STRATEGIES FOR ENHANCING THE COMPETENCE OF LAY COUNSELLORS THAT PROVIDE VOLUNTARY HIV AND AIDS COUNSELLING AND TESTING PROGRAMME IN THE MOPANI DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA

by

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DECLARATION

" I declare that this thesis, **STRATEGIES FOR ENHANCING THE COMPETENCE OF LAY COUNSELLORS THAT PROVIDE VOLUNTARY HIV AND AIDS COUNSELLING AND TESTING PROGRAMME IN THE MOPANI DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA**

submitted for the degree of Doctor of Philosophy at the University of Venda, is my own work and that all sources that I have used are referenced and acknowledged"

Signature_____ Date _____

MJ Ramalepe

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DEDICATION

This study is dedicated to my beloved mother Dinah Rabutebu Senelo Moleba and my late father Josiah Naledi Madumetja Moleba who gave me a foundation of love and life, who valued education and encouraged me to continue learning to make me the person I am, and to my late mother- and father-in-law, Maite and Matome Ramalepe, for their love.

Praise to the LORD ALMIGTY! With GOD, everything is possible.

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The Directorate, Department of Health Research Ethics Committee and the Mopani District Senior Manager for granting me permission to carry out this study in the health facilities.

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ABSTRACT

HIV counselling and testing has been recognised as an important component of HIV and Acquired Immune Deficiency Syndrome (AIDS) care and support, and is an essential part of HIV testing. In South Africa a commonly used model for counselling for HIV and AIDS in health facilities is performed by lay counsellors. In many countries Voluntary Counselling and Testing (VCT) has been found to be effective in reducing HIV infection, and helping partners to cope with illness. The use of lay counsellors is a way of scaling up VCT uptake services. Lay counsellors are trained and supervised by Non-Governmental Organizations working in partnership with the government Department of Health. The trained lay counsellors work alongside health professional in public health clinics and hospitals.

The purpose of the study was to develop strategies to enhance the competence of the lay counsellors implementing VCT in the health facilities of Mopani District, Limpopo Province. The findings of the study were used to develop strategies to enhance the competence of lay counsellors when implementing VCT programme.

Both qualitative and quantitative methods were used in this study. The qualitative study assisted the researcher to develop an understanding of the phenomenon as it exists in the real world. The research was conducted in the health facilities of the Mopani Districts, Greater Tzaneen, Greater Letaba and Baphalaborwa. The population consisted of lay counsellors implementing VCT in the health facilities. Data were collected using a semi-structured interview tool for Focus Group Discussions and individual interviews, and a structured checklist for observational sessions. Data collected from focus groups and from individual interviews were analysed qualitatively through the open coding method. Data from the structured observational checklist were analysed using the SPSS Version 15 to obtain frequency distributions and percentages.

Ethical clearance was submitted together with the research proposal to the Limpopo Department of Health and Social Development Research Ethics Committee. All lay counsellors signed informed consent form before they could participate in the study.

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The researcher obtained permission to conduct the study from Mopani District Department of Health and Social Development and supervisors of the clinics.

The research results revealed that lay counsellors were proficient in implementing the basic competencies of the VCT programme; however, they lacked some important counselling skills and knowledge of processes that should be implemented when counselling clients. The researcher recommends that regular in-service training, supervision, mentoring and monitoring should be implemented to increase the competence of lay counsellors. Based on the findings of this study, strategies were developed to improve the competence of lay counsellors.

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ACRONYMS		XII
ANC	Antenatal Care	
AIDS	Acquired Immune Deficiency Syndrome	
ARV	Anti-retroviral	
CDC	Community Based Organization	
CD4 CELL	Cluster Designated cells	
DOH	Department of Health	
ELISA	Enzyme Linked Immune Sorbent Assay	
EC	Eastern Cape	
FBO	Faith Based Organizations	
FS	Free State	
FPD	Foundation for Professional Development	
GP	Gauteng Province	
HIV	Human Immune Virus	
HCT	HIV Counselling and Testing	
HTA	High Transmission Areas	
IBC	Inter Church Body	
IV	Intravenous	
LAV	Lymphadenopathy Associated Virus	
LP	Limpopo Province	
KZN	Kwa Zulu Natal	
MTCT	Mother to Child Transmission	
PMTCT	Prevention of Mother to Child transmission	
MP	Mpumalanga	
NGO	Non-Governmental Organization	
NSP	National Strategic Plan	
NW	North West	
NDOH	National Department of Health	
PEP	Post Exposure Prophylaxis	
PLWA	People Living with HIV and AIDS	
OIs	Opportunistic Infections	
SAQA	South African Qualification Authority	
STI	Sexually Transmitted Infection	
SA	South Africa	
USA	United States of America	
TB	Tuberculosis	
TASO	Aids Support Organization	
UNAIDS	United Nations Aids Partnership for HIV	
UNGASS	United National General Assembly Special Session	
VCT	Voluntary Counselling and Testing	
WHO	World Health Organizations	

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CHAPTER 1

ORIENTATION

1.1 INTRODUCTION

The competence of lay counsellors who implement the Voluntary Counselling and Testing (VCT) programme deserves serious attention if appropriate and effective counselling sessions are to be achieved by people who provide Human Immune Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) counselling in the Mopani District of Limpopo in particular and in South Africa in general. It is only when lay counsellors are respected and acknowledged as members of a health team, and when they work in supportive environments where they enjoy good relationships with other health professionals, that they will be able to be empowered to provide appropriate, efficient and effective counselling sessions.

1.2 RATIONAL AND BACKGROUND OF THE PROBLEM

In 2006 an estimated 39.5 million people were thought to be living with HIV worldwide; the number of people newly infected was estimated at 4.3 million. It was further estimated that 3.1 million people had died as a result of the disease. An estimated 2.8 million new infections had occurred in sub-Saharan Africa, Eastern Europe and Central Asia and approximately 2.9 million people had died of HIV and AIDS-related diseases. In 2012, UNAIDS report estimated that there were 35 Million people living with HIV globally. There is reduction marked of people living with HIV in the world by 4 million from 39.5 million. Number of newly infected were reduced from 4.3 million to 3.1 million. Number of deaths was also reduced all these gains are due to the fact that many people living with HIV are using lifesaving drugs (UNAIDS 2013). Although there is a marked decrease, HIV and AIDS infections still pose a serious challenge to governments and communities, and requires collaboration of all structures in fighting the epidemic. The impact of HIV and AIDS on all countries has social, economic, legal, ethical, personal, political, and cultural health implication (Joint United Nations Programme on HIV /AIDS UNAIDS (2006:6).

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There is a concomitant increase in the demand for VCT programmes that can assist in the prevention of the spreading of HIV infection. As a result of encouragement from UNAIDS, many countries have increased their VCT programmes, and have trained lay counsellors to assist nurses and doctors to counsel clients to be tested for HIV. Lay counsellors assist people to understand the mode of the infection and methods to prevent HIV through education, counselling and testing. Southern African countries such as Malawi, Botswana, Zimbabwe, Lesotho Swaziland Zambia (UNAIDS (2001:3), Zimbabwe and South Africa. All these countries are severely affected by HIV and AIDS, UNAIDS (2004:25). In 2005 national adult HIV prevalence exceeded 15% in the above mentioned countries. There is a need to train more competent human power to be able to fight the scourge of the epidemic Joint United Nations General Assembly Session (UNGASS) Report, (2008:9), and thus need competent VCT counsellors.

UNAIDS/WHO (2004:7) AIDS Epidemic Update, the authors have, identified strategies to prevent HIV and AIDS, including the use of condoms during sexual intercourse. The use of sterile injection needles by drug users, as well as Prevention-of-Mother-to-Child-Transmission (PMTCT). Trained counsellors help to facilitate these strategies to ensure the reduction of HIV and AIDS in communities. The problem with the topic of HIV and AIDS is that the disease is very sensitive as it is associated with sex, and in most cases people do not want to be tested for HIV because they fear being stigmatised and discriminated against, and being rejected by families and friends.

The Sub-Saharan Africa region is the most affected region in the Global AIDS epidemic. Even though only ten per cent of the world population resides in Sub-Saharan region of Africa the region accounts for 60% of people living with HIV (PLWH) worldwide. More than three quarters (76%) of AIDS-related deaths in 2007 occurred in the region. It is estimated that in 2006, 2.1 million people died from the epidemic. The epidemic has cut life expectancy by more than 10 years. In 2006, there were an estimated number of 12 million orphans in the sub-Saharan region. It is probable that these children will be deprived of the proper care and supervision they need at critical periods of their lives. Fortson (2011:1) indicated that orphans in Africa are significantly less likely to be enrolled in school than non-orphans and progress more slowly when enrolled. It is further reported that women and children are affected more than men.

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In the study conducted in Tanzania by UNAIDS (2004:15), in the document AIDS Epidemic Update, the researchers found that women whose husbands were sick spent up to 45% less time doing agriculture or income-generating work than before the illness. In Lusaka, Zambia an independent VCT programme undertook outreach programmes in the community in an effort to increase the number of couples who participated in VCT counselling sessions. Individuals were selected from the community and trained as counsellors to give guidance in their households and to encourage individuals and couples to be tested for HIV.

South Africa has the largest number of HIV infected people in the world. In 2006 the estimated population was 45 million people, and approximately 5.5 million people, including adults and children, were living with HIV. In addition there were about 400 000 children orphaned as a result of the AIDS pandemic. According to the HIV and AIDS and STI, National Strategic Plan of South Africa (DOH 2007-2011:7), HIV prevalence among pregnant women rose by 23.01% in 2001, 24% in 2003, and 30% in 2005; there was a slight reduction of 29.1% in 2006. The statistics show that between 1997 and 2005 the death rate among men aged 30-39 doubled while among women aged 24-34 it quadrupled. The life expectancy of the population was predicted to fall from 54 years to 41years by 2010. Minnaar (2005: 31:38) stresses that HIV/AIDS has a devastating impact on South Africa. However in 2013 life expectancy in South Africa has increased to over 60% (WHO/UNAIDS/UNICEF 2013) due to the use of antiretroviral treatment. The influence of HIV is also felt in the health sector, because 15% of the health workers in the public and private sectors are HIV positive. There are many possible reasons why South Africa is so badly affected by AIDS; these include poverty, instability and the lack of government action prior to 1994, as well as the government's hesitation in providing ARV to HIV positive people.

Limpopo Province consists of five districts namely, Capricorn, Mopani, Waterberg, Vembe and Sekhukhune. Each district is further divided into sub–districts and municipalities. Ninety per cent (90%) of the districts are rural with poor roads and transport facilities and inadequate water and sanitation. The population of the province is 5,404,868 million. HIV prevalence in Limpopo Province among pregnant women is increasing, despite vigorous prevention strategies that have been implemented by numerous NGOs, CBOs and FBOs and funded by the Department of Health to assist in the prevention of the HIV infections. The District had the highest antenatal HIV prevalence in the Province: 27.5% in 2006, and 25.4% in 2007; a

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very small decrease was observed in 2009 when it was 19.7%, but it rose again to 21.9% in 2010. The Mopani and Waterberg districts had the highest prevalence of all the districts in 2006, 2007 and 2008. The prevalence was still high in these two districts in 2009 and 2010. Although the prevalence is decreasing, though the decrease does not seem to be stabilising.

Voluntary Counselling and Testing (VCT) for HIV is known to increase communities' awareness of the disease and reduce sexually risky behaviour. VCT by itself it is an important preventive strategy. The process consists of a pre-test, a post-test and follow-up counselling. The lay counsellor prepares the client for the test by explaining what an HIV test is, as well as correcting myths and misinformation about HIV and AIDS. Prevention counselling is a key element of routine care provided to all patients presenting for HIV testing. For patients who test HIV-positive, repeated interaction with trusted providers enables discussion on how to avoid transmission of the virus to family, friends and partners. This includes counselling concerning high-risk sexual behaviour, intravenous (IV) drug abuse, ways to avoid re-infection, as well as the diagnosis and treatment of STIs, opportunistic infections and clinical screening for TB. Post counselling assists clients to understand their test results and initiate adaptation to their sero-positive and sero-negative status (UNAIDS 2000a:5). Patients who undergo VCT and test HIV-negative will receive prevention counselling that emphasises behaviour that keeps this population HIV negative. The benefits of VCT include, but are not limited to, promoting and sustaining changes in risk behaviour in order to reduce HIV infections. These interventions complement other preventative interventions such as PMTCT, the prevention of sexually transmitted infections (STIs) and referrals to home based Care.

In order to make VCT available and accessible, World Health Organizations (WHO) has encouraged governments to train members of the community as lay counsellors to increase the provision of VCT programmes in communities. Using members of the community is a way of improving VCT, making it available to communities accessible and acceptable to many people. Lay counsellors play a very important role in increasing accessibility of VCT in many countries including South Africa,(WHO, 1990:11).

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VCT is a dialogue between the counsellor and a client to achieve the following:

- To provide the client with information on HIV testing, its benefits and the risks involved;
- To provide clients with background information on HIV and AIDS infection, modes of transmission, prevention methods, treatment and care;
- To encourage the maintenance of safe behaviour to avoid future infections and to prevent the further spread of HIV;
- To help clients to handle possible emotional reactions related to HIV tests;
- To discuss the course of action that has been adapted to each client's needs, family and circumstances (Landi & Bokhari, 2001:1).

The VCT programme includes a process in which an individual undergoes counselling to enable him or her to make an informed choice about being tested for HIV. This decision to take the test must be entirely that of the individual (DOH 2001: 94).

According to Cooke and Wilkinson (2006:18) VCT programmes started in the Eastern Cape where counsellors, community health workers and peer educators conducted door-to-door visits to promote HIV awareness and thereafter did HIV testing on days arranged with the local chief. As community counselling and testing often coincided with government grant collection day, it was possible to reach many people. Counsellors were organised and trained to counsel people in homes and villages. Those who were already ill were organised to form patient support groups. This intensive community health involvement has led to the success of the Madwaleni HIV and ARV programme as it has lightened the workload of nurses without compromising their relationship with and care of their patients. The counsellors also undertake follow-up visits to patients and prepare families to administer ARV treatment (Cooke & Wilkinson, 2006:18).

In all the countries where HIV and AIDS is a problem, women and children carry the burden because about half of those infected with HIV are women. Women are becoming infected at a faster rate than men. This is because many experience sexual and economic subordination in their personal relationships at work and in their families as in many instances they cannot negotiate for safer sex. In addition, the traditional domestic and nurturing role of women

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positions them to bear the greatest burden of care; this adds to their workload and undermines the vital productive, reproductive and community role that they play. Furthermore, women employment, property, credit and income. UNAIDS (2004:1-4)

HIV and AIDS violates the basic human rights of children, including the right not to be discriminated against; the right to survival and development; the right to have other people behave in their best interest; the right to participate in life. Their rights are also abused when children are tested without their consent, and when their HIV status is disclosed without their consent. Moreover, many children have to take care of other children because their parents have died of HIV and AIDS. The Constitution of the republic South Africa 108 of 1996 is committed to protect human rights, but in the case of HIV and AIDS it is quite difficult to protect the rights of children (Strode and Grant, 2001:45).

Baggaley (2001:1-13) presented a paper on guideline VCT during the UNAIDS expert panel on HIV testing in the United Nations peace keeping operations. The guidelines indicate that VCT plays an important role within a comprehensive range of measures that can be taken to assist in the prevention HIV and in the care of patients. In addition, UNAIDS encourages countries to assist with the creation and execution of policies that reflect best practices in the prevention of HIV and the care of those infected, including VCT programmes, through increased international cooperation. This can be enhanced by personnel of the peace keeping forces being counselled and tested before they are deployed internationally. In order for this to be successful countries were encouraged to establish national VCT programmes for peace keepers (Baggaley, 2001:2). It was hoped that this initiative would assist peace keepers to protect themselves from being infected and infecting others; those who were sick with HIV and AIDS would be treated to prevent illnesses and promote their health. Thus counsellors were expected to be competent.

VCT services focus on the prevention of new infections. Now that treatment has become more readily available, more health planners view VCT as a way of identifying those who need care McCauley (2004:1) mentioned that clients who had been counselled and tested reported safer sex behaviour as compared with those who had not been tested regardless of their sero-status.

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This finding suggests that counsellors in Kampala [illegible] competent in counselling their clients; they shared relevant information with them and were able to test them for HIV and help them prevent further HIV infections through the implementation of safe sex practices.

The study conducted by van de Perre (2000a:14) in Kenya Tanzania and Trinidad to determine the efficacy of VCT in reducing the incidence of unprotected intercourse revealed that the number of individuals reporting unprotected sex with non-primary partners declined significantly among those who had received VCT. The study revealed that, those who had enrolled as couples in the VCT programmes reported a decrease in the instances they had had of unprotected intercourse as compared with those who had enrolled for health education only. The results of this study support the notion that VCT is efficacious in promoting behavioural change. There was significant sexual behavioural change in individual men and women who had enrolled for VCT.

Three studies conducted in Kenya, Uganda and Zambia by McCauley (2004:3) provides insight into barriers young people face when seeking VCT. Youths seeking VCT indicated that they were concerned about confidentiality, testing processes applied, the accuracy of the results and the cost of the services. In Kenya and Uganda 41% of untested youths and 38% of tested youths reported that they would prefer to be tested at a youth facility rather than at an adult facility to protect their privacy and the confidentiality of their health status. The youths also wanted to deal with staff who were kind and who understood their issues. Untested youths wanted to be sure that they saw qualified staff that used reliable testing equipment. In Zambia youths stressed the need for privacy, and wanted counsellors who would give them accurate information in a friendly manner (McCauley, 2004:3). The youths wanted the same treatment that the counsellors offer adults when seeking VCT services.

1.3 PROBLEM STATEMENT

The prevalence of HIV among antenatal women in Mopani from 2007 to 2009 as documented by the Department of Health (2010) was:

2007	2008	2009
23,8%	25,2%	26,2%

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- What are the strategies that could be employed to enhance the competence of lay counsellors during the implementation of the VCT programme in the health facilities of the Mopani District in Limpopo Province?

- How effectively will the strategies developed enhance the competence of lay counsellors?

1.4 PURPOSE OF THE STUDY

The purpose of the study was to develop strategies to enhance the competence of lay counsellors who were implementing the VCT programme in health facilities of the Mopani District of Limpopo Province, South Africa. This was achieved by assessing the competence of the lay counsellors through focus group discussions, individual interviews and observational sessions. A questionnaire was used to determine the perceived challenges faced by lay counsellors implementing VCT programmes.

1.5 OBJECTIVES OF THE STUDY

The objectives of this study were to:

- Assess the competence of lay counsellors implementing VCT programmes in the Mopani District;
- Determine what the challenges implementing VCT programmes were as perceived by lay counsellors;
- Develop strategies to enhance the competence of lay counsellors;
- Assess the effectiveness of the strategies used during the implementation of VCT programmes in health facilities in the Mopani District of Limpopo Province;

1.6 SIGNIFICANCE OF THE STUDY

The successful implementation of the strategies developed will ensure that lay counsellors are competent in implementing the VCT programme in the Mopani District. It is hoped that more

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clients will be counselled and tested, which, in turn, the results of the study will contribute to the promotion of health in the community.

The strategies developed from the study will enhance the competencies of lay counsellors in the Mopani District to ensure better health service delivery. As a result it is envisioned that the prevention of HIV and AIDS will be promoted and that there will be a reduction in HIV infections.

The results of the study will contribute to the standardization of VCT programmes offered in the Mopani District and in Limpopo Province. The research findings will guide policy makers in the Department of Health and Social Development in Limpopo Province and will assist officials of this department to plan and implement the strategies developed to the benefit of the VCT programmes. The strategies developed will be available for use by other NGOs that are training VCT lay counsellors in the province. The research results may also serve as a research resource for lay counsellor training. The researcher hopes that other researchers will be inspired to undertake further research into VCT programmes in the province. The research will contribute to the body of scientific knowledge.

The present investigation is an applied research project that will contribute to theory by testing the theories of the issue in question. The research may help clarify concepts and contribute new facts that may lead to the formulation or redefinition of theory (Nicoll 1992:16).

1.7 PARADIGMATIC PERSPECTIVE

The researcher believes that there is no research without value. The value of the present research will direct the thinking and activities. The research process followed was interactive in nature and reports of the interaction between the researcher and the participants in the study. In this study the term 'paradigm' is explained as a set of shared accepted assurances that shapes both what we see and how we understand it; this provides a framework for scientific practice where it is expected that lay counsellors must be competent when executing their activities. It integrates meta-theoretical, theoretical and methodological assumptions that guide research (Babbie & Mouton, 2009:645).

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1.7.1 Meta–theoretical assumptions

Mouton (2006:174) had a view that meta-theoretical assumptions are important in research studies because they comprise the underlying theories, models and paradigms that contribute to defining the people and the contexts and social exchanges that constitute their daily lives. Shrink (in de Vos 2001:240) describe meta-theoretical assumptions as the researcher's perceptions regarding the nature of reality. Since the theory on strategy development, has not been documented, the view of Houben et, al. (2009:216); Hay & Castilla (2005) of the use of SWOT as a tool for strategic management and decision making was adapted as a frame for this study. This framework guided the researcher in the development of the strategies for enhancing the competence of lay counsellors. The principles of empowerment by Guillory and Galindo were further used as a frame of reference as described in chapter 4. The researcher assumes that a competent lay counsellor is one who has acquired good counselling skills and is happy in his or her workplace, and is supported by health professionals. Competent lay counsellors are able to provide clear information on HIV and AIDS, in order to help clients understand and make positive decisions to be tested for HIV. This assumption will be tested using qualitative and quantitative data collection tools.

1.7.2 Theories and models

According to Chinn and Kramer (1995:51), theory is creative and includes the rigorous structuring of ideas that project a tentative, purposive and systematic view of phenomena. A theory summarises and organises current understanding of particular phenomena, and may be systematically tested against the real world by research.
The researcher conducted the research without any preconceived ideas. A thorough search of literature dealing with theories that would be applicable for competent lay counsellors was undertaken, and used to support the analysis of data and the control of the research results. Guillory and Galindo's nine major principles of empowerment (1995) were adapted as follows:

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- Lay counsellors are viewed as organization's health facility's most valuable resource;
- Health facilities to maximise the involvement of lay counsellors;

Health professionals and lay counsellors to work as teams and value each other's contribution;

- Lay counsellors to be motivated to continue to grow personally and professionally;
- Lay counsellors to take responsibility and be accountable for their work;
- Self-determination, self-motivation and self-management of lay counsellors to be enhanced;
- Delegation of duties to lay counsellors to be a continuous process;
- Hierarchy in health facilities to be minimised;
- Organisational leadership and support are necessary to drive and sustain the empowerment of lay counsellors.
- The researcher felt that empowerment would facilitate the building of strength, overcome weaknesses, and enable her to explore opportunities and to minimise threats in her attempt to enhance the competence of lay counsellors in the health facilities of Mopani District.

1.7.3 Definition of concepts

Lay counsellors: Lay counsellors are community members, who have been selected, trained in HIV and AIDS counselling and testing, and are supported and mentored to provide pre-test, post- test and on-going counselling to those with HIV. They are placed in health facilities to assist health workers in providing education about HIV and AIDS, counselling and testing to clients. Department of Health (2007:1-22)

***HIV and AIDS counselling*:** It is the process that provides emotional support to those infected and affected by HIV in order to help them to cope with stress and pain. Their tasks include assessing risks and planning for risk reduction, as well as providing information regarding options clients have for the prevention of HIV and AIDS. In this study it refers to the process that assists counsellors and clients to understand the situation of HIV and

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Competence: Having the ability or knowledge to do something successfully (South African Concise Oxford Dictionary, 2007: 235). In this study, competence means that lay counsellors have the necessary ability to give relevant information about HIV, and counsel clients according to the principles of good counselling. In order to strengthen their skills, lay counsellors should counsel clients in the context of the lay counsellors' programmes and should take the core principles of counselling into consideration.

Enhancement: Enhancement means to improve or increase quality and value, to strengthen, to intensify, and enrich the quality and value of something (South African Concise Oxford Dictionary, 2007: 383). In this study 'enhancement' means that lay counsellors' skills will be strengthened. Their skills will be improved to the degree that will make them competent; the assumption is that with improved skills lay counsellors will be able to counsel and test many clients, thus reaching their target number of clients that will result in a high HIV uptake.

Strategies: Strategies are plans designed to achieve a long term aim (South African Concise Oxford Dictionary, 2007:1180). In this study the term 'strategies' means the tactics that will be recommended and implemented as a means of enhancing the competences of lay counsellors

1.8 RESEARCH METHODOLOGY

Both qualitative and quantitative designs were used in the study; the focus was on assessing and describing the competence of lay counsellors who were implementing VCT programmes. The research was conducted in the health facilities of the Mopani Districts, Greater Tzaneen, Greater Letaba and Baphalaborwa. The population consisted of the lay counsellors implementing VCT in the health facilities. Data was collected using a semi-structured interview tool for Focus Group Discussions (FGD) and individual interviews, and a structured interview checklist during observational sessions with lay counsellors who were providing VCT programmes in the Mopani District. Data collected from focus groups and from individual interviews were analysed qualitatively through the open coding method (Tesch, 1990 cited in Cresswell, 1994:155). Data from the structured observational checklist were analysed quantitatively using the SPSS Version 15 to obtain percentages and frequency distribution. Chapter 2 provides a full discussion of the research design and methodology.

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1.9 DIVISION OF CHAPTERS

Chapter 1	Orientation to this study that includes the background, purpose, problem Statement, research questions, objectives and methodology.
Chapter 2	Research methodology of the study includes qualitative and quantitative research methods. The methods, research design, research setting, population, data collection and instrument and data analysis are described.
Chapter 3	Discussions of research findings that describe the experiences of lay counsellors in providing VCT programmes that relate to their competence, challenges in implementing VCT programmes, and strategies that could improve their competence are presented.
Chapter 4	Strategies for the enhancement of the competence of lay counsellors are proposed. The developed strategies were aligned to the National and District Department of Health Counselling and Testing Policy Guidelines and the nine principles of empowerment as defined by Guillory and Galindo (1995). A SWOT analysis and BOEM action plan were adopted
Chapter 5	Conclusions, validations, limitations of the study are submitted. The recommended strategies that have been developed are validated by the lay counsellors and facility managers. Limitations of the study include the fact that the study did not include the health professionals and clients. There is a need to conduct a study where clients and health workers are involved to obtain a more comprehensive idea of the situation. Recommendations that the strategies should be implemented in health facilities that provide HIV and AIDS counselling and testing as well as in any other institution where there is interaction between lay health workers and health professionals are made.

1.10 SUMMARY

This orientation chapter describes the rationale and the background of the study, the problem statement, and purpose of the study, study objectives, research questions and research methodology. In this chapter the problem to be researched as well as the motivation of the study has been described. The research design and methods used in this study were highlighted, followed by a sequential organisation of the chapters.

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CHAPTER 2
RESEARCH METHODOLOGY

2.1 INTRODUCTION

The purpose of this chapter is to describe the research methodology followed in this study to assess the competence of lay counsellors implementing VCT programme in the health facilities of the Mopani District in Limpopo Province. An outline of the qualitative and quantitative research designs used in this study was provided as well as measures to ensure trustworthiness and ethical standards that were adhered to throughout. de Vos, Strydom, Fouché and Delport, (2001:358) outline methodological triangulation as the use of two or more methods of data collection procedures within a single study. Triangulation of data collection methods was used in this study because the researcher used focus group discussions and individual interviews, followed by observational interviews using a structured checklist.

2.2 RESEARCH DESIGN AND METHODOLOGY

A research design is a plan for scientific enquiry where a strategy is developed on how the processes should be undertaken in addressing a research problem. The underlining principle for the design is that the researcher must be able to outline what needs to be investigated and be able to explain the way the investigation will be carried out (Babbie & Mouton, 2009:72). Burns and Grove (2009:185) refer to study design as the blueprint for conducting a study that maximises the control over factors that could interfere with the desired outcome of the study. In order to establish the factors that promote or hinder the competence of lay counsellors in the Mopani District, a qualitative and quantitative descriptive research design was used. The researcher's reasoning approach was to develop strategies to enhance the competence of lay counsellors based on an understanding of the participants' perceptions as they existed in their natural setting. The research design that was used was qualitative and descriptive in nature. Newman (2006:181) mentions that qualitative and quantitative researchers use careful systematic methods to gather high quality data. Differences in the styles of research and the types of data collected mean that they approach measurement differently. Qualitative researchers measure data during data collection. Data for qualitative research often includes written or spoken words, actions, sound, symbols, physical objects or visual images.

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Quantitative researchers think about variables and convert them into specific actions during planning that occurs before and separate from gathering or analysing data. Quantitative researchers develop techniques that produce data in the form of numbers. Brink (2006:13) indicates that qualitative research attempts to understand a phenomenon in its entirety, rather than focusing on concepts. In the present study the phenomenon was studied through descriptions that were provided by the people involved (Brink 2006:119). Lay counsellors described their competence, perceived challenges and strategies that could enhance their competence while providing VCT programme in the Mopani District.

2.2.1 Qualitative research design

Qualitative research is a descriptive, useful and important inquiry that takes place in a natural setting. The qualitative researchers go to the homes or offices of participants to conduct research; they involve participants in the data collection and seek understanding to build rapport with the individuals in the study (Brink 2006:13). Qualitative and descriptive study designs were used in this study with the aim of developing strategies to enhance the competence of lay counsellors who implement VCT in health facilities of the Mopani District in Limpopo Province. Qualitative researchers interpret data. This includes developing a description of individuals and the setting, analysing data for themes and finally interpreting its meaning personally and theoretically, stating the lessons learned, and further questions to be asked (Cresswell, 1994:163).

Burns and Grove (2009:99) refer to qualitative research as a systematic, subjective approach used to describe life experiences and give them meaning. This corresponds with the definition of qualitative research proposed by Walker and Avant (1995:99) that the researcher is interested in the process, meaning and understanding gained through words. These researchers mention that qualitative researchers seek understanding and interpretation aimed at generating theory and hypotheses whereas quantitative methods seek explanation aimed at generalization. In this study the focus is on developing strategies for enhancement of competence of lay counsellors. The design provided qualitative information that cannot usually be obtained from surveys or formal interviews, whereas the quantitative aspect of the research provided a broad general view of the topic.

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2.2.2 Quantitative research design

Quantitative research involves the systematic collection of numerical information using statistical procedures (Burns and Grove, 2009:15). In quantitative research a questionnaire can be completed by a respondent in any setting in which he/she feels comfortable. Quantitative research designs usually are created by selecting observable indicators. In this study the quantitative research design element consisted of observing lay counsellors as they conducted counselling sessions. A check list was used during the observation and after responses had been acquired from the participants the responses were analysed using frequency distribution. The researcher used this quantitative research design in this study to strengthen the data collected from group and individual interviews.

2.3 STUDY SETTING

The study was conducted in the Mopani District of Limpopo Province. The Mopani District is one of the five districts of Limpopo Province, and is situated in the North East of the province. The area of jurisdiction covers approximately 1109 square kilometres. The district is divided into five sub districts namely: Ba-Phalaborwa, Greater Giyani, Greater Letaba, Maruleng and Greater Tzaneen. The study was conducted in the health facilities of three sub-districts, namely Ba-Phalaborwa, Greater Letaba, and Greater Tzaneen. The research was conducted in these facilities because the NGO that the researcher worked for provided training, support, and mentoring to lay counsellors in these sub-districts. The study was conducted in four hospitals, four health centres and 20 clinics. Sixty lay counsellors participated. Twenty lay counsellors participated in each of the three aspects of the research, namely the individual interviews, observational sessions and focus group discussions. The interviews and observations were conducted in the health facilities where the participants worked, but the focus group discussions were conducted at a neutral venue in the sub-district.

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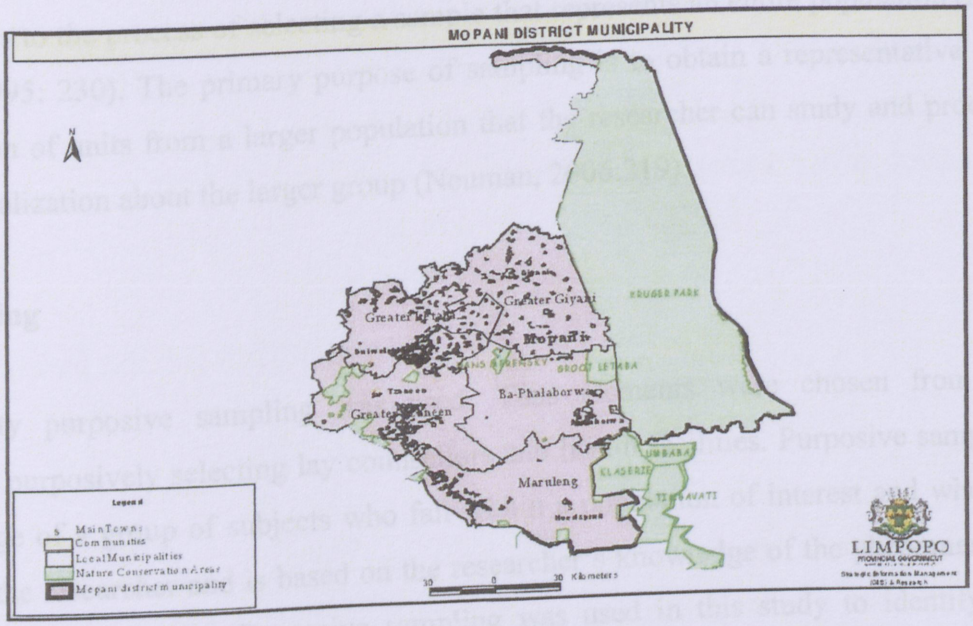


Figure 1: Map of Mopani District Municipality. Source: Reviewed Integrated Development Plan 2007/20

2.4 POPULATION

Population refers to the entire set of individuals or a group of people who possess some common characteristics or who meet the criteria the researcher is interested in studying (Brink, 1996:132). In this study the research population consisted of all lay counsellors who had been trained by CRP and were based in the health facilities in the Mopani District. It was assumed that as lay counsellors they had information about HIV and AIDS, and had learned the skills necessary to provide effective, supportive counselling to their clients. The population of lay counsellors had been trained and were supported by CRP. The lay counsellors were placed in health facilities in the three sub-districts of the Mopani District namely, Greater Tzaneen, Greater Letaba and Ba-Phalaborwa. A sample was obtained from the lay counsellors providing VCT programmes in these sub-districts. In this study the research population consisted of all 105 lay counsellors trained by CRP and based in the health facilities in the Mopani District.

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2.4.1 Sampling and sample

Sampling refers to the process of selecting a sample that represents an entire population (Polit & Hungler, 1995: 230). The primary purpose of sampling is to obtain a representative or a small collection of units from a larger population that the researcher can study and produce accurate generalization about the larger group (Neuman, 2006:219).

