the context of HIV/AIDS. To clarify their viewpoint, the authors cited the example of the stated counselling objectives listed by Bor, Miller, Scher & Salt (2004:21) for HIV positive clients, namely:

- To place the responsibility of problem-solving with those who define the problem (i.e. the client).
- To help the client find meaning or a new understanding of what it is to have AIDS.
- To normalise the views, feelings and experiences of the client.
- To help clients to feel that they have choices.

On the other hand, the latter authors noted by comparison, that the World Health Organization's Global Program on AIDS (WHO/GPA) formulated different aims for HIV/AIDS counselling namely:

- The prevention of HIV infection and psychosocial support for those infected by the virus.

Bor et al (in Solomon et al 2004: 21) promoted a perspective of facilitative counselling objectives in this field which favours the following key performance areas and attitudes, and these are:

- To facilitate and promote coping according to the clients level.

In sharp contrast to this, the World Health Organization's Global Program on AIDS (WHO/GPA), emphasises this and the provision of psycho-social support and the prevention of HIV infection. This perspective promotes pre-determined health goals such as disclosure, condom use and treatment compliance and adopts a top down approach of helping. The emphasis on prevention counselling has been criticised because it has historically failed to arrest the spread of HIV/AIDS. This perspective has been criticised by Balmer (in Solomon et al 2004:22) who added that it was unwise for us to ascribe an aim to counsellors that is unattainable for them. Expecting HIV/AIDS counsellors to prevent the spread of HIV/AIDS is an impossible task.

Against the background of the above information, Solomon et al (2004:21-22) deduced that there existed a critical and intrinsic difference within the respective definitions, namely, between the Global Program on AIDS counselling model for HIV/AIDS counselling and the conventional facilitative counselling approach.

At a local level, South African author van Dyk (2005:175) in her book 'HIV/AIDS care & counselling,' cited the description of the aims of counselling in accordance with Gerard Egan, which is to:

- "help clients manage their problems more effectively and develop unused or underused opportunities to cope more fully;"
- "help and empower clients to become more effective self-helpers in the future."

More particularly, with regard to HIV/AIDS counselling, van Dyk (2005:175) documented the works of Johnson to the effect that the aim of counselling the HIV-positive individual was to focus on the life beyond infection and not to dwell unnecessarily on the constraints of the disease.

Interestingly, Nulty (2003:6) also put the spotlight on the double role of HIV/AIDS counselling, and commented that counselling should be defined in the following two ways:

- “it can either be seen as giving someone information and advice for solving or coping with a problem;” or
- “facilitating a process whereby that person could make an informed decision concerning how to solve or cope with that problem.”

Richter et al (2001:153-4) said that HIV/AIDS counselling in South Africa was initiated by committed professionals and activists, who have continued to push their efforts forward in the policy and training domains. However, the aims of counselling that covers the full continuum of counselling and care, necessary to address the HIV/AIDS epidemic, still needs to be clearly defined at a national level to avoid counselling being inappropriately assigned responsibility for the major portion of all non-medical services in response to the epidemic, including welfare services. It was hoped that feedback from the HIV/AIDS counsellor sample could provide relevant insight in this regard, based on their involvement at a practical level and the diversity of their training experiences.

2.5 ISSUES OF HIV/AIDS COUNSELLOR IDENTITY

In the nineties, awareness was raised about the increasing numbers of HIV/AIDS infections. In response to this, counsellors were called upon to work with people whose lives had been affected by the epidemic, according to Richter et al (2001), Vollmer & Valadez, (1999), Hoffman, (1996) and Dworkin & Pincu (1993). However, the literature cautioned that at a local level, there was a distinction which had to be drawn between ‘Western’ counselling and ‘African’ counselling. Specialist counsellors in the West were seen to largely carry out the counselling of HIV/AIDS positive persons. In contrast, Green (cited in Solomon et al 2004:22), was of the view that developing countries with soaring infection rates, and by inference South Africa, could not build adequate counselling systems for HIV positive persons based on specialist workers. Primary health care staff had to be trained to provide counselling to HIV/AIDS people within the South African communities.

Nevertheless, van Delft (cited in Grobler, Schenk & Du Toit: 2003:vii) affirmed that people in the helping professions can make a positive contribution to the overall capacity-building of other people, empowering them towards developing new strategies for effective living. This, by implication, pointed to the involvement of counsellors within the sphere of HIV/AIDS. Even so, words of caution by Bor, Elford & Salt (1991:88) still echo, that specialists HIV/AIDS counsellors were potentially a costly addition to the health care team and that there was a strong case for training of existing health care workers in some HIV/AIDS related counselling skills. This better enabled existing health care workers to manage the psychosocial problems associated with the illness. More recently, van Dyk (2005:174) expressed concern that, with the exception of pre-and post-test counselling, very few people actually have access to trained counsellors in sub-Saharan Africa.

So, for the purpose of clarification and to put matters into perspective, there were 12, 163 social workers registered with the South African Council for Social Service Professions (Personal communication with the SACSSP 2007) out of a population of 44,187,637 (South African Statistics: 2006) and 6,000 registered psychologists according to the Health Professions Council (Personal communication, email, July 2007) Clearly, in the light of the latter statistics, it appeared that South Africa, out of necessity needed to enlist the services of all health related professionals as well as additional so-called lay counsellors who were conversant with HIV/AIDS counselling, to make counselling available to the estimated 5.54 million South Africans grappling with the effects of the pandemic. In addition, there existed many other reasons besides HIV/AIDS that might require services of such professionals.

The researcher was thus influenced to include HIV/AIDS counsellors from diverse training backgrounds, both professional and so-called lay counsellors, from different operational settings, since all of them face challenges posed by the epidemic. How and to what extent such counsellors believe their training equipped them for their role as HIV/AIDS counsellors, was crucial to the current research.

2. 6 HIV/AIDS COUNSELLING SERVICE DEVELOPMENT IN SOUTH AFRICA

Some historical background with regard to the origin of the research problem concerning HIV/AIDS counsellor training was sought in order to provide the researcher with further insights into the study. In this regard, Richter, Durrheim, Griesel & Solomon & van Rooyen (1999) and Richter et al & (2001) primarily provided some background concerning HIV/AIDS counsellor training in South Africa and are discussed below.

In 1992 a formal consultative process began when the Department of Health and the African National Congress (ANC) in partnership with representatives from labour, business and local authorities, faith-and community-based and non-governmental organizations, formed a networking structure called National AIDS Co-ordinating Committee of South Africa (NACOSA). The purpose of this coordinated commitment was to develop a national AIDS strategy for South Africa. The latter AIDS Plan was based on the fundamental principles of universal human rights, socio-economic developments to improve the quality of life of all South Africans and the integration of HIV/AIDS activities into the primary health care system. The National AIDS Plan, in relation to the counselling strategy highlighted five goals, namely:

- “To ensure that all people receive pre-and post-test counselling.
- To develop an extensive network of trained counsellors both within the healthcare settings and in the community.
- To ensure that all counselling is accessible and culturally sensitive.
- To develop and sustain an ethos of confidentiality and support.
- To integrate counselling into other service.”

However, five years after the Plan was adopted by key stakeholders including government, many elements failed to be fully implemented. This was due to insufficient consideration of the impact of the transformation processes, including restructuring at all levels of government. Another factor related to the uncertainty that the restructuring had occasioned for key role-players in counselling services, including the ATICC’s and NGO’s. The NACOSA Implementation Plan suggested that counselling services needed to occur from a continuum, from pre-infection through to the final

stages of the disease and after death. In order to provide such services of care, specific activities were identified, namely:

- “The formulation of a national counselling policy.
 - National standards of HIV testing.
 - National counselling guidelines and a national counselling curriculum.
 - To strengthen and expand counselling service and to increase access to counselling.”
- (Richter et al 2001: 149).

In 1996 there was increased capacity - building by the new democratic South African government concerning HIV/AIDS lay-counselling. Short-term funding to the value of R25 million from the Reconstruction and Development Program (RDP) funds were injected. The local lay-counselling project was significantly extended throughout the country to recruit, train and employ 30 lay-counsellors in each of the nine provinces, together with additional monetary provincial input. Ironically, a succeeding audit in 1997 revealed that more than half of the allocated money was not used for the designated purpose. Lay-counsellor projects were operating in only five of the nine provinces in South Africa. By implication, the training of counsellors at a local level to attend to people in the context of HIV/AIDS, was compromised at the time.

In 1997 when the Directorate for HIV/AIDS and Sexually Transmitted Infections (STI's) commissioned a review of the Implementation Plan, it drew attention to many of its unmet goals. Budgetary constraints compromised results even though the importance HIV/AIDS counselling was generally acknowledged. Subsequently nineteen municipality-based AIDS Training and Information and Counselling Centres (ATICC's) were opened during the 1990's in collaboration with provincial authorities to offer HIV/AIDS counselling (ATICC in eThekweni had been renamed as eThekweni Aids Program). The swing in funding from central to provincial budgets and the continued association of the ATICC's with the Apartheid government at that time, brought with it limited resources and heightened uncertainty. These severely affected services. Subsequently, the government built on an initiative from ATICC in Pietermaritzburg, which provided short-term funding to explore the feasibility of the Lay-Counsellor Project.

Richter et al (1999: ii) conducted an evaluation of HIV/AIDS counselling in South Africa. Firstly, based on an acknowledgement of HIV/AIDS counselling in prevention, care and support and the ways in which HIV/AIDS counselling differs from traditional individual or group health counselling. Secondly, the diversity of beneficial counselling approaches that might have developed in a country of heterogeneous people, conditions of life and circumstances under which services came to be established. The third factor related to the importance of a participatory approach to defining issues and perspectives in the field of HIV/AIDS counselling. The evaluation indicated that counselling services were vulnerable due to inconsistencies in funding administration and requirements. Nonetheless, high expectations of HIV/AIDS counselling as a key care component of AIDS strategies remained and additional evaluations in the study, made considerable recommendations in this regard.

2.6.1 TRAINING HIV/AIDS COUNSELLORS IN KWAZULU NATAL

An article by Brouard (1998) was traced and made interesting reading. His reflections on the topic are briefly summarized. Brouard was involved in HIV/AIDS counsellor training programmes in Gauteng, KwaZulu Natal and the Northern Cape and in the article, he shared some of his experiences about the realities and constraints in rendering effective localized HIV/AIDS counsellor training. Brouard said that the level of training varied in accordance with the capacity of each province and that the dynamics in each province was also an important variable. He wrote that KwaZulu Natal for example, due to high HIV prevalence, had more depth and variety in its training programmes. Brouard's view was that staff appointed to run counselling in the provinces were too junior (in terms of salary and power) and lacked the necessary professional background to train and manage such programmes. He believed that the ideal person to train should be a social worker or psychologist with a training background, with the minimum qualification being a psychiatric nurse with lots of training and counselling experience. He concluded that there were major problems with counsellor training in South Africa, despite there being pockets of excellence and some real commitment across the provinces to the development of proper training and counselling. Some of the other issues identified by Brouard that required further attention, were:

- **Standards:** There was a general lack of understanding regarding the intensity and difficulty of counsellor training. Sadly, only a superficial commitment to the minimum standards process existed, which stipulated that counsellors must be selected, properly trained, evaluated and supervised and that one trainer should train at most twelve counsellors at a time.
- **Time constraints and selection:** With the ever-growing need for HIV/AIDS counsellors, getting sufficient trainees to take ten days off from work to train as counsellors was very difficult. Also, trainees were often just informed that they had to pursue the counsellor training, without clear assessment of their interest and willingness to do so.
- **Advocacy and funding:** Major work was required to raise the status of counselling and counsellor training. Clearly, training budgets were often limited or inadequate.
- **Space and capacity:** Proper training venues, facilities and equipment were required as well as more experienced and competent HIV/AIDS counsellor trainers.
- **Counselling and training experience:** Counselling was seen as one of the 'soft sciences' and was given a lower status, priority and funding, despite being nationally and internationally accepted as an accepted component of the support for persons with HIV/AIDS.
- **Political infighting:** This was seen to be problematic and it was suspected that if the mentorship or Lay Counsellor Project was examined, it could become evident that some of the provinces were given money to run such projects, but simply absorbed the funds into other more favoured projects.

Brouard was convinced that until there was an equal political commitment across all provinces in South Africa to adhere to the Minimum Standards for HIV/AIDS counsellor training, matched by ongoing funding and appropriate appointments, the process would stall.

2.6.2 MINIMUM TRAINING STANDARDS FOR HIV/AIDS COUNSELLOR TRAINING

Brouard (1998:15-16) said that whilst we continually hear that standards of HIV/AIDS counselling should be improved, counsellors were only as good as the training they received. The Minimum Standards included the prerequisites, training requisites, post-training requisites and monitoring

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

requisites for HIV/AIDS counsellors and HIV/AIDS 501 Trainers and Early Intervention Consultants., mentioned in the Minimum Standards. The requirements were prescribed for all Department of Health staff, contract providers and volunteers who performed HIV counselling and testing for the public and training for HIV/AIDS counsellors and HIV Trainers. The guidelines specified that staff cannot perform HIV counselling and testing services without having successfully completed the HIV/AIDS 501 Client-Centred Counselling and Testing, Partner Counselling and Referral Services course as defined in the prescribed manual known as the HIV/AIDS 501 Course Manual. In order for a service-provider to offer HIV/AIDS counselling and testing services, the service provider must have completed the HIV/AIDS 501 Course Manual requirements. This prescribed training in client-centred counselling and testing, partner and referral services and provided a set course manual. Only people who had completed an HIV/AIDS 501 pre-requisite or equivalent course were considered eligible for the HIV/AIDS 501 training and full attendance of the entire course were required. On completion of the course, post training was recommended which involved training observing a minimum of

- one pre-test counselling session,
- one HIV-negative post-test counselling session and
- one HIV-positive counselling session.

According to the Minimum Standards, candidates who completed the course were required to conduct a minimum of one pre-test counselling session and one HIV-negative post-test counselling session under the supervision of an experienced counsellor. All trainers are held to the same standards and must have successfully completed the HIV/AIDS 501 Course and all post-training requisites within a six month period prior to becoming an HIV/AIDS 501 trained Trainer. Trainers must have a minimum of 40 hours counselling and testing experience, which included actual pre-and post-test counselling sessions and have the ability to teach, train and speak in public settings. On completion of their training, the trainers should first co-present at least one HIV/AIDS 501 Course with an Early Intervention Consultant and thereafter personally conduct a minimum of one HIV/AIDS 501 course under the observation of an Early Intervention Consultant. Subsequently Minimum Standards were also prescribed for early Intervention Consultants. Currently, the HIV/AIDS counselling course offered through the eThekweni AIDS Program (formally ATICC), is

aligned to these Minimum Standards, however, slight variations in course content offered by the other provincial branch in Pietermaritzburg, existed. This was in accordance with the Minimum Standards which stated that although training should be adequate and available, it must be locally coordinated, taking into consideration locally specific needs and resources.

2.7 SERVICE STANDARDS OF HIV/AIDS COUNSELLORS IN SOUTH AFRICA

De Zoysa et al (cited in Grinstead, van der Straten & The Voluntary HIV – Counseling and Testing Efficacy Group 2000: 625) said that the demand for HIV counselling with and without testing, was increasing in developing countries and counselling services were becoming more common. Yet, counsellor training and supervision in developing countries remained uneven and unregulated. The identified training parameters for HIV/AIDS counsellors are as indicated below.

2.7.1 ACCREDITATION

The South African Qualifications Authority (SAQA) is a body of 29 members appointed by the Ministers of Education and Labour and the functions of this body are essentially twofold, namely:

- To oversee the development of the National Qualifications Framework (NQF) by formulating and publishing policies and criteria for the registration of bodies responsible for establishing education and training standards or qualifications.
- The accreditation of bodies who fulfill monitoring and auditing achievements in terms of the minimum standards and qualifications required.

SAQA oversees the implementation of the NQF by regulating and monitoring the registration, accreditation and roles of the bodies referred to, as well as the registration of national standards and qualifications based on the framework. It specifies requirements for accreditation reward. It ensures that the registered standards and qualifications are internationally comparable in these instances. Only training courses that comply with these Minimum Standards are accredited. Even though this accreditation body exists for HIV/AIDS counsellor training, many service providers have not yet had their training courses accredited. As a result, HIV/AIDS counsellor training continues to take place in different forms, resulting in varied standards and offering little protection for people seeking HIV/AIDS counsellor training.

Moreover, accreditation was not a requirement for the provision of HIV/AIDS counsellor training in South Africa at the time of the study. <http://www.saqa.org.za>

2.7.2 BATHO PELE PRINCIPLES (putting people first)

The Department of Public Service and Administration (1997) launched The White Paper on Transforming Public Service Delivery, Batho Pele - People First.

<http://www.info.gov.za/whitepapers/1997/transpubserv.pdf>

The Batho Pele Principles are mentioned here as they pertain to service delivery to the public, and by implication, HIV/AIDS counsellors' training through service providers as well as to clients who are recipients of counseling services from the counsellors. Members of the public, including HIV/AIDS counsellors and their clients should thus expect adequate services based on these eight national principles referred to as the Batho Pele Principles. These are:

- **Consultation** - Citizens should be consulted about the level and quality of public services they receive and wherever possible, be given choices about the services offered to them.
- **Service Standards** - Citizens should be told what level and quality of public services they would receive so that they could be aware of what to expect.
- **Access** - All citizens should have equal access to the services to which they were entitled.
- **Courtesy** - Citizens should be treated with courtesy and consideration.
- **Information** - Citizens should be given full, accurate information about the public services they were entitled to receive.
- **Openness and Transparency** - Citizens should be told how national and provincial departments were run, how much they cost, who was in charge and which people were responsible for the services rendered to them.
- **Redress** - If the promised standard of service were not delivered, citizens should be offered an apology, a full explanation and a speedy remedy. When complaints were made, citizens should receive a sympathetic, positive response.
- **Value for money**- Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

For HIV/AIDS counselling to fulfill the eight Batho Pele Principles, one would expect that counsellors in this field should be consulted about the training and the training standards they would receive. Counsellor training should be accessible and HIV/AIDS counsellors should be treated courteously. They should be informed about the kind of training they would be receiving and nothing of relevance should be concealed from them. If the HIV/AIDS counsellors were not pleased after having completed the training, their complaints should be heard and responded to in a sympathetic and appropriate manner. In the light of the eighth Batho Pele Principle, counsellors could demand that the HIV/AIDS counsellor training offered to them should give them value for money.

2.8 HIV/AIDS COUNSELLOR TRAINING

Training of HIV/AIDS counsellors is diverse, nevertheless, one training course will briefly be outlined to facilitate better understanding of the training of HIV/AIDS counsellors at a local level.

2.8.1 REGISTERED UNIT STANDARD: BASIC LAY COUNSELLING IN A STRUCTURED ENVIRONMENT

The accredited counsellor training course entitled ‘Conduct basic lay counseling in a structured environment,’ is offered by SAQA(South Qualifications Authority). <http://www.regqs.sqa.org.za>

The purpose of this Unit Standard is to train counsellors who plan to offer lay counselling to individual clients (and their partners) from any community. The aims, definition, elements, functions and context of lay counselling are identified and explained using examples in the Unit Standard. Entry level is at NQF (National Qualifications framework) Level Four, which refers to Further Education and Training (FET) at school, colleges and trade.

Of note is that this particular counsellor training course is not intended for persons who seek to offer counselling to children, couples or groups, because counselling to such groups require additional and more specialized knowledge, skills and competencies. They were dealt with separately in other Unit Standards. Nevertheless, on completion of the course, an accredited lay counsellor should be able to describe the functions and limits of the lay counsellor and set up a structured counselling environment, which offers confidentiality and encouraged freedom of expression. In addition, the course familiarises the candidate with the requirements of lay counselling, whilst providing the

means to reflect on the process of counselling, within the context guided by stated principles. Essential counselling skills such as attending to questions, listening, body language, summarising, paraphrasing, silences, pacing and timing are dealt with. <http://www.regqs.saqa.org.za>

The Person Centred approach of Carl Rogers together with guidelines in the Skilled Helper, written by Gerard Egan (whose model of helping was earlier discussed in this document), forms the basis of the content approach to lay counselling with regard to cognitive, behavioural, interpersonal relationships and groupwork. Trainees are expected to develop an understanding of the requisite approach towards enabling them to acquire a deepened understanding of themselves and others, and to give insightful guidance and support within the framework of respect and unconditional acceptance. The training emphasises specific qualities, skills and personal abilities of the trainees towards becoming competent lay counsellors, such as empathy, reliability, unbiased feelings, integrity, a non-judgemental attitude, professionalism, communication skills and interpersonal skills.

Importantly, legal and ethical issues and limits pertaining to clients in a lay counsellor capacity are dealt with. Also, issues concerning responsibility to clients and critical values, responsibilities, contracts and boundaries within counselling, whilst stressing confidentiality, accountability and supervision of lay counsellors are covered in the Lay Counseling course. Specific outcomes and assessment criteria of these lay counsellors therefore relate to their ability to describe the functions, limits as well as the qualities and skills of a lay counsellor. The counsellor and counselling session is managed and mentored and includes ongoing supervision, monitoring, assessment and debriefing. An assessment session might be scheduled. The researcher would like to stipulate that HIV/AIDS counsellor training courses in eThekweni and elsewhere in South Africa were not compelled to seek accreditation with the Health and Welfare SETA at the time when the research was conducted.

2.8.2 NURSE COUNSELLORS

Nurses were at the forefront of the health care delivery system in South Africa and carried the core responsibility for the delivery of primary health care. This was the view of two South Africans, Middleton & Solomon who presented a paper at the International Conference on AIDS (2002), and the relevant issues they highlighted in their paper, will briefly be mentioned here.

Within the context of the HIV epidemic, nurses and lay counsellors form the majority of those responsible for the delivery of VCT and ongoing counselling, care and support. They pointed out that VCT evaluation research has drawn attention to the adequacy of initial and ongoing training of counsellors and the necessity for supervision and support. However, they noted that HIV/AIDS counselling training courses appear to be developed in relative isolation and are argued to be deficient in several respects. They highlighted amongst others things, a need for critical reflection of counselling that facilitates skills and processes grounded in theory and the ability to respond to relevant and important contextual and cultural factors. They said it might be that counsellors were inadequately prepared to render a service that matches the primary health care agenda. In addition, their paper reviewed HIV/AIDS counselling with reference to counsellor training and training models and highlighted that criticism of the conceptual frameworks and training processes was evident. The authors recommended that HIV/AIDS counsellor training should be informed by various professional training theories and methods and that Psychiatric nurse training for catalytic practice together with the incorporation of a critical discourse analysis capacity, could help to accomplish an emancipatory counselling practice. The researcher hoped that involvement of a broad spectrum of counsellors, including nurse-counsellors, in this piece of research, could shed some light on the issues and possible concerns as well as suggestions they might have with regard to the training of counsellors in HIV and AIDS the in the eThekweni Metropolitan area.

2.9 TRAINING NEEDS OF HIV/AIDS COUNSELLORS

As indicated in chapter one of this dissertation, there had been a scarcity of literature on the training needs of HIV/AIDS counsellors. Nevertheless, in scanning the literature, the researcher identified a few significant studies which are listed below, highlighting specific outcomes relevant this study.

TABLE 1: RELEVANT STUDIES PERTAINING TO THE RESEARCH

No.	Author/s , Date & Place	Title & Context of the Study	Significant Conclusions of the Study
1.	Adendorff C. & Wood G. 1995. Pietermaritzburg, KwaZulu Natal South Africa.	<p>Evaluation of ATICC's basic HIV/AIDS counselling course.</p> <p>The Department of National Health sponsored a study to investigate whether ATICC's (Aids Training and Information Counselling Centre) ten-day course in basic pre-and-post test counselling skills was positively impacting on trainees and if it is possible to predict successful counsellors. A variety of methods were used to assess a sample of 90 trainees before and after training over a period of 19 months.</p>	<p>The study concluded that ways needed to be found to assess (or develop) trainees' acquisition of theoretical knowledge about HIV/AIDS after training; their self-knowledge and insight; attitudes and beliefs and skills at different stages of the counselling process. Many trainees lacked self-confidence and role-play was found to be especially stressful by self-conscious and shy trainees.</p> <p>Training in basic counselling skills must be viewed as part of training and a supervision process and subsequent exposure to advanced counselling courses; candidate screening is imperative for training courses that must be conducted by experienced trainers in a flexible and intelligent way, through screening instruments; empathy scales were found to be effective; candidates must be vocationally and emotionally equipped to conduct maximum counselling sessions; ongoing evaluation of counsellor training was considered essential; course content should be addressed in the context of dynamic research findings in the field.</p>
2.	Stein J, Steinberg M, Van Zyl S, Allwood C, Karstaedt A, Brouard P. 1995. Soweto, South Africa	<p>Nurse-counsellors' perceptions regarding HIV/AIDS counselling objectives at Baragwanath Hospital, Soweto.</p> <p>The study attempted to gain insight into the ways in which nurse-counsellors at Baragwanath, a large South African hospital in an area of high HIV prevalence,</p>	<p>The findings of this study suggested HIV/AIDS counselling goals of emotional support and health promotion were set at variance in unsuspected ways.</p> <p>(a) the provision of emotional support was interpreted by the nurse-counsellors as the alleviation of immediate distress, and</p> <p>(b) the facilitation of health promotion was interpreted by them as the provision of information and advice.</p> <p>It was suggested that the development of adequate standards for the initial training and ongoing supervision of HIV/AIDS nurse-counsellors in South Africa, as</p>

		perceived their counselling objectives.	Africa, as elsewhere, was considered to be imperative.
3.	Vollmer NA. & Valadez JJ. 1999. Kenya	<p>A psychological epidemiology of people seeking HIV/AIDS counselling in Kenya: an approach for improving counsellor training.</p> <p>Study participants included 307 Kenyans tested for HIV at any of the six clinics in Nairobi specialising in STDs, tuberculosis and other infectious diseases. Pre-and post-test and follow-up counselling was provided by sixteen HIV positive Para-professional counsellors (PPC's). Data consisted of demographic, physical and psychological information reported by 168 clients who sought follow-up counselling.</p>	<p>The study concluded that training of Para-professional counsellors (PPC's) should be relevant to problems encountered during counselling. Results indicate that PPC's could expect clients to present one or more of fifteen factors during counselling. The authors further simplified the fifteen factors into seven broad problem areas, as follows:</p> <ol style="list-style-type: none"> 1. Financial worries (meeting my family responsibilities; economic concerns about basic needs). (1- 2 factors) 2. Children (concern for children's future; protecting my children from HIV infection). (3 - 4 factors) 3. Dilemma in personal relationships (hate and blame partner; problems with partner/ spouse). (5- 6 factors) 4. Relationship with others (communication and counselling; rejection; secrecy; I am a burden to others). (7- 10 factors) 5. Self-image (self-hate; I am a burden to others). (11 – 12 factors) 6. Treatment (responding to treatment concerns; gaining access to treatment). (13 – 14 factors) 7. Denial (denial - was I bewitched?). (15th factor) <p>Demographic characteristics explained small amounts of variance in the distribution of factor scores. The authors said that the fifteen factors identified in the study, although descriptive and preliminary, could form the basis of a training curriculum for HIV PPC's. In addition Minimum Standards and accreditation policy development offered new hope in terms of counsellor training.</p>

4.	<p>Britton PJ Rak CF. Cimini KT. & Shepherd JB.</p> <p>1999.</p> <p>America.</p>	<p>HIV/AIDS education for counsellors: Efficacy of training.</p> <p>The study addressed the efficacy of an intensive model of HIV/AIDS counsellor training. The elective course had been taught at two universities in counsellor education Masters' programme over a period of four years. From 1994-1997 at an urban university on two consecutive weekends and in 1996 as a daily weeklong course at a private university in a suburban area. Both formats were intensive and experiential and the average class size was 24.</p>	<p>The study supported the efficacy of HIV counselling training for graduate students in counselling education; there was positive evaluation of the course and experiential training methods, which positively affected students. There was no specific information as to what made training effective; perhaps counsellor education programmes might consider offering an elective course in HIV/AIDS to provide intensive training to interested students; adding HIV/AIDS content material to the curricula of required courses e.g. classes in multicultural counselling and ethics, would allow all students to receive basic HIV/AIDS training; the data supported the strength of experiential/ intensive types of curricula, because many students felt the course positively affected their overall counselling skills.</p> <p>The authors said that there was a need to further explore the efficacy of these types of training in other counsellor education content areas.</p>
5.	<p>Richter L. Durrheim K. Griesel D. Solomon V. van Rooyen H.</p> <p>1999.</p> <p>Pietermaritzburg, South Africa</p>	<p>Evaluation of HIV/AIDS counselling in South Africa.</p> <p>The situational analysis, constructed from key informant interviews and archival documents on HIV/AIDS counselling, depicts the historical background to HIV/AIDS counselling in South Africa, and specifically the role lay counselling services.</p>	<p>One overarching conclusion of the study was that despite valuable service rendered by counselling services (in 1999), the impact and reach of counselling (relative to its potential) was relatively narrow and limited. The situation appeared little changed from that depicted in the 1997 counselling Review in South Africa. Richter et al identified various contributing factors, amongst others:</p> <p>Limited financial and physical resources; insufficient awareness and acceptance of counselling (by both institutions and communities); limited capacity to reach target populations; secrecy and stigma as off-shoots of confidentiality concerns; counselling models that seem over-determined by the nature of the setting and possibly</p>

