

**EVALUATION OF THE QUALITY OF HIV/AIDS COUNSELLING AND  
TESTING PROGRAM AT GEORGE STEGMAN ARV CLINIC.**

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Assignment presented in partial fulfillment of the requirements for the degree of  
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**DECLARATION**

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it at any university for a degree.

Signature:

Date: 14 February 2008

## **ABSTRACT**

The purpose of the study was to evaluate the quality of voluntary counselling and testing program at George Stegman ARV Clinic, with the aim of determining how well does the program operate and what it has achieved since its inception

Non-experimental quantitative design i.e. cross sectional design together with survey design was used to plan on gathering the data and make conclusions Data was collected through open and closed questionnaires handed to the respondents to fill and return back to the researcher. Another method of data collection was through video-recording the counselling observations to assess the standard of counselling quality and content.

The results revealed , lack of superiors 'support and supervision to the HIV/AIDS counselor's performance, lack of resources to operate effective and efficient counselling service and minimal consultations amongst the NGO's, FBO's and home based care centers.

Despite the efforts of the Department of Health to scale-up the voluntary counselling and testing availability and accessibility, the George Stegman management is confronted with challenges to improve and monitor their VCT site to sustain its effectiveness. The recommendations were drawn that identified the loopholes; therefore the issues that need urgent attention should be addressed.

## **OPSOMMING**

Die doel van die studie was om te evalueer wat die kwaliteit van vrywillige berading en toets program by George Stegman se ARV kliniek was, met die doel om vas te stel hoe goed die program funksioneer en wat bereik is sedert die ontstaan van die kliniek.

Nie-eksperimentele kwantitatiewe ontwerpe, byvoorbeeld: kruis afdeling ontwerpe saam met 'n oorsig ontwerp was gebruik om te beplan hoe om data te verkry en dan gevolgtrekkings te maak. Die navorser het data verkry deur middel van vraelyste te sirkuleer vir die voltooiing. Nog 'n metode wat gebruik was vir die versameling van data was om die beradings sessie te monitor deur middel van 'n video opname om die standaard en kwaliteit van die berading te evalueer.

Die navorsings het tekort kominge uitgewys van seniors se betrokkenheid aan toesighouding aan die MIV/AIDS raadgewers se werksverrigtinge. Te kerk kominge aan hulpmiddels om effektiewe en doeltreffende beradings diens te lewer en minimale konsultansies tussen die nie-Goeverment Organisasies, Vertroue Grondslag Organisasies en Huis Grondslag Sorg Sentrums.

Ten spyte van die poging van die Department van Gesondheid om vrywillige berading en toetsing meer toeganklik en beskikbaar te maak, is die George Stegman bestuur gekonfronteer met die uitdagings om die vrywille berading en toets sentrum te verbeter en te monitor om doeltreffendheid te volhou. Die voorstel was om die probleme en misverstande te identifiseer en dan word drigende aandag vereis.

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**LIST OF ACRONYMS USED IN THE STUDY**

VCT	-	Voluntary Counseling and Testing
HIV	-	Human Immunodeficiency Virus
AIDS	-	Acquired Immune Deficiency Syndrome
ARV's	-	Antiretroviral drugs
ART	-	Antiretroviral therapy
PMTCT	-	Prevention of mother-to-child transmission
TB	-	Tuberculosis
UNAIDS	-	United Nations Programs on HIV/AIDS
WHO	-	World Health Organization
FHI	-	Family Health International
MSM	-	Men who have sex with men
IDU's	-	Injecting drug use
NGO'S	-	Non-governmental organizations

## **DEFINITION OF TERMS**

**HIV**- Van Dyk (2005:10) explains the abbreviation as H stands for Human, I for immunodeficiency and V for virus. Furthermore, she explained that it is a virus that causes AIDS. It transmitted through blood, sperms and vaginal fluids. It can also be transmitted through unprotected sexual intercourse.

HIV Counselling Testing is regarded as a comprehensive HIV/AIDS program and it should be widely accessible WHO (2003:1)

**HIV Counselling**- is considered to be a confidential process that enables a person to assess his/her risk of acquiring or spreading the HI virus. It helps an individual to decide to be tested and know his/her status, so that if that individual is sero-positive can at an early stage access HIV specific care, treatment and support. (Fact Sheet of Family Health International cited in WHO 2003).

**HIV testing**- It does involve the analysis of blood for the presence of antibodies produced in response to HIV. New technology now avails the high rapid HIV test i.e. knowing your results in some few minutes (WHO 2003:3)

**Quality of HIV counseling and testing**- in the study quality of this program will mean when the participants have shown change on the behavior compared to the previous life, adherence to their medications, and thorough knowledge about their disease (i.e. acquiring and transmission) and when the counseling is performed by the trained personnel in a very confidential environment.

**Confidentiality**- Vos, Strydom, Fouche, Delpont (2002:67) emphasized confidentiality as an indicative of handling of information and refers to an agreement between two people that limit other's access to private information. It is an individual's right to decide, when, where, to whom and to what extent his/her attitudes, beliefs and behavior will be revealed.

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## CHAPTER 1

### 1.1 Introduction

According to the Family Health International (2001:2), the HIV/AIDS epidemic continues to spread at an alarming rate with an estimation of 6,000 new infections per day worldwide. In addition, AIDS is the leading cause of death in the Sub-Saharan Africa; therefore it continues to bear the greatest burden of the disease (Family Health International 2001:2).

UNAIDS 2002b declared that beyond the devastating health implications, it also prevents millions of young people from enjoying their rights to education, employment, good health and a decent standard of living. Further reported that young people aged 15-24 years old are infected with HIV/AIDS every day (UNAIDS 2002b).

Bancroft (2001:8) confirmed that in both developing and developed countries, young disadvantaged people are at greater risk of contracting HIV/AIDS. In isolation, HIV/AIDS has been labeled as a “disease of poverty”, which in high-income nations often means ethnic minorities are at increased risk. Globally, the intravenous drug users, young women, migrant workers or displaced workers and marginalized youth are considered to be the most vulnerable groups for HIV/AIDS (Bancroft 2001:8).

The HIV pandemic also has consequences for the social and economic development of many countries. For example, in Sub-Saharan Africa, it is estimated that due to the HIV/AIDS pandemic, life expectancy has fallen from 62 years to 47 years (UNAIDS 2002c).

The widespread illness and death that this pandemic causes, places a direct strain on national resources that negatively affect productivity and economic growth. The loss of productivity is also felt at the household level and particularly

pose an impact on young people's life experiences as they are expected to leave school to care for the sick family members or work to support families already under heavy financial burden (World Bank 2002).

The Declaration of Commitment on HIV/AIDS (2002:13) recognized the need to establish a target for reducing HIV infection in young people by 95% in the worst affected countries by 2010. The response will require billions for prevention alone and along with development of infrastructure to implement HIV/AIDS treatment programs including the:

- Voluntary counseling and testing,
- treatment of opportunistic infections,
- psychosocial support, education and information on healthy living with HIV/AIDS and
- Provision and monitoring of compliance with antiretroviral treatment (medication that prolong the lives of people living with the disease (Van Dyk 2005:227)

The latest surveys about the AIDS epidemic from UNAIDS (2007:15) reported that Sub Saharan Africa remains the most affected region in the global AIDS epidemic. Further mentioned that more than two thirds (68%) of all HIV-positive people who live in this region, where more than three quarters (76%) of all deaths occurred in 2007. In addition, it is estimated that 1.7 million people were newly infected with HIV in this year 2007, bringing to the total number of people living with HIV/AIDS disease to 22.5 million. Of which the majority are women at 61%.

Besides the above Sub Saharan surveillance results, the South African HIV prevalence data collected from the latest round of antenatal clinic surveillance suggest that HIV infection levels might be leveling off. The HIV prevalence among pregnant women was at 30% in 2005 and 29% in 2006. According to the

Department of health in South Africa (2007), the epidemic varies considerably between provinces, stated percentage of 15% in the Western Cape to 39% in the Kwazulu-Natal (UNAIDS & WHO, AIDS Epidemic Update (2007:15).

## **1.2 Background of the problem**

International Labor Organization (2003:34) mentioned that voluntary HIV/AIDS counseling is a key element in the HIV prevention whilst testing is often the entry point for the provision of antiretroviral drugs and other therapies.

(UNAIDS 2000:2), further mentioned that access to VCT services remains limited and demand is often low. In addition, VCT in many high-prevalence countries is not widely available and people are often afraid of knowing their HIV status because of little care and support available after testing. The high infection rate among people is largely due to a lack of information about how the disease is spread and the stigma and discrimination they receive from the communities. Young people are often unaware of their reproductive health, which leads to an increase in HIV/AIDS infection. The information can be found through the HIV/AIDS counseling and testing program (FHI 2003:34).

The voluntary counseling and testing has been recognized in National AIDS control program but they are not fully developed in most resource- constrained countries. If they are available, the services tend to be of limited quality and coverage. Limited quality arise due to lack of trained staff, commodities needed for the program, concerns about privacy and confidentiality, stigma and discrimination, lack of knowledge about the existence and benefits of the program and lack of financial resources of running such a cost effective service (FHI 2001:2).

Setting up of VCT service and ensuring its quality create a demand, thus a considerable challenge. Continuous monitoring, regular evaluation and

continuous assessment and training of counselors will be an important tool to improve the quality of VCT service (UNAIDS 2000:5).

UNAIDS (1997:6) reported that one way counseling should be consistent by conducting studies on its delivery, quality and impact. Moreover, the research findings on counseling can help convince the decision-makers and service managers to endorse and provide resources in support of counseling services. A study of long-term counseling to 730 HIV- positive clients, conducted in Uganda by the AIDS Service organization, appeared being helpful to those clients. Of 90% of clients had revealed the fact of their infection to another person and were able to cope with their infection (UNAIDS 1997:6).

### **1.3 Problem statement**

Despite the efforts of government to its commitment to expand access to voluntary counselling and testing, the surveys conducted show no decline of HIV/AIDS epidemic in Sub-Saharan Africa. Some international countries have made a great success in expanding access to treatment, but have made little progress in bringing HIV/AIDS prevention programs to scale.

Communities delay to visit the HIV counseling and testing services on time, but wait to experience HIV related symptoms and be referred to utilize the service. Lack of technical and financial resources, long queues of Counseling attendance, privacy and confidentiality that is not assured, awkward opening hours of the VCT services Clinics do affect the quality of the service (Family Health International 2002:2 & UNAIDS 2000:19).

Van Dyk (2005:103) added to the counselling and testing service that the availability of accessible and affordable VCT services is a huge problem in many countries and this need thorough attention from the state.



#### **1.4 Significance of the study**

Polit & Hungler (1996:70) reinforced that a crucial factor in selecting a problem to be studied was its significance it brings to health and a contributing factor to the body of knowledge in health. The research would enhance improvements to quality of voluntary counselling and testing service and thorough managing and monitoring of the service.

#### **1.5 Scope of the study**

The study will evaluate the quality of HIV/AIDS Counseling and testing program at George Stegman Hospital ARV Clinic, where people attending the HIV/AIDS counseling and testing program will be present. The study will cover people living with HIV/AIDS, HIV/AIDS counselors, VCT site manager, and people on antiretroviral treatment, both the newly infected and affected people and women on prevention of mother to child transmission program.

#### **1.6 Purpose of the study**

The purpose of the study is to evaluate the quality of voluntary counselling and testing program at George Stegman ARV clinic, with the intention of assisting the management to develop and improve the available voluntary counseling and testing program.

#### **1.7 Research question**

The researcher wanted to answer the following question when conducting the study: - Is the voluntary counselling and testing program offered at George Stegman ARV clinic of quality?

- What are the roles of the counseling and testing program managers in terms of managing and monitoring the site staff members and the program itself?
- How can the current research findings be useful to develop and improve better quality of VCT program?

### **1.8 Research objectives**

The study aimed:

- To assess the HIV/AIDS counseling and testing service site at George Stegman Hospital.
- To evaluate the counseling quality and content of George Stegman VCT service i.e. on different vulnerable groups such as pregnant women, young people, children and adults
- To assess the HIV/AIDS counselor's requirements and satisfaction
- To evaluate the client satisfaction about the VCT service offered at George Stegman Hospital.

### **1.9 Research design**

Brink (1996:100) and White (2002:10) define the research design as a set of logical steps taken by the researcher to answer the research question. It forms a blue print pattern or recipe for the study and determines the methods used to obtain subjects, collect a data, analyze the data and interpret the results.

The researcher employed the non-experimental quantitative research design. According to Brink (1996:116) the non-experimental design is meant to be an evaluation research design, of which its purpose is to find out how well a program, treatment or policy concerning any intervention is implemented, how well it accomplishes its purpose and how useful it is.

The study is under the phenomenon of evaluations, therefore the quantitative approach was considered the best approach. Brink 1996:116 further stated that the evaluations can employ experimental, quasi-experimental, non-experimental or qualitative design and can either be cross-sectional or longitudinal. Therefore the researcher employed the cross-section design with a combination of survey design as the suitable approaches to plan for gathering data in this research study.

### **1.10 Population**

Polit & Hungler (1995:185) define population as the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying. The target population comprised of HIV/AIDS counselors performing counselling sessions, clients receiving or utilizing the VCT service at George Stegman ARV Clinic, staff members of the site this include the administration and support services members. All the members at the site were included in the sample but were assured to participate voluntarily.

### **1.11 Sampling**

According to De Vos (2000:197) sampling refers to the process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest. The stratified random sampling was employed. The target population was those who were available on the site on the days of data collection. When the random sampling is used, every member of the population has an equal chance of being selected for the study (Christensen 2004:59)

### **1.12 Data collection**

The researcher employed two techniques to collect a data that is the structured observations and questionnaires. According to Brink (1996:50) define the structured observation as the method of observations most commonly used in quantitative studies. It is where the researcher or trained observer observes and record certain aspects of subject's behavioral or duties, for example, nurses' willingness to interact or listening to the patients. The observations were conducted using video-recording method to avoid the interruption of third person during the counseling session. The researcher prepared a rating scale that provided a score on counseling aspects to observe counseling skills of the HIV/AIDS counselors.

The other technique employed in the study was open and closed questionnaires method. Questionnaires are considered to be a quick way of obtaining data from a large group of people and less expensive in terms of money and time (Brink 1996:153)

### **1.13 Pilot study**

The researcher and her team conducted a study few days before the actual study with the similar participants to those of researcher's interest. White (2002:69) explained that in all cases, it is essential that newly constructed questionnaires be thoroughly pilot tested on a limited number of subjects from the same population before being utilized in the main investigation. Its main purpose is to detect possible flaws in the data collecting instruments.

### **1.14 Data analysis**

According to Polit & Hungler (1995: 190) define the data analysis as analysis that entails categorizing, ordering, manipulating and summarizing the data and describing them in a meaningful terms. The researcher employed descriptive statistics and graphic display to describe and summarize the data. The statistical strategy in conjunction with the graphic strategies was suitable approaches to analyze the data.