2.4.2 Sampling

Non-probability purposive sampling was used. Thus elements were chosen from the population by purposively selecting lay counsellors and health facilities. Purposive sampling takes advantage of a group of subjects who fall within a population of interest and who are accessible to the researcher and is based on the researcher's knowledge of the phenomena of the study (Brink, 1996: 141). Purposive sampling was used in this study to identify the hospitals and health centres in the three sub-districts. In Greater Tzaneen, the Letaba hospital was selected because lay counsellors employed by two organisations, CRP and Foundation for Professional Development (FPD), worked there. Another reason for selecting Letaba Hospital was that it is a regional hospital and lay counsellors see many clients to provide adherence counselling. In Greater Letaba, Kgapane hospital was selected because there were many clients for lay counsellors to advice on adherence to treatment. Maphuta Malatjie hospital in Greater Ba-Phalaborwa was selected because even though counsellors saw very few clients, it is the only hospital in the sub-district. The Lulekane Health Centre in Greater Ba-Phalaborwa was selected because lay counsellors saw many clients and the centre had facilities to offer mother-to-mothers programmes in which mothers assist other mothers to enrol and accept PMTCT support. In Greater Tzaneen the Nkowankowa Health Centre was chosen because the lay counsellors saw many clients. In Greater Letaba the Duiwelskloof Health Centre was chosen because the hospital had recently been turned into a health centre. The researcher assumed that there might be interesting challenges experienced by the lay counsellors who worked there because they would have had to adjust to working in an institution that had changed from being a hospital to being a health centre.

All lay counsellors who were in the purposively selected facilities constituted a convenience sample for interview and observation when conducting counselling sessions. A convenient sampling was followed because not all lay counsellors were available on duty at the same

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time. This could be attributed to the fact that some took leave, off time and it was finally observed that the total number of lay counsellors was relatively low. Twenty seven lay counsellors attended focus group discussions and individual interviews as follows: Seven lay counsellors from Baphalaborwa, ten lay counsellors from Greater Letaba and ten lay counsellors from Greater Tzaneen sub districts. An additional six counsellors were included in observational session only, which resulted to 33 of them observed while conducting counselling

2.5 DATA COLLECTION METHODS

2.5.1 Instrument

A semi-structured interview guide in which the questions had been developed by the researcher was used. This guide was used for focus group discussions and individual interviews. The semi structured interview guide was useful because the researcher could obtain all the information required while affording participants freedom to respond and describe concepts (Morse & Field, 1996:76). The semi-structured interview guide and observational checklist were used to obtain information from the lay counsellors through FGD, individual interviews and through observation sessions. de Vos et al (2001: 298) describes the semi-structured interview as a social interaction between equals in order to obtain research relevant information. Brink, (1996:158) describes semi-structured interviews as normal conversation, but with a purpose for descriptive qualitative research studies where the researcher does not have enough knowledge about the topic to structure questions for data collection in advance. The questions gave the lay counsellors the opportunity to describe how competent they were in implementing the VCT programme

A checklist used during the observation phase of the research was adapted from the UNAIDS VCT tool for evaluating VCT (UNAIDS, 2000b:20). The original check list has 62 questions. The researcher reduced the questions to 43 taking specifically those relevant to the study. The themes in the questionnaire was used, themes such as: establishes therapeutic and supportive environment; uses active listening; sue effective questionnaire; summarises information; give messages; pre-test counselling; post-test counselling; giving negative results and giving positive results. The checklist helped the researcher to observe the competences of the lay counsellors while they were providing VCT. The following three questions assisted the

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researcher to discover the lay counsellors' opinion of their own competence as well as their challenges during friendly discussions:

Question1: How competent are you in implementing VCT? The question was followed by probes such as 'In which skills do you think you are most competent?' 'In which skills do you think you are just competent?' 'In which skills do you think you are less competent?'

Question 2: What are the challenges you face in implementing the lay counsellor programme? This question was followed by probes such as 'What challenges affect your competences?' 'What challenges do you experience with your clients?' 'What challenges do you experience in the environment?' 'What challenges do you experience with the health professionals?' 'How do you deal with the challenges?. The same semi-structured interview questions were used for both focus group discussions and individual interviews.

Question 3: What strategies do you think could be employed to strengthen the competence of the lay counsellors?

Focus group discussions were conducted as open conversations in which each participant made comments, asked questions or responded to comments by others (de Vos et al 2001:314). The group discussions of 7-10 lay counsellors were organised in each of the three (3) sub-districts as described above. The times, dates and venues of the focus group discussions were organised in advance by the researcher. Participants were informed about the time and venue for interview in advance. The researcher provided incurred travelling costs and meals for all the participants. The sampled facilities provided venues which were found to be conducive for interviews by the researcher. Discussions were tape recorded with the permission of the participants. The focus groups discussions were conducted by the researcher during October, 2010.

Regarding the individual interviews, the researcher visited lay counsellors at their places of work. These visits were organised with the clinic, hospital or health centre managers long in advance. Written correspondence was sent to both lay counsellors and managers. Lay counsellors had enough time to arrange their schedules to see their clients as well as attend the interviews. The institutions made arrangements for the services to be continued while the lay

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counsellors were interviewed. Before the tape recorder was used, the lay counsellors were asked if they agreed to its use. All the lay counsellors were asked the same questions in the same order. The questions were in English and translated to Xitsonga and Northern Sotho. Interviews were conducted in November. Observational sessions were conducted in December 2010 and January 2011.

2.5.2 Field Notes

Field notes were also used as the method to collect information. In order to avoid trial and error during the interviews, to identify errors in the interview schedule and adjust the order of questions, the researcher discussed the interview schedule with her promoter who is experienced in qualitative research methods. The schedule was tested with groups in the district who were not part of the sample of the study. Field notes were taken to have a written account of the information obtained, observations made of surrounding and the lay counsellors. What the researcher heard, saw, experienced, and thought about in the course of the interviews. The field notes included thoughts on emotions, preconceptions, expectations and prejudices as they were important for the final product. Observations and interpretations were kept distinct (de Vos *et al.*, 2001: 298).

The researcher used field notes to describe her own reflections, feelings, ideas, interpretations of all the events related to lay counsellors competence, challenges and recommendation they made. A field diary was used to record daily schedules and interviews as well as direct quotations from people in the setting that the researcher thought might be useful later when she reflected on the study. Transcripts of the tape recorded interviews were made on a daily basis after interviews and notes had been written, data encoded, themes identified and data analysed. This was done to analyse the competence of lay counsellors and explore the challenges they experienced with the aim of developing strategies to enhance their competence in implementing the VCT programme.

2.5.3 Observational data collection methods (see Addendum 4)

The checklist used in the research was adopted from UNAIDS tools for evaluating VCT (2000a:20) to check lay counsellor's counselling competence and the processes they used during counselling sessions. The observational checklist is qualitative research in order for

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the researcher to observe and record participants' behaviour and actions as well the way in which they interacted with their environment and the people around them (Brink 2006: 151). The checklist assisted the researcher to obtain a detailed description of lay counsellors' competence in implementing the VCT programmes. Lay counsellors were visited in the health facilities where they worked. Facility managers were informed of the time and dates of the interview in advance. Furthermore, field notes were taken in order to capture the behaviour of all participants and to record how they interacted in their working contexts when they implemented the VCT programmes. Permission was sought from the clients if they were comfortable being counselled when there is another person. The lay counsellors explained to the clients the purpose of the researcher being present during the counselling sessions. No client refused to be counselled after the explanation. Recording of checklist was done. The researcher conducted the observations. Lay counsellors knew that they were observed.

2.5.4 Pilot study

A pilot study is a small experiment, designed to test the logistics and gather information prior to the implementation of a large study so that the quality and efficiency of a large study can be improved. By performing a pilot study problems can be recognised early and information can be obtained that can lead to improving the large study. Problems in deficiencies in the design and proposed procedure can be addressed before the large study is carried out. In this way resources that could have expended on the larger study can be saved if it is found that there are deficiencies in the design (Altman, Burton, Cuthil, Festing, Hutton & Playle 2006:1).

In this research, the pilot study was conducted with 10 lay counsellors in May 2010. Data collection methods used in the research included focus group discussions, individual interviews, using a semi -structured interview guide, and an observational checklist to observe lay counsellors as they conducted counselling sessions. Two lay counsellors were interviewed, two were observed as they conducted counselling sessions. The focus group discussion was conducted with five lay counsellors. The data collection tools were written in English. A voice recorder was used during the focus group discussions and individual interviews to record the conversations. The individual interviews and observation sessions each took an hour, while the focus group discussions took one hour and thirty minutes.

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The semi-structured interview guide and the checklist mentioned above were piloted with 10 participants in the Greater Maruleng sub-district, an area that was not included in the main study. Kodumela is the organization like CRP that trains and supervises lay counsellors in the Maruleng sub-district. Permission was obtained from the organisation to interview the lay counsellors. Permission was further sought from the participants to use the tape recorder. After the interview data was arranged according to the following themes: competent, most competent, just competent, less competent and not competent. The data obtained from the second research tool was also arranged according to themes, namely, challenges that the lay counsellors experience with clients, the environment, and with health professionals.

2.6 DATA ANALYSIS

2.6.1 Qualitative data analysis

In this study, data was collected from focus group discussions and individual interviews using a tape recorder. The recordings were transcribed verbatim. The field notes that included observations made by the researcher during the individual and focus group discussions were analysed is it simultaneously together with the transcribed data.

Tesch's inductive, descriptive coding technique Cresswell was used. The steps below are recommended to facilitate the coding process (in Cresswell 1994:155-156).

1. The co-coder, who is a qualitative research expert, obtains a sense of the whole by reading through the transcriptions carefully. Ideas that come to mind are jotted down.
2. The co-coder selects one interview, for example the shortest, the one at the top of the pile, and the most interesting one, and goes through them by asking: "What is this all about?" while he/she thinks about the underlying meaning in the information. Again any thoughts that come to mind are jotted down in the margin.
3. When the co-coder has completed this task for several respondents, a list is made of all the identified topics. Similar topics were clustered together and formed into columns that are arranged into major topics, unique topics and leftovers.
4. The co-coder takes the list and returns to the data. The topics are abbreviated as codes and the codes written next to the appropriate segments of the text.

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5. The co-coder decides on the most descriptive wording for each of the topics and groups them into themes, reducing the total list of themes by grouping together related topics. Lines are drawn between themes to show interrelationships. The co-coder tries to see whether new themes and sub-themes emerge.
6. The co-coder makes a final decision on the abbreviations for each theme and sub-theme and places them in the table according their importance.
7. The data belonging to each theme are assembled in one column and a preliminary analysis is performed which is followed by a meeting between the researcher and co-coder to reach consensus on the themes and sub-themes that each one has identified.

The researcher followed the process outlined above. She first transcribed the data and studied the field notes. This assisted her to understand and learn about the data. The data was organised into a meaningful format. Patterns, themes and similarities were identified and the meaning of each answer described. The responses were read several times while the researcher constantly thought about the similarities and grouped them to distinct categories. A copy of the original data was kept for reference purposes, the themes and patterns were described, and direct quotes were used as examples in a discussion of the findings (Walsh, 2001:85:90; de Vos, 2001: 334:338; Burns & Grove, 2009: 557).

The themes identified from the interviews included the following: lay counsellors' competence related to counselling and testing processes; lay counsellors' perceptions regarding the implementation of the VCT programmes; lay counsellors views regarding the strategies developed to improve their competence.

2.6.2 Quantitative data analysis

The data obtained through the checklist from the observation was analysed quantitatively, using the SPSS Version 15 to obtain frequency distributions and percentages. The data was coded and analysed quantitatively and are presented in the form of tables in chapter 3 of this study.

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2.7 MEASURES OF TRUSTWORTHINESS

To validate the research methodology, measures to ensure the credibility, dependability, transferability and applicability were applied (Polit & Hungler, 1995:362).

2.7.1 Credibility

Brink (1996: 124) refers to credibility as internal validity. In order to ensure credibility, the researcher asked herself the following questions: 'Are the findings credible with regard to the people I am studying?' She considered her readers when she asked herself 'Do I have an authentic portrait of what I am looking for?' The researcher further endeavoured to ensure credibility by allocating sufficient time to collecting data. This meant that she had the time to learn from the participants, to test any misinformation and distorted perceptions, and to build trust between her and the participants. Researcher credibility was thus ensured by the extended engagement with participants over a period of three months. Also, during the individual interviews, participants were allowed to describe their experiences with regard to the phenomena until data saturation had occurred.

Triangulation of data collection methods was ensured because semi-structured individual interviews, focus group discussions and observation sessions were conducted. All the semi-structured individual interviews and focus group discussions were captured on a voice recorder (Babbie and Mouton, 2009:276). As mentioned above, both qualitative and quantitative research methods were used. Persistent observation and deliberate attempts on the part of the researcher to understand the views of the participants implementing the VCT programme enhanced the credibility of the data collection process. The semi-structured individual interviews and focus interview sessions were conducted to assist the researcher to understand lived experiences of the lay counsellors. In this study the use of different data collection methods namely: Semi structured interviews, structured checklist and field notes to cross check the collected data. The researcher posed questions to facilitate interaction between the participants and herself.

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2.7.2 Transferability

Transferability refers to the degree to which the findings of research can be applied to other contexts and settings or with other participants or groups. In this study the researcher presented the findings with rich descriptions of the phenomena studied in Chapter 3. The researcher collected sufficient detailed data in the natural setting of the participants, in other words in health facilities in the Mopani District of Limpopo Province to allow judgment about transferability to be made by the reader. In this study purposive sampling was applied. The researcher purposively selected locations and participants that differed from one another in order to maximise the range of specific information that could be obtained (Mouton, 2001:207, Polit & Hungler, 1995: 362).

2.7.3 Dependability

Dependability refers to the stability of findings over time and conformability refers to the internal coherence of data in relation to the findings, the interpretation of those findings and the recommendations made based on the findings (Polit & Hungler, 1995:362). Brink (1996:125) as well as Babbie and Mouton (2009:278) describe the concept of dependability as the consistency of the research finding in qualitative study.

2.7.4 Conformability

Conformability and reliability is the degree to which the findings are a product of the focus of the inquiry and not of the bias of the researcher (Babbie and Mouton, 2009: 278). In this study conformability was tested through the involvement of an experienced supervisor who, as an independent coder analysed the transcripts, reviewed the raw data and written field notes, and listened to the tape recorded data.

2.8 ETHICAL CONSIDERATION

Ethical clearance was requested from the Research Ethics Committee of the Faculty of Health Sciences of the University of Venda. Once the ethical clearance had been granted, it was submitted together with the research proposal to the Research Ethics Committee of the Limpopo Department of Health and Social Development. The researcher wrote a letter to the

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senior district manager of the Department of Health and Social Development of the Mopani District asking permission to use lay counsellors based in the district health facilities. The researcher gained trust by establishing on-going rapport with the lay counsellors. The relationship facilitated data collection (Muller, 2012:69). de Vos et al (2001:257) state that if preparation to collect data has been done properly and if background information about the nature of the research field has been obtained, the researcher will be confident and will have received guidance on how to approach the participants in the field.

2.8.1 The quality of the research

In this study, the researcher demonstrated accountability and ability to execute the research process by adhering to the highest possible standards of research planning, implementation, evaluation and reporting. The results and recommendations of the study will be presented to the Limpopo Department of Health and Social Development Ethics Committee. The researcher was supervised by two professors who are qualified research specialists from the University of Venda.

Quality was ensured by writing an acceptable research proposal that was submitted to the Ethics Committee of the University of Venda and to the Limpopo Province Department of Health and Social Development Research Committee for approval. The research was conducted after permission had been granted. The researcher undertook to make available the contact details of the participants in case questions regarding the research report arose.

2.8.2 Anonymity and confidentiality

The researcher undertook to protect the anonymity and confidentiality of the participants and of the data collected during the study and after it had been completed. The researcher made sure that the anonymity of any person or institution was protected in the report by ensuring that it would not be possible to trace any data to a particular person or institution. The information might have had names attached to it but the researcher held these names in confidence, keeping them secret to the public. The researcher guarded against divulging or making information available to any other person and protected any information provided by the participants. The information provided by participants was treated as confidential.

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Information obtained from participants was not shared with others without the authority of the participants (Burns & Grove, 2009:344; Brink, 1996:51; Newman, 2006: 139).

2.8.3 Right to self–determination

This principle means that individuals have the right to decide voluntarily whether to participate in a study or not without the risk of penalty or prejudicial treatment. Anonymity refers to the act of keeping individuals nameless in relation to their participation in the research. Information regarding the fact that they have participated in a study should not be available to anyone beyond the immediate research team. Individuals have the right to withdraw from a study at any time, or refuse to give information or to ask for clarification about the purpose of study (Brink, 1996:38). Informed consent was obtained from the participants and relevant authorities. Permission to use a tape recorder was obtained. Transparency was upheld in terms of the objectives of the research, the type of data collected, the methods of data collection and possible benefits to the authorities and participants. There was no victimisation of individuals who refused to participate in the research or who withdrew during the course of the study.

In this study the lay counsellors were given latitude to express their views about their competence and the challenges they experienced when they implemented the VCT programme without any pressure from the researcher.

2.9 LITERATURE CONTROL

One of the main reasons for conducting a qualitative study was to describe the perception of the lay counsellors as a phenomenon that has not been written about or studied, and the researcher wanted to listen to informants and build a picture based on their ideas (Cresswell, 1994: 21). Literature review in qualitative research helps to determine what is already known about the topic to be studied so that a comprehensive picture of the state of knowledge on the topic can be obtained. The literature is presented in the discussion of the research results at the end of each category as a basis for comparing and contrasting findings of the study with existing literature.

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2.10 DEVELOPMENT AND VALIDATION OF THE STRATEGIES

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The development of the strategies to enhance the competence of the lay counsellors was aligned to the principles of empowerment by Guillory and Galindo described in chapter 1 of this study. SWOT analysis was used as a technique to analyse the environment in which the lay counsellors implement the VCT programme.

The newly-developed strategies were validated by facility managers and the lay counsellors themselves. The strategies were given to the five facility managers and five lay counsellors to evaluate and validate. Qualitative methods were conducted to collected data. The researcher then made appointments and interviewed managers and lay counsellors in the facilities, and used an interview guide in this process.

These structured face-to-face interviews were conducted for about 45 minutes with the health professionals in their respective offices. The aim of the interviews was to evaluate and validate the strategies that had been developed to enhance the competence of lay counsellors who implemented the VCT programme in the Mopani District of Limpopo Province. It was necessary to include the facility managers as they were officers in charge of the health facilities, and the lay counsellors' work was under their supervision, they also offered support, mentoring, monitoring and evaluation.

2.11 SUMMARY

In this chapter, qualitative and quantitative descriptive research designs specific to lay counsellors was described. A sample was selected from the total population of lay counsellors implementing VCT programmes in the Mopani District. After data analysis had been completed the major concepts were synthesised and the strategies for enhancing the competence of lay counsellors were conceptualised. It is assumed that the developed strategies will assist the health professionals and lay counsellors to enhance the competence of the lay counsellors implementing VCT in the health facilities of Mopani District of Limpopo Province.

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DISCUSSION OF RESEARCH FINDINGS

3.1. INTRODUCTION

Chapter 2 of this study dealt with a detailed description of the research design and methods of data collection. This chapter presents a discussion of the results of the focus group discussions, individual interviews and the observations of lay counsellors involved in HIV and AIDS counselling using a checklist.

Data were collected until data saturation was reached at the clinics, health centres and hospitals where VCT is provided by lay counsellors. The data were gained during the qualitative research using focus group discussions; semi-structured interviews using an interview tool. The same interview schedule and questions were used for both the focus group discussions and the individual interviews. The interview schedule consisted of the following questions:

- How competent are the Lay counsellors in implementing the VCT programme?
- What challenges were perceived regarding the implementation of the lay counsellors' programme?
- What strategies could be employed to enhance the competence of the lay counsellors?
- How effective could the strategies developed be in enhancing the competence of lay counsellors?

The data gained from the individual interviews using the check lists were used as the basis of the focus group discussions. The data gained from the focus group discussions data served as the basis of the data analysis.

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3.2 RESEARCH RESULTS

3.2.1 Competence of lay counsellors

Table 3.1 presents the findings regarding the competence of lay counsellors, using the observational checklist.

Table 3.1: The competence of lay counsellors N=33

No	Counselling skills and techniques/communication	Responses			
A	Establishes a therapeutic and supportive environment	Yes	%	No	%
1	Creates a comfortable external environment	25	76	8	24
2	Uses culturally appropriate greetings and gestures that convey respect and caring	28	85	5	15
3	Offers seats to clients (if available)	25	76	8	24
4	Uses appropriate body language and tone of voice	23	70	10	30
5	Provides a comfortable, trusting atmosphere for clients to ask questions; is welcoming/ and displays openness/acceptance/warmth	22	69	11	33
6	Responds appropriately to questions and concerns	15	45	18	55
7	Maintains client privacy and confidentiality	26	79	7	21
B	**Use of active listening**				
8	Looks at the client when speaking and maintains eye contact	11	33	22	67
9	Has attentive body language and facial expression	26	79	7	21
10	Maintain minimal continuous use of eye contact	14	35	19	65
11	Uses occasional non-verbal gestures such as nods or touches to acknowledge client.	20	61	13	52
12	Uses verbal cues such as "Yes" or "OK"	16	49	17	52
C	**Use of effective questioning**				
13	Uses open ended questions to elicit information	26	79	7	21
14	Asks relevant questions	16	48	17	52
15	Waits for answers rather than speaking immediately	17	52	16	48
16	Refers statements back to client for information	18	56	15	44
	Respond to questions appropriately	18	56	15	44
D	**Messages/ Giving information**				
17	Gives positive messages	28	85	5	15
18	Provides factual information to the client without judgment	20	61	13	39
19	Guides client to prioritise	10	30	23	70
20	Helps client to identify steps of action for identified concerns	14	42	19	58
21	Comments on client's challenges and strengths	5	15	28	85
E	**Pre- test counselling / information sharing and gathering**				
22	Introduces self	26	79	7	21
23	Asks client to introduce self	22	67	11	33
24	Assures client of confidentiality	24	73	9	27
25	Asks client why she/he came to voluntary counselling and testing (VCT)?	24	73	9	29
26	Asks client what she/he knows about HIV and how it is transmitted	14	12	19	58
27	Assesses risk profile of client	19	58	14	42

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Province supported by direct quotes from participants follows below. The direct quotes represent the experiences of the participants. The descriptions focused on integrating a consolidated picture of similar and unique experiences of the categories, sub-categories and descriptions reflecting the experiences of lay counsellors implementing voluntary counselling and testing (VCT) in the health facilities of the Mopani District, Limpopo Province.

Table: 3.2 Competence of the lay counsellors during FGD and individual interviews

Category	Sub- Categories	Descriptions
Lay counsellors' competence related to counselling skills and processes	Utilisation of effective verbal communication skills	Lay counsellors welcome, greet and introduce themselves to the clients. Lay counsellors reassure clients' privacy and confidentiality, so that they are free to talk, develop trust. Lay counsellors make use of appropriate language so that there is effective communication and understanding.
	Use of effective non-verbal communication.	Lay counsellors use appropriate language and body signs to communicate with the clients. Lay counsellors do not judge their clients as this might hamper communication. Lay counsellors are sincere when talking to the clients and they tell the truth. If they do not know something they mention it. Lay counsellors attend to their clients physically. They show their clients that they are listening to them. Lay counsellors attend to their clients psychologically by letting them talk and do not interrupt them during discussions.
	Lay counsellors show positive attitudes to their clients.	Lay counsellors show respect for their clients. Lay counsellors show patience towards their clients Lay counsellors are non-judgemental towards their clients.
	Lay counsellors make use of effective counselling skills and processes	Lay counsellors are competent in the use of counselling skills and processes /not competent Lay counsellors conduct pre- and post-test counselling Sessions and give positive and negative feedback to clients. Lay counsellors conduct pre-test counselling/information sharing sessions.

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	Lay counsellors are trained/empowered to share information on HIV, PMTCT ARV and CD4 cell blood count	Lay counsellors are trained in VCT, PMTCT, ARV and couple counselling and they are able to share relevant information with the clients.
Category 2		
Lay counsellors' perceptions regarding implementation of the VCT programme .	Challenges with regard to clients	Lay counsellors experience challenges with clients who deny their HIV status, default on treatment, do not come to collect their CD4 cell counts, and HIV positive couples who do not want to use condoms/practise safe sex
	Challenges related to the Environment	Lay counsellors experience challenges with the use of small counselling rooms, shared counselling rooms or no specific counselling rooms.
	Challenges with regard to health professionals	Lay counsellors experience challenges with regard to health professionals who delay coming to conduct HIV tests after pre-test counselling; who do not respect the counselling sessions and come into the counselling room during counselling. Lay counsellors experience a shortage of health professionals who do not have time for them during testing and the interpretation of the results due to other work assignments.
	Challenges with regard to stipends.	Lay counsellors receive meagre stipends. Lay counsellors want to be absorbed by the government so that their wages will improve. Lay counsellors are committed to their task and love to perform their work even if is very stressful Lay counsellors assist health workers by relieving them of the pressure of having too much work to do.
Category 3		
Lay counsellors' views regarding strategies that could improve their competence	Lay counsellors need empowerment through trainings/workshops to be competent	Lay counsellors need empowerment by attending updates or in-service training on VCT PMTCT ARV and couple counselling
	Lay counsellors need pamphlet, manuals for referral	Pamphlets, manual books and protocol to read and in order to improve their knowledge and competence
	Lay counsellors need support mentoring and supervision regularly to be competent	Regular support mentoring and supervision could improve their competence
	Lay counsellors need	Regular monitoring and evaluation of the work

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	regular monitoring and evaluation to improve their competence	of lay counsellors could empower them
	Lay counsellors want to conduct HIV test	If we can test time will be saved, clients will not wait long hours, workload for will be reduce.
	Need networking/meeting with others to be competent	Meeting with other lay counsellors from other districts, provinces could also empower them. lay counsellors will learn from their colleagues

Question1: How competent are you in implementing VCT programme?

In this category the following sub-categories were identified, namely: Lay counsellors' use of effective communication skills; Lay counsellors' use of effective non-verbal communication skills; Lay counsellor's demonstration of positive attitudes to their clients; Lay counsellors use of effective counselling skills and counselling processes. Each sub-category will be discussed in detail separately below.

3.2.1.1 Lay counsellors' use of effective verbal communication skills

The study revealed that participants make use of verbal communication skills to welcome, greet and introduce themselves to the clients and ask the clients to introduce themselves. This enables the clients to know who is helping them and the counsellor knows the client so that they can address the client by his/her name and offer the client a seat.

The study revealed that the majority of the participants greet and welcome the clients and invite them to sit down; they reassure their clients of confidentiality and privacy. Similarly in the individual interviews participants indicated that they welcome their clients, introduce themselves and offer them a seat. During a focus group discussion one female participant mentioned the following: *I welcome the client, offer him/her to a seat. I then introduce myself and ask the client to introduce himself/herself. When the client is settled, I emphasise that what we discuss in that particular room will be known to me and him/her and no other person it is our secret.*

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The participant was supported by an overwhelming majority. During the individual interview, one female participant said: *I promise my clients that the discussion will be between them and me, and that no other person will know about the discussions except the professional nurse who conducts the tests. I discuss shared confidentiality with the client.*

The findings from the use of the observational checklist, as shown in Table 3.3 match and not match the findings obtained from the focus group discussions and the individual interviews.

Table 3.3: Verbal Communication Skills.

N=33				
	No	%	No	%
Establish therapeutic environment/ Verbal communication skills				
Creates comfortable external environment	25	76	8	24
Uses culturally appropriate greetings and gestures that convey respect and caring	28	85	5	15
Offers seat (if available)	25	76	8	24
Uses appropriate body language and tone of voice	23	70	10	30
Provides comfortable, trusting atmosphere for clients to ask questions, is welcoming/shows openness/acceptance/warmth.	22	67	11	33
Maintains client privacy and confidentiality	26	79	7	21

Table 3.3 indicates that 76 % of the participants were observed greeting clients using culturally appropriate gestures that conveyed respect and caring. Twenty four per cent per cent of the participants were observed to be not competently welcoming when meeting their clients; they did not tell their clients that they were welcome or invite them to enter in a confident and competent manner nor did they make eye contact with the clients to show that they cared and that the clients were welcome.

Seventy six per cent of the participants were observed offering clients seats; 24% were not observed offering seats to their clients. This percentage is significantly high and it implies that the counsellors did not welcome their clients properly, and this might affect further communication with the client. Seventy per cent of the participants used appropriate language and an acceptable tone of voice when communicating with clients while 30% were not

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observed using appropriate language and tone of voice when communicating with clients. Use of tone in counselling is important as harsh loud voice might be interpreted as being angry. Sixty seven per cent of the participants provided a comfortable trusting atmosphere for patient to ask question; 33% of the participants did not. Other health workers came into the counselling room while the counselling session was in progress. (79%) of the participants maintained privacy and confidentiality, while 21% of the participants were not observed maintaining privacy and confidentiality. To gain a client's confidence with regard to privacy is critical in HIV counselling. This will make clients feel that their secrets will be kept safe and they will feel free to talk and share their secrets with someone they trust.

According to DOH training manual for lay counsellors, the counsellors should welcome their clients, introduce themselves and offer seats in a friendly manner (DOH 2001:68). The manual further stresses the view that the initial contact with the client is very important as it determines the future relationship with the client. It is the first impression the counsellors make on clients that determines the success or failure of future communication. The attitude and the behaviour of the counsellor will make the client decide whether she/he can continue with the counselling in future. A counselling relationship is based on genuine trust between the practitioner and the client concerned. The counsellor should display characteristics such as welcoming the person warmly, introducing themselves and assuring the client of confidentiality (DOH 2001:93, UNAIDS 2001:13). The National Training Guidelines of the Government of Pakistan and UNAIDS by Landi and Bokhari (2001:13) indicated that for a successful VCT session, counsellors should welcome, greet and introduce themselves to their clients, the counsellors should emphasise confidentiality and anonymity and explain the counselling process to the clients.

Concerning confidentiality, the WHO guidelines (1990:19) for counselling of HIV clients, indicated that given the possibility that the client could be discriminated against and ostracised, clients who are diagnosed as HIV positive, it is extremely important that confidentiality is guaranteed. The counselling relationship must be built on the understanding that whatever is discussed will remain a private issue until the client decides otherwise. The guidelines further indicated that testing for HIV infection should be organised in a way that minimises the possibility of the disclosure of information or that people who are HIV positive will suffer discrimination.

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The National Training Guidelines of the Government of Pakistan and the UNAIDS (2001:13) Guidelines on Voluntary Counselling and Testing stresses that confidentiality is one of the most important factors in the relationship between the counsellor and the client and increases the likelihood that the client will act on the information provided. At the beginning of the counselling session the client should be clearly briefed about the measures to keep his/her HIV status or any linked information confidential. The guidelines further indicated that the counsellors should use language that the client can understand, and should avoid using technical jargon. Counsellors_should avoid using judgmental language and should support their explanations with facts. (Landi & Bokhari 2001:6)

Evian (2000:270) further shares the same view that clients who are ensured of confidentiality will be free to talk. Evian (2000:270) further mentioned that health workers should provide effective counselling and should be confidential, professional and non-judgmental. AIDSMAP (2005) view the root causes of stigma as fear that HIV can be transmitted through ordinary daily interaction with people living with HIV and AIDS. Fear of transmission leads directly to stigma such as avoidance or isolation of people living with HIV and AIDS. People believe that Illness is the results of some transgression or sin. HIV infected people are associated with behaviours that are illegal or society sensitive.

van Dyk and van Dyk (2003:119-120) in their study which investigated participants' attitudes towards VCT identify erroneous perceptions of VCT and mention the various reasons why people in South Africa may resist the VCT programme. The researchers found that 67.2% of the respondents said they would not go to the nearest clinic for counselling and testing, but to their own doctors. Thirty-two per cent of the respondents said they would go to clinics or doctors where nobody would know them; 50% of the participants said they would definitely go where nobody would know them and 30% feared that confidentiality would not be observed at the nearby clinic (Pfaff and de Beer (2011:17). A study about expanding access to HIV counselling and testing (HCT) to schools conducted by the researcher in Kwa Zulu Natal, revealed that young people are reluctant to use health care facilities to access HCT. The reasons they gave were: the distances to the health care facilities, the waiting time at the facilities and issues of confidentiality. Offering VCT at schools was feasible and acceptable as part of a package for increasing the provision of HIV care to young people. The reasons given by the participants concerning their expressed preference for going to their own clinics or doctors for VCT were related to trust in the health services close to their homes. The clients

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said they feared there could be a lack of confidentiality at the nearby clinic and that it is better to be tested by people who do not know them. This has cost implications as the clients would have to pay for transport and their own doctor's fees far from their homes. In the current study only 50% of the participants ensured clients of confidentiality; this may have implications for the prevention of HIV and AIDS in the district.

Concerning the language barrier van Dyk (2001:235) stresses the point that a language barrier between counsellors and clients poses a problem especially in South Africa where there are 11 official languages. There is always not enough time to train counsellors to address clients in their own language. Counsellors who are not able to speak the language of the client are often forced to use interpreters. Van Dyk warns that counsellors should be aware that the presence of a third person in counselling venue will seriously affect privacy and confidentiality. Participants in the current study did not have to use interpreters as they were able to speak the language of their clients.

Ismail and Ali (2009:192) share the view that counsellors should welcome, greet and introduce themselves to their clients. The research was conducted in Addis Ababa on the quality of antenatal-based HIV counselling and testing as an intervention for PMTCT. Counsellors' communication skills with the mother were observed. The results of the study revealed that 45% of the participants greeted and introduced themselves to the clients at the beginning of the session. In 60% of the sessions counsellors actively and supportively listened to clients. In the current study results revealed that 60% of the participants welcomed, greeted and introduced themselves to their clients, and 40% did not; 40% is a significant percentage and could have implications for the counselling services that the counsellors provide.

A study conducted by Mqimeti, Pengpid and Peltzer (2011:151) in the Greater Tzaneen Municipality of the Mopani District in Limpopo Province, evaluated counsellors' accessibility and effectiveness in counselling and HIV testing as well as the barriers in the implementation of the VCT programme. The result indicated that 96.6% of the counsellors were confident or very comfortable in providing VCT services.

Another study conducted in the Capricorn district of Limpopo Province by Malema, Malaka and Mothiba (2010:18) about the experiences of lay counsellors who provide VCT for PMTCT and AIDS revealed that the counsellor learned one of the qualities of an effective

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counsellor is to address clients by their names. A study conducted in Nigeria by Omawale , Faturoti and Omolase (2010:309-314) revealed that the majority of participants (87%) said they would support VCT if the results were confidential, while less than 30% would undergo testing if the results were to be shared with partners or relatives. This showed that confidentiality is important to the clients and that if it is not maintained, people would not come for counselling and testing; VCT would fail as the strategy for preventing HIV and AIDS and as an entry point to access treatment and care. Aman and Ahmed (2010:1028) maintain that counselling education and practice is very important in producing quality counsellors. A good quality counsellor should have theoretical and practical knowledge for effective counselling of clients.

Makhunga-Ramfolo, Chidarekire, Farirai and Matji (2011:6) state that although HCT is a confidential process, clients should be encouraged to disclose their status to their sexual partners. Counsellors should discuss the concept of shared confidentiality and that health care workers who contribute to the care of the clients may have access to their results and that this should be discussed with the client.

Sprague, Sprague and Simon (2011:17), conducted a survey in Kenya and Zambia about the current state of HIV related stigma and discrimination in the workplace. The authors view stigma and discrimination as substantial barriers to the prevention of HIV transmission and the treatment, care and support of clients. The main barrier to counselling services is a lack of confidentiality. They further mention that since people rely on employment for their livelihood, workplace responses to the HIV status of clients can be particularly powerful influences on attitude and behaviour towards HIV positive clients. The results revealed that in Kenya 68% of women mentioned that they were subjected to discrimination at work and in Zambia 57% of women mentioned that they were denied promotion because of their HIV positive status. These are significant percentages of PLWA who are discriminated against due to lack of confidentiality (Sparague *et al.*, 2011; 17).