			<p>by training; shortage of well-selected and trained counsellor staff; reliance on volunteers; reliance on staff with multiple roles; deployment of counsellors in non-counselling functions; high stress and burnout of counsellors; limited promotion and maintenance of skill, knowledge and standards amongst counsellors; systemic effects(linkage with referral networks; non-existence of referral service resources; low levels of inter- sectoral coordination; low levels of national and provincial support); burdening counselling with most of the social and welfare issues in HIV/AIDS.</p> <p>Counselling services appeared effective in narrow domain (at the time), but precariously balanced and vulnerable to breakdown and multi-pronged intervention needed to address this towards being effective in the epidemic; there needed to be separate and clear goals for counselling and its functions, and the clarification of which psycho-social and medical services along with the continuum of care need to be developed in support of counselling function. These should constitute a focal objective for strategic planning.</p>
6.	<p>Grinstead OA. & van der Straten 2000.</p> <p>Kenya and Tanzania</p>	<p>Counsellors' perspectives on the experience of providing HIV counselling in Kenya and Tanzania: the voluntary HIV-1 counselling and testing efficacy study.</p> <p>A sub-study of the Voluntary Counseling and Testing Efficacy Study, conducted focus groups and individual interviews with eleven HIV/AIDS counsellors in Kenya and</p>	<p>The counsellors said that their jobs were both stressful and rewarding. In addition to their obligations in the counselling relationship (providing information; protecting confidentiality and being non-judgemental), they also perceived pressure on them to provide information and to be good role models in their communities. Additional stresses related to external (economic and political) conditions; 'spill over' of HIV issues from their personal lives and providing counselling in a research setting.</p> <p>Counsellor stress might be reduced and their effectiveness and retention improved by the following six ways:</p>

		Tanzania to describe their roles and experiences of providing HIV-related counselling in developing countries.	<ol style="list-style-type: none"> 1. Allowing work flexibility. 2. Providing supportive, non-evaluative supervision. 3. Offering alternatives to client behaviour change as the indication of counsellor performance. 4. Acknowledging and educating about 'emotional labour' in counselling. 5. Providing frequent information updates and incentive training. 6. Encouraging counsellor participation in the development of research protocols.
7.	<p>Panter AT. Huba GJ. Melchior LA. Anderson D. Driscoll M. German VF. Henderson H. Henderson R. Lalonde B, Uldall KK. & Zalumas J.</p> <p>2000.</p> <p>America</p>	<p>Trainee characteristics and perceptions of HIV/AIDS training quality.</p> <p>The study presented findings from 6,388 trainees who participated in 604 HIV/AIDS educational training sessions offered by seven Cooperative Agreement Projects.</p>	<p>Across a diverse set of HIV/AIDS training projects, findings of the study showed that trainee attributes were associated systematically with higher mean ratings in training quality. Recognizing limitations on self-reported documentations of trainee characteristics and perceived quality, impacting the qualities were:</p> <p>ethnicity, age, professional credentials, primary involvement with HIV-positive individuals, comfort levels in treating HIV-positive individuals, and reasons for doing the training. Factors un-related to training quality included gender and experience in the HIV/AIDS field.</p> <p>In addition, when designing HIV/AIDS education programmes, it was important to pay special effect that some professionals (e.g. doctors), would not perceive the training as useful as opposed to others (e.g. nurses). Therefore, the educational programmes needed to be adjusted to maximise educational experiences and excellence in HIV/AIDS training for all trainees.</p>
8.	<p>Lahav N.</p> <p>2001.</p> <p>Port Elizabeth</p>	<p>An HIV/AIDS counsellor training programme: an evaluation.</p> <p>The study evaluated a HIV/AIDS counsellor training programme</p>	<p>The study concluded that those involved in the counsellor-training programme, had been satisfied with the development and implementation of the programme. Suggestions for change would influence the development and implementation of future programmes, which would continue to undergo a process of evaluation to suit the changing needs of HIV/AIDS counsellors in</p>

		<p>conducted in 1999 at the University of Port Elizabeth. The programme was funded by the Department of Health and coordinated by the Faculty of Health sciences. The programme included 54 trainees, mostly nurses and the aim of the study was to explore and describe the perceptions and experiences of trainees.</p>	<p>the region. The role of counsellors in addressing the challenge posed to those affected by HIV/AIDS was essential. The ongoing training of such counsellors was a priority, which necessitated multi-disciplinary collaboration and partnership between educational institutions and the community.</p> <p>It was found that the training curriculum was valid, however, there was concern about acquisition of practical skills. The study found that trainers provided expertise and that trainee selection methods were adequate and that the language and style were appropriate. However, sometimes the trainees had difficulty understanding medical terms. The study confirmed that the training programme was relevant to the local HIV/AIDS epidemic and that time structuring of the programme was optimal, but that daily running time should be changed.</p>
9.	<p>Nulty M. 2003. Grahamstown, South Africa</p>	<p>The experiences and needs of HIV/AIDS counsellors at Settlers Hospital, Grahamstown: a multiple case study.</p> <p>The sample consisted of four HIV/AIDS nurse-counsellors working at Settlers Hospital, Grahamstown. The study focussed on how they dealt with the dual roles of non-directive listening and the more prescriptive advice-giving; their stressors and the support-structures they had or needed to be more effective counsellors.</p>	<p>The findings of the study indicated that HIV/AIDS counselling is an emotionally stressful occupation.</p> <p>Contributory factors included the twofold role of promoting prevention and serving as empathic listeners. Other stresses derive from issues of confidentiality and stigma concerning HIV/AIDS, counsellor identification with clients' experiences and the demographics of HIV/AIDS in South Africa. Situational stresses which arise from working as both nurses and counsellors in a public health institution were also identified.</p> <p>Recommendations were made to alleviate the counsellors' stress in the form of facilitated emotional support groups, professional supervision, managerial support to improve the working environment and ongoing supervision.</p>

10.	<p>Hlalele MK. 2004.</p> <p>Pretoria South Africa</p>	<p>An exploratory study of the psychological impact of HIV/AIDS patients on the counsellor.</p> <p>The study presents the narratives of four female counsellors at the neurological clinic in Kalafong Hospital, Pretoria, who share their experiences of working with HIV/AIDS patients.</p>	<p>Central themes that emerged from the study related mainly to the unique psychological effects and experiences of the counsellors whilst working with HIV positive persons. Some of the counselling issues identified that captured the attention of the researcher were:</p> <p>Counter-transference; coping with work stress; high level of perceived expectations; psychological responses to HIV-positive results; counsellors as emotional workers and boundary between private and professional life.</p> <p>The participants experienced other manifestations of distress, for example depression, anger, guilt and loneliness.</p> <p>The study concluded that little attention was given by health authorities and researchers to the well-being of the HIV/AIDS counsellors who provided significant services. In addition, it was crucial that regular counsellor education programmes adequately prepare counsellors to address issues faced by patients.</p>
11.	<p>Richards K. 2004.</p> <p>Zimbabwe</p>	<p>Combating the spread of HIV in Zimbabwe through improved counsellor, practice, supervision, and support.</p> <p>Eight counsellors participated in the study, half were male and half female and they represented the four main racial groups in Zimbabwe. They worked in public settings and geographically represented rural, high-density, town, and city settings.</p>	<p>Though the counsellors in this study were well trained, they reported that most counsellors in Zimbabwe were not. They also relayed that most counsellors did not have adequate support and supervision. Counsellors should have weekly supervision and have access daily to counsellor supervision. The Release Counsellor Supervision model might be a useful model to help counsellors in Zimbabwe to develop their skills. Institutes of higher education could partner with VCT centres in order that the partners benefit in terms of research and manpower. Training across VCT centres or NGO's needed to be consistent.</p> <p>Voluntary counselling and testing (VCT) centres needed to operate in an ethical manner in regard to all aspects of their operations, whether it was around confidentiality, advertising, staff training, and support and supervision services. VCT services should be accessible and affordable. The government could play an active role in the development of counsellor training and VCT policy.</p>

			<p>The government could set policy that requires national guidelines on HIV counselling training and testing to be developed and disseminated. The government could require that counsellors were certified and/or licensed through the Health Professions Council.</p>
12.	<p>Solomon V. Van Rooyen H. Griesel R. Gray D. Stein J. Nott V.</p> <p>2004.</p> <p>Pietermaritzburg KwaZulu Natal</p>	<p>Critical review and analysis of voluntary counselling and testing literature in Africa.</p> <p>This investigation forms part of a wider audit of the current status of VCT services in South Africa. A primary aim of the audit was to provide an analysis of facilitative or obstructive factors affecting effective VCT service delivery in South Africa. Thus, an audit of critical literature review and analysis of all VCT literature in Africa.</p>	<p>The analysis strongly demonstrated the construction of VCT fundamentally as primary prevention and secondly as health promotion or secondary prevention. VCT as preventative hinged on two themes, namely the assumption that a linear relationship existed between knowledge of HIV status and behaviour change, and the educational outcomes of the counselling process assumed to yield behaviour changes. A sub-theme in secondary prevention construction includes the notion of psychosocial support.</p> <p>The construction of VCT as primary prevention prioritises the population whereas the secondary construction prioritizes the well-being and health status of HIV positive individuals. Many studies had not supported the primary prevention outcomes of VCT. Also, health promotion construction hinges on assumptions about the integrity and competence of health services that may not match policy aims in many instances.</p> <p>In the unpublished literature and the study as a whole, the lack of agreement and the tensions between varying constructions of VCT was identified as an important barrier to implementation. The authors said that an implementation strategy rooted in a confused conceptual base generates difficulties down the implementation line. Agreement needs to exist between the construction and definition of VCT on all levels within the HIV context.</p>

The researcher's scanning of the above-mentioned tabled studies, was valuable to inform and contextualize her study and amongst others, provided the following insights:

- HIV/AIDS counselling should be more clearly defined in terms of the objectives, definitions and roles expected of counsellors in this field.
- HIV/AIDS counsellors were expected to perform double roles, which is to address the psychological well-being of clients as well as promote health promotion goals.
- HIV/AIDS counselling was a broad concept and clearly refers to providing a continuum of care ranging from pre-test, post-test and counselling in palliative care.
- The range of psycho-social issues that counsellors had to deal with were extremely broad and complex for example, dealing with the impact of HIV/AIDS at a personal level; stigma-related issues; family responses to the client's positive status; relationship challenges; financial implications; coming to terms with mortality, and so on.
- Home-based care was quite specialized and basic training in HIV/AIDS was inadequate to equip one to provide this meaningful function adequately.
- Best practice training was experiential and didactic and included ongoing evaluation and support. It should enhance trainee's self-awareness and at the same time provide sufficient information about the medical component of the disease. The information must be able to promote understanding of complex medical aspects so that the lay counsellors could be able to impart the knowledge to their clients.
- Training of local para-professional HIV/AIDS counsellors should be relevant to the issues that they encountered within counselling.
- Training in basic counselling skills must be viewed as part of training and a supervision process and subsequent exposure to advanced counselling courses and candidate screening was imperative for training courses that must be conducted by experienced trainers in a flexible and intelligent way.
- Best practice standards needed to be identified and linked so that service-providers nationwide could benefit from sharing information about workable models. Inter-sectoral collaboration was required and for this to happen, one needed to provide detailed data-bases

of service-providers and networks of resources.

- If one wanted to explore the training experiences of HIV/AIDS counsellors, it is important to involve these counsellors qualitatively to obtain information about their perceptions and experiences at a local level.

Clearly, one should not try to plan training programmes for HIV/AIDS counsellors without understanding what they will be practically involved in and what kind of challenges they are likely to encounter within their counselling situations.

2.9.1 SKILLS PERTINENT TO HIV/AIDS COUNSELLING

Before addressing the areas of competencies and self-awareness required in training courses for HIV/AIDS counsellors, one needs to be mindful of two major issues that often occurred in the literature, which were:

- That training courses should not be generalized and that diversity requires that helping must be contextualized. For example, a training programme for HIV/AIDS counsellors based in a residential university in the city will be very different to a training course conducted at a residential university in a more rural setting.
- That there was a lack of clarity as to whether HIV/AIDS counselling should favour health promotion strategies instead of facilitative psycho-social healing.

Clarity should be sought in terms of which paradigm of counselling was suited to the context where the counselling would be applied. Therefore, even though the researcher identified what positives were prevalent in terms of areas of competencies required by HIV/AIDS counsellors that appeared in the literature, one needed to bear one of the above mentioned factors in mind, namely, one should never plan a training programme without engaging the trainees in the planning.

Some recognized skills or areas of competency and self-awareness required by HIV/AIDS counsellors as pointed out in the literature, included the following:

- Respect - This alludes to the counsellor's ability to balance cultural variables and to develop new ways of thinking about culture to seek innovative, culturally appropriate counselling methods that are not offensive to the clients (Richards 2004:3); to recognise and be cognisant of their own bias and how their attitudes could impact on the counselling and the people they counsel (Kiemle in Britton, Rak, Cimini & Shepherd 1999:54); to keep the clients affairs confidential and discuss and facilitate options of disclosure, instead of divulging personal information (van Dyk 2005:211).
- Empathy - To demonstrate compassion during someone else's struggles to live beyond the confines of HIV/AIDS and the willingness and commitment to show empathy (Johnson in van Dyk 2005:17).
- Openness and genuineness – To confront and address certain themes within themselves which could hinder them from being supportive of their clients (Dworkin & Pincu 1993:275); to know how to cope with personal emotional experiences during counselling (Richards 2004: 9).
- Personal power - The capability to facilitate improved self-concept and self-esteem of their clients by means of their counselling (Balmer in Solomon et al 2004:22); good problem-solving and decision-making skills to enable them to counsel people with enormous emotional, psychological, practical and social challenges (van Dyk 2005:213).
- Basic counselling skills - To proactively extend their knowledge base on an ongoing basis and improve their counselling techniques and skills in order to meet the psychological demands of counselling (van Niekerk & Prins 2001:115).
- Facilitating new perspectives - To help the HIV-positive client to live a healthy and happy life (Maclaim 2003:194).
- Networking skills - To be aware of physical and psychiatric conditions relating to HIV and AIDS and to readily refer clients whenever the need arose according to Hoffman (1991) and Winiarski (1991) cited in Dworkin & Pincu (1993:275); HIV/AIDS counsellors in South Africa are faced with difficulties which are specific to developing countries and counsellors find themselves dealing with issues stemming from the socio-economic problems caused by

the poverty of their clients. By implication, they are functioning as de facto welfare agents who need to link clients with agencies that might be useful them (Nulty 2003:5).

- Professionalism - To have a sense of professionalism and ethical responsibility (van Niekerk & Prins 2001:241); to be self-driven and keep abreast of developments within the sphere of HIV/AIDS (van Dyk 2005:1); Basic training was not sufficient, recognition of ongoing training and training is indicated (Richards 2004:9).
- Tolerant - Counsellors must be flexible and open to change (van Niekerk & Prins 2001:1).

The researcher was thus interested to find out from the counsellors in the sample what they perceived as important skills and competencies.

2.9.2 TRAINING TECHNIQUES FOR HIV/AIDS COUNSELLORS

The term 'teaching' is not a term widely used in the literature regarding training and adult education. The term facilitation is used instead. Facilitators as opposed to teachers assist trainees in acquiring new insights and information as a part of an experiential group through a self-directed learning process (Tight 1996 in Bates 2004:15). Whereas 'learning' is a change in behaviour as a result of experience and or practice and learning occurs when knowledge is created through experiences which are transformed into knowledge, skills and attitudes. Learning was also characterised by an ability to memorise new information (Tight 1996 in Bates 2004:15). Evaluation of training typically measures the improvement of performance of trainees subsequent to the training intervention, and questions the trainees' responses to criteria from the trainers and facilitation. Bates suggested that HIV/AIDS training needed to take this facilitation further and identified two important issues, which had to be considered in training.

- Firstly, the capacity of the training to meet the needs of the trainees, in other words, to impart the information that the trainees require about HIV/AIDS.
- Secondly, the extent to which trainees considered the training offered to them, as acceptable.

Britton, Cimini & Rak (1999) provided a guide with regard to experiential as well as didactic methods that was used in an HIV/AIDS counselling course in Ohio. The authors based their

teaching guide on an approach that was successfully implemented at two graduate counsellor education programmes over a period of four years. The counsellor students had been involved in a basic counselling course prior to the HIV/AIDS counsellor training. Topics covered in the HIV/AIDS counsellor course were dealt with by using experiential activities and methods. These topics formed the basis for discovering emerging themes amongst the counsellor trainees during the training. These included various levels of homophobia; fear about transmission of HIV/AIDS; anger; feelings of being tired and overwhelmed by the enormity of HIV/AIDS; trainees' fear of developing a sense of incompetence and ineptitude in treating people with HIV/AIDS; issues of spirituality and religion related to the incurability of HIV/AIDS; trainees' increased commitment towards becoming actively involved in the sphere of HIV/AIDS and finally, acknowledgement that training evoked a strong emotional component. The focus of the article was on the manner and teaching methods in which topics were introduced and covered in the training, (a blend of experiential and didactic), which the authors advocated for possible generalization, hence a brief summary of the training methods:

2.9.2.1 Summary of training methods

The training began with an opening experiential component. Each graduate student was asked to reflect on their reasons for attending the training. This allowed for the processing and sharing of individual issues and helped to formulate personal and professional goals. The exercise allowed an inter- actional component to emerge. Trainees proved to be honest and open about the multitude of feelings they were experiencing. A presentation was then conducted by a medical person who specialized in working with people with HIV/AIDS. This person presented an overview of HIV/AIDS. The impetus was placed on familiarizing trainees about important medical facts concerning the disease. A secondary benefit derived from including a medical person, was that he or she was able to address the hidden fears or concerns harboured by trainees, for example fear about transmission. Considerable time was spent on addressing such concerns and fears until the trainees appeared to be comfortable with their understanding of the physical aspects of this social reality.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

A case was presented of an HIV positive person and trainees were assisted to identify the multi-stressors prevalent in that case scenario. Trainees were encouraged to raise their personalized queries, concerns and reactions to dealing with each stressor. This resulted in a powerful collective overview of the chaotic complexities inherent in counselling patients who are HIV positive. Trainees also participated in exercises where they role-played being recipients of services. This enabled them to explore their own attitudes and feelings and identify the psychological implications of working with HIV/AIDS patients and their relatives.

Midway through the training programme, HIV/AIDS infected persons were invited to tell their stories to the trainees. Students frequently described this component as the most salient part of the training programme, because they were able to directly learn from and interact with someone who was HIV positive (which was what the training is preparing them for). This exposure provided an excellent opportunity for ethical issues to be strategically introduced and trainees had by then become more comfortable to express themselves. Family dynamics of HIV/AIDS were identified, discussed and role-played and different interventions that were appropriate, were entertained. Multicultural issues around women, ethnic minorities, gay and lesbian communities, were vigorously discussed to enable trainees to identify their possible prejudices and values. Exercises on safe sex techniques and practices provided the opportunity for the trainees to become at ease with discussing sexual issues.

Discourse surrounding talk about HIV/AIDS was actualized and trainees were alerted to the language they used in relation to HIV/AIDS issues, in case it was derogatory or prejudiced. Trainees participated in simulations of counselling sessions through role-plays. Since bereavement was a hard-core issue associated with AIDS counselling, trainees were encouraged to share their personal bereavement experiences. In order to teach group counselling techniques and processes, a few members of the HIV/AIDS training panel were invited to act as group members and the counsellor trainees were exposed to the experience of how HIV/AIDS groups are facilitated. It must be remembered that this was a first world-training programme and whilst it certainly appears to provide opportunities for trainees to develop appropriate skills and competencies in an experiential way, we cannot assume that this would work as well at a local level in South Africa.

2.9.3 IMPLEMENTATION CHALLENGES

2.9.3.1 Results of National Audit on voluntary counselling and testing (VCT)

An audit of voluntary counselling and testing (VCT) services in South Africa was prepared for the Health Systems Trust (Solomon et al 2004). The primary aim of the audit was to provide an analysis of facilitative or obstructive factors affecting VCT in counselling in South Africa. Critical literature and all available studies about VCT were analysed. It emerged that voluntary counselling and testing was considered as a major strategy for the prevention of HIV infection and AIDS in Africa. Amongst the enormous volume of published literature located, the search traced 13,618 articles which were narrowed down to 385, seemingly related to this study. With regard to unpublished literature until 2001, nineteen Masters and Doctoral research studies from South African universities were traced. In addition, various other forms of literature were collected which included research reports and discussion documents, unpublished research reports, strategic documents and policies, as well as media reports from both national and local newspapers, conference and workshop proceedings, organizational reports and best practice guidelines.

The researcher was subsequently exposed to a glimpse of a very wide range of related literature in a synergistic way and this provided the researcher with an overview of what had already been discovered in this field. Of interest to the researcher, were quotes from the abovementioned research document, although the authors did not include the respective literature sources due to the sheer volume of the literature included in the study. Significant extracts related to the researcher's study will be presented that suggest that the quality and benefits of VCT vary enormously, particularly with regard to confidentiality, counselling and access to clinical and social support. Nevertheless, as countries developed their counselling services, new ideas and experiences helped to guide the further refinement of services. Because of the immense problem of HIV/AIDS, it appeared as though service-providers had been encouraged towards quantifying service-provision, and in so doing, this could compromise the quality of their services.

The themes that emerged from the literature revealed the following aspects, pertaining to the researcher's study:

- There remained inadequate consensus about whether counselling should address health promotion objectives or be more remedial and offer deeper psychosocial support in a more participatory manner.
- The lack of a universal definition resulted in mixed or even confused interpretations of the purpose of HIV/AIDS counselling.
- The authors noted that quantitative data dominated published literature and the researcher was also interested to learn from the study that the next decade of HIV/AIDS prevention and support programmes would have to locate VCT more specifically and more exactly as part of a much broader strategy for dealing with HIV/AIDS. As such it must go beyond the health promotion and medical components and link VCT to adequate care, support and welfare services.
- The authors' conclusions were that there was a steady increase in the interest in VCT over the past thirty years, however, there was a lack of African research specifically on VCT. They said that an implementation strategy rooted in a confused conceptual base, generated difficulties down the implementation line. Furthermore, they said that agreement needed to exist between the construction and definition of VCT on all levels within the context of HIV/AIDS.

Some of the respondents in the researcher's study were based at VCT sites and their views might be useful to listen to on a practical implementation level, as suggested in the above study.

2.9.3.2 South African Health Care system (state and NGO's)

According to Barron and Asia (2001) South Africa's health care system was severely fragmented before 1994 during the Apartheid era, along racial, social and geographical lines. Issues of equity were addressed through legislative and financial systems, however, with decentralisation South Africa faced major implementation challenges whilst endeavouring to make service delivery more accessible, especially in areas where services were scarce or not available. Decentralisation placed a heavy burden on local government. Decentralization of basic infrastructures as mentioned above

were still in progress, especially in deep rural areas. This compromised the management of sexually transmitted diseases (STD's). VCT was not widely available at a primary health care level and clinical care and support for HIV/AIDS was poorly coordinated (in 2001). Many provinces were under-spending the money allocated to address this social reality whilst their potentially effective partners in the delivery of services (including NGO's), continued to struggle to survive (Kenyon, Heywood and Conway: 2001).

In the light of the aforementioned, it appeared to the researcher that service-delivery to persons affected and infected with HIV/AIDS was lacking, especially in deep rural areas.

2.9.4 WHAT TASKS SHOULD HIV/AIDS COUNSELLORS BE TRAINED TO PERFORM?

van Niekerk & Prins (2001:47) emphasised that a counsellor should be conversant with theory underlying counselling interventions and that it was often proposed that a counsellor who was not well grounded in theory, might be of relatively little therapeutic value to the client. Worse still, such ignorance on the part of the counsellor might even lead to the client being harmed. In this regard, Moses & Plummer (cited in Solomon et al 2004:22) cautioned that most health workers had minimal training or experience with a client-centred counselling approach.

Hunt's perspective (1996:298) was that counsellors had an ethical obligation to be adequately trained in order to provide the needed services to people who were infected and affected by HIV/AIDS and that those who set up training programs had an ethical obligation to provide relevant training, in keeping with this perspective. Similarly, Delaney (cited in Nulty 2003:1) challenged training providers to broaden their scope of training so as to deal with the complexities discussed earlier. The role of the HIV/AIDS counsellor was not only to educate and encourage people to change their behaviour, but also to help clients and their families explore the psychological demands associated with HIV/AIDS. In order to do this, counsellors needed additional information about a range of psycho-social issues. This was in keeping with the findings of an earlier study conducted by Coyle & Soodin (1992). They recommended that HIV counsellors needed to be adequately trained in general or basic counselling and that HIV counselling courses should be expanded to include a range of issues not directly related to HIV/AIDS; such as relationship problems, suicide, death and

dying and bereavement. Not only was there a need to review the training given to HIV counsellors, but also the criteria HIV testing centres applied when appointing HIV counsellors. Such changes could enable training providers to establish basic criteria for training based on the experiences of the counsellors. In the light of this, training providers were urged to reform training courses so that they could be based on well-defined counselling principles and approaches.

Hunt (1996:298) said that the arena of HIV and AIDS was rapidly changing. Therefore it was imperative that counsellors needed to be provided with opportunities to stay abreast of new developments. He said that whilst there was a genuine attempt to develop local models of counselling which challenged Western ones, more research into their efficacy was required (Rankin & Gilbert cited in Solomon et al 2004: 21). However, to counsel effectively counsellors needed to be relatively free from stress themselves (Dryden 1995 cited in Nulty 2003:8) both in the course of their work as counsellors and as a result of their personal life experiences. This clearly reflected the need to offer ongoing debriefing and supervision to the counsellors engaged in HIV/AIDS counselling.

2.9.5 LEGAL AND POLICY ISSUES

HIV/AIDS introduces and presents the most complex unprecedented issues that continue to challenge the moral fibre of society (van Dyk 2005:334). We need laws and policies, ethical and moral values coupled with compassion and respect to uphold the humanity and dignity of all people.

2.9.5.1 National (South Africa)

The South African Constitution is (Act 108 of 1996) the supreme law of the country against which all other laws and policies must be measured. As such, the constitution incorporates basic human rights that should be upheld with regard to all people, including HIV/AIDS infected and affected persons. Furthermore, it includes rights relating to people's liberty, autonomy, security and freedom of movement, confidentiality and privacy, HIV and testing, education concerning HIV/AIDS, employment, health and support services, insurance, media responsibilities, safer sex, prisoners' rights, equal protection under the law and access to public benefits, duties of positive persons, and

so forth. Moreover, the Bill of Rights enshrined in the Constitution is applicable to all South African citizens irrespective of their HIV status (van Dyk:2005:334-336). The Constitution prescribes that public services must be governed by the democratic values and principles enshrined in the constitution, which includes the promotion and maintenance of a high standard of professional ethics (HIV/AIDS Training Manual for Facilitators 2005:29). As such, a number of laws, policies, guidelines and judgments exist that specifically protect the rights of people living with HIV and AIDS in South Africa. However, information on these rights is not widely disseminated and HIV/AIDS counsellor training should encompass this information.

Richards (2004:9) stated that a key area for policy development was the standardization of HIV/AIDS counselling training curricula and materials. The author said that the government could play an active role in the development of counsellor training and VCT policy (Richards 2004:11). The government should develop policy that requires national guidelines on HIV counselling training and testing to be developed and disseminated. Counsellors should be required to be certified and/or licensed through the Health Professions Council.

The HIV and AIDS and STI Strategic Plan for South Africa, (2007-2011) released on the 12 March 2007, flowed from the National Strategic Plan of 2000-2005 as well as the Operational Plan for Comprehensive HIV/ and AIDS Care, Management and Treatment. The Plan represented the South Africa's multi- sectoral response to the challenge with HIV infection and the wide-ranging impacts of AIDS. According to the Strategic Plan (2007-2011:50) South Africa developed a sophisticated legal framework to protect and offer respect for human rights within the health sector. A newspaper article (Mail&Guardian, August 3 to 9, 2007:14) reported that the latter AIDS Plan required that a number of departments should work together and that the office of the individual charged with managing the AIDS Plan needed to be properly resourced, according to experts in the field. Yet, the article stated that the highly regarded head of the government's AIDS unit, Nomonde Xundu, who resigned but later withdrew her resignation, "works as little more than a woman with a laptop." Nevertheless, a key priority area of the national Strategic Plan was Research, Monitoring and Surveillance (HIV and AIDS and STI Strategic Plan 2007-2011:15).

2.9.5.2 Provincial (KwaZulu Natal)

Coovadia (2000:58) said that within South Africa, one of the top ten priorities for the National Department of Health was “access to care, counselling and support” for HIV/AIDS and STD’s. He explained that most hospitals in the country had existing policies for HIV Informed Consent, Pre- and Post-Test Counselling and confidentiality, even though the quality of VCT offered was not known. In KwaZulu Natal (where this research took place), the Office of the Premier released its own HIV and AIDS Strategy for the Province of KwaZulu Natal with the assistance and support of committed individuals and organizations broadly representative of the people of KwaZulu Natal (Office of the Premier HIV and AIDS Strategy for the Province of KwaZulu Natal 2006-2010). According to the latter Plan (p16) there were 1,600 lay counsellors who were receiving stipends by the end of 2005/06. The same Plan (p 48) reflected a need for the Office of the Premier to mobilize support for capacity-building programmes. It acknowledged that much of this capacity building, which includes skills-development, was being provided by NGO’s and private and development sectors. To what extent such capacity building affected the training of HIV/AIDS counsellors in KwaZulu Natal, remained to be seen.

In an Editorial Review discussing emerging issues in HIV/AIDS Social Research, Friedman, Kippax, Phaswana-Mafuya, Rossi & Newman (2006:963) called for the inclusion of the establishment of strategies for incorporating social researchers within decision-making structures in the field, so that relevant research results will influence decisions by policy- makers.

Included within this chapter were clarification of key concepts, definitions and significant pieces of research from scholars in the field of HIV/AIDS counsellor training in order to shed more light on the research topic. Also included, were some identified gaps located within this field of research in order to indicate the relevance of the researcher’s study as well as information to ground the study within a theoretical paradigm. Furthermore, relevant information to establish the context of the research problem by learning from the valued works of other scholars and existing policy issues that affect research in this field have been incorporated in the chapter. In the following chapter, the researcher outlines how she set out to find answers to the research problem and also discusses the sample that was included in this qualitative study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

INTRODUCTION

This chapter explains how the researcher set out to address the research problem by highlighting the design and qualitative methods in accordance with research practices. The researcher was guided by Robson (2002 in Saunders et al 2003: 421-422) concerning the content included in this particular chapter. Consequently chapter three includes a discussion about the research setting; the participants or the HIV/AIDS counsellor sample, materials utilised to seek answers in the study as well the procedures that the researcher adopted throughout the research process.

3.1 OVERVIEW OF THE RESEARCH CONCERNING HIV/AIDS COUNSELLORS.

The researcher's preference of the identifying features of the research as listed below was directly influenced by the purpose of the study, which was to explore and describe the levels of satisfaction of eThekweni Metropolitan-based HIV/AIDS counsellors in terms of their training experiences.

Counselling has become an essential aspect of dealing with HIV/AIDS in South Africa (Nulty 2003: ii). Nevertheless, HIV/AIDS counselling services within South Africa (Richter et al 2000:148) were thinly stretched, though they provided welfare services unavailable from other sources, despite the high expectations of the role of VCT. At the end of 2005/06 there were 1,600 lay HIV/AIDS counsellors who were receiving stipends in KwaZulu-Natal (KZN HIV and AIDS Strategy for 2006-2010: 16), apart from the others who were operational from other work platforms. The researcher therefore felt that a qualitative exploratory, phenomenological case study was best suited to uncover the varying experiences and perceptions of knowledge and skills gained or not gained, during the training process of these counsellors. More especially, because the researcher sought to identify and describe emergent patterns of concerns, through an exploratory study with the intent to inform the development of a theoretical perspective regarding HIV/AIDS counsellor training in the region. Such insights would not have been gained by means of a quantitative study.

The researcher was guided by Padgett (1998:28) that the research needed to be designed, which actually referred to the plans or procedures that the researcher followed to achieve the goals of the study. In other words the design entailed the problem formulation, selection of the sample, collecting data for the research, analysing the data and writing up the research findings.

The process of designing the study thus began at the onset of the study as advised by Richards & Morse (2007:73), when the research topic was developed into a researchable question. In addition, the design also incorporated the different ways the researcher planned and paced the processes and strategies that were utilized in the study, whilst simultaneously remaining focussed on the project as a whole. However, the researcher understood from Padgett (1998:28) that unlike quantitative research designs which unfold in a more linear fashion, qualitative research was distinguished by its recursiveness and flexibility. This for example, allowed the researcher the flexibility to add an additional category of participants to the sample (HIV/AIDS counsellors from tertiary institutions), during the course of the study.

3.1.1 IDENTIFYING FEATURES OF THE RESEARCH

This particular research has the following identifying features:

The design was an exploratory, descriptive, case study and the research method was qualitative, based on a phenomenological perspective. The study used a multi-methods approach utilizing 24 semi-structured interviews plus one focus group, using purposive and non-probability sampling.

The data collection instruments included the researcher, the literature study, semi-structured interviews and a focus group. The data analysis procedures consisted of thematic content analysis and pattern analysis. Triangulation was used as a method of authentication for this study that was conducted in eThekweni, South Africa.

3.1.2 RESEARCH QUESTIONS

The researcher formulated specific research questions in order to focus on and seek answers to the research problem namely, HIV/AIDS counsellors' experiences pertaining to their training. Mouton (2001:53) affirmed that we often formulate research problems in the form of research questions as a way of focussing on the research problem. The research questions therefore set out to find out what the learning or training experiences of the participants were when undergoing training to become HIV/AIDS counsellors and their related levels of satisfaction associated with such training.

Specifically, the researcher addressed the following questions in the study:

- What training have counsellors received to prepare them as HIV/AIDS counsellors?
- What do counsellors perceive to be the core skills and competencies required of HIV/AIDS counsellors?
- To what extent do HIV/AIDS counsellors feel that the training they received covered these core skills and competencies?
- What do they regard as focus areas for the improvement of HIV/AIDS counsellor training?

However, Richards and Morse (2007:51) cautioned that when thinking phenomenologically, the researcher needed to bear in mind that attempts to understand or grasp the essence of how participants (HIV/AIDS counsellors) experienced an event, that the counsellors' descriptions are perceptions or a form of personal interpretation.

3.1.3 RESEARCH SETTING OR SITES

At the time the research commenced in 2006 until it was finalized in September 2007, the highest HIV/AIDS prevalence was within the province of KwaZulu Natal in South Africa (39.1%), where the study unfolded (HIV Strategic Plan 2007 -2011: 27). Padgett (1998:51) highlighted that although access and availability are key criteria in site selection, the researcher should not let convenience alone dictate where the research should take place. The population in eThekweni within the province of KwaZulu Natal totalled 3,090,122 in 2005 (Population by municipality Table 11) <http://www.statssa.gov.za/census01/html/C2001DPLG.as>), therefore being strategic to the province of KwaZulu Natal population of 9 426 017. <http://www.statssa.gov.za/census01/html/default.asp>

The eThekweni region within the province where the research was undertaken is a well known international tourist destination in South Africa that hosts many important national and international events, amongst others, the HIV/AIDS Convention in June 2007. Not surprising therefore, that there existed a hub of HIV/AIDS - associated service-providers offering a variety of essential HIV specific services, including HIV/AIDS counselling. In fact, guided by the South African Strategic plan on HIV/AIDS and STI's mentioned above, a new Chief Directorate of HIV/AIDS was established within the provincial Office of The Premier in 2006, especially to spearhead a coordinated and comprehensive response to the HIV/AIDS crisis (KZN HIV/AIDS Strategic Plan 2006-2010:1). VCT is recognized as a key strategic function in both of the latter-mentioned Plans, which places the spotlight on the training HIV/AIDS counsellors who have to deliver such essential counselling services in the region.

3.2 ETHICAL CONSIDERATIONS OF THE RESEARCH

The researcher was reminded by Monette, Thomas, Sullivan & DeJong (2005: 49) that because people are the subjects of social research and due to the fact that they have rights and feelings, special ethical considerations apply when engaging them in research. In the same vain the authors stress that for social researchers, ethics involves the responsibilities that researchers bear towards those who participate in the research as well as those who are potential beneficiaries of the research. Consequently, the researcher submitted a research proposal to the University of South Africa for scrutiny prior to engaging in the study in 2006, in order to promote ethical compliance (Richards & Morse 2007:235). On the other hand, no scientific tests could conclusively show whether actions were ethical in research. In fact, debate continues amongst scientists about ethical issues in research, because such issues involve matters of judgement (Monette, et al 2005: 49). However, there is no group more concerned about ethics and fairness than qualitative researchers (Padgett 1998:33).

According to Mouton (2001: 243), the most basic rights of research participants include:

- The right to privacy.
- The right to full disclosure about the research (informed consent).
- The right not to be harmed in any manner (physically, psychologically or emotionally).

Therefore, the required consent form developed for the research contained information explaining the participants' right to anonymity and confidentiality. Moreover, the consent form included the following statement for the protection of the HIV/AIDS counsellors who took part in the study:

“... I know that I may withdraw from the research if I choose to or become uncomfortable.”

As it happened, whilst one of the counsellors was being interviewed after signing the consent form when the researcher explained the reason for tape recording the interview, she paused and told the researcher to stop the recording. This was duly done. Following the ensuing deliberations about the matter, the researcher gladly obliged to take written notes instead, since the counsellor was adamant that it occurred to her that “sometimes in research you might one day hear your voice on the radio.” However, after the interview the counsellor conceded that she enjoyed being heard and appreciated that the researcher came all the way especially to talk to her. Afterwards, the researcher spent time to show the counsellor the content of the written transcript since hers was the only interview that was not taped.

Finally, the researcher would like to point out that all the semi-structured interviews were conducted at the respective workplaces of the HIV/AIDS counsellors after observing their work-related protocol. In addition, the researcher engaged in discussions with her supervisor throughout the study, and was mindful that ethical issues could arise at any time during the research.

3.3 DATA COLLECTION METHOD OR STRATEGY

Monette et al (2005:89) informed that one of the aspects of refining a research problem was to decide whether to use one or two broad strategies towards research, namely: qualitative or quantitative research. The same authors clarified the difference between the two strategies or methods, as follows:

- **Qualitative research** - involves data in the form of words, pictures, descriptions or narratives Monette et al (2005:89).
- **Quantitative research** - uses numbers, counts, and measures of things (Berg 2004 & Wakefield 1995 in Monette et al: 2005:89).

Like quantitative methods, qualitative methods were empirical and systemic (Padgett 1998:17) however, the researcher's choice of a qualitative method was simply because the research questions and nature of the data required such a method. In this respect Richards & Morse (2007:30) advised that if the purpose of the research was to understand phenomena deeply and in detail, you needed methods for discovery of central themes and analysis of core concerns. Moreover, Saunders et al (2003:99) elaborated that there was an inevitable relationship between the data collection method employed and the results obtained, hence the selection of the utilized qualitative research method.

Specifically in terms of research methods deployed, an important point of departure was the literature review of previous research on the topic of HIV/AIDS counsellor training. Padgett (1998:31) pointed out that the literature review shapes the study, prevented reinventing the wheel and promotes cumulative advances in knowledge. In addition, it positions the researcher's study within a scholarly context, thus ensuring that the study is linked to previous research in the area of HIV/AIDS counsellor training. Since this research was carried out within the realm of social work, the researcher would like to emphasise (Padgett (1998:17) that qualitative methods were however, not synonymous with social work practice since there were several critical dimensions on which research and practice differ. Three qualitative methods were commonly described in textbooks (Richards & Morse 2007:31), namely:

- **Phenomenology** - Usually (but not always) best addresses a question about meaning, i.e. "what is the experience of...?"
- **Ethnography** - Offer tools to answer questions such as "what is happening?"
- **Grounded Theory** – Directed by questions of interaction, i.e. How does one become a...?"

The researcher's choice of phenomenology as a qualitative method was informed by Saunders et al (2003:250). The author described a phenomenological study as a study that attempted to understand people's perceptions, perspectives and understandings of a particular situation or event, which in this particular case, attempted to understand HIV/AIDS counsellors' perceptions of the meaning of their HIV/AIDS counsellor training.

3.4 MULTI METHODS

Multi-methods were used in the research in the form of twenty four semi-structured interviews and a focus group with six HIV/AIDS counsellors from the same sample. The focus group was held after completion of all the interviews. Saunders et al (2003:99) advised that one of the advantages of using multi-methods was that it enabled the researcher to utilize triangulation. Moreover, Monette et al (2005:444) explained that triangulation also offered an opportunity to approach a problem from a different direction. In addition, Padgett (1998:32) confirmed that triangulation or diversifying sources of information (semi-structured interviews and a focus group), enhanced the credibility of qualitative research findings. Since each method had its own effect, using different methods could cancel out the 'method effect' thus giving a more reliable conclusion. Thus, although the study was qualitative, reliability and validity was increased by the use of more than one research tool or method, which were individual in-depth interviews and focus group discussions. Saunders et al (2003:100) stated that reliability could be determined by the question of whether similar observations would be made by different researchers on different occasions and whether the study would yield the same results on different occasions.

The issue of credibility was therefore based on whether the findings are really what they appear to be about and will also have to be monitored. However, the research was also a case study, defined as a strategy for doing research that involved an empirical investigation of a particular contemporary phenomenon (HIV/AIDS counsellors training experience at a local level), using multiple sources of evidence (semi-structured interviews and focus-group), as explained by Robson (in Saunders et al 2003:93). Primary or new data was required for this purpose. Monette et al (2005:9) highlighted that a part of any research design was a description of what data would be collected and how this would be done, since it constituted the main information from which conclusions would be drawn. Moreover, qualitative research such as the researcher's study is always about discovery (Richard & Morse 2007:1).

The researcher was guided by Padgett (1998:47) who said that gaining entry and maintaining rapport are ongoing processes that do not end until the study was over. Unlike quantitative surveys

where one-shot data brings minimum contact, qualitative research demanded immersion and engagement and research relationships that had to be negotiated and renegotiated as needed.

3.5 PARTICIPANTS IN THE RESEARCH SAMPLE

3.5.1 SAMPLE SOURCES

Richards & Morse (2007:194) said that sampling was the key to good qualitative inquiry. Subsequently, the research design integrated empirical research that was undertaken with a sample of twenty four HIV/AIDS counsellors who were drawn from faith-based organizations, non-governmental and government organizations in eThekweni. An additional category was added to include HIV/AIDS counsellors from tertiary institutions. It was felt that such a sample would be fairly representative of the HIV/AIDS counsellor population and provide a collective voice of the counsellors in eThekweni, although the researcher is aware that HIV/AIDS counsellors are also active via other work stations in the region.

3.5.2 SCREENING AND RECRUITMENT OF PARTICIPANTS IN THE SAMPLE

Padgett (1998:45) cautioned that given the fact that there were wide variety of places where social work researchers undertook research, it was challenging to offer general guidelines for entering the field. Nevertheless, the same author recognised some commonalities and said that in every case, the researcher wished to: “.....gain entry, develop rapport and proceed to sampling and data collection with a minimum of problems.”

The researcher therefore had to find a sampling technique that would suit the study. Richards & Morse (2007: 195) advised that instead of using random sampling, qualitative researchers seek valid representation through other sampling techniques, namely:

- **Purposive sampling:** in which the researcher selected participants because of their characteristics (good informants – ‘HIV/AIDS counsellors,’ described as those who know the information required, were willing to reflect on the phenomena of interest, have the time, and were willing to participate), according to Spradley (1979 cited in Richards & Morse 2007: 195).

- **Nominated or snowball sampling:** when participants already in the study recommend other persons to participate.
- **Convenience sampling:** in which those invited to participate in the study were simply those who were available to the researcher.
- **Theoretical sampling:** when the researcher deliberately sought persons for the study according to the emerging theoretical scheme (Richards & Morse 2007: 195).

The sampling technique that was selected was therefore purposive, which enabled the researcher to use her judgement and select only HIV/AIDS counsellors who fitted the sample profile (Saunders et al 2003: 175). Such a purposive sample was best suited to assist the researcher to uncover the issues specifically related to satisfaction levels of HIV/AIDS counsellor training at a local level. The researcher used screening procedures for recruitment of the counsellors in order to ensure a fair distribution of some common characteristics.

Basic criteria utilized for the inclusion of the counsellor participants were:

- Counsellors who were trained in HIV/AIDS counselling.
- Counsellors who had more than one year practical experience as HIV/AIDS counsellors at the time of the study.
- HIV/AIDS counsellors operational from FBO's, NGO's and government organizations as well as tertiary institutions.
- Counsellors who were practicing HIV/AIDS counsellors within the eThekweni Metropolitan area.
- HIV/AIDS counsellors who expressed willingness to partake in the study since participation had to be voluntary.
- HIV/AIDS counsellors who indicated their readiness to inform and offer insights, since the study was of a phenomenological nature.

Every effort was made to include counsellors from different genders, racial and ethnic backgrounds to accommodate the rich diversity of people within the region. Prospective participants were obtained from a resource list of HIV/AIDS counsellors (HIVAN/KZNCAN DIRECTORY 2005:8). The researcher used the screening process based on the principle of reactivity by allowing participants to view the consent form, which contains an introductory note about the research. Usually the reactivity arising from the screening process was seen as a liability because participants were given the opportunity to familiarise themselves with the research issues and can therefore enter the study with prejudice and bias. However, reactivity could also be advantageous by giving respondents time to reflect on the topic in advance and thus enhance rather than under-mine the validity of the content generated by the discussion (Breakwell, Hammond & Shaw 2000:311). The latter view was taken by the researcher who firstly, telephonically contacted prospective service-providers who offer HIV/AIDS counselling services. This action was followed by written exposition and subsequent request to interview HIV/AIDS counsellors through their respective work-related protocol. This proved to be very a challenging exercise however, the researcher heeded the advice of Padgett (1998:47), who said that research relationships might have to be negotiated and renegotiated as needed. In addition, some HIV/AIDS counsellors did not wish to take part in the study.

3.5.3 REASONS OF HIV/AIDS COUNSELLORS FOR ABSTAINING FROM RESEARCH:

Amongst the counsellors who abstained from the research, the following were their reasons given:

Being short staffed; too busy; already participated in other HIV/AIDS research projects that failed to change things for them personally; clients need them now whereas research results may or may not make a difference; interviews were time-consuming as every minute was precious due to the urgency of the epidemic; researchers earned money by writing books about their stories and participants don't benefit financially; angry because obtaining certificates in HIV/AIDS counselling did not improve their salaries even though the work was more demanding.

In fact, such negative responses were at times discouraging and cause for great concern and at some stage during the study, the researcher even wondered whether a smaller sample or perhaps a quantitative study might have been more convenient to manage. Nevertheless, the researcher tried to address the concerns of the prospective participants and even availed herself for face to face meetings in order to clarify or elaborate about the research, if this was required. Nonetheless, counsellor participation was at all times voluntary and at no time was anyone pressurised to take part in the study. The researcher was reassured by the words of Rosalie Wax (1971 in Padgett 1998:45) who paraphrased that

“anyone unprepared to make mistakes, be embarrassed, and feel like a fool should think twice before embarking on the qualitative journey of discovery.”

3.6 DATA COLLECTION PROCEDURE

The procedure that was followed for the semi-structured interviews and focus-group discussions with the HIV/AIDS counsellors was as follows:

Introduction of self by the researcher; a brief description of the research topic and the sample being used; a description of the purpose of the research; an estimation of how long the interview or focus-group discussion would take to complete and an undertaking of anonymity and confidentiality in as far as is practically possible. The counsellors were then asked if they would volunteer to participate in the study and informed by the researcher that she intended to use audio tape recordings to document the proceedings in order to ensure accuracy of information gathered. Participants were informed that the tape recordings would only be used for the purpose of the researcher’s study. Thereafter participants were presented with a consent form to facilitate their participation as respondents. After allowing individual respondents adequate time to read the consent form prepared by the researcher, the individual counsellors were asked to sign the form thereby consenting to participate in the study on a voluntary basis. Semi-structured interviews and a focus group were selected since it was important to explore the experiences, feelings and perceptions of HIV/AIDS counsellors.

3.7. DATA COLLECTION INSTRUMENTS

3.7.1 THE RESEARCHER

Padgett (1998:18-19) said that “If qualitative research is a voyage of discovery, then the researcher is the captain and the navigator of the ship.”

The latter author proclaimed that the researcher as an instrument was a defining characteristic of qualitative research. Hence, the dynamic interplay between the researcher and the participants, each affecting one another in unforeseen ways, was one of the significant features of qualitative research (Padgett 1998:23-24). Often, in phenomenological interviews both the researcher and participant work together to “arrive at the heart of the matter,” however it was important that the researcher suspended personal experiences that could influence what the researcher “hears” the participants saying.

The researcher thus attempted to heed the advice of Grobler, Schenk & Du Toit (2003:2) that whilst facilitating the semi-structured interviews and focus-group discussions, she should adhere to empathy, congruence and unconditional positive regard towards the HIV/AIDS counsellor participants. In this regard, Padgett (1998:21) cautioned that the interpersonal skills of empathy and sensitivity that were so important in social work practice, were put to somewhat different ends with regard to qualitative research. Therefore, instead of engaging with clients to achieve treatment goals, researchers become listeners seeking knowledge and understanding. The researcher therefore noted that Monette et al (2005:233) explained that her role as a participant observer in this study, required her to be part of the activities being studied and also as a participant. The researcher as a participant observer, was therefore able to influence the direction of the discussions, whilst simultaneously observing the responses of the HIV/AIDS counsellor participants.

3.7.2 PILOT SEMI- STRUCTURED INTERVIEWS AND PILOT FOCUS-GROUP

Padgett (1998:30) stated that one way to enhance the credibility of a qualitative study was to carry out a pilot study. Hence, two pilot semi-structured interviews were carried out and a focus group with four counsellors who were randomly selected. The purpose of the pilot studies was to develop

the research tools further and ensure inclusiveness of key issues as well as question construction that did not bias the interviewee. The researcher used a draft version of the questionnaire in the two pilot semi-structured interviews that were held with counsellors who were randomly selected. The pilot focus group was held only after completion of the twenty-four semi-structured interviews.

3.7.3 SEMI -STRUCTURED INTERVIEWS AND INTERVIEW GUIDE

The researcher was guided by Padget (1998:34) who said that the bulk of data in most qualitative studies was collected through observation and interviewing. The researcher was also encouraged by Monette et al (2005:181) who affirmed that interviews could help to motivate participants to give more accurate and complete information. In addition, further clarification by Saunders et al (2003:246-248) enlightened the researcher about three types of interviews, namely:

- **Structured interviews** – which use standardized questionnaires with identical and set questions.
- **Semi-structured interviews** – that list questions or themes to be covered, although the order and content might vary depending on the unfolding interview.
- **In -depth interviews** – which were unstructured with no pre-determined guidelines and such interviews were sometimes called ‘non-directive.’

Wass & Wells (1994 in Saunders et al (2003:248) explained that semi-structured interviews might be used to explore and explain themes that emerged from the use of the questionnaire guide. The researcher was therefore of the opinion that it was important to conduct the semi-structured interviews with HIV/AIDS counsellors in order to understand one on one, what key issues were actually presenting themselves, in order to gain more insight into the perceptions of the counsellors in the study. Semi-structured interview guides were subsequently developed based on the literature study. Interviews were consequently negotiated and conducted at places of employment with counsellors at mutually agreed and suitable times. Major themes for discussion were then developed for the semi-structured interviews with the twenty four counsellors with open-ended framed questions. Monette et al (2005:159) agreed that open-ended questions were appropriate in an

exploratory study in which the lack of theoretical development suggested that few restrictions should be placed on the participants' answers. A phenomenological perspective influenced the focus of inquiry in such a way that the semi-structured interview schedule was primarily in an open-ended question format. Closed-ended questions on the other hand (Monette et al 2005:158), would have provided participants with a fixed set of alternatives from which to choose, which would not have been appropriate for this study.

3.7.4 FOCUS GROUP AND FOCUS GROUP DISCUSSION GUIDE

The participants for the focus group discussions were from the same sample as those HIV/AIDS counsellors who were involved in the semi-structured interviews. HIV/AIDS counsellors who expressed willingness to participate in the focus group were included in the discussions that took place at a mutually agreed venue. Padgett (1998:64) explained that a focus group should be large enough to generate diversity of opinions, but small enough to allow for individual participation. The focus group was held for the purpose of triangulation and to obtain more credible results. According to Saunders et al (2003:99), triangulation refers to the use of different data-collection methods within one study (24 semi-structured interviews and one focus group), in order to ensure that the data was telling you what you thought it was telling you, and thus added to the credibility of the findings. The focus group discussion guide was designed based on insights taken from the following sources: semi-structured interviews and literature study.

Richard & Morse (2007:122) cautioned that transcribing even a short focus group could be very challenging due to the complexity of the data and therefore suggested introducing structure. Hence, the researcher decided on the use of a technique for the focus group, known as Nominal Group Technique (NGT). Such a technique (NGT) was actually a structured form of Brainstorming or Brain Writing with an experienced facilitator. This particular Nominal Group Technique incorporated three fundamental, research-based principles, namely:

- 'Nominal Groups' were thought to generate higher quality ideas than interacting groups typical of Classic Brainstorming. A nominal group consists of several people (usually gathered in one room) who are prepared to work as a team to resolve a problem. This sharing of ideas (which were anonymously submitted) promotes a sense of involvement and

motivation within the group.

- The 'round robin' element provided encouragement and equal opportunities for all members to contribute. Contribution from all participants was encouraged and every individual's idea was given equal standing, whether unique or not.
- 'Reliable communication' required that the recipient's understanding of a message be checked with the sender, especially in the case of 'new ideas' being put forward. Checks for accurate communication were built in to the technique.

There existed many variants about the Nominal Group Technique when utilized in practice (Jones 2003:22). http://www.mycoted.com/Nominal_Group_Technique

The primary advantage of the NGT over other strategies was the enhanced opportunity for all participants to contribute ideas and to minimize the domination of the process by more confident or outspoken individuals (Vella, Goldfrad, Rowan, Bion & Black 2000 cited in Jones 2003:22). However, one of the limitations of this technique was that only limited number of topics could be covered and such focus groups tended to be single-topic sessions (de Ruyter 1996, Brahm & Kleiner 1996 in Jones 2003: 24). The researcher jotted down clue words and short phrases (field notes) during the process and was careful to stay focused on the unfolding discussions. The researcher refunded each of the participants their transport fees for travelling to the venue and refreshments were provided for them.

3.8 DATA CAPTURING

The researcher made use of audio tape recordings and data capturing field notes to physically collect the raw data from the counsellor participants during the semi-structured interviews and focus group, using the semi-structured interview guide and focus group discussion guide. Monette et al (2005:9) highlighted that collection constituted the basic information from which the conclusions would be drawn in the research. However, Padgett (1998:59) cautioned that whilst a qualitative interview was a goal-directed interview, it should not be confused with a clinical or therapeutic interview.

Saunders et al (2003:254) mentioned some important points to consider concerning interviewer and interviewee bias, namely:

- Your own preparation and readiness for the interview
- The level of information supplied to the interviewee
- The appropriateness of your appearance
- The nature of the opening comments
- Your approach to questioning
- The impact of your behaviour during the course of the interview
- Your ability to demonstrate attentive listening skills
- Your scope to test understanding
- Your approach to recording information

With the exception of one, all the semi-structured interviews were audio taped, which was preferred with regard to a phenomenological study such as the researcher's (Richards & Morse 2007:33). The researcher transcribed the tapes herself.

Telephonic interviews were conducted with participants after the semi-structured interviews to ask the counsellors to rate their levels of satisfaction with their training numerically. The rating scale appears as Appendix F.

3.9 DATA ANALYSIS

The researcher heeded the advice of Richards & Morse (2007:171) that phenomenological data analysis was a process of reading, reflection and writing and rewriting that enabled the researcher to transform the lived experiences of the HIV/AIDS counsellors. Data analysis of the research therefore included identification of statements relevant to the topic, grouping into meaningful units, searching for differing perspectives and composite formation of the information gained via the semi-structured interviews and focus group held with the HIV/AIDS counsellors.

More specifically, Monette et al (2005:9) spelt out that data analyses was that which unlocked the information hidden in the raw data (obtained from the semi -structured interviews and focus group), and transformed it into something useful and meaningful.

Richards & Morse (2007: 47-48 quoted from Huberman 1994) listed six analytical strategies that were used in different ways in different methods in qualitative research, namely:

- Meeting and coding data as data records were created.
- Recording reflections and insights.
- Sorting and sifting through the data to identify similar phrases, relationships, patterns, themes, distinguishing features and common sequences.
- Seeking patterns or processes, commonalities and differences and extracting them for subsequent analysis.
- Gradually elaborating a small set of generalizations that cover the consistencies discerned in the database.
- Confronting these generalizations with a formalized body of knowledge in the form of constructs or theories.

With regard to the above, Richard & Morse (2007:119) counselled that interviews about the experiences or perceptions of an event (HIV/AIDS counsellors' training experiences) should not be judged in terms of accuracy to recall the event. Rather what mattered was how they felt or experienced the event at the time.

The most important break characteristic was between participants, that is, to explore how HIV/AIDS counsellors working from different organizational backgrounds perceived their training in order to access a fairly representative HIV/AIDS counsellor sample. Where the respondents were trained and where they were employed was noted and if the researcher happened to uncover similarities and/or differences among counsellor perceptions, this was examined and discussed. In this regard, Breakwall et al (2000:311) stated that "Break characteristics were selected on substantive grounds and involved the subdivision of groups according to their potentially contrasting views and experiences concerning the issues being investigated."

Overall, using content analysis, the researcher, analyzed the transcripts utilising pattern seeking analysis, using the information obtained from the transcribed audio recordings. The tapes were numbered to correspond with the numbering noted on the respective consent form and demographic detail forms of each of the counsellor participants.

Data was organised into units for example, stories, words or categories were suggested by perusing the entire data set several times. General themes were identified to begin to make sense of the similarities and differences in the text based on break characteristics. Finally the data were integrated and summarised for readers. This process was carried out manually and captured onto power point slides and no computer databases were utilised. This process was ongoing whilst the semi - structured interviews were conducted so that the researcher grouped the content information of five interviews at a time. Such a process was more manageable, instead of having to deal with all the data simultaneously. Richard & Morse (2007:247) advised that there could be serious problems for a project using qualitative data method if the researcher started data collection without starting data analysis, thus allowing data to build up untouched. The researcher showed the slides to her supervisor during the process.

Now that the research design and methodology had been clarified in this third chapter, the data obtained from the study will be presented in the next chapter together with the research findings, based on the semi- structured interviews and focus group discussions with the counsellors who participated in the study.

CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

INTRODUCTION

Throughout this chapter the researcher presents and discusses the data obtained from her qualitative research that focused on the satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to the training they received. The study commenced in 2006 under the auspices of the Social Work Department of the University of South Africa - UNISA.