De Vos (2000:204) stated that the purpose of the descriptive statistics is to reduce large amounts of data to facilitate drawing of the conclusions about them. Data collected from the questionnaires may be summarized by tabulating or graphically depicting them and it can be done manually or by a computer.

Data was analysed based on the answers received from the questionnaire and ratings scored of counselling sessions from the video-recording. Robert & Burke 1989:277 cited by Brink (1996:178) data analysis strategies were used. Other participants' views will be presented in tables and charts where necessary.

### **1.15 Ethical aspects**

Ethical issues need to be considered when conducting research, while human beings are the objects of study, it is important to understand the ethical and legal responsibilities of conducting research (White 2002:85)

The researcher identified the following ethical issues in the study:

- No risks or discomfort to the clients when sharing their own stories
- Participants were informed about the purpose of the study and what is expected from them. They were asked to complete an informed consent (Appendix 2) if they agree to partake in the study.
- Participants were assured that video-recording tapes will be cleaned after the data analysis.
- Participants were told that participation is voluntary; they are free to withdraw at any time of the study.
- Confidentiality and privacy of participants were always assured.

### **1.16 Conclusion**

The chapter focused mainly on the study problem, background and purpose of conducting the project. The following chapter will entail the literature review of the study.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

According to Brink (1996:76) literature review is defined as the most important context to determine what is already known about the topic of the study, so that a comprehensive picture of the state of knowledge on the topic can be obtained. The literature review further minimizes the possibility of unintentional duplication and increase the probability that the new study may make a distinctive contribution.

The literature review covered effective management of voluntary counselling and testing service as an entry point to prevention care and support with relation to HIV/AIDS disease. It also addressed the National attentiveness and obligation to VCT program and other country's issues with regard to the service. Authors who identified new knowledge to manage the VCT, gaps; contradictions of the study were given full acknowledgement. The benefits and advantages of the service were addressed in the literature review.

### **2.2 Voluntary HIV/AIDS Counseling and Testing program**

Van Dyk (2005:103) reported that voluntary HIV/AIDS counselling and testing has emerged as a major strategy for the prevention of HIV infection and AIDS in Africa. VCT should therefore be a key component of any prevention and care program offered to the communities. Figure 1 will illustrate the VCT as the main entry point for prevention, care and support services.

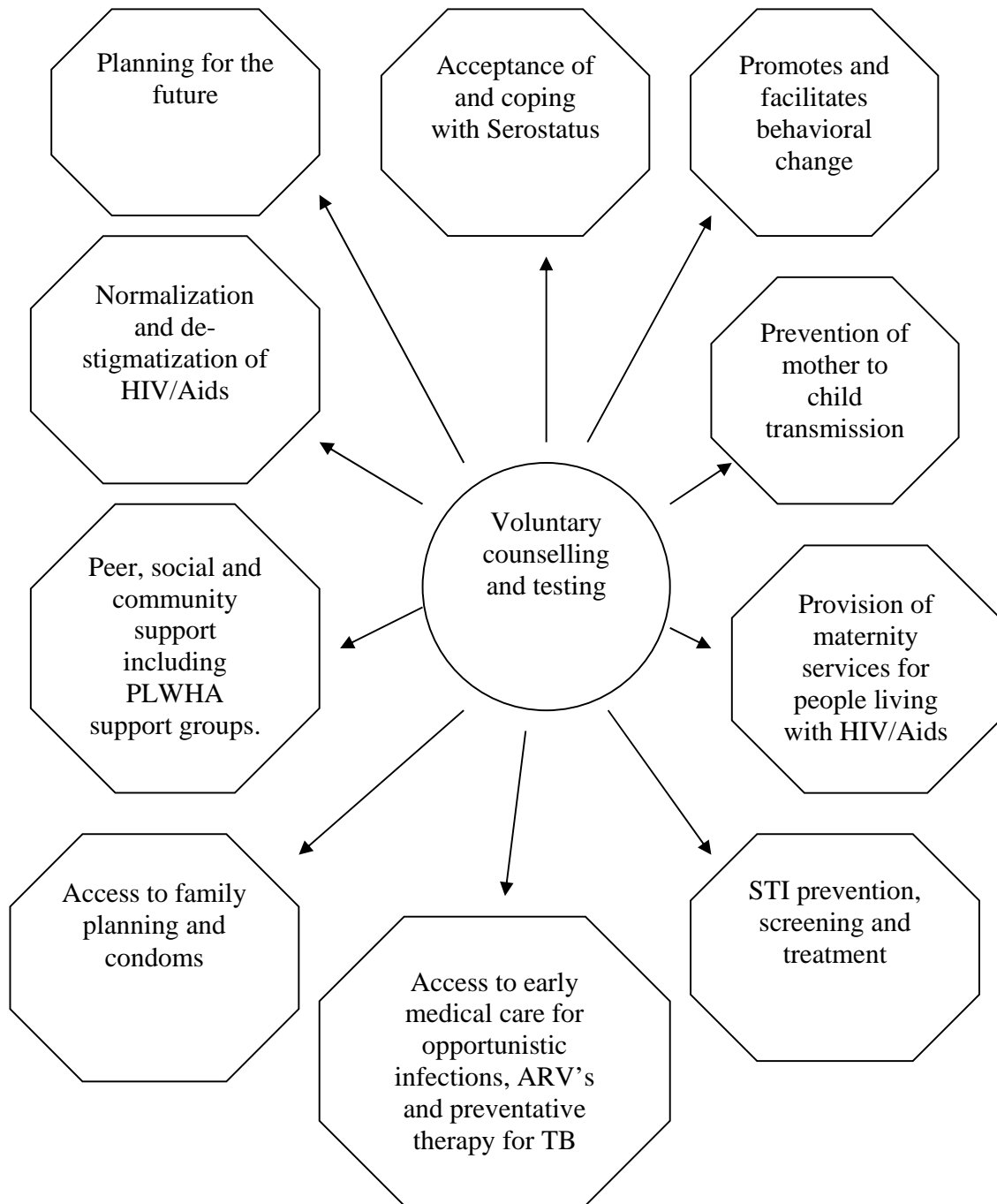


Figure 2.1 VCT as an entry point for HIV prevention and care (Source: UNAIDS 2002:123 cited Van Dyk 2005:104)

It is considered to be a process whereby an individual undergoes counselling to enable him/her to make informed decision about being tested for HI virus (Van Dyk 2005:103).

The WHO (1995:12) defines voluntary HIV/AIDS counseling and testing as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress, knowing their status and take personal decisions related to HIV/AIDS. Three main steps of VCT are identified;

- Pre test counseling where questions about HIV/AIDS and the test are discussed with the counselor.
- When a person decides to have an HIV test, the informed consent need to be signed
- After the test, the counselor gives the result in a post-test counseling session (Van Dyk 2005: 203)

The following elements are essential when performing the HIV counseling and testing service: - test should be administered after the clients have given informed consent.

- Confidentiality must be assured at all the times.
- Clients must be able to access their test result.

Thorough understanding of HIV test result meaning i.e. positive & negative, how to prevent HIV transmission, how to change risky behaviors and what kind of services (treatment options) are available after getting their results (FHI 2000:34 & UNAIDS Policy 1997:2) - the HIV counseling and testing are available to all individuals who may engaged in behavior that places them at risk of contracting HIV. High risk behavior includes any activity involving the exchange of contaminated bodily fluids (Department of Health Services California Fact sheet 2005).



The counseling and testing program serves also the following populations deemed to be at high risk for HIV transmission-Men who have sex with men

- Female who have sex with men
- Injection drug users and
- Sex industry workers

According to Mkaya-Mwamburi et al (2000), many studies revealed that knowing one's HIV status whether is positive or negative; it is instrumental in effecting behavior change and the implementation safer sex practices. Depending on the results of VCT, people usually take steps to avoid becoming infected or infecting others. Wider access to VCT may also lead to greater openness about HIV/AIDS disease, raised awareness and less stigma, prejudice and discrimination (UNAIDS 2002:122)

Van Dyk (2005:103) reinforced that the availability of accessible and affordable VCT services is a problem in many countries and this should be addressed by the state. She also emphasized that when the VCT service do exist in the community centers or clinics, people should be well informed of such a service. They should be widely advertised and the health workers or community workers should be well trained in Pre, post and ongoing counseling.

Many countries have plans of expanding antiretroviral drug access and this will greatly increase the need of VCT in hospitals or community centers.

Ongoing counseling will be beneficial to ensure that people on antiretroviral therapy are supported, adhere to their medication and they do cope with the adverse effects of the medication. Family and couple counseling will be beneficial in the context of mother-to-child-transmission for both the partners to adhere and give each other support.

UNAIDS (2002:124) pointed out that HIV testing should be supported always by effective counseling, adequately trained counselors, non-stigma environment, user-friendly venues and with privacy and guaranteed confidentiality.

### **2.3 Assessment of National (South Africa) commitment to voluntary counseling and testing service**

UNAIDS Policy on HIV testing and Counseling (1997:1) encouraged the countries to establish their own national policies along the following lines; The voluntary HIV testing accompanied by counseling has a vital role to play within a comprehensive range of measures for HIV/AIDS prevention and support, and should be encouraged.

- Make good-quality, voluntary and confidential HIV testing and counseling available and accessible.
- Reliable HIV testing should be made available on a voluntary and confidential basis.
- In addition, testing and counseling should be provided in a non-stigmatizing environment and the service should include the pre-test counseling (where possible and if desired), informed consent filled by the client and post-test counseling.

In addressing the HIV/AIDS epidemic, the South African Government developed a five-year strategic plan (2000-2005), which sort to have an integrated plan. The Departments that play a leading role in this plan are Education, Health, Social, Development and Agriculture. The programs developed by the above mentioned Departments are Life skills education (offered by the Department of Education), Voluntary HIV counseling and Testing (VCT), the Prevention of Mother to child Transmission of HIV (PMTCT) offered by the Department of Health, Home based or Community care offered by the Department of Health in collaboration with the Department of Social development and Poverty alleviation offered by the Department of Agriculture (Department of Health, Mpumalanga Province 2001).

According to Birdsall, Hajjiannis, Nkosi, Parker (2004:1) the VCT has been available in South Africa since the early 1990's – notably through city-based AIDS Training, Information and Counseling Centers (ATICCs), NGO's, private sectors and in some clinics and hospitals. In 2000, the process of expanding the VCT within the public sector health care was initiated as part of the above mentioned National strategic plan on HIV/AIDS and STI's.

### **2.3.1 The South African voluntary counseling testing context**

According to Birdsall et al (2004:1) the VCT is a central component of the South African government's strategy to prevent the spread of HIV and to provide care and support to those living with HIV/AIDS. Moreover emphasized that the Government's commitment to expand access to VCT for people create a policy framework for increased uptake of VCT services in the country. Therefore the scope of challenge in scaling –up VCT is considerable.

The South African VCT Strategy declares that VCT is the provision of service sites where people can test for the HI Virus or get information about protecting themselves from HIV/AIDS on a personal level. HIV rapid tests are available and used, so that a person can know his/her status immediately after testing without waiting for some few days.

The country's VCT goal sets as “ To provide universal access to voluntary HIV Counseling and Testing services, through public health and non-governmental sector partnership, to an adult population between 15–49 yrs, targeting the worried well to facilitate behavior change and HIV prevention (Parker et al 2004:2).

There are series of guidelines, protocols and policies that outline the specific aspects of the South African VCT strategy. The guides on HIV testing, guidelines on the circumstances under which HIV tests maybe conducted with client's informed consent and also the guidelines to provide the definition of pre- and

post-counseling and informed consent and standards for how these steps should be undertaken. Rapid tests are uniformly used in the Public sector VCT services in South Africa and the guidelines thereof (Parker et al 2004:2).

### **2.3.2 Issues relating to voluntary counseling and testing service in South Africa**

Parker et al (2004:2) identified several issues that should be addressed in order to expand the VCT services in South Africa, which includes:

- Developing and strengthening the human and infrastructural resources required to deliver VCT services.
- Promoting VCT among target audiences and encouraging large numbers of people to test.
- Monitoring, evaluating and ensuring quality control of VCT programs.

A report released on public sector VCT services in South Africa commissioned by the Department of Health, provided an interim assessment of the government's expansion of VCT in terms of access, infrastructure, organization of VCT service delivery, quality of VCT services, marketing for VCT, routine data collection and policy planning and management. Along with the report the findings were:

- Access to VCT within the public sector is overly dependent on primary health care clinics, which may discourage people from testing;
- The service tend to be provided during standard working hours only, which may put off the employed people and students from utilizing the service;
- Some VCT sites face environmental or infrastructural challenges, such as lack of privacy, inadequate storage and waiting space;
- Absence of routine data collection and lack of quality control systems around testing;

- HIV/AIDS counselors work under challenging conditions and support systems are lacking for them to continue working at a professional level and
- The absence of well-organized VCT promotional strategy, this imply that voluntary uptake of VCT is low (Parker et al 2004:3).

Parker et al (2004:3) further reported that, in March 2004, the VCT was available at more than 1900 service sites in South Africa. The sites were primarily catering for clients who access VCT in the context of Prevention of mother-to-child-transmission or the home-based care not much of voluntary.

According to Van Dyk (2005:204), as like in many countries, stigma continues to surrounds HIV/AIDS in South Africa. People fear to know their status and have fear of the implications of positive results. A study conducted by Day et al 2003 identified that 105 of South African mineworkers, one third of whom undertaken the VCT had a fear of positive results. Study respondents identified potential consequences such as stigmatization, rejection, being sick and ultimate death as the main barriers to test.

Van Dyk AC & Van Dyk PJ (2003:119) from the South African Journal of Psychology 33(2) conducted a non-representative survey on attitudes to VCT among the South Africans, the results of the study revealed that the idea of VCT in and of itself is greatly acceptable, but people are concerned about the confidentiality of the process, possible rejection by friends and families or rejection from medical workers should a positive result become known. Matovu et al., 2002 reinforced that features of VCT services that are valued by clients are confidentiality, continuous counseling, nonresident counselor to ensure greater confidentiality and counseling outside the health centers.

In 2003, the South African Cabinet announced an intention to provide ARV treatment for free through the public health system Therefore this objective of

government to freely roll out the antiretroviral treatment may impact on the uptake of VCT (<http://www.gov.za/issues/hiv/cabinetaidsga19nov03.htm>). Consequently the VCT will be an entry point to the ARV program. Once diagnosed as HIV-positive, individuals will be assessed for the stage of illness (through the CD4 count) and referred to medical care. HIV positive individuals who are symptomatic (showing symptoms of illness) or having a CD4 count of < 200 cell/mm<sup>3</sup> will be offered the option of anti-retroviral treatment (<http://www.gov.za/issues/hiv/cabinetaidsga19nov03.htm>).