Perretti-Watel, Spire, Obadia, and Maotti (2007:2) conducted a study in France about discrimination against HIV infected people and the spread of HIV. The authors found that 12% of PLWHIV reported that they had experienced discrimination from relatives, 24% reported that they had experienced discrimination in their closed social environment and 27% of the respondents experienced discrimination from health care providers. Legal measures

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have been introduced to protect patients with chronic illness, including HIV and AIDS, from discrimination in the labour and insurance markets.

HIV stigma is considered a barrier to effective HIV prevention and treatment programmes. HIV stigma is blamed for a low uptake and poor adherence to prevention and treatment services. Focusing attention on the fundamental prevention of HIV and maintaining adherence to antiretroviral therapy would make it possible to assess the effects of the stigma on both general and PLWHIV (Mahajan, Slays, Patel, Remin, Ortis, Szekeres and Coates 2008:7).

A study conducted in Cape Town by Kalichman and Simbayi (2003:442) about HIV testing and attitude, AIDS stigma and VCT, found that AIDS related stigma is another factor that probably influences seeking VCT. Stigmatising beliefs about AIDS and the associated fear of discrimination could influence the decision to seek HIV testing and HIV treatment services.

A base line study conducted in three hospitals in India by Mahendra, Gilborn, George, Samson, Mudai, Jadau, Gupta, Bharat and Daly (2009:2) revealed that health care workers discriminated against and stigmatised patient. The common manifestation of discrimination and stigma included judgemental and moralistic attitudes among staff, segregation and labelling of patients, excessive use of barrier precautions when treating patients, un-concerted HIV testing; inadequate pre- and post-test counselling, withholding of HIV test results from the patient and the disclosure of the test results to family and friends. Misinformation and judgemental attitudes among all ranks of health care workers could foster stigma and fear of differential treatment in PLWA. Counsellors in the study are trained in understanding how HIV is contracted and educate their clients to be aware of stigma and discrimination against PLWA

Hansen and Groce (2003:2875) in their study conducted in Cuba maintain that there is a relationship between HIV related stigma and prevention and treatment programmes. HIV stigma is considered a barrier to effective prevention and treatment programmes. HIV stigma is blamed for low uptake and poor adherence to prevention and treatment services. People living with HIV who experienced stigma or discrimination were less likely to disclose their HIV status to their sexual partners and non-disclosure is associated with transmission behaviour.

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Wynia (2006:6) in the study titled, *Routine Screening, Informed Consent and Stigma and the Waning of HIV Exceptionalism* found that HIV screening should be done routinely because of the continuous stigma associated with the infection. The author believes that the fact that HIV screening is treated so differently probably contributes to the continuous presence of stigma. Routine testing could be associated with declining stigmatisation. The stigma of syphilis waned when syphilis screening became widespread.

Psychological factors associated with the uptake of voluntary counselling and testing for HIV among men who have sex with men in Hong Kong by Gu, Lau and Tsui (2011:275:282) revealed that men having sex with men (MSM) fear discrimination related to HIV infection. Respondents with better knowledge were more likely to take the test. The perceived fear of contracting HIV was associated with a lower likelihood of VCT uptake. Lay counsellors in the study are taught not to discriminate against clients because of their sexual orientation and they therefore treat their clients equally.

According to Cameron (2010:6) internal stigmatisation is related to the fear of discrimination or hostile treatment by peers or colleagues, as well as the dread of other actions. It is something very subtle and therefore difficult to confront, is often stronger than a cognitive appreciation that friends and family and colleagues will offer love and is stronger than the knowledge that treatment is now readily available. It ultimately proves stronger than the capacity to make life choices, because it prevents clients from taking action, resulting in postponement, avoidance and death.

In a study conducted among adults and youths in Zambia, McCauley (2004:5) found that individuals who are scheduled to receive VCT either at the local clinic or at an alternative location, preferred to be tested at an alternative clinic rather than at the local clinic. The result also indicated that a high percentage of youth were willing to be tested if they were offered testing in a private setting; this showed that confidentiality is more important to the individuals because they opted to be tested in a private place not known to protect themselves from discrimination and stigma. HIV related stigma is compounded, because affected individuals come from already stigmatised groups. The stigmatised patients often blame themselves. Lay counsellors assist clients to understand their situation and accept it.

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In a study conducted in Northern Tanzania, de Paoli, Manongi and Klepp (2004:414), identified factors associated with the expressed willingness of pregnant women to accept VCT. Results revealed that the social stigma was perceived as a factor related to the willingness to be tested; women would hide the disease due to social consequences. Women stressed the importance of keeping their HIV status confidential. They did not want to infect their unborn children, and therefore felt confident that they would carry out an alternative feeding procedure. Women thought VCT was a good initiative; they perceived it that it would reduce the risk of infecting the unborn child.

However women had misconceptions about routes of transmission. More than half (66 %) believed that HIV could be transmitted through kissing. Rural women were more likely than urban women to believe that HIV could be transmitted by touching an infected person. Barriers to VCT were related to confidentiality and partner involvement. Women in the research find it difficult to make a transition from accepting VCT and accepting HIV status and finding effective and culturally appropriate coping mechanisms within their families and communities. The authors further mentioned that sharing the results with the partner may cause women to be blamed and rejected. (de Pauli *et al.*, 2004:419).

COMMENTS OF LAY COUSELLORS

LC 12: *I welcome the client, offer the client seat, then introduce myself, using the language that the client understands by the client and ask the client to introduce him/herself when the client is settled, I say to the client that what we going to discuss in this room it will be known to me and you and no other person, it is our secret.*

LC 17: *During training we are taught how to communicate and relate to the client. We don't show serious looking faces. Serious looking faces will chase clients away, we put on a smiling face and accept the client as he/she is.*

LC 20: *We introduce ourselves and ask the client to introduce him/herself, before we start with counselling. We reassure start counselling. We discuss the issues of confidentiality, We let the client know about sharing confidentiality and promise the client that their information will be kept a secret, until the client decide otherwise.*

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LC 3: *We welcome the client and greet the clients and tell the clients they are welcome and give the client a good impression that you care about him/her; this builds the relationship and trust. First impressions last long.*

LC 8: *I promise my clients that the discussion will be between them and me "We don't share with anyone the HIV status of the client, no person will know about the discussions except the professional nurse who will come and conduct the test and take the CD4 cell blood, I discuss shared confidentiality with the client.*

LC 20: *I discuss confidentiality with my clients at the beginning of the session I promise them that the discussions in this counselling room will be between us. When I promise the client that no one will know about our conversation, the client becomes open and feels free and safe and opens up, then shares with me his/her problems. The client will have trust in us, and will come to us if they could realise that we keep their secret.*

LC 7: *We promise our clients that, we will not talk to anyone about what we discussed in the counselling room. We don't talk about people's issues when clients are HIV positive; we encourage clients to disclose the results to one they trust at home.*

LC 5*I: don't have a counselling room; it is difficult to maintain privacy because this room, is a duty room. I share it with other nurses. They have put their files in here, they come in at any time to get the files and other things; in the meantime we are disturbed.*

LC 2: *I discuss with the clients about the shared confidentiality. I tell clients before testing that the nurse will come and conduct the test since I am not allowed to conduct the test.*

LC 4: *The clients' records are kept in a safe cupboard that is locked to ensure their privacy and confidentiality.*

LC 12: *Clients become open to talk to us, when we promise them that, what we are going to discuss in the counselling room is between the two of us. I discuss with clients that disclosing the status is in the best interest of all, the client and the family.*

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LC 6: *When counselling, we close the door and write on the door" Please don't disturb" to ensure privacy and confidentiality.*

There were similarities in focus group discussions and individual interviews where the majority of the participants welcomed their clients, introduced themselves to the clients and asked the clients to introduce themselves, and offered clients seats. One participant said: *I welcome the client offer the clients a seat, then introduce myself and ask the client to introduce him/herself. When the client is settled, I say to the client that what we going to discuss in this room it will be known to me and you and no other person; it is our secret.* This was supported by one participant who said: *We welcome our clients to make them feel at home, introduce ourselves and ask the client to introduce him/herself so that I can call him/her by her/his name.* However, there were differences with observational sessions where many participants were observed not competently making use of verbal communication skills that could make the client feel welcome. However the majority of participants (60%) reassured their clients of confidentiality and privacy, and 40% did not. This is a significant percentage and could have implications in further counselling sessions with clients.

Literature supports the view that counsellors should welcome clients, introduce themselves and then offer them a seat (Ismail and Ali2009:192-193, Evian 2002:54 and van Dyk 2001:214). A significant amount of literature indicated that confidentiality is important to maintain in HIV and AIDS counselling to prevent the creation of a stigma and discrimination against the clients.

3.2.1.2 Lay counsellors use of effective non-verbal communication skills

The majority of the participants in the group discussions mentioned that they make use of non-verbal communication skills to counsel the clients. Very few participants during the individual interviews mentioned that they make use of non-verbal communication skills such as nodding, positive use of eye contacts and body movements to make the client feel that they are welcome and they are in the right place with the right person.

The majority of the participants mentioned during the focus groups interviews that they used body language such as nodding the head, a pleasant voice, looking at the client or being seated. The majority of the participants during individual interviews also mentioned that they

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used body language and facial expressions to communicate with the clients. One male participant during a focus group discussion mentioned: *We use minimal encouragers such as nodding the head and looking at the client.*

The majority of participants mentioned during focus groups interviews that they make use of active listening skills. Similarly the majority mentioned in individual interviews they used listening skills to communicate with clients. Participants indicated that skills such as listening make them competent in their work. Clients are able to see that they are being listened to, and that lay counsellors care about them.

One of the participants said during a focus group discussion: *We listen well to the client to hear what the client is saying; we listen to spoken and unspoken messages and capture the information in order to understand what the client is saying, as the client tells his/her story.* The participant was supported by the majority of the focus group participants. One female participant during an individual interview mentioned: *When you listen to your client and show that you care, the client will open up and even tell you private issues such as, 'At home I don't have food'' My child has just passed Grade 12, and I don't have money to take my child to school'. As a result you will be able to assist the client by referring the client to the social workers for help.*

Participants mentioned that they physically and psychologically attend to the clients showing the client that they care about them. Showing the client that he/she is accepted by the way you relate to him/her is important for future counselling sessions.

It was revealed during the focus group discussions that some of the participants mentioned that they attend to the clients physically and psychologically and during individual interviews some participants revealed that they attend to their client physically and psychologically. One female participant during the individual interviews said: *"We listen to our clients and do not interrupt the clients when they talk; this shows that we care, and the client will open up, because she/he can see there is someone who wants to listen to them.*

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Table 3.4 **Non-Verbal Communication Skills**

N=33	Yes		No	
Use of active listening /Non-verbal communication.	**No**	**%**	**No**	**%**
Look at the client when speaking and maintain eye contact	11	33	22	67
Has attentive body language and facial expression	26	79	7	21
Main tains minimal continuos eye contact	14	35	19	65
Uses occasional non-verbal gestures, such as nodding or touching, to acknowledge the patient	20	61	13	39
Use verbal cues such as "Yes' or "OK"	16	48	17	52

Table 3.4 indicates that 79 % of the participants were noted displaying attentive body language and facial expressions such as showing a happy face or welcoming the client with a smile. Twenty one per cent were noticeably not using non-verbal communication in a competent manner. Some participants (35%) were notably using minimal eye contact while talking to their clients. Almost half (47%) of the participants were notably not frequently using the non-verbal communication skills. In 33% of the sessions, participants were observed maintaining eye contact, while in 67% of the sessions participant did not. Participants were observed writing or looking through the window, others were answering cell phones while counselling. In many instances participants were observed being disturbed by other health workers coming into the consulting venue. In 61% of the sessions participants were observed using effective non-verbal gestures, such as nodding or touching, whilst 39% were not. During a significant percentage (47%) of sessions participants did not competently make use of non-verbal communication skills. It was observed that only 48% of the participants used verbal cues such as "Yes" "OK" and a significant percentage (52%) of the participants did not use verbal cues such as "Yes" "OK". The use of verbal cues is important in verbal communication as they indicate that the counsellors are listening and care about the client.

According to the HIV Counsellors' Training Manual non-verbal and attending skills play a very important role in HIV and AIDS counselling. Non-verbal communication complements verbal communication; it adds to what is said verbally. It can unconsciously display attitudes and feelings that are not being verbally communicated. To show attentiveness the counsellor should keep an open posture and keep arms and legs uncrossed. Listening and attending skills are both non-verbal and take place at the same time (DOH 2001:74). The manual stresses that counsellors should be aware of the importance of non-verbal communication in counselling

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for HIV and AIDS. The counsellor should welcome his/her client in a warm and friendly manner by showing a happy smiling face to make the client feel welcomed. The counsellor who is friendly and warm, is patient and a good listener would be able to facilitate effective counselling sessions. It is important for clients to experience acceptance and feelings of unconditional love. The manual further indicates that counsellors should sit squarely facing the client during counselling to show that they are attending to their clients fully. Counsellors should maintain an open posture keeping arms and legs uncrossed as a sign of openness and acceptance.

DOH (2001:74) mentions that concerning patience and acceptance, the Lay Counsellors' Training Manual stresses that lay counsellors should not interrupt the client but should listen when the client is speaking, and should take note of what the client says, how he/she is saying it, and should notice the posture, facial expression and tone of voice of the client to determine whether they are in agreement with what the client is saying. The counsellor should be able to listen to unsaid messages, and be able to assist the client. The manual further stresses that accepting the person, is the basic requirement of counselling. Clients who experience that they are accepted have a feeling of being understood, loved, cared for and respected.

COMMENTS OF LAY COUSELLORS

LC 14: *We use minimal encouragers such as nodding the head and looking at the client.*

LC 5: *We learned during training how to use minimal encouragers such as saying Mmm! or nodding of the head to encourage the client to talk.*

LC 12: *We make use of a good tone of voice when we communicate.*

LC 11: *I sit facing the client and give the client my full attention.*

LC 13: *When I counsel I don't look away from my clients I show attention.*

LC 2: *I present a happy face to my clients so that they feel accepted.*

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LC18: *I listen to the client carefully so that I can understand him/her very well. I listen to verbal and non-verbal messages of the client such as the body movement, facial expression, or voice tone.*

LC 2: *We learned the importance of listening skills during trainings; I use a lot of listening skill. It is the one that make us competent.*

LC 3: *I listen to the feeling and emotions associated with the experience and behaviour of the client.*

LC 5: *We listen to our clients and do not interrupt clients when they talk; this shows you care, and the client will open up, because she/he can see there is someone who wants to listen to them.*

LC 2: *If I listen actively, there will be no communication breakdown between us.*

LC 20: *We don't have problem communicating with the client; we can speak the languages spoken in this area.*

LC 19: *I use the language that the client understands. I am lucky I know how to communicate with all the local languages of the people in this area.*

LC 9: *I have counselled clients who are talking xi-Tsonga /Sesotho and Tshi-Venda coming to the counselling room, and I am able to communicate with them well. Those clients who speak English, I can also communicate with them too.*

LC12: *I had a client who was dumb and deaf and I could not communicate with him. It is important to learn the sign language. I referred the client to the social worker.*

LC 14: *I once had a client who cannot talk English and I cannot talk Shona. It was difficult to talk with the client.*

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LC 8 *I get distracted because, I don't have a specific counselling room I use the labour ward and when a patient in labour comes in, I have to move to find another place and this disturbs me as I have to start from the beginning.*

LC 20: *I sometimes keep silence for good. I do not hurry or rush the client but give the client enough time to think and respond.*

LC 19: *When you listen to the client the client will tell you even his/her darkest secrets.*

LC 20: *When I counsel, I sit facing the client, this makes the client relax and feel welcome If I am relaxed the client will be relaxed too. I don't sit on the edge of the chair; I sit facing the client and give the client my full attention.*

LC 6: *When we counsel we sit squarely with no barrier between the counsellor and the client; this shows that there is attention given to the client.*

Similar comments were made in other focus group discussions and in individual interviews. The majority of the participants mentioned that they actively listen to their client. Very few participants make use of physical and psychological attending behaviour such as non-verbal communication skills. In observational sessions, there were similarities and differences; between 35% and 40% of the participants used minimal eye contact, and did not look at the client when speaking, while more than half (60%) used attentive body language and facial expressions and occasional non-verbal gestures, such as nodding or touching, to acknowledge the client when counselling and 40% did not. A significant percentage of the participants were not competent in using non-verbal communication skills.

3.2.1.3 Lay counsellors' demonstration of positive attitudes to their clients

During focus group discussions the majority of participants mentioned that they display attitudes that are respectful non-judgemental and accepting of the clients. Similarly, during individual interviews the majority of participants mentioned that they show positive attitudes to their clients. One female participant mentioned during a focus group discussion that: *clients who feel that they are respected, quickly, open up and feel and trust the counsellor. Clients who are not respected and are shown that they are not worthy and that the counsellor doesn't*

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care about them will tell others not to use the service. This participant's view was supported by an overwhelming majority of the participants.

During the focus group discussion the majority of the participants mentioned that they show respect towards their clients. During individual interviews participants also mentioned that they show respect to their clients during counselling sessions. One of the participants in a focus group discussion mentioned that respect is the key to successful counselling. She said: *I treat my clients the same when clients tell me their problems, I accept them I don't say is because of your behaviour you are HIV positive, I don't judge client according to religion culture or tradition.*

The majority of participants mentioned during focus group discussions that they show patience toward their clients, while very few participants during individual interviews mentioned that they show patience towards their clients.

During a focus group discussion, one of the male participants mentioned: Clients *are not the same, some are shy, some slow and they need to be accommodated and I give them time and do not rush.* The participant was supported by several members of the focus group,

The majority of the participants during focus group discussions mentioned that they do not judge their clients but accept the clients as they are. Similarly, the majority of the participants during individual interviews mentioned that they do not judge their clients. One of the female participants during a focus group discussion mentioned: *We don't criticise the client in any way whatsoever, we take them as they are. They have rights and responsibilities; we accept them, we don't say "It is because of your behaviour that you are HIV positive. We don't judge clients according to religion, culture or tradition.* This view was supported by an overwhelming majority of participants.

Mahendra, Gilborn, George, Samson, Mudoi, Jadav, Gupta, Bharat and Daly (2006:19:48) conducted a study in two Indian hospitals with regard to discrimination against clients. Health workers had displayed a negative attitude toward PLWHIV HIV patients; they were isolated, consent forms were not taken, no professional counselling was provided, patients' test results were disclosed to family members and confidentiality was breached by the use of markings on hospital beds. To reduce the stigma the research team engaged hospital managers in a

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participatory process to develop actions plans to address stigmatisation and discrimination in the hospitals.

Table: 3.5 Findings obtained from the observational checklist: use of effective questioning

N=33				
Use of effective questioning	**yes**	**%**	**No**	**%**
Uses open ended questions to illicit information	26	79	7	21
Asks relevant question	16	48	17	52
Waits for answers rather than speaking immediately	17	52	16	48
Refers statements back to the client for confirmation	18	56	15	44
Responding to questions appropriately	18	56	15	44

Table 3.6 reveals that 79% of the participants were observed using open ended questions to illicit information and 21% did not. Forty-eight per cent of the participants were observed asking relevant questions whilst 52% were not. Fifty-two per cent of the participants were observed waiting for answers rather than speaking immediately and 48% were not. Fifty six per cent were noted referring statements back to their clients to confirm, while 44% did not. Fifty-six per cent of the participants responded to questions and concerns appropriately and 56 % did not. More than 57% of the participants were observed using effective questioning competently.

The majority of the participants during focus group discussions mentioned that they conduct pre-testing and similarly the majority of participants in individual interviews mentioned that they conduct pre-test counselling. One of the participants in a focus group discussion mentioned: *During pre-test counselling the counsellor assesses a client's knowledge about HIV and AIDS, assesses the risk factors of the client, ask why the client wants to be counselled and tested, learns about the history of the client and with whom the client would like to share the HIV test results. . We tell the client how the test is done. We also tell the clients how HIV and AIDS is contracted*

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Table 3.6: Findings from observational checklists with regard to giving HIV and AIDS information N=33

N=33				
Giving information	**Yes**	**%**	**No**	**%**
Give positive messages	28	85	5	15
Provide factual information to the client without judging	20	61	13	39
Guide clients to prioritise concerns	10	30	23	70
Help client to identify steps of action for Identified concerns	14	42	19	58
Comments on the client's challenges and strength	5	15	28	85

Table 3.5 indicates that 61% of the participants during observational sessions showed participants providing factual information to clients without judging them, whilst 39% did not. Thirty-one percent guided clients to prioritise concerns. Only 15% of the participants were observed commenting on client's challenges and strength.

Landi and Bokhari in The National Guidelines of Pakistan and UNAIDS (2001:42) on Voluntary Counselling and Testing, the authors stress the view that people irrespective of their lifestyle, sexual preferences, socio economic, ethnic or religious background, should be fully accepted and respected by the counsellors. The Guidelines further indicate that people should not be judged by their lifestyle or sexual preference. All clients should be treated the same.

WHO (1990:18) in the document published about the guidelines about HIV infection and disease, the authors concurs with the view that, if counselling is to be effective it must be seen by the client as acceptable. Counselling should take into account the many social relationships, commitments and obligations of the client. WHO further emphasises the view that people with HIV and AIDS should feel that they are fully accepted by the counsellor irrespective of their lifestyle.

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Concerning respect and acceptance van Dyk (2001:211), maintains that respect is fundamental for the counselling relationship. Van Dyk further mentions that the counsellor who is without an attitude of respect, and does not believe that every person is worthy of respect and esteem, cannot communicate empathetically with a client, because he/she cannot create an atmosphere of acceptance and freedom where the client will reveal his/her darkest and most painful experiences without fear of rejection. Van Dyk further has the view that counsellors should learn how to listen and read non-verbal messages such as body language, facial expression and voice related indicators such as tone, pitch, voice level, pauses and fluency. Counsellors should learn to listen to these messages without distorting or over interpreting them. The counsellor should listen to the whole person in the context of his or her social setting to be able to provide effective counselling.

Barnes (2005:2) is of the opinion that an effective therapist displays affirming and nurturing behaviour and the ability to appreciate the client with warmth, support and attention in a healing setting. This researcher further mentions that a less effective therapist displays more "watch and manage", "belittle and blame" and "ignore and neglect". Henkelman and Paulson (2006:145) in their study indicated that counsellors guide the counselling process and this includes noticing hindering experiences.

Lie and Biswalo (1994:10) in their study conducted in the Arusha and Kilimanjaro regions of Tanzania about the perceptions of the appropriate HIV and AIDS counsellors, the researchers mentioned that client centred counselling requires at least two things: the development of certain personal qualities and the learning of basic interpersonal skills. Rogers further identified the three personal qualities necessary for a therapeutic change in a counselling relationship as warmth and genuineness; empathetic understanding and an unconditional positive attitude.

Grinstead and Van Der Straten (2009:6) mentioned that lay counsellors in their study saw the most personal attributes of counsellors as patience, neutrality and understanding. The most important professional qualities are good listening skills and respect for clients and confidentiality. Counsellors in the study saw themselves as being specifically trained to assist clients to gain insight into their own problems, to look for solutions to their problems and plan how to go about solving their own problems.

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According to the study conducted by Malema *et al.* (2010:18), lay counsellors mentioned that one of the qualities of an effective counsellor is respect for the clients. Clients who are counselled should be respected and addressed by their names. Counsellors mentioned that during their training they were taught to be respectful. These researchers further mentioned that the attitudes of counsellors should be observed because this has an influence on the success of counselling. Attitudes towards clients need to be therapeutic because clients who are counselled are usually hurt or they have to deal with hurting situations.

van de Kwaak, Ferris, van Kats and Dieleman (2010: 338-339), conducted research to analyse issues about sexuality, reproductive health and HIV/AIDS in Uganda and Kenya. The study revealed that positive relationships are built on trust and respect. Lay counsellors and health professionals should base their relationships on understanding each other to achieve high quality counselling services. Mutual trust and respect between lay counsellors and health professionals are the cornerstones of effective counselling (van de Kwaak *et al.*, 2010:338-339).

COMMENTS OF LAY COUSELLORS

LC 10: *If we don't respect the client and show them love and warmth they will not come to us for help, client like any person need to be respected and shown respect for their traditions religion and culture so that they can feel free to use the health services without fear of being judged. This will enable them to build good relationship with their clients for future counselling.*

LC 5: *Clients who feel that they are respected will feel free to ask questions. If the attitude of counsellors is not good, clients will not come because they are afraid. Clients walk long distance to come to our clinic because we show them respect.*

LC 4: *I take time when counselling. Clients are not all the same; some talk very slow, some are shy. If I am impatient I will lose a lot if information that could assist me and the client to make good decisions. I give clients time to answer all the questions without interrupting; when you interrupt the client you shut the client up and the client will not talk*

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LC 2: *When you are impatient with clients, you will miss important messages as the clients tell all the information or even tell other client not to come to you. Some of the clients are shy and take time to open up, so by being patient you will be able to get the information from the client.*

LC 8: *I have a good approach I am always smiling and my face is not serious; this makes the client relax and be free to talk. Clients come back looking for me because I am approachable. If you show love, the clients will in turn have trust in you, this will make counselling effective.*

LC 3: *I don't judge clients irrespective of their sexual preferences and social economic status or lifestyle. I take my clients as they are rich or poor, educated or not they all get the same information and treatment.*

LC 12: *I welcome them with a smile; I am friendly to the clients and talk to them in a nice way. I am not harsh with the clients.*

LC5: *I treat my clients the same. I handle clients like my sisters and brothers, when they tell me their problems I accept them. I don't say it is because of your behaviour that you are HIV positive.*

LC 12: *I don't criticise the client in any way whatsoever, I take them as they are. They have rights and responsibilities. I accept them. I don't say it is because of behaviour that you are HIV positive. I don't judge clients according to religion culture or tradition*

LC 11: *I am always telling the truth to my clients. I always tell them the truth so that I can earn their trust and respect. If we don't have information we tell them that we don't know and that we will look for the information.*

There were similarities and differences in the results. The majority of participants in both focus group and individual interviews mentioned that they show respect to their client. However the observational studies revealed that only 50% of the participants showed positive attitudes to their clients.

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3.2.1.4 Lay counsellors' use effective counselling skills and processes

Focus group discussion revealed that the majority of the participants make use of effective counselling skills such as open ended questioning, reflection, empathy, and summarising important points. During individual interviews the majority also mentioned that they make use of effective counselling skills learned during their training. Participants mentioned that these skills made them competent in their work.

During the focus group discussions the majority of participants mentioned that they make use of open ended questions during counselling. Similarly the participants in individual interviews use open-ended questions to gain information from clients. One female participant during focus group discussions said: *We use open ended questions a lot; using questions assist us to get information from the client. We use open ended questions to get information about the history of the clients.*

Participants mentioned that they use reflection to make sure that they understand their clients or that their clients understand them. They reflect on what the client has said or give a short review of what the client has said in order to make sure that they have understood the client. This shows that the counsellors are listening.

Observation revealed that very few participants during focus group and individual interviews use reflection as a counselling skill. One participant during a focus group discussion said: *I reflect on important ideas that the client needs to explore further in the discussions, this show the client that I am listening carefully.* Very few participants during focus group discussions and individual interviews mentioned that they use empathy during counselling. One male participant mentioned during individual interviews: *I put myself into the shoes of the client, see the problems with the eye of the client. I used to sympathise with the clients instead of empathising, and this affected me a lot.* One participant during a focus group discussion mentioned: *I used to take the problems of clients home with me; I did not empathise but sympathised with the client. A mentoring session helped me understand empathy and sympathy.* Participants mentioned that they summarise points mentioned by clients and or they ask clients to summarise important points during counselling to enable them to focus.

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Focus group discussions revealed that very few participants summarise important points during counselling. Similarly very few participants during individual interviews mentioned that they use summarising as a skill during counselling. One participant during a focus group discussion said: *I can summarise what the client has said to get some meaning and make sure I have understood her/him.*

The majority of the participants during focus group discussions mentioned that they use probing, but very few during individual interviews mentioned that they use probing when counselling clients. One female participant during a focus group discussion said: *We use probing to dig more information from the client, A* male participant during an individual interview said: *I use probing when I see that there is something that the client wants to say, but is not saying it, I don't take for granted that I understood what the client has said.*

Regarding non-competent counselling skills, participants mentioned that there are some skills that they feel they do not apply competently; such skills are: summarising, empathy and paraphrasing,

Few participants during focus group discussions mentioned that summarising is sometimes difficult to implement during counselling. Similarly few participants during individual interviews mentioned using summarising during counselling. One participant during focus group discussion mentioned: *When the client talks softly and fast I find that summarising is very difficult.*

A few participants during focus group discussions mentioned that they are not competent in using empathy as a skill during counselling. Similarly very few during individual interviews mentioned that they are not competent using empathy as a counselling skill. One female participant during individual interviews said: *I used to take the problems of the clients home, I did not empathise with the clients but sympathised with them, and I was miserable.*

The majority of participants during focus group discussions mentioned that paraphrasing is difficult to use during counselling and the majority during individual interviews mentioned that they are not competent using paraphrasing during counselling. One male participant during a focus group discussion mentioned: P*araphrasing assisted me to understand the clients more but sometimes I find it difficult to implement it*

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Table: 3.7 Findings from observational checklist pre- test counselling

N=33	Yes		No	
Pre- test counselling	#	%	#	%
Introduces self	22	67	11	33
Ask client to introduce self	22	67	11	33
Assures patient of confidentiality	24	73	9	27
Asks client why he/she came to voluntary counselling and testing VCT	24	73	9	27
Ask the patient what he/she knows about HIV/AIDS and how it is transmitted	14	42	19	58
Assesses the risk profile of the client	19	58	14	42

Table 3.7 indicates that 73%% of the participants asked clients why they came to VCT and 27% did not. 73% assured clients confidentiality. Forty-two % ask patients what they know about how HIV is transmitted. Fifty-eight percent of the participants observed assessed the risk profile of the patient and 42 % did not. Fifty eight of the participants were observed explaining the actual HIV test 42% did not. The results revealed that more than 60% of the participants conduct pre-test counselling competently.

Post-test counselling

The majority of participants during focus group discussions mentioned that they conduct post-test counselling. Similarly, the majority of the participants during individual interviews mentioned that they also conduct post- test counselling. One of the male participants during focus group discussions mentioned: A *negative result is a relief for the client and the counsellor. However the client who is frequently involved in high risk behaviour might have a false sense of security and therefore it is extremely important for the counsellor to further counsel HIV negative clients in order to reduce the chances of future infections.*

The majority of the participants during focus group discussions mentioned that they discuss HIV positive results with clients. Similarly, the majority of the participants during individual interviews mentioned that they discuss HIV positive results with their clients. One male participant during individual interviews mentioned that the following when discussing HIV positive results with clients: *I counsel them on safe sex to prevent further transmissions, explain the differences between HIV and AIDS and the importance of making known the HIV results with a trusted friend or family members.*

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Table: 3.8 Findings of observational check-list post- test counselling

N=33				
	Yes		No	
Post –test counselling	#	%	#	%
Remind client of prevention strategy ABC	19	58	14	42
Makes appropriate follow up appointment	16	50	17	50
Make appropriate referrals for clients/ call nurse for the test	19	52	14	48
Assess clients readiness for receiving test results	17	52	16	48
Set up follow-up appointments	17	52	16	48
Give the results in a simple and clear manner	17	52	16	48
Give the client time to reflect on the results	18	54	15	46
Giving of relevant information				
If negative results: Helps patient to understand that HIV was not detected at this time, however since the client could be in the window period, recommend a second test in 3to 6 months	20	61	13	39
Emphasises the need to engage in non-risky behaviour to prevent his/her exposure to HIV infection/ reminds client ABC strategy	8	24	25	76
If positive: Explains the difference between HIV infection and having AIDS	21	64	12	36
Reminds the client of the need for safe sex to prevent further Transmissions	19	58	14	42

Table 3.8 indicates that 61% of the participants discussed positive results with clients and 39 % did not. Sixty two per cent gave information about negative results and 35% did not. Twenty-four per cent emphasised the need to engage in non-risky sexual behaviour to prevent exposure to HIV infection. Only 20% explained the difference between HIV and AIDS and 80% did not. Fifty-eight per cent reminded patient of safe sex to prevent further transmission and 42 % did not. Results revealed that more that 50% gave post-test counselling to their clients. More than 50% of the participants assessed clients readiness for receiving test results; set up follow-up appointment; gave results in a simple and clear manner; gave client time to reflect on the results and asked Some of the elements of post-test counselling such as emphasising on the need to engage in non-risky sexual behaviour and explaining to the clients the differences between HIV and AIDS were not facilitated competently (DOH 2003:15).

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According to the DOH (2001:86), in the in the Manual for training the lay counsellors, the authors indicated that, summarising could assist the counsellor in a session that does not seem to be progressing well. The counsellor can summarise and together with the client establish way forward. The client and the lay counsellor can summarise content, ideas and feelings. Summarising tells the client that the counsellor was listening actively and has understood him/her.

The authors Landi and Bokhari (2001:20) in the National Guidelines of the Government of Pakistan and UNAIDS on VCT, hold the view that summarising helps to ensure that the counsellors and the client understand each other correctly. Summarising can be done by the counsellor or the client, at the end of the session. According to the Lay Counsellor Training Manual (2001:79) counsellors should use probing to clarify information instead of accepting general statements. Sometimes clients use complex words which the lay counsellors need to further explore, instead of taking for granted that the counsellor has understood the client. (Landi & Borakhi 2001:12).

With regard to counselling skills, the Landi and Bokhari further mention that questioning is critical in counselling and should be practised only through honest open dialogue; through questioning counsellors can elicit information about risks, check the outstanding misunderstanding of facts and assist the clients in deciding about the course of action. Concerning empathy the Guidelines further state that empathy exists when the counsellor places himself/herself in another person's situation and that empathy is a difficult skill to master; it requires the counsellor to suspend all his/her own feelings and judgment and enter the experience of the client.

According to UNAIDS (2000e:10) counselling before the test should provide individual who are considering being tested with information on the technical aspects of screening and the medical, social, psychological and legal implications of being diagnose as either HIV positive or negative. The information should be given in a manner that is easy to understand and should be up to date. Testing should be discussed as a positive act that is linked to changes in risk behaviours. The guidelines further mention that testing for HIV infection should be organised in a way that minimises the possibility of disclosure of information and discrimination. In pre-test counselling individuals are given an opportunity to assess their own risk of infection with the counsellor.

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The guidelines further mention that testing for HIV infection should be organised in way that minimises the possibility of disclosure of information and discrimination. The decision to be tested should be an informed decision, with an awareness of the possible implications of the results of the test. Pre-test counselling should focus on two main topics: the client's personal history and risk of having been exposed to HIV; assessment of the client's understanding of HIV/AIDS and previous experiences in dealing with crisis situations.

Concerning counselling after a negative HIV test result (WHO1990:25) indicated that it is important to discuss carefully the meaning of a negative test result. It should be emphasised that if there has been a possible exposure to HIV, a window period exists during which negative test results cannot be considered reliable. Further infectious exposure can be prevented only by avoiding high risk behaviours. The client should practise safe sex and avoid needle sharing.