HIV/AIDS counsellor involvement should be viewed against the background of an estimated 5.54 million individuals living with HIV/AIDS in South Africa in 2005 (HIV and AIDS and STI Strategic Plan 2007-2011: 9). Such a depiction, presents the gravity of the challenges confronting counsellors in the HIV/AIDS arena (Bekker & Wood 2006:1235). Grinstead & van der Straten (2000:626) emphasized that there is a need to improve counsellor training and that HIV/AIDS counsellors who provide the counselling services are an important source of information about the process of counselling and the impact of being a counsellor. They should be informants about their training and support needs.

As indicated in the previous chapter, there is a striking lack of literature about counsellors' experiences in working with HIV/AIDS patients and that most of the readings cited were of a quantitative nature. The researcher's study sought to afford eThekweni HIV/AIDS counsellors a voice and opportunity to express their views and possible concerns about the training they received and encourage them to make suggestions about how it could be improved. The researcher hoped that such insights could increase our understanding of the strengths and growth opportunities as well as possible shortcomings and threats in terms of HIV counsellor training at a local level. The researcher therefore set specific objectives for this study.

4.1 THE OBJECTIVES OF THE RESEARCH

The objectives of this study were:

- To investigate the training that counsellors in the eThekweni Metropolitan area had received to prepare them as HIV/AIDS counsellors.
- To explore what these counsellors perceived to be the core skills and competencies of HIV/AIDS counsellors.
- To probe the extent to which counsellors in the eThekweni Metropolitan area felt that the training they received covered the core skills and competencies required of them.
- To explore what the counsellors regarded as focus areas for the improvement of HIV/AIDS counsellor training.

4.2 FINDINGS OF THE STUDY

Todres (in Holloway 2005:273) advised that the findings of the research should be considered in dialogue with the literature and current research on the topic. Significantly, Monette Sullivan & DeJong (2005:439) counselled that data obtained in research should be displayed in such a way that a convincing argument could be made to support the conclusions reached in the study. In this respect, Holloway (2005:273) emphasized that many qualitative researchers concurred that the results and discussion of the results should be presented as an integrated whole. The latter author clarifies that such integration allowed the researcher to place the findings in the context of early and current literature that either confirmed or challenged the findings of the research. Furthermore, such an approach may also assist the researcher with a language to label themes or categories generated by the enquiry.

Mouton (2001: 124) and Saunders et al (2003:422) encourage the use of tables to summarize and highlight the results prior to the presentation of emerging themes, which would then form the basis of subsequent discussions about the researcher's findings. Similarly Monette et al (2005:439- 440) confirmed that qualitative researchers used a variety of visual formats to display their data. This became part of data analysis, because it assisted in conceptualization and theory development.

Holloway also said that everything in the feedback had to be linked to the original research problem as well as the context and setting in which the study took place. As such, Mouton (2001:114) affirmed that this chapter should highlight the evidence revealed during the research process, whilst Padget (1998:116) called it 'the heart of the matter.' Hence, based on research guidelines, the people who formed part of the research sample are profiled below (Mouton 200:124).

4.2.1 PROFILE OF THE RESEARCH SAMPLE

The research participants consisted of twenty-four counsellors who were actively engaged as HIV/AIDS counsellors in eThekweni Municipality area in KwaZulu Natal, South Africa. They were based in government and local government, non - governmental organizations, faith-based organizations and tertiary institutions. Seven of the respondents were based at NGO's and six worked in a governmental setting. The researcher's experience was that it was much harder to access governmental HIV/AIDS counsellors, due to their work-related protocol. Eight of the respondents worked at FBO's at the time of the study and three in tertiary settings.

The small purposive sample indicated that one should not make any hard and fast inferences from these findings. At a glance, one might say that all service-providers of HIV/AIDS counsellors in eThekweni area were represented. One assumed that there was effective coordination across these sectors in keeping with the HIV/AIDS provincial strategic plan of KwaZulu Natal (2006-2010), which acknowledged the crucial role of all stakeholders (government, NGO's, FBO's and tertiary responses) in the fight against HIV/AIDS. For the purpose of triangulation, seven of the counsellors in the sample initially agreed to be part of a focus group discussion however, due to unforeseen circumstances one of the counsellors withdrew.

Early questions asked in the interview were, "where they were trained and where they were employed at the time of the study." Breakwall et al (2000:311) stated that, "break characteristics are selected on substantive grounds and involve the subdivision of groups according to their potentially contrasting views and experience concerning the issues being investigated."

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

Demographic information about the HIV/AIDS counsellor sample are presented in terms of gender, age and base-level education.

TABLE 2: GENDER OF THE HIV/AIDS COUNSELLORS

Category	Sub-Category	NGO	FBO	GOV	Tertiary	Total
Gender	Male		2		1	3
	Female	7	5	7	2	21
	Total	7	7	7	3	24

Three males and twenty-one females took part in the study even though the researcher endeavoured to recruit more males. The reality is that most HIV/AIDS counsellors in South Africa are female (Richter, van Rooyen, Solomon, Griesel & Durrheim 2001:150).

TABLE 3: AGES OF HIV/AIDS COUNSELLORS

Category	Sub - category	NGO	FBO	GOV.	Tertiary	Total
Age	18 - 25 years	1		1		2
	26 - 34 years	1	1	3	3	8
	35 - 44 years	3	6	2		11
	45 - 55 years		2			2
	56 and above	1				1
	Total	6	9	6	3	24

Amongst the participants in the study, fourteen of the twenty four HIV/AIDS counsellors were older than 35, whilst eight participants were between 26 and 34 and two were between eighteen and 25 years. The researcher was reminded that Erikson (cited in Engler 1995:159) said that persons between 25 and 64, amongst other things, tend to have the ability to show concern for the welfare of ensuing generations and actively participate towards this end.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

TABLE 4: BASE LEVEL EDUCATION OF HIV/AIDS COUNSELLORS

Category	Sub-category	NGO	FBO	GOV	Tertiary	Total
Base level education	High School	2	4	4	2	10
	College/technikon	2	1	2	1	7
	University	4	2	1		7
	Total	8	7	7	3	24

As indicated in the above table, ten of the respondents had some high school education so that fourteen trained at tertiary level (seven at university and seven at college/ technikon). Profile information indicated that most of the participants in the study were female, older than 35 and had graduated from tertiary institutions. The counsellors were all based in NGO, FBO, tertiary and government (local government) settings. Four of the counsellors in the sample were trained by NGO's, four by government organizations, seven by FBO's and nine by tertiary institutions, i.e. four were trained by college/ technikon and five counsellors were trained at universities.

Initially only HIV/AIDS counsellors working at NGO's and FBO's were earmarked for the study. However, an additional category was later added to include HIV/AIDS counsellors who worked at tertiary institutions. As advised by Richards & Morse (2007: 237) the researcher endeavoured to afford each of the participants in the sample, the right to information about the purpose of the study and the extent and duration they would be involved in the research project. The researcher also briefed them about their rights to confidentiality and anonymity, the right to ask questions, as well as their right to refuse participation or to withdraw from the study at any time without any ramifications. The participants were informed about their right to know what was expected from them during the research process and who would have access to the information obtained about them and how it would be utilized. More information about the counsellors is presented in the tables below. Firstly, the researcher presented a collective illustration of the work bases of the counsellors in table 4 and thereafter discussed and illustrated relevant issues from the data.

TABLE 5: WORK AND TRAINING INFORMATION OF HIV/AIDS COUNSELLORS

SECTION A: GOVERNMENT WORK BASE						
C	Service Provider	Training Duration	Work status at training	Practical in training	Levels of confidence to counsel after training	Level of satisfaction with training
1	NGO	Staggered: 20 days – 2 d.p.w.	Unemployed	Role play & group work	Okay - training when employed afterwards	8
2	Gov.	Staggered: 10 days 2.d.p.w.	Unemployed	Role play & group work	Nurse / learnt on the job / supervision of files only	5
16	FBO	Block: 10 days	Unemployed	Role play & group work	Okay - could counsel (HIV positive experience)	6
17	NGO	Block: 10 days	Unemployed	Role play / group work	Reluctant / very nervous	5
23	Col/Tech	Block: 20 days	Unemployed	Role play / group work	Not confident	4
24	NGO	Staggered 2 months, 2 d.p.w.	Unemployed	Role play	Got a job & had in-service training	8
SECTION B: NGO WORK BASE						
3	Col/Tech	Block: 6 mnths.	Unemployed	Role play / group work	Too little practice	5
4	Univ.	Block: 1 year	Unemployed	Role play / group work	Uneasy / one week practice only	5
5	NGO	Block: 20 days	Unemployed	Role play / group work	Yes, after in-service training when employed	7
7	Univ.	Block: 6 mnths.	Unemployed	Role play / group work	Needed more practical	5
10	Univ.	Block: 6 mnths.	Volunteer	Role play / group work	No	5
18	FBO	Block: 10 days	Volunteer	Role play	Okay - volunteered	6
22	Univ.	Block: 6 mnths.	Student	Role play / group work	Yes, due to social work background	8
SECTION C: FBO WORK BASE						
6	Univ.	Block: 6 months	Volunteer	Role play / group work	Unsure, but learnt while volunteering	3
9	FBO	Block: 10 days	Employed	Role play / group work Supervised	Employed - supervised	8
11	FBO	Block: 10 Days	Volunteer	Role play / group work	Okay - volunteered	7
12	Col/Tech	Block: 20 days	Employed	Role play / group work	Okay - supervised at work	6
13	Gov.	Block: 5 days	Employed	Role play / group work	Managed - employed as Trauma counsellor / mentored	8
19	FBO	Block: 10 Days	Unemployed	Role play / group work	Nervous – lacked practice	5
20	FBO	Block: 10 days	Volunteer	Role play / group work	Okay – volunteered	6
21	FBO	Block: 20 Days	Unemployed	Role play / group work	Scared - lacked practice	4
SECTION D: TERTIARY WORK BASE						
8	Gov.	Staggered: 2 d.p.w. 3 Months	Unemployed	Role play / group work & placement	Yes, practical placement arranged by service provider	7
14	Col/Tech	Block: 20 days	Unemployed	Role play / group work & placement	Yes, practical placement arranged by service provider	7
15	Gov.	Block: 10 days	Volunteer	Role play / group work	Yes, (experience as positive status)	8

Codes: Days per week = d.p.w

Univ. = University

Block = training consecutively

College/Technikon = Col/ Tech

Mnths. = Months

Gov. = government

NGO = Nongovernmental organization

Staggered= training not done on consecutive days

FBO = Faith based organization

4.2.2 WORK BASES OF HIV/AIDS COUNSELLORS

Based on the afore-mentioned TABLE 5, the information presented below refer to the work bases of the 24 HIV/AIDS counsellors, the nature of the practical training they were exposed to, duration of their training, employment nature at the time of training, confidence levels on completion of their training, training providers and the counsellors' level of satisfaction about the training they received. TABLE 5 reflects the data in sections A, B, C and D, which will be discussed here. Six counsellors were employed in government settings, seven were employed within NGO's, eight counsellors worked in FBO settings and three in tertiary institutions.

4.2.2.1 Government work base (section A of TABLE 5)

As indicated in section A of the above table concerning counsellors in a government setting, only one of the six counsellors were trained by a government organization. Three had been trained by NGO's (which appear to indicate that NGO candidates were welcomed in government settings). Equal numbers (one each) trained in a faith based organization and college/ technikon setting. Training varied between 10 days (three), 20 days (two) and 2 months (one). Five were unemployed whilst undergoing training. One of the counsellors who had received 10 days training felt competent to counsel after training due to personal experience as an HIV positive person. Two NGO trained counsellors rated their levels of satisfaction with their training as 8. Both of these counsellors were employed on completion of their training.

4.2.2.2 NGO work base (Section B of TABLE 5)

As indicated in section B of the above table only one of the seven counsellors who were employed at an NGO had been trained by an NGO training provider. Most of the counsellors trained at universities (four) and one at college/ technikon, whilst one received training at a FBO. Duration of training variations include 10 days (one), 20 days (one) and 6 months (four) and one year (one). One of the counsellors (university - 6 months training) was a social work student and her professional background proved useful. Four were unemployed and one was a student. The one was a volunteer and said she felt okay to counsel.

4.2.2.3 FBO work base (Section C of TABLE 5)

Eight counsellors were employed by FBOs. Most of these counsellors (five) trained at FBO. The others trained at university (one), college/ technikon (one) and government (one). The shortest training was 5 days (one) and the longest was 6 months. Two trained for 20 days and 4 for 10 days. The counsellor with the shortest training (five) days said she was comfortable to counsel an HIV client for the first time and was employed as a trained trauma counsellor and had regular supervision at work. On the other hand, the counsellor with the longest training (6 months/ university) indicated she was uncertain of her ability to counsel, but gained confidence at a volunteering agency.

4.2.2.4 Tertiary work base (Section D of TABLE 5)

Three counsellors worked in tertiary settings. Two of these counsellors trained at a governmental organization and the other one at a college or technikon. Training varied from 20 days to 3 months and one trained for ten days. Two of the counsellors had practical placements arranged by the service-providers (Government and College or technikon) and were unemployed at the time. The counsellor with ten days training reported being comfortable to counsel after training because she had experience as an HIV positive person and had worked as a volunteer.

4.2.3 NATURE OF PRACTICAL TRAINING

Practical training varied and consisted of role play; role play and group work; role play and group work as well as supervision and role play coupled with group work and practical field placement in an organization, as arranged by the training provider. Each category will be briefly discussed:

- **Role play:** Two counsellors were exposed to role play and respectively rated their training as 8 and 6. The counsellor who rated training as 8 got a job immediately after training and was exposed to in service training. The counsellor who gave a rating of 6 was a volunteer at the time of training.
- **Role play and group work:** Nineteen counsellors did role play and group work as practical training. Seven counsellors rated their training 5, four rated it 8, three gave a rating of 6, two rated it 7, two rated it 4 and one counsellor rated training as 3. Out of the four counsellors

who rated training 8, one of them was employed after training, one was a social work student who had been exposed to practical field placement during the course of social work training, one was employed as a trauma counsellor and was mentored at work and the fourth one had life experience as an HIV positive person.

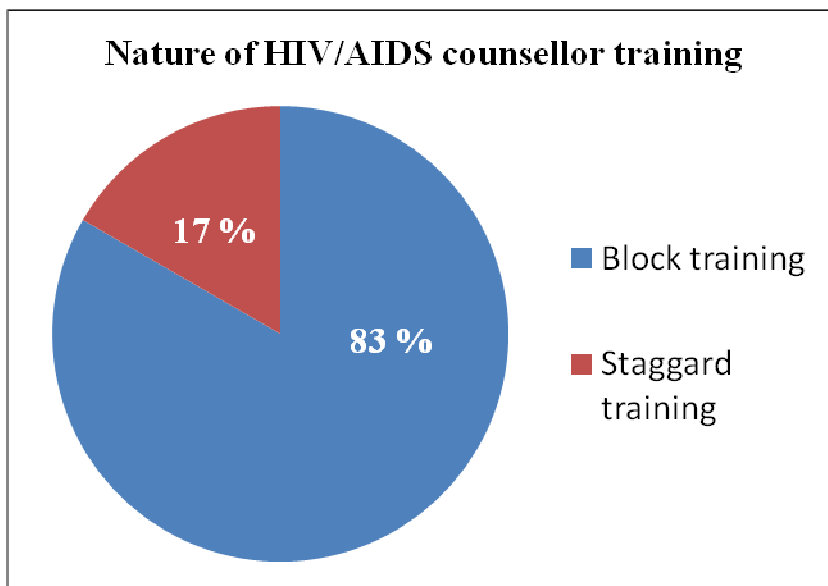
- **Role play, group work and supervision:** One counsellor was exposed to role play, group work and supervision and rated training as 8.
- **Role play, group work and practical field placement:** Two counsellors in this category rated their training as 7.

The twenty four counsellors had been exposed to four different categories of practical training. Most of the counsellors were exposed to role play and group work for the duration of their training.

4.2.3.1 Duration and nature of training

Counsellor training was staggered (not done on consecutive days) or block training, which took place on consecutive days. The nature of counsellor training was as follows:

PIE CHART 1: NATURE OF HIV/AIDS COUNSELLOR TRAINING



In the study 83% (twenty counsellors) of the counsellors had block training and 17% (four counsellors) had staggered training.

The duration of the training is illustrated and discussed below:

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

TABLE 6: DURATION OF HIV/AIDS COUNSELLOR TRAINING

Nature of training	5 days	10 days	20 days	2 mnths	3 mnths	6 mnths	1 year	Total
Block	1	8	5			5	1	20
Staggered		1	1	1	1			4
Total	1	9	6	1	1	5	1	24

Twenty counsellors were exposed to block training and four underwent staggered training. Sixteen counsellors trained for twenty days and less, two trained for 2 months and 3 months respectively, one trained for 6 months and one trained for one year. Counsellor training appeared to be diverse and the 24 counsellors were exposed to nine different types of training programmes. There was preference for block training, as indicated by one counsellor who said:

“ I had to rush back to work immediately on training days and it was too hectic... they should give us off one time to complete the training...”

Twenty counsellors underwent block training ranging in length from five days to one year. Four rated level of satisfaction with training as 8, three rated levels of satisfaction levels at 7, four gave ratings of 6, two gave ratings of 4 and one counsellor rated training as 3. Out of the four counsellors who underwent staggered training, two were employed immediately after training (8 rating), one benefited from practical field placement (7) and one had to learn on the job (5).

4.2.3.2 Employment status at time of training

At the time of training the counsellors had varied employment statuses. Thirteen of the counsellors were unemployed, four were employed and six were volunteers at the time, whilst one was a student social worker. The thirteen counsellors who were unemployed rated their level of satisfaction with training as 4 (one counsellor), 5 (six counsellors), 6 (one counsellor), 7 (three counsellors) and 8 (two counsellors). The two counsellors who rated their level of satisfaction with training as 8 were employed immediately after training. Four counsellors who were employed rated training 8 (two counsellors), 6 (one counsellor) and 5 (one counsellor). The latter counsellor was a nurse counsellor

who was exposed to staggered training and had to learn on the job and had supervision after seeing clients. The four counsellors who were volunteers at the time of training, rated their levels of satisfaction with training as 3 (one counsellor), 5 (one counsellor), 6 (two counsellors) and 7 (one counsellor). The counsellor who rated training 3 trained for 6 months. One counsellor was a student social worker and rated training 8.

4.2.4 LEVELS OF CONFIDENCE ON COMPLETION OF TRAINING

Counsellors expressed varied levels of confidence after completion their counsellor training.

- **Okay:** Fifteen counsellors felt okay due to the following reasons:

Three counsellors had ongoing training when they were employed; three counsellors benefited from on the job supervision; three counsellors had personal life experience as HIV positive persons; three counsellors had experience as volunteers; two counsellors utilized training from their own professional training (for example, as a trauma counsellor and student social work student) and one of the counsellors was exposed to field placement, arranged by the training provider.

- **Uneasy, lacking in confidence:** Nine counsellors, due to the following reasons:

Three counsellors said they were reluctant, nervous to counsel on completion of training. Five counsellors said they had too little practice and one was dissatisfied with the training. Counsellors who appeared more satisfied to counsel on completion of the training were amongst the counsellors who were engaged in the field as a trauma counsellor, social work student, volunteers, social workers, nurse counsellor. Likewise, trainees who had personal life experience HIV positive persons appeared confident to counsel when they completed their training. On the other hand, the trainee counsellors who did not have enough opportunity to practice counselling appeared less satisfied with their training.

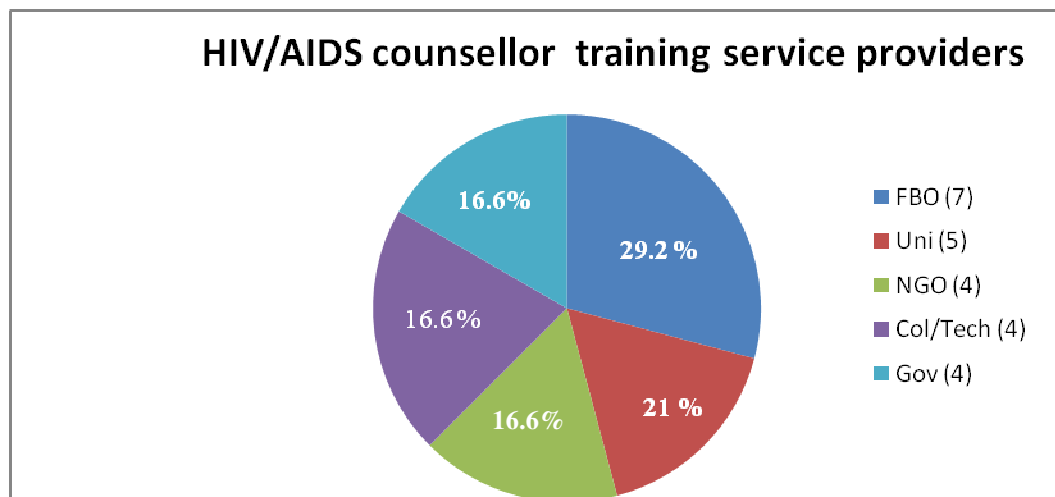
Upon reflection of all the above mentioned data, the researcher was reminded that Panter et al (2000) pointed out that trainee characteristics were related to assessments of training quality

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

for example, trainee demographic characteristics, life and work experience. The authors suggested that greater understanding of participants' characteristics could provide clues about how training experiences were perceived and processed and might inform decision-making about instructional HIV/AIDS curricula. The researcher thus continued to explore the perceptions of the eThekweni counsellors concerning the training they received.

4.2.5 TRAINING PROVIDERS

PIE CHART 2: TRAINING PROVIDERS OF HIV/AIDS COUNSELLORS



The twenty four HIV/AIDS counsellors were trained by five training providers. Four counsellors were trained by government (16.6%), four were trained by college/ technikon (16.6%), four by NGO (16.6%), five were trained in trained university settings (21%), and seven counsellors were trained by FBO (29.2%) in eThekweni. This indicates the diverse training backgrounds of the counsellors who were involved in this study, so that twenty four of them had five training service -providers.

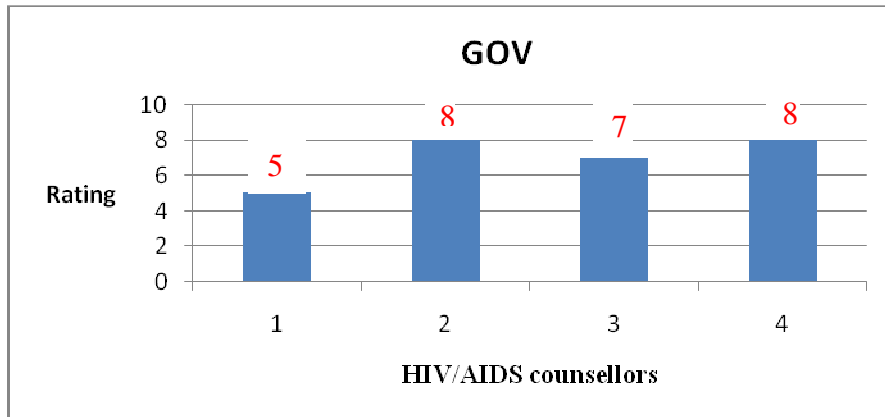
4.2.5.1 Levels of satisfaction with training

Counsellors rated their training out of 10, which ranged between 3 and 8 and are discussed in the five graphs below according to the training providers where they trained. The researcher utilized a rating scale to ascertain the counsellors' level of satisfaction with their counsellor training. The data for the rating scale was obtained telephonically from the counsellors as a post interview follow-up in order to obtain a clearer picture of the level of satisfaction regarding their counsellor training. Counsellors were asked to rate their level of satisfaction with their training out of 10.

According to the rating scale, 1 meant that the counsellor was 'completely dissatisfied' with the training and a rating of 10 meant that the training was 'completely satisfied.' The individual ratings given by the counsellors telephonically were graded by the researcher and then verified in terms of the stipulated anchor or rating description. The use of the rating scale was to gain overall impressions (Appendix F: Rating scale).

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

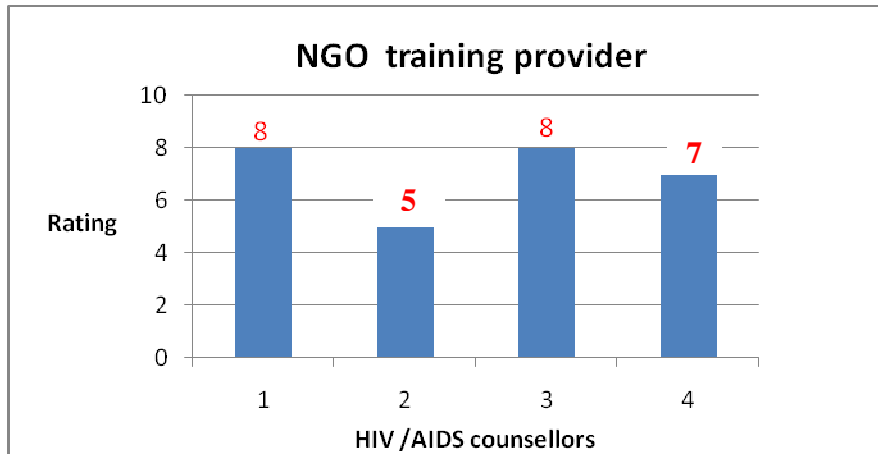
GRAPH 1: GOVERNMENT TRAINING PROVIDER



Four HIV/AIDS counsellors in the sample trained in government settings. One counsellor did twenty days staggered training two days per week. One counsellor did ten days staggered training two days per week. One counsellor completed five days block training and one counsellor did ten days block training. Three people indicated that their personal life experiences were an advantage during training. One had been employed as a trauma counsellor, one as a nurse and one was HIV positive. They rated their training as 8 and 5 and 8 respectively. The person who rated levels of satisfaction with training as 7 was fortunate to have been exposed to a fieldwork placement that had been arranged by the training provider. Interestingly, in spite of the benefit of life experience, the nurse counsellor rated levels of satisfaction with training 5.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

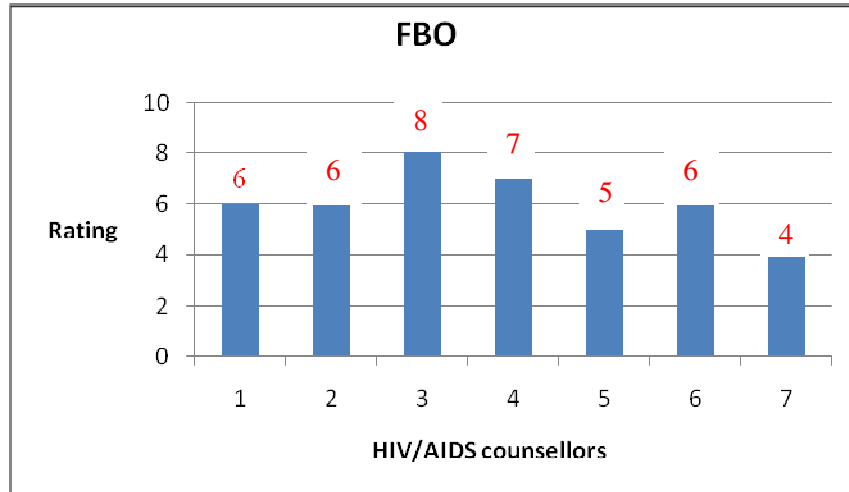
GRAPH 2: NGO TRAINING PROVIDER



Four of the counsellors had received their training from NGO's. Two counsellors rated their levels of satisfaction with their training as 8. Both of them were exposed to staggered training for twenty days (two days per week) over a two months period and were employed on completion of their training. The counsellor who gave a rating of 7 had block training for twenty days and was employed after completion of the training. The counsellor who rated levels of satisfaction with training as 5 had block training for ten days and was unemployed at the time.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

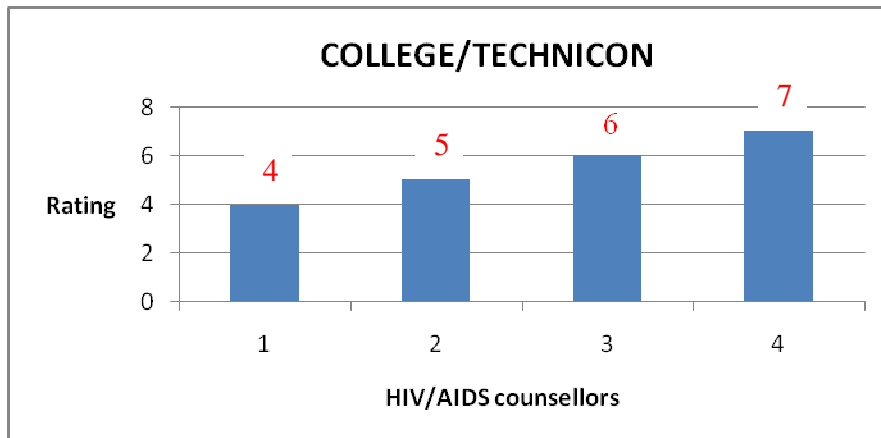
GRAPH 3: FAITH BASED ORGANIZATIONS



Seven FBO trained counsellors gave the following ratings of their levels of satisfaction with their training: One counsellor rated it as 8. One counsellor rated it 7 and three rated it 6. One counsellor rated it 5 and one gave a rating of 4. The FBO training tended to be much shorter. All seven of the counsellors attended block training. Six counsellors attended training courses that lasted ten days and one trained for twenty days. Their ratings of their levels of satisfaction appeared to be slightly lower than the NGO and government trained counsellors. One counsellor had life experience as an HIV positive person (6 rating). Two worked as volunteers after their training (6 and 7 ratings). Two counsellors lacked practical training experience (4 and 5 ratings). Interestingly, there were high incidents of FBO trained counsellors who remained in the employment of FBO organizations after training, despite slightly lower ratings of levels of satisfaction with training.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

GRAPH 4: COLLEGE/ TECHNIKON TRAINING PROVIDER

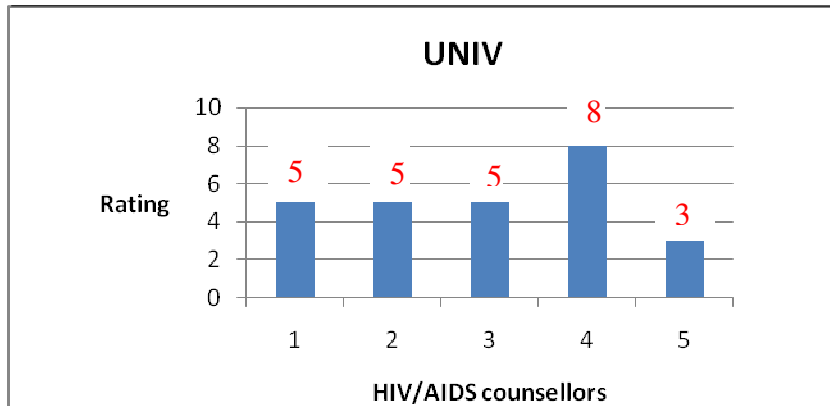


Four counsellors trained at college/ technikon. One counsellor rated her level of satisfaction with training as 7. One counsellor rated it 6. One counsellor rated it 5 and one counsellor rated it 4. One counsellor did block training for 6 months and 3 counsellors did block training for twenty days.

The four counsellors were exposed to role play and group work and one of them (5 rating) said that too little practical work was done. One counsellor who did role play and group work was fortunate to receive supervision when working as a counsellor (6 rating). One counsellor was fortunate to do a fieldwork placement whilst training (7 rating).

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

GRAPH 5: UNIVERSITY TRAINING PROVIDER



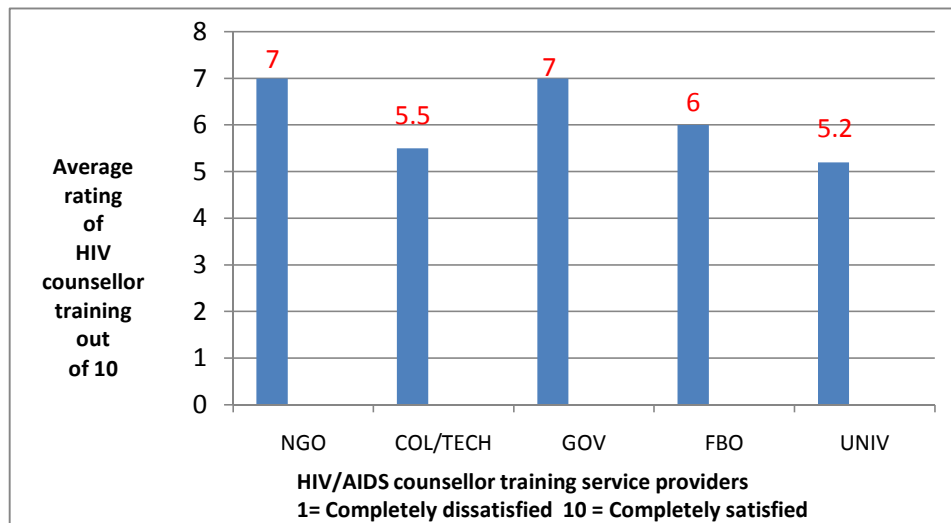
Five of the HIV/AIDS counsellors were trained at university. Generally the ratings levels of satisfaction with training of the university trained counsellors were lower. One counsellor rated it as 3. Three counsellors rated it as 5 and one counsellor rated it as 8. Interestingly, these counsellors were exposed to longer training. One counsellor did block training for one year and four counsellors did block training for six months.

The counsellor with the lowest rating of 3, trained for 6 months, underwent role play and group work as practical training, was a volunteer and despite this, felt unsure to counsel on completion of training. The researcher was reminded of the statement by Maclaim (2003:186) who said that perceptions counsellors have about training, is critical to the confidence of new counsellors. Upon reflection, the researcher noted that the counsellors' highest levels of satisfaction concerning the training they received, appeared to be attributed to ongoing in-service-training, supervision, practical field placement during training and the counsellor's ability to apply personal life experiences with regard to counselling in the field of HIV/AIDS. In instances where role play was the only form of practical training method counsellors were exposed to during their training, their levels of satisfaction about their training appeared to be much lower.

The satisfaction of hiv/aids counsellors in the ethekwini metropolitan area with regard to their counsellor training

For the purpose of clarification and to put matters into perspective, the following graph depicts the average satisfaction rating of all the training providers by the counsellors.

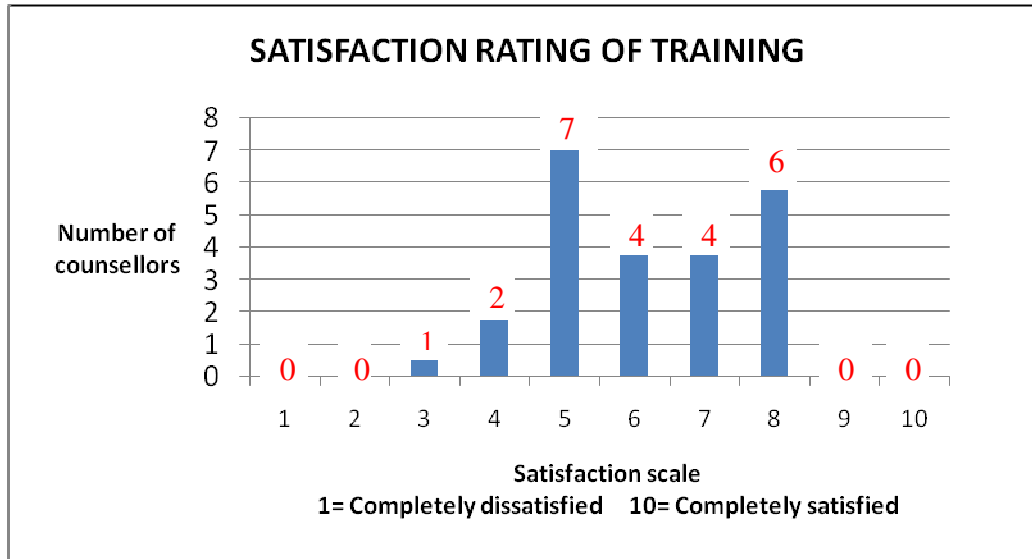
GRAPH 6: MEAN SATISFACTION RATINGS OF HIV/AIDS COUNSELLORS CONCERNING THEIR TRAINING



The respective service providers that trained the counsellors in HIV/AIDS counselling, were rated by them as follows: The highest rating of 7 was equal for NGO and government (or local government) service providers. FBO were rated as 6, college or technikon was as 5.5 and 5.2 for their university service providers.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

GRAPH 7: SATISFACTION RATINGS OF HIV/AIDS COUNSELLOR TRAINING ON A SCALE OF 1 TO 10



The twenty four counsellors rated their satisfaction with the HIV/AIDS counsellor training they received on a scale of 1 to 10. According to the rating scale, 1 is 'completely dissatisfied' and 10 means 'completely satisfied' (Rating scale: Appendix F).

The counsellors rated their level of satisfaction with their training as follows: One counsellor rated training as 3, two counsellors rated it 4, seven counsellors rated training 5, four counsellors rated their training 6, four gave ratings of 7 and six counsellors rated their satisfaction with the training as 8. Overall fifteen counsellors rated training between 7 and 8 and nine rated training below 7.

It appeared to the researcher that generally the counsellors were satisfied to have an opportunity to learn more about HIV and AIDS. When being more specific about the extent to which they felt satisfied with the training, it was evident that they did not feel fully equipped to work as counsellors. Their levels of satisfaction varied from ratings 3 to 8. Fourteen rated their level of satisfaction with their training as 6 and below. Ten rated their level of satisfaction with training as 7 or 8.

The researcher was keen to search for patterns or themes that might provide clues concerning the counsellors' ratings about their training. The counsellors' perceptions of HIV/AIDS counselling were subsequently explored.

4.3 COUNSELLORS' PERCEPTIONS ABOUT HIV/AIDS COUNSELLING

This qualitative and phenomenological study provided the opportunity to explore what motivated the counsellors to train in HIV and AIDS counselling and why they thought it was important for them to do the training. The researcher encouraged them to explore what their perceptions were about the skills and roles they needed to acquire before they commenced training.

4.3.1 PERCEPTIONS OF MOTIVATION TO BECOME HIV/AIDS COUNSELLORS

During the interviews the counsellors had the opportunity to express themselves freely. When discussing what motivated them to train as counsellors in the sphere of HIV and AIDS, seven predominant themes emerged and the individual counsellors attested to being motivated by more than one reason, as reflected in the following tables.

The seven predominant themes were philanthropic reasons, a personal encounter with HIV and AIDS, religious reasons, commitment to the community, self actualization, a need to help others deal with the psycho social aspects of HIV and AIDS and finally, training in this field was some form of occupational compromise. The highlights of each of these themes are discussed below.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

TABLE 8: PHILANTHROPIC REASONS

THEME	SUB-THEMES	FREQUENCY
Philanthropic or Altruism	- To help people.	24
	- To make a difference in the suffering of people.	24
	- Previous experience as teachers and many students affected and infected.	2
	- Needed more information to help others.	20
	- Help ease the shortage of counsellors.	10

All the counsellors were motivated by philanthropic or altruistic reasons as illustrated in the table.

The following quotation by one of the counsellors, best illustrates this:

“The number one reason why I wanted to do counselling was because I wanted people to get helped.”

TABLE 9: PERSONAL ENCOUNTER WITH HIV

THEME	SUB-THEMES	FREQUENCY INDICATED
Personal encounter with HIV	- People infected in family and wanted to train to assist loved ones and others.	18
	- Knew friends or people in the community who are affected with HIV.	24
	- HIV positive and did not get proper counselling; disclosed status on training for the first time.	3
	- Family members died of AIDS.	13

All of the counsellors knew of friends or people in their community who were affected by the disease. Eighteen professed to having loved ones who were HIV positive. Thirteen of the counsellors had family members who had passed away due to the disease. Three of the counsellors were HIV positive themselves and wanted to reach out to others in similar situations. They

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

anticipated that their undergoing training would be able to offer more assurance to themselves, to their loves ones, friends and associates in the community. Such personal encounters with HIV indicated that this had become an overriding motivator for them to gain more skills and knowledge as illustrated by the following quotation by one of the counsellors:

“I had so many people in my family who was infected with HIV. They were getting sick and I didn’t know how to help them, so I figured out. ...so I thought if I had some sort of training I could help them and probably also more other people.”

TABLE 10: RELIGIOUS REASONS

THEME	SUB-THEMES	FREQUENCY INDICATED
Religious Reasons	- Religious duty (Christians and Muslims).	15
	- Personal calling from God to offer support to people; spiritual upliftment.	6
	- HIV/AIDS is a sickness; must pray for healing and miracle.	14
	- God loves us. Positive people feel unloved, so we must re-assure them of Gods’ love.	12

Religious factors featured prominently in the motivation of the counsellors to undergo training in HIV/AIDS counselling. The fact that there is no cure for HIV and AIDS is a significant motivator to turn to a higher spiritual power for healing and strength. It should be noted that seven of the respondents were trained in HIV/AIDS counselling by FBO’s. This was close to 29% of the respondents.

A counsellor clearly described the inherent spiritual motivation for becoming involved in HIV/AIDS training and said:

“.... I think God called me to be a counsellor to help people with HIV and AIDS...”

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

TABLE 11: COMMITMENT TO EMPOWERING THE COMMUNITY

THEME	SUB-THEMES	FREQUENCY INDICATED
Commitment to empowering the Community	- To educate and empower people to overcome the stereotypes.	24
	- To assist in educating professionals e.g. doctors and nurses and other healthcare professionals how to deal with people with HIV/AIDS.	3
	- Previous experience as teachers and many students affected and infected.	2
	- Educate people about the social reality of HIV/AIDS.	24

All the counsellors felt strongly motivated to affect positive changes within their respective communities with regard to dealing with the social reality of HIV and AIDS. Educating others about its harsh impact was seen as an important motivator for all of them in an effort to curb the pandemic. This was aptly illustrated by one of the counsellors who said:

“... so many children are affected with HIV and all the things that are related to HIV, and so I sat down with my colleagues and we asked what can we do to help the children, and that’s when the two of us decided to go for training.”

The one specific area where three of the counsellors felt they needed to bring about change was to assist in educating professionals, for example, doctors and nurses and other healthcare professionals on how to more sensitively handle people who are HIV and AIDS positive. It was interesting that all the respondents considered counselling as an effective tool to educate people about the real nature of HIV and AIDS.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

TABLE 12: SELF-ACTUALIZATION

THEME	SUB-THEMES	FREQUENCY INDICATED
Self - actualization	-To challenge self to learn more, be more, do more.	13
	-Training was part of academic requirements towards a qualification.	6
	- Training was a compulsory work requirement.	4

Thirteen of the counsellors (54%) were also motivated to empower themselves through the acquisition of training. They wanted to improve the quality of their lives. As thirteen were unemployed when they did the training, one wonders whether they considered HIV counsellor training to be an effective stepping stone to securing employment.

“ and learning new skills each and every day you learn things in general, and you add more into your knowledge bag....”

It was encouraging to note that 6 (25%) of the respondents underwent HIV counsellor training in order to strengthen their professionalism in their respective occupations. It was hoped that this was an indicator that HIV training was being mainstreamed in all occupations as this would enhance the inter- sectoral response to the pandemic.

TABLE 13: A NEED TO HELP OTHERS DEAL WITH THE PSYCHOSOCIAL ASPECTS OF HIV/AIDS

THEME	SUB-THEMES	FREQUENCY INDICATED
Help with the Psycho- social aspects of HIV/AIDS	To kindle positive persons' will to live; To reduce social stigma in the community; To give people hope; Be confidants; Offer support; Overcome stereotyping; Non-judgmental helper.	24

From their responses one could deduce that the counsellors felt that HIV positive people had to struggle against social stigma, helplessness and hopelessness. Counsellors believed that acceptance demonstrated by the helper could rekindle HIV positive persons' will to live; offer much needed support and enable them to be more positive about their futures.

All the counsellors were motivated to assist others to manage the effects of the disease and wanted to be trained helpers so that those infected and affected with HIV and AIDS could better manage the psychological and social implications of the disease. One of them explained:

“.....Well, there's a lot of issues that need to be talked about and like I said ... very sensitive issues”

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

TABLE 14: COMPROMISE

THEME	SUB-THEMES	FREQUENCY INDICATED
Compromise	<ul style="list-style-type: none"> - Unable to do social work due to financial constraints; HIV/AIDS counsellor training was compromise. - Wanted to be a nurse and became a counsellor instead due to lack financial constraints. - Immigrant to SA– volunteered whilst studying and wanted to help with HIV. 	<p style="text-align: center;">1</p> <p style="text-align: center;">1</p> <p style="text-align: center;">1</p>

Three counsellors viewed the training as a compromise in terms of their personal circumstances. One was motivated to go for training because it was regarded as the next best thing to becoming a nurse. One wanted to be a social worker but lacked the resources to go for training, HIV/AIDS counsellor training was the next and closest option available to her. The third was an immigrant who initially assisted a feeding scheme at a FBO whilst studying and was subsequently trained and employed as an HIV/AIDS counsellor at the same organization.

All the data presented in the above seven tables, showed that there were multiple factors that motivated the counsellors to train in HIV and AIDS. The counsellors were clearly self-driven and motivated to make a difference. Their motivation to do the training, was linked to self-preservation (work-related, academic requirements and compromises); personal life experiences (personal; HIV positive status); and values (religious; philanthropic; social; psychosocial).

Carl Rogers who developed the Person Centred Theory provides a framework to understand human nature. Based on his theory, Grobler, et al (2003:18) discusses the ‘self’ of the facilitator (in this case, the HIV/AIDS counsellor) and reminds us that it is important to reflect on personal needs for helping others. Helper needs motivate helper behaviour during the helping process. Clearly, involvement as an HIV/AIDS counsellor was seen by many as a selfless act of care granted to people in need. It was anticipated that personal satisfaction would be derived in helping those less

fortunate than themselves. The counsellors appeared to be motivated by the knowledge that HIV and AIDS is a severe health crisis in South Africa and a challenge that goes beyond the provision of medical treatment. As indicated in Strand et al (2005:1), they were motivated to make a difference.

4.3.2 PERCEPTION OF IMPORTANCE OF HIV/AIDS COUNSELLORS

The research participants offered their insights as to why they believed it was important for society to have HIV and AIDS counsellors, to attend to people who are infected and affected with the disease. Their responses are grouped as follows:

- **Unique psychosocial affects of HIV/AIDS:**

HIV and AIDS counsellors were viewed as important because the epidemic is different from any other and releases unique and complex life challenges. Counsellors therefore help people who are infected and affected to deal with the psychosocial effects of the disease in their capacity as confidants. There remains a lot of stigma attached to HIV and AIDS. Counsellors are also needed to give emotional support, help boost their clients' self esteem and respond to those in pain because they were trained to deal with sensitive issues. As such, HIV/AIDS counsellors are approachable, empathic, non-judgmental and can be trusted and they know how to talk to people of all ages. Counsellors ensure that their clients find ways to feel better about their problems.

- **Need for specialized response**

Normal training in human sciences and health professions are not enough. It is important for counsellors to have specialized training in HIV/AIDS even if they have been trained as other health professionals or in human sciences. This would ensure a multi sectoral response to the pandemic. Professionals from different disciplines would do no harm when properly trained in HIV/AIDS counselling.

- **Multi- faceted consequences of HIV/AIDS**

Counsellors in HIV and AIDS offer holistic services and do not only focus their counselling interventions on HIV and AIDS. They endeavour to assist their clients with whatever life challenges or problems they are faced with. Counsellors are needed to counsel, to advise and inform people about HIV-related issues and facilitate the process of assisting them to manage their lives and lifestyles appropriately in the wake of the devastation of the HIV epidemic.

- **HIV/AIDS knows no boundaries**

HIV can affect anyone and counsellors are trained to interact and talk to all kinds of people, irrespective of their age, gender, culture, sexual-orientation or social status. Their professional values and communication skills enable them to do so.

- **To ensure legal and ethical compliance**

HIV and AIDS counsellors are professionals who are trained in ethical and legal issues related to the disease and are therefore needed to assist their clients who experience challenges in this regard. Alternately, counsellors could link their clients to appropriate persons or organizations to enable them to obtain required legal or ethical guidance.

- **Restore morality and humanity**

Counsellors help clients to understand the importance of being faithful to life partners. They are respectful and compassionate and are trained to help people to live positively after finding out about a positive HIV diagnosis.

- **HIV/AIDS is a lifestyle disease:**

Counsellors were seen as important educators with regard to providing appropriate medical and wellness information because HIV is an incurable sickness.

In the light of the above data, the research participants appeared to view HIV/AIDS counsellors as an important resource for assisting clients to manage the consequences of the disease. HIV/AIDS is perceived as a lifestyle disease and therefore counsellors have a role to play in order to counsel people and facilitate the processes of restoring morality and humanity in society.

The information presented by the counsellors concurs with Hlalele (2004:6) that while the disease keeps ravaging the bodies, lives and social networks of their patients, committed counsellors are needed to continue counselling work and help people to lead more fulfilling lives. The counsellors stressed their importance in society. Bor & Elford (1992:435) recognized the importance of counsellors as far back as 1992. They said that it was important to train every helper in the sphere of HIV and AIDS counselling, because there would never be enough professionals to address the scourge.

4.3.3 PERCEPTIONS OF HIV/AIDS COUNSELLOR ABOUT THEIR ROLES

The participants in the study reported a variety of roles they believed they fulfilled during the course of their work. The different roles were linked to numerous disciples as illustrated below:

- **Facilitators**

Counsellors facilitate crisis - intervention and other types of counselling in a variety of settings. They convey high levels of acceptance of persons with positive HIV status. As counsellors they facilitate disclosure to the clients' friends and family. Their role is to facilitate positive problem-solving and behaviour change actions. They enable clients' decision-making and management of their personal life challenges. In extreme situations they monitor clients' suicidal tendencies and pave the way for them to receive the necessary help to address self-harming tendencies. Intervention is not only directed at individual client systems, but also at groups such as the facilitation of work-related HIV/AIDS awareness programmes and support groups (Johnson in van Dyk 2005, Maclaim 2003).

- **Educators**

Counsellors educate clients about important issues relating to HIV/AIDS topics such as positive living, universal precautions and appropriate management of the virus, relevant treatment interventions and compliance of ARV treatment.

- **Psychosocial practitioners**

Counsellors give clients hope, boost clients' self-esteem, guide their decision-making and deal with their emotional problems. Counsellors extend their clients' support-base to ensure that they maximize the support that they can receive. They become and are primary confidants of their clients' deepest secrets. They assist their clients to manage the psychological issues that impact on them (van Niekerk & Prins 2001, van Dyk 2005, Hoffman 1991). Counsellors were expected to listen empathically to the life stories of the infected and affected as a means of assisting them to clarify what core life challenges they have to manage.

- **Multi-disciplinary interventions**

The different types of counselling include basic counselling, pre-and post-test counselling, ongoing counselling, specialized counselling of minority groups, counselling different age groups, relationship counselling and bereavement counselling. HIV/AIDS counsellors are expected to have knowledge in many aspects of the multi-faceted face of HIV and AIDS. Clients expect 'one stop' counselling and it was not uncommon for a counsellor to feel stretched to be a psychosocial practitioner, a theologian, a spiritual leader, a resource agent, a health practitioner, a welfare officer, an educator, a news bearer, an intermediary, a legal and ethical practitioner, a management consultant and a personal tutor to their clients. One counsellor explained how she felt:

“...well you know there's a lot of their immediate needs... you can't only do counselling... unemployment in our communities is so high, and when people wait for grants they have no food and they come to you ... so in the counselling, you cannot just talk about their emotional needs, you must also help them to address other things...and help them... maybe to get food parcels or to start a vegetable garden.... and that is very challenging.”

4.3.4 THE ROLE OF NURSES VERSUS HIV/AIDS COUNSELLORS

A theme which spontaneously unfolded during the interviews was counsellors' views about the role of nurses versus HIV/AIDS counsellors. Two different perspectives emerged during interviews with six participants. They indicated that as counsellors, they perform an essential service to augment the services provided by nurses. They indicated that "counsellors are more approachable" and people find it easier to talk to them than nurses. One of the counsellors said:

".....they have less fear when talking to a counsellor instead of a medical person and we don't wear uniform and don't use hard terminology."

They proposed that counsellors have time to focus on clients' feelings as illustrated by one of the participants who said:

"If you have a headache, the medical people will give you a tablet, but counsellors will try to understand why you have a headache."

It was felt that counsellors made effort to understand people holistically. These responses indicate that the counsellors had grasped the importance of establishing a relationship with those they counsel. They indicated that their interventions assist nurses because they offer more time to patients and they were in the front-line to answer clients' questions and assist them to know where to go and what to do before they reach the medical personnel. Nonetheless, in ideal circumstances, both interventions are needed to 'cure' the client's headache, namely, tablets and counselling, and not tablets versus counselling.

On the other hand five counsellors indicated that nurses were better at counselling HIV/AIDS patients than HIV/AIDS counsellors. They regarded HIV as a disease and believed that nurses know much more about medical issues. One of the counsellors indicated her intention to be a nurse. Further probing revealed that when attempting to facilitate wellness of clients, the counsellors felt inadequate and regarded professional nurses as more knowledgeable. One realizes that training of such counsellors and nurses may need to be revisited. Middleton and Solomon (2002) highlighted the need for counsellors to have ongoing supervision and support. As suggested by these authors, the

responses of the participants in this study suggested that nurses and HIV/AIDS counsellor training courses were developed in relative isolation. Both groups would benefit from expanding their courses and not developing them in isolation. One of the counsellors said:

“Because I think that one thing I’m sure of is that most people who come to us... who approach us for counselling, they are not scared... because we are approachable. And I think it’s because we don’t wear uniform. So that’s what I find it’s much more easier and in most cases they won’t approach a nurse for a simple questions, but they would actually approach me for information that they can actually get from a nurse.”

4.3.5 PERCEPTIONS OF HIV/AIDS COUNSELLORS ABOUT THEIR EXPANDED ROLES

HIV/AIDS counselling is psychologically demanding on the counsellors in a way that other case scenarios were not. Likewise, Richards (2004) pointed out that the counsellors in Zimbabwe took on a variety of roles that counsellors in the developed world did not have to. Because of the scarcity of manpower to address HIV/AIDS issues counsellors did not seem to be able to specialize and were expected to manage challenges specific to developing countries. Counsellors for example, found themselves dealing with issues stemming from the socio-economic problems caused by the poverty of their clients. By implication, counsellors in the sphere of HIV/AIDS acted as de facto welfare agents and needed to be skilled in facilitating appropriate interventions. They clearly experienced HIV counselling as a multi-faceted process in accordance with Richards (2004).

HIV/AIDS counsellors were involved in numerous roles other than counselling. They were required to have an extensive knowledge base in many areas and a large repertoire of counselling techniques and skills. Because of this, Richards (2004) said HIV/AIDS counselling was psychologically demanding on the counsellors in a way that other case scenarios were not. On the other hand, a strikingly different factor between the findings of Richards (2004) and that of the researcher’s study was that none of the eThekweni HIV/AIDS counsellors described their role as ‘preventative.’ No one mentioned the terms ‘preventing infection’ and ‘preventing re- infection’ (Richards 2004: 5/6); also in line with World Health Organization’s Global Program on AIDS definition), when describing their counselling roles. They did however, say they ‘facilitate’ behaviour change and ‘educate’ and

‘inform’ people about HIV-/AIDS related issues. They did not make a big thing about fulfilling a preventative role. They referred to some preventative measures, such as behaviour change and condom-use to advocate prevention.

The researcher wondered if the reality was that these HIV/AIDS counsellors in eThekweni who were confronted with the highest prevalence of HIV infections in South Africa (HIV/AIDS statistics since Richard’s study in 2004), realized that they could not prevent HIV infection nor the spread of the disease. Solomon et al (2004:22) cautioned that we should be hesitant to ascribe a preventative aim to HIV/AIDS counsellors (prevention), because this was unattainable.

Of the twenty four interviewees in the study, only two HIV/AIDS counsellors indicated that they were comfortable with their current roles and stated that they were coping. Counsellors were clearly stressed. The others stated that they depended on spiritual sustenance, stress relief mechanisms such as a change of environment and their personal support bases to survive. Other counsellors expressed their feelings of frustration due to unclear job descriptions and having to work under pressure. They resorted to self - deprivation and not taking lunch breaks at work. Furthermore, counsellors said that they felt fatigued, drained and anxious because of the workload. They despaired when they were unable to help their clients. Because of major manpower shortages in the field of service, they had no choice but to tackle whatever had to be done.

The impact of being expected to fulfil such multi-faceted roles, clearly placed stress on counsellors in a context of working in a province with the highest HIV prevalence in South Africa. It should be taken into consideration that most of the counsellors themselves had family or friends in the community who were infected or affected with the disease. Three of the counsellors interviewed were HIV positive. The counsellors in the study had limited access to debriefing, had inadequate supervision, unclear job descriptions and limited support for themselves. Dealing with HIV positive people was seen to be quite volatile and counsellors had to be very cautious to avoid the risk of human rights violations.

4.3.6 COUNSELLORS' PERCEPTIONS OF CORE SKILLS AND COMPETENCIES REQUIRED OF HIV/AIDS COUNSELLORS

It became apparent that many respondents did not understand the word skill. They appeared to confuse the term skill with knowledge, professional values and personal awareness. Most of them recognized that in order to fulfil their roles as counsellor, there were critical skills that they needed to master. These were:

- **Communication skills**

Active listening, understanding and becoming aware of non-verbal communications skills and empathy were considered essential interviewing skills.

- **Facilitation skills**

These were pertinent to creating the right context for counsellors to establish relationships with clients. These facilitation skills included putting people at ease, finding ways of relating to different groups, minority groups and people of different developmental stages, applying interview skills in a group context such as initiating and conducting groups.

- **Social skills**

It appeared as though they viewed professional values as skills. Amongst these were skills to work cross-culturally, show respect at all times, adopt a non-judgmental stance, to be able to respect clients confidentiality and target the social stigma associated with HIV and AIDS within the community.

- **Administrative skills**

Respondents identified the need to be professional about counselling and administrative skills were seen to enhance levels of professionalism. Keeping proper records, statistics, writing reports and referral letters and basic office administration were considered to be important in their functioning as counsellors.

- **Self-care skills**

Addressing the harsh reality of HIV and AIDS was seen to generate a great deal of stress for the counsellors who participated in the study. In view of this they spoke of the importance of developing

self-care skills. These skills enable them to balance their personal lives and work, identify and accept their personal limitations during counselling, enhance their self-awareness, increase personal growth, monitor self-motivation and remain introspective.

- **HIV/AIDS**

Counsellors must know how to conduct pre-test and post-test counselling. In addition, counsellors must be skilled to deal with HIV related issues such as demonstrations of condom-use, ARV's, diet and HIV and AIDS management, promoters of positive living and wellness amongst HIV- positive persons.

- **Spiritual facilitating**

HIV/AIDS counsellors must have the ability to facilitate their clients' own spiritual awareness as a coping strategy (if applicable). Facilitators need skills to be able to say appropriate prayers that give clients hope, facilitate their clients' spiritual awareness and guide them to pray. Britton, et al (1999) concurred that issues of spirituality did occur, which implied that the component of spirituality in the sphere of HIV and AIDS counselling exists. One of the counsellors in the study pointedly explained:

“... when you are in a crisis ... when you face a crisis in your life, spirituality is critical, because it can give you inner strength that you need to face the challenges... so I think whatever religion you belong to, it is important to encourage clients to find out how they can find comfort and hope in focusing on spirituality.”

- **Entrepreneurial skills**

HIV/AIDS counsellors should be skilled in initiating, creating, monitoring and sustaining projects such as gardening projects. Most of the skills mentioned concurred with the findings of Richards (2004:5) who undertook research with Zimbabwean counsellors. Providing HIV/AIDS counselling in Zimbabwe was difficult, because counsellors were required to have an extensive knowledge base in many areas, and because they need to have a large repertoire of counselling techniques and skills. Clearly this was the experience of the eThekweni counsellors too.

Being completely convinced of their relevance the counsellors were strongly motivated to acquire relevant skills and knowledge. Basic training was not considered enough. Ongoing training and development were considered a pre-requisite for enhancing counsellors' levels of competence so that they would feel confident enough to deliver good service. The counsellors were motivated to undergo relevant training and clearly understood the skills they needed and the roles they were expected to perform as counsellors in the field of HIV and AIDS.

4.4 NATURE OF TRAINING HIV/AIDS COUNSELLORS WERE EXPOSED TO

Lahav (2001:209) and Hlalele (2004:110) counselled that the process of exploring and describing perceptions and experiences of counsellors involved in training programmes should continue in the interest of enhancing training for counsellors. The researcher explored further with the counsellors about their training.

4.4.1 STRUCTURE OF TRAINING COURSES

4.4.1.1 Entrance criteria

Participants were asked about the criteria for selection or entry into their training courses. Three main categories were identified from their responses, namely rigorous criteria, non-rigorous criteria and work/academic-related criteria.

- **Rigorous criteria**

Various entrance criteria included in the rigorous category that the trainee counsellors were required to meet in the diverse training courses they attended, were that prospective trainees had to be Christian, had to be literate, be able to speak English, be older than 20 years and that trainees must have Grade 12 base level education.

- **Non rigorous criteria**

Entrance criteria to the training programmes considered as non rigorous were: counsellors should have a love for people, a willingness to commit to full attendance. Amongst non - rigorous criteria was that trainee counsellors should be encouraged (not forced) to know their HIV status and/ or hands on exposure a pre-and post-test counselling experience. Some training courses had no specific entrance criteria except that trainees were expected to pay the required fee.

One of the counsellors explained:

“.....they didn’t need any standard that I had to pass, but they only needed money.”

- **Work / Academic related criteria**

Criteria in this particular category were that trainee counsellors had to belong to the nursing profession or that training should be undertaken because it was work-related. Some trainees had no choice in the matter and did the training to fulfill work or academic requirements. For them there was no selection process. Nevertheless, all the HIV/AIDS counsellors were passionate about their work and felt that there should be levels of entry criteria according to the nature of the training courses offered. They felt that entrance to training courses for HIV/AIDS counsellors should be stipulated according to the nature of training being offered and that standardized entrance criteria should exist. For example, prospective trainees should be able to speak English and have at least grade 10 base- level education if coupled with life experience, or else grade 12 should be a pre-requisite for younger people.

4.4.1.2 Size of class

Counsellors were trained in groups ranging from ten to 50. Respondents indicated preference for classes sized between ten to fifteen trainees, as this was considered suited to the facilitation of group discussions, introspection, personal growth sessions and informal discussions. Trainee counsellors would then have more opportunities to ask questions or raise concerns when the size of the class was limited.

4.5 TRAINING METHODS

4.5.1 PARTICIPATORY EXPERIENTIAL TRAINING METHODS

The interviews revealed that respondents valued interactive learning methods. Interactive learning methods made learning more interesting. These methods facilitated more positive rapport between trainees and facilitators, leaving the trainees feeling that facilitators cared for them. They also enhanced the quality of relationships between trainees. The positives of interactive learning methods as identified by the respondents in the study were as follows:

1. Interactive learning methods resulted in networking between participants. Learners shared a lot of information and became more aware of community resources, the organizations that other trainees were based in and how they operated. Networking promoted the formation of self-study groups amongst trainees and the exchange of contact details, which they found useful on completion of training in terms of referring clients. Networking facilitated the development of collaborative working relationships amongst them after completion of their training.
2. Participatory and experiential training meant that trainees were exposed to other professionals who taught them special skills or helped them gain deeper insight into HIV/AIDS. Some were exposed to play therapy techniques such as using puppets and dolls. Some were enthralled by meeting HIV positive people and learning firsthand about their experiences.
3. Interactive learning promoted the personal growth of the trainees. In some instances learners completed self-administered questionnaires to make them more aware of their own lives, stresses and their personal responses and attitudes to HIV and AIDS.
4. Mentoring and ongoing supervision after training enhanced respondents' confidence to counsel and fifteen counsellors (62.5%) expressed that they were satisfied with their training because it was augmented with ongoing training from their employers. They received on the job supervision or gained valuable experience from doing volunteer work or received field-based training from the training provider.
5. Trainees felt they benefited from observing skilled trainers who facilitated their group discussions.

4.5.2 DIDACTIC TRAINING METHODS

4.5.2.1 Formal didactic training methods that counsellors regarded as positive

Counsellors indicated preference for audio-visual material such as videos and capturing information on flipcharts and blackboards. Other didactic methods included providing learners with notes, well-prepared theoretical presentations and the issuing of relevant brochures to trainees.

4.5.2.2 Didactic learning methods learners were dissatisfied with

Responses from respondents pointed to the fact that learners did not favour didactic methods as much as the participatory, experiential ones. Furthermore, didactic learning failed to build learner confidence. Sometimes theoretical training meant that information imparted was not realistic for application in a real life setting. One example of this was a learner who in training was given a pre and post- test interview script that was not appropriate for her setting. Training without site visits or adequate role-plays left members feeling dissatisfied. One member said that she was dissatisfied that she was only exposed to practical work after her one year training ended. According to her frame of reference, practical training and theoretical training should be concurrent. The preference for mixed methods with lots of opportunity for skills transfer as expressed by the counsellors in the study was in accordance with Bor & Elford (2000).

4.5.3 EVALUATION AND CERTIFICATION PROCESSES COUNSELLORS WERE EXPOSED TO

HIV counselling was identified as being a multi-faceted process dependent upon good training and ongoing personal development. Criticism was levelled at the issuing of certificates based on attendance of HIV/AIDS counsellor training programmes. The respondents felt that counsellor trainees should be evaluated on their ability to put into practice what they had learned. In this regard, standardized evaluation tools were recommended to assess both the stated theoretical and practical outcomes of the training received to prepare trainees as HIV/AIDS counsellors. Basing their performance on role-plays alone was not regarded as sufficient.

Most of the participants suggested that they should be evaluated by the way they counselled 'real people' before certificates were issued. It was suggested that testing be used to measure trainees understanding of the course content but only if they were also evaluated according to the way they conducted a counselling session. Participants expected certificates after training and felt that attainment of different levels of training, should entitle them to remuneration based on the level of HIV/AIDS training they had attained as HIV/AIDS counsellors. Examples of such levels include pre-and post test counselling, ongoing counselling, bereavement counselling, adherence counselling, and so forth. It was suggested that the levels of training undertaken by counsellors should be taken

into consideration by employers with regard to performance appraisals or promotions for HIV and AIDS counsellors.

4.5.4 COUNSELLORS' LIKES AND DISLIKES OF TRAINING

The researcher asked the counsellors about the things they liked or disliked about their training, in line with the phenomenological nature of this research. The researcher hoped that this would provide possible indicators towards the improvement of counsellor training in HIV and AIDS, at a local level.

4.5.4.1 What the HIV/AIDS counsellors liked about their training

The HIV and AIDS counsellors in this study said they expected to be trained by trainers or facilitators whom they perceived to care about them and take an interest in their overall well-being. They liked the sessions that allowed them to share their personal experiences of how HIV affected them personally. Although these sessions were described as being emotionally charged, they provided valuable opportunities for the counsellor trainees to 'offload.' All of them had experienced the devastation of HIV/AIDS that either affected them personally, or their families, friends or others in their communities. They liked the introspective sessions. These provided them with an opportunity to take cognizance of themselves in terms of their strengths and recognize areas for personal growth. The use of self-administered questionnaires about their personal lives and HIV status enabled them to take stock of their private lives. With regard to training, some of the counsellors said they liked being trained by trainers who were skilled and field experts. They liked being trained through interactive learning methods that used role-plays. These afforded them opportunities for integrating theory and practice, which enhanced their skills. They liked being exposed to visiting lecturers, such as HIV/AIDS activists who shared their personal stories and they enjoyed play therapy. They also enjoyed audio-visual materials, such as videos, flipcharts, blackboard, pamphlets, notes and group discussions about theory learnt. The counsellors liked the fact that they gained lots of information about HIV and AIDS and this was an empowering experience for them. Mentoring or supervision after training was considered to be very important because they prevented the exposure of clients to trial and error methods.

4.5.4.2 What HIV/AIDS counsellors did not like about their training

The issues raised by the counsellors concerning things they did not like about their training, emphasized insufficient skills transfer opportunities. Counsellors referred to inadequate opportunities to integrate theory and practice as resulting in skill loss. For them, practice built confidence. Other things they disliked about their training included having no volunteer internships arranged for them after training and undergoing counselling skills training that was too vague. Examples of these were pre and post test interview scripts that were not realistic for application in real life settings, no site visits or only role-plays. They indicated that these did little to prepare them for dealing with the psychological and social impact of the disease. Once-off or insufficient role-playing in the absence of any other practical learning methods resulted in imbalance between theory and practical.

Practical training after theoretical training was disliked because counsellors felt that these should happen concurrently. In addition, practical placements that were out of town were not liked because the logistics involved in the trainees getting there placed additional burdens on them. Trainees did not like the lack or exclusion of subject experts in related fields such as medicine and law. They criticized staggered training as mentioned. In addition, facilitators who did not keep to scheduled times and who did not adhere to appropriate dress codes were not liked.

4.5.5 TRAINING CONTENT

Further exploration with the counsellors about their training experiences, led to discussions about their perceptions about the outcome of their training and how it impacted on their ability to fulfil their roles as counsellors.

The participants appeared positive about the knowledge they had acquired. They indicated that there had been so much to learn and so it was impossible to remember everything that had been covered during training. They considered the information presented in the training courses very useful. Richard and Morse (2007:119) counsel us that HIV and AIDS counsellor training experiences

should not be judged in terms of the accuracy with which trainees recall what was covered, but rather how they felt and what they experienced during the training.

Generally the counsellors in the study acknowledged that their training was very informative and provided them with much needed insight. Training prepared them for counselling in the HIV arena. Mostly, they indicated that the training enabled them to counsel in the eThekweni area. When the researcher asked them whether or not they were satisfied with their training, they said they were satisfied. However, when the researcher specifically asked them to rate their level of satisfaction on a rating scale from 1-10 it was surprising to notice how they actually rated it as was illustrated in above-mentioned sections.

The researcher's view was that the levels of satisfaction of the counsellors about their training provided an opportunity for service-providers to network and support one another in the training of counsellors. Essentially, the training of counsellors should be prioritized as a multi - disciplinary collaboration and partnership between educational institutions and the community at large, as pointed out by Lahav (2001:210). This could strengthen service-provision across the sectors especially in the light of the fact that counsellors are not exclusively employed by the service-providers that train them.

4.5.6. SKILLS ACQUIRED

Participants were asked to share what skill competencies they remembered being covered in their training courses. The themes that emerged were:

1. Professional values

These included confidentiality, being non-judgmental, skills on how to contain their personal attitudes when dealing with people whose values were different from their own.

2. Professionalism

This included appropriate dress code, self- presentation during counselling sessions, displaying a sense of professionalism when interacting with colleagues and the manner in which work-related responsibilities were carried out.

3. HIV related discourse

This covered information about how HIV is transmitted, signs and symptoms of HIV/AIDS, anatomy and physiology of HIV and AIDS and STI's.

4. HIV management

This included relevant information about ARV's, appropriate dietary requirement of persons living with HIV and the enhancement of wellness and positive living. Also covered were information relating to infection control with regard to the management of the disease in the interest of the HIV infected persons and significant others and the promotion of healthy lifestyles.

5. Basic counselling skills

Skills highlighted were listening, empathy, verbal and non-verbal communication skills.

6. Legal

Issues covered related to securing the informed consent of persons undergoing HIV anti-body tests and legal and the ethical considerations that pertain to the disease.

7. Self-awareness

This dealt with the introspection of trainees and their personal exploration of their perceptions of HIV and AIDS, personal growth, self examination of any attitudes that are barriers or enablers to counselling and the identification of any form of negative stereotyping.

When counsellors were prompted by the researcher to remember anything else that had been covered in their training, the following content emerged:

1. Sexuality

This highlighted information about the diversity of human sexual orientation and included terms such as dealing with homosexual or lesbian persons in the context of HIV/AIDS.

2. Medical aspects

Mother to child transmission was dealt with and women's susceptibility to HIV. Also covered was medical information pertaining to HIV management and health care.

3. Counselling skills

Paraphrasing as a counselling skill was dealt with.

4. Psychosocial support

Issues highlighted related to the value of support groups, CD 4 count and its relevance to receiving a social grant and the role of religion.

5. Ethics

Pertinent ethical issues concerning death and dying in the sphere of HIV and AIDS and the role of HIV management in terms of traditional medicines were also included.

6. Sociological factors

This included information about relevant cultural issues, prevailing myths about the disease at a local level as well as the role of a traditional healer in the context of the HIV and AIDS.

7. Coping skills

Assertiveness, anger management and stress management were dealt with during the training.

4.6 eTHEKWINI COUNSELLORS' DESCRIPTION OF THEIR PRIMARY ROLES AS HIV/AIDS COUNSELLORS

The eThekweni HIV/AIDS counsellors' description of their roles, indicate congruence with aspects of three HIV/AIDS counselling definitions. Two of these definitions describe the facilitative process of counselling and one incorporates advice-giving. The counsellors in the study identified three main purposes of their counselling role.

1. To facilitate a process of helping HIV positive persons and their families to empower clients to manage their HIV and AIDS situations. This concurs with the following definition:

“To help clients manage their problems more effectively and develop unused or underused opportunities to cope more fully and to help and empower clients to become more effective self-helpers in the future” (Egan 1998 in van Dyk 2005:175) and

“To place the responsibility of problem-solving with those who define the problem (i.e. the client). To help clients find meaning or a new understanding of what it is to have AIDS” (Bor, Miller, Scher & Salt in Solomon et al 2004:21).

2. To normalize clients' feelings which is in agreement with the following definition as stated by Bor, Miller, Scher & Salt (in Solomon et al 2004:21)

- "To normalise the views, feelings and experiences of the client.
- To help clients to feel that they have choices."

3. To offer accurate information that will enable clients to manage their problems more effectively. This corresponds with the definition of Nulty (2003:6):

"It (HIV/AIDS counselling) can either be seen as giving someone information and advice for solving or coping with a problem; or as facilitating a process whereby that person could make an informed decision concerning how to solve or cope with that problem ."

The latter definition of the (role) purpose of HIV/AIDS counsellors appeared to be pertinent to the HIV/AIDS counsellors because it included the element of advice giving. This was expressed by some of the counsellors as exemplified by the following extracts from two interviews:

"Yes, it's an advice ... but at the same time you are telling them to do this.... otherwise you will die you see, because it's life and death..."

"...but when people are sick like in HIV, they don't want to do anything and you need to push them to do this otherwise they will die.....that is what is different in HIV counselling."

Seven years ago, Richter et al (2001) counselled that the goal or purpose of HIV/AIDS counselling had to be more clearly defined. Based on the information obtained from the counsellors, it remained unclear whether the training courses the counsellors attended had clearly defined the purpose of HIV/AIDS counselling.

The study confirmed that the aims of counselling in terms of the development of a national perspective for addressing all stages of the HIV/AIDS epidemic needed to be more clearly defined. Responsibility for the major portion of all non-medical services related to HIV and AIDS, including welfare services, is being inappropriately assigned to HIV/AIDS counsellors.

4.6.1 COPING MECHANISMS USED BY COUNSELLORS IN THE STUDY

4.6.1.1 Spiritual practices

HIV/AIDS counsellors were faced with addressing an incurable disease that has enormous multi-faceted consequences for individuals concerned, family and friends and the community at large. They were surrounded with the prospect of life and death on a daily basis and felt inclined to rely on spiritual sustenance. This was done by means of prayer. Counsellors prayed each morning before counselling their clients. They prayed with their clients. They prayed before and after each counselling session. Counsellors motivated their clients to pray. Counsellors prayed for guidance and wisdom to help and not to harm their clients as illustrated by the following quote by one of the counsellors:

“Every morning when I wake up I pray and late at night, I pray... because I’m used to dealing with a lot of people who are having problems and sometimes I feel I’m tired and I can’t move on to the next day, so I ask God to give me power and all those things to help those who come to me.....”

4.6.1.2 Supervision

Only one counsellor who happened to be based in a FBO reported having supervision twice a week. This greatly helped her to cope with her expanded roles.

4.6.1.3 Clearly defined job descriptions

Two other counsellors described themselves as ‘managing’ because their role descriptions were apparent and tasks were well allocated. One of them said that she could not imagine herself doing pre-and-post test as well as ongoing counselling, because it would result in burnout.

4.6.1.4 Other coping mechanisms

The others expressed a range of coping responses, which ranged from reliance on spiritual sustenance, stress relief mechanisms, environmental manipulation or phoning someone to have a good cry.

De Zoysa et al (in Grinstead & van der Straten 2000) said that the demand for HIV counselling with and without testing was increasing in developing countries, and counselling services were becoming more common. Despite this, counsellor training and supervision in developing countries remained uneven and unregulated, as confirmed in this study. Richards (2004) found that most counsellors in her study had only a few weeks of training for such a demanding job. Subsequently, the need for ongoing training and supervision is evident especially since these counsellors are presented with some of the most complex and difficult counselling scenarios as confirmed in the researcher's study.

4.7 FOCUS GROUP

When permission was sought from the counsellors and their respective employers to conduct the 24 semi-structured interviews, the researcher indicated that a focus group would be held on completion of all the interviews. Most of the counsellors interviewed were again requested to participate in the focus group and most of them declined due to heavy workloads. However ten counsellors said the researcher could liaise with them once the interviews had all been completed. Out of the ten counsellors, seven availed themselves for the focus group, but one counsellor withdrew due to unforeseen circumstances.

For the purpose of triangulation the researcher conducted a focus group with six counsellors in the sample. Triangulation refers to the use of different data collection methods within one study in order to ensure that the data is telling you what you think it is telling you (Saunders et al 2003:99). The researcher used semi-structured interviews and a focus group to see whether the same results were produced in an attempt to add to the credibility or objectivity of the research. Krueger & Casey (2000: 4) said that a focus group was not just a group of people talking together, but a purposeful selection of six to eight people in a comfortable and permissive environment in order to explore their thoughts and feelings about a particular topic. Padgett (1998: 64) recommended that the focus group should ideally compose of persons with similar background (in this case, HIV/AIDS counsellors) who did not know each other very well because familiarity among the group can lead to habitual interaction and inhibit emergence of fresh opinions. Sometimes within focus group discussions people who were more expressive or who had a higher status in the group, were heard

more than others. The researcher hoped to overcome this problem by using a Nominal Group Technique (NGT) as explained by Delbecq and Van de Ven (1975 in Jones 2003:22). The primary advantage being the enhanced opportunity for all participants to contribute their ideas equally and minimize the domination of the process by more confident or outspoken individuals (Vella, Goldfrad, Rowan, Bion & Black 2000 in Jones 2003:22).

4.7.1 PROGRAMME OF THE FOCUS GROUP

The researcher re-confirmed the counsellors' participation in the focus group two days before the group met and reminded the counsellors that transport costs to and from the venue would be covered by the researcher. The researcher obtained a venue in a hospital setting at her place of employment at no cost after establishing that all the group members found the venue accessible and convenient. The researcher ensured that the venue was clean and presentable and conducive to the facilitation of a focus group. The programme was as follows:

4.7.1.1 Introductions and setting group norms

The researcher thanked the counsellors for their attendance and counsellors were given the opportunity to introduce themselves. Group norms were facilitated by the researcher and the following norms were established.

1. Cell phones must be switched off or kept on silent mode.
2. Discussions must be held in an atmosphere of respect and friendliness.
3. Each person must feel free to express an opinion.
4. There would be no break time since all the counsellors had commitments immediately after focus group, which would last for three hours.
5. Refreshments would only be served on completion of the group discussions. However, water was made available during the meeting.
6. Members would all sign individual consents forms to participate in the focus group.
7. Discussions would be of a confidential nature.

Members would simply excuse themselves when needing to use the bathroom, adjacent to the room.

4.7.1.2 Ice breaker

The researcher facilitated an icebreaker and one of the counsellors volunteered to lead the group in a simple physical exercise lasting five minutes. This evoked much laughter and created a relaxed atmosphere.

4.7.1.3 Addressing the objectives of the focus group

The researcher reiterated the purpose of the group meeting and explained how the group would unfold. Members were informed that in terms of the way forward, two objectives of the research would be discussed in the focus group, namely:

- To explore what these counsellors perceived to be the core skills and competencies required of HIV/AIDS counsellors.
- To explore what these counsellors regarded as key areas for the improvement of HIV/AIDS counsellor training.

The researcher collectively discussed the consent form which was issued to each counsellor and asked if anyone had any queries, concerns or suggestions before signing the form which was similar to the consent form they signed for the semi-structures interviews. Everyone said they were fine. The researcher noticed that one of the members had a slight flu and provided her with tissues and extra water and cough sweets. This act was appreciated by the member as well as the group. The process of the Nominal Group Technique was outlined. Members felt that since they were only six members, there should only be one group and not two groups of three each as initially requested by the researcher. At this point the member who was not feeling well excused herself and returned after five minutes. In her absence, the other members strongly felt that the group should not be divided, because they were concerned that the sick member might leave. So we ended up with one group.

It was decided that every member be given an opportunity to respond or make contributions and each one was provided with a pen and paper and encouraged to jot down their ideas whilst someone else was speaking. This provided an opportunity for members to organize their thoughts in preparation for their feedback. The researcher captured their contributions on newsprint.

During the focus group discussion members tended to integrate the two objectives in their discussions. They seemed to focus more on discussing options for further development and training of HIV/AIDS counsellors.

4.7.1.4 Focus group members' perceptions of core skills and competencies required of HIV/AIDS counsellors

The discussions in the group were largely consistent with the feedback given during the semi-structured interviews.

- Basic counselling skills

Members felt all HIV/AIDS counsellors should first be trained in basic counselling skills such as communication skills essential in the counselling process. They felt that counsellor trainees should have an opportunity to practice basic counselling skills prior to obtaining related certificates so that all counsellors are efficiently grounded in basic counselling. Group members specifically highlighted active listening, and explained that in order to ascertain what clients really need one has to 'listen to the client's feelings.' In this regard, non verbal communication skills were regarded as very important. How to effectively utilize empathy was considered an essential skill, especially in view of members' perception that people with HIV tend to feel misunderstood, unloved and rejected due to the high levels of stigma in society. Members were in agreement that paraphrasing was an important skill which all of them had used with positive results. Counsellors have to be skilled in knowing how to facilitate. This was regarded as an important skill which should be included as a basic counselling skill to get clients to tell their stories and deep concerns and facilitate disclosure to partners and family. Facilitation was also useful in terms of networking with stakeholders to address concerns of clients. Also considered as a basic counselling skill, was the ability and skill to relate to persons from diverse cultural backgrounds, sexual and social orientations.

- Pre-and Post test counselling skills

Members felt that all HIV/AIDS counsellors had to be skilled to conduct pre and post-test counselling, irrespective of their job requirements.

4.7.2 FOCUS GROUP MEMBERS' VIEWS ON HOW TO IMPROVE COUNSELLOR TRAINING

4.7.2.1 Practical skills transfer

There was unanimous consensus that counsellor training should offer lots of practical work. Counsellors must get many opportunities to integrate theory with practice and trainees must first counsel 'real people' before receiving certification for courses offered. This included training courses for basic counselling skills, pre-and - post test counselling and different types of ongoing counselling. Group members suggested that there must be 50% practical in every training course because counselling is part skill and part art and requires lots of practice. Site visits were recommended to provide exposure to counselling environments.

4.7.2.2. Personal growth and introspection sessions

Group members considered introspection and personal growth sessions as vital to the training of HIV and AIDS counsellors. They were in agreement that all training courses should commence with such sessions, especially in view of the perception that most people are affected personally or infected when enrolling for training courses. They need an opportunity to deal with personal issues and life challenges at the outset of the training. Personal growth sessions were considered important to facilitate personal development.

4.7.2.3 Volunteering

Members felt that trainee counsellors must be encouraged to seek volunteer opportunities in their communities and training providers should recommend this. This was something that should be encouraged right at the outset of the training courses and members should be given letters of recommendation by the training providers to facilitate the volunteering process.

4.7.2.4 In-service training based on in-service training manuals

Group members were in agreement that newly trained HIV/AIDS counsellors should have access to in- service training at work. It was recommended that it should be compulsory for all service providers employing HIV/AIDS counsellors to offer in-service training. They believed that generic

in service training manuals or guides should be developed for different training courses and used by all training providers. This would enable counsellors to feel more confident about their training and it should be advantages to prospective employers who would be guaranteed that counsellors' training had been standardized.

4.7.2.5 Knowledge-based ongoing counselling skills training

Counsellors regarded ongoing counselling as essential. However, they felt that training courses should offer work specific counsellor training. This would enable counsellors to become skilled in work specific areas. Examples of work specific counselling training courses included counselling related to adherence, bereavement, managing minority groups, dealing with children, and so forth. It was generally felt that diversified training courses would allow counsellors to acquire appropriate practical skills instead of being expected to have a basket of generic skills. The counsellors' view was that training should occur in accordance with generic guides or training material and that training providers could network in this regard. Such an approach would favour the development of acceptable broad-based training for counsellors in the interest of the counsellors and service-providers who employ them, thereby promoting recognition of such counsellor training. In addition, group members strongly felt that all skills training offered to counsellors should present the opportunity for practical skills transfer as well.

4.7.2.6 Certification and recognition

Members were of the opinion that certification should only happen after counsellor trainees had been practically assessed. They felt that counselling certificates should 'mean' something and ought to translate into tangible outcomes and professional recognition. An example of this would be that if a counsellor is awarded a certificate after assessment, it should benefit him or her in terms of a work promotion or a salary increase.

4.7.2.7 Training content

A big criticism of the training was that the counsellor training that they had received was not adapted and adjusted to the unique situations of clients and different counselling contexts. In this regard members felt that because of the high prevalence of HIV and AIDS in the eThekweni

Metropolitan area where they worked as counsellors, training should stress the importance of prayer because HIV is incurable and prayer was considered as a vital coping mechanism for both clients and counsellors.

4.7.3 SUMMARY OF FOCUS GROUP

Of note was that the issues discussed in the focus group concurred with those raised during the semi-structured interviews. On completion of the discussions, the researcher summarized the captured notes to confirm content. There was consensus that the focus group was very useful to re-affirm their commitment as practicing counsellors in the field of HIV and AIDS.

4.8 COUNSELLORS' SUGGESTIONS FOR THE ENHANCEMENT OF COUNSELLOR TRAINING

Counsellors had thought about the weaknesses in their training programmes and made clear, specific proposals for improving training. Their responses have been divided into several themes. They include the modification of selection criteria, movement towards an integrated learning approach, developing benchmarking training courses so that learning could be structured and progressive and counsellors could then complete standardized modules relevant to their context in a tiered manner. Counsellors also suggested the inclusion of more medical terms of reference and learner mentoring.

4.8.1 SELECTION CRITERIA

Counsellors suggested a minimum entry level of grade 10 for the persons with life experience and grade 12 for younger persons. They said English must be an entry requirement for counsellor training because they have to deal with all kinds of people in South Africa. Counsellors suggested that training providers should use more rigorous screening devices and selection criteria. Amongst those suggested were interviews or short written submissions by prospective trainees of their motivations to do the training. It was generally felt that an interviewer administered questionnaire was indicated before training because the prospective trainee might have loved ones who are affected by the disease or could be disclosing their positive status for the first time, which could be very emotional and traumatic for the applicant.

4.8.2 DURATION OF THE TRAINING

Contrary to the researcher's expectations, longer training was not necessarily regarded as better. Counsellors believed that it all depended upon what the trainee's previous training or life experience was when entering the training course.

One counsellor who was trained for five days was comfortable to counsel because she had working experience as a trauma counsellor for more than two years before undergoing training in HIV and AIDS counselling. Participants also indicated that training needed to be conducted on consecutive days and not staggered days. They suggested that training should be longer than ten days if it was to boost counsellors' confidence and cover the most important themes required to work in this field. Counsellors suggested that the duration of the training should be calculated on the basis of what needed to be taught and the amount of time that had to be allocated to allow trainees to practice the skills they were expected to acquire.

4.8.3 CREATING A CONDUCTIVE ENVIRONMENT FOR LEARNING

Participants said it was important to pay attention to the training environment. It should be clean and visually stimulating. This could be achieved by using posters on the wall or by organizing the venue in advance and ensuring adequate seating that was properly arranged.

4.8.4 EVALUATION OF TRAINEES AND ISSUING OF CERTIFICATES

Criticism was levelled at the issuing of certificates based on attendance of training programmes alone. Trainees should be evaluated on their ability to put into practice what they had learnt. Basing their performance on role plays alone was not regarded as sufficient. Most participants suggested that they should be evaluated by the way they counselled 'real people' before any certificate was issued. It was even suggested that testing be used to measure trainees understanding of theory, but only if this was done in conjunction with an evaluation of the way they conducted a counselling session. In this regard one of the counsellors asked:

“... how can you be a counsellor if you've never counselled before?”

Participants expected certificates after training and felt that attainment of different levels of training, should in the long term entitle them to remuneration based on the level of training achieved, as pointed out by one of the counsellors who said:

“..... you can't just get a certificate because you attended the whole course... you must be tested properly so you can feel like a counsellor, because counselling is a skill ... like driving a car... if you want to get a license, you can't only read a book about driving... you must get in the car and show you can drive..”

4.8.5 SUGGESTED CONTENT

The HIV/AIDS counsellors in the study identified specific areas to improve training content of HIV/AIDS counsellor courses. Their suggestions included:

- More information on basic counselling skills.
- More information relevant to counsellor roles and issues pertinent to counselling in the field as identified by the counsellors, for example, how to deal with the psychological impact of HIV and AIDS.
- More medical information and dealing with the psychological and social impact of HIV/AIDS to equip counsellors with skills relevant to the different scenarios they might face.
- Reflections of cultural diversities in the region to prepare counsellor trainees to counsel people with different cultural orientations.
- How to counsel in different contexts relating to minority groups, sexual orientations, family counselling, adherence counselling, and dealing with children.
- Information about the significance of spirituality with regard to coping strategies for counsellors and their clients.
- More information about the management of the disease in terms of positive living and how to conduct support groups.

- Practical and relevant administrative skills to enhance practice, such as report writing, writing referral letters, keeping of statistics and so on.
- Appropriate self presentation, for example dress code appropriate and professional for the working environment.
- Personal growth or introspection sessions as HIV/AIDS affects everyone. Counsellors need to be assisted to deal with their personal issues prior to training. This aspect was considered to be vital as exemplified in the following quote by one of the counsellors who said:

“..... the personal growth session is so important, because it makes us realize that as much as we want to help other people, we still need help at the end of the day..... and the pain that we are feeling now... probably will stay with us if we don't deal with it...”

4.8.6 EXPERIENTIAL LEARNING AND THE BALANCE BETWEEN THEORY AND PRACTICE

Counsellors stressed the need for a balance between relevant theoretical content and meaningful practice opportunities. According to responses from the participants this balance can be achieved by including simulated counselling experiences like role plays, arranging for trainees to observe counselling sessions, counselling settings providing trainees with learning opportunities to practice counselling in the presence of a mentor or supervisor who offers constructive feedback. These suggestions will go a long way to shape and enhance the development of trainees' counselling skills. Arranged visits to counselling sites and encouraging trainees to volunteer their services whilst training, undergoing field placements of students who have completed training under agency supervisors for a minimum period and making sure that trainees observe the process of HIV testing before actually undertaking VCT counselling, were amongst the most practical suggestions. The respondents made two main recommendations for future training programmes. These were:

- that training should allocate time for practical training and field visits.
- that training rely on block or consecutive days rather than programmes that offer staggered training days.

There was a unanimous call for more practical training to parallel the theoretical training received as one of the counsellors highlighted:

“.... We can’t only focus so much on the theory because when you see the client, you must be able to counsel... so I think there must be a balance.... maybe even 50/50...”

4.8.7 FACILITATORS

Suggestions of how counsellors’ experiences of facilitators during the training could be enhanced included more effective time management and proper coordination with co-facilitators when sessions were co-facilitated as one of the counsellors explained:

“ ... people complained, because sometimes in a session, one facilitator leaves the session and goes somewhere and maybe gets delayed and then another one comes in... and there’s no proper communication... we don’t like things like that to happen... we want things to be done in an organized way.”

Suggestions were made for the inclusion of facilitators who were subject experts in the topics concerning the topics required during training, such as medical and legal experts, so that trainees could have the opportunity to address their concerns and queries. To this extent it was suggested that facilitators must take more care about their personal presentation, so that facilitators are appropriately attired, as exemplified in the following quotation by a counsellor who was referring to a male counsellor:

“.... facilitators should not wear shorts when facilitating as this indicated lack of respect for trainees....”

It was also felt that facilitators should be aware of their importance as role models when training counsellors. Counsellors indicated preference to be trained by facilitators who were less formal in their interaction, whom they perceived to be more approachable. In this regard, one of the counsellors said:

“ The staff was incredible... they were always there. I mean they actually practiced what they put in they were the same with everybody... and that’s so important when you train...”

4.9 SUMMARY

This chapter detailed the empirical findings of the study. All the counsellors said they were satisfied that their counsellor training was useful and that they gained a lot of HIV/AIDS- related information. However, when they asked to rate their level of satisfaction with their training out of ten, the ratings ranged between 3 and 8. Fifteen counsellors gave ratings between 7 and 8 and nine counsellors rated their satisfaction levels with their training below 7.

The findings further indicate that the counsellors were motivated to work as HIV/AIDS counsellors and that they were aware of pertinent skills and competencies required of them as HIV/AIDS counsellors. Facilitation skills, communication skills, such as empathy, listening and paraphrasing were emphasized. Counsellors identified a lesser publicized required skill of counsellors, namely, the ability of counsellors to facilitate appropriate spiritual awareness of clients. Even for themselves, spiritual awareness was considered as a significant coping mechanism that offers hope in the wake of the devastation of HIV and AIDS.

Counsellors expressed uniformity in the roles they performed and did not view their role as 'preventative' or 'preventing the spread of HIV/AIDS.' They spoke of being 'informants' and 'educators' to their clients in terms of facilitating wellness, positive living, advocating condom-use, providing needed medical and HIV-related information, and so forth. Counsellors viewed their roles as important to offering hope and assistance to persons affected and infected with the disease and spoke of the expanded roles that they were performing which placed a lot of stress on them. Counsellors were exposed to diverse training programmes in eThekweni ranging from five days to one year. Based on the empirical evidence of the study, the duration of counsellor training should not be viewed as an isolated variable which indicates training effectiveness without taking into account impacting factors such as the life and work experiences of the counsellors, their professional and work status at the time of entering into training, mentoring or supervision in their respective work places, and so forth.

Counsellors favoured experiential learning methods as opposed to didactic training methods and generally felt that not enough practical training was afforded to them to integrate the theoretical knowledge imparted to them during their counsellor training. To this end, counsellors suggested that training providers should network and cooperate, especially since the study provided evidence that counsellors are not necessarily employed by the service providers that trained them, with the exception of FBO counsellors. The counsellors' view was that all HIV/AIDS counsellors should first attend a basic counselling skills course and be certified as such after they have been subjected to a practical evaluation. Thereafter, counsellors will be required to acquire other HIV-related counselling skills. Further empirical evidence of the study reveals that training providers continue to develop and utilize their training materials in isolation and that the lack of uniformity of training exists even amongst the same type of training providers.

The counsellors identified several focus areas for the improvement of HIV/AIDS counsellor training. They proposed a training model that offers a balance between theory and practice. The need for this was indicated by one of the counsellors who said:

“ ... I think after training there must be a programme to help us... if we are not working because we forget...”

The use of more experiential training methods, more standardized entrance and assessment criteria and certification of counsellors should only take place after trainees have demonstrated the required outcomes and competencies of learning programmes. Training should be benchmarked and standardized training material utilized so that more uniformity exists with regard to the training of HIV/AIDS counsellors. One of the counsellors alluded to benchmarking when she said:

“ ... they must give us the same books to learn from, then we can work anywhere and people won't think they are better than others because they were trained in government and someone else was trained by and NGO... so there must be guidelines ...”

Counsellors said that certificates awarded to them after counsellor training must mean something and should be useful and improve their professional status in some manner.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

One of the counsellors vented her frustration in this regard when she lamented:

“ no matter what you do or where you go... no matter what training you do or no matter what degree or diploma you got... you'll just be an HIV counsellor that's just it... you'll just be a lay counsellor.... it must change...”

The above mentioned summary concludes this chapter which presented and discussed the findings of the study and set the tone for the fifth and final chapter, 'Conclusions, Summary and Recommendations.'

CHAPTER 5

CONCLUSIONS, SUMMARY AND RECOMMENDATIONS

INTRODUCTION

This study highlighted numerous HIV/AIDS counsellor training issues within a qualitative framework. The study explored the satisfaction with counsellor training of twenty-four HIV/AIDS counsellors who had been trained in the region by five different training providers. This was a locally specific study conducted within eThekweni Municipality. The findings outlined in the previous chapter highlighted the views and perceptions of these counsellors, which should be contextualized. Another study with the same number of HIV/AIDS counsellors in different work settings, in different regions and involving different training providers might yield different results. In this final chapter, the researcher highlights the rationale and theoretical framework of the study, the research approach, the conclusions, summary and recommendations and limitations of the study.

5.1 RATIONALE AND CONTEXT

Within the eThekweni region within the province of KwaZulu Natal (KZN) where the research was undertaken, there exists a hub of service-providers offering a variety of essential HIV specific services, including HIV/AIDS counselling and training. Guided by the South African Strategic Plan on HIV/AIDS and STI's (2007 - 2011) a new Chief Directorate of HIV/AIDS was established within the provincial Office of The Premier in 2006, especially to spearhead a coordinate and comprehensive response to the HIV/AIDS crisis in KZN (Office of the Premier HIV/AIDS Strategy 2006-2010:1).

A plethora of HIV/AIDS counselling courses emerged. The magnitude of HIV/AIDS counsellor involvement appeared to be escalating and the researcher believed that a concerted local effort was needed to support existing counsellors by establishing whether they felt that they were adequately prepared and trained for their counselling roles. According to the researcher's frame of reference, there appeared to be no standardization of training. The researcher wanted empirical evidence based on the personal experiences of HIV/AIDS counsellors. Moreover, the researcher was keen to explore

the perceptions of a range of HIV/AIDS counsellors who were rendering services within eThekweni Metropolitan area, about their counsellor training experience.

Over the past decade, growth in the number of HIV/AIDS counsellors trained in South Africa was rapid. Sustainability of counsellors in the HIV/AIDS arena is critical to the provision of efficient and effective services. Adequate preparation and training is one way of ensuring a slower turnaround of staff. By understanding what the counsellors considered to be positive or negative factors in their training, it was hoped that some progress would be made towards developing relevant and strategic training models for future HIV and AIDS counsellor trainees.

The research would be of significance, especially viewed against the strategic and significant role of HIV/AIDS counsellors in South Africa. A key priority area according to the current HIV and AIDS and STI Strategic Plan (2007-2011:14), is to increase voluntary counselling and testing (VCT) coverage and society can ill afford to lose the critical services rendered by HIV/AIDS counsellors. The researcher's study sought to afford counsellors a voice and opportunity to express their views and possible concerns, and make suggestions concerning the training of future counsellors. The researcher hoped that such insights would increase our understanding of where the strengths of the current training models lie as well as opportunities for growth, in order to ensure that we will have suitably qualified manpower to address and manage HIV/AIDS counselling service-delivery.

5.2 THEORETICAL FRAMEWORK

The researcher chose to conduct the research within a phenomenological perspective because it usually (but not always) best addresses a question about meaning, namely: "what is the experience of...?" The researcher's choice of phenomenology was informed by Saunders et al (2003:250) who stated that a phenomenological study attempts to understand people's perceptions, perspectives, and understandings of a particular situation. In this case, the researcher's attempt was to understand HIV/AIDS counsellors' perceptions of the HIV/AIDS counsellor training they had received and learn from their suggestions to shape the training of future HIV/AIDS counsellors.

The phenomenological approach was useful and provided the research participants a voice and opportunity to express their views and possible concerns about their training and how training of HIV/AIDS counsellors could be improved upon.

5.3 RESEARCH APPROACH

The researcher's preference of the identifying features of the research was directly influenced by the purpose of the study, which was to explore and describe the levels of satisfaction of eThekweni Metropolitan-based HIV/AIDS counsellors in terms of training they had received. The design of the study was a qualitative exploratory and descriptive one. The researcher used a multi-methods approach of twenty four semi-structured interviews plus one focus group discussion. Purposive and non-probability sampling methods were employed. The data collection instruments included the researcher administered semi-structured interviews, the researcher, a literature review and a focus group discussion. Data analysis procedures consisted of thematic content analysis and pattern analysis. Triangulation was used as a method of authentication of this study.

5.4 THE OBJECTIVES OF THE RESEARCH

The four stated objectives of the study were:

- To investigate what training counsellors in the eThekweni Metropolitan area had received to prepare them as HIV/AIDS counsellors.
- To explore what these counsellors perceived to be the core skills and competencies of HIV/AIDS counsellors.
- To probe the extent counsellors in the eThekweni Metropolitan area felt that the training they received covered these core skills and competencies.
- To explore what these counsellors regarded as focus areas for the improvement of HIV/AIDS counsellor training.

5.5 CONCLUSIONS OF THE STUDY

Saunders et al (2003:422) proposed that one way of presenting findings, is to return to the research objectives and be guided by it. The extent to which this study addressed each of the above objectives, are now briefly discussed.

5.5.1 OBJECTIVE 1: To investigate what training counsellors in the eThekweni Metropolitan area had received to prepare them as HIV/AIDS counsellors.

The twenty four HIV/AIDS counsellors were trained by five training providers. Four counsellors were trained by government (16.6%), four were trained by college/ technikon (16.6%), four by NGO (16.6%), five were trained in university settings (21%), and seven counsellors were trained by FBO (29.2%) in eThekweni. Their training varied, ranging from five days to one year. Training was either done consecutively in block training, which was preferred, or staggered, meaning not on consecutive days. Training occurred horizontally, meaning short courses which did not enable counsellors to work towards a qualification, nor did it allow them to train in a vertical fashion and work upward towards a qualification to enhance their work status.

The training they received was acknowledged by all the counsellors as very useful because it covered much needed HIV-related information. They could not fully recall everything that had been taught at the courses they attended because the study was conducted one or more years after completion of their training. There was a general consensus that the training they had experienced, imparted useful information. It was however limited in the provision of practical opportunities that trainees longed for. Many saw field-based training as more relevant to the development of their confidence to render efficient and effective services to their clients. The courses they attended favoured the use of role plays and group discussions. Counsellors who were part of smaller training groups indicated that they had benefited from the intimate and interactive discussions that were part of their training. Those groups that were bigger than twenty did not express the same positive sentiments.

Contrary to the researcher's belief that longer training would indicate higher levels of satisfaction, this was not true. There appeared to be less satisfaction with training offered by tertiary institutions whose courses were longer. This may be attributed to the fact that this training was more theoretical and the classes were bigger. These training providers failed to offer field-based practical opportunities. Experiential participatory learning methods were enjoyed more than didactic learning methods, such as lectures. The aspects pertaining to didactic learning methods that learners were dissatisfied with, were numerous. In fact, it pointed to the fact that learners did not favour these learning methods as much as the participatory, experiential ones.

5.5.2: OBJECTIVE 2: To explore what these counsellors perceived to be the core skills and competencies required of HIV/AIDS counsellors.

Specific skills, roles and competencies covered and acquired during the training in relation to theory related to: trust building, appropriate communication and facilitation skills, how to deal with the psychological and social implications and life challenges of HIV and AIDS, self care skills, pre-and post test and basic counselling skills, skills in how to relay pertinent medical information to the client and family system, condom-use, skills to deal with people from different cultures, religious orientations and age groups, important skills in networking with other organizations who provide clients with needed services. Other skills mentioned related to the counsellors' abilities to facilitate environments that stimulate spirituality because this was a positive means of imparting hope and assisting clients and counsellors themselves to cope better and to feel comforted by a higher power. In addition, administrative skills learned were seen as important skills and group work facilitation skills enabled counsellors to initiate support groups.

Counsellors mentioned roles across disciplines such as: psychology in terms of their roles as psycho-social practitioners, or counsellors or confidants. Roles pertaining to theology included being a spiritual leader or counsellor to their clients; educational roles were significant to educate clients about positive living and appropriate medical information. The role of resource agent was relevant in order to help their clients obtain assistance to meet life challenges. Social work roles help

to facilitate management of the impact of the disease; the roles as welfare officers assist clients source social relief to manage high levels of poverty. Counsellors were supporters of their clients and informants and had to be strong enough to break the news of a positive HIV status to clients. A strikingly different factor between the findings of Richards (2004) and that of the researcher's study was that none of the eThekweni HIV/AIDS counsellors described their role as a being a 'preventative' one.

5.5. 3 OBJECTIVE 3: To probe the extent to which counsellors in the eThekweni Metropolitan area felt that the training they received had covered these core skills and competencies.

When the researcher reflected on the responses of the counsellors about their training after probing, all the counsellors in the study acknowledged that their training was very informative and provided much needed insight to prepare them as counsellors in the HIV arena. However several gaps in training were identified (which are covered in the next section). When the researcher asked them whether or not they were satisfied that the training met their expectations they replied in the affirmative, saying that they felt satisfied with the training they received. However, in order to gain a broad view of self-perceived satisfaction about the counsellors' training, the researcher telephoned participants back. Participants were telephonically presented with a ten point rating scale with 1 equivalent to completely dissatisfied with the counsellor training and 10 meant that the counsellor viewed the training as completely satisfactory. The subsequent gradation was done by the researcher in accordance with the scale and the ratings given by the counsellors.

Satisfaction ratings ranged from 3 to 8. Overall fifteen of the counsellors rated their satisfaction with their training between 7 and 8 and nine rated training below 7. It appeared to the researcher that generally the counsellors were satisfied to have an opportunity to learn more about HIV and AIDS, but when contemplating the extent to which they felt satisfied that the training equipped them to work and deal with all aspects of their perceived role as practicing counsellors, it seemed that they were less satisfied.

5.5.4: OBJECTIVE 4: To explore what these counsellors regarded as focus areas for the improvement of HIV/AIDS counsellor training.

Counsellors thought about the weaknesses in their training programmes and made clear, specific proposals for improving training. Their responses have been divided into several themes. Themes included modifying selection criteria; moving towards an integrated learning approach; developing benchmarking training courses so that learning could be progressive and counsellors were able to complete modules relevant to their contexts; the inclusion of more medical terms of reference; learner mentoring.

Specifically, counsellors suggested that selection and entry criteria for counsellor training courses should be revisited. They suggested that there should be a minimum entry level of grade ten coupled with life experience, or grade twelve for younger trainees. Screening instruments were recommended. These included brief personal interviews with prospective trainees, an interviewer administered questionnaire and/ or a short written motivation to undertake training. In addition, it was suggested that the duration of training courses should be dictated by the time factor that would facilitate the achievement of both stated theoretical and practical outcomes of the training. Block training was preferred as opposed to staggered training. Longer courses were not necessarily more effective unless they incorporated practical components.

It was felt that care should be taken to ensure a stimulating training environment, conducive to learning. There were also suggestions concerning evaluation and certification on completion of the training. It was recommended that trainees should be assessed on both theoretical and practical skills prior to being issued HIV/AIDS counsellor certificates. It was strongly suggested that counselling in the real life context should be the yardstick for assessing a trainee's counselling skills because role-plays provided inadequate evaluations of counselling skills.

The counsellors identified content that they perceived as necessary for all counsellors irrespective of the nature of their employment. This ranged from basic and pre-and post-test counselling skills to

different types of counselling, information about disease management and positive living, how to counsel persons from different cultural, social and sexual orientations, family counselling, dealing with children, adherence and bereavement counselling and administrative skills. Standardized training material and benchmarking were proposed.

It was suggested that preference should be given to personal growth and introspection sessions as an integral part of all training programs. Experiential learning methods were favoured and counsellors proposed the inclusion of more subject experts during training. Counsellors indicated preference to training presented by facilitators whom they perceived to be more approachable, less formal, professional, organized role models who took care with personal presentation.

Counsellors strongly suggested the inclusion of a universal spiritual component as this promoted an effective coping mechanism for both clients and counsellors. Clearly the data obtained in the study, confirmed that the counsellors in eThekweni Municipality were self-driven and motivated towards making a difference in the lives of persons infected and affected by HIV and AIDS. They were all convinced of the importance of the role that counsellors have to play in the area HIV/AIDS and regarded the HIV and AIDS epidemic as different and unique from any other in the history of humanity. Counsellors viewed their roles as significant and emphasized the need for specialized training to enable them to address the multi-faceted consequences of HIV/AIDS.

Counsellors in the study stressed the need for counsellors in the field to develop a holistic understanding of human nature, develop professionalism, adopt an empathic and non-judgmental stance and act as approachable confidants and forceful advocates for their clients. Counsellors have to be skilled helpers.

5.6 SUMMARY

Most of the counsellors who took part in the study were female between the ages of 35 to 44 and the majority of them (ten) had high school education at the time of commencing their training as HIV/AIDS counsellors. In addition, the majority of the participants (thirteen) trained more than two years ago, whilst eight of the sample had previous work experience as volunteers or counsellors in HIV/AIDS counselling settings and within health care as nurses. The research indicated that many training variations existed within counsellors training in eThekweni. Such diversity was highlighted by Brouard as far back as 1998. The counsellors in this study were exposed to training durations ranging between five days and one year according to the data obtained in this study. Interestingly, the counsellor with the shortest training of five days was employed at a FBO. She was employed as a trauma counsellor and received supervision twice a week. This counsellor's work experience prepared her because she had been trained in basic counselling skills and trauma counselling. On the other hand, the counsellor who trained for one year was uneasy about performing HIV/AIDS counselling. She expressed concern about the lack of practical skills transfer opportunities given to her.

The duration of training should not be viewed in isolation. It appears that recognition of prior learning was important as prior learning may be counsellor - related. Not only should previous training be taken into consideration, but also previous work experience, especially if it included supervision and regular mentoring.

Despite training variations, on completion of their training, counsellors moved around in settings other than those they had trained in. The exception being the FBO workers who appeared to remain in FBO organizations to perform their roles as HIV/AIDS counsellors.

Entrance to the HIV/AIDS counsellor training courses and eventual assessment criteria of trainees, were found to be diverse, even with regard to the same types of training service-provider, and not

necessarily related to the requirements for counselling in HIV/AIDS. The network of diverse training was evident in that the twenty-four HIV/AIDS counsellors in the sample trained by means of nine different types of courses within the eThekweni Metropolitan area. Overall, the counsellors had reservations about the duration of the training and results show that extended duration of counsellor training did not necessarily achieve more effective results. Several factors should be taken into consideration before assigning trainees to training programmes. These factors include previous work experience, educational base level, personal motivation to do the training, life experience, mentoring or supervision, age group, facilitators and training method as well as exposure to practical counsellor training. All the participants (counsellor interviews and focus-group) identified the need to balance theoretical and practical training and participants favoured a mix of experiential and didactic methods of training.

Counsellors did not see their role as 'preventative' or 'preventing the spread of HIV/AIDS,' in line with the recognized global definition of HIV/AIDS counselling as pointed out in the literature study. Nonetheless, counsellors described that they aim to 'facilitate' behaviour change and 'educate' and 'inform' people about HIV-AIDS related issues. However, whilst they did not cite their role as 'preventative,' counsellors referred to some preventative measures such as behaviour change and condom-use to advocate prevention. The researcher wondered if the reality was that these HIV/AIDS counsellors in eThekweni who were confronted with the highest prevalence of HIV infections in South Africa realized that they could not prevent the spread HIV/AIDS. The purpose of HIV/AIDS counselling needs to be more clearly defined. Counsellors echoed concern that they were not doing justice to their clients and felt inadequate in their current roles. Lack of supervision, debriefing and ongoing training, coupled with heavy workloads, were mentioned in this regard. They called for initial training in basic counselling skills, which should be followed by tiered training, dependent upon the counsellors' work orientation. Such a tiered approach would enable counsellors to acquire relevant work-related skills and grow in their professional development. Based on their experience in the field, the counsellors suggested improvements at a local level, which are incorporated in the following recommendations.

5.7 RECOMMENDATIONS

5.7.1 RECOMMENDATIONS FOR PRACTICE

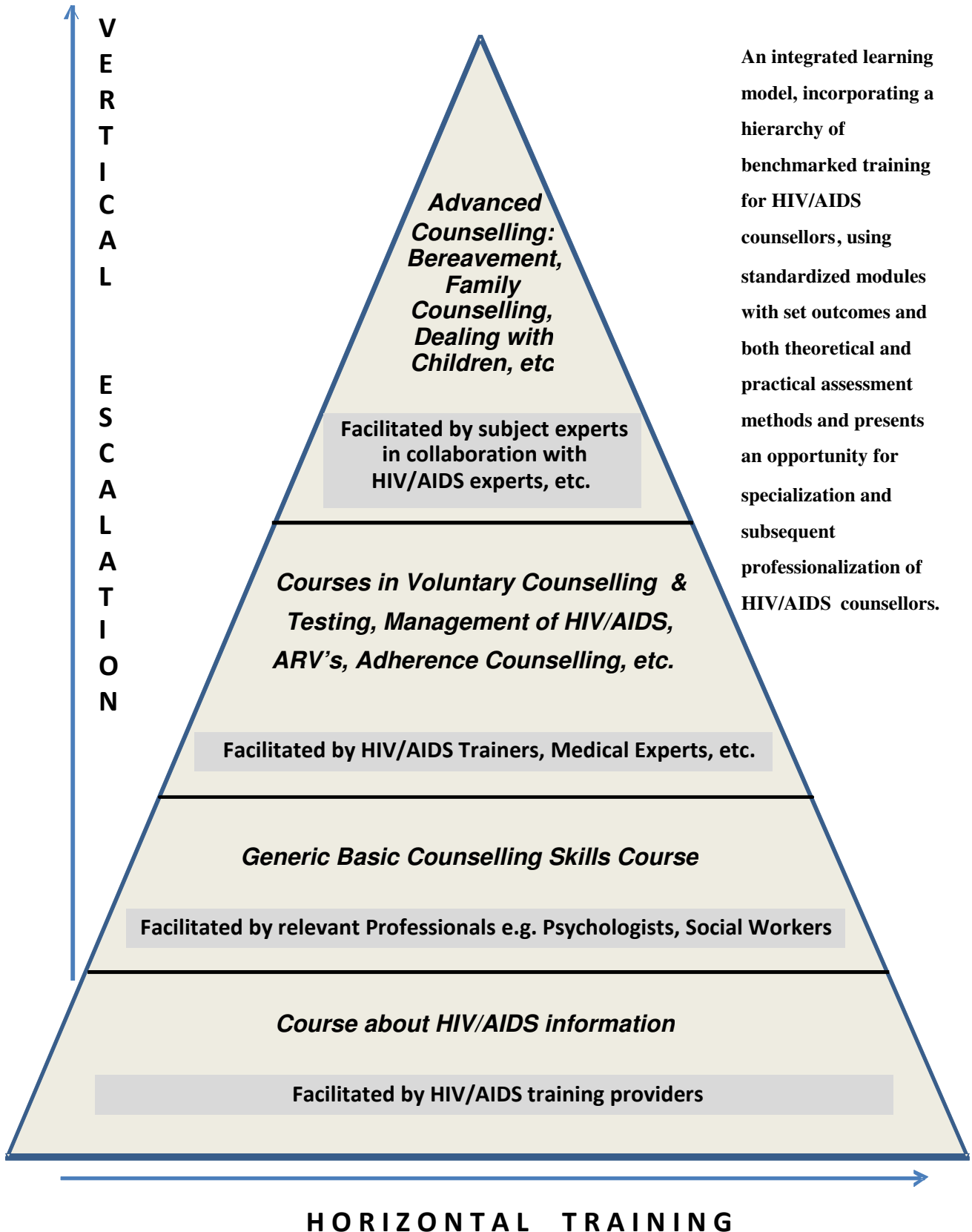
5.7.1.1 An integrated learning model

Careful review of the participants' suggestions points towards the development of an integrated learning model with regard to the training of counsellors in the field of HIV and AIDS. The researcher therefore suggests the introduction of a model for HIV/AIDS counsellor training, Progressive Training Model (PTM), to accommodate the needs of the counsellors in a tiered and developmental way. As a matter of introduction, the researcher reiterates that data indicated that training of HIV/AIDS counsellors occurred vertically and horizontally. Vertical training of HIV/AIDS counsellors refers to training undertaken towards the attainment of a qualification or profession or work-related requirements, and escalates upwards in a vertical progressive line. Horizontal training refers to short training courses that train counsellors, but do not lead upward towards the attainment of a qualification or professional status or advancement in employment opportunities.

An integrated learning model that offers a hierarchy of learning with modules relevant to the training of HIV/AIDS counsellors, could lead to the development of standardized training modules that are outcome based. Counsellors could then be grounded in a 'common base' of general knowledge pertaining to HIV and AIDS and progress to more specialized modules allowing for specialization with accredited qualifications. By comparison the field of social work, has evolved (and continues to), in much the same way. We have social workers specializing in areas such as mental health, disability, family life, adoption, and so on.

The researcher therefore recommends A Progressive Training Model, illustrated below.

Hendricks Progressive Training Model (PTM)



In the light of the counsellors' call for inter sectoral collaboration in the training of counsellors, it was felt that specialists in different sectors could be called upon to present their knowledge in some areas, rather than expecting HIV/AIDS training providers to present such a wide range of topics themselves. A generic basic counseling skills course could be offered by social workers or psychologists. Bereavement counselling theory could be presented by bereavement counsellors. The legal implications pertaining to HIV and AIDS could be dealt with by lawyers, management of poverty alleviation programmes should be covered by management consultants, and so forth. Counsellors would then acquire skills relevant to their interest.

A standardized and prescribed generic HIV/AIDS counselling course is suggested consisting of two compulsory modules, namely:

- HIV/AIDS - related information
- Basic counselling

The basic counselling course should include content such as how to establishing a conducive helping context and pertinent communication skills for example, attending, probing, paraphrasing, summarizing and being empathic. The difference and use of facilitation skills as opposed to advice-giving should be included together with relevant professional values. On completion of these two modules the trainee is encouraged to pursue extra modules. This part of the learning programme should be more flexible. Trainees should be allowed to pursue different modules according to their work-related needs and personal interests. They can space the attainment of these electives to allow for work pressures, securing adequate opportunities for practical implementation of the theory learned and allow adequate assessment by training providers. Some form of specialization of HIV/AIDS with regard to the acquisition of multi-faceted skills (e.g. counselling children, sexual minorities, adherence counselling, etc.) related to employment requirements, might be less demanding and stressful instead of expecting HIV/AIDS counsellors to master a diverse basket of skills and competencies. Training would then be less overwhelming and counsellors would be able to take time in between different modules to master the application of knowledge and skills covered in each module.

It is more important for us to have fewer, but better qualified counsellors than allow courses to mushroom without trainee counsellors having the relevant competencies to perform their important roles in our society. The idea should be to rather focus on quality service-provision. Valuable HIV/AIDS counsellor resources should be used in a more sustainable and less challenging manner whilst simultaneously facilitating and providing essential ‘specialized HIV/AIDS counsellor networks’ of service-provision. Professional standards for HIV/AIDS counsellors might then be easier to determine, maintain and monitor and lead to more accountability in this field of service. Better co-ordination and collaboration of HIV/AIDS counsellor training networks should result in pooled pockets of specialization in HIV/AIDS counsellor training. Specialization allows for a more intensive and thorough selection process. However, the researcher believes that at a vertical level, subject experts are needed to ensure dissemination of essential skills in the HIV/AIDS arena across the sectors.

5.7.1.2 Benchmarking

In this study, counsellors indicated a preference for standardized training material. This may lead to training outcomes being more clearly defined. Counsellors can then operate from a common frame of reference. This will provide a benchmark for monitoring, evaluation, performance appraisals, promotions and clear job descriptions for HIV/AIDS counsellors. Clear definitions will make it more manageable for HIV and AIDS counsellors to cope in the field. Counsellors will be able to undergo training with clear and specific outcomes and be provided with standardized training material. They may engage in training that is credible and work specific. This will strengthen employment opportunities, especially since the findings in this study point to the movement of HIV/AIDS counsellors within the different service providers.

5.7.1.3 Mentoring, in-service training and ongoing support

Training was viewed as a vital ongoing process which ensures efficient and effective services. There was a strong call for ongoing supervision and mentoring in the workplace and follow-up and fresher courses after training. It was felt that ongoing training was so critical that training-providers should

help to develop in-service-training programmes for service providers and attendance at in-service training should be compulsory for all HIV/AIDS counsellors working in the field.

5.7.1.4 Effective inter-sectoral collaboration

Training providers should not work in isolation. They should pool their expertise and work together to develop suitable training courses in collaboration with many different disciplines such as health practitioners, legal practitioners, religious leaders, psychologists, social workers, traditional healers, traditional leaders and the corporate world.

5.7.1.5 Minimum Standards and SAQA accredited counsellor training

Minimum Standards for the training of HIV/AIDS counsellors have existed in South Africa since 1999 but have not been fully implemented nationally. Furthermore, SAQA accreditation for the HIV/AIDS counsellors are in existence, however it appeared from the study that many of the counsellor training courses offered in eThekweni had not been accredited. An investigation into how Minimum Standards for HIV/AIDS counsellor training should be operationalized and SAQA accredited training be implemented within South Africa need our urgent attention. Standardization of training material will better enable training providers to measure or evaluate the outcome of training and ensure that HIV and AIDS counsellors receive adequate training before they embark upon field work. On the other hand, the public will be better protected and have recourse to complain if they feel they have been harmed in any way by a counsellor in the field of HIV and AIDS.

5.7.2 POLICY RECOMMENDATIONS

Apart from the national HIV/AIDS Strategic Plan (2007-2011), the province of KwaZulu Natal has developed its own provincial HIV/AIDS Plan (2006-2010) as well as an HIV/AIDS desk, located within the Office of the provincial Premier. As indicated in this document, there already exist excellent guidelines, policies as well as documented research that could greatly impact on service delivery in eThekweni. The challenge is to view this piece of research within the framework of existing local policies and procedures within the province to respond to the concerns and needs of

the HIV/AIDS counsellors in the region. Specific issues were identified and suggested by the counsellors in this study, such as the need for specialization of HIV/AIDS training and development. The counsellors in this study clearly suggested a way forward in terms of mentioned policy implications. One of the counsellors was hopeful when she commented:

“Maybe they can change HIV/AIDS policies and they can understand how people down here feel and they can then act on the needs of the counsellorsand not assume what HIV is like and what counsellors are facing daily”

5.7.3 RESEARCH RECOMMENDATIONS

Recommendations for areas of research based on the findings of the study are as follows:

- Ongoing participatory research involving counsellors to further explore their needs and expectations in this field.
- Investigating why the Minimum Standards regarding HIV/AIDS counsellor training developed has not been fully implemented in South Africa and identify what needs to happen to operationalize this process.
- Involving HIV and AIDS counsellors in more qualitative research. The literature study undertaken points to the development of more quantitative research.
- Undertaking quantitative research of comparative learning programmes for HIV/AIDS counsellors.
- Undertaking quantitative research to identify specific growth areas with regard to counsellor options for and in-service training that were manageable and realistic.
- Developing the proposed Progressive Training Model and implications for practice.
- Investigating the phenomena of spirituality and its significance in HIV/AIDS counsellor training and practice.

5.8 LIMITATIONS OF THE STUDY

Eighteen of the research participants in the sample of 24 were female and three were males. Perhaps the research results would have been different had the gender dynamic been better balanced. In

addition racial diversity was not evenly represented in the research sample. The research lacked white participants, even though attempts to this effect were made by the researcher. Insights and perceptions across broader spectrum of ethnic groups might have influenced the results.

The use of a ten point rating scale could have been reduced to a five point scale, thus reducing the range. In addition, the scale could have been used as a tool at the point of the semi-structured interviews conducted with the counsellors and not as a telephonic post interview follow-up. However, the use of the follow-up scale in this study was to gain overall impressions as opposed to obtaining specific measurements.

5.9 FINAL NOTE

Hunt (1996) highlighted more than a decade ago that HIV/AIDS counsellors have an ethical obligation to be adequately trained in order to provide the needed services to people who are affected by HIV/AIDS, and that those who set up training programs had an ethical obligation to provide such training. However, due to the escalation over the years of the HIV and AIDS pandemic, the results of this research indicate that 'being adequately trained' now supposes that HIV/AIDS counsellors with minimal training of a few days, weeks or months, are expected to have a multitude of skills and competencies, whilst many of them are not formally schooled in the health sciences and are consequently faced with huge challenges. Thirteen years ago Lindegger & Wood (1995) pointed out that there was no standardization of lay-counsellor training in South Africa. This was confirmed by the participants in this study, despite the existence of national Minimum Standards concerning HIV/AIDS counsellor training.

The study confirmed the great need and significance of HIV/AIDS counsellors and counselling services. However, it appears to the researcher that the great need for counsellors has superseded the amount of research undertaken in this field. For training to be effective and efficient, practitioners in this field have to place more emphasis on developing relevant training models and therefore any research around this topic is critical.

Whilst the researcher set out to achieve an academic qualification through this study, she has emerged from this research with a deep sense of admiration for the people whose daily work struggles are characterized by the countless and daunting challenges of HIV and AIDS.

Every disease brings its own challenges and its own training specific to the epidemic. Perhaps the movement and acceptability (or preference) of HIV/AIDS counsellors across the sectors presented an opportunity for the training of counsellors in the sphere HIV and AIDS to adhere to some form of commonality or consistency in the eThekweni Metropolitan area. The researcher's view is that perhaps HIV/AIDS counsellor training could become one of the means or vehicles to create synergies and partnerships between various service-delivery stakeholders in eThekweni, currently operating in isolation in the HIV and AIDS battleground.

BIBLIOGRAPHY

Amod F. 2006. Religion and HIV/AIDS. Durban: IMA (Islamic Medical Association of South Africa).

Adendorff C. & Wood G. 1995. Evaluation of ATICC's basic HIV/AIDS counseling course. Positive Outlook, 2(3): 6-7.

Barron P and Asia B. 2001. The district health system. South African Health Review. Durban: Health Systems Trust.

Bates BM. 2004. Improving HIV/AIDS training interventions by evaluating the effects of learning styles on training. Johannesburg: University of the Witwatersrand.

Bekker LG. & Wood R. 2006. Is it time to change our HIV/AIDS testing policy in health care facilities? South African Medical Journal (SAMJ), 96 (12): 1235-1236.

Bor R. & Elford J. & Salt H. 1991. Evaluation of an intensive 'train the trainer' course in aids counseling in Zimbabwe. Journal of Royal Society for the Promotion of Health.1991(111): 86-89

Bor R. & Elford J. 1992. Evaluation of an intensive HIV/AIDS counselling course in Zimbabwe, Health and Education Research, 7 (3): 431- 436.

Breakwell GM., Hammond S. & Shaw S. 2000. Research methods in psychology. London: Sage Publishers LTD.

Britton PJ., Cimini KT. & Rak CF. 1999. Techniques for teachings HIV counselling: An experiential model. Journal of Counselling and Development, 77 (2):171-176.

Britton PJ., Rak CF., Cimini KT. & Shepherd JB. 1999. HIV/AIDS education for counselors: efficacy of training. Counselor Education and Supervision, 1: 53-65. Proquest Psychology Journal.

Brouard P. 1998. The realities of counsellor training. AIDS Bulletin, 7(3): 15- 16.

Carnie T. 2006. KZN's shocking HIV rates. The Mercury, September 7, 2006. Edition 1.
<http://www.themercury.co.za/index.php?fArticleId=3428253.html> Accessed 4 June 2007.

Constitution of the Republic of South Africa, 1996, Act 108 of 1996
<http://www.constitutionalcourt.org.za/site/theconstitution/thetext.htm> Accessed 13 September 2007.

Coovadia HM. 2000. Access to voluntary counseling and testing for HIV in developing countries. Annals of New York Academy of Sciences, 918: 57- 63.

Council for Social Service Professions. Personal communication 12 July, 2007.

Coyle A. & Soodin M. 1992. Training, workload and stress among HIV counsellors, AIDS Care, 4(2): 217 - 221.

Department of Health Technical Assistance: HIV/AIDS 17 July 1999. Minimum standards for counsellors,
http://www.doh.state.fl.us/Disease_Ctrl/aids/testing/HIV17-TA.pdf Accessed 3 August 2007.

Department of Labour HIV/AIDS Technical Assistance Guidelines 1999. Published by the Department of Labour, Chief Directorate of Communication ASBN, No. 0621-336566-4: 58. Pretoria: South Africa. Accessed 17 December 2007.
<http://www.salga.net/home.asp?pid=1461> Accessed 17 September 2007.

Department of Public Service and Administration 1997. White Paper on transforming Public Service Delivery. Batho Pele – “People First.

www.info.gov.za/whitepapers/1997/transpubserv.pdf Accessed 16 August 2007.

Dworkin SH. & Pincu L. 1993. Counselling in the era of AIDS. Journal of Counseling & Development, 71: 275-281.

Engler B. 1995. Personality theories. An introduction. USA: Houghton Mifflin Company. 4th edition.

Egan G. 1994. The skilled helper: a problem-management approach to helping. Brooks/Cole, Pacific Grove: California. 5th edition.

Friedman SR., Kippax SC., Phaswana-Mafuya N., Rossi D. & Newman CE. 2006. Emerging future issues in HIV/AIDS social research. AIDS, 20: 959-965.

Gladding ST. 2007. Counselling – a Comprehensive Profession. Pearson: Merrill Prentice Hall. 5th edition.

Grinstead OA., van Der Straten A. & The Voluntary HIV-1 Counselling and Testing Efficacy Study Group 2000. Counsellors’ perspectives on the experience of providing HIV counselling in Kenya and Tanzania: the voluntary HIV-1 counselling and efficacy study. AIDS Care, 12(5): 625-642,

Green JH. 1989. Evaluation of a lay counselling programme that trains lay counsellors from the townships. Johannesburg: University of the Witwatersrand.

Grobler H., Schenck R. & Du Toit D. 2003. Person-centred communication, theory and practice. South Africa: Oxford University Press, 2nd edition.

Health Professions Council of South Africa (HPCSA). Personal communication, e-mail received 12 July 2007.

Health Systems Trust, 2001. Preface: Listening to voices. South African Health Review. Durban: Health Systems Trust.

Hendricks M. 2004. To evaluate the individual counselling services at C.A.R.E. (Christian aids response and education). Research exercise in B.A. Social Work for Non Degree Purposes. Durban: University of South Africa.

Hendricks 2006. Research proposal submitted in fulfillment of the requirements for the degree of masters in social work. Durban: University of South Africa.

HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011. Draft 9: 12 March 2007. <http://www.info.gov.za/otherdocs/2007/aidsplan07.pdfhtml> Accessed 17 May 2007.

HIV/AIDS training manual for facilitators 2005. Compiled for the National Department of Health by The Health systems Trust (HST) and Health Information Systems Program (HISP) Monitoring and evaluation of the operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa April.

<http://www.hst.org.za/publications/678> Accessed 12 June 2007.

HIVAN/KZNCAN DIRECTORY 2005. HIVAN (Centre for HIV and AIDS Networking) & KZNCAN (KwaZulu-Natal Church)

Hlalele MK. 2004. An exploratory study of the psychological impact of HIV/AIDS patients on the counsellor. Pretoria: University of Pretoria.

Hoffman MA. 1991. Counseling the HIV-infected client; a psychological model for assessment and intervention. The Counselling Psychologist, 19 (4): 467-542.

Hoffman MA. 1996. Counselling clients with HIV disease. Assessment, intervention and prevention. New York: The Guilford Press.

Holloway I. 2005. Qualitative research in health care. Individual contributors. England: Open University Press.

Howard EE., Inman AG., & Altman AN. 2006. Critical incidents among novice counselor trainees. Counselor Education and Supervision, 46:88-102.

Hunt B. 1996. HIV/AIDS training in CACREP – approved counsellor education programs. Journal of Counselling and Development, 74(3): 295- 299.

Jones 2003. Nominal Group Technique (NGT)

http://www.mycoted.com/Nominal_Group_Technique Accessed 10 July 2007

Kenyon S, Heywood M. and Conway S. 2001. Mainstreaming HIV/AIDS: Progress and Challenges. South African Health Review. Durban: Health Systems Trust.

Krueger RA & Casey MA. 2000. A practical guide for applied research. Thousand Oaks: Sage Publications, 3rd edition

Lahav N. 2001. An HIV/AIDS counsellor training programme: an evaluation. Port Elizabeth: University of Port Elizabeth.

Lindegger G. & Wood G. 1995. The AIDS crisis: review of psychological issues and implications, with special reference to the South African situation. South African Journal of Psychology, 25(1):1-11.

Maclaim JK. 2003. An exploration of the experience and effects of trauma counselling on lay counsellors: A constructivist approach. University of South Africa (UNISA).

Mail&Guardian, 3 to 9 August 2007:14.

Middleton LE. & Solomon VP. 2002. Emancipatory nursing practice: Lessons for HIV/AIDS counselling training. <http://gateway.nlm.nih.gov/MeetingAbstracts/102255761.html> Accessed 12 August 2007.

Monette DR., Thomas J. Sullivan TJ. & DeJong CR. 2005. Applied social research: a tool for the human services. Belmont, CA: Brooks/Cole-Thomson Learning. 6th edition.

Mouton J. & Marais HC. 1994. Assisted by Prinsloo KP. & Rhodie NJ. Basic concepts in the methodology of the social sciences. Pretoria: Penrose Book Printers, 4th edition.

Mouton J. 2001. How to succeed in your Masters & Doctoral Studies. Pretoria: Van Schaik Publishers, 1st edition.

Monette DR., Sullivan TJ. & DeJong CR. 2005. Applied social research. A tool for the human sciences. Belmont: Thompson Brooks/Cole. 6th edition.

Nulty M. 2003. The experiences and needs of HIV/AIDS counsellors at Settlers Hospital, Grahamstown: a multiple case study. Grahamstown: Rhodes University.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

Office of the Premier, HIV and AIDS strategy for the province of KwaZulu-Natal 2006 – 2010.

Draft version: 25 September 2006.

Padgett DK. 1998. Qualitative methods in social work research, challenges and rewards.

Thousand Oaks. London. New Delhi: Sage Publications.

Palitza K. 2006. Health South Africa: A burden that will only become heavier.

Durban: Inter Press Service News Agency, <http://www.ipsnews.net/africa/nota.asp?idnews=33396>

Accessed May, 2007.

Panter AT., Huba. GJ., Melchior LA., Anderson D., Driscoll M., German VF., Henderson H., Henderson R., Lalonde B., Uldall KK. & Zalumas J. 2000. Trainee characteristics and perceptions of HIV/AIDS training quality. Evaluation & the Health Professions, 23 (2): 149-171. Sage Publications. Inc.

Pembrey G. 2007. The scale of South Africa's AIDS crisis. HIV/AIDS in South Africa, Last updated April 26, 2007. <http://www.info.gov.za/otherdocs/2007/aidsplan07.pdf> Accessed 28 May 2007.

Population by Municipality- Table 11.

<http://www.statssa.gov.za/census01/html/C2001DPLG.as> Accessed 3 August 2007

KwaZulu Natal Population <http://www.statssa.gov.za/census01/html/default.asp>

Accessed 3 August 2007.

Raemer FG. 2001. The handbook of social work research methods , edited by Thyer BA. 2001.

London, New Delhi: Sage Publications, Thousand Oaks.

Richards L. & Morse JM. 2007. Readme first for a user's guide to qualitative methods.

London, New Delhi: Sage Publications, 2nd edition.

Richards K. 2004. Combating the Spread of HIV in Zimbabwe through improved counsellor, practice, supervision and support. Global Forum for Health Research Forum, 8, Mexico. North Carolina: A & T State University.

www.globalforumhealth.org/Forum8/Forum8-CDROM/Posters/Richards%20K%20F8-063.doc

Accessed 15 February 2007.

Richter L., Durrheim K., Griesel D. & Solomon V. & van Rooyen H. 1999. Evaluation of HIV/AIDS counseling in South Africa. Contract report submitted to the Department of Health by the School of Psychology, University of Natal, Pietermaritzburg.

http://www.nu.ac.za/departement/data/psych_dohfinalreport.pdf Accessed 16 June 2007.

Richter L., van Rooyen H., Solomon V., Griesel D. & Durrheim K. 2001. Putting HIV/AIDS counselling in South Africa in its place. Society in Transition, 32 (1):148-154.

Rubin A. & Babbie E. 1992. Research methods for social work. Pacific Grove. 2nd edition.

SACSSP (South African Council for Social Service Professions) Policy guidelines for code of ethics (course of conduct) and the rules for social workers. Pretoria: SACSSP.

<http://www.sacssp.co.za/UserFiles/File/SACSSP>

SAQA 2007. South African Qualifications Authority. Registered Unit Standard: Conduct basic lay counseling in a structured environment <http://www.regqs.saqa.org.za> Accessed 12 May 2007.

Saunders M., Lewis P. and Thornhill, A. 2003. Research Methods for Business Students. FT Prentice Hall, financial Times, 3rd edition.

Solomon V., Van Rooyen H., Griesel R., Gray D., Stein J. & Nott V. 2004. Critical review and analysis of voluntary counselling and testing literature in Africa. Durban: Health Systems Trust, <http://www.hst.org.za/uploads/files/vct.pdf> Accessed 14 May 2007.

The satisfaction of HIV/AIDS counsellors in the eThekweni Metropolitan area with regard to their counsellor training

South African Qualifications Authority (SAQA). <http://www.saqa.org.za> Accessed 13 May 2007.

South African Statistics: 2006. <http://www.answer.com./statistics&r=67>

Accessed July 2007.

Strand P., Matlosa K., Strode A., and Chirambo K. 2005. HIV/AIDS and Democratic Governance in South Africa, Illustrating the impact on Electoral Processes. Edited by Per Strand & Kondwani Chirambo, South Africa: IDASA (Institute for Democracy in South Africa).

Stein J., Steinberg M., Van Zyl S., Allwood C, Karstaedt A. & Brouard P. 1995.

Nurse counsellors perceptions regarding HIV/AIDS counseling objectives at Baragwanath Hospital, Soweto. Johannesburg: University Witwatersrand.

Thyer BA. 2001. The handbook of social work research methods. United States of America: Sage Publications. 2001

UNAIDS action plan on intensifying HIV prevention 2006 - 2007. Prepared for the United Nations Programme on AIDS (UNAIDS). Genève: Switzerland.

<http://www.search.unaids.org/Results.aspx?q=action+plan+on+intensifying+HIV+preveni&o=html&d=en&l=en&s=false&x=15&y=12> Accessed 14 July 2007.

UNAIDS and WHO AIDS epidemic update December 2007. Joint United Nations Programme on HIV/AIDS.

<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007default.asp>

Accessed 12 October 2007.

van Dyk A. 2005. HIV/AIDS care & counselling, a multidisciplinary approach.

Cape Town: Pearson Education, 3rd edition.

van Niekerk E. & Prins A. 2001. Counselling in South Africa. A youth perspective. Heineman: Sandown.

Veenstra N. 2004. The actual burden of HIV/AIDS on the KwaZulu- Natal Provincial Health Services (Work in progress). Health Economics and the HIV/AIDS Research Division, Supported by USAID. University of KwaZulu- Natal: Durban.

Vollmer NA. & Valadez JJ. 1999. A psychological epidemiology of people seeking HIV/AIDS counselling in Kenya: an approach for improving counsellor training. AIDS, 13(1):1557- 1567.

APPENDIX A***REQUEST AND CONSENT FORM TO PARTICIPATE IN A SEMI-STRUCTURED INTERVIEW FOR RESEARCH PURPOSES***

By
Mimona Hendricks
UNISA

Dear Counsellor,

Thank you for your interest.

My name is Mimona Hendricks and I am pursuing a Masters Degree in Social Work at UNISA. The focus of my research is to explore the levels of satisfaction of HIV/AIDS counsellors in the Durban Metropolitan area with regard to the training they received. Counsellors are a vital people resource in the HIV/AIDS arena, therefore my research will include counsellors from diverse backgrounds in order to take a fresh look at understanding how counsellors feel about their training and at a level of perception, and how these HIV/AIDS counsellors perceive their current level of functioning. It is hoped that such insights might increase understanding of where the strengths and opportunities for growth lie in terms of disease management from a HIV/AIDS counsellor resource perspective and your contribution towards this study will be highly valued in the interest of promoting service delivery.

I would appreciate your cooperation as a participant in this research and request that u please read and complete the section below to confirm your willingness to take part in the study:

Declaration:

My name is _____

and I am an HIV/AIDS counsellor. If I agree to take part in the study, I will participate in a semi-structured interview, which might take about 45 to 60 minutes. I understand that the interview will be tape-recorded, that the interview information will only be used for the purpose of this piece of research, and that my research records will be kept in a safe place. I realize that I will not be paid for my time and I hereby agree to willingly participate in this study. I also understand that any information gained from this research will protect my anonymity and if I have any queries or comments about this study, I may contact Mrs. Mimona Hendricks at 031-2081750.

By signing below, I state that I understand the nature of this research and I know that I may withdraw from the study if I choose to or become uncomfortable. By signing below, I also acknowledge that I have read this consent form and willingly agree to take part in this study.

SIGNATURE OF PARTICIPANT

DATE: _____

APPENDIX B***REQUEST AND CONSENT FORM TO PARTICIPATE IN
A FOCUS GROUP FOR RESEARCH PURPOSES***

***By
Mimona Hendricks
UNISA***

Dear Counsellor,

Thank you for your interest.

My name is Mimona Hendricks and I am pursuing a Masters Degree in Social Work at UNISA. The focus of my research is to explore the levels of satisfaction of HIV/AIDS counsellors in the Durban Metropolitan area with regard to the training they received. Counsellors are a vital people resource in the HIV/AIDS arena, therefore my research will include counsellors from diverse backgrounds in order to take a fresh look at understanding how counsellors feel about their training and at a level of perception, and how these HIV/AIDS counsellors perceive their current level of functioning. It is hoped that such insights might increase understanding of where the strengths and opportunities for growth lie in terms of disease management from a HIV/AIDS counsellor resource perspective and your contribution towards this study will be highly valued in the interest of promoting service delivery.

I would appreciate your cooperation as a participant in this research and request that u please read and complete the section below to confirm your willingness to take part in the study:

Declaration:

My name is _____

and I am an HIV/AIDS counsellor. If I agree to take part in the study, I will participate in a focus group discussion for about two hours, with other counsellors who took part in the individual semi-structured interviews of this study. I understand that the information gained will only be used for the purpose of this piece of research and that the research records will be kept in a safe place. I realize that I will not be paid for my time and I hereby agree to willingly participate in this research. I also understand that any information gained from this research will protect my anonymity and if I have any queries or comments about this study, I may contact Mrs. Mimona Hendricks at 031-2081750.

By signing below, I state that I understand the nature of this research and I know that I may withdraw from the study if I choose to or become uncomfortable. By signing below, I also acknowledge that I have read this consent form and willingly agree to take part in this study.

SIGNATURE OF PARTICIPANT

DATE: _____

APPENDIX C

DEAR COUNSELLOR,

Thank you for taking part in this research project. The following questionnaire is part of a semi-structured interview to explore how you as an HIV/AIDS counsellor feel about the training you have received.

Kindly begin by answering the questions below and placing a tick in the appropriate box.

DEMOGRAPHIC DETAILS

1. What is your gender?

Male	
Female	

2. In which age group do you fall?

18 to 25 years	
26 to 34 years	
35 to 44 years	
45 to 55 years	
56 years and above	

3. What is the highest level of education that you completed?

High school	
College/ Technikon	
University	

4. From which base are you currently working as an HIV/AIDS counsellor?

Non-Governmental	
Governmental	
Faith – based organization	
Other	

5. How long are you working at with this organization as an HIV/AIDS counsellor?

0 – 11 months	
1 – 2 years	
2 years & more	

6. Please indicate if you have previously worked elsewhere as an HIV/AIDS counsellor.

Non-Governmental	
Governmental	
Faith-based organization	
Other – please state nature of organization	

7. From which service provider did you receive your training to be an HIV/AIDS counsellor?

University	Government	Faith based organization	Community based organization	Private Sector
College/ Technikon	NGO	Other		

8. Duration of your HIV/AIDS counsellor training course?

How long was your HIV/AIDS Counsellor training course?	
--	--

APPENDIX D

DISCUSSION GUIDE FOR SEMI-STRUCTURED INTERVIEW

(Interview – guide for exploration of open-ended questions – prompting questions e.g. what do you mean by that/ please tell me more/ why do you say that ...etc.)

1. Can you please tell me what motivated you to become an HIV/AIDS counsellor?
2. Why do you think it is important to have HIV/AIDS counsellors like yourself?
3. What is your status at the organization where you work as an HIV/AIDS counsellor?
4. How often do you counsel persons who are affected or infected with HIV/AIDS?
5. How soon after your training did you begin to work as an HIV/AIDS counsellor?
6. I am interested to find out how the training was conducted.
7. What did you not like about the training you received?
8. What did you like best about the training course you attended?
9. What kind of support was available to you after you completed the training and started working as an HIV/AIDS counsellor?
10. What can you remember concerning aspects or topics that were included in the training program you attended to become a counsellor in the field of HIV/AIDS?
11. Can you please tell me what you think are some of the most important skills and competencies that HIV/AIDS counsellors should have?
12. To what extent did the training course you attended cover these core skills and competencies that you mentioned?
13. What do you think is your most important task or role as an HIV/AIDS counsellor?
14. To what extent did the training you received equip you to perform the task/role you mentioned?
15. What would you suggest are focus areas to improve training of HIV/AIDS counsellors?
16. If training was available to you, what specifically would you like to be trained on?
17. To what extent do you think your training prepared you for the work that you do as a counsellor?
18. To what extent do you think the training met your expectations?
19. Just to summarize, I'm wondering whether or not you feel satisfied with the training you received to become a counsellor in HIV/AIDS?

Thank you very much for your participation.

APPENDIX E***FOCUS GROUP DISCUSSION GUIDE***

The discussion guide for the focus group discussions related directly to two objectives of the study, namely:

- To explore what these counsellors perceived to be the core skills and competencies required of HIV/AIDS counsellors.
- To explore what these counsellors regarded as key areas for the improvement of HIV/AIDS counsellor training.

APPENDIX F***RATING SCALE***

TABLE 7: RATING SCALE

Rating	1	2	3	4	5	6	7	8	9	10
Anchor	Completely dissatisfied	Extremely dissatisfied	Very dissatisfied	Dissatisfied	Fairly dissatisfied	Reasonably satisfied	Satisfied	Very satisfied	Extremely satisfied	Completely satisfied

This rating scale was used to ascertain the counsellor's level of satisfaction with their HIV/AIDS counsellor training.