It is further emphasized by Van Dyk (2005:47) that a low CD4 count of (<200cells/mm<sup>3</sup>) is usually a sign of immune deficiency as well as a certain indication that a patient will develop opportunistic infections such as oral thrush, skin infections, herpes simplex (cold sores) or herpes zoster (shingles) and these need to be prevented with timely treatment.

In conclusion of the National commitment to VCT service, UNAIDS (2000:13) indicated that for the benefits of VCT to be understood and used, services must be authorized by and included in the National AIDS Program plan. In addition, it declares that in Uganda, compared to other countries in Sub-Saharan Africa, thought to be in part due to the political commitment to VCT as part of the overall HIV prevention and care program. However, if political commitment to VCT does not exist, NGO's can advocate the concept and set up projects to demonstrate the need for and benefits of VCT (UNAIDS 2000:13).

#### **2.4 Evaluation of VCT site and its service use**

According to Irlam, Reagon, Levin (2003) facility survey conducted revealed the following percentage of primary health care facilities offering VCT per South African province:

- Eastern Cape 54%
- Free State 96%

- Gauteng 76%
- KwaZulu- Natal 53%
- Limpopo- 78%
- Mpumalanga 88%
- Northern Cape 64%
- North West 59%
- Western Cape 81%

VCT is being carried out in various settings in developing and industrialized countries, depending on demands and resources, such as public and private hospitals and clinics, that offers other primary health care services for STI's, TB, ANC etc, mobile clinics ,stand- alone sites provided by NGO's/CBO's/ FBO's, health centers for vulnerable groups, school health service, etc). The stand - alone sites are linked to the medical integrated sites for the administration of HIV rapid tests (Levin et al 2003).

In order to have a well-organized VCT service the following should be looked at when evaluating the VCT sites (UNAIDS 2000:18).

#### **2.4.1 Site Accessibility**

UNAIDS (2000:18) reinforced that the VCT need to be accessible for the population they are helping. The following aspects will be addressed to verify the accessibility and convenient of the VCT site. The clinic or service opening hours need to take into account the needs of the clients. This should allow easy access for those who are working or studying. The lunchtime, early mornings, early evenings and weekend services should be considered to cater all the clients at any time of the day. To allow a less interrupted counseling, service provided to the families or women, who brought the child along, should provide a supervised space where their children can play.

In support of VCT to be carried out correctly and effectively privacy should be ensured. There are issues pertaining to previous risky sexual behaviors or previous relationships that need to be discussed, therefore private space should be required (UNAIDS 2000:18). Furthermore, UNAIDS (2000:18) reported that a well-ventilated waiting area is very essential. Tuberculosis infection is associated with HIV and people with reduced immunity are vulnerable to nosocomial tuberculosis infection.

Confidentiality must be guaranteed, non-negotiable and it is controversial. People living with AIDS have the right to confidentiality and privacy about health and HIV status. Health care professionals are ethically and legally required to keep all information about clients or patients confidential. HIV remains a stigmatizing and isolating condition in most countries and its uptake will be low if confidentiality and privacy are not respected (Van Dyk 2005:184).

According to Baggaley, Kelly, Weinreich, Kayawe, Phiri, Mulongo (1998:4) there should be a system in place to avoid breaches of confidentiality at all stages in the VCT process. People feel comfortable if they do attend the VCT site as anonymous whilst anonymous testing is commonly available in many industrialized countries (Baggaley et al 1998:4).

Past studies indicated that the VCT become more effective when it is developed in conjunction with support services such as medical, social, psychosocial support, family planning services, STI services, antenatal services, home-based care and palliative care services, support group for PLWA, NGO's, CBO's and community groups. HIV/AIDS counselors should be aware of the above mentioned resources for appropriate referrals and special medical needs of people living with the disease (UNAIDS 2000:18).



### **2.4.2 Methods of HIV/AIDS testing**

World Health Organization (2004:10) reported that there has been a fast evolution in HIV diagnostic technology since the first HIV antibody tests became available in 1985. Currently a wide range of different HIV antibody tests are available such as Enzyme linked immunosorbant assays (ELISA) and Rapid HIV tests. Until the development of rapid tests in 1990 the diagnosis of HIV infection was made by using ELISAs to detect antibodies against HIV.

In addition, advances in technology have led to the development of a wide variety of rapid test that can be useful in resource- constrained settings. Those rapid tests include agglutination assays, dipstick assays, flow-through assays and lateral flow membrane assays. They are suitable for the performance of single tests, easy to use, and can be carried out by any health care worker who has received appropriate training (WHO 2004:10).

Among the practical advantages of the introduction of rapid tests for VCT service are the following: - increased numbers of people benefit from knowing their HIV status; increased uptake of results by people being tested; test results are obtained quickly and less reliance is placed on laboratory services for obtaining the results (WHO 2004:10)

### **2.4.3 Service for special and vulnerable groups**

VCT service should be considered for groups of people particularly affected by AIDS. For example there is experience of working with the following groups in South Africa:

- Sex workers
- Prison populations
- Refugees
- Men who have sex with men (MSM)
- Children, orphans, young people, women and street kids

- Pregnant women attending the special intervention such as PMTCT

The experience from working with the above mentioned vulnerable groups and providing special services shows that VCT service must be carried out sensitively. UNAIDS Technical Update 2000 reported that when VCT services are being developed consideration should be given to the different needs of the people attending and the communities for which VCT services are designed.

VCT can benefit women who are or want to become pregnant. Preferably, women should access the VCT service before they become pregnant so that they can make informed decisions about their pregnancy and family planning. Those who test sero-positive, counseling should help them decide whether or not to terminate or keep their pregnancy. Women who decide to keep their pregnancy, they are advised about the use of short term interventions such as drugs known as zidovudine (ZDV) or AZT in order to reduce the risk of transmitting the virus to the unborn child (UNAIDS Technical Update 2000)

Further mentioned by UNAIDS Technical Update 2000, in many countries HIV increasingly affects children, they may themselves be infected or they may be part of a family in which one or both of the parents are either infected or may be orphaned because of AIDS – related deaths of their parents (Van Dyk 2005:232, UNAIDS Technical Update 2000). As a result their counseling should have specific counseling needs such as understanding and coping with their own illness, dealing with discrimination from other children or adults and coping with illness or deaths of other HIV-infected family members (Johnson 2000, unpublished manuscript).

VCT service for other vulnerable groups such as commercial sex workers need to be sensitive to the problems of stigma and illegality associated with sex workers in many societies. UNAIDS Technical Update further reported that sex work is usually the client's livelihood and by stopping it will reduce their ability to earn

a living. As a result counselor should understand the above issues of a sex worker, in order to assist the sex worker find ways to work around or reduce the obstacles they face when trying to reduce their risk.

The HIV epidemic does not affect all sectors of society equally, or in the same way within countries or cities. Some groups are particularly vulnerable to HIV for a variety of reasons including age, sex, profession or specific risk behavior (UNAIDS May 2000:8)

Boswell, Baggaley (2002:87) reported that recent studies indicate that many young people in countries where the HIV prevalence is high want to know their HIV status, therefore the VCT service can be an appropriate entry point to address young people's HIV prevention and care needs.

In order for the VCT to be effective for young people, counselors should take into account the emotional and social context of young people's lives, such as strong influence of peer pressure and development of sexual and social identities (UNAIDS May 2000:8). Wong et al 1999:210 stated that the VCT service should always take into account any relevant laws regarding the rights and autonomy of minors and they must also remember that the dignity and confidentiality of the young persons must always be protected irrespective of his/her age.

#### **2.4.4 Commodities needed in VCT sites**

According to FHI (2002:1), the VCT provides entry to an extended range of HIV/AIDS support, care and prevention activities. However, access to VCT services in many developing countries is limited.

The availability of HIV test kits and other commodities for HIV testing, together with the referral system that links to treatment, care and prevention services where clients can access essential drugs and commodities, is critical to the success of all VCT programs (FHI 2002:1)

Demand for HIV testing is influenced by an individual's understanding of the importance of the service and by incentives and disincentives for having an HIV test, such as perceived level of confidentiality of the service and options for treatment if test is positive (FHI 2002:2).

Disincentives for HIV testing- Stock-outs of HIV test kits such as syringes and needles to draw blood may require clients to return home another day or not coming at all.

Incentive for HIV testing- Knowing that HIV testing offers entry to a range of prevention, treatment and care services where drugs and commodities are available and affordable can be powerful incentive to seek testing (FHI 2002:2)

According to (FHI 2002:4) the following commodities are needed for VCT site:

- HIV test kit
- Automated analyzers, such as enzyme-linked immunoassay (ELISA) readers
- Reagents and controls for ELISA testing
- Refrigerators
- Test-tubes racks
- Consumables such as specimen tubes
- Supplies used to collect specimen, such as lancets, needles, syringes and plasters
- Disposable gloves
- Disinfectants and cleaning supplies
- Sharps disposal bins for used needles and lancets and waste disposal bags for contaminated materials such as gauze, swabs, gloves and testing cards
- Male and female condoms
- Tissues
- Information leaflets

By FHI (2002:5) the following commodities are needed for VCT service that offers on site care or treatment:

- Supplies to diagnose and treat sexually transmitted infections (STI'S)
- Contraceptives
- Drugs for palliative and supportive care such as pain management
- Antiretroviral (ARV) drugs for treatment and prevention of mother to child transmission.
- Drugs to prevent or treat occupational Injuries, such as TB prophylaxis
- Laboratory equipment and reagents for monitoring CD4/ viral load and side effects of ARV's (FHI 2002:5)

## **2.5 HIV/AIDS Counselor's requirement and satisfaction**

### **2.5.1 Counselor selection**

There is a very great need for counseling and for skilled HIV/AIDS counselors. Professional psychologist, counselors, Social workers, Nurses and psychiatrists cannot cope with the demand and many people do not have access to professional services. Therefore we should consider getting every helper in the HIV/AIDS field to give the basic counseling. Those selected need to be trained to recognize serious problems and to refer clients timeously (Van Dyk 2005:173).

The counselor selection reports indicated that the process of selection is inadequate. Majority of counselors are selected by the VCT site managers who have little or no understanding of the need and responsibilities of the HIV/AIDS counselor. Reported by UNAIDS Technical Update 1997:6 that the candidates for a counseling training course should satisfy a number of conditions. They must have a necessary agreed professional background i.e. social workers, health workers, teachers, community workers or volunteers from a group of PLWH. They should also be good listeners, respected by others, empathetic, motivated

and resilient and have warm and caring personalities (UNAIDS Technical Update 1997:6).

It has been further mentioned that the counselors may not necessarily have a health background but should be trained as HIV/AIDS counselors. With regards to counseling people from vulnerable groups, counselors should require training in special communication skills. The counselors should show welcoming face, be friendly, sensitive and non-judgmental attitudes (UNAIDS 2000:24).

### **2.5.2 Counselor Training**

According to the UNAIDS Technical Update 1997:6 stated that most of the current effort in training takes the form of a workshop, with no follow-up supervision and no further training on new things. The Zambian national AIDS program has set up a countrywide program for training in HIV counseling. This start with a basic counseling workshop, followed by placement of counselors to work situation, then followed up by an advanced counseling workshop.

Further stated by UNAIDS (2000:24) that counselors will need training that will consist of basic information on HIV, HIV transmission modes, risks factors, possible and available interventions, the role and process of pre-test, post-test and continuous counseling. For the continuous counseling, counselors need to acquire new skills. The need for refresher courses and continuous training and support is widely recognized.

### **2.5.3 Counselor support**

It is reported by UNAIDS Technical Update (1997:6) that the counselors often leave their jobs because of burnout, stress and lack of proper support. Previous studies revealed that in Tanzania workers who received counseling training, less than a quarter were reported to be practicing counseling.

If counselors are given proper support, the stresses which can build up and cause burnout can be reduced. UNAIDS Technical Update (1997:7) stated the following as forms of support to the HIV/AIDS counselors:

- administrative support, that include the provision of better working facilities, work schedule, job descriptions that accommodate counseling;
- UNAIDS 2000 added that for support of counselors regular support and supervision should be planned and provided. It has been shown to be effective and feasible in busy tertiary hospitals providing care in high HIV-prevalence communities.
- FHI (2002:2) added the importance of peer support from colleagues and the availability of resources. For the reason that, staff attitudes towards clients and service delivery may be negatively affected when the commodities they need to perform their job efficiently and safely are not consistently available e.g. turning clients away because of shortages of HIV/AIDS kits or when gloves and sharps bins to safeguard staff and clients are not available and these exacerbate the stigma at the VCT service site.

Kalimbala, Miller, Bennett, Ross 1995 reported that counselors may be able to function more effectively if they alternate their counseling with other activities. It must be recognized that many health care workers, may have had little formal training in HIV and may have prejudices to those held by others in the community. Therefore, these prejudices that arise should be challenged during training.

In conclusion of the counselor support many have limited training or work, therefore they need a thorough structure for supervision and referral system of difficult cases related to HIV/AIDS (UNAIDS 2000:25).

## **2.6 Evaluation of counseling quality and content**

It is reported by Kamenga, De Zoysa, Phillips (1995:97) that although the effectiveness of this intervention in changing people's behavior to reduce the risk for HIV infection had been under debate until recently, VCT is a major component of HIV prevention and care programs of most developing countries. In the United States, HIV counseling and testing is used for surveillance, promoting behavior change, public education and referring individuals into treatment and care systems.

In most developing countries, counseling and testing programs are essentially designed to influence client's risk behavior and facilitate social and medical support for clients who test positive (Kamenga et al., 1995:98)

According to Juma, McCauley, Kirumira (2002:2) reported that surveys conducted in Uganda of young people aged 14 to 21 years decided to get counseling and tested when intending to get married, enjoyed their partner's support and knew their partners were willing to pay for the service.

The Lancet (2000:104) stated that in a randomized trial involving 4,000 adults in Kenya, Tanzania and Trinidad, reduction of unprotected intercourse with non-primary partners was statistically significantly greater among individuals who received VCT than among individuals who received only basic HIV prevention information (Lancet 2000:104).

In South Africa, the Department of Health would like to increase access to VCT services that recognize diversity of needs and promote regular HIV testing. The target by 2011 is to establish a national culture in which all people in South Africa regularly seek voluntary testing and counseling for HIV/AIDS (Department of Health 2006:58).



According to Van Dyk (2005:105), in South Africa the comprehensive VCT service faces various challenges such as appointing sufficient counselors, establishing trust in the counseling services, setting up adequate testing sites and making rapid testing generally available.

The VCT process consists of pre-test, post-test, follow-up counseling and counseling associated with specific interventions such as tuberculosis prevention therapy (TBPT) and interventions to prevent mother-to-child transmission (MTCT) It can be adapted to the needs of the clients and can be for individuals, couples, families and children. It should also be adapted to the needs and capacities of the settings in which it is to be delivered (UNAIDS May 2000:4).

The content and approach may vary for men and women and with various groups, such as counseling for young people, men who have sex with men (MSM), injecting drug users (IDU's) or sex workers. Additionally, establishing good rapport and showing respect and understanding will make problem-solving easier in difficult circumstances.

The study will evaluate the HIV related counseling in two common elements that is the content and quality of counseling i.e. under the counseling content, pre-test, post-test counseling and counseling associated with intervention such as prevention of mother-to-child transmission will be evaluated. While under the quality, the counselor will be evaluated on the use of guidelines she/he has been trained to follow and the interpersonal relationship between the counselor and client that should be taken into account when evaluating the quality of counseling session.

## **2.6.1 Quality –based elements**

### **2.6.1.1 Relationship building** (establish working relationship with the client).

The goal of this phase is to establish an open and trusting relationship in which the client will feel safe enough to address personal issues and to disclose information to the counselor (Van Dyk (2005:176). The relationship building is very important and ethical counseling phase and is done in the first few minutes of counseling.

According to the UNAIDS (2000:30), the interpersonal interactions are influenced by gender, cultural and socio-economic factors. The following should be kept in mind when performing the counseling: Introduce yourself to the client, the process of VCT and its context (welcoming reception)

- Counselor's respect towards the clients, interest and empathy
- Do not be judgmental about others in the client's life
- Have active listening skill
- Establish a safe, comfort and confidential setting that will distinguish the counseling relationship from social conversation.

#### **2.6.1.2 Gathering of information**

These phase assist the client to tell his/her story and explore the situation. It is essential because it determines the counselor to understand the client's world. It also determines what and how much the counselor does understand the client's problem (Egan 1998).

#### **2.6.1.3 Giving information**

The goal of this phase is to explore the intervention options and to take action to solve the client's problem. Intervention is not in a way of offering a solution but a process in which the client becomes involved in order to improve his /her life. The counselor should provide information about the HIV –related issues to the clients but she/he does not have to overwhelm the clients with information especially after a positive HIV test result. The counselor should also not let the client to

leave the VCT room with misunderstanding of information (UNAIDS 2000:31 & Van Dyk 2005:194).

#### **2.6.1.4 Handling special circumstances**

The following should be adhered to when handling special circumstances:

-sensitivity to and accommodation of language difficulties UNAIDS (200:31). It is supported by Wong et al (1999:208) that language barriers between the counselor and the clients can cause severe difficulties, especially in South Africa with 11 official languages. The counselors are allowed to use the interpreters to rephrase what they have said in a way that is understandable to the client.

- The counselors should talk about the issues plainly and appropriately to the culture, educational level and beliefs of the client.

- Flexibility of counselors to advice the clients to involve the partners or others especially for the pregnant women and

- The counselor should prioritize the issues to cope with limited time and short contacts. Van Dyk 2005:208 emphasized that the counselors should remember that it might be the one and the only time you seeing the clients because they might not come back to test after pre-test counseling or they may test but not coming back at all for the result.

#### **2.6.2 HIV/AIDS Counseling Content**

The study will only assess and observe the pre-test, post-test counseling session and the observation of counseling of special intervention such as PMTCT.

##### **2.6.2.1 Pre-test Counseling**

UNAIDS November (1997:3) reported that the pre-test counseling is often given in connection with a voluntary HIV test. This process helps to prepare the client for the HIV test, explains the implications of knowing that one is or is not infected with HIV. It helps to correct the myths and misconception around the AIDS

disease. It also involves a discussion of sexuality, relationships, possible sex-and drug-related risk behaviors and prevention of the infection.

UNAIDS (1997:3), further reported that whenever the resources permit, pre-test should be made available to those who desire it.

### **2.6.2.2 Post –test Counseling**

Not many things in life could be stressful as waiting for HIV test results. For many clients it feels as if the counselor holds the key to the future in his/her hands (Van Dyk 2005:208). According to UNAIDS Technical update (2000:4) post-test counseling should always be offered after a test whether positive or negative. Its main goal is to help clients understand their test results and initiate adaptation to their sero-positive or negative status. When the test reveal positive, the counselor informs the client about the result clearly and sensitively, providing emotional support. The counselor must ensure that after telling the client about his/her sero-positive status, she/he has an immediate emotional support from a friend, partner or friend. When the client is ready, the counselor may offer information on referral services that will assist the client to accept the status adopt a positive life (UNAIDS Technical Update 2000:5).

Counseling is also important when the results are negative. Negative results had been seen as a tremendous relief. The negative results clients need to be counseled to reduce the chances of future infection. The risk reduction and safer sex practices must be emphasized (Albers,G.R 1990)

### **2.6.2.3 Counseling for special intervention such as PMTCT**

Blom, S (unpublished workshop notes) (2001), revealed that there is an increase in number of countries that are offering interventions to PMTCT. VCT is offered within the antenatal setting or close links are formed with VCT services. It is important that women receiving VCT in this setting have adequate time to discuss their needs. When counseling is performed in the antenatal setting for PMTCT intervention, special consideration should be given;

- counseling about infant feeding options
- counseling about the availability of PMTCT options e.g. termination of pregnancy, antiretroviral therapy
- family planning counseling
- For women who are ser-positive, there should be a system of referral for ongoing medical and emotional support
- For the negative women, counseling about prevention of HIV infection during pregnancy and breast-feeding
- And involving the partner or baby's father in counseling and decision making (Blom, 2001)

In addition, UNAIDS (2000:38) stated that where interventions to prevent mother-to-child transmission are available, antenatal testing should always be offered to couples, hence testing of women individually should be the exception at the women' request and not the rule.

## **2.7 Client satisfaction**

The aim of VCT is to enable a person to know and understand his/her status. Those who test sero-positive can be assisted to access care and support at an earlier stage, cope better with their infection, plan future lives for their dependants and prevent HIV transmission to sexual partners. For those who test negative, the aim of VCT is to enable them to make informed decisions about their sexual behavior to remain negative. In order to evaluate the clients satisfaction about the above matters after their post counseling session, evaluation tool of client satisfaction from the UNAIDS (2000:47) will be used.

Lancet issue 354 (2000:109) stated that VCT can help adults and young people to use safer sexual practices and even reduce their rates of sexually transmitted infection. In a trial involving 4,000 adults in Kenya, Tanzania and Trinidad, reduction of unprotected intercourse with non-primary partners was statistically

greater among individuals among who received only basic HIV-prevention information. Family Health International (2002:3) reported that the survey conducted in Uganda and Kenya, revealed most of 240 people who had been tested, said that they intended to adopt safer sexual behaviors such as sexual abstinence, monogamy, using condoms and reducing the number of their sexual partners.

As it is stated by UNAIDS (2000:46) that for people to benefit fully from the VCT, they need to have access to further emotional, medical and social support. The researcher will have an exit interview with people who attended counseling in order to have their views about the VCT service. The interview questionnaires will cover the following areas; waiting times to get counseling and the result, opening hours of the clinic, counselor's attitudes, assurance of privacy and confidentiality and any future needs.

## **2.8 Summary**

This study therefore extends the scope of existing studies by reinforcing the importance of VCT as it has been promoted as a key motivating force for a safer sexual behavior. Gaps identified are that the VCT site is still far to reach especially from the community where the study was taking place. People are still not aware of such service until they are hospitalized, diagnosed and be referred to have counselling about their status. A silence in this research is that VCT program has very minimal awareness.

Contradictions of the VCT program are that people are still having denial to utilize the service due to unsure of confidentiality as people who perform the counseling are resident counselors and that the service is offered at the hospital center, where everybody will associate an individual to a sick person (stigmatize).

The study enlighten the VCT site management to reinforce on quality service by conducting continuous training and support on Counselors, create non-

stigmatized site, make people aware of such a prevention and care service, continuous monitoring and evaluation of the program to maintain its effectiveness and get a way of expanding the service to local clinics or to the community centers.

## **2.9 Conclusion**

This chapter revealed the way in which various authors had dealt with the current study program. It sheltered the importance of quality of HIV/AIDS voluntary counseling and testing to the community i.e. the way it should be conducted and maintained in order to be beneficial, advantageous and continue being effective.

## **CHAPTER 3: RESEARCH METHODOLOGY**

### **3.1 Introduction**

The chapter will identify the research design, method, and the instruments used to collect a data and how the data was analyzed and interpreted to draw up conclusions of the study.

### **3.2 Research Design**

Non-experimental quantitative design i.e. cross sectional design together with survey design was used in the study. It is further mentioned that non-experimental designs are clearly distinguishable from true experimental and quasi-experimental designs in that there is no manipulation of the independent variable.

Simple Survey design was employed in the study thus it helps the researcher to search for accurate information about the characteristics of particular subjects, groups or situations or about the frequency of a phenomenon's occurrence (Brink 1996:100). The researcher wished to determine how well the quality of counselling and testing program since its inception at George Stegman ARV Clinic has achieved.

Cross-sectional study design was also employed to plan on gathering the data, it is defined by Christensen (2004:45) as a study which identifies representative samples of individuals that differ on some characteristics such as age, gender, religion and measure these different samples of individuals on the same variable often at one point in time.

### **3.3 Research method**

Quantitative method was employed in the study. It is further defined by Christensen (2004:40) that is descriptive type of research in which the goal is to attempt to provide an accurate description or picture of a particular situation.



White (2002:42) emphasized that the quantitative designs maximize objectivity by using numbers, statistics and structures.

### **3.4 Research Setting**

The study took place at George Stegman hospital ARV Clinic. It is one of the hospital in the North-west province at the Moses Kotane local municipality rendering the health services to +40 000 of mainly low-socioeconomic black people from the surrounding rural villages.

### **3.5 Population and Sampling**

Polit & Hungler (1995:243) defines population as the entire group of persons or objects that is of interest to the researcher or that meets the criteria the researcher is interested in studying. The population of the study could be defined as all the HIV/AIDS Counsellors who perform counselling at the George Stegman ARV Clinic, the administration and support services members working at the site and all the clients who receive or utilize the counselling and testing service. The totaled numbers of the target population who are expected to be included in the sample are as follows:

- Site comprised of 30 staff members (n=30). They are broken down into the following disciplines, professional nurses (n=6), Social workers (n=2), Assistant Social workers (n=2), Administration and support service members (n=5), HIV/AIDS lay counsellors (n=15)
- The total number of structured observations of counselling sessions expected at 25 sessions to be observed.
- Total number of clients receiving or utilizing the VCT service expected on the day of data collection (n=50 )

#### **3.5.1 Sample size**

Stoker (1985) cited by White (2002:59) was adopted to determine the size of a sample (See table 3.1 below). White (2002:58) stated that the larger the

population, the smaller the percentage of that population the sample needs to be. If the population itself is relatively small, the sample should comprise a reasonably large percentage of the population. De Vos (2000:191) reported that large samples enable the researchers to draw more accurate conclusions and make more accurate predictions.

**Table 3.1** *determining the size of the sample*

Population	Percentage suggested	Number of respondents
20	100%	20
30	80%	24
50	64%	32
100	45%	45
200	32%	64
500	20%	100

Stoker (1985) cited by White (2002:59). Indication of what the size of a sample ought to be.

### 3.5.2 Sampling approach

The sampling approach of the study involved a stratified random sampling of population working only at the George Stegman hospital ARV Clinic. Random sampling is mentioned to be a sampling where population is divided into subgroups or according to some variables of importance to the study, so that each element of the population belongs to one and only one stratum (Brink 1996:138)

### 3.6 Data collection

Brink (1996:148) defines data collection as the process whereby the researcher collect information needed to answer the research question so that the conclusion can be drawn. Data was collected by means of structured observation and open and closed questionnaires. In collecting the data more than one person was involved, therefore training was provided to the data collectors and checks was made on the reliability of the collected data by the main researcher.

### **3.6.1 Structured Observation**

Observation was mentioned to be a technique for collecting descriptive data on behavior, events and situations (Brink 1996:150). The researcher employed structured observation. It is a method of observation commonly used in quantitative studies where the researcher simply observes and record certain aspects of subject's behavior. The structured observation employed was precisely used to observe the counselling skills of the HIV/AIDS counsellors at the VCT site. Observations were recorded through a video-recording method to avoid interruption of a third person during the sessions. The researcher prepared a rating scale (Scoreboard) form to rate the counselor's skills during counselling session on an individual.

### **3.6.2 Open and Closed questionnaires**

White (2002:87) & Brink (1996:153) reported that the purpose of questions is to find out what is going on in the minds of the subjects, their perceptions, attitudes, beliefs, feelings, motives, past events, knowledge levels and recalls, as well as to gather factual information about the subjects. The self report instrument chosen for the study was the questionnaires. White (2002:87) defines questionnaires as instrument where the respondent writes his/her answers in response to printed questions on a document. Questionnaires were handed out to all the target population to fill and return back to the researcher or assistants.

### **3.7 Pilot study**

According to Christensen (2004:394) pilot study is an experiment that is conducted on a few participants prior to actual collection of data. The researcher employed the pilot testing to check all the parts of the experiment whether they are working properly; this is mainly checking the data collection instruments whether are they constructed properly. If there is malfunction, it can be corrected without any damage to the main study (Christensen 2004:395). The researcher conducted a pilot study few days before the actual research on two counselling session's observations, two staff member of the site, two HIV/AIDS counsellors

and two clients who utilize the VCT service. The pilot testing respondents were excluded during the main research. The result obtained was summarized and interpreted in the findings.

### **3.8 Data analysis**

Christensen (2004:407) reported that the data analysis reveals the importance of statistical analysis to reach conclusions regarding the result of the experiment that we have conducted. The study conducted a non-experimental quantitative design, therefore the outcome data will be a bunch of numbers and this is where statistics is coming in (Christensen 2004:407). The researcher employed descriptive statistics and graphic display to describe and summarize the data. De Vos (2002:204) stated that the purpose of descriptive statistics is to reduce large amounts of data physically to facilitate the drawing of conclusion about them. Data collected from the questionnaires was summarized by tabulating or graphically depicting them. The researcher transcribed the video tape and analyzed the scores obtained by the counsellors during the counselling session's observations. Feedback on counsellors' performance on the observations is available when needed.

### **3.9 Ethical aspects**

Ethical issues need to be considered when conducting a research, while human beings are the objects of study, it is important to understand the ethical and legal responsibilities of conducting research. Ethics are considered to deal with beliefs about what is right or wrong, proper or improper, good or bad (White 2002:84).

#### **3.9.1 Consent to Participate**

According to Christensen (2004:397) when the research participants arrive at the experimental site, the first task of the researcher is to obtain their consent to participate in the study. Most studies require that you obtain the research participant's informed consent to participate in the study (see Annexure 2). Therefore each and every participant did fill an informed consent, as it addressed

the purpose of taking part; if any uncertainties aroused the participants were free to withdraw at any time and no risks or discomfort may occur.

### **3.9.2 Confidentiality and Privacy**

Confidentiality in the context of the research study, refers to an agreement with research investigators about what may be done with the information obtained about a research participant, This means that the information obtained should not be revealed to anyone one other than the researcher and his/her team (Christensen 2004:163). Privacy refers to controlling other people's access to information about a person. Researcher attempts to ensure the privacy of research participants by either collecting the anonymous information or ensuring that information collected is kept confidential (Christensen 2004:162). The researcher in the current study employed to obtain anonymous information and assured participants that any information gathered will be kept confidential.

### **3.10 Conclusion**

The chapter focused mainly on the research methodology of the study, thus including the population, research settings, data collection and analysis and ethical aspect that revolve around when conducting a research study. The next chapter discusses the findings obtained from the data analysis.

## CHAPTER 4: ANALYSIS AND FINDINGS OF THE STUDY

### 4.1 Introduction

The chapter revealed the results obtained from the data collected from the research field. The results are presented using tables, graphs through the MS-excel spreadsheet and Epi-info analysis program.

### 4.2 Site evaluation findings

The total population expected to fill the questionnaires were 30, but only 23 of returned questionnaires were filled. According to Stoker (1985), the researcher had 76.6% of the population; therefore we had a sample size of 23 respondents.

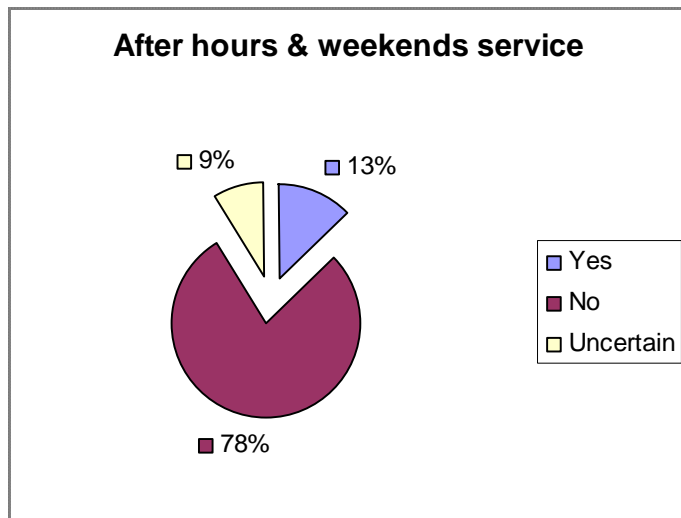
*Table 4.1 indicated the services offered at the site.*

n=23 respondents		
Services offered	Respondents	Percentage
Pre & Post Counselling	5	21.7%
Pre, Post & Testing	10	43.4%
Pre, Post, Testing, Continuous, PMTCT or TB	8	34.7%

#### 4.2.1 Service time

The respondents were asked if willingly they can offer the VCT service after hours and weekends. The study revealed that 78% of respondents do not agree to operate the VCT site after hours or during the weekends, while only 13% agrees to operate and 9% were undecided. See Figure 4.1

**Fig 4.1** after- hours and weekends service



**4.2.2** Question was posed to the respondents if there is an appointment system in the site. Of 100% respondents reported that the site do not have the appointment system, the clients are always seen the same day as long as it is within the clinic official opening hours.

**4.2.3** Respondents were asked if there is adequate space to ensure private counselling sessions. As indicated below on table 4.2, only 65% of respondents said that the space to ensure private counselling session is insufficient, while 35% agreed to have adequate space.

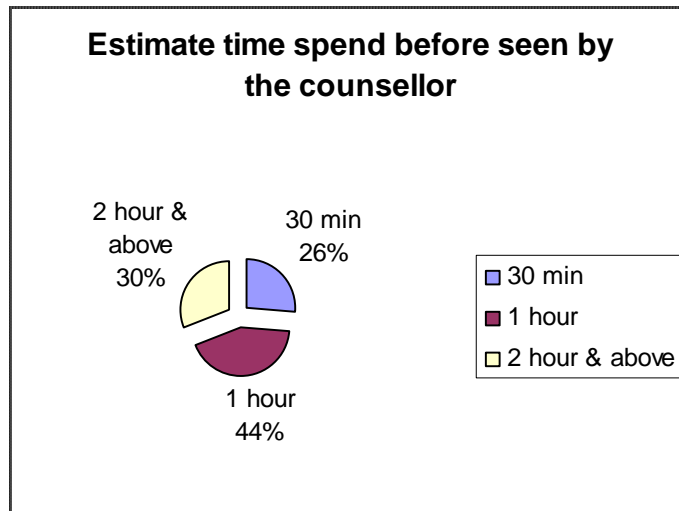
**Table 4.2** illustrates the response on adequate space to ensure private counselling

Response	Respondents	Percentage
Yes	8	34.7%
No	15	65.2%

**4.2.4** The VCT staff were asked to estimate time spend by the clients to be seen by the counsellor. The study showed that 44% of staff members estimated an hour wait of clients before they can be helped, while 26% remain agreeing that clients only spend 30 min to hang around. Of other remaining 30% of

respondents estimated 2 hours and above of time spend by the clients waiting to be helped.

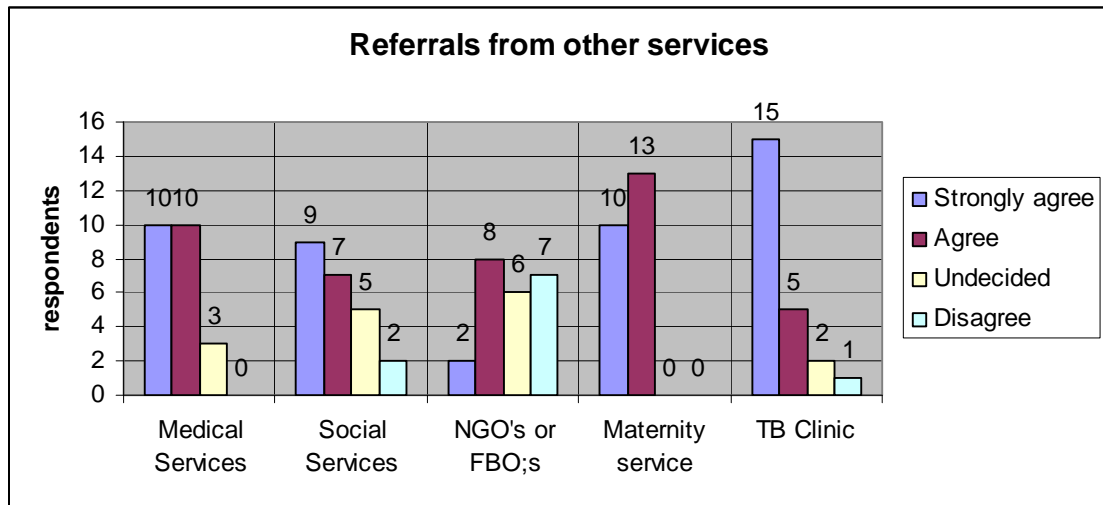
**Fig 4.2** Estimate time spend by clients before seen by the counsellor



**4.2.5 Referral from other services-** The respondents was asked if they receive clients from other different services. The study findings from figure 4.3 below indicated that the most referral service are from the TB Clinic followed by the maternity and medical, while the least referral are from the social services and the non-governmental organizations.

Services	Response			
	Strongly agree	Agree	Undecided	Disagree
Medical Services	10	10	3	0
Social Services	9	7	5	2
NGO's or FBO;s	2	8	6	7
Maternity service	10	13	0	0
TB Clinic	15	5	2	1

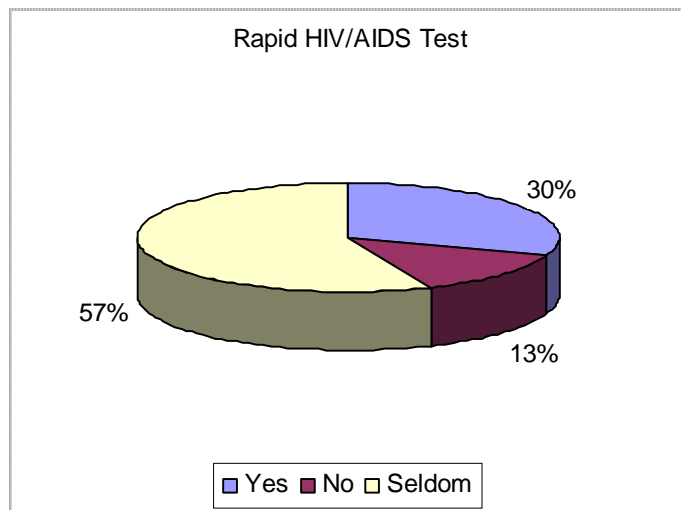




**Figure 4.3** illustrate referrals from other services

**4.2.6** The respondents were asked whether they do also refer clients to different services after the counselling and testing procedures had been performed. Total of 70% of respondents agreed that they do refer the clients to different service to receive another forms of therapies or treatments.

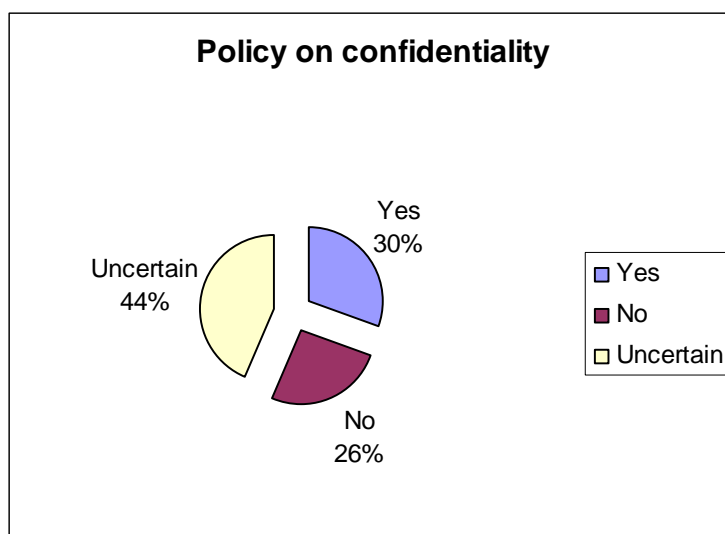
**4.2.7** The respondents were asked if they do perform rapid HIV test. The study revealed that 57% of respondents said those rapid tests are used very seldom.



**Figure 4.4** Pie diagram illustrating the utilization of rapid HIV/AIDS test

#### 4.2.8 Confidential Information

The question was asked to the respondents to identify if the site does have a written policy on confidentiality and another question was to tell if there is a system in place to protect confidential information. Of 44% of the respondents were uncertain, 26% said they do not know of such policy whilst 30% agreed that there is a policy on confidentiality. Of 78% do not agree that there is a place to protect confidential information and 22% agreed to have the place to protect the confidential information.



*Figure 4.5 illustrate the response on the presence of policy on confidentiality*

#### 4.2.9 Service offered to the special and vulnerable groups.

The question was posed to the respondents to tell which vulnerable groups are mostly receiving the VCT service. The study revealed that the mostly seen vulnerable groups are young people followed by children and pregnant women. Whilst other respondents agreed that also sex workers, refugees and couples are sometimes receiving the service.

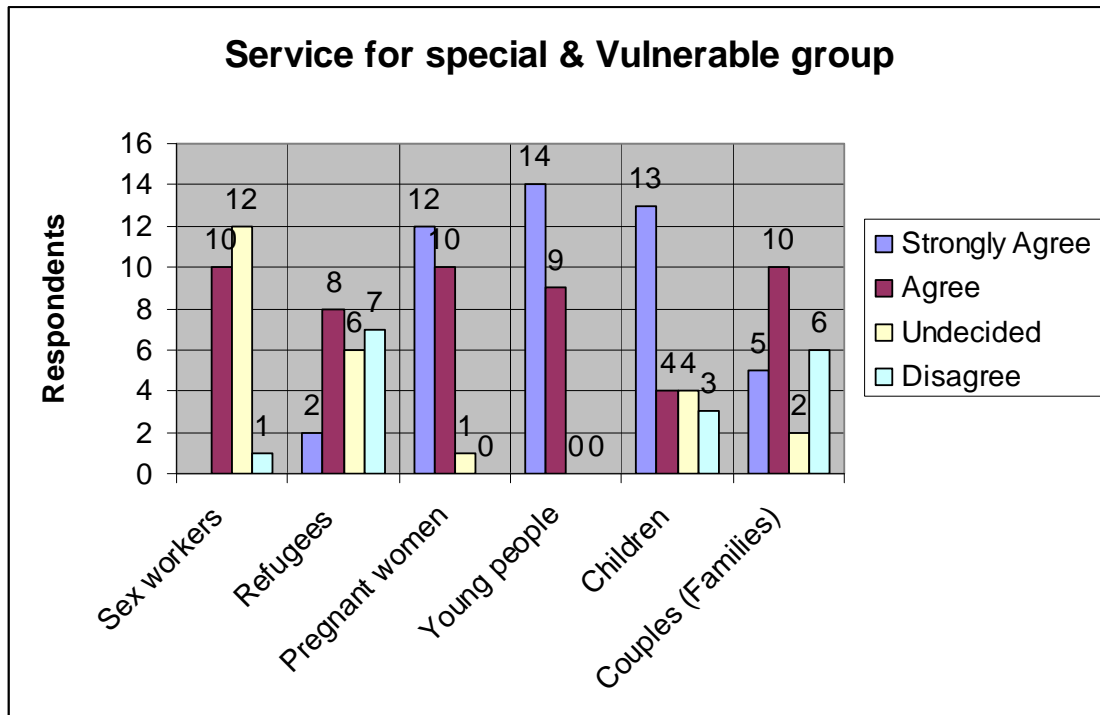


Figure 4.6 Bar graph illustrating the most vulnerable groups receiving the service.

#### 4.3. Findings from the video-recording observation of counseling quality and content.

The aim of this section of observation was to evaluate the counselling process, quality and content and the client-counsellor interaction. The researcher used the scoreboard adapted from UNAIDS 2000 to score the counsellors when performing the counseling session on an individual. The observation incorporated the Pre-test counselling, post-test counselling, counseling of people on antiretroviral therapy and pre and post counseling of pregnant women.



	Building Relationship	2
	Gathering of information	4
	Giving of information	2
	Handling Special circumstances	3

<b>Observation 7</b>	<b>Counselling Phases</b>	<b>Ratings</b>
	Building Relationship	2
	Gathering of information	3
	Giving of information	4
	Handling Special circumstances	1

<b>Observation 8</b>	<b>Counselling Phases</b>	<b>Ratings</b>
	Building Relationship	3
	Gathering of information	3
	Giving of information	1
	Handling Special circumstances	4

<b>Observation 9</b>	<b>Counselling Phases</b>	<b>Ratings</b>
	Building Relationship	3
	Gathering of information	3
	Giving of information	2
	Handling Special circumstances	4

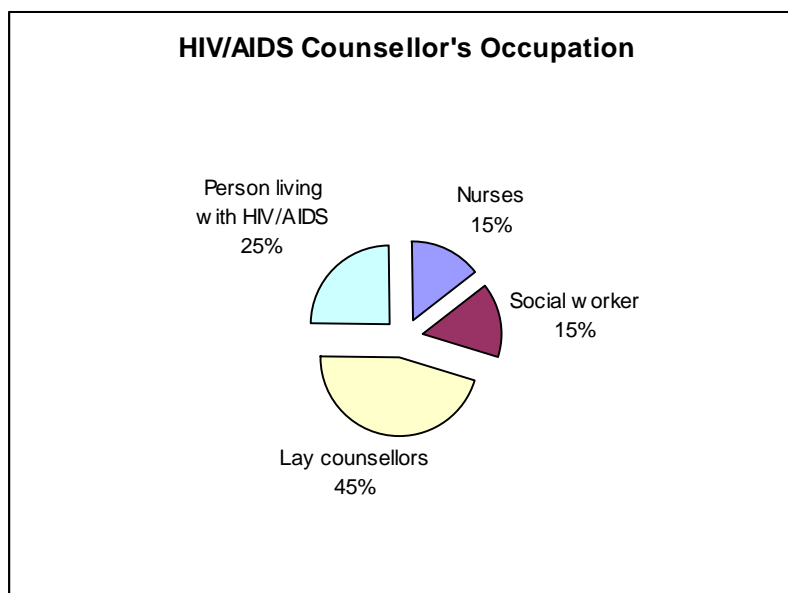
<b>Observation 10</b>	<b>Counselling Phases</b>	<b>Ratings</b>
	Building Relationship	3
	Gathering of information	3
	Giving of information	2
	Handling Special circumstances	4

<b>Ratings: 4 very good 3- good 2- Fair 1- poor</b>		
n=10 respondents		
<b>Counselling Phases</b>	<b>Average/Mean</b>	<b>Ratings</b>
Building Relationship	2.6	Good
Gathering Info	2.9	Good
Giving Information	2.1	Fair
Handling special Circumstances	3	Good

The study discovered that the counsellors according to the ratings their counselling skills on building relationship phase they are competent, whilst on the giving of information phase they showed incompetence or lack of skill.

#### 4.4 Findings about the counselor’s requirements and satisfaction

The researcher expected 35 of the staff members to fill and return back the questionnaires, but only twenty filled and returned the questionnaires. The respondents were asked to identify their occupation. The study discovered that majority of the counselling duties are occupied by 45% of volunteered lay HIV/AIDS Counsellors and 25% of people living with HIV/AIDS, whilst all the qualified occupations hold both 15% each of the counselling activity.



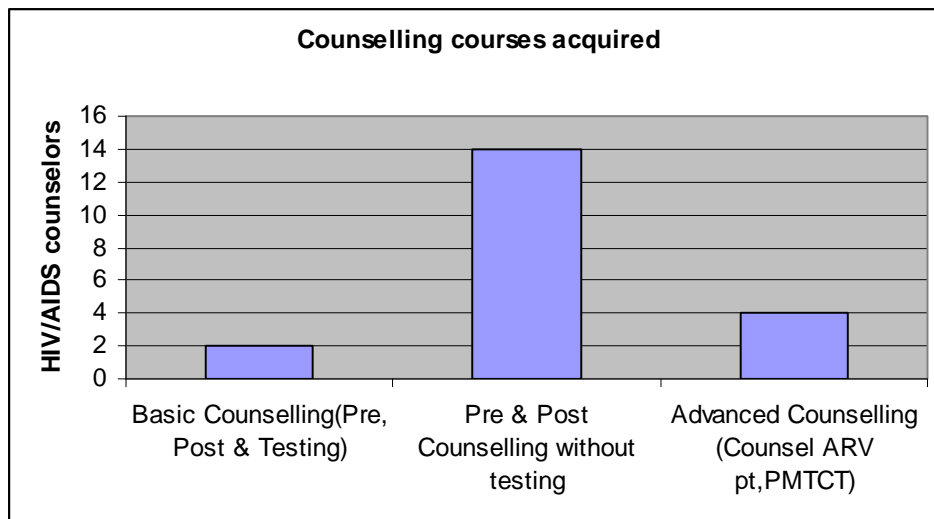
**Figure 4.7** Pie chart showing the HIV/AIDS counselor’s occupation

**4.4.1** The respondents were asked if they were selected to become counselor. The study revealed that all the lay counselors did volunteer whilst the PLWA thought of helping and sharing their feelings and ideas with the community members.

**4.4.2** The other question that was posed was that if they don't feel pressured when performing the counselling activity. The response was that they do enjoy what they are doing since no one forced them to do the counselling activity.

**4.4.3 Acquired counseling skills**

The question was phrased to the respondents to identify the courses they attended to perform counselling. The study showed fourteen of the HIV/AIDS counselors do have Pre & Post counseling without testing skills, whilst two staff members have Pre & post counselling and testing. The last four of the staff members had an advanced counselling course.



*Figure 4.8 illustrate the counselling courses attended by the HIV/AIDS Counselors*

**4.4.4** The staff members were asked to rate their counselling courses acquired, of 70% responded that their courses are inadequate. They felt to have sufficient training as an additional benefit from the hospital management.

**4.4.5 VCT Manager's support and superiors**

The respondents were asked if they do receive support from their VCT manager. The study showed that 60% of the respondent said they receive minimal support from the VCT manager.

#### 4.4.6 Challenges when communicating with the clients.

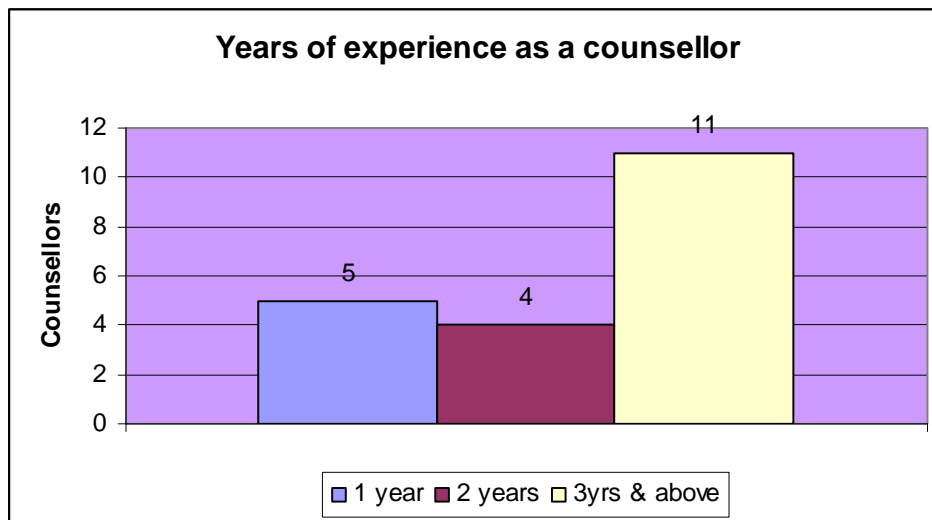
The respondents were asked if they do experience problems when communicating with the clients. The study revealed the ability of communication to the clients as the people visiting the site are mainly blacks who communicate Tswana language.

*Table 4.4 demonstrates the counselor's ability when communicating with clients.*

Response	Sample	Percentage %
NO	16	80
YES	4	20

#### 4.4.7 Years of counselling experience

The respondents were asked to identify their years of experience on counselling activity. The study showed that eleven of the HIV/AIDS counsellors have 3 years and above of experience, five have one year of experience whilst the last four have two years of service performing counselling.



*Figure 4.9 demonstrate the years of experience as a counsellor*



## 4.5. Findings about the client satisfaction

### 4.5.1 Local Clinic referral

The researcher handed out questionnaires to fifty people, regrettably only thirty-seven responded. The clients were asked to tell how they came to the VCT site for counselling and testing sessions. Of 13.4% said they had been referred by their local clinic, whilst 81% reported different stories. See figure 4.8. The study showed that 13 of the clients said they came in to the VCT site because of their sickness, nine came in voluntarily, four were referred from the private clinics and the last four were recommended by friends or family members.

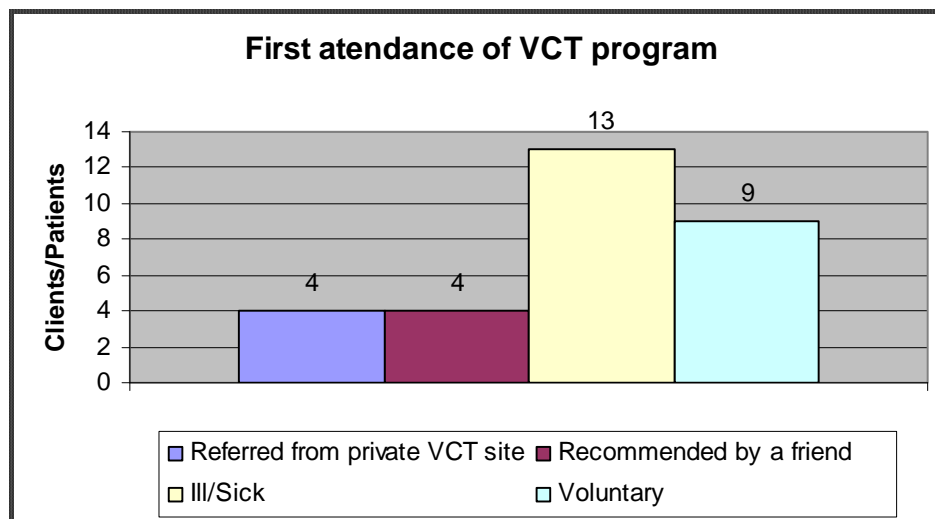
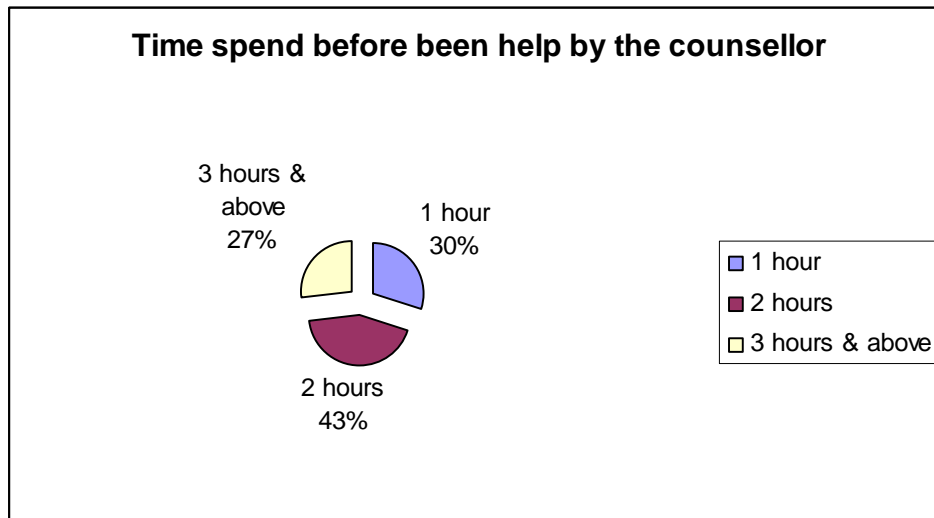


Figure 4.10 illustrate the first visit of clients to the VCT program

### 4.5.2 Time spend before seen by the counsellor

The clients were asked to estimate how long they wait before receiving help. The study showed that 43% of clients said they do wait two hours before they can be seen by the counsellor, 30% reported to wait only one hour and the last 27% said they wait three hours and above before they can commence with the counselling session.



*Figure 4.11 illustrate time spend before been seen by the counsellor*

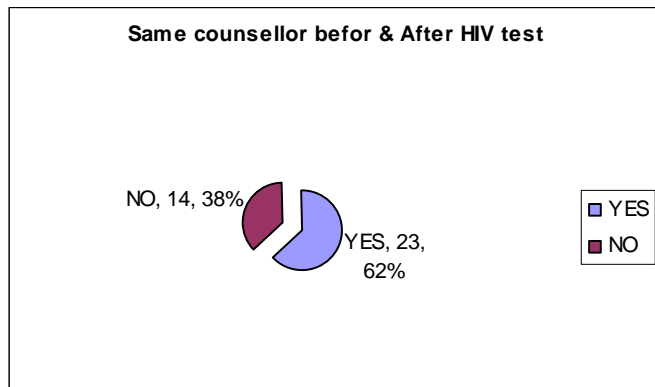
#### **4.5.3 View your HIV/AIDS Counsellor**

The question was posed to the clients to tell how they view their counsellors. Of 73% rated their counsellors bad whilst 27% considered the counsellors good.

**4.5.4** The clients were asked if they wish to have different counsellor with regards to sex, age or race. The study revealed that 54% can accommodate the different counsellor with regards to their sex, age and race. Of 46% of clients seem not to have a problem.

#### **4.5.5 Same counsellor before and after the HIV test**

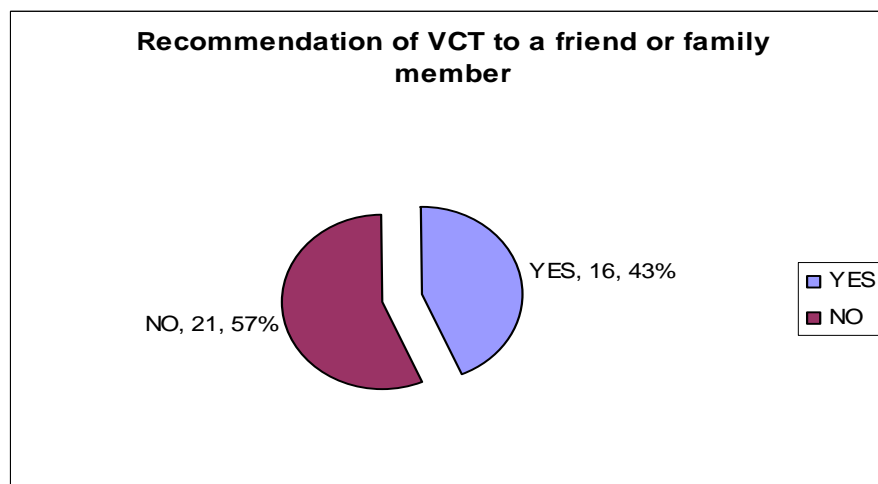
The clients were asked if they can be able to be counseled by the same counsellor before and after the HIV test. The result revealed that 62% preferred one counsellor whilst 38% they preferred a new counsellor.



**Figure 4.12** pie chart presenting preference of same or different counsellor before and after HIV Test

#### 4.5.6 Recommend a friend/family member

The clients were asked to tell if they can recommend either a friend or family member to utilize the VCT service. The results showed 57% of clients refused to recommend a friend or family member to receive voluntary counselling and testing. Of 43% said they can recommend a friend or family member.

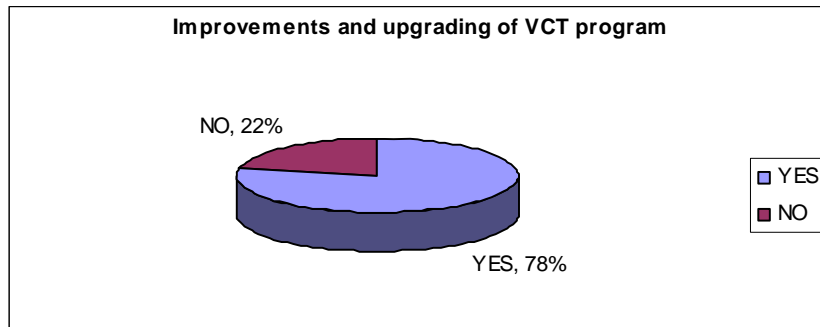


**Figure 4.13** illustrate the response to recommend a friend/family member

#### 4.5.7 Improvements or upgrading of the VCT service

Firstly the clients were asked if they do need the service to be improved or not. Of 78% clients agreed with the point of improving the service whilst 22% said the

service does not need improvements. Therefore only the clients, who answered yes, can provide their own views, suggestions and ideas on how to improve the service.



**Figure 4.14** Response to improve the VCT program

The following cryptic views were given:

- Reduction of long time spend
- Employ qualified nurses to perform counselling
- Do not need the resident counsellors because our confidentiality is not assured
- Hospital should provide them with food while waiting to be helped
- Conducive waiting area (posters with information, TV broadcasting HIV/AIDS related issues)
- Staff attitudes towards the clients
- Have mobile VCT program in rural areas or in our local clinics so that we do not travel long distance
- No enough chairs
- Waiting long for the result
- Missing file problems
- Sometimes no Doctor to prescribe ARV drugs for patients

#### **4.6 Conclusion**

In this chapter, the attention was given to the findings obtained after the collection of the data. Computer program such as Ms excel was used to analyze the collected data. The following chapter will discuss the findings of the study with reference to the literature.

## **CHAPTER 5: DISCUSSION OF THE FINDINGS**

### **5.1 Introduction**

In the previous two chapters we dealt with the design of the study, method of data collection and the findings of the study. This chapter will focus on the discussion of the findings with the reference to the literature review. According to Brink (1996:179) stated that the discussion of research findings should relate to the literature review, should also indicate correlations or contrast obtained in response to different research questions.

### **5.2 Discussion of site evaluation findings**

#### **5.2.1 Services offered**

The study consisted of 76.6% of population who responded to the questionnaires, it result in 23 respondents out of 30 staff members. It was found from the findings that the services offered are Pre and Post Counselling, Pre And Post Counselling And testing, and Pre, Post counselling, Continuous (administration of antiretroviral), and counselling to PMTCT and TB. Of 21.7% respondents agreed that Pre and Post counselling are agreed to be offered but in lower percentage, 43.4% of respondents agreed that Pre, Post and testing is offered whilst 34.7% of respondents agreed that also Pre, Post, Continuous, Counselling on PMTCT or TB are offered.

According to the respondents the Pre, Post counselling and testing are offered most, then followed by the Pre, Post counselling, testing, continuous counselling and PMTCT and TB counselling. The literature in this regard stated that the VCT services need to be available or accessible for the population they are serving. In high prevalence areas, a wide range of care and support activities need to be in place for the community (UNAIDS 2000:18).

Pronyk et al (2002:861) indicated that the pre, post counselling and testing is a prerequisite for effective treatment, care and support services, including programs to reduce mother-to-child- transmission, preventative therapy for TB and administration of antiretroviral. Furthermore, it can result in behavior change and improve the coping strategies of people with HIV reductions in risk behavior. The research result showed that the respondents agreed in low percentage that pre and post counselling is offered, this indicated that people need to test to know their status. It is stated by UNAIDS (1997:2) that people need to know their status and make informed decision.

### **5.2.2 Services time**

There results showed that 78% of respondents do not agree to operate the VCT service site after hours or during the weekends while only 13% agreed to can offer the service and 9% are undecided. The literature indicated that the opening hours of the service need to take into account the needs of the clients. This is to allow easy access to people who are working and who are schooling and those who need the service after hour. (UNAIDS 2000:18) further conflict with the research result that there should be service offered during lunch time, early evening and weekends.

The result revealed that 44% of staff members estimated that the clients do wait an hour before they can be helped by the clients, whilst 43% of clients do not agree with what the staff members are indicating. They reported to wait two hours before they can be helped due to long queues of administration to get a record file and long queues to receive the counselling. UNAIDS (1997:5) reinforced that the service can be inappropriate for the clients because of inconvenient opening times of administration services or any difficult access around the hospital.

With regards to the appointment system, the respondents agree that there is no system in place; clients are seen on the same day as long as it is within the normal clinic opening hours.

### **5.2.3 Adequate space**

In terms of adequate space to ensure private counselling sessions, 65% of respondents, said the space is insufficient. UNAIDS (2000:18) emphasized that in services used by women, families, the site should have a supervised space where children can play to enable less interrupted counselling. A well-ventilated waiting area is important because TB infection is commonly associated with HIV and people with reduced immunity are particularly vulnerable to nosocomial tuberculosis infection and also reduce less interruption of passing-by people i.e. cleaners, clerks and those enquiring of any form of information. Van Dyk (2005:335) also reinforced the importance of having private space to ensure privacy and confidentiality without any interruption of people. She further stated that counselling should be done in any location that offers peace of mind and privacy of the clients.

### **5.2.4 Confidentiality information**

The results showed that respondents who agreed to have a written confidentiality policy and a system in place to secure confidential information are only 30% of professional counsellors, whilst 70% they are not aware of such policy. Van Dyk (2005:203) indicated that health-care professional are ethically and legally required to keep clients information confidential. Opinion of researcher: what about the lay-counsellor in terms of ensuring that confidentiality is kept, should this be reinforced in their training? Van Dyk (2005:204) further stated that if clients are not assured of confidentiality, they tend not to come for treatment or continue with counselling process.



### **5.2.5 Referral from other services**

The findings showed that the most referral service to the counselling service are from the TB clinic, followed by medical and maternity or obstetrics service, whilst the least referral are from social services and NGO's. It is indicated by UNAIDS (1997:7) that the existence of good support for counsellors is directly related to the existence of good referral system. A referral system should be developed in consultation with the NGO's, community-based organizations, hospital directors, service managers and the networks of people living with HIV/AIDS. A efficient referral system will also enable AIDS service organization and other NGO's to refer their clients who require medical care to the hospital or clinics. The result showed interaction with the literature with regards to referral system. It is considered to be good system as the clients need to be referred for continuous counselling, home-based care and social services for those who qualify to receive disability grants (UNAIDS 1997:7)

### **5.2.6 Rapid test**

The findings of the study revealed that the rapid test at George Stegman VCT site is used seldom. It showed that there is a problem about the presence of the rapid test on site. According to WHO (2004), the simple/rapid tests are manufactured and already introduced to the public sectors. WHO (2004:4) indicated that to ensure access to HIV testing for large population and to facilitate access to antiretroviral treatment, a radical scaling up of rapid HIV testing and counseling services is urgently required. To back-up the above statement also Parker et al (2004:4) reinforced that rapid test are uniformly available in the public sectors and the guidelines thereof.

Amongst other things, advantages of rapid tests for HIV testing and counselling are: increased number of people benefit from knowing their HIV status, there is an increased uptake of results by people being tested, results are obtained quickly and less reliance is placed on laboratory services for analysis of blood and obtaining the results.

### **5.2.7 Service offered to special and vulnerable groups**

It was found from the findings that the most vulnerable group visiting the site are young people followed by children and pregnant women. The least were the sex workers, refugees and couples or families. FHI (2002) considered this as a goal that the VCT service has reached by young people who are at highest risk of contracting the HIV/AIDS. UNAIDS (2000:10) pointed out that when VCT services are being developed consideration should be given to the different needs of people attending and the communities for which the VCT services are designed. Taking into account that the study revealed young people as the most people utilizing the service, FHI (2002:2) indicated that young people are often particularly vulnerable to HIV infection.

FHI (2002:2) further indicated that many young people desire such services, but the services are limited. Recent studies showed that many young people in the countries where the HIV prevalence is high want to know their studies. Therefore the only service that can address the young people's HIV prevention and care needs is voluntary counselling and testing program.

The study revealed children for utilizing the service most often. Van Dyk (2005:89) stated that HIV increasingly affects children. Therefore special counselling to address the understanding and coping with their own illness and dealing with discrimination by other children or adults should be given.

Other vulnerable group mentioned in the findings to be utilizing the service is the pregnant women. UNAIDS May (2000:10) reported that pregnant women do benefit from VCT service, as they need to make the decision about themselves and their unborn child and explore on family planning options.

### **5.3 Discussion of the counselling quality and content observations' findings**

The observations were performed on different steps of counselling, different vulnerable people such as young people, sex workers, pregnant women, children etc. The observations were mainly focusing on the following counselling phases; Building relationship, gathering information, giving information and handling special circumstances. Ten counsellors were observed while performing counselling on an individual. The results revealed that in Building relationship phase, the counsellor scored 2.6 of which according to the ratings is good. According to Van Dyk (2005:177) the counsellors established an open and trusting relationship with clients, to feel safe enough to address personal issues and to disclose their information.

In the gathering of information phase, the counsellors scored 2.9 which indicate good rating. The good rating indicated that the counsellor managed to spend time to find out about the client's current and preferred scenario so that both can understand the problems and begin to think about planning possible intervention strategies (Egan 1998).

Giving of information to the clients, the counsellors scored a fair rating. The phase entails developing an increased understanding of the problem. Counsellor should help the client break the 'blind spots' that prevent them from seeing themselves and their problems as they really are (Van Dyk 2005:179).

The counsellor should explore and identify themes in the client's story, linking feelings, behaviors and experience and giving recent knowledge about the HIV disease. The fair rating indicated a lack of skill from our counsellors to identify and implement actions that will improve the client's situation e.g. providing national statistics of HIV prevalence can make the clients feel better that he/she is not alone in this battle (Van Dyk 2005:179).

In handling special circumstances phase, the counsellors were rated good. It did indicate that counsellors had appropriate management of client's distress or emotional reactions. They talked plainly about sensitive issues to the clients and were able to accommodate the clients' language difficulty. Van Dyk (2005:200) stated that language difficulties between a counsellor and clients can cause severe difficulties especially in South Africa with eleven official languages.

#### **5.4 Discussion of counselor's requirement and satisfaction findings**

##### **5.4.1 HIV/AIDS Counselor's occupation**

It was found that 45% of the respondents are lay- counselors, 25% are people living with HIV/AIDS, 15% of social workers and 15% of nurses. Therefore the George Stegman VCT site comprised of 70% of non-professional counsellors and 30% of professional people who participated in the study.

Van Dyk (2005:173) emphasized that there is a very great need for counselling and for skilled HIV/AIDS counsellors. Professional people cannot cope with the demand as they still have to do their career duties. She further stated that there should be training on each and every helper in the field of HIV/AIDS to give basic counselling, but they should be trained to recognize serious problems i.e. informed consent, confidentiality and be trained to refer clients if they not sure they should ask the counselling-mentor or professional people.

The lay-counsellors are non-clerical, non-professional people but volunteers; they only perform counselling without testing, whilst testing is performed by the nurses. Researcher's opinion- since there is an availability of rapid tests, can't there be a way of training the lay-counselors to utilize the simple/rapid tests to offload the nurses' workload they experiencing.

#### **5.4.2 Counselor selection**

The study showed that counselors at the site are not selected but offered themselves to assist and they reported not to feel any pressure when performing the activity. Van Dyk (2005:324) indicated that health professional indicated they do experience burnout and stress when they have to do their duties and perform also the counselling.

The findings revealed that the Lay counsellors reported lack of support from their superiors, indicated that their counselling skills are inadequate and often they reported to lack health care materials and medications for the clients and this do hinder to perform their daily task of duties.

#### **5.4.3 VCT manager's support or superior's support**

The results illustrated 60% of respondents reported to have minimal support from their superiors and VCT manager. It is found that the George Stegman HIV/AIDS counselors are not appropriately supervised; they are all on their own. The FHI (2002:33) indicated that every VCT centre should have a counsellor – mentor who will provide professional support and supervision to the lay-counsellors. UNAIDS May (2000:9) indicated counsellors need adequate training, ongoing support and supervision to ensure that they give good-quality counselling and can cope with stresses and avoid burnout.

#### **5.4.4 Years of experience**

It was found that most of the counsellors had three years and above of service. UNAIDS (2000:25) indicated that to retain the most experienced counsellors or to avoid losing valuable and experience staff, regular support, continuous training and supervision should be planned and provided.

#### **5.4.5 Acquire counselling courses**

The result revealed that fourteen of the HIV/AIDS counselors acquired Pre-test and post-test counselling without testing. It showed that testing are referred to

the professional staff i.e. nurses, as literature stated that lay-counsellors do not perform testing but refer the clients to a nurse for HIV test ( Van Dyk 2005:177). The findings showed that the advance counselling that include administration of ARV counseling and PMTCT counselling had been acquired by quite small number of professional staff.

## **5.5 Client satisfaction**

### **5.5.1 Local Clinic referral**

The question from the study was posed with the intention of seeing whether people do voluntarily utilize the service, but the results showed that clients are mostly referred from the clinics due to their HIV/AIDS related illnesses. The literature stated that communities delay to visit the VCT site voluntarily and on time but wait to experience HIV related symptoms and be referred to utilize the service. Parker et al (2004:3) reported that in March 2004, the VCT was available at more than 1900 sites in South Africa; the sites were catering primarily for clients who access VCT in the context of PMTCT of the home-based care not much of voluntary.

### **5.5.2 Views about HIV/AIDS counsellors**

The result showed that they do prefer non-residents counsellor and they do prefer different counsellors with regards to their age, sex and race. It was also found that the clients preferred a same counsellor before and after the HIV test. To ensure a good record and building a strong relationship with a counselor (Van Dyk (2005:177)

### **5.5.3 Recommend a friend or family member**

The results revealed that 57% of clients did not agree to recommend VCT service to a friend or family member. It is found that community participation to publicize the benefits of VCT is minimal; therefore there should be a way of raising awareness about the VCT. The reluctance of people to tell about the

benefits of VCT or to attend for HIV testing, UNAIDS May (2000:2) indicated that it can be because of denial, stigma and discrimination that people who test seropositive may face.

Furthermore, stated that to overcome such barriers to establish quality of service, its important to demonstrate its effectiveness and to challenge stigma and discrimination. It will ensure that people are no longer reluctant to utilize the service and recommend a friend (UNAIDS May 2000:3).

#### **5.5.4 Improvement and upgrading of the VCT service or site**

The results showed that 78% of respondents agreed that the service need to be improved. Literature identified that where VCT is considered important, its widespread implementation is often limited by lack of funding, lack of resources and infrastructure, lack of trained and designated staff, lack of clear policies and service sustainability. WHO (2004:86)

The respondents reported that counsellors have attitude towards them. All the above do hinder the quality of VCT that need to be delivered to the community. The respondents stated in their improvement views that there should be a way of offering mobile VCT program to rural villages. FHI (2002:3) indicated that in Uganda they also implemented mobile VCT services in their youth centers.

#### **5.6 Conclusion**

The discussion of the findings had been concluded with numerous areas that need attention. The following chapter presents the limitations, recommendations made from the findings and the conclusion of the study.

## **CHAPTER 6: RECOMMENDATIONS, LIMITATIONS AND CONCLUSION**

### **6.1 Introduction**

The chapter reflected back to the purpose and objectives of the study, the purpose of the study was to evaluate the quality of voluntary HIV/AIDS counselling and testing program at George Stegman VCT site. The chapter will conclude the study by providing recommendations that can be useful to the VCT site managers to make improvements on offering quality of counselling and testing service.

### **6.2 Limitations**

The research study was examined only in one of the constrained- resource setting in public sector, although the North- West province has a total of 56% of VCT sites, so the study could not necessarily be generalisable to the entire province. Palmer (2004: 12) indicated that doing research into issues surrounding HIV/AIDS is a highly sensitive task. The reluctance of people not to fill the questionnaires with the total number expected by the researcher did hinder the data collection. The study was highly focused on evaluating the VCT program but it does reveal numerous areas that would need attention.

### **6.3 Recommendations**

On the basis of the previous chapter of study findings, the following recommendations were made:

- Convenient opening hours of the VCT site by introducing a well planned system of shifts
- More research is needed to determine the VCT' impact on young people's behavior
- Develop a good referral system with the NGO's and community-based organization. Hold regular meetings to review the referral system implemented.



- Provision of advanced counselling training to the Lay-counsellors
- Raise community awareness about the VCT offered.
- Provision of mobile VCT service to accommodate those who are far from the hospital to utilize the service.
- Develop tools to monitor and review the counselling quality and content.
- The management or the VCT manager should provide regular monitoring of HIV/AIDS counselor's performance to ensure quality of the service and it may also assist to avoid the stress that the counselor's are most often experiencing

#### **6.4 Conclusion**

The stated objectives were fulfilled through this research study. In a nutshell, the aim was to determine how well the voluntary HIV/AIDS counselling and testing program since its inception has achieved.

The study revealed inconvenient opening hours of the voluntary counselling and testing site, long queues and long time spend of clients before they can be helped by the counsellors, insufficient private rooms for counselling, lack of medical material such as rapid test kits and ARV drugs , lack of confidentiality due to residents who volunteered to be HIV/AIDS counsellors and minimal consultation with the NGO'S, FBO'S and the home based care centers.

Despite the Strategic plan of the Department of health 2007 to scale-up the VCT's availability and accessibility, the package of HIV/AIDS prevention, care and treatment services has not yet been reached to the rural areas. With reference to the literature voluntary counselling and testing has been recognized in the National AIDS control program but they are not fully developed in most resource constrained countries. It can be concluded that the voluntary counselling and testing site offered at George Stegman is not yet of quality, but with the recommendations drawn, they can assist to make improvements and changes were needed.

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**Annexure A**

GAUTENG PROVINCIAL HEALTH  
PRETORIA ACADEMIC HOSPITAL  
Private Bag X169, PTA, 0001

Tel No: 012 354 2210/1688  
Cell No: 072 908 6764  
Date: 22<sup>nd</sup> September 2007  
Enquiries: Mrs. R.M. Monageng  
Control Clinical Technologist

Attention: The Clinical Manager  
Dr Isila  
George Stegman Hospital ARV Clinic  
Moruleng Section

Sir/ Madam

Requesting permission to conduct a study at George Stegman ARV Clinic.

I am presently studying a Master of Philosophy (HIV/AIDS Management) with the University of Stellenbosch (Stellenbosch Campus - Africa Centre of HIV/AIDS). The course requires me to submit a research project on topic of my choice related to HIV/AIDS. The research study will be conducted to evaluate the quality of HIV/AIDS Counselling and Testing Program rendered in your Clinic.

I hereby request your permission, which will involve me to hand in the questionnaires, conduct interviews to the participants attending the HIV clinic, VCT manager and counsellors performing counselling session.

Confidentiality of all the results obtained whilst conducting the study will be maintained. The results may be published, but names will not be used. The outcome of the research study may assist in improvements on rendering quality service of HIV/AIDS Counseling and Testing program. The program is designed to be a great intervention against the spread of HIV/AIDS especially in rural areas, and it should bring a change in risky human behaviors.

Any question concerning the study, please feel free to contact the study Supervisor: Dr Thozì Qubuda Tel no: 021 959 2615 e-mail: [tqubuda@uwc.ac.za](mailto:tqubuda@uwc.ac.za)

I will be grateful if I can be granted the permission to conduct and complete my research project at George Stegman Hospital ARV Clinic.

Yours Faithfully

REGINA MONAGENG



## **Annexure B**

QUESTIONNAIRES SCHEDULE (questionnaires handed and filled by the following people:

- Those who visited the VCT program i.e. Infected or affected those on ARV therapy, etc.
- VCT managers and the VCT site staff members,
- HIV/AIDS counsellors

The responses received from the questionnaires or video recording counselling observation will be treated confidential.

Title: A Study to evaluate the quality of HIV/AIDS counseling and testing program at George Stegman ARV Clinic.

Research is intended for partial fulfillment of the requirement for the degree of Master of Philosophy (HIV/AIDS Management), University of Stellenbosch.

Supervisor: Dr Thozì Qubuda

**Purpose:** To evaluate the quality of HIV/AIDS counseling and testing program at George Stegman Hospital ARV Clinic.

### **This research is conducted under the following conclusions:**

- i) The questions consist of open and closed ended questions.
- ii) There are no wrong or right answers.
- iii) The identity of the respondents will not be divulged to the public.
- iv) The information obtained will be used for research purposes only, and not for personal gains.
- v) The responses to the questions will be taken as presented by the respondents.

**Your co-operation will be highly appreciated!**

**VCT Site evaluation tool** (Please indicate by placing X in an appropriate block).  
The VCT manager and all the staff members of the VCT site were given the questionnaires to fill in and return back.

1.1 Which services do you offer at your VCT site? Mark with an X

Pre-test & Post-test counselling	
Pre, Post & Testing	
Pre, Post, Testing, continuous counselling & PMTCT or TB testing & counseling	

1.2 Can you willingly offer VCT services after hours and weekends?

Yes	
No	
Uncertain	

1.3. Do you have an appointment system in place?

Yes	
No	

1.4. Do you have adequate space to ensure private counseling sessions?

Yes	
No	

1.5. How long do the patients wait before they are attended by the Counsellor?

Thirty min	
One hour	
Two hours and above	

1.6. Does the site have a written policy on confidentiality?

Yes	
No	
Uncertain	

1.7. Is there any system in place to protect confidential information?

Yes	
No	

1.8. Do you receive referrals from any of the following service? (Please use the key below as provided to tick the appropriate box)

SA=strongly agree

A=agree

U=undecided

D=disagree

Medical service e.g. clinic/hospital	SA	A	U	D
Social services				
Maternity/Obstetrics services)				
NGOs/FBO's				
TB/chest clinic				

1.9 After the counselling and testing service you offered, do you also refer clients to different services for further therapies or treatment?

Yes	
No	

1.10. Do you perform the rapid HIV tests?

Yes	
No	
Seldom	

1.11. Do you have services for special and vulnerable groups? (Please use the key below as provided to tick the appropriate box)

SA= strongly agree

A= Agree

U= Undecided

D= Disagree

	SA	A	U	D
Sex workers				
Refugees				
Pregnant women				
Young people				
Children				
Couples (Families)				

**INSTRUCTIONS**

**3. Tool to observe the counselling quality and content adapted from UNAIDS 2004.**

- i) The observations will be carried out by the researcher or the assistants.
- ii) Researcher should indicate the answer by circling the number in the score box.

**3.1 Scoreboard to assess the overall standard of counselling performed on an individual in different counselling steps i.e. pre-test counselling, post-test counselling and Pre & post counselling for PMTCT.**

<b>Phases in the counselling process</b>	<b>Skills</b>	<b>Score</b>
3.1.1.Client and Counsellor's building relationship	<ul style="list-style-type: none"> <li>• Greetings to the client</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>• Self-introduction</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>• Engages the client to the conversation</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>• Listens the client attentively</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>• Is the counsellor supportive and non-judgmental to the client?</li> </ul>	4 3 2 1
3.1.2.Helping the client to tell his/her story (Gathering of information)	<ul style="list-style-type: none"> <li>• Open and closed questionnaires are used in appropriate balance</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>• Seeks clarification about the information given by the client</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>• Counsellor's patience and revisiting of topics</li> </ul>	4 3 2 1

	if necessary	
	<ul style="list-style-type: none"> <li>Used minimal encouragers to allow client's self-expression</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Avoid early conclusions.</li> </ul>	4 3 2 1
3.1.3 Giving of information	<ul style="list-style-type: none"> <li>Gave information in very clear and understanding terms.</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Counsellor had recent knowledge about the HIV disease.</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Checked for misunderstanding and understanding of information.</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Repeated and reinforced necessary information.</li> </ul>	4 3 2 1
3.1.4. Handling special circumstances	<ul style="list-style-type: none"> <li>Talked about sensitive issues plainly.</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Accommodated language difficulty.</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Able to manage the client's distress.</li> </ul>	4 3 2 1
	<ul style="list-style-type: none"> <li>Flexibility of a client to involve the partner or any trusted person.</li> </ul>	4 3 2 1

**2. EVALUATION TOOL FOR COUNSELLOR'S SKILLS AND SATISFACTION  
INSTRUCTIONS**

- iii) Indicate your answer by placing X in the box beside the appropriate question.
- iv) Check instructions carefully to answer questions that are applicable to you.
- v) Give as much information as you have in the spaces provided for questions that need your explanation or any additional information.
- vi) There is no right or wrong answers.
- vii) You won't be victimized in anyway for participation, so answer the questions as honestly as possible.

2.1 What is your occupation?

Nurse	
Social worker	
Person living with HIV/AIDS	
Lay counsellors	

2.2 How were you selected to be a counselor?

Proposed by VCT Manager	
Self motivated	

2.3 Did you feel pressured into performing counseling activity?

Yes	
No	

Pre & Post-counseling	
-----------------------	--

Basic counseling (Pre, Post & Testing)	
Advanced counseling (Pre, Post , continuous, testing & PMTCT)	

2.4 Which counseling courses have you acquired?

2.5. How would you rate your counselling training?

Very good	
Good	
Adequate	
Inadequate	

2.6 Do you have your VCT Manager's support and technical back ups?

Yes	
No	

2.7 How do you feel about your counselling activity?

Good	
Bad	



2.8 How does superiors/hospital management rate you?

Value	
Undervalued	

2.9 Do you experience challenges when communicating with your clients?

Yes	
No	

2.10 How many years have you been doing counseling duty?

One	
Two	
three and above	

#### **4. EVALUATION OF CLIENT SATISFACTION INSTRUCTIONS**

##### **4.2 Client satisfaction questionnaires**

- viii) Indicate your answer by placing X in the box beside the appropriate question.

- ix) Check instructions carefully to answer questions that are applicable to you.
- x) Give as much information as you have in the spaces provided for questions that need your explanation or any additional information.
- xi) There is no right or wrong answers.
- xii) You won't be victimized in anyway for participation, so answer the questions as honestly as possible.

4.2.1 Did your local clinic refer you to the site?

Yes	
No	

4.2.2 If No, how did you first come to the centre?

Referred from private VCT site	
Sick/ill	
Recommended to come by a e.g. partner/friend	
Just came in (Voluntary)	

4.2.3 How long did you wait to see your counsellor?

1hour	
3 hours & above	
2 hours	

4.2.4 How long (time) did you spend in the counselling session with your counsellor?

30min	
-------	--

1 hour	
2 hours & above	

4.2.5 How did you view your HIV/AIDS counsellor?

Good	
Bad	

4.2.6 Do you wish you had a different counsellor (the one with different sex as you, older, younger?)

Yes	
No	

4.2.7 Were/Can you able to see the same counselor for discussion both before and after the test?

Yes	
No	

4.2.8 Would you recommend a friend, partner or family member to utilize the service?

Yes	
No	

4.2.9 Do you think the service needs any improvements or upgrading?

Yes	
No	

4.3.0 If yes, explain-----  
-----  
-----

***Thank you for your co-operation!!!!!!!!!!!!!!***

## **Annexure C**

### **INFORMED CONSENT**

#### **AUTHORISATION TO PARTICIPATE IN A RESEARCH PROJECT**

**TITLE OF STUDY:** Evaluation of the quality of Voluntary HIV/AIDS Counseling and Testing program at George Stegman ARV Clinic.

#### **PURPOSE OF THIS STUDY:**

To evaluate the quality of voluntary HIV/AIDS counselling and testing program.

#### **PROCEDURE TO BE FOLLOWED:**

The purpose of the research is to evaluate the quality of counselling and testing program offered at George Stegman ARV Clinic. Of which the result can be shared with the hospital management to develop and improve the program.

Although the study will not only benefit you, but may also help those who are still unaware of the Counselling and testing benefits and advantages.

There should be no risks or discomfort to you in sharing your own story. Your participation will mean that you will not meet with the researcher but your counselling sessions will be recorded using audio-taped method to avoid discomfort.

N.B other participants will be excluded from the video-recording method; these participants include the VCT manager, HIV/AIDS counsellor and other clients who already undergone the counselling sessions. They will be interviewed by the researcher and her team.

The researcher will keep a record and video of who has participated in this study. No name will appear on a video tape. Data will be stored in a secure place and no one except the researcher team will have access to the records. All the information obtained will be regarded as confidential. Your identity will not be revealed when the study is published.

Your participation in this study is totally voluntary. You are under no obligation to participate. You have the right to withdraw at any time without penalties.

**Declaration of a Researcher:** I discussed the above points with the subject. It is my opinion that the subject understands the risks, benefits and obligations involved in participating in this project.

-----  
Researcher/investigator

-----  
Date

**Declaration of a subject/ Consent to partake in the study:** I understand that my participation is voluntary and that I *may* refuse to participate or withdraw my consent and stop taking part at any time without penalties. I hereby freely consent to take part in this research project.

-----  
Signature of subject

-----  
Date