AN EVALUATION OF THE EFFECTIVENESS OF A CLINIC-BASED HIV/AIDS COUNSELLING COURSE ON TRAINEE FUNCTIONING AT THEIR WORK SITES

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DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.

Carmen Arendse

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ABSTRACT

The Western Cape AIDS Training, Information and Counselling Centre (ATICC) primarily focuses on the development and provision of information and different types of training programmes on HIV/AIDS/STIs. The Director of the Health Service of the Cape Metropolitan Council was invited by ATICC to select seven health educators and nurses who were involved in health education and counselling in their local clinics to complete a six-month training course. The objective of the study was to evaluate the effectiveness of the ATICC training course on the counselling practice of trainees at their respective clinics. An archival study was conducted utilising existing data collected by the researcher during the period of the training course from August 1998 to January 1999. Qualitative and quantitative data was collected using evaluation forms and focus group discussions. This was collected during and after the completion of the training course. The results generally showed improved changes in the trainees' knowledge and attitudes regarding HIV/AIDS. Trainees attributed the improvement in their counselling skills to the theoretical and practical training they received at ATICC. They were able to apply these skills within their work setting. Trainees highlighted that the training course also equipped them with improved listening and communication skills, which allowed them to feel confident about the counselling they were offering. Implication of these findings for future lay counsellor training by ATICC and other similar organisations are discussed.

CHAPTER 1

GENERAL INTRODUCTION

1.0. Introduction

This chapter focuses on global statistics relating to the growing rate of people infected with HIV. It also highlights the psychological impact on individuals who are diagnosed with HIV/AIDS. The importance of counselling and the need for ongoing training in HIV/AIDS counselling is also discussed. The rationale as well as the aims and objectives of the study are highlighted at the end of the chapter.

1.1. Background to the study

AIDS (Acquired Immuno-Deficiency Syndrome) has emerged as the single greatest threat to development worldwide. According to UNAIDS (2001), since the epidemic began, more than 60 million people have been infected with the virus. At the end of 2001, globally, an estimated 40 million people are living with HIV. It was estimated that over the course of 1999 alone, some 5.6 million people became infected with the human immunodeficiency virus (HIV), which causes AIDS. The year 1999 also saw 2.6 million deaths resulting from HIV/AIDS - a higher global total than in any year since the beginning of the epidemic. This, despite antiretroviral therapy that staved off AIDS and AIDS deaths in the richer countries (UNAIDS, 1999).

Sub-Saharan Africa continues to bear the brunt of HIV and AIDS, with close to 70% of the global total of HIV-positive people (UNAIDS, 1999). HIV/AIDS is noted to be the leading cause of death in Sub-Saharan Africa (UNAIDS, 2001). Approximately 3.4 million new infections occurred in 2001 bringing the total number of people living with HIV/AIDS in this region to 28.1 million (UNAIDS, 2001).

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According to the statistics released by UNAIDS (August, 2000), South Africa is considered to have the highest HIV/AIDS figures in the world, with about 4.7 million people living with HIV/AIDS (UNAIDS, 2001).

Furthermore, women are disproportionately affected by the epidemic. It is estimated that 1 in 4 South African women between the ages of 20 and 29yrs are infected with HIV (Nursing Update, 2000). There are a variety of biological, economical, social and cultural factors that make women more vulnerable to HIV infection. This, in turn contributes to the high incidence rate of HIV infections among women. Compounding the issue of women's vulnerability, is the unequal gender (social, economic, and power) relations. The impact on women relates to bearing the psychosocial and physical burden of AIDS care, as well as suffering particular discrimination. These factors are often blamed for spreading the infection.

It has long been recognised that HIV/AIDS is a disease that requires more than just medical care. In the absence of a cure or vaccine, an HIV-infected person is confronted with mortality. This in itself causes severe emotional distress. This distress relates primarily to the fact that AIDS is essentially sexually transmitted and is socially stigmatised. The disease is often wrongly associated with minority groups like homosexuals, prostitutes or drug users (Mokhobo, 1991). Moreover, Grania (1991) states that people living with HIV/AIDS have to cope with the many ramifications that invariably arise from testing HIV positive. These include disruptions of relationships or breakdown in the family unit, economic burden of being precluded from employment, medical aid or dental treatment, and restrictions on travel or immigration. Ng`weshemi, Boerma, Bennett and Schapink (1997) highlight that AIDS is more visible in the towns where HIV testing and hospitalisation take place. This is where the epidemic is fuelled by overcrowding, commercial sex

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work and movement of people, as well as cultural and economic diversity. People may attempt to escape this, but as Ng'weshemi et al.(1997) highlight, "there is no area,no matter how rural that is too secluded or isolated for HIV transmission"(p. 9).