Evian (2000:270) holds the view that probing encourages non-assertive clients to tell their story and helps the client to remain focused on relevant and important issues. The author further stresses that empathy exists when counsellors see the world from the client's view point and helps the counsellor to understand the client better. van Dyk (2001: 215), views empathy as understanding the feelings of the client and further mentions that the counsellor should respond to the client's feelings appropriately and not distort the content of what the client is saying. Counsellors should avoid having arguments with their clients. Counsellors who argue with their clients are not showing empathy, they are approaching the client from their own frame of reference. This may cause the client to be defensive.

Egan (1998) in van Dyk (2001:216) holds the view that questions enable the counsellor to explore relevant information about issues in the life of the client. Concerning summarising, van Dyk (2001:222) views it as a focus of what was said before and challenges the client to move forward

Malema *et al.* (2010:19) mention that that counselling is a practical skill and should be ideally taught using demonstrations and simulations of different situations to understand the client better. Counsellors should be taught how to communicate with clients.

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Participants in the study by Grinstead and Van Der Straten (2009:7) mention that, clients think that the counsellors will automatically erase their problems or provide solutions to their problems; they do not realise that solutions to their problems lie within themselves. Other clients come to the counselling expecting to be helped, saved or rescued; this expectation makes it difficult for the counsellors not to assume the role of the problem solver.

With regard to counselling, testing and sharing negative and positive results with client, Makhunga-Ramfolo *et al.* (2011:6) hold the view that despite voluntary counselling and testing services conducted in South Africa since 2000 many South Africans still do not know their status, and HIV infected patients who consult their family doctors are still missing an opportunity to be tested.

Ismail and Ali (2009:193) mention that the purpose of post-test counselling is to provide clients with HIV test results, help them, to understand the meaning of the HIV test results and encourage them to disclose the results to their partners. It is also an opportunity to offer clients on-going counselling and education with regard to HIV prevention, as well as to inform clients about support and referral services.

COMMENTS OF LAY COUNSELLORS

LC 20: *I use open ended questions to assist clients to talk more and I get a lot of information from the clients. The open ended questions help me to understand what I did not understand from the client, I don't use closed questions because they make clients answer with yes or no, and it makes the client not to talk.*

LC 8: *I ask the client why she/he came and why she/he is seeking counselling today.*

LC 4: *Questioning assists the clients who are shy, to open up and talk more and the counsellor to get more information. Questions assist the client to expand on the information. Listening and, probing are counselling skills we learned from the VCT training course.*

LC 8: *"I reflect on important ideas that the client said to explore further in the discussions; this show the client that I am listening carefully I use reflection to make sure I understand the client.*

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LC 15: *When started counselling I used to take the problems of the clients home and I was miserable, now I put myself into the shoes of my client and see the world with the eyes of the client, and feel what she/he is feeling.*

LC 5 *Clients come with the idea that the counsellors will solve their problems but to their surprise I mention to them that they are capable of solving their own problems.*

LC 18: *When young people come for counselling and have tested positive this used to disturb me a lot. I sympathised with them, I think about my children who are the same age, and think about their future.*

LC 10: *We use empathy to show the client that we are with him and we feel what the client is feeling.*

LC 6: *We summarise what the client has said to make sure we have understood the client. When you don't have good listening skills, it is difficult to summarise to affirm the client that I have understood him/her. You said this.*

LC 2: *I can summarise what the client has said to get some meaning and make sure I have understood her/him, but when the client is talking too soft or too fast, I find it difficult to summarise.*

LC 19: *I use probing when I see that there is something that the client wants to say, but is not saying. I don't take for granted that I understand what the client has said. I dig to get information by using relevant questions.*

LC 5: *When I see that the client is shy to talk I use probing. To assist me to get the information that I would have not got. Probing helps the client understand their problems and situation well.*

LC 15: *Probing is digging the information from the client. I use probing to identify experiences, feelings and behaviours that can give me a full picture, to fill the missing pieces.*

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LC 12: *I sometimes find it difficult to paraphrase, especially when the client said many things within a very short space of time and is talking too fast.*

LC 17: *We can summarise what the client has said to get some meaning and make sure we understood her/him well, but when the client is talking too soft or too quick sometimes we cannot summarise, it becomes difficult.*

LC 18: *you cannot summarise when you don't listen actively because you will miss lot of important information.*

LC 19: *When I started counselling, I used to take the problems of the clients home, I did not empathise with the clients but sympathised with them, and I was miserable.*

LC 12: *Mentoring sessions assisted us not sympathise but empathise with the client.*

LC 9: *When young teenagers come for counselling and test positive, this disturbs me a lot. I sympathise with them, I think about my children who are the same age, and think of their future.*

LC 10: *When two or three clients are counselled and test HIV positive following one another, I feel discouraged and down especially at the end of the day.*

LC 1: *Paraphrasing assists us to understand the client but sometimes we find it difficult.*

LC 4: *When the client says an idea, and the counsellor says it again using other words, this tells the clients that you were listening.*

LC 5: *I sometimes let the client summarise to get more clarity about what she/he is saying.*

LC 19: *In paraphrasing the counsellor formulates the core key points of the clients in order to get more clarity and meaning of what the client is saying.*

LC 2: *During pre- test counselling, I discuss with the client and ask why the client wants to be counselled and tested.*

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LC 10: *I ask the client what he/she knows about HIV and AIDS to find out how much the client knows about HIV and AIDS.*

LC 5: *We assess the likelihood or how frequently the client has been exposed to HIV and AIDS and the risk of being infected.*

LC 10: *I discuss the knowledge about the mode of transmission and prevention of HIV and AIDS, I inform them that you can get the virus today but it will not show, it will show after six weeks.*

LC 5: *I discuss with the clients HIV and AIDS information and discuss how the test is done, and how long it takes that it is the rapid test, this makes clients to want to take the test. Actually I don't have clients who refuse the test.*

LC 12: *I can counsel clients, clients are coming back to thank me, for assisting them this is a sign that I am competent in my work.*

LC 8: *When I have pre- counselled the clients, they don't refuse to take the test.*

LC 12: *I ask the client, with whom they will share the test results, and encourage the client to share their HIV status with family members. If the family can know of the client's status from the neighbour they will are likely not to support the client.*

LC 16: *We discuss with the client the importance of the consent form. We ask the client to agree to be tested by signing the consent form.*

There were similarities and differences in this category with regard to technical counselling skills where half of the participants (50%) are competent in the use of technical counselling skills and the counselling process, and 50% of the participants were not competent. Participants were not competent in referring statements back to the patients for confirmation. It was shown that only 15% of the participants competently referred statements back to the clients. Participants were not competent in commenting on clients' challenges and strengths;

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LC 10: *I ask the client what he/she knows about HIV and AIDS to find out how much the client knows about HIV and AIDS.*

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only 25% of the participants commented on patients' challenges and strengths. Explaining the difference between HIV and AIDS was not competently done by many of the participants.

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3.2.1.5 Lay counsellors' training/empowerment to share information with clients on HIVPMTCT, ARV and CD4 cell blood count.

Participants mentioned that they share with their clients as well as couples comprehensive information about HIV and AIDS, PMTCT, treatment adherence for ARV.

The majority of participants in focus group discussions mentioned that they share information about HIV and AIDS, PMTCT and treatment adherence with clients and couples. Similarly participants during individual interviews mentioned that they counsel and share information with client and couples about HIV and AIDS, PMTCT, ARV and couples. One female participant during focus group discussions mentioned: *We learned a lot of information about HIV and AIDS during training; we share HIV and AIDS knowledge with clients. Many, people used to die in the beginning, and it was not known what the cause of deaths was. Since the VCT programme started many people have recovered from their illnesses. People know their status and get treatment, get better and go back to work.* The participant was supported by an overwhelming majority of the participants. A few participants during the focus group discussions mentioned that they share information with pregnant women and lactating mothers about the prevention of mother–to-child transmission. Similarly, during individual interviews participants mentioned that they share information with clients. Male participant during a focus group discussion mentioned*: Mothers who get ARV tablets before delivery and children getting treatment after delivery, produce HIV negative children. If we can continue with PMTCT programme in the future we can have HIV free children.*

One female participant during an individual interview mentioned*: We empower pregnant women and lactating mothers to prevent infecting children, and empower those who need treatment about drugs, how to receive information about the side effects of treatment, and share information with couples about how to live positively with HIV and AIDS and the challenges that face discordant couples.*

One participant mentioned that PMTCT is an important strategy to prevent HIV infection from the mother to child. Therefore it is important for lay counsellors to educate pregnant

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women and breast feeding mothers to prevent HIV virus transmission to the baby. She said: *If mothers, could cooperate we can have children born without HIV. Even participants in the current study have contributed significantly towards the reduction of MTCT by educating pregnant women and mothers on how they can prevent PMTCT.*

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About treatment adherence, very few participants during focus group discussions and individual interviews mentioned that they share information with clients who are HIV positive to adhere to treatment. One female participant during a focus group discussion mentioned: *Information about ARV treatment helped many people who were sick to use the ARV drugs and they are better now. I have seen men and women arriving in wheel chairs not able to walk, but after taking the ARV treatment, clients regain their strength and could walk again.*

One participant during an individual interview mentioned: *When clients they feel better they default on treatment and come back when they become sick again.*

With regard to sharing information with couples, very few participants during focus group discussions mentioned that they shared HIV and AIDS information with couples. Similarly very few during individual interviews mentioned that they share HIV information with clients. One female participant during individual interviews said: *Couple counselling is not* easy. *I once counselled a couple where the man was positive and the woman negative and the man did not want to use a condom*. Other participants during focus group discussions mentioned: *Couples don't come together and when one comes he/she does not share information with the partner or does not make decisions with the partner.*

Table 3.9: Lay counsellors share information with clients on HIV, ARVs, CD4 cell blood count.

N=33	Yes	%	No	%
Explains that the ARVs are available at the ARV centre if the patient is eligible	10	30	23	70
Explains the CD4 blood cell count - a special blood test that needs to be done to detect whether the patient needs treatment now or later	10	30	23	70
Discuss the importance of sharing the results with a trusted friend or family member	20	61	13	39
Gives information about support groups/ or other community	10	30	23	70

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resources				
Asks client whether he/she has any further questions	17	52	16	48

Table 3.9 indicates that only 30% of the participants were observed explaining to the client that the ARVs are available in the centres. Thirty per cent of the participants explained the CD4 cell blood count to the client. Sixty one per cent of the participants discussed with clients the importance of sharing the results with a friend or family member. Thirty percent share information about support groups with the client, while 52% of the participants asked the patients if they have other questions to ask; 48% of the participants did not.

UNAIDS (2000f:5) in the publication voluntary counselling and testing, the authors views pre-test initiatives for HIV counselling and testing as an entry point to access care, treatment and prevention. VCT is an access to prevention of mother to child transmission, access to early medical care including ARVs and preventive therapy for TB and other opportunistic infections (OIs), access to family planning and access to peer, social and community support. The purpose of pre-test counselling is to provide clients with adequate information on HIV and AIDS and to learn from the client how much he/she knows about the HIV/AIDS epidemic. The information gives the client a chance to make an informed decision about HIV testing.

Concerning pre-testing, van Dyk (2001:217) holds the view that pre-test counselling provides people who are considering being tested with information, and the possible personal medical, legal and ethical implications of being diagnosed HIV positive or HIV negative. van Dyk (2001:218) further mentions that pre- test counselling gives the counsellors a glimpse of what to expect in post-test counselling, that pre and post-test counselling should be done by the same person because the established relationship between the client and the counsellor provides a sense of continuity with the client. The counsellor will have a better idea of how to approach the post-test.

Regarding post- test counselling, van Dyk (2001:246) and Evian (2000:55) stress that HIV negative and positive results should be given to the client personally. Feedback should take place in a quiet place, in a private environment and enough time should be allowed for discussions. The counsellors should communicate the news of HIV and AIDS openly, honestly and without fuss. Simple and clear language should be used. The counsellors should

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not give the client false hopes but and should also not paint a hopeless scenario. According to the law health professionals may not do an HIV test unless the client understands the purpose of the test and what the advantages and disadvantages are for him/her as a client. The client should be informed why the health professional wants to conduct the HIV test and what impact the test result will have on the client.

Evian (2000:55) shares the view that counsellors should ensure that the client understands the basic facts about HIV infection and AIDS, and should assist the client to understand the test and what the results mean and should be able to prepare the client to receive the HIV test result. The counsellor should explore what the client might do if the test is positive or negative and should ask what potential support is available from loved ones, family and friends.

With regard to information-sharing Eagan (1998) in van Dyk (2001:226) mentions that information sharing is important because sometimes clients are not able to explore their problems due to lack of information. It is therefore important for the counsellors to provide their clients with information. Information sharing is important in HIV counselling. Information does not always solve the problems of the client but can provide new perspectives on how to deal with the problem as well as to make informed choices and decisions.

Concerning revealing HIV test results, Evian (2000:271) holds the view that counsellors should give the client enough time to express his/her feelings and fears and encourage the client to talk about them. The client may experience many different feelings such as anger, fear, confusion, or disbelief; the client may be emotionally shocked or unclear or confused about what to do next. Counsellors should give clients a chance to feel and express their emotions which are normal responses.

Moosa and Jeenah (2010:40), in their study conducted in South Africa about feelings of hopelessness in the stable HIV positive patient on antiretroviral treatment found that feelings of hopelessness in individuals with AIDS may be associated with depression, which may lead to a decrease in adherence to medication regimes, further suppression of immunity and accelerated disease progression, as well as a risk of suicide. Optimal adherence to antiretroviral regimes is closely associated with achieving and maintaining viral suppression

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infection. A study of the impact of the national access to the antiretroviral programme on the incidence of opportunistic infection in Thailand, found that Highly Active Antiretroviral Therapy (HAART) was very effective in reducing OIs especially PCP, TB Cryptococcus meningitis in the early phase of antiretroviral drug therapy. Opportunistic infections are a major cause of death in HIV infected individuals. The decline in AIDS related mortality in the HAART era is mainly attributed to the decline in OIs (Rojanawiwat, Tsuchiya, Pathipvanich, Pumpradit, Schmidt, Honda, Auwanit, Sawanpayalet and Ariyoshi 2011:101).

The researchers further mentioned that failure of a client to disclose his/her HIV positive sero-status can have a number of important consequences. This includes the effect of cutting off potential social support from family and friends, which sustains the client's psychological vulnerability and interferes with the work of potential informal care-givers who can assist in providing tangible as well as social support as the illness progresses. Even those who do not disclose their sero-status experience distress when they hear derogatory remarks about people with HIV and AIDS.

In a study conducted in South Korea by Shin, Kang and Moneyham (2007:5) on pre-test assessment of HIV risk factors of clients revealed that the reason that participants wanted to undergo testing is their engagement in high risk sexual behaviour. This was evidenced by 52% of the participants whose clients have sex with sex workers and 13%, of participants whose clients were having extramarital sex.

Omolase, Faturoti and Omolase (2010:310), who conducted a study in Nigeria, maintain that VCT is a process by which an individual undergoes counselling to enable him/her to make an informed decision about being tested for HIV. Counsellors assess their personal risk of contracting HIV and develop a risk reduction strategy. VCT services are essential components of HIV prevention programmes.

Voluntary Counselling and Testing is viewed by Corbett, Dauya, Matambo, Cheung, Makamure, Bassett, Chandiwana, Munyati, Mason, Butterworth, Godfrey and Faussett (2006:1010 e238), as a gateway to HIV and care and contributes to HIV prevention by reducing high risk sexual behaviour in individuals who know themselves to be HIV positive. These researchers indicate that despite the high potential benefits of VCT, there is a limited understanding of the factors that determine acceptability and uptake for clients.

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COMMENTS OF LAY COUSELLORS

LC 8: *I have learned and clearly understanding of the information about prevention of Mother to child transmission of HIV and AIDS. I share it with pregnant mothers who are HIV positive and breast feeding mother mothers.*

LC 2: *Many clients know how HIV is transmitted and how it can be prevented; they learn this from the education and information discussed with lay counsellors before counselling.*

LC 4: *With the education that the client receives from us clients know that, when tested for HIV they can be positive or negative; we inform HIV negative clients, how to remain negative and how to prevent infections.*

LC 3: *Discuss with HIV positive mothers how to prevent infecting others and protecting themselves from re infection.*

LC 12:*From the information we share with clients, those who are HIV positive, knows that even when one is HIV positive, life continues that they should use condoms to prevent infecting other people and re infecting themselves and that there is treatment to make those ill better."*

LC 10: *From the discussions clients know that when HIV positive there is treatment, that can help improve their health and feel better, even if the treatment cannot cue HIV and AIDS.*

LC 11: *We have learned a lot of information about HIV and AIDS during training. We share the HIV and AIDS knowledge, many people used to die in the beginning, and it was not known, what was the course of the deaths. Since VCT programme started many people have improved from the illnesses. People come for counselling and testing, now know their status and get treatment, get better and go back to works.*

LC 5: *Traditional healers when they have clients, they bring them to the clinic to test so that they can know how to treat the client, People were ill and it was not known what was the*

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problem?, doctors were treating people in the dark but with VCT doctor now know how to treat the client.

LC 2: Now because of the information we share, people are not afraid of being counselled and tested, they come for counselling and testing many people want to know their status.

LC 8: Information about the ARV helped many people who were sick. I have seen man and women coming being on wheel chairs not able to walk, but after taking the ARV treatment, client regain their strength and could walk again.

LC 20: We have seen that mothers who get the ARV tablets before delivery and the child getting treatment after delivery, giving birth to HIV negative children. If we can continue with PMTCT programme in the future we can have HIV free children.

LC 19: When I have discussed HIV and AIDS information with clients, they come back to thank me. If one appreciate what you do it raises the moral, in this way I feel I am competent.

LC 10: I let the client know that having a negative test result it does not mean that the client will not get the infection. I discuss with the client to protect him/herself from the infection by avoiding risky activities and use of condom abstain and being faithful to the partner.

LC 8: I discuss with the client the window period, I let then understand that when the HIV test is negative, it might be that the antibody test is negative and that the virus was not detected.

LC 12: After testing, I give the client results in a clear and simple manner, I give the client enough time to reflect on the results, I don't rush the client, I ask the client with whom she/he would like to share the results because it is important.

LC 10: I plan with the client follow-up visits, provide comprehensive information about prevention of HIV, use of condom how to put on the condom and refer clients to institution that could further help.

LC 5: I encourage the client to share the results with someone can trust. Family members who hear of the status from other people turn not to support the family member who is positive.

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LC 2: *I discuss with the clients the dangers of spreading the infection when HIV positive and how to prevent getting the infection if HIV negative. I discuss information on safer sex with the client.*

LC 4: *I discuss the information about HIV and AIDS with the client, the importance of testing and knowing their status and the client make a decision from the information.*

LC 3: *I discuss with the client to engage in non-risk sexual behaviour.*

LC 2: *I thoroughly prepare the clients to receive the positive results, I indicate to the client that HIV is not AIDS and it does not mean the person will develop AIDS and that there is treatment when the person is ready and willing to adhere to the treatment.*

LC 5: *We give the client time to think about the results because clients who receive HIV positive results may be shocked and not believe that he/she is HIV positive.*

LC 12: *I am able to give the HIV positive test in a simple sensitive straight forward manner, in a manner that will give hope to the client, that there is life after being HIV positive.*

LC 6: *We discuss with the clients the support systems that is family and friends are there to help and support, that it is important for him/her to disclose the HIV status early.*

LC 10: *We encourage the clients to share the results with family members; family members who hear of the results from nonfamily members may not support the client.*

LC 2: *Couple counselling is not easy, I once counselled a couple where the man was positive and the women negative and the man did not want to use the condom.*

LC 3: *Couple doesn't come together and when one comes does not share information with the other or does not support the decision taken by the other.*

There were similarities and differences of the findings in this sub-category. The majority of the participants shared information on HIV and AIDS with clients. A few participants shared

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LC 2: *I discuss with the clients the dangers of spreading the infection when HIV positive and how to prevent getting the infection if HIV negative. I discuss information on safer sex with the client.*

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There were similarities and differences of the findings in this sub-category. The majority of the participants shared information on HIV and AIDS with clients. A few participants shared

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information about PMTCT, ARV and couple counselling. Some participants explained to the clients that ARVs are available in the centres. This is evidenced by 40% of participants observed sharing information about treatment adherence. Only 20% of the participants explained the importance of the CD4 cell blood count to the clients. Twenty per cent discussed the importance of ARV with the clients. Thirty per cent were observed sharing information about support groups. No participants were observed counselling couples during individual observations.

The findings regarding the competence of lay counsellors during focus group discussions and individual interviews are discussed. The focus is on responses to Question 2: What are your challenges with regard to the environment? This section describes the challenges of lay counsellors with regard to clients' environments and health professionals as shown in Table

3.10. **Table 3.10: Perceived challenges of lay counsellors' regarding environment**

Category 2	Sub –Category	Descriptions
Lay counsellors' perceptions of challenges at the workplace	Lay counsellors' perceptions of challenges with regard to clients	Lay counsellors experience challenges with clients who deny their HIV status, default on treatment, do not come to collect their CD4 cell counts and HIV positive couples who do not want to use condoms/practise safe sex

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information about PMTCT, ARV and couple counselling. Some participants explained to the clients that ARVs are available in the centres. This is evidenced by 40% of participants observed sharing information about treatment adherence. Only 20% of the participants explained the importance of the CD4 cell blood count to the clients. Twenty per cent discussed the importance of ARV with the clients. Thirty per cent were observed sharing information about support groups. No participants were observed counselling couples during individual observations.

The findings regarding the competence of lay counsellors during focus group discussions and individual interviews are discussed. The focus is on responses to Question 2: What are your challenges with regard to the environment? This section describes the challenges of lay counsellors with regard to clients' environments and health professionals as shown in Table

3.10. **Table 3.10: Perceived challenges of lay counsellors' regarding environment**

Category 2	Sub –Category	Descriptions
Lay counsellors' perceptions of challenges at the workplace	Lay counsellors' perceptions of challenges with regard to clients	Lay counsellors experience challenges with clients who deny their HIV status, default on treatment, do not come to collect their CD4 cell counts and HIV positive couples who do not want to use condoms/practise safe sex

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	Lay counsellors' perceptions challenges in the environment	Lay counsellors experience challenges with small counselling rooms, shared counselling rooms or no specific counselling rooms
	Lay counsellors' perceptions of challenges with regard to health professionals	Lay counsellors experience challenges with health professionals who delay coming to conduct HIV tests after pre-test counselling who do not respect the counselling sessions. Lay counsellors experience a shortage of health professionals who do not spend time with them during testing and the interpretation of the results due to other work assignments
	Lay counsellors' experience challenges with regard to stipends	Lay counsellors receive very low stipends Lay counsellors perceive that, if they could be absorbed by the government the problem of stipend will improve, they will get their stipend every month.

Category 2 consists of the following sub-categories namely: Lay counsellors' perceived challenges with clients; Lay counsellors' perceived challenges with the environment; Lay counsellors' perceived challenges with health professionals; and Lay counsellors' experience challenges with stipends.

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3.3 Lay Counsellors' perceived challenges with the environment.

3.3.1 Lay counsellors' perceived challenges with regard to clients

Participants mentioned that they perceived challenges with clients who came for VCT, pregnant and breast feeding mothers who come for PMTCT, clients on ARV or who need to receive treatment; and couples.

Participants mentioned that some of the VCT clients reject their HIV results when presented to them. Participants felt that this is due to anger, guilt, depression, anxiety or fear of being discriminated against by their family members and the community. Women do not accept their HIV positive status because they are afraid of being discriminated against or that their husbands will divorce them.

Results revealed that the majority of the participants had perceived challenges with clients who denied their HIV and AIDS status. However, very few participants during individual interviews mentioned they had experienced clients who denied their HIV status. One participant during a focus group discussion mentioned that clients deny their status because they do not believe they could be infected and they are afraid of not being welcomed by friends and family members.

Another female participant during individual interviews mentioned: *There is lot of denial in our area and a lot of polygamy. If a woman is married to a man who has other wives, and tests positive, she says she will not tell anyone in the family because they will say I am the one who came with the disease.*

Participants mentioned that they have challenges with clients who are HIV positive and whose blood has been taken to the laboratory for CD4 blood cell counts, but who do not come to collect their CD4 blood cell counts. Results revealed that some of the participants during focus group discussions had perceived challenges with clients who do not collect their CD4 cell blood counts. Similarly some participants during individual interviews had perceived challenges with clients who do not come to collect their CD4 cell blood counts. One participant during focus group discussions mentioned: Clients who do not come to collect their CD4 cell blood counts, give reasons such as: *"I did not have money for transport; "My*

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grant is taken;, "I went to the farms to look for work because I did not have food; "I had to go and look for work, that is why I did not come to collect the blood test.

Another participant during focus group discussions said: *Clients who are HIV positive and do not come to collect the CD4 cell blood count, make me hurt. I feel as if the dropping CD4 cell counts are mine. When they come they are very sick.*

Participants mentioned that PMTCT clients pose a big challenge to them, if they do not accept that they are HIV positive, because if they do not accept their HIV status, the child is in danger of getting the HIV virus during pregnancy, on delivery and during breast feeding.

Very few participants mentioned that they had had challenges with mothers who do not accept their HIV positive status. Some participants during individual interviews mentioned that they had had challenges with PMTCT clients who do not accept their HIV positive status. One participant during focus group discussions mentioned: Pregnant *women deny their HIV status because they fear they will be blamed for bringing the disease in the family and that may result in discrimination and stigma and divorce.*

Another participant during a focus individual interview said*: Mothers who are afraid of being stigmatised will come to the health facility and say: "I came to collect milk, but I* am not HIV positive. Artificial feeding is connected with being HIV positive, and not breast feeding the baby is associated with the mother being HIV positive. Only 20% of the participants were observed giving information about MTCT to pregnant mothers; these were participants who during observation were found counselling a pregnant woman or a pregnant mother.

One female participant during individual interviews said: *VCT clients deny their status because they don't believe they could be infected. They say: "Why me? I don't have AIDS." They are afraid of not being welcomed by friends and family members.*

Participants mentioned that they had challenges with clients who default on treatment. Results revealed that very few of the participants during focus group discussions mentioned challenges with clients who default on treatment. Some had challenges with clients that defaulted on treatment. Five per cent of the participants during observation were seen counselling a client who defaulted on treatment.

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One participant during an individual interview mentioned: *Some clients receive ARVs when they are still being assessed for placement on treatment; they are very good and listen to everything we discuss and suggest to them, but after they have been on treatment and are feeling much better, they no longer cooperate; they are impatient, they no longer listen, do not want to give blood for CD4 count cells, and no longer want to receive health education and are always in a hurry.*

With regard to couples, participants mentioned that they had challenges with couples. Couples do not come together for counselling, when one comes and receives counselling and testing, he/she does not share the result with the other one who was left at home. Some couples are uncooperative and do not want to use condoms; couples who are HIV positive have children and want to have still more children.

Very few participants during focus group discussions mentioned that they had challenges with couples. A few participants during individual interviews mentioned that they had challenges with couples. One female participant during individual interviews mentioned: *I met a couple where they were both on ARV, and both did not disclose this to each other. One day the man wanted to accompany the woman to the clinic. The woman refused but the man followed her and found her at the ARV clinic. The woman did not want the man to hear what the counsellor is saying and sent the man to buy her food. While the man was away the lay counsellor continued telling the woman the importance of disclosing her status. The man was also on ARV but they both did not disclose this.*

One female participant said: *I once counselled a couple, where the man was positive and did not want to use the condoms with the aim of infecting the women. This was a big problem; the man wanted me to tell the woman that she is HIV positive, so that he can have sex without a condom, so that they can be all HIV positive. I refused to do what the man asked me to do, because the woman also has rights too.*

Concerning couple counselling the UNAIDS Best Practices Collection (2001:55) indicated that it is ideal for women and their partners to go through the whole pre- test counselling, testing procedure and post- test together. However since men very rarely accompany their wives or partners to reproductive health facilities, this is unlikely to happen unless efforts are

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made, where culturally appropriate, to make reproductive health care settings male friendly. Glick (2005), in a *Strategies and Analysis for Growth* working paper about scaling up VCT revealed that the policy of promoting couple-oriented VCT would be more successful than emphasizing individual testing. VCT demands and prevention impacts will be enhanced where scaling up is accompanied by the provision of anti-retroviral drugs. It is recommended that counsellors discuss the benefits of couple counselling with women during pre-test counselling sessions. Those women who would like to be counselled with their partners should be catered for, or referred to specialised counselling and testing services.

UNAIDS guidelines (1990:12) indicates that for women to take advantage to reduce MTCT they need to know and accept their HIV status. VCT services therefore need to be widely acceptable. Everyone should have access to such services since there are clear advantages to knowing one's serological status. People who know that they are HIV infected are likely to be motivated to look after their health, perhaps with behaviour and lifestyle changes, and to seek early medical attention for problems. They can make informed decisions about sexual practices, childbearing and infant feeding, and take steps to protect partners.

UNAIDS (1999:11). The publication on prevention of HIV transmission from mother and child indicated that providing VCT ante-retroviral drugs and replacement feeding for the reduction on MTCT has benefits that extend far beyond the direct benefits to the health and survival of the infant. All pregnant women, mothers and infants will benefit from the expanded provision of improved quality care especially regarding mother and child health, as well as antenatal, delivery and post natal services.

According to the manual for counselling couples about HIV and AIDS, counsellors should reflect critically on their own experience while couples reflect on how they feel about their relationships, how they have behaved as individuals and how they respond to other couples who depend on their experience (DOH 2001:26).

Evian (2000:53) has the view that people with HIV infection have great difficulty believing and accepting that they have a serious condition. This resulted in people not returning for follow up counselling but continuing with unsafe sexual practices. However it is important for the client to accept his/her HIV infection. Ongoing counselling will help the client to develop responsible and positive attitudes. Evian further indicates that clients should be told that blood

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has been taken to the laboratory for a CD4 blood cell count; clients should be encouraged to come back and collect the result as this will assist them to find out whether they must start ARV treatment. Participants mentioned that they get worried when clients do not come back to collect the CD4 blood cell count. They think they did not do a good job of educating the client.

Concerning denial, van Dyk (2001:257) indicates that most HIV and AIDS people go through a phase of denial when given HIV positive results. He further mentions that denial is an important and protective defence mechanism because it temporarily reduces emotional stress. Clients should be allowed to cling to their denial if they are not ready to accept their diagnosis because denial gives them a breathing space in which to rest and gather strength. The counsellor should however confront denial if it causes destructive behaviour such as refusing medical care or if the client continues to indulge in unrestrained high risk behaviour.

Dworkin and Pincu (2011:4) indicate that when clients hear that they are HIV positive or that they have been diagnosed with AIDS they are likely, for a few weeks, to experience shock, anger, depression, fear and anxiety, resentment towards HIV negative persons, and to engage in bargaining, HIV infected people need information; they are often confused about the nature of the infection, the mode of transmission and testing. The clients are often shocked and in a state of disbelief which makes them deny the results. The researchers further indicate that counsellors should understand some of the difficulties that the clients have and should assist them to internalise a positive self-concept and shed the stigma that is associated with the illness.

Concerning denial, Mqimeti *et al.* (2011:159) in their study found that 71% of respondents reported that denial is the main reason for people not coming to follow up sessions. Fifteen per cent of the participants said that fear of a lack of confidentiality is the reason for this, and 3.0% mentioned a lack of trust. Other reasons mentioned included the trauma of receiving HIV positive results, the fear of a change of status and a lack of transport and transport costs.

Morin, Khumalo, Sakutukwa, Charlebois, Routh, Fritz, lane, Vaki, Fiamma and Coates (2006:222) in their study of removing barriers to knowing HIV status, found that the most frequent reasons for not testing were the inconvenience of the location, hours of service and cost. The authors further mentioned that when barriers were removed, the demand for VCT

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exceeded the source of the research staff. The researchers therefore suggest that removing the practical and logistical barriers to testing could greatly increase the number of people who know their HIV status. Same-day rapid testing seems to be an acceptable approach; 99% of the participants opted for same-day HIV test results. A mobile VCT was able to identify a large number (29%) of individuals with HIV infections Wanyenre, Nawavvu, Namale, Mayanja, Bunnell, Abang, Amanyire, Senwankambo and Kamya (2008:3). The researchers conducted their study in a large Ugandan hospital. The study found that providing HIV Counselling and Testing (HCT) was feasible and highly acceptable. Routine HCT identified a large number of undiagnosed HIV infection and HIV discordant partnerships among patients and their families.

A study conducted by Van de Perre (2000a:7) in Kenya, Tanzania and Trinidad, of the efficacy of VCT, revealed that VCT encourages couples to undergo testing as compared to having health education only. VCT encourages individuals and couples to be tested; clients also come back to collect their blood test results.

Okonkwa, K.C., Reich, K., Alabi, A.I., Umeike N., & Nachman (2007:240), evaluated awareness, attitudes and beliefs of pregnant Nigerian women towards VCT for HIV. The results of their study revealed that 92% of the women who agreed to accept VCT believed that counselling and testing may reduce the risk of transmission of HIV to the baby. The study further revealed that 89% of women in the study reported that they would agree to be tested if they were to be tested simultaneously with their partners. Only 17% said they would ask permission from their husbands to be tested. It is beneficial for couples to come together for testing because they will be counselled at the same time and they will understand the HIV and AIDS dynamic and there is no pressure on one to disclose his/her status to the other.

Ismail and Ali (2009:190) in their study in Addis Ababa found that mother to child transmission of HIV is below two per cent because of the use of antiretroviral treatment, safe delivery and safe infant feeding. The researcher further mentioned that without this intervention the estimated rates of infection range from14% to 25% in Western Europe and North America, and 13% to 42% in developing countries. The researcher further highlighted that poor counselling and limited information provided to women is likely to result in misunderstanding and poor adherence to the information given to prevent MTCT, and to poor infant feeding practices and even resistance. Researchers are of the view that quality

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counselling and competent counsellors with good communication skills will assist mothers to make good decisions and adhere to information given. Lay counsellors should have the ability to concentrate well, show empathy and acceptance, and take responsibility for completely understanding their clients for successful counselling.

A study conducted by Dabis, Newel, Fransen, Saba, Lepage, Leroy, Cartoux, Meda, Whynes, Pinkham, Nduati, Msellati Vincent, and Van Der Perre in (2000:45) about PMTCT in developing countries found that there was clear evidence that in a non-breastfeeding population MTCT can be greatly reduced by the administration of ARV Zidovudine to women at 14-34 weeks of gestation, and intravenously during labour and orally to the neonate in the first six weeks of life.

Another study conducted in Nigeria by Omosale *et al.* (2010: 310), on assessing the acceptability of VCT for HIV, identified possible barriers to uptake among pregnant women. The majority of the respondents (85%) in the study had some knowledge about vertical transmission while only 19% did not know about it; 83% were aware of VCT for HIV; 72% were willing to accept VCT and 65% of the respondents had heard about VCT from health workers. A barrier to undergoing VCT was the fear of the outcome and the risk of divorce.

A study conducted in Zimbabwe by Mukoma et al (2011:18) that examined the relationship between the level of knowledge about ART and the rate of adherence to ART in HIV positive adults attending the Opportunistic Infections Clinic, showed that knowledge about ART was determined by the knowledge of the respondent about the indication or ART, how ART works, dosages, and side effects. The study revealed that 95% of the participants were adherent, which is the required level for successful ART; 71% of the participants had a moderate adherence rate and seven per cent had a low rate. Adherence rates decreased over time. The average knowledge of ART was 51%. Study participants had a very high level of knowledge; 97% had a high level of knowledge; 99% were aware that ART is supposed to be taken for life, while 69% knew that three drugs were effective in managing HIV infection because they interrupt the life cycle of HIV at many different stages of its multiplication in the body. However knowledge of the effects of failing to adhere was generally found with the largest group (33%), (Mukoma, Charumbira, Nyamukura, Zvinavashe and Manwere 2011:18) maintain that health workers should encourage literate HIV positive people to read the pamphlets included in medication packages regularly to boost their knowledge of ART and to

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keep abreast with new developments in the treatment of HIV/AIDS. This knowledge will empower clients who will be motivated to be part of the collaborative process which should be made jointly between informed patients and health workers

In a study conducted in Keiskama, South Africa by Hofmeyer, Georgiou and Baker (2009:39-43), counsellors found that, clients defaulted on treatment because they did not have money to come to the hospital to collect their medication. The researchers found that patients living beyond the community health work networks find adherence monitoring very complicated. The Keiskamma AIDS Treatment Programme gives care to people living with HIV and AIDS regardless of where they live. The programme provides treatment to people who are too sick to walk to the health facility for care, or too poor to afford transport costs. The rolling out of ARV treatment to the clinics will solve the problem of defaulting on treatment as the clinics are nearer to the people and home based care givers will assist clients who are not able to reach the clinics. In the current study counsellors mentioned that clients defaulted on treatment because they do not have money to come to the hospital and because clients live far from the facilities.

A study conducted in Malawi by Zacharia *et al.* (2007b) revealed that community support is associated with better anti-retroviral treatment outcomes. Adherence to ART may be greater than the average adherence to other chronic medication. A study by Rudd, Toverud, Radloff and Srinivas (2010:425) revealed that very few patients missed the required doses of their medication.

Stringer, Zulu, Levy, Stringer, Mwango, Chi, Mtonga, Reid, Cantrel, Bulterys, Saag, Marlink, Mwinga, Ellerbrock, and Sinkala (2011:782), conducted a study on the rapid up scaling of antiretroviral therapy at a primary care site in Zambia. The study revealed that mortality was strongly associated with a CD4 blood cell count that was between 50µl and 199µl when patients had low body mass index, severe anaemia and a poor adherence to treatment. A massive up scaling of HIV and AIDS treatment services with good clinical outcomes is feasible in primary health care settings in Sub-Saharan Africa. Early diagnosis and treatment improve outcomes. Lay counsellors assist people to know their HIV status, therefore clients receive an early diagnosis and scaled-p antiretroviral therapy

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A study conducted in South Africa by Boule, Tomlinson, Laubcher, Jonhson, Sayed, Brody, Draper, Cotton, Abdullah, Myers and Bourne (2011:20-23) about infant deaths between 1 and 11 months, revealed that infant deaths increased over the period but the annual increase was not seen in one province due to the availability of the ARVs. The research supports the statements of the participants in the current study, that, they have experienced sick people getting better after adhering to their ARVs.

Omosale *et al.* (2010:310) who conducted a study in Nigeria among pregnant women to prevent MTCT found that in Africa vertical transmission rates of HIV are between 21%and 43% and most children acquire HIV during the peri-partum period. The researchers further mentioned that trials of Neverapin in Uganda showed a reduced risk of HIV transmission by 50% during the first 14-16 weeks of life. The researchers found that pregnant women interviewed in their study were aware of the risk of MTCT of HIV. If mothers did not undertake the intervention, MTCT will not be prevented. A study conducted in sub Saharan Africa by Tomasoni, Galie, Declich, Pietra, Crose, Pigatelli, Fabian, Simpore, Mabila, Ayela, Caracciolo, Russo, Guaraldi, Gamniraso, Vullo, Castelli (2011:61-62), about knowledge, attitudes and practice regarding newborns feeding modalities in HIV–infected pregnant women revealed that through counselling, knowledge of HIV transmission in pregnant women was greater in women who had previously lost children as a result of AIDSs. Women living in selected rural areas exclusively breastfed their babies up to six months while women in selected urban areas expressed breast milk for six months.

Rose, Violari, Bolton, and Gray (2005:) in a study conducted in South Africa, found that although PMTCT is growing, there are still many women who are identified during antenatal care as being HIV positive and therefore do not have the opportunity of receiving the benefit of post exposure benefit. Lay counsellors discuss PMTCT and they educate pregnant mothers to understand how MTCT occurs and how to prevent MTCT.

In a study conducted in Uganda by Were Mermin, Wamai, Awor, Bechange, S., Moss, Solberg, Downing, Coutinho (2006 91-95) the researchers assessed the acceptance of home-based VCT, HIV prevalence, HIV discordance and the rate of ARV eligibility. The VCT was voluntary, confidential and standardised information about testing was collected. Infected households were offered cotrimoxazole prophylasis and those found eligible by a CD4 count of 250 cells or less or with symptomatic AIDS were offered standard ART. The results

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revealed that 99% of household members accepted VCT; among the adults; 37% were infected and 95% of household members were first testers.

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Barriers to testing were cited as distance from the testing site fear of knowing one's own HIV test. Seven point five per cent of household members were diagnosed with HIV and 74% of the household members had never been tested for HIV before while 43% who were eligible for ARV initiated treatment and received cotrimoxazole as prophylaxis. HIV discordance with couples was high; 43% of HIV–infected participants were HIV negative. Counsellors encouraged couples to receive results together and where HIV discordance was recognised, they offered enhanced couple counselling, focusing on understanding discordance, making personalised risk reduction plans and coping with challenges and social pressures with regard to child bearing (Were, Mermin, Wamai, Awor, Bechange, Moss, Solberg, Downing, Coutinho and Bennell 2006:92)

Creek, Alwano, Molosiwa, Roels, Kenyon, Mwasalla, Llyod, Mokomane, Hastings, Taylor and Kilmarx (2006:210) the researchers analysed data from the Botswana Tebelopele VCT network to describe client factors associated with infection and trends in VCT from 2002 to 2004, revealed that before ARV treatment was introduced only eight per cent of clients sought a test because of illness, and 23% were HIV positive. After ARV treatment was available, 20% of clients sought HIV testing because they were ill, and 38% were HIV positive; 82% were unmarried and 90% report no sexual partner or one sexual partner in the previous three months. Fifty per cent of unmarried clients reported always using a condom in the previous three months. Clients with higher education levels, and married clients were associated with lower risks of HIV.

Concerning couple counselling, Grinstead and Van Der Straten (2009:11) mentioned in their study that participants found that couple counselling was very stressful, in particular regarding the issue of results disclosure. Other issues in couple counselling were the interpersonal stresses of couple counselling and ethical issues related to disclosure to partners. In the study, researchers mentioned that partners were given results individually and then they were encouraged to share the results in counselling sessions. Counsellors mentioned that couple counselling is difficult; Not every woman is able to talk when the husband is present, but they

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agreed that couple counselling is more likely to be effective as it increases the likelihood of behavioural change by facilitating disclosure and reducing relationship disruption.

A study conducted by van de Perre (2000a:2) on behalf of the Voluntary Counselling and Testing Efficacy Study Group (2000a:2) and a study involving individuals and couples in Kenya, Tanzania and Trinidad using a randomised trial reported that counsellors found sessions with couples to be difficult but also more satisfactory than individual sessions. When an opportunity was offered for couples to come together to discuss their sero-status results in a safe setting and to negotiate a risk reduction plan there was a great potential for reducing the high transmission rate of HIV among couples in less developed countries.

A study conducted by Allen, Tice, Van der Perre, Serufilira, Hudes Nsengumuremyi, Bogaerts, Lindan and Hulley (1992:1605), to determine whether HIV testing and counselling increased condom use and decreased heterosexual transmission of HIV in discordant couples revealed that after an average of 2.2 years of follow up consultations with sero discordant couples, the proportion of discordant couples using condoms increased from four per cent to 57% after one year of follow- up consultation. Confidential HIV sero testing with counselling led to a large increase in condom use and was associated with lower rates of HIV infection.

Creek et al. (2006:214) found that clients who came for testing as part of a couple consisted of eight per cent of all clients. Sixty per cent of clients who tested as part of a couple were unmarried; 8.0% were tested because they wanted to get married 5.7% were tested before they have sex with their partners. Forty–two per cent of sexually active clients reported always using a condom in the previous three months, while 28% reported sometimes using a condom in recent months.

COMMENTS OF LAY COUSELLORS

LC 10: *When the clients deny their HIV status I think of the CD4 count blood cell that will be dropping in the meantime while the client is in the denial stage, I feel hurt, as if the CD4 cells blood cells that are dropping are mine.*

LC 12: *Clients who come to test while they know their status they make our statistic too high with HIV positive people; they move from one clinic to the other they are in denial.*

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LC 8: *Client don't come to collect the for CD4 cell blood count. When they come back, they will come being very sick, and when the clients are sick it is difficult to educate or talk to them.*

LC 10: *When they don't come to collect the result for CD4 cell the nurse will make a follow-up by phoning those with phones.*

LC 8: *Some client will say the results are not true; the results don't belong to me, last week I tested negative why now I am positive, today.*

LC 2: *Clients will say "I am not ready to test. I need talk to my husband first."*

LC10: *There is lot of denial in our area, one will say I will go home to Mozambique and get treatment.*

LC4: *There is lot of denial in our area and s lot of polygamy. If a woman enters into a polygamous marriage and tests positive, she says she will not tell anyone in the family because they will say I am the one who came with the disease.*

LC 13: *VCT clients deny their status, because they don't believe they could be infected, saying 'why me? I don't have AIDS' they are afraid of not being welcomed by friends and family members.*

LC 5: *Clients who deny their status make me feel discouraged and I feel that I did not do the right thing, I did not counsel them well.*

LC 8: *I am worried about the clients who are in denial and don't come to follow-up counselling; they continue with unsafe sexual behaviour and continue to infect other people.*

LC 2: *Clients in denial move from one clinic to the other, testing for HIV and not accepting their HIV status deny themselves early treatment.*

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LC10: *When the clients deny their HIV status I think of the CD4 count blood cell that will be dropping in the meantime while the client is in the denial stage, I feel hurt, as if the CD4 cells blood cells that are dropping are mine.*

LC 12: *Clients who come to test while they know their status they make our statistic too high with HIV positive people, they move from one clinic to the other they are in denial.*

LC 8: *Client don't come to collect the CD4 cell blood count, when they come back, they will come being very sick, and when the clients are sick it is difficult to educate or talk to them.*

LC 10: *When they don't come to collect the result for CD4 cell count the nurse will make a follow-up by phoning those with phones.*

LC5: *HIV positive pregnant woman who delivered at home, when you ask why? She will say I have forgotten, this is because they did not disclose to anybody, they were not reminded.*

LC20: *I am hurt about mothers who are HIV positive and are pregnant or breast feeding and not accept their HIV status. These women are a concern because they end up denying their children treatment.*

LC15: *Clients who will say, I came to collect milk, but I am not HIV positive because artificial feeding is connected to being HIV positive and not breast feeding." is associated with being HIV positive.*

LC 2: *Mothers who are married in polygamy marriage are afraid to disclose the HIV status to their husband, or any family member say they will be accused of bringing the disease in the home they keep quite posing a danger to the children and husband.*

LC 20: *ARV clients when they are still assessed to be placed on treatment, they are very good, and listen to everything we discuss and suggest to them, but after when they are on treatment and feeling much better, they are no longer simple, they no longer cooperate, they are impatient, they no longer listen, don't want to take blood for CD4 count cells, and no longer want to listen to health education they are always in a hurry.*

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LC 2: *When clients are asked why you did not come to collect treatment, client will say" I did not have money for transport or i did not have food my grand is taken. I had to go and look for work to get food.*

LC 13: *Clients are asked to bring the treatment supporter who will encourage the client to take treatment, Client who do not bring treatment supporter are the once who forget to take treatment and finally they default treatment.*

LC 4: *Client default coming to collect treatment and will say, 'I did not have money to come to the clinic' or 'I went home Mozambique and I did not have money to come back, or I went to the farms to lock for work, I was afraid to tell the employer that I have to the hospital to get the treatment.*

LC 20: *Clients who are given treatment before they understand the importance of treatment, how the treatment is taken, and side effects of the treatment are the clients that default treatment". In the beginning we use to counsel client for adherence for 2 weeks we seen little defaulting in these clients, now clients are adhered for few days and given treatment.*

LC3: *I met a couple where, they were both on ARV, and did both did not disclose to each other. One day the man wanted to accompany the woman to the clinic the woman refused but the man followed her and found her at the ARV clinic. The woman did not want the man to hear what the counsellor is saying and send the man to buy her food. The man went to buy food. The lay counsellors said "I remained telling the woman the importance of disclosing her status.*

LC 20: *Couple where woman comes for testing alone, and test positive and not disclose to the man, when the men find out, it end in a fight and divorce.*

LC 12: *I once counsel couples, where the man was positive and did not want to use condoms with the aim of infecting the woman. This was a big problem the man wanted me to tell the woman that she is HIV positive, so that he can have sex without condom so that they can be are HIV all positive. The counsellors refused to do what the man ask me to do, because the woman also has rights too.*

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LC 1: *Couples where the other one is positive and the other one is negative counselling them to use a condom is a problem especially when the one who is positive is the man, he will say we have not being using the condom and she was not getting infected why now.*

LC 16: *Women who will say I don't want to see any man next to me when they are still very sick, when they get better, the counsellor will realise that the women is pregnant and she is hiding it or coming to deliver a baby.*

LC 6: *I counselled a couple where the women have 5 children from another marriage. The men want the child if his own and the women is HIV negative the man positive.*

The findings of this subcategory showed that the majority of the participants have experienced clients who denied their HIV positive results. Some participants experienced challenges with clients who do not come to collect their CD4 cell blood count. Very few clients defaulted on treatment. Similarly very few mothers denied their HIV positive status. Some experienced challenges with couples who did not come together for counselling and who have not shared their HIV status with their partners. In a study conducted in Uganda, by Bwambale, Ssali, Byaruhanga, Kalyango and Karamagi (2008:6-7) the researchers found that men want to know their HIV status and support PMTCT. The disclosure of HIV test results can be used as a strategy to encourage men to increase their utilisation of VCT. VCT programmes should make couple testing more attractive by improving confidentiality and using the home based VCT approach.

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3.3.2 Lay counsellors' perceived challenges with regard to counselling rooms

Participants mentioned that they have challenges with the environment. In some facilities the counselling rooms are small and hot with no air conditioning, while in other facilities there are no specific rooms for counselling. The challenges relating to the environment will be discussed in detail below:

Participants mentioned that they do not have counselling rooms. Participants mentioned that they share rooms with the nurses, work in the labour wards, store rooms and shower rooms.

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The results revealed that some of the participants during focus group discussions experience challenges with small and hot counselling rooms. However, the majority of participants during individual interviews mentioned that they had experienced challenges with the environment. Thirty five per cent of the participants during observational sessions were observed counselling in small rooms that are very hot in summer with no air conditioning. Some participants were observed counselling in rooms not specifically designated for counselling. Counsellors sometimes have to use maternity and labour wards. One female participant during an individual interview mentioned: *When there are many clients I use the shower room which is very small. The chairs are placed very close to each other and it is uncomfortable.*

During observational sessions in health care facilities, health workers were observed coming into the counselling room while the counselling was in process. She said: *You see what they do, they just open without knocking there is no privacy. I have written DO NOT DISTURB on the door but this does not mean anything. They come in, even when the counselling session is in progress. They just come and you see the fridge in which the placentas are stored before collection.* Participants mentioned that there are no hand-washing basins in the counselling rooms. The majority of participants during focus group discussions did not mention the hand washing basins. Some of the participants mentioned that they do not have hand washing basins in the rooms. Observation revealed that 45% of the participants did not have hand washing basins in the counselling rooms.

van Dyk (2001:409) is of the opinion that counselling should be done in a quiet private environment and enough time should be allowed for discussion. Where there is no specific counselling, privacy and confidentiality will not be maintained and there will be disturbances.

A study conducted in Greater Tzaneen by Mqimeti *et al.* (2011:151), results revealed that not all counsellors had private counselling rooms available; only 8.3% had private rooms. In the current study 35% of the sessions were observed where lay counsellors did not have private counselling rooms.

Sontyle (2012:9) in the study implementation of rural HIV programmes indicated that scaling up of HIV programmes is faced with multiple challenges; some of them need long term strategies to overcome such as no proper monitoring and evaluation tools, scarce human

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resources; inadequate health care infrastructures and availability of suitable counselling and clinical care space.

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COMMENTS OF LAY COUSELLORS

LC 6: *There is no good working space, today you are in consulting room 1, tomorrow in consulting room 2, the consulting rooms are for nurses no good space for the lay counsellor, it make our clients not to be comfortable when coming for counselling.*

LC 10: *I don't have special room for counselling this disturbs as in the middle of the counselling session I will be told to move out there is a client coming.*

LC 7: *This room is too small, it does not have windows to open, there is an air conditioner but when you open it other client don't like it, and this place is hot, if I want to conduct group discussions I cannot the room is small.*

LC 5: *When there are many clients, I counsel in the shower room, the room is small the chair are very close is not comfortable.*

LC 8: *There is no counselling room, this room is very hot you can even feint in this room there is no air.*

LC 10: *This room that I am counselling in is used as store room the duty room. Many items for the clinic use are placed in this room and health workers comes any time, to take items such as vaccines, files and books.*

LC 5: *You see what they do, they just open without knocking there is no privacy I have written "don't disturb but is does not mean anything they come in, even when the counselling session in on they just come in you see, this fridge is for placing placentas they are collected to be burned somewhere else.*

L C2: *We are two lay counsellors, and only one counselling room, we rotate using this one room, we losing a lot of time waiting for the other counsellors to finish.*

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LC 4: *As you can see in this room, there is no basin for washing hands, I have to go and look for a basin to wash my hands, I have to move out go to the other room to wash my hands.*

The results of this category revealed that 35% of the participants have experienced counselling rooms that are small and hot and not conducive to counselling. The majority of the counsellors are not supported by the health professionals who do not respect the counsellors and who do not regard them as members of the team. The majority did not have hand washing basins; this was evidenced by 45% of the participants. The majority of the participants mentioned that their stipends are too low. However, only one participant mentioned that if they could be absorbed by the government they would receive better stipends. The overwhelming majority of the participants all want to conduct HIV tests.

3.3.3 Lay counsellors' perceived challenges with regard to health professionals.

During focus group discussions and individual discussions participants mentioned that they have challenges with health professionals. The majority of the participants in focus groups mentioned that they are not supported by health professionals. Some participants in individual interviews mentioned that they are supported by health professionals. One participant during an individual interview mentioned that the health professionals are very good and supported them. She said: *I sometimes hear other counsellors complaining about their health professionals, who are not good to them, but with us we are happy; the health workers are very good and they support us.*

Another participant mentioned: *I am working with the health workers very well, they are willing to assist me, they understand that I am not working for the government and they assist me with the statistics.*

One of the participants during a focus group discussion mentioned: *Health workers don't take us as part of them. We don't work as team, we don't attend meetings with them; when we have personal problems we are afraid to tell them.*

Another participant during a focus group discussion mentioned: *Health workers don't conduct counselling during weekends, telling the clients to come on Monday. On Monday when I come to work there are many clients that I cannot handle.*

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Another participant during individual interviews mentioned: *When clients leave without being tested, I feel stupid. I cannot finish my work. If lay counsellors could able to conduct the tests, this will save time for clients, lay counsellors and that of the health workers, and will improve trust and the relationship between clients and the lay counsellors.*

Concerning shortages of staff, the majority of participants during focus group discussions mentioned that there is a shortage of health professionals in health facilities. Similarly, the majority of the participants during individual interviews mentioned that they experience a shortage of health professionals and it affects their competence. One participant in an individual interview mentioned: *There are only two professional nurses; when one is attending a workshop the other will be doing all the work. I also expect her to assist me in counselling. During observations many clients needed assistance from the health professionals; in many instances there were only one or two professional nurses.* Participants mentioned that health professionals delay coming to conduct the tests and this makes the lay counsellors to be incompetent because clients have to wait a long time after they are counselled and before the tests can be done. Some clients even leave without being tested.

With regard to delays in conducting HIV tests, the majority of the participants during focus group discussions mentioned that health professionals delay coming to undergo the tests. Similarly participants during individual interviews mentioned delays by health professionals coming to conduct the HIV tests. During observational sessions no delays were observed. One participant during a focus group discussion mentioned: *When clients leave without being tested, I feel stupid; I cannot do my work in full. I cannot finish. If lay counsellors would conduct the tests, this will save time for clients, lay counsellors and that of the health workers, and it would improve trust and the relationship between clients and the lay counsellors.*

Health professionals who came to conduct the tests spontaneously remarked: *Lay counsellors are doing their work well; they have reduced the workload for us.*

Malema *et al.* (2010:22) found that counsellors experienced health professionals who were appreciative of their work but there were some, who looked down on the counsellors. Kigozi, Heunis and van den Berg (2011), the authors' support the view that, there are some nurses who are reluctant to delegate HIV counselling to lay counsellors.

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Concerning the shortage of staff, Ismail and Ali (2009:196) conducted a study in Addis Ababa to assess the quality of antenatal care for PMTCT. It was found that the shortage of manpower in health care facilities resulted in counsellors not devoting sufficient time for counselling because of they are engaged in other mother and child health (MCH) activities in the health centre such as managing deliveries and family planning.

Zacharia, Tech, Buhendra, Fitzerland, Lebana, Chinji, Humblet, Haries (2007:168 -171) the researchers found that HIV and TB places a major burden on existing health services in Malawi. This has caused a shortage of staff in public health facilities. A study conducted in Zimbabwe by Shetty, Mhazo, Moyo, Lieven, Matela, Katzenstein and Bassett (2005:757) found that the use of paid or volunteer lay counsellors can augment the counselling capacity in public health facilities. Nurses are reluctant to take on the additional task of counselling. Pre- and post-counselling by lay counsellors is acceptable to clinic staff and clients.

Leshabari, Blastat, de Paoli, and Moland (2007:11) studied the experiences and concerns of nurses working as infant feeding counsellors to HIV-exposed mothers in the Kilimanjaro region in northern Tanzania. Their study revealed an overwhelmingly high level of stress and frustration by counsellors as a result of the constantly increasing workload. There was a pressure to compromise the quality of work for the sake of increased workload. The counsellors mentioned that they were stressed and frustrated. They experienced a feeling of hopelessness and felt that their work had little in common with their desire to heal which they see as the heart of the nursing profession. The new roles in which they are trained require a very different approach to patient interaction and that the health related decisions rest to a large extent with the patient.

Sanjana, Torpey, Schwarzwalder, Simumba, Kasonde, Nyirenda, Kapanda, Kakungu-Simpungwe, Kaboso & Thompson (2009:3) interviewed health care workers (HCW) about workload and human resources issues. The HCW mentioned that lay counsellors have contributed significantly to reducing the workload of HCW. *They have given us relief; the courage of Counselling and Testing services has gone up, and we have been able to reach our target*. The presence of lay counsellors has resulted in the uptake of services increasing by 27.0%. Lay counsellors have provided a high quality of work. A review of the records revealed that data accuracy was high among both lay counsellors and HCW. Health care

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centres expressed concern about retaining lay counsellors because the stipends they receive are too low. One participant remarked: *We may lose them if they find better payment in future. If they leave us, it will impact negatively on the services.*

Grinstead and Van Der Straten (2009:10), in their study exploring counsellors' perceptions of providing HIV counselling in Kenya and Tanzania mentioned that lay counsellors their internal problems relate from hours of work, patient flow, compensation and benefits related to co-workers. Job related stress Counsellors describe their work as heavy and unpredictable; they feel fatigued and work under pressure. The external problems relate difficulties of getting to work such as transport and stressful condition in the surrounding settlement. Wilkinson (1998:40) holds the view that bureaucratic workplaces where creativity is stifled and workers become alienated results in individual and collective discord.

With regard to the shortage of staff, Mqimeti *et al.* (2011: 160), revealed a shortage of staff in health care facilities; more than half (58%) of the participants reported a shortage of counsellors as the main obstacle in rendering VCT, followed by a lack of support for counsellors. The majority of the participants (65%) reported that counsellors have never attended debriefing or mentoring sessions and 58% have not attended update or refresher courses on VCT.

A study conducted in Addis Ababa by Ismail and Ali (2009:192-193), about the quality of HIV counselling given to pregnant women for PMTCT found that clients who received counselling and testing from the lay counsellors waited less time than clients who received counselling and testing from health care workers. Data further revealed that 70% of clients interviewed preferred to receive CT from the lay counsellors rather than from the health care workers; lay counsellors were available almost all the time to provide CT services on an average of 2.8 days and see an average of 5.6 clients per day. The quality of counselling provided by lay counsellors was high compared with CT services conducted by health care workers. Clients who received counselling from the counsellors waited an average of almost 15 minutes less than clients who received CT from the HCW (Sanjana *et al.*, 2009:5).

Concerning testing by lay counsellors, a study conducted in Nigeria by Omolase *et al.* (2010:310) found that lay counsellors provide counselling and testing services of quality and relieve the workload of over-stretched health care workers. The facility manager recognises

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and appreciates the services provided by lay counsellors. It revealed that lower error rates were found in the work of lay counsellors as compared with that of health care workers. Researchers noted that health workers contributed to inform the people about VCT. Half of the respondents in the study mentioned that they received information from the health care workers. The management of the hospital sent health workers on VCT courses. Health workers in the current study were positive in assisting the lay counsellors.

Khaturima (2009:2) has the view that, the introduction of lay counsellors as a means of reducing strain on nursing staff was an interestingly new and unusual method of planning and implementing HIV counselling, although the model is not without its challenges. Because of the burden already exerted on the available health care workers with regard to HIV and AIDS lay counsellors have been used to take on some of their roles.

Venter in (Dlamini, 2011:2) was of the view that, while deployment of lay counsellors obviously contributed enormously to ease the burden of nurses and doctors, there were legal constraints in their sphere of responsibility. Lay counsellors were not permitted to test patients and relied on nurses to complete the testing process. Venter further mentioned that VCT is an important diagnostic tool but is held back by the fact that lay counsellors are not able to test clients to complete the counselling process. It was clear that the rule had to change in order to scale up treatment access and enable health care workers to become involved in particular stages of treatment provision which they were previously not allowed to do. Lay counsellors are now permitted to carry out HIV tests

COMMENTS OF LAY COUNSELLORS

LC 4: *Health professionals don't receive us well, they look down at us meanwhile we do our work well. They don't take us as part of them we don't work as team, we don't attend meeting with them, when we have personal problem we are afraid to tell them. Staff nurses undermine us.*

LC 2*: The manager want me to come to the clinic when I am ill, and not to call, other health workers can call her to say they are ill, I think she does not trust me, she think I can say I am ill when I am not.*

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LC 4: *Nurses delay coming to conduct the test, this make us lose many clients. Some of the clients are in a hurry to go back to work; they only have lunch time to come for counselling and testing, if the nurse delay, they go without being tested.*

LC 12: *Some nurses want to conduct the test outside the counselling room in nurses' station where there is no privacy, the nurse will say, I must bring the client to her because she is busy, I refused because testing should be private.*

LC 13: *Nurses will delay coming to take blood for CD4 blood count, the client end up leaving, this affect our statistic as the HIV positive tested clients will not match those that the CD 4 blood cell were taken, they will say counselling is not an emergency this shows no respect for the other person's work.*

LC.1: *Health professionals just come into the counselling room without knocking while the counselling if in process they even ignore the don't disturb sign they have to come in to the room, they want are at work.*

LC 3: *Sometimes we have to wait for "Tick" registers consent forms which are out of stock. We draw line similar to those in the tick register and use, and let the client sign names in the book for our records, this affect our work it courses delays.*

LC 10: *If nurses delay to conduct the test, I have no choice I have to wait because, I cannot conduct the test. I have to wait until the nurse come, there is shortage of health professionals or VCT nurses, and this contributes to the delay in conducting the HIV test.*

LC 1: *Clients stay for a long time after being counselled waiting for a nurse to come and conduct the HIV test client get impatient and say they will come tomorrow, the client have go without testing because the nurse is not available some clients end up not coming back.*

LC 4: *There are only two professional nurses when one is attending workshop there will be one doing all the work and I also expect her to assist me in counselling, I cannot blame the nurse delaying to come to conduct the HIV test because I could see she is having many patients to attend to. We are all waiting for her to assist us.*

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LC 14: *The only challenge affecting my competence I don't have a nurse to conduct the test. I will counsel and stay with client waiting to be pricked for hours.*

LC 2: *Client who are counselled and not tested within an hour they become impatient and leave the clinic, this affect my competence, I have counselled the client the client agree to test and the nurse delay to come due to other activities.*

LC 9: *Health workers could not afford the number of clients coming to health facilities for counselling, lay counsellors have reduce a huge load from the health professionals, we need to be supported encouraged and motivated to do the job, this job is stressful.*

LC 8: *When client leave without being tested, I feel stupid, I cannot do my work in full is like, I have started but I cannot finish. If lay counsellors could able to conduct the test, this will safe time for clients lay counsellors and that of the health workers, and improve trust and relationship between clients and the lay client counsellors.*

LC 15: *To tell the truth our health professionals are very good they support us I sometime hear other counsellors complaining about their health professional who are not good to them, but with us we are happy, health workers are very good they support us.*

LC 10: *We work as team, when they see that I am not well they will ask me and counsel me before I can counsel the clients, and they are not doing this to me only but to all of us lay counsellors.*

LC 2: *In the beginning they were undermining us saying we are not nurses, because I love my work, I came out to defend my position and have to say, even if I am not a nurse,. I am doing my work I know how to do my work, now is better when you ask them to come to assist in testing they do come, we are colloquies we attend meeting with them.*

LC 20: *Health professionals are over worked and they are over burden by the work of conducting the test for the counsellors when they delay due to other duties it might be seen as they are not supportive.*

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LC 7: *When clients leave without being tested, I feel [illegible] cannot do my work in full is like, I have started but I cannot finish. If lay counsellors could able to conduct the test, this will safe time for clients lay counsellors and that of the health workers, and improve trust and relationship between clients and the lay client counsellors.*

3.3.4 Lay counsellors' perceived challenges with regard to stipends

The majority of participants in the group discussions mentioned that their stipends are too low. However, only one participant during individual interviews mentioned that the stipends are too low. One of the participants during focus group discussions said: *The stipend is too little compared to the type of work we do; the work is stressful. The stipend stresses us even more. We love our work, we are committed, we enjoy what we doing, we are helping people but we get too little.*

Only one of the participants during focus discussions mentioned being absorbed by the government. Observation revealed that counsellors are not happy because the stipend is too low.

Venter in (Dlamini, 2011:2) further mentions that lay counsellors are among the most passionate and dedicated care workers in the health sector and usually are women; they display a genuine compassion for the members of the communities that are infected and affected by HIV and AIDS. They do this day after day, month after month in spite of the delays in the payments that they require to maintain their families. There is still a lack of recognition of lay counsellors in the health sector. Venter continues to mention that lay counsellors are regularly not paid their monthly stipends by the government; a stipend is just around R1000 per month. There is little or nothing in the way of formal recognition of training or skills transfer training, career recognition or opportunities for advancement. Black, Sparague, and Chersich (2013) support the authors by mentioning that employment and remuneration of lay counsellors in South Africa are characterised by the payment of stipend rather than formal employment contract. The department contact with NGO to manage and pay lay counsellors. Late payment and poor working conditions are reported frequently. Ambiguity in employment status limits the counsellors under labour law.

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Sanjana *et al.* (2009:3) share the view with Venter saying that lay counsellors are able to devote more time to each client than are health workers, but they are not part of the current Ministry of Health establishment. The Zambian programme for counselling and testing gives the counsellors stipends of 100 000 Zambian Kwatsha per month (approximately USD 25 per month and about R300 per month). Lay counsellors with one to two years in counselling in the current study received R1900, R2, 300 for counsellors with three to four years' experience and R2 600 for counsellors who have been in counselling for five years or more.

Peltzer, *et al.* (2010:382) conducted a study in Mpumalanga, South Africa where exit interviews were conducted with 10 counsellors who were counselling clients in an intervention programme. It was found that counsellors are paid after each completed counselling session. Counsellors are paid R10 per specific intervention counselling session and R1000 per month. van Rensburg (2013:10) reported that lay counsellors mentioned that they have needs and have requested that, if they could be given money or stipend especially to cover transport costs, it will be appreciated

3.3.5 Lay counsellors want to conduct HIV test

Concerning testing by lay counsellors, Baiden, Akanlu, Hodson Akweongo, Debpuur and Binka (2007:4) assessed the use of lay counsellors to promote community based VCT for HIV related stigma, in rural Northern Ghana. After 13 focus group discussions they found reinforced approval for community based VCT by lay counsellors, but revealed concern about stigma and confidentiality. An overwhelming majority of 98% of respondents approved the use of lay counsellors to promote CBVCT. However, there is apprehension regarding giving HIV rapid test kits to lay counsellors fearing that a breach of confidentiality was possible.

COMMENTS OF LAY COUNSELLORS

LC 20: *If we are absorbed by the government we will get a lot of money, I want to go on with my work, not to end up in the air.*

LC 10: *If I can get R5000.00 it will be better I can support my children.*

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LC 1: *The government should increase the stipend we getting is too little it stresses me. Nurses receive money every day from the department you will hear nurses saying; I received money for this and that.*

LC 10: *We work with nurses and you will hear them saying I received money for this and this claims then you think of your little stipend and get depressed, not being sure this month you will get the little because the stipend is not regularly.*

LC 13: *It is stipend that stress us is too little, I cannot cope with the stipend that I get .This work is difficult if the department could increase the stipend.*

LC 8: *Nurses are getting a lot of money, every week, you will hear saying, "I have received money for the claims they made us feel very little".*

LC 15: *The government should give the partners NGOs enough money and they will give us regularly.*

There were similarities and difference with regard to the results of this sub-category. The results revealed that the majority of the participants are not supported by the health professionals. The majority of the participants have experienced a shortage of health professionals in the health facilities with the result that, health professionals delay coming to conduct HIV tests. However, during observational sessions delays of health professionals coming to conduct the test were not observed.

With regard to the stipends, participants mentioned that the stipends are too low. The majority of participants in the group discussions mentioned that the stipend is too low. Only one participant during individual interviews mentioned that the stipend is too low. One of the participants during focus group sessions said: *The stipend is too little compared to the type of the work we do, the work is stressful, and the stipend stresses us more. We love our work, we are committed, we enjoy what we doing, we are helping people but we get too little.*

Only one of the participants during focus discussions mentioned being absorbed by the government. Observation revealed that counsellors are not happy because the stipend is too low. About lay counsellors conducting the tests, participants mentioned that if they could

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conduct the HIV tests, the lives of the clients and [illegible] professional would be better. The study revealed that the majority of the participants during focus group discussions wanted to conduct the tests themselves. Similarly the majority of the participants during individual interviews wanted to conduct the tests. "One of the participants during individual interviews mentioned: *We have learned how to conduct the test. During VCT training we are taught how to test; if only the law could allow us to conduct the test*. The majority of participants in the focus group discussions mentioned that it would be good if they could be able to do the testing. During observation participants were not seen conducting the tests.

Venter in (Dlamini, 2011:2) further mentions that lay counsellors are among the most passionate and dedicated workers in the health sector; they are usually women and have a genuine compassion for the members of the communities that are infected and affected by HIV and AIDS. They do this day after day, month after month in spite of the delays in the payment of the stipends that they require to maintain their families. There is still a lack of recognition of lay counsellors in the health sector. Venter further mentions that lay counsellors are regularly not paid their monthly stipend that is around R1000. There is little or nothing in the way of formal recognition of training or skills transfer training, career recognition or opportunities for advancement.

Sanjana *et al.* (2009:3) share the view with Venter by saying that lay counsellors are able to devote more time to each client than are health workers, but they are not part of the current Ministry of Health establishment. The Zambian programme for counselling and testing gives the counsellors stipends of 100 000 Zambian Kwatsha per month (approximately USD 25 per month and about R300 per month).

The counsellors in the current study received R1900 for counsellors with one to two years in counselling, R2 300 for counsellors with three to four years and R2600, for counsellors who have been in counselling for five years or more.

Concerning testing by lay counsellors, Baiden, Akanlu, Hodson Akweongo, Debpuur and Binka (2007:1), the researchers, in their study that assessed the use of lay counsellors to promote community based VCT for HIV related stigma, in rural Northern Ghana, finding from 13 focus group discussion reinforced approval for community based VCT by lay counsellors, but revealed concern about stigma and confidentiality. Overwhelming majority 98% of respondents approved the use of lay counsellors to promote CBVCT. However there

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is apprehension of giving HIV rapid test kits to the lay counsellor for a breach of confidentiality.

3.4 LAY COUNSELLORS' VIEWS REGARDING STRATEGIES TO IMPROVE COMPETENCE

The findings about the competence of lay counsellors during FGD and individual interviews are mentioned below. This section shows the responses to Questions 3: What strategies do you think could be employed to improve your competence? This section indicates lay counsellors' views, with regard to the strategies that could improve their competence

Table 3.11 Lay counsellors' views regarding strategies that could improve their competence

Category 3	Sub –Categories	Descriptions
Lay counsellors mentioned some of the strategies that they think could enhance their competence.	Lay counsellors need empowerment through training workshops.	Lay counsellors need empowerment by attending updates or in-service training on VCT PMTCT ARV and couple counselling.
	Lay counsellors need books and pamphlets/manual and protocols.	Lay counsellors need to have books, pamphlets, manuals and protocols to read in order to improve their competence.

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	Lay counsellors need support mentoring and supervision regularly.	Regular support mentoring and supervision could improve their competence.
	Lay counsellors need regular monitoring and evaluation sessions.	Regular monitoring and evaluation of the work of lay counsellors could empower them.
	Lay counsellors need to conduct HIV tests.	Lay counsellors need to conduct the HIV tests to save time for clients and health workers. The confidentiality of the clients must be maintained.
	Lay counsellors need to network with others.	Meetings with lay counsellors from other districts and provinces could also empower them.

In this category the following subcategories, were identified namely: Lay counsellors need empowerment to be competent; Lay counsellors need to read books and pamphlets; Lay Counsellors need support, mentoring and supervision regularly to be competent; Lay Counsellors need regular monitoring and evaluation to improve their competence; Lay Counsellors need to conduct HIV tests; Lay counsellors need to network with others.

3.4.1 Lay counsellors' need for empowerment through training workshops

Participants mentioned that they need empowerment through continuing updates and training workshops. Participants mentioned they are trained in VCT PMTCT, adherence counselling and couple counselling. Participants mentioned that the continuing in-service training and updates could be employed as strategies to improve their competence.

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The focus group discussions revealed that all the participants are trained in VCT. Similarly the individual interviews revealed all the participants are trained in VCT. Observation sessions revealed that 100% of the participants are trained in VCT. However all the participants (100%) had not received VCT up-date. One of the participants during focus group discussions mentioned: *We need VCT updates. Since I trained for VCT; we never attended any updates for VCT. Please organise updates for us.*

Concerning PMTCT, participants mentioned that they had attended an update workshop on PMTCT, The majority of the participants during focus group discussions mentioned that they had attended PMTCT update workshops. Similarly, the majority of the participants during individual interviews mentioned that they had also attended update workshops on PMTCT. However, only 15% of the participants during observational sessions did not attend PMTCT training and 20% of the participants did not attend PMTCT update workshops. One of the participants during focus group discussions mentioned: *The PMTCT update helped me understand how the ARV that the mother takes before delivery works to prevent MTCT and understand the importance of the feeding options for HIV positive mother we need updates on ARVs.*

One participant during a focus group discussion mentioned that the update workshops about PMTCT helped her to know that HIV positive children should be referred immediately to the ARV centre.

Concerning treatment adherence update workshops, participants mentioned that they had not attended update workshops on treatment adherence. The results revealed that the majority of all the participants during focus group discussions and individual interviews had not attended update workshops on treatment adherence. During observation sessions it was found that none of the participants had attended update workshops on treatment adherence

With regard to couple counselling update workshops, participants mentioned that they had not attended couple counselling update workshops. None of the participants in focus group discussions had attended update workshops on couple counselling. Similarly the majority of the participants had not attended update workshops on couple counselling. The results of the observational sessions indicated that none of the participants had attended update workshops on couple counselling.

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VCT workshops helped participants to reflect on the impact of HIV and AIDS on themselves as counsellors and as people. Counsellors need to know themselves before they can understand their clients. They need to understand their own attitudes and how their attitudes may affect counselling especially when working with people from different cultures (DOH 2001:18). Mat Min, (2009:443) mentioned that trainees need to be more confident and competent when they engage in counselling sessions; this is developed from their experience in counselling sessions. Regular training workshop will develop confident and competent lay counsellors.

Voluntary counselling and testing of pregnant women is important for the mother to make informed and correct choices about infant feeding methods. The mother and her partner should be provided with sufficient information and counselling on the risks of MTCT and on alternative feeding methods (Evian 2000: 213). The update training may improve their competence as new developments about PMTCT will empower them and in turn they will empower their clients. The author further mentions that for lay counsellors to be empowered they should be regularly informed about new developments and should attend update workshops on treatment adherence. Evian further encourages counsellors to keep themselves informed about changes in HIV and AIDS treatment and the drugs that are involved. By reading HIV related books, manuals and protocols lay counsellors will learn about new developments and will be able to keep up with new information that they will share with their clients.

Grinstead and Van Der Straten (2009:7) mentioned that lay counsellors need to be highly knowledgeable and keep up to date with the changing nature of the disease so that they can correctly answer a variety of questions asked by clients. Researchers further mentioned that counsellors in the study saw their role as information sharing, being, supportive and motivational. Counsellors should be able to correct misconceptions, remove feelings of isolation and alienation, and connect the client to services required. Counsellors should be able to explore clients' personal medical problems.

According to Mqimeti *et al.* (2011:151), 65% of respondents in their study that evaluated VCT in Greater Tzaneen, the sub-district of Mopani District, found that respondents had never attended a briefing or mentoring session and 58% of the participants indicated that they

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had not attended an update or refresher course on VCT. The results are similar to the results in the current study where 100% of the participants had not attended VCT, treatment adherence workshops or couple counselling update workshops.

According to Sanjana *et al.* (2009:6) sustaining the quality of services requires refresher training to maintain skills and knowledge. Additional training was rated by 85% of the lay counsellors as important and necessary. All the participants who were interviewed were interested in future training in what was considered a professional field, including obtaining advanced counselling certificates and degrees.

According to Oktay (1991:7), a study that examines burnout in a sample of hospital social workers who work with AIDS patients revealed that emotional exhaustion was significantly correlated with inefficiencies, less support and more depersonalisation. Personal accomplishment was significantly related to more efficiency, more support, fewer HIV positive clients to counsel and more education. Support from co-workers and supervisors and greater feelings of job efficacy generated less burnout. Lay counsellors requested support in dealing with stress and burnout as important for their wellbeing (van Rensburg 2013:10)

Dworkin and Pincu (2011:1) stress the view that HIV and AIDS counsellors must be more flexible and willing to take on new and different roles from those they had before. They mention that information changes almost every day in terms of the conceptualisation of the illness. What was once a death sentence had now become a chronic illness. HIV and AIDS have affected many people and counsellors are called to counsel various groups and should be empowered to deal with the special needs of specific populations. Counsellors should know the physical and psychological symptoms presented by clients and should be ready to refer the clients to appropriate services

COMMENTS OF LAY COUNSELLORS

LC 2: *We need VCT update since we trained for VCT, we never attended the update for VCT, please organises update for us.*

LC 15: *The update workshop about PMTCT helped me to know that HIV positive children should be referred to the ARV centre. We need regular update.*

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LC 20: *The PMTCT update helped me understand how the ARV that the mother takes before delivery works to prevent MTCT and understand the importance of the feeding options for HIV positive mother we need updates we further learned about the counselling skills during PMTCT update workshop.*

LC 13: *Counselling couples is not easy, during update we could share the challenges we encounter with couples.*

The results of this sub-category revealed that the majority of the participants have not attended update workshop on VCT. Very few have attended the PMTCT update workshops and none of participants have attended treatment adherence workshops and couple counselling update workshops.

3.4.2 Lay counsellors' need for books/pamphlets /manuals and protocols

The majority of the participants during focus group discussions mentioned that if they could have books, manuals or counselling protocols it would improve their competence. Similarly participants during individual interviews mentioned that books, manual and counselling protocols would improve their competence. One of the participants during individual interviews mentioned that a written list of counselling skills available in the consulting rooms will assist them to improve their competence; they would have a guide to use, and would be able to learn all the technical skills. One of the participants during focus group discussions mentioned that they did not have any relevant reading material to refer to when they are counselling.

COMMENTS OF LAY COUNSELLORS

LC 15: *Give us books on HIV and AIDS we will read and gain more information and improve knowledge.*

LC 8: *I don't have any relevant reading material to refer to when I am counselling, written counselling skills could assist me not to forget them.*

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LC 19 *We don't refer to any training manuals before counselling session, if we do we will reminded of the counselling skills and other important information that we have learned during training that we can use during counselling.*

LC 10: *I have to read, to have knowledge about new development in HIV and AIDS.*

LC 8: *Since I learned about the counselling skills in training, it is long time, if I don't see counselling skills written I will forget them (skills).*

The results of this sub-category revealed that none of the participants have referral material and protocols that could assist and guide them during counselling to enhance their competence.

3.4.3 Lay counsellors' need for regular monitoring and evaluation sessions

Participants mentioned that if monitoring evaluation sessions could be provided regularly it would improve their competence because after evaluation feedback is given to them and they learn from the feedback.

Very few participants mentioned that monitoring and evaluation could be a strategy that could improve their competence. Some participants during individual interviews mentioned that monitoring and evaluation could be a strategy to improve their competence.

Department of Health (2010:65). The National HIV Counselling and Testing Policy Guidelines emphasise the importance of monitoring and evaluating the HCT programme which is necessary for ensuring that the resources available for the programme are used. Services could be accessed in an efficient and guided manner so that the expected results could be achieved. If service quality were improved, maximum health benefits for the population would be obtained.

Kiputu (2005:4) in the study conducted in Tanzania about quality of voluntary counselling and testing that explored clients experience, expectations and satisfaction, author has the opinion that, HIV research for HIV services need to be conducted. The researcher mentioned that a study conducted in Kenya assessed the implications of quality assurance of VCT, providing interaction in 20 VCT sides. The study found that overall VCT providers are doing

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a good job of counselling about HIV transmission and prevention. However counselling on condom use and the distribution of condoms to prevent STI and unwanted pregnancies was less common. Research about clients' views on delivering VCT services in South Africa revealed that 63% of clients were satisfied with the counselling sessions.

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COMMENTS FROM LAY CONSELLORS

LC 18: *Monitoring and evaluation is important because after the session the counsellor is given feedback and from the feedback I have learned and improved.*

LC 2: *If we are evaluated regularly we could learn from the feedback following an evaluation in relation to counselling skills and processes.*

The results of this category revealed that very few participants viewed monitoring and evaluation as a strategy that could improve their competence. The majority of the participants wanted books, protocols and manuals to be available in the counselling processes for referral purposes.

3.4.4 Lay counsellors' desire to conduct HIV testing

Participants strongly felt that they want to conduct the HIV tests. Results revealed that the majority of the participants during focus group discussions mentioned that they wanted to conduct the HIV tests. Similarly the majority of the participants during individual interviews mentioned that wanted to conduct the tests. During observational sessions the majority of the participants revealed that they wanted to conduct the tests. One of the participants during a focus group discussion mentioned: *If we counsel and test the clients ourselves, the confidentiality will be maintained. I counsel and then call someone to come and conduct the test. Some clients do not understand. We should be taught how to conduct the tests; the work will be simple.* Another participant during individual interviews mentioned: *During training we were taught how to counsel but we are not allowed by the law to conduct the HIV test.*

A study conducted by Malema *et al.* (2010:20), about the experiences of lay counsellors who provide VCT for PMTCT in the Capricorn district, Limpopo Province revealed that lay counsellors cannot perform a rapid HIV test because they are not registered in terms of the Health Professionals Act. According to the Government Gazette of 5 January 2007, only

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persons registered in terms of the Health Professions Act number 56 of 1974 i.e. medical practitioners, nurses or persons trained as nurses according to Act number 33 of 2005 or any person who has been trained to perform such a procedure may withdraw blood for testing DOH (2009: 8-28).

According to Dlamini (2011:2) lay counsellors are contributing enormously to ease the burden on doctors and nurses. There were legal restrictions defining their sphere of responsibility: they were not permitted to draw blood and until May 2010 relied on nurses to complete the testing process. Venter (in Dlamin 2011:2 mentioned that lay counsellors are an important part of human resources because they conduct VCT. VCT is an important diagnostic tool. Venter further mentions that the laws have to change in order to scale up access to medical attention and enable health care workers to become involved in particular stages of treatment in areas where they were not previously allowed. Now lay counsellors are permitted to carry out HIV testing, increasing the human resources capacity and making the role of lay counsellors in the government's HIV Counselling and Testing (HCT) campaign even more important.

COMMENTS FROM LAY CONSELLORS

LC 12: If lay counsellors could be taught how to conduct HIV test, it will help a lot, clients will not stay for long and we will not lose clients, we could see many and reach our target.

LC 16: *Client stays for a long time waiting for the professional nurse to come and perform the HIV test" because I am not allowed to conduct the test.*

LC 20: *We know how to test let them allow us to test things will be easy.*

LC 8: *Our statistic is low because many client leave, when you tell them that I will counsel you and give you all the information, but the nurse will come and test the client become unhappy to make matter worse the nurse even come very late.*

LC 5: *If we counsel and test the client ourselves, the confidentiality will be maintained, this thing of counselling, that we counsel and then call someone will come and conduct the test,*

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some client doesn't understand. We should be taught how to conduct the test the work will be simple.

LC 17: *If we can test we will be assuring our client full confidentiality as I will do everything counselling and testing, I think we contradict ourselves by discussing confidentiality with the client and then say the nurse will come and conduct the test.*

LC 10: *If lay counsellors could be allowed to test we will save a lot of time for nurses and for the client.*

LC 5: *If the lay counsellors could be taught how to conduct an HIV test, this could make their job easy, we will not lose many clients, will safe time, and improve trust and relationship between clients and the lay counsellor.*

3.4.5 Lay counsellors' need for mentoring, support and supervision

Participants mentioned that mentoring; support and supervision sessions are important and could contribute to their competence if conducted regularly. The majority of the participants during focus group discussions mentioned that support and supervision could be employed as a strategy to improve their competence. The majority of the participants during individual interviews mentioned that they thought that mentoring sessions are helpful. There is a need for regular support and debriefing of lay counsellors to deal with stress and burnout (van Rensburg 2013:10).

One of the participants during focus group discussions mentioned that mentoring assisted her. She said she used to sympathise with clients. The mentoring sessions helped her not to sympathise but to empathise with the clients.

Dworkin and Pincu (2011:5) support the view that counsellors and care givers must take care of themselves. They must seek their own therapy supervision and support from groups that focus on healing. All counsellors working with HIV and AIDS clients must seek experience from other organizations that are beyond their professional roles.

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About caring for care givers, Bharat and Mahen (2007:112) have the view that stress management must be recognised as essential for improving provider productivity and sensitive responses to people with living with HIV. NGOs should provide services that address providers' needs. Providers must not only have clinical skills, knowledge of biomedical aspects and skills for caring and counselling, but must also have a good knowledge of national programmes and programmatic linkages as well as understanding of and sensitivity to rights and gender issues in the context of HIV and AIDS. As the number of clients seeking VCT increases so the need to supervise the lay counsellors is vital to ensure quality counselling and improve working relationships where a supervisory role is concerned (Rachier, Gikundu, Balmer, Robson, Hunt & Cohen 2004).

In a study assessing the quality of ante-natal care as an intervention for PMTCT in Addis Ababa, Ismail and Ali (2009:192) found that counsellors need adequate training and on-going support and supervision to ensure that they give high quality counselling and can cope with the workload. They further mentioned that a lack of training and on-going support of counsellors working in PMTCT programmes could lead to burnout or a decline in the quality of services and contribute to the low coverage of ARV. It was also important for HIV positive pregnant women to receive adequate on-going counselling to reinforce the importance of adherence. Maman, Campbell, Sweat and Gielen (2000) mention that HIV counselling programmes offer unique opportunities to assist women who may be at high risk of contracting HIV as a result of their history of assault.

Oktay (1991:3) examined issues of burnout in a sample of social workers working with AIDS patients. The researcher studied the factors that correlate with burnout, including the characteristics of the workers, the setting of the workplace, the nature of AIDS work, and social support. The results revealed high levels of emotional exhaustion and depersonalisation of the social workers working with AIDS patients. However, the social workers found special satisfaction in helping others in need and in empowering patients. It was also found that it was necessary for administrators to aim to minimise the emotional exhaustion and depersonalisation of the workers. In the present study lay counsellors mentioned that they had experienced emotional exhaustion and also found satisfaction in helping people.

Good relationships are important for mentoring. It is through the trust between nurse mentor and the mentee that learning takes place. One of the most important skills in mentoring is that

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of empathy. Mentoring programmes help to focus on the obstacles and challenges the mentee is facing, (Muller 2012:19)

COMMENTS OF LAY COUNSELLORS

LC 11: *When the mentor comes to mentor me at the facility after discussing with the mentor, I feel renewed and have energy to continue working.*

LC 4: *Individual mentoring assisted me to be able to share problems that we encounter at the work place with the mentor.*

LC 8: *When we are at mentoring sessions we share challenges and successes of our counselling sessions, we learn from others.*

LC 8: *When we are many at the group mentoring session, we share our experiences and challenges that we encounter during counselling and learn and grow from other counsellors. The case studies we present at group mentoring sessions empower us on how to handle similar clients during counselling.*

LC 4: *Group mentoring assisted me to understand the difference between sympathy and empathy during counselling, I used to take the problems of clients home because I sympathised with the clients.*

LC 2: *We want to have mentoring session with nurses to discuss important issues affecting us all.*

The result of the sub-category revealed that the majority of the participants identified mentoring, support visits and supervision as strategies that could improve their competence.

3.4.6 Lay counsellors' need for networking with other counsellors

Participants mentioned that networking with lay counsellors from other districts could provide a learning curve and improve their competence. The results revealed that very few of the participants during focus group discussions mentioned that networking with counsellors from other districts could improve their competence. Similarly very few participants during individual interviews mentioned that networking with counsellors from other districts could improve their competence. One participant in a focus group discussion mentioned: *We need to*

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meet with other counsellors from other districts to learn from them share our success and challenges.

COMMENTS OF LAY COUNSELLORS

LC 10: *We can learn from other lay counsellors from visiting them in their areas.*

LC 11: *Meeting with other lay counsellors we can share information and experience.*

LC 8: *We need to meet with other counsellors from other district during conference; we could learn from them share our success and challenges and improve the way we work.*

The results of this category revealed that the majority of the participants have not attended update workshops on VCT, treatment adherence or couple counselling. Very few have attended PMTCT update workshop. The majority did not have referral material and protocols for referrals during counselling. Very few participants viewed monitoring and evaluation as the strategy for improvement. All the lay participants wanted to conduct the HIV tests. Mentoring, support and supervision was identified by the majority of the participants as strategies for improvement. Very few participants viewed networking as a strategy that could improve their competence.

3.5 SUMMARY

Chapter 3 focuses on the competence of lay counsellors implementing VCT programmes in the Mopani District of Limpopo Province. The competence of lay counsellors related to counselling skills and processes was described. The challenges that lay counsellors experienced with clients, the counselling environment and health professionals were assessed and views about the strategies that could improve their competence were presented.

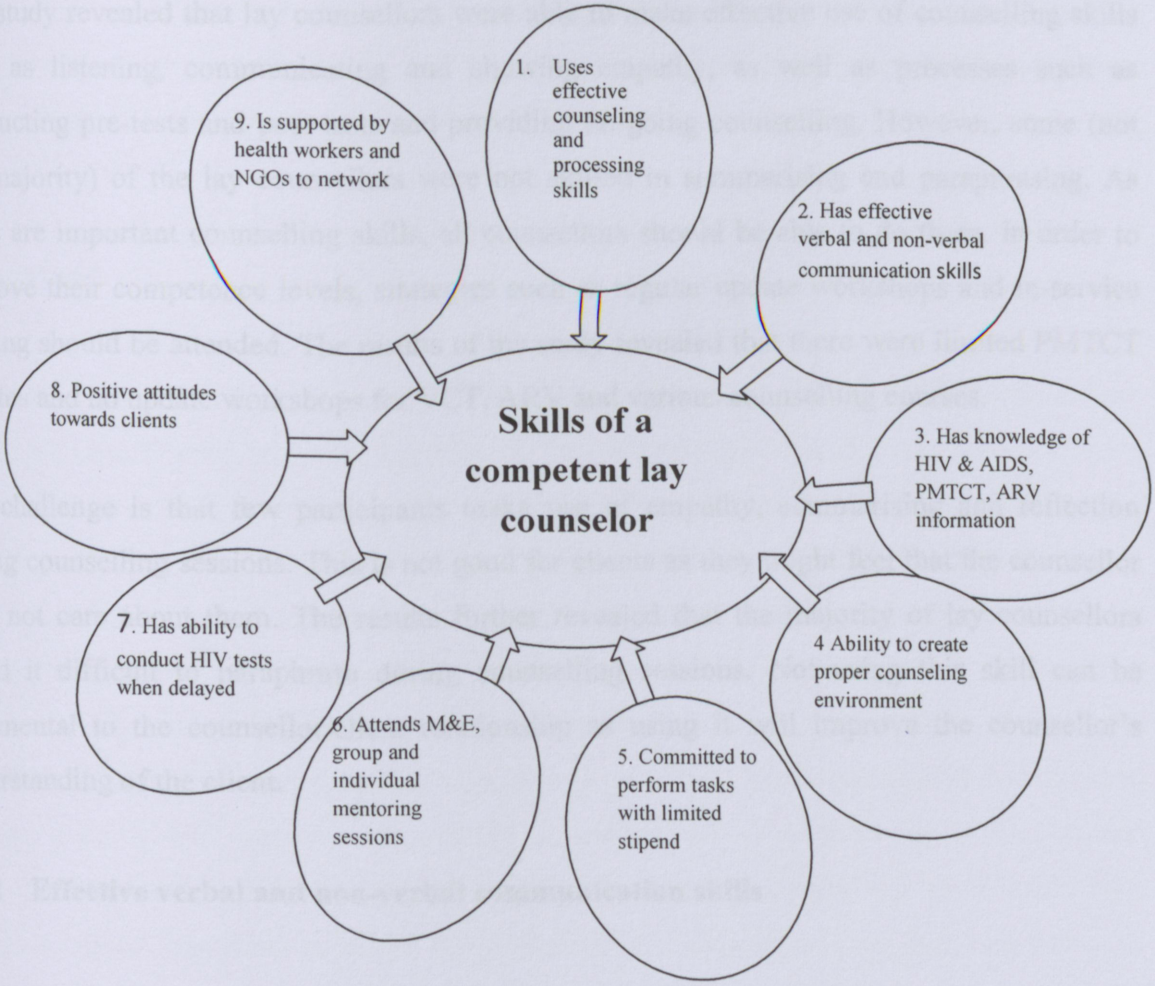
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DEVELOPMENT OF STRATEGIES FOR ENHANCING THE COMPETENCE OF THE LAY COUNSELLORS

4.1 INTRODUCTION

The study revealed variable findings regarding the competence of lay counsellors. Most lay counsellors were competent when implementing the VCT programme. They made use of effective counselling skills and processes; however, there were some who were not competent in using these skills. Figure 4.1 below illustrates graphically the skills of a competent lay counsellor as identified from the data analysis.

Fig 4.1 Skills of a competent lay counsellor



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4.2 DESCRIPTION OF SKILLS OF LAY COUNSELLOR COMPETENCE

4.2.1 Effective counselling skills and processes

Lay counsellors who are able to effectively make use of the necessary counselling skills and processes are able to conduct successful, effective, efficient counselling sessions. Effective counselling skills include listening skills, the use of open-ended questions to elicit information, probing, empathy, summarising and paraphrasing. The results revealed that good counsellors make use of effective counselling skills. Counselling processes such as explaining the counselling process, the issue of pre-testing and post-testing, the importance of consent forms and how tests are conducted are important processes that counsellors should effectively use for successful counselling sessions. However there are other skills in which lay counsellors were not competent.

The study revealed that lay counsellors were able to make effective use of counselling skills such as listening, communicating and showing empathy, as well as processes such as conducting pre-tests and post-tests and providing on-going counselling. However, some (not the majority) of the lay counsellors were not skilled in summarising and paraphrasing. As these are important counselling skills, all counsellors should be able to do them. In order to improve their competence levels, strategies such as regular update workshops and in-service training should be attended. The results of the study revealed that there were limited PMTCT updates and no update workshops for VCT, ARV and various counselling courses.

The challenge is that few participants make use of empathy, summarising and reflection during counselling sessions. This is not good for clients as they might feel that the counsellor does not care about them. The results further revealed that the majority of lay counsellors found it difficult to paraphrase during counselling sessions. Not using this skill can be detrimental to the counsellor/client relationship as using it will improve the counsellor's understanding of the client.

4.2.2 Effective verbal and non-verbal communication skills

Making use of effective non-verbal communication skills is of great benefit to the counsellor and the client because it creates a comfortable environment for both parties. The clients feel

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accepted and welcome, gain the impression that they have been attended to, and that they are respected and trusted. van der Kwaak *et al.* (2010:339) indicate that positive encounters between providers and clients are built on trust and respect. Such encounters consist of the use of good practice and processes and are influenced by space, place and context. According to Landi and Borakhi (2001:6) successful counselling sessions have the following characteristics: the promise of privacy and confidentiality, the provision of enough time for development of trust, and the acceptance of the clients, irrespective of their life style. The services should be accessible in terms of physical accessibility and the availability of counsellors. The study revealed that good lay counsellors make use of effective verbal and non-verbal and verbal communication to conduct successful counselling sessions. Successful counsellors use attentive body and facial expressions, maintain good eye contact and use non-verbal gestures such as nods or touching to acknowledge the client. However, the study also revealed that a significant proportion of lay counsellors did not use non-verbal communication effectively. The researcher believes that regular onsite in-service training could assist lay counsellor to internalise verbal and non-verbal communication skills and use them effectively. It is advantageous for counsellors to use these skills because verbal and non-verbal communication determines future relationships between clients and counsellors.

4.2.3 Knowledge and sharing of HIV and AIDS, PMTCT and ARV information with clients

Lay counsellors need to be competent in counselling clients and therefore should know about and possess information about HIV and AIDS. This knowledge will ensure that clients receive relevant information that will help them understand how HIV can be prevented. The training that the participants in the study received empowered them to share relevant information with their clients: they had extensive knowledge about HIV and AIDS, and thus were able to educate their clients. The results of the observational checklist revealed that lay counsellors had knowledge about HIV, in particular about the modes of transmission, myths, misinformation and misunderstanding related to the conditions. The knowledge that they had enabled them to share what are the implications of being HIV positive when married, and what the benefits are of disclosing one's HIV status to one's family and loved ones. They could also discuss the implications of being HIV positive, as well as issues like stigmatisation, discrimination and safe sex practices. They could explain ways of coping when faced with positive HIV results.

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The study further revealed that successful lay counsellors had attended courses on counselling people infected with and affected by HIV and AIDS. At the courses they learned skills on how to communicate with the clients, counsel, and share information on HIV and AIDS. Lay counsellors also learned how to counsel special groups such as pregnant mothers who are HIV positive, HIV-positive clients who need treatment, and couples when one or both are HIV positive and need treatment and support.

When the researcher observed counsellors providing post-test counselling during VCT sessions, she found that good counsellors were knowledgeable about HIV and AIDS and could share information with their clients. After the counselling sessions clients seemed to know how HIV is contracted and how they can prevent being infected or infecting others. The counsellors knew how to share information with pregnant mothers to prevent MTCT. They could share information with clients who needed treatment, as well as explain the advantages taking ARV treatment and the side effects of ARVs. the findings were to the research conducted in China in 2006 by Khoshnood *et al.* (2006:672) the researchers, assessed the efficacy of VCT interventions with regard to pregnant women and their male partners. The authors found that being knowledgeable about HIV was positively associated with willingness to be tested for HIV. Unfortunately the study revealed that the majority of the participants had not attended update workshops on VCT, treatment adherence, and couple counselling to improve their counselling skills and processes. This could significantly affect their ability to share information.

4.2.4 Creation of proper counselling environment

To have a private counselling environment is beneficial to clients and counsellors. Counselling for HIV and AIDS should be conducted in a private space to maintain privacy and confidentiality. The study revealed that the majority of the lay counsellors did not have proper counselling spaces that would be conducive to effective counselling. The participants had to share counselling space and this delayed the flow of clients as they had to wait while the other counsellors or health workers used the counselling rooms. Sometimes the spaces were used for other activities. The challenge is that when the environment is not adequate, it disturbs the counselling process and the effectiveness of the counselling session. Thus, although lay counsellors promise clients privacy and confidentiality, the fact that most of

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them had to share facilities meant that this was not possible. Another disturbing issue was that professional health workers often interfere while a session is in progress. One participant said: *It is difficult to maintain privacy in this room, this room is a duty room, I share it with other nurses they put their files in here, they come any time to get the files and other things, in the meantime we are disturbed.*

Counsellors need to be able to use special counselling rooms that they do not have to share with other health workers in order for them to conduct effective counselling sessions. The rooms should also be air-conditioned, especially in the heat of summer. The strategy suggested by the researcher is to provide lay counsellors with private rooms that are designated for counselling only, and that are adequately equipped to ensure basic physical comfort. (van der Kwaak *et al.* (2010:340) express the view that the place in which counsellors and clients meet is crucial; it should provide physical comfort as well as privacy and confidentiality. The authors found that, in the AIDS support organisation, TASO quality of counselling was well-perceived but that the privacy and confidentiality of clients was a challenge when counselling sessions were interrupted by others who needed to find files and folders.

4.2.5 Commitment to perform tasks with limited stipend

Lay counsellors have continued to do their work with limited stipend (Black, Sparague & Chersich,2013:5). Lay counsellors over the years have demonstrated responsibility, accountability and commitment while providing counselling and testing services in the health facilities. The lay counsellors love the work of helping others with limited stipend.

4.2.6 Attendance of regular monitoring and evaluation, group mentoring and individual sessions

Regular monitoring and evaluation of the lay counsellors could benefit lay counsellors and clients. Counsellors should avail themselves of these sessions which are important for the development of counsellors. The sessions are good because the counsellors are given feedback that could assist to improve their counselling skills and processes. For the programmes, gaps should be identified, and training could be organised to address the gaps as

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this is likely to have positive outcomes. The study revealed that lay counsellors are not monitored and evaluated regularly.

Mentoring sessions are meetings where mentors visit the lay counsellors in the facilities where they work to assist them with any problems they might encounter, be they personal or work-related. Mentoring sessions assist lay counsellors to share information and problems they encounter in their work. When work-related problems are solved, the counsellor gains experience and becomes competent. It is important for lay counsellors to attend mentoring session as they minimise burnout and stress.

Counselling is emotionally taxing; therefore lay counsellors need to be able to access regular group and individual mentoring sessions. Lay counsellors should subject themselves to these sessions. The sessions are beneficial to the lay counsellors as they are relieved of the tensions and emotional stresses associated with counselling client for HIV and AIDS. Reports of stress when conveying positive HIV results to clients emphasised the need for mentoring and support of health workers performing VCT in order to maintain motivation, reduce stress, burn-out and sustain quality service (Grienstead & van der Straten, 2000:10). Donder, Roskes and van der Gulden (2007:581) view greater satisfaction with employment terms, work variety, information on work possibilities for learning and support from the colleagues associated with less fatigue and emotional exhaustion. The study revealed that lay counsellors are not provided with regular group and individual mentoring sessions. The strategy to enhance regular group and individual mentoring sessions is to organise small groups of mentoring sessions and on site mentoring sessions regularly,

4.2.7 Ability to conduct HIV testing when it delayed

Until May 2010 there were legal restrictions defining the sphere of responsibility of lay counsellors; they were not permitted to draw blood and relied on nurses to complete the testing process. If lay counsellors were allowed to conduct the tests they would be able to counsel clients at the same time. The benefit of lay counsellors conducting HIV tests is that they would be able to complete the work with limited involvement of health professionals. The clients would not wait for a long time for the health professional to come and conduct the test. The health professionals will also be relieved because they have other activities to do. The study revealed that the majority of health professionals delayed conducting the test due to other duties and clients leave without being tested. Dr. Francios Venter, president of the SA

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HIV Clinicians Society and head of HIV Cluster Management in Johannesburg's Reproductive health and HIV unit, said: *It is ridiculous that of our most important tools are held hostage to our human resource crises; lay counsellors are a tool that could assist in counselling and testing but they are not allowed to conduct HIV test.*

During training lay counsellors are taught how to conduct HIV tests but are not allowed to do so according to the Human Tissues Act number 53 of 1983 that allows only trained health personnel to administer HIV tests. New guidelines on counselling and testing now allow the lay counsellors to conduct HIV test (DOH 2009:12).

4.2.8 Positive attitudes towards clients

Lay counselors should show their clients a positive attitude all the times. Positive attitude will assist lay counselors to respect their clients, be patient with the clients and accept the clients without judging them. Showing positive attitude to clients enable them to have trust and hope that they will receive help. When clients have trust in the counselors, the clients will be free to discuss their personal issues. One of the qualities of an effective counselor is respect, patience and warmth (Malema et al 2010:18; Van Der Straten 2009:6).

4.2.9 Supported by health workers and NGOs to network

To be competent, lay counsellors should receive full support from professionals, NGOs and the Department of Health that trains, mentors and supervises them. Counselling for HIV is an emotionally taxing activity for counsellors; and they should feel that they are supported when performing the important task of educating people about HIV and AIDS, educating mothers how to prevent MTCT of the virus, and assisting people to understand how the ARV treatment works and how to adhere to treatment. Shoptaw, Stein, Richard and Rawson (2000:121) mention that support from the co-workers and supervisors gave counsellors a greater feeling of job efficiency and generated less burnout. Counsellors felt that they are not part of the health services although they are required to do this huge task of counselling clients in the health facilities. Counsellors need to feel that they are wanted, valued and that they have good relationships with health professionals. When they feel that they are not important counsellors tend to feel demoralised.

Armstrong (2012:40) defines motivation as a reason for doing something. Motivation is concerned with the factors that influence people to behave in a certain way. Health

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professionals should motivate lay counsellors to move in the direction they want them to go in order to achieve the task.

The study revealed that not all the lay counsellors are supported by the health professionals in the health facilities where they work. The study conducted by Ruud, Toverud, Radloff and Srinivas (2010:417:428) in South Africa, about ARV and the follow up of infected patients by health care providers in South African Public Primary Care revealed that the majority of the health workers had to prioritise their work with HIV and AIDS patients because of time shortages and workloads with other patients who needed their services. Managers who seek to empower employees need to remove the feeling of separation by levels in the organization. Managers should reduce status barriers, and make employees more comfortable in the workplace. The authors continue to say that the non-verbal communication skills of managers are important in reducing the status barriers. The key is creating an environment that challenges people to reach their capabilities (Coleman, 1996:32). Lay counsellors should show a need for achievement beyond minimum standards by anticipating any extra tasks that need to be done even if they were asked to do less.

Motivating and encouraging lay counsellors by health professionals to continue with their work is important as the work they do is difficult but important. The strategy is to let the health professionals formally know that the lay counsellors are part of them, even if they are trained and paid by the government through the NGOs. Some health professionals do not respect the lay counsellors and some lay counsellor in turn; do not respect the health professionals. It seems health professionals were imposed on the lay counsellors without proper consultation or clear guidelines with regard to supervision and communication.

With regard to support by the Department of Health for the lay counsellors, the stipends paid to lay counsellors should be increased according to the years of service they have worked and the stipends should be regular. One participant mentioned: *If you are not sure that this month you will get paid, you return to work being worried of how to cope with life*. It is reported that lay counsellors are not paid their monthly stipends regularly by the government. The stipend for the new Lay counsellors is 1500 rand. Lay counsellors are performing an important task within the health department and they need to be acknowledged and be supported.

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4.3 DEVELOPMENT OF STRATEGIES FOR ENHANCING THE COMPETENCE OF LAY COUNSELLORS

The Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis technique was used to analyse categories that emerged from data analysis, namely, lay counsellors' competence related to counselling skills and processes; lay counsellors' perceptions regarding implementation of VCT and lay counsellors' views regarding strategies that could improve their competence. Following the SWOT analysis the matrix was developed and the nine major principles of empowerment formulated by Guillory and Galindo (1995) were applied to facilitate the building of strengths, overcome weaknesses, enable to explore opportunities and to minimise threats in attempt to enhance the competence of lay counsellors in health facilities of the Mopani District.

4.3.1 Process followed in the development of strategies for enhancing the competence of lay counsellors

Strategy development helps to establish the framework for setting direction and helps in determining criteria for day to day decisions. It also helps people to answer questions like 'where are we going' and 'how we are going to get there'. To analyse the environment where the lay counsellors were implementing VCT programme, the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis technique was used. Pearce (2007:25; Dosher, Benepe, Humphry, Steward and Lie, (1970:126) view SWOT as an effective way of identifying strength and, weaknesses, and of examining opportunities and Threats. SWOT was further used as a strategic planning, brainstorming and decision making tool to achieve the objectives. The following steps were followed:

Step 1, the use of SWOT was considered because it is a tool for strategic management and decision making (Houben et, al. 2009:216; Hay & Castilla 2005). The researcher went through the findings of the study and developed **the list if internal strengths** of lay counsellors and facilities. Step 2, the process was repeated to generate a **list of weaknesses** which were internal factors and which were found to impact workforce planning and implementation negatively of the VCT programme. Step 3, the process was then conducted to **list opportunities**; these are external factors as opposed to internal factors of strength and weaknesses. Step, 4 the process was repeated to identify **list of threats**, which were all external factors. External factors would have negative impact on workforce planning and could include a projected increase in the cost of

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employees. Step 5, this step was to establish priorities. A piece of a chart was used and divided it in to four equal each section (Table 4.1) and labelled strength, weaknesses, opportunities and threats. This prioritised process was used to reduce each of the four list to top priorities and develop **SWOT Matrix** was applied to reduce each of the four list to top priorities. A SWOT Matrix was applied to the competence of lay counsellors (Table 4.1 below).

Table 4.1: SWOT Matrix analysis of lay counsellors' competence

Strengths	**Weaknesses**
Effective use of counselling skills; Effective use of verbal and non-verbal communication; Knowledgeable about HIV and AIDS to be a valuable resource Knowledge of how to counsel groups such as couples, pregnant women and people living with HIV; Capacity building to grow personally and professionally Support by health professionals organizational leadership support are necessary to drive and sustain empowerment	Limited provision of update workshops, mentoring, Limited support of health professionals (no team work) Lack of proper counselling rooms; Degrees of competence in skills such as summarising, paraphrasing and showing empathy vary from being limited to non-existence Ineffective use of verbal and non-verbal communication skills Not allowed to conduct HIV testing; Limited involvement in facility issues.
Opportunities	**Threats**
Could complete a professional counselling course and become professional counsellors; Could study social work at tertiary institutions; Could follow other health-related careers such as nursing; Could be absorbed into the Health Department; Support from health professionals, NGOs and the Department of Health would improve their levels of job	Lay counsellors might not be accepted to further their studies because of their age and levels of education; Their own economic situation as counsellors because they are irregularly paid poor stipends; Incompetence in some critically important skills such as showing empathy, summarising and paraphrasing; The lack of proper counselling rooms; Demoralised lay counsellors;

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satisfaction and confidence; Increased regular stipends would improve their circumstances.	High turnover of lay counsellors means that services are compromised when experienced counsellors need to be replaced and new candidates need to be trained; Lay counsellors suffering from burnout.

Step 6: This step was used to turn the results into actionable. The following four questions were asked to develop the strategies.

- How can we build/ maximise the use of our strengths?
- What do we need to do to overcome the identified weaknesses?
- How can we overcome the identified threats?
- How can we take advantage of our opportunities?

The actionable will be incorporated in principles of empowerment Guillory and Galindo (1995: 33). The nine major principles of empowerment were applied to enhance lay counsellors' competence. The principles of empowerment would facilitate building of strength , overcoming weaknesses, enable her to explore the opportunities and to minimise threats (BOEM) as outlined in the Foundation of Professional Development (2010:1) in attempt to enhance the competency of lay counsellors of Mopani district (Table: 4.2).

4.3.2 Description of the adapted principles of empowerment

Guillory and Galindo (1995: 33) define empowerment as the capacity to perform, while Hochwalder and Brucefors (2005:1238) define empowerment as giving power and capacity in order to energise. In this study the concept of empowerment is seen as the process to help lay counsellors to increase their knowledge, develop skills and heighten their values and needs. This could be done by defining goals, taking responsibility, improving problem solving abilities, and developing communication skills (Verekamp et al. 2009: 405). The empowered counsellors will be able to define goals take responsibility for their work and increase their autonomy. The lay counsellors will be encouraged to implement VCT guidelines to be able to define goals. The implementation of HCT will develop their understanding of own abilities, maintain social relationships, consult others and negotiate with regard to work issues. Empowered counsellors will be able to complete their task have a clear idea about their work

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have access to information and accept feedback about their work. They will improve problem solving skills and develop better communication with clients and health professionals. In their study Hochwalder and Brucefors (2005:1238) found that greater psychological empowerment at work correspond generally with less ill health. Psychological empowerment might be one of the many factors that can provide protection against ill health. It is hoped that once lay counsellors are psychologically empowered there will be less absenteeism and no staff turnover; they will be happy, feel free to ask questions and be able to communicate well with health professionals

Guillory and Galindo's nine major principles of empowerment (1995) as adapted to the situation of lay counsellors are:

- Lay counsellors are an organization's/health facility's most valuable resource;
- Health facilities should maximise the involvement of lay counsellors;
- Health professionals and lay counsellors should work as teams and value each other's contribution;
- Lay counsellors should continue to grow personally and professionally;
- Lay counsellors should take responsibility and be accountable for their work;
- Self-determination, self-motivation and self-management are expected;
- Delegation of duties to lay counsellors should be a continuous process;
- Hierarchy in health facilities should be minimised;
- Organisational leadership and support are necessary to drive and sustain the empowerment of lay counsellors.

4.3.3 Lay counsellors are an organisation's/health facility's most valuable resource

Lay counsellors who display effective use of counselling skills; effective use of verbal and non-verbal communication; knowledgeable about HIV and AIDS; knowledge of how to counsel groups, pregnant women and people living with HIV could be most valuable resource for the facility. The founding principle of empowerment is that people are important than management systems. The essence of this principle is that the manner in which the management system operates is determined by the people who compromise the organization. It assumes that people are not expandable, simply because they bring difference which may

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force the system of operation to change. Although [illegible] may come and go the most recyclable resource which is used over and over again are people (Lay counsellors). For this reason it is necessary to preserve the mental, physical, emotional and even the spiritual well-being of the lay counsellors. For this reason in the resent progression from the information era to the knowledge based era of spirituality, the development utilization and retention of creative and innovative employees will determine the survival of the organization (Guillory and Galindo 1995:34).

Lay counsellors are an important human resource in the health facilities as they work together with other health workers. They play a key role in the implementation of government's HIV and AIDS programmes. Despite easing the pressure on hospitals and clinics when they provide counselling and testing services, there is still no commitment on the part of the government to recognise them properly, (Dlamini 2011:1-3). Lay counsellors have a specific job description as they are meant to educate clients in health facilities about HIV and AIDS. Their assistance relieves health workers of this burden so that they can focus on clients who need help with other health issues. Thus lay counsellors are a valuable resource because they contribute to improving the health of individuals. They educate clients on HIV and AIDS issues, educate mothers on how to prevent MTCT and encourage clients to adhere to treatment to promote the health of people infected with HIV. Because of all these factors their dignity needs to be protected and organisational authority needs to be used to help them reach their potential. They need to be included in decision making, be informed and know about the mission, vision and objectives of the institution in which they work. This study revealed that not all lay counsellors were included in decision-making, and information was merely given to them. For these reasons it is necessary to preserve the spiritual well-being of lay counsellors so that they can conduct effective, efficient counselling sessions.

Harley (1995:10), in his article named Eight Principles of Empowerment, expresses the view that managers should balance human and operational issues. They should protect the dignity of all employees, manage perceptions and not just facts, release rather than inhibit human potential, use consensus decision making, and clarify the vision and mission, objectives, goals and job description of the organisation and provide feedback requested by employees. This will enable them to unshackle the human desire to be of service, and entrench values. These principles are similar to the principles of Guillory and Galindo (1995:33) mentioned above.

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If these principles were to be applied they would co[illegible] improved communication and lay counsellors would feel free to talk to health professionals and thus develop self-esteem and self-determination. Strategies to enhance competence would be to allow free communication between lay counsellors and health professionals, to include them in discussions about health services, and let them feel as if they were part of the health services and not outsiders.

4.3.4 Health facilities should maximise involvement of lay counsellors

High-involvement is based upon the assumption that the more employees are involved in designing and controlling their work functions, the more productively and efficiently the organisation operates. The basis of this assumption is that structured management systems severely limit the performance capacities of lay counsellors. For high-involvement in their work, lay counsellors must assume responsibility and accountability for understanding and ensuring the successful production of the whole aspect of work. Individually and collectively, lay counsellors must have a high degree of self-discipline and self-management in order to operate with the least amount of supervision or management.

Coleman (1996:34) in his study conducted in California found that employee empowerment had removed obstacles to good performance. He suggested that good performance meant continuous improvement for efficacy and better responsiveness to clients or customers. As mentioned in the first principle, because lay counsellors are a valuable resource they should be involved or accepted as members of the heath team in the health care facility, so that they can feel part of the health profession. When they feel that they are part of it, they will feel important and valued and their performance (counselling skills) will improve.

This study revealed that lay counsellors were not highly involved in the issues of the facilities in which they worked. Not all the counsellors were regarded as members of the teams in the health facilities, and they enjoyed limited support from health professionals. Lay counsellors were not involved in other matters of the health facilities. This is not good for the counselling services. Lay counsellors felt that they were not part of the services, and they were being undermined by the health professionals. They informed their clients competently and therefore deserved to be involved. The strategy suggested to improve this situation is to involve lay counsellors in all health facility matters so that they can feel that they are part of

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the health services, and that they are not treated as outsiders in the facilities. Recognising them as valuable members of the teams could help to improve their competence. They would be able to ask questions where they felt they needed guidance, they would work without fear of being disrespected, as they would be treated with respect and would not feel isolated.

4.3.5 Health professionals and lay counsellors should work as a team

Teamwork, according to Guillory and Galindo (1995:35) is advantageous because teams provide the opportunity for synergism which is not possible for an individual working alone. In addition high-involvement is based upon the assumption that the more lay counsellors are involved in designing and controlling their work functions, the more productively and efficiently the organisation will operate. The basis of this assumption is that structured management systems severely limit the performance capacities of lay counsellors. For high-involvement with work, lay counsellors must assume responsibility and accountability for understanding and ensuring the successful production of the whole aspect of work. Individually and collectively, employees must have a high degree of self-discipline and self-management in order to operate with the least amount of oversight or management. The crucial fact to understand is that in today's hyper-accelerated world, high-involvement is inevitable. Guillory and Galindo further indicate that over a sustained period, team functioning preserves the overall health and well-being of lay counsellors. Empowered teams have two vital elements: the full expression of individual excellence, and the necessity (or preference) for interdependence in order to achieve the team goal. In this study the result revealed limited team work amongst the lay counsellors and the health professionals.

To work as a team means that good interpersonal relationships are essential. Galer, Vriesendorp and Elis (2005:105) claim that managers are responsible for cultivating and maintaining positive working relationships in the working environment because this results in marked respect, honesty and commitment to the mission of the organisation by all members. Gerein, Green and Pearson (2006:44), suggest that a continued inability to provide quality care can contribute to job dissatisfaction, stress, demoralisation and intention to seek other employment creating a vicious cycle of attrition. In addition, working in an environment that is under-staffed can reduce job satisfaction.

Teamwork is essential for the success of empowerment initiatives since so few products and services can be delivered by the efforts of a single employee. When this principle is applied to

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an organisation, the organization is viewed as a network of interdependent centres of excellence. The commitment to team projects must be balanced with commitment to the overall success of the organisation. For teamwork to be successful there should be mutual respect, trust and communication, and the fostering of better understanding of each other. Lay counsellors' involvement in the health services has increased; health professional that used to counsel and test are now assisted by the lay counsellors. The inclusion of lay counsellors has also brought new responsibilities to health professionals who have to ensure that they do their work correctly. If they were not involved as members of the team, poor communication would result. Good communication was viewed as the most important skill that health workers should have so that they would be able to provide effective self-management and support (Lawn, Battersby, Lindner, Mathews, Morris, Wells, Litt, and Reed 2009:38-44). Team work entails mutual respect and trust. When lay counsellors are respected and trusted they are able to do their jobs well and experience job satisfaction.

Teamwork can enhance and encourage self-determination, self-motivation and self-management. The work of lay counsellors is recognised as part of the health system. They tend to reason that they make a difference, and because they are serving others they continue doing the work. The present study revealed that lay counsellors were not accepted as part of the health services. Lay counsellors and health professionals should work together as teams to provide effective health services and effective, efficient counselling services in particular. Like the first and second principle, team work will result in lay counsellors being valued and made to feel important and members of the team of the health facility. Applying this principle will help counsellors to improve their verbal and verbal and non-verbal communication skills, to successfully provide clients with information regarding HIV and AIDS, and to learn from health professionals. They will be able to respond to clients and health professionals, there will be no delays in testing clients, and no client will leave a facility without being tested. In fact, good, effective, efficient service will be rendered.

In their study Sawasky, Jevne and Clark (1994:180) found that when counsellors developed effective methods, they increasingly began to own the process for themselves, and relied on their own judgement with greater frequency. This led them to have greater control over their own responses both within and outside of the workplace. Empowered lay counsellors who develop effective methods and who feel that they own the process, rely on themselves and their own judgement and have a feeling of control over the counselling process. These are

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nurtured by organisational strategies that include the provision of supervision and mentoring, a healthy, safe and pleasant working environment, team and individual strategies that include proactive development of mentoring relationships, openness to change and innovative work practices.

The implementation of teamwork is one of the elements of empowering lay counsellors and will thus enhance their communication skills. The study has further revealed that lay counsellors and health professionals in the facilities work as individuals. Health professionals do not consider lay counsellors to be important team members. They do not accept them as part of their teams. Health professionals regard the clients who come to the health facilities as their responsibility and that they must ensure that the clients receive quality health services from all members of the team, including the lay counsellors.

4.3.6 Lay counsellors should continue to grow personally and professionally

Personal growth and professional development are a way of life in empowered organisations (Guillory & Galindo 1995:35). Since empowerment is a dynamic process rather than a specific goal to be reached, it is the sequential cycle of self-motivation, goal setting and achievement, all of which continually drive the enhanced capability of lay counsellors. Involvement necessitates people-oriented skills, hence the corresponding necessity for continual personal growth. The most severe limitation to performance in high-involvement organisations is employees' reluctance to accept the process of personal growth proactively. The four principles contribute to the personal growth and professional growth of the lay counsellors. When counsellors feel that they are important and that they are involved and are regarded as members of a team with health professionals, and when they know that there will be work-based training conducted by health professionals, they will be encouraged and motivated. They will continue learning and the job will be interesting, fun and creative because of the continuous improvement (Guillory & Galindo 1995:35). Lay counsellors' competence in communication and sharing information will improve because they will have knowledge and information about HIV and AIDS and related issues that they have learned from the health professionals. Counsellor development is found to be a cyclical process as all the principles are linked to assist lay counsellors to enhance their skills.

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4.3.7 Lay counsellors should maximise responsibility and accountability

Empowerment is based upon maximising individual and collective responsibility and accountability. This means that there should be a predisposed mind-set of total responsibility for projects or tasks that have been delegated to them. Such a mind-set has the potential for not only meeting but also exceeding customer or client expectations. Without a critical proportion of highly responsible and accountable employees, empowerment is not possible. The more difficult of these two requirements is holding self and others accountable. Accountability is probably the limiting factor in determining the extent to which high-involvement is possible. Principles 1 to 4 contribute to Principle 5 that maximises responsibility and accountability. If lay counsellors are seen as valued members of the team and are involved highly in the health facility issues, they will grow personally and professionally and as a result they will take responsibility for and be accountable in their work.

The study revealed that when lay counsellors are responsible, they are always available to their clients to educate them and counsel them effectively using the counselling skills and processes that they have learned. They provide enough time to discuss HIV and AIDS with clients and ensure that their clients understand the dynamics of HIV and AIDS. They also make sure that clients understand the implications of being tested positive for HIV and understand how to prevent infections. They are accountable for their counselling sessions and make sure they always do the right thing. By being responsible and accountable they will be able ensure that they provide effective counselling using effective verbal and non-verbal communication skills. They are also able to conduct pre- and post-tests, and give clients relevant information that will encourage them to be tested and prevent further infections. Lay counsellors should be willing and able to access the best available information, and to implement and sustain changes that are based on evidence in their working practices. The willingness of lay counsellors should be supported by the provision of sufficient resources that will ensure supervision that will maintain their well-being. This will ensure that they apply their skills and knowledge to work practices and that they will engage in effective teamwork to implement and achieve the best practice (Mahoney, 2007: 11).

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4.3.8 Self-determination, self-motivation and self-management are expected of lay counsellors

An inherent assumption of empowerment is that most, if not all, lay counsellors have the talent and capability to perform their jobs and responsibilities with the least amount of oversight and management. The major limitation in fully living up to one's potential is a mind-set that compromises self-determination in difficult situations. Where talent or capability is lacking, Principle 4, above, applies. An additional assumption is that the incentive to meet (and possibly exceed) job expectations comes from within an individual. If they are given Principles 1, 2, 3, 4 and 5 above as well as a clear organisational support systems, will assist employees to be self-driven in terms of self-determination, self-motivation and self-management. They will be competent to be able to conduct HIV tests will enhance the self-determination, self-motivation and self-management of counsellors. They will be self-motivated to do their work with little supervision. Varekamp, Verbeek, de Boer and van Dijk (2011: 228-297) view job maintenance training programmes as having a positive effect on employees as self–efficacy increased; they interacted better, fatigue decreased, their overall job dissatisfaction decreased, work-related problems decreased and the employees maintained their jobs. In addition the physical quality of life of the employees improved significantly.

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The present study revealed that lay counsellors had the capacity to perform counselling services when they had been trained to counsel clients about HIV and AIDS. They could provide information on HIV and AIDS, the prevention of MTCT, ARV and could counsel couples on how to live with HIV. This shows that trained lay counsellors are responsible and accountable for their actions. Nevertheless, trained lay counsellors still need support from organisations, health facilities and the Department of Health for them to achieve their job expectations.

Stinson, Wilson, Gills, Yamanda and Holt (2008:495) reviewed internet-based self-management interventions for youth with health conditions. These authors define self-management as an individual's ability to manage the symptoms, treatment, physical and psychological consequences and life-style changes demanded by a health condition. Self-management increased participants' knowledge, self-efficacy and use of self -management behaviours. Lawn and Shoo (2009: 206) suggest that in order for patients to develop self-management and self-management support they should have a broad set of attitudes,

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behaviours and skills that they direct towards the impact that the chronic condition has on their lives. Lawn, McMillan and Pulvirenti (2010:e5) in their study of the self-management of chronic conditions include expectations of their responsibilities. The authors mention that when patients are involved in the management of their conditions, they are placed at the centre of their care, decisions about their care and treatment. They own and take responsibility for their illness.

Self-determination is a perception that one has autonomy in performing tasks and can choose how to behave in various job-related situations. Self-determination has been found to result in higher levels of initiative and self-regulation and is seen as essential for self-motivation (Gooddale *et al.,* 1997:196). On another level Mir and Mir (2011:e6) say that workplace empowerment must be seen as a broader managerial discourse that attempts to serve an organisational project. Workplace empowerment should be read as part of the modern operation of empowerment. Sol, van der Graaf, Brouwer, Hickox and Visseren (2010:139) in their study of the effects of self-management to reduce vascular risk factors in patients, who manifest vascular disease, mention that patients in self-management groups achieve treatment goals more often than patients not in groups. Knowledge about the disease and psycho-social mediators such as self-efficacy and social support, influences self-management.

4.3.9 Health professionals should continuously expand the delegation of lay counsellors' responsibilities

It is vitally important to understand that the act of delegation is not empowerment. The procedure for implementing empowerment is the delegation of responsibility within clearly defined guidelines. Empowerment ultimately depends on an individual's ability to perform the expanded responsibility that has been delegated to him or her. A requirement of expanded delegation is ensuring that an individual or a team is maximally prepared to accept the expanded responsibility. A central issue to the success of empowerment is giving up control. This act requires trust and the willingness to share information, knowledge and power. The question a manager constantly asks himself or herself in an empowering environment is, *How do I mentor and coach others to do what I do, and give it away?* This means that mentoring and coaching has become critical management skills in support of delegation. Teams and learning pairs provide natural opportunities for mentoring and coaching relationships. Lay

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counsellors should work within clearly defined guidelines. This will empower them and encourage them to be willing to be supervised, mentored, monitored and evaluated. Counsellors should not view supervision, mentoring, monitoring and evaluation as an indication of a lack of trust, disrespect, or as being undermining. They should rather see it as support and caring being demonstrated by their supervisors.

It is important for health professionals to provide expanded support to lay counsellors, because in this way they can ensure that lay counsellors are prepared to do the job. They should share information and skills with counsellors. It is also important for health professionals to mentor lay counsellors. As they are with counsellors most of the time they can be reliable mentors and supervisors. The counsellors will then be able to develop communication competence and feel free to ask for advice when they do not understand. Supportive and knowledgeable counsellors are crucial in helping HIV positive people to seek treatment and adhere to treatment; advise on the prevention of sexually transmitted infections, unintended pregnancies and transmission of HIV. They can also support HIV positive people to live free from stigma and discrimination (Bharat and Mahendra, 2007: 93).

4.3.10 Health professionals should minimise the importance of hierarchy in health facilities

A natural consequence of extensive delegation is the systematic reduction of hierarchy. Hierarchical organisational structures discourage empowerment by supporting a line-of-authority system and discouraging cross-functional teams. Cross-functional teams focus on clients or customers, products, goods, or services. This principle, in an indirect way, means that influence and authority are based on demonstrated competence, performance, and an ability to manage oneself, rather than solely on position power. Hierarchical structures or systems of operation are very cumbersome and slow to respond to demands.

Lay counsellors work in health facilities where there are systems, procedures and lines of communication. Managers need to create an environment that challenges people to reach their potential. There is a need for cross functional teams to focus on clients. Lay counsellors and health professionals should work together in a non-hierarchical situation for the benefit of their clients. This study revealed that lay counsellors are competent in conducting counselling sessions; however there are some counselling skills that they need to develop to improve their

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competence. These counselling skills and processes should be enhanced if health professionals were to provide onsite in-service training for lay counsellors. Coleman (1996:32) suggests that empowerment works best when there is an emphasis on organisational learning that incorporates the sharing of information and self-control that is based on performance feedback. Removing or minimising the hierarchy and including lay counsellors in the health facility structures will make them feel that they belong and are free to communicate and engage in discussions. They will feel happy and accepted in their work. Gooddale, Koerne and Roney (1997:195) propose that managers can improve the quality of service provided by focusing on enhancing variables of individual empowerment like allowing employees (in this case lay counsellors) to follow their own instincts when working with clients. Thus the deliberate involvement of lay counsellors as members of the health facility team; plans for their support, supervised monitoring and evaluation need to be developed.

4.3.11 Organisational/health facility leadership support is necessary to drive and sustain the empowerment of lay counsellors

Empowerment cannot exist without a clear commitment from the leadership of the organisation. Leaders must communicate the necessity for and desirability of empowerment and link it to the organisation's strategy in order to achieve greater success. A support system to encourage empowerment involves a systematic change in processes, procedures and structures, as well as a redesign in the way work is done, i.e. a greater emphasis on teamwork. The simplest way to express this principle is that leaders and managers must live the empowerment vision and model the values by putting into visible practice what is preached. For empowerment to take hold, leaders must be living examples of the principles discussed. Good leadership and support are important to empower the lay counsellors. Bharat and Mahendra (2007: 93-94) found that health care workers are key implementers of the HIV policy guidelines, treatment and support, and unless they are supported, major systems constraints in improving services might occur. Leaders of NGOs should make sure the counsellors are supported, and that they receive important messages in time to ensure that they are always happy to perform their counselling duties. If health professionals demonstrate that they regard lay counsellors positively, lay counsellors will feel valued. Health professionals should involve them and work to develop a team spirit. Lay counsellors will grow personally and professionally and they will develop self-determination, self-motivation

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and self-management. Lay counsellors will also be responsible and accountable in their work.

This study revealed that lay counsellors were not all supported by health professionals. This demoralised the counsellors who felt they were not wanted and that they were not part of the health services. It was further discovered that there was lack of team work. In addition lay counsellors were not paid their stipends regularly. This does not enhance the competence of lay counsellors and reduce their self-development and self-motivation. Explicit or implicit supervisor and supervisory processes were reflected in counsellors' development reports after counselling sessions. Supervisor/supervisory relations are important in counsellors' development (Sawasky *et al.*, 1994:177). Gooddale *et al.* (1997:195) view empowerment as having four dimensions, namely competence, meaningfulness, self-determination and impact. Each component is individually expected to increase perceived service quality, and therefore high levels of service quality should be associated with high levels of empowerment. The authors further mention that organisations should give employees the training, preparation and resources necessary to deliver a service, and conceptualise empowerment as autonomy and involvement.

Bharat and Mahendra (2007:101) mention that service providers should behave as change agents but must also know their own needs and rights. The need for supervision and periodic updates in training of lay counsellors is important. Adequate infrastructure is crucial for them to be able to do their work well. However, it is common in developing countries for providers, particularly those who are poor, to delay payment or not pay. Conger and Kanungu (1988:476) mention that when individuals are empowered, their expectations of personal usefulness are strengthened. They develop a sense of personal mastery, or a "can do" attitude. The adapted principle of Guillory and Galindo (1995:13), if they were to be integrated with the developed strategies for the competence of lay counsellors. Lay counsellors, lay counsellors will be empowered lay counsellors will be happy to work in an environment where they are accepted and respected, where they are encouraged to develop personally and professionally, where they have a feeling that they are valuable and that they contribute to the health of the clients and the community in general.

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4.4 STRATEGIES FOR ENHACING THE COMPETENCE OF LAY COUNSELLORS

Following the SWOT analysis of lay counsellors' competence, the nine major principles of empowerment formulated by Guillory and Galindo (1995) were applied. The researcher felt that empowerment would facilitate the building of strengths, overcome weaknesses, enable her to explore opportunities and to minimise threats in her attempt to enhance the competence of lay counsellors in health facilities of the Mopani District. The approach to developing an action plan: *'Build strengths, Overcome weaknesses, Explore opportunities and Minimise threats'* (BOEM) as outlined in the Foundation of Professional Development (2010:1) was adopted to develop the strategies to enhance competence of lay counsellors (Table: 4.2)

Table: 4.2: Strategies for enhancing the competence lay counsellors

Building on the strengths of lay counsellors.
• Conduct regular in-service training and update workshops on counselling skills, including couple counselling, pregnant women and people living with HIV and AIDS, should be provided. Regular training and workshops will enable counsellors to build on their strengths and enhance their capabilities. Regular training will make counsellors to be most valuable resource of the health facility. • Self-determination, self-motivation and self-management of counsellors are expected. Counsellors should strive to gain more information and be willing to learn new information (Barnes 2005:2). • Health professionals should relate well to lay counsellors as members of health teams and should not discriminate against them because they are paid by the NGOs and earn very little. Lay counsellors are a valuable resource in the health facility. Health professional should maximise the involvement the lay counsellors in their health team plans. This will build on the strength of the lay counsellors and improve their confidence. • To strengthen lay counsellors' ability to take responsibility and accountability. • Reference works on HIV as well as other important resources should be provided in counselling rooms, for further reference and step-by-step information on counselling procedures. Having manuals and other reference material in the counselling room will motivate lay counsellors to read and learn about new development in HIV and AIDS, and therefore continue to grow personally and professionally Regular supervision; support, mentoring, monitoring, and evaluation should be provided to ensure that lay counsellors are competently doing their work. Support for lay counsellors by the health professionals will create opportunities to explore their ability and value and this will minimise the threats the delivery of VCT services.

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Overcome the Weakness

- The Department of Health and NGOs should organise regular update workshops to overcome the weaknesses of the lay counsellors. Regular workshops will ensure that lay counsellors improve on their counselling skills and processes and overcome their weaknesses.
- Health facilities and the Department of Health should ensure that proper counselling rooms are provided for effective counselling sessions. Rooms should be furnished with washing basins, fans or air conditioners as the rooms are very hot during summer. When lay counsellors are viewed as the organization's or health facility's most valuable resource they will be provided with proper counselling rooms that are conducive to counselling to do this valuable work
- NGOs should organise strict, regular monitoring and evaluation sessions for lay counsellors. Lay counsellor to submit themselves to these monitoring and evaluation sessions. The sessions will assist lay counsellors to grow personally and professionally.

Exploration of the Opportunities

- Lay counsellor must explore opportunities to become professional counsellors by continuing their education. This learning will occur when there is maximum involvement of lay counsellor health facility activities. Lay counsellors will be able to explore opportunities.
- If lay counsellors remain in the counselling services for a certain length of time, they could be absorbed into government service. Lay counsellors are most valuable resource. Counselling services will be sustainable if specific people remain in the service for long. When they stay long they also have a chance of exploring further opportunities within their career path
- Delegation of duties to lay counsellors will make them accountable and responsible; be motivated and self-determined, and opportunity-driven. The role of lay counsellors as providers of health services should were extended; for example, in 2011 lay counsellors were allowed to conduct HIV tests (National Department of Health Guidelines, 2009: 8-29).
- Sustain the provision of the stipend. Although the stipend that lay counsellors receives, is too little, it assists them to earn continuously and therefore make a living.

Minimising the Threats

- Create opportunities for lay counsellors to continue to explore other avenues of employment and should further their education to enable them to enter other fields such as nursing. Motivated and supported lay counsellors will continue to grow personally and professionally to minimise the threats.
- The Department of Health should increase the stipends of lay counsellors to retain the services of experienced people. Regular payment of stipend will motivate lay counsellors to do their work with enthusiasm and minimise the threats.
- Lay counsellors should be evaluated and assisted to gain the skills which they are less competent at executing. Opportunities to be created for lay counsellors to avail themselves to attend regular mentoring sessions to avoid stress and burnout.
- Facilitate employment of adequate numbers of health workers in facilities, as this will ensure that health professionals have time to supervise lay counsellors, and lay counsellors will not feel isolated. Health professionals and lay counsellors are to work as team and value each other's contribution. The hierarchy in the health facility should

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be minimised.

- Create conducive environment for both lay counsellors and health professionals to be honest, respectful and be committed to the mission of the NGOs and the Department of Health in order to provide effective services. Responsibility and accountability be maximised.
- The Department of Health to provide bursaries for lay counsellors to continue their studies. Organizational and/health facility leadership are necessary to drive and sustain the empowerment of lay counsellors.
- Lay counsellors should receive certificates from the government, and not from NGOs. Having certificates will motivate and encourage lay counsellors to continue with their studies therefore minimising the threats.

In this study the concept of empowerment is seen as the process to help lay counsellors to increase their knowledge, develop skills and heighten their values and needs. This could be done by defining goals, taking responsibility, improving problem solving abilities, and developing communication skills (Verekamp et al. 2009: 405). Empowered lay counsellors will be able to define their goals, take responsibility for their work and increase their autonomy. They will be able to develop understanding of their own abilities, maintain social relationships, consult others and negotiate with regard to work issues. Empowered counsellors will be able to complete their tasks, have a clear idea about their work, have access to information, and accept feedback about their work. They will improve their problem-solving skills and develop better communication with clients and health professionals. In their study on psychological empowerment at the work place as the predictor of ill health conducted in Sweden, Hochwalder and Brucefors (2005:1238) found that greater psychological empowerment at work corresponded generally with less ill health. Psychological empowerment might be one of the many factors that can provide protection against ill health. It is hoped that once lay counsellors are psychologically empowered there will be less absenteeism and no staff turnover; they will be happy, feel free to ask questions and be able to communicate well with health professionals.

4.5 SUMMARY

In this chapter the components of competent lay counsellors were identified and discussed. The strength, weaknesses opportunities and the threats to lay counsellors were assessed by means of a SWOT analysis. An action plan to build on strength, overcome weaknesses, explore opportunities and minimise threats was adopted and integrated with the principles of empowerment suggested by Guillory and Galindo (1995:35). Strategies for the enhancement of competent lay counsellors were developed.

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CONCLUSIONS, VALIDATION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

5.1 INTRODUCTION

The previous chapters dealt with the following, orientation of the study; rational and background information of the study; problem statement; purpose and objectives of the research. The research questions and research methods of the study were highlighted in Chapter 1. In Chapter 2 the research methods which included the research design and the data collection methods were described. A discussion of the research findings and a description of the categories and subcategories, and the results were analysed in Chapter 3. Literature was discussed after each category was described. In Chapter 4 Strategies for the enhancement of the competence of the lay counsellors were developed.

In this chapter assessment of whether the objectives of the study have been met and validated, and whether the developed strategies and criteria could be applicable for improving the competence of lay counsellors. Recommendations for the implementation of the strategies in health facilities were suggested for HIV and AIDS counselling services, as well as for general nursing sciences, research and for the Department of Health and other institutions where there is an interaction to facilitate effective counselling and other health services were described.

5.2 CONCLUSION OF THE STUDY

The overall purpose of the study has been to develop strategies for enhancing the competence of lay counsellors. The principles of empowerment as outlined by Guillory and Galindo (1995) were integrated with the developed strategies. A SWOT analysis was used to analyse the strengths and weaknesses and explored available opportunities to minimise the potential threats identified. The BOEM Plan (see 4.6 above) for exploring opportunities and minimising weaknesses was used to build on the strengths of lay counsellors, overcome their weaknesses, explore their opportunities and minimise their potential threats and was incorporated into the strategies. Integrating the principles of empowerment with the SWOT analysis and BOEM, attempted to enhance the competence of lay counsellors in the facilities of the Mopani district of Limpopo Province

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This process was achieved through the following:

- Analysing the competence of lay counsellors implementing the VCT programme in the Mopani District;
- Exploring the challenges faced by lay counsellors when they implement VCT programme in the Mopani District.
- Developing strategies for enhancing the competence of the lay counsellors
- Assessing the effectiveness of the strategies for enhancing competence of the lay counsellors

The first and the second objectives were met by making use of a qualitative approach which is exploratory, descriptive, contextual and inductive in nature. In-depth semi-structured interviews with focus groups and individuals as well as observational sessions using a check list were used. Data were collected from 33 lay counsellors in group discussions, individual interviews and observations. The quantitative approach was used to analyse the qualitative data obtained from the focus groups and individual interviews. Quantitative data analysis was conducted for qualitative data. The third and fourth objectives we met by utilising information obtained from the data analysis to develop strategies for enhancing the competence of lay counsellors.

From the results of the study it became clear that lay counsellors have challenges in their work environment. Not all lay counsellors receive support from the health professionals; majority of the lay counsellors have no counselling room; there is limited support from the department of health and the NGO responsible for training, mentoring, supporting the lay counsellors and the stipend is very little and irregular. These challenges affect the competence of the lay counsellors. Burnout and psychological barriers hamper provision of effective and efficient VCT programme.

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5.3 A BRIEF SUMMARY OF THE CHAPTERS

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Table: 5.1 Summaries of Chapters

Chapter	Description
1	Chapter 1 is an orientation. It forms the structural point of reference for the study. The purpose of the study was to analyse the competence of lay counsellors in the implementation of the VCT programme in the Mopani District with the purpose of developing strategies to enhance the competence of lay counsellors. The findings provided the basis for developing strategies for enhancing the competence of lay counsellors in the facilities of the Mopani District in Limpopo Province.
2	Chapter 2 presents a detailed description of the research design and methods, which included qualitative and quantitative descriptive designs, data collection methods, data analysis, measures to ensure trustworthiness, ethical considerations and validation of the strategies used
3	Chapter 3 deals with the findings following focus group discussions, individual interviews and observations conducted with lay counsellors. The results revealed that lay counsellors are competent in providing VCT programmes; however there are some skills and processes in which lay counsellors are not competent. Lay counsellors are not supported by health professionals with the result that they do not part of the health services. This feeling demoralises lay counsellors and leads to their becoming incompetent. This chapter also highlighted the dissatisfaction of lay counsellors with their not being authorised to conduct HIV tests as well as their dissatisfaction with their meagre stipends.
4	Chapter 4 focuses on the development of strategies for developing the competence of lay counsellors. This included a description of the characteristics of a competent lay counsellor, a SWOT analysis for developing competent counsellors, and the BOEM action plan to build on the strengths of lay counsellors, overcome their weaknesses, to explore opportunities available to them and to minimise threats that they faced.
5	Chapter 5 focuses on the conclusions drawn from the findings and a validation of strategies and methods of used in the study including sampling, data collection and data analysis. The limitations of the study and the recommendations were presented.

5.4 VALIDATION OF THE DEVELOPED STRATEGIES

Methodology for validation

Validation is the method used for determining the credibility of empirical knowledge in relation to a scientific model of a discipline (Chinn and Jacobs 1987:13). It includes taking

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decisions as to whether the strategies developed are valid. The first purpose of validation in this study was to identify the value and potential contribution that these strategies could make for enhancing the competence of lay counsellors. The second purpose was to close the identified gaps and correct inconsistencies in the provision of counselling services. A qualitative research design was followed to validate the developed strategies.

Sampling

Non-probability purposive sampling was used to select the participants. Purposive sampling is a type of non-probability which is collected from a key of characteristics (Sells 1997:172). The discretion of the researcher was used to select the participants who had the required characteristics and attributes and represented the different categories to validate the strategies for implementation. For validation, participants who participated in the main study were included. Five lay counsellors and five managers from the three sub-districts were sampled. The facilities that were identified were the Maphuta Malatjie Hospital, the Lulekane Health Centre, and the Kgapane, Lenyenye and Carlotta Clinics.

Specific Criteria for Inclusion

Table 5.2: Facility Manager and lay counsellors included in the validation of strategies

Facility Managers	5 Facility Managers; 2 from Greater Tzaneen, 2 from Baphalaborwa and 1 from Greater Letaba municipalities
lay Counsellors	5 Lay counsellors; 2 from greater Tzaneen, 2 from Baphalaborwa and 1 from Greater Letaba

Although this was a subjective method of sampling for validation it was necessary to include the facility managers and the lay counsellors who participated in the study and who are working together in the facilities. The participants were purposively selected from the three sub-districts. The following facilities were sampled: Maphuta-Malatjie Hospital, Lulekani Health Centre in Baphalaborwa, Kgapane clinic in Greater Letaba, Lenyenye clinic and Jamela clinic in Greater Tzaneen.

5.5 DATA COLLECTION METHODS

The validation tool (checklist) was developed and used for all the participants (See Table 5.1). Facility managers and lay counsellors were used to validate the formulated strategies. Appointments was made with the facility managers and lay counsellors, copies of the

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developed strategies were presented to the participants who were given time to read the material and to understand the developed strategies. A date was set with the participants when the researcher would validate the strategies. A structured interview procedure using a check list was used in the discussions with facility managers and lay counsellors.

The structured face-to-face interviews were conducted for about 30 minutes with managers and lay counsellors in their respective offices. The aim of the interviews was to validate the strategies, make modifications and obtain suggestions for inclusion in their implementation of the strategies for enhancing the competence of lay counsellors.

Table: 5.3 Data Collection Tool for Validation of Strategies

Strategy 1:Build on strengths of lay counsellors			
Criterion	Yes	No	Comments
Does the strategy build on strengths of lay counsellors and empower them?			
Can you identify any gaps and inconsistencies in this strategy?			
Strategy 2:Overcome weaknesses			
Criterion	Yes	No	Comments
Could the strategy developed to overcome weakness be successful?			
Can you identify any gaps and inconsistencies in this strategy?			
Strategy 3: Explore opportunities			
Criterion	Yes	No	Comments
Do the strategies for exploring opportunities enhance the ability of lay counsellors to explore opportunities?			
Can you identify any gaps and inconsistencies in this strategy?			
Strategy 4: Minimise the threats			
Does the strategy help to minimise threats?	Yes	No	Comments
Can you identify any gaps and inconsistencies in this strategy?	Yes	NO	Comments

5.5.1 Responses of the facility managers (See Table 5.4)

Table 5.4 Responses from the managers

Strategy 1: Build on Strengths	**Responses**
Does the strategy build on strengths of lay counsellors and empower them?	All the managers agreed that the strategies developed could be of value if they were implemented by the counselling services and would strengthen the competence of lay counsellors.

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Can you identify any gaps and inconsistencies in this strategy?	All participants indicated that they could identify no gaps in this strategy.
Strategy 2 Overcome weaknesses	**Responses**
Could the strategy developed to overcome weaknesses be successful?	Participants agreed that if the strategy were implemented it could assist counsellors to overcome their weaknesses.
Can you identify any gaps and inconsistencies in this strategy?	None of the participants indicated that they had identified any gaps in the strategy Three participants emphasised that without proper counselling rooms, confidentiality and privacy with regard to HIV counselling is violated.
Strategy 3: Explore opportunities	**Responses**
Do the strategies for exploring opportunities enhance the ability of lay counsellors to explore opportunities?	Participants agreed that the strategy developed could assist lay counsellors to explore opportunities.
Can you identify any gaps and inconsistencies in this strategy?	Participants indicated that there no gaps were identified; however, four participant suggested that lay counsellors should be absorbed by the government. Stipends should be increased and should be regarded as salaries. Lay counsellors should have benefits such as housing, medical aid and uniforms. Lay counsellors should use the opportunity of being present in the health facilities to learn more about health issues
Strategy 4: Minimise threats	**Responses**
Does the strategy help to minimise threats?	Participants agreed that the strategy could minimise threats
Can you identify any gaps and inconsistencies in this strategy?	Participants agreed that there were no gaps in the strategy; however two participants suggested that lay counsellors should have copies of their job descriptions and the scope of their work at the clinic. NGO coordinators should communicate with facility managers first when they need lay counsellors. Facility managers should not have to hear from lay counsellors that they are going to attend workshops. This will prevent misunderstanding between lay counsellors and facility managers One participant suggested that adequate staff in health facilities would ensure that lay counsellors are properly supervised.

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5.5.2 Responses of the lay counsellors

The responses of the facility manager and those of lay counsellors were similar. They all agreed on the following: lay counsellors should attend in-service training workshops; health workers should form good relationships with lay counsellors and accept them as valuable members of the health teams; regular supervision should be provided; proper counselling rooms should be made available for lay counsellors; stipends should be paid regularly and payment and annual increases should be negotiated.

The responses of the five lay counsellors are indicated in Table 5.3

Table: 5.5 Responses of lay counsellors

Strategy 1: Build on strengths	**Responses**
Does the strategy build on strengths of lay counsellors and empower them?	All the lay counsellors agreed that if they could be implemented the developed strategies would strengthen them.
Can you identify any gaps and inconsistencies in this strategy?	Participants indicated that they could identify any gaps or inconsistencies in this strategy.
Strategy 2 Overcome weakness	**Responses**
Could the strategy developed to overcome weakness be successful?	Participants agreed that if the strategy were to be implemented it could assist them to overcome their weaknesses.
Can you identify any gaps in the strategy?	All participants indicated that there were no gaps in the strategy. Three participants emphasised that having proper counselling rooms could overcome the weakness and improve their competence.
Strategy 3: Explore opportunities	**Responses**
Do the strategies for exploring opportunities enhance the ability of lay counsellors to explore opportunities?	Participants agreed that the strategies could assist them to explore opportunities.
Can you identify any gaps and inconsistencies in this strategy?	Participants indicated that there were no gaps. However, four participants indicated that the stipends paid to lay counsellors should be increased and that lay counsellors could be absorbed into the health services by the government.

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Strategy 4: Minimise threats	Responses
Does the strategy help to minimise threats?	All participants agreed that the strategy could minimise the threats.
Can you identify any gaps and inconsistencies in this strategy?	All participants agreed that there were no gaps in the strategy.

5.6 DATA ANALYSIS

The comments from the participants indicated that they were happy about the description of the strategies as these addressed real issues. One facility manager said: *this is what I was thinking. You have written it down and you mentioned everything.* Five facility managers and five lay counsellors were given the opportunity to make suggestions and comments that could contribute to the finalisation of the strategies. They all agreed that the strategies could be put forward for implementation in the HCT services as a measure of enhancing the competence of lay counsellors and improve service in general.

The total sample of facility managers who were involved in supervising lay counsellors agreed that all the strategies could enhance the competence of lay counsellors. Therefore, it can be concluded that the participants reached consensus on the proposed strategies. They agreed that these should be recommended and implemented in the Mopani District as a pilot study (practical validation). Chin and Jacobs (1987:165) point out that the theory of testing research has immediate practice application. By conducting or replicating the study in other districts in the province at a later stage, the results may suggest further revisions or recommendations for application.

All the lay counsellors who were involved in implementing VCT in the Mopani District agreed that the strategies could enhance their competence and improve services. Additional strategies identified by the lay counsellors and managers were integrated in the strategies that were developed.

5.6.1 Discussion of findings

All 10 participants, five facility managers and five lay counsellors strongly agreed that all the developed strategies were applicable and relevant to the enhancement of the competence of lay counsellors. However, some of the strategies such as increasing the stipend, additional benefits such as uniforms and housing could boost the morale of lay counsellors. All four

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managers and five lay counsellors emphasised that having proper, private counselling rooms was a very important strategy that would improve their competence. Four lay counsellors and three managers supported the idea that regular workshops, supervision, mentoring, monitoring and evaluation could improve the competence of the lay counsellors.

The challenges that might be experienced in the implementation of these strategies are that lay counsellors are volunteers employed by the NGOs, and the NGOs are only in partnership with the Department of Health and Social Development. Fund-raising by the NGOs is not easy as double funding for one programme is not accepted, and the mobilisation of resources is difficult. Proper counselling rooms were viewed as a challenge as it would not be easy for the Department of Health to change the present building structure to build the counselling rooms. The only option was to use any available space in the facility to conduct counselling sessions.

As part of the validation lay counsellors agreed that implementation of strategies strengthen their capacity of counselling skills. It was further pointed implementation of strategies could assist them to overcome their weakness, explore their opportunities, and to minimise the threats by removing harmful conditions that prevents them to achieve their objectives (Pears 2007:25). The facility managers were of the opinion that strategies could be of value to strengthen competence of lay counsellors and could assist counsellors to overcome their weaknesses. Managers mentioned that lay counsellors should take the opportunity of being part of the health centre to learn more and grow personally and professionally. Managers further indicated that adequate health professionals in health facilities could minimise the threats and they will have time to supervise the lay counsellors.

5.7 LIMITATIONS OF THE STUDY

The study was limited to lay counsellors of one out of three NGOs providing lay counselling programmes in the district. The researcher is the trainer of lay counsellors involved in the study. There is a need to conduct a study that will include all lay counsellors in the Mopani District and the province in general. The study did not include health professionals and clients. There is a need to conduct a study where clients and health workers are involved in order to obtain an overall view.

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5.8 RECOMMENDATIONS

In order to build on the strengths of lay counsellors the following should be implemented:

The Department of Health and Social Services together with the NGOs should provide regular in-service training.

Supervision, mentoring, monitoring and support sessions should be provided for lay counsellors.

The relationship between lay counsellors and health professionals should be improved.

Lay counsellors should be accepted as members of the health facility teams.

Reference works and other important material should be available in counselling rooms.

The Department of Health and Social Services should provide another name for lay counsellors and give them some identifying insignia.

The stipends paid to lay counsellors should be increased.

To overcome the weaknesses of lay counsellors the following should be implemented:

Adequate counselling rooms should be made available.

NGOs and the Department of Health and Social Services should organise workshops and updates to improve the skills of lay counsellors.

Strict regular monitoring and evaluation sessions should be arranged for lay counsellors in Mopani District, Limpopo province

Lay counsellors should explore available opportunities by means of the following:

Continuing to improve their knowledge;

Enrolling at tertiary institutions to improve their counselling skills;

Staying in the service long enough to gain experience;

Taking advantage of the available opportunities to increase their chances of being absorbed into professional health services, which would lead to an increase in their stipends.

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The threats facing lay counsellors could be minimised by means of the following:

Being acknowledged by health professionals as valuable members of health teams;

Being encouraged by health professionals who should motivate them, supervise and mentor them to ensure that they are doing their work well;

The payment of better stipends by the Department of Health and Social Services would boost their morale;

Communication by NGOs with health facility managers to request permission for lay counsellors to attend workshops and meetings;

The organisation of regular workshops to improve counselling skills;

The employment of adequate numbers of health professionals to assist, monitor, mentor and supervises lay counsellors.

On the basis of the results there was a need to develop strategies to enhance the competence of the lay counsellors. It is recommended that the application of the strategies be implemented in the health facilities that provide HIV and AIDS counselling and testing, as well as any other institution where there is interaction between lay health workers and health professionals.

5.8.1 Recommendations to improve HIV and AIDS counselling

It is important for lay counsellors who are involved in VCT to improve their counselling skills and processes. The strategies could serve as a frame of reference to enhance their competence through team work, acknowledgement and support, as well as involvement in the issues of the health facilities. The researcher will be ready to discuss the strategies with the health facilities where counselling and testing is provided in the Mopani District of Limpopo Province. It is that in -service training and update training be regular to keep the lay counsellors on a par with new information and improve their counselling skills.

5.8.2 Recommendations for health facilities

Inadequate of support, acknowledgement, and teamwork spirit on the part of health professionals might contribute to poor levels of competence in lay counsellors, implementing VCT programmes. Employees who believe that they are being treated fairly in the workplace have been found to be more committed and less interested in changing jobs than employees

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with contradictory beliefs (Rothrauff, Abraham, Bride, and Roman 2011:68). It is recommended that lay counsellors should receive support from the health professionals to reduce stress and burnout. Health professional should be well oriented about the lay counsellors and familiarise with lay counsellor's role and activities. Reference material and other important resources should be available in the counselling rooms and lay counsellors should be encouraged to study.

5.8.3. Recommendation for research

Lack of support of lay counsellors and other lay health workers may be experienced in health facilities where different health workers interact. It is recommended that the principles of empowerment should be used in all the health facilities, as they would enhance cooperation, teamwork, support, as well as self-motivation, self-determination and self-management of the lay counsellors. This would also help to minimise hierarchies, and encourage and maximise responsible and accountable behaviour among lay counsellors. Rapp, Ahearne, Mathieu and Schillewaert (2006:281) express the view that employees with a low level of productivity or experience may benefit most from leaders' empowering behaviour. Lay counsellors will learn and benefit more from health professionals who support them and work with them as team members. The study found that good relationships exist between health practitioners and lay counsellors when lay counsellors are respected and valued as an important member of the health teams. The research on the competence of and challenges faced by counsellors should be replicated in other health facilities, in other districts of the Limpopo Province. Such research could address the strategies for enhancing team work, respect, as well as acknowledgement of lay health workers when they provide counselling and testing and other services. More research should be conducted with the lay counsellors, health workers implementing VCT and clients who receive the services.

5.8.4 Recommendations for the Department of Health: Limpopo Province

The results of this study, together with the developed strategies for the enhancement of the competence of lay counsellors will be made available to the Department of Health: HAST Directorate of Limpopo Province. It is hoped that they will consider the strategies with the view to implementing them in the Department of Health and Social Services. As lay counsellors promote the vision and mission of the Department of Health and Social Services

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by providing an environment for HIV counselling and testing their well-being deserves to be considered. It is recommended that proper counselling rooms be provided for the lay counsellors, not having proper counselling rooms does not only affect the lay counsellors but also the clients. Regular stipend for the lay counsellors is recommended as their remuneration may continue to affect the course of the VCT programme in terms of retention, rates and ultimate impact of the lay counsellors in the HIV prevention programme.

5.9 CONCLUSION

The counselling skills of lay counsellors were satisfactory. The majority of lay counsellors who participated in the study were competent in using verbal and non-verbal communication skills, as well as in counselling skills and processes. However, there were some counselling skills and processes that they were not competent in. The researcher believes that these could be improved through regular update workshops and training. The results revealed that there was limited support of the lay counsellors from health professionals. Lay counsellors felt that they were not part of the health services. Lay counsellors felt isolated and not part of the teams in which they desired to be. Low remuneration in the form of irregularly paid stipends demoralised the lay counsellors and made them incompetent.

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NAME OF RESEARCHER/INVESTIGATOR:
Mrs. J.M Ramalepe

PROJECT TITLE: Strategies for enhancement of competence of lay counsellors that provide voluntary counselling and testing programme in Mopani District, Limpopo, South Africa

PROJECT NO: SHS/10/PDC/007

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof. L.B Khoza	University of Venda, Advanced Nursing Science	Supervisor
Dr. S. Maputle	University of Venda, Advanced Nursing Science	Co-Supervisor

ISSUED BY:

UNIVERSITY OF VENDA, HEALTH, SAFETY AND RESEARCH ETHICS COMMITTEE

Date Considered: 21 May 2010

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: .....

Name of the Chairperson of the Committee: Prof. P.E. Lukhele-Olorunju

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ADDENDUM 2: REQUEST FOR PERMISION TO CONDUCT RESEARCH

P. O. Box 1276
Lenyenye
0857
29 July, 2009

The Head of the Department
Department of Health and Social Development
Private bag x9302
Polokwane
0700

ATTENTION: RESEARCH COMMITTEE

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a student at the University of Venda registered for a Doctoral degree in the Department of advanced Nursing Sciences. I am doing research on the topic: **Development of strategies for the enhancement of competences of lay counsellors for Voluntary Counselling and Testing Programme in Mopani District, Limpopo Province, South Africa**

The purpose of the study is to enhance the competences of the lay counsellors in counselling for HIV and AIDS.

The following objectives will be sought:

- To analyse the competences of lay counsellors for VCT
- To explore the challenges experienced by the lay counsellors
- To develop strategies to enhance competences of lay counsellors
- To pilot developed strategies

The study will be conducted in 3 sub-district of Mopani District. The participants will be only the lay counsellors. Data will be collected through in-depth interviews

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I hereby request permission to conduct the study in 3 sub-districts namely: Greater Baphalaborwa, Greater Letaba, and Greater Tzaneen

Thanking you in anticipation for a positive response

M.J. Ramalepe

Professor: L.B. Khoza

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ADDENDUM 3: REQUEST FOR PERMISION TO CONDUCT RESEARCH

P. O. Box 1276
Lenyenye
0857
29 July, 2011

The Head of the Department
Department of Health and Social Development
Mopani District
Giyani

ATTENTION: M. SM Bogale (Senior Manager

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a student at the University of Venda registered for a Doctoral degree in the Department of advanced Nursing Sciences. I am doing research on the topic: D**evelopment of strategies for the enhancement of competences of lay counsellors for Voluntary Counselling and Testing Programme in Mopani District, Limpopo Province, South Africa**
The purpose of the study is to enhance the competences of the lay counsellors in counselling for HIV and AIDS.
The following objectives will be sought:

- To analyse the competences of lay counsellors for VCT
- To explore the challenges experienced by the lay counsellors
- To develop strategies to enhance competences of lay counsellors
- To pilot developed strategies

The study will be conducted in 3 sub-district of Mopani District. The participants will be only the lay counsellors. Data will be collected through in-depth interviews

I hereby request permission to conduct the study in 3 sub-districts namely: Greater Baphalaborwa, Greater Letaba, and Greater Tzaneen I will make sure not to disturb the provision of the health services
Thanking you in anticipation for a positive response

M.J. Ramalepe

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ADDENDUM 4: LETTER TO THE STUDY PARTICPANTS

P.O. Box 1276
Lenyenye
0857
29 March, 2009

REQUEST FOR YOUR PARTICPATION IN THE RESEARCH STUDY

Dear Colleagues,

I am a Doctoral student in the Department of Advanced Nursing Science registered with the University of Venda. I am conducting research on the topic: **Development of strategies for the enhancement of competence of lay counsellors for Voluntary Counselling and Testing Programme in Mopani District, Limpopo Province, South Africa.**
The purpose of the study is to enhance the competences of the lay counsellors, in counselling for HIV and AIDS, and to get their experiences in implementing the VCT programme in the district.

You are hereby kindly requested to participate in the interviews that will be conducted at your facility as a means of collecting data. Your participation will add value to the findings of this research project as well as enhancing the competences of the lay counsellors in the district.

Your participation in the research is voluntary. You have the right to withdraw at any point of the study, for any reason. If you withdraw, information collected from you and records and reports based on information you have provided will not be used.

Yours faithfully
M.J. Ramalepe
Student number: 11576251

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ADDENDUM 5

Research Title: Strategies, for enhancing the Competence of Lay Counsellors that provide the Voluntary HIV and AIDS Counselling and Testing Programme in Mopani District, Limpopo Province, South Africa.

Researcher: M J Ramalepe

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ADDENDUM 6: CONSENT FORM

The purpose of this study is to improve the competencies of lay counsellors in Mopani District Limpopo Province. In-depth individual interviews will be conducted and each interview will last until the lay counsellors is satisfied that he/she has given the researcher all the information. During the interview you will be asked about your competencies in providing VCT programme; about your challenges in implementing VCT programme.

The tape recorder will be used but cannot be shared with the rest of the members or participants. The researcher will also make notes of some information during interviews to supplement the tape recorded information. The final report containing anonymous quotations will be available to all at the end of the study.

THIS IS TO CERTIFY THAT I.....

Print name

Hereby agree to participate as a volunteer in the above mentioned research.

I understand that there will be no health risks to me resulting from my participation in the research.

I hereby give permission to be interviewed and for these interviews to be tape recorded.

I understand that, at the completion of the research, the tapes will be erased.

I understand that the information may be published but my name will not be associated with the research.

I understand that I am free to deny any answers to specific questions during the interviews.

I understand that I am free to withdraw my consent and terminate my participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire and all such questions have been answered to my satisfaction.

---------- ---------- ----------

Participant **Witness** **Researcher**

Date----------

Adapted from Morse &Field 1995: 45

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ADDENDUM 7: SEMI-STRUCTURED INTERVIEW GUIDE

Personal profile

Age:

Gender:

Highest Educational Standard:

Other courses done:

When started to be a counsellor:

Name of sub-district:

Name of facility; Hospital, Health Centre, Clinic:

1. How competent are you in implementing VCT? For this question

Probes

- Which skill do you think you are most competent?
- Which skills do you think you are just competent?
- Which skill do you think you are less competent?
- Which skills do you think you are not competent?

2. What are you challenges in implementing the lay counsellor programme?

Probes

- What are your challenges affecting your competences?
- What are the challenges do you experience from your clients?
- What challenges do you experience from the environment?
- What challenges do you experience from the health professionals?
- How do you deal with these challenges?

3. What strategies do you think could be employed to improve your competence?

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ADDENDUM 8: Counselling Assessment Checklist: VCT (Adopted)

No	Counselling skills and techniques/communication	Check out			
A	Establishes Therapeutic and Supportive Environment	Yes	%	No	%
1	Creates comfortable external environment				
2	Uses culturally appropriate greeting gestures that convey respect and caring				
3	Offers seat (if available)				
4	Uses appropriate body language and tone of voice				
5	Provides comfortable, trusting atmosphere for patients to ask questions, well coming/ openness / acceptance/warmth				
6	Responds to questions and concerns appropriately				
7	Maintains patient privacy and confidentiality				
B	Use of active listening				
8	Look at patient when speaking: maintains eye contact				
9	Has attentive body language and facial expression				
10	Minimal continuous eye contact				
11	Use occasional non-verbal gestures such as nods or touch to acknowledge patient.				
12	Use verbal cues such as "yes" or "OK"				
C	Use of effective questioning				
13	Use open ended questions to elicit information				
14	Ask relevant questions				
15	Waits from answers rather than speak immediately				
16	Reflect statements back to patient for information				
D	Messages/ Giving information				
17	Give positive messages				
18	Provide factual information to the patient without judgement				
19	Guide patient to prioritise				
20	Helps patient to identify steps of action for identified concerns				
21	Comments on patient's challenges and strengths				
E	Pre- test counselling / information sharing and gathering				
22	Introduces self				
23	Asks patient to introduce self				
24	Assures patient of confidentiality				
25	Asks patient why she/he came to voluntary counselling and testing (VCT)?				
26	Asks patient about what she/he knows about HIV and how it is transmitted				
27	Assesses risk profile of patient				
28	*Post-test:* Reminds of prevention (ABC strategy)				
29	Explains the actual HIV test				
30	Make appropriate referrals for patient/ call nurse to conduct the test				
31	Assess patient readiness for the results				
32	Set up follow-up appointment				

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33	Gives the results in a simple and clear manner				
34	Gives the patient time to reflect on the results				
F	Giving of relevant information				
35	*If negative:* Helps patient understand that HIV was not detected at this time, however, since the patient could be in the window period recommends a second test in 3 to 6 months				
36	Emphasizes the need to engage in non-risky behaviour to prevent his/her exposure to HIV infection, reminds patient of ABC prevention strategy				
37	*If positive:* Explains the difference between being HIV-infected and having AIDS				
38	Reminds patient of the need for safe sex to prevent further transmission				
39	Explains that antiretroviral therapy (ART) is available at the ART centre if patient is eligible				
40	Explains the CD4 count- a special blood test that needs to be done first to determine whether the patient needs treatment now or later				
41	Discusses the importance of sharing the result with a trusted friend or family member				
42	Gives information about support groups and/or other community resources				
43	Asks patient whether she/he has any further question				

Adopted from Joint United Nation on HIV and AIDS and AIDS (2000) Tools for Evaluating VCT.

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ADDENDUM 9: BIOGRAPHICAL DATA TRANSCRIPTS OF LAY COUNSELLORS

Age:

20-30 years - 5

30-40 years - 16

40-50 year - 10

60 years - 2

Gender:-

Female: 27

Males: 6

Highest standard Passed

Grade 12----10

Grade 11----5

Grade 10----3

Grade 09----2

No of year in counselling /experience

2004: 4

2005: 4

2006: 4

2007: 5

2008: 4

2009: 2

Health facilities

Hospitals: 5

Health: Centres 4

Clinics: 11

Key: Interview

I: Interviewer

P: participant

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I: Good Morning, how are you?

P: *I am fine thank you.*

I: Although I believe you know me (my name), my name is Mankuba Ramalepe. I am conducting a research on development of strategies for enhancement of the competence of the lay counsellors in Mopani District of Limpopo Province. I already know your name for the purpose of confidentiality and anonymity I can call you LC1 I hope you don't mind?

P: Yes, I don't mind, its ok I understand

I: can I also indicate that the information obtained will be kept confidential, your name will appear nowhere in the document the information you provide will be used to improve the lay counsellor's programme by developing the strategies to enhance competence of the lay counsellors.

P: OK I see you promise the client's confidentiality and privacy this is good

I: thank you very much could you please tell me how competent are you in implementing the VCT programme? Can I indicate that there is no right or wrong answers?
I would like you to share with me your experience in implementing the VCT programme

I: Quite I don't know where to start

P: OK tell me about your work counselling work

I: I am competent in my work; I have been trained to do the work. When I receive my client I welcome my client offer him/her a seat. I ask the client why he/she came to day. I reassured client's confidentiality and privacy that what we discuss in this room is between us no one will know about it. During counselling I sit facing the clients and attending to the client. I switch off my cell phone close the door and write don't disturb at the door
I ask the tell me why he came to the counselling ask the client questions using open ended question I make sure I listen attentively to what the client is saying. I encourage the client to talk by nodding the head or saying "yes, continue, what else, is that all". When counselling I use the skills that I have learned they make me to be competent

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I: it is the skills that you have learned that make you competent

P: Yes I am able to counsel a client for HIV

I: Which skill do you think you are most competent?

I: Listening skill, I listen to the client to understand the needs of the clients. I give the client more time to talk and share his /her story when you listen to the client you will hear even hidden important messages

The client will tell you her personal issues such I don't have food my child has just passed I don't have money to take my child to school.

I: Mmm you listen to your client

P: Yes we listen to the emotional situation of the client

I: Other skills that we use for counselling?

P: Questioning skills we use open ended questions. We use questions that will make the client to talk no questions that will need yes or no answers

P: Which skill do you think you are less competent?

I don't remembers, I am not sure which one I am not competent clients come back. When we counsel our clients we take time, we don't rush. We are competent client come back to thank us that we have helped them. If we were not competent they would come back. We show our clients that we care about them. They are important to us.

I: Which skills do you think you are not competent?

Summarising is a skill that sometimes I am not implementing, I ask the client to say in few words what we have been saying to understand is I am hearing him/her

P: Empathy is another skill that is difficult. When I started counselling I did not use empathy but I sympathized with the clients, I used to go home and think about all the people have counselled and this made me very miserable. Mentoring session assisted me a lot. When the mentor came and visits me I will ask about empathy and explained to me the difference. "This is the labour ward when the patient comes I have to move out and look for another counselling space. Sometimes the is no space I have to look for space outside I have to do something while the client is hear and want to be counselled"

I: Ok I see you have to start again why you start again

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P: Because you will be disturbed and not knowing what to do now the best thing is to start again

I: What are your challenges you experience from your client?

P: The challenges with clients are many, clients deny their HIV status, when you give them appositive results and talk to them to come and collect the CD4 cell blood count they don't come. They will go to another clinic and be counselled and tested again they waist time by moving from clinic to clinic in search of a negative HIV test when positive they don't come and collect CD4 cell blood count. Client who are on ARV when they fell pregnant they don't come they will come when they are about to deliver. Clients who will not come to collect the CD4 cell blood count when they come they are very sick, when you ask why they did not come clients will say they did not have money to come to the clinic/hospital

I: Oh what do you do with these challenges?

P: We keep on educating the client about the importance of knowing the status and that there is treatment that can assist clients to be better

I: What challenges do you experience from the health professionals?

P: There is no support that we receive from the health professionals, they undermine us, and they don't take us as part of them. We don't attend meeting with them. To speak the truth our health professionals are good to us they assist us I all what we do.

I: OH!! You don't have support from the health professionals what do you do.

P: There is nothing I can do he/she is in-charge I find it is stressing

I have to tell myself I have come to work. I know what I am doing

I: are all the professionals not supporting in your clinic?

P: No some are better when you ask them to come and assist they do come, some don't come even when they are not busy

I: What are the strategies that can be employed to improve your competence?

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P: I think attending workshops could improve our competency. I attended workshop on PMTCT and I learned that children who are HIV positive should be referred to the hospital ARV centre. I attend VCT workshop long time ago, I did not attend any update workshop on VCT. Mentoring session are important we learn from other presenting their case work. Having books in the counselling rooms about HIV.

I: I see, it is good if you attend mentoring sessions and it helps you a lot

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ADDENDUM 10: GUIDE TO VALIDATE WHETHER THE STRATEGIES

Strategy 1: Building on Strength of Lay Counsellors			
Criterion	**Yes**	**No**	**Suggestion**
Does the developed strategy build be the strength of the lay counsellors?			
Are there gaps and inconsistencies identified in this strategy?			
Strategy 2:Overcome the weakness			
Criterion	**Yes**	**No**	**Suggestions**
Does the developed strategy assist to overcome the weakness?			
Are there gaps and inconsistencies identified in this strategy?			
Strategy 3: Exploration of the opportunities			
Criterion	**Yes**	**No**	**Suggestions**
Does the developed strategy explore opportunities?			
Are there gaps and inconsistencies identified that could assist lay counsellors explore opportunities?			
Strategy 4 Minimizing the threats			
Criterion	**Yes**	**No**	**Suggestions**
Does the developed strategy assist to minimise the threats			
Are there gaps and inconsistencies identified that could assist minimize the threats?			

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

Enquiries: Selamolela Donald

Ref: 4/2/2

07 February 2011
Ramalepe M
University of Venda
Thohoyandou
0950

Dear Madam

Re: Permission to conduct the study titled: Strategies for enhancement of competence of lay counsellors that provide voluntary counselling and testing programme in Mopani District, Limpopo Province, South Africa.

1. The above matter refers.
2. The permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
   - Further arrangement should be made with the targeted institutions.
   - In the course of your study there should not be any action that will disrupt the services
   - After completion of the study, a copy should be submitted to the Department to serves as a resource
   - The researcher should be prepared to assist in the interpretation and implementation of study recommendation where possible

Your cooperation will be highly appreciated

Head of Department
Health and Social Development
Limpopo Province

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