Grania (1991) further highlights the importance of counselling as a vital component in the overall delivery of health care service for people with HIV/AIDS, their families, friends and colleagues. Krabbendam, Kuijper, Wolffers and Drew (1998) and Kaleeba and Kalibala (1997) maintain that the basic goal of counselling is to help and provide support to people dealing with the results of the HIV test and to help HIV-positive persons better cope with the consequences of their HIV-infected status.

With the rapidly increasing incidence of STIs/HIV/AIDS and TB, the health service finds itself having to meet a growing demand for information not only from the public, but also from within its own ranks. In addition, a growing number of nursing staff find themselves having to counsel HIV positive patients, those considering taking the test, those who are concerned, as well as bereaved friends and relatives. This has led to an urgent demand for training courses. Some highly specialised and others of a more general nature, and an energetic pursuit of experts in such fields as pre- and post-test counselling (Green & McGreaner, 1990).

In an effort to develop skills at primary care level, and equip staff to handle the unifunctional counselling needs, the Western Cape ATICC aims to train clinic-based staff in health education and counselling skills and hereby to provide the selected staff with skills in counselling HIV/AIDS, STIs and TB. The training courses aim for a comprehensive understanding of the ethical and practical implications with which these diseases challenge our society as well as skills transfer to health care workers whose daily work involves the provision of counselling and health education to a

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range of clients and communities. The minimum standards guidelines for HIV/AIDS training are utilised to shape the ATICC training courses. The Western Cape ATICC conducts various training courses including 4$1/2$ day information courses, 15 day counselling courses, train-the-trainer courses, refresher courses and 25 day clinic-based counselling courses. The aim of the present study is therefore to assess the effectiveness of one of the clinic-based counselling courses run at the Western Cape ATICC on the counselling skills of lay counsellors.

1.2. Rationale of the study

A study done by Bor and Elford (1992) highlight a need for training and skills development in HIV/AIDS counselling indicating that this is likely to increase as the number of people affected and infected by HIV continues to grow. Brouard (1998) argues that counsellors are only as good as the training they receive. Therefore, an evaluation of training courses of this nature is important, in order to assess the quality of the training received and the impact on the counselling skills of trainees.

The present study investigated the trainees' experience of the 25-day (six-month) counselling course in order to determine how adequately the course equipped them to cope with the myriad of issues that may arise during HIV counselling. Furthermore, the evaluation focused on the impact of the training course on their counselling practice within their work setting. The study also aimed to highlight the extent to which goals and objectives of the course were reached, based on the trainees' evaluation of the course. This information may be seen as important for ongoing training courses of this nature.

1.3. Statement of the research problem

The research focuses on the evaluation of the effectiveness of a clinic-based

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HIV/AIDS counselling course on trainees functioning at their work sites.

1.4. Aims and objectives of the study

The two main aims of the study were:

i.   Elicit trainee evaluation of the 25-day counselling course to

(a) determine the degree of attainment of programme objectives and,

(b) document the strength and weaknesses of the course.

ii.   Assess the effectiveness of the counselling training course on the practice at their work sites.

1.5. Layout of the rest of the mini-thesis

The rest of the mini-thesis is organised as follows:

Chapter 2 introduces theoretical perspectives around HIV/AIDS and counselling. The psychological and psychosocial impact of HIV/AIDS is discussed, thereby highlighting the importance of counselling. This chapter also focuses on the training of health care workers in HIV/AIDS counselling and reviews previous studies, highlighting the effectiveness of counselling.

Chapter 3 looks at the methodology of the present study. A description of the trainees, the instruments used, the counselling course, the procedure and the analysis of the study is presented.

Chapter 4 presents the analysis of the results from the questionnaire and the focus group. Common themes were extracted from the data to illustrate the trainees' perspective and experiences of the counselling training course. Thereby, highlighting their evaluation of the course and the impact this had on their counselling skills.

Chapter 5 presents the discussion of the results that includes explanations of the findings, a critique of the present study as well as suggestions for future research. It also presents conclusions drawn from the study and practical implications of the findings for future lay counselor training by ATICC and other similar organizations.

CHAPTER 2

LITERATURE REVIEW

2.0. Introduction

"Never before in the history of the human race has one disease presented so many challenges and brought about so many unanticipated changes" (Van Dyk, 2001). Being HIV positive impacts on the medical, psychological, social, spiritual and economic life of the infected person, as well as family and friends. All of this places an enormous burden on the shoulders of health care professionals, who need to offer HIV infected individuals and their significant others support and dedicated services.

This chapter offers a definition of HIV and AIDS. It surveys the historical background to the contemporary HIV/AIDS pandemic. The unique characteristics of HI virus and how it affects the human system is explained. The chapter explores the psychological impact of HIV/AIDS highlighting the challenges an individual is faced with when confronted with an HIV positive diagnosis. It also explores important issues. Firstly, the factors relating to women's vulnerability to HIV infection. Secondly, the importance of counselling as an important part of support for individuals infected, as well as those affected by HIV/AIDS are highlighted. The chapter also examines other studies evaluating the efficacy of lay counsellor training programmes on their functioning.

2.1. The HIV/AIDS pandemic

AIDS in Africa is a catastrophe without end, a searing epidemic that has destroyed families, orphaned millions of children, killed the elite and crippled the already impoverished economies of the world's poorest countries. Van Dyk(2001)

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states that "HIV/AIDS is known to be a virus unlike any virus previously encountered by the human race. Its devastating effects are being felt all over the world, but nowhere more tragically than in Sub-Saharan Africa. This is by far where the majority of all infections in the world occur" (p. 4). In exploring the complexity of this disease, it is important to gain an understanding of the definition of AIDS, its origin and how it affects the body's immune system.

2.1.1. The definition of AIDS

AIDS is the acronym for Acquired Immune Deficiency Syndrome. This disease is *acquired* because it is not a disease that is inherited. It is caused by a virus (the human immunodeficiency virus or HIV) which enters the body from outside. *Immunity* refers to the body's natural inherent ability to defend itself against infection and disease. *Deficiency* refers to the fact that the body's immune system has been weakened so that it can no longer defend itself against passing infections. AIDS can be defined as a *syndrome* of opportunistic infections and certain cancers each or all of which has the ability to kill the infected person in the final stages of the disease.
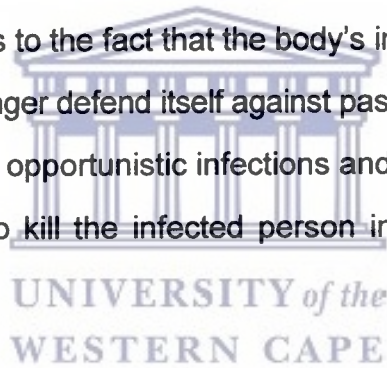
2.1.2. Historical background to AIDS

According to Adler (1988), the first recognised cases of Acquired Immune Deficiency Syndrome occurred in America in 1981. A very rare form of pneumonia, caused by the micro-organism *Pneumocystis carinii*, and *Kaposi's sarcoma* (a rare form of skin cancer), suddenly appeared simultaneously in several patients. These patients had a number of characteristics in common: they were all young homosexual men with compromised (damaged) immune systems.

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Soon afterwards, a new disease, which undermined the immune system and caused diarrhoea and weight loss, was identified in Central Africa in heterosexual people. According to Van Dyk (2001) scientists and doctors could not immediately identify the causes and the modes of transmission of this 'new' disease (called 'slimming disease' in Africa). In 1983, it was discovered that the disease was caused by a virus known as LAV (*lymphadenopathy* associated virus). In 1986 the virus causing this condition was renamed HIV (human immunodeficiency virus).

At present there are two viruses associated with AIDS, namely, HIV-1 and HIV-2. HIV-1 is associated with infections in Central, East and Southern Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa in 1986 and it is mostly restricted to West Africa.

2.1.3. Origins of HIV

Van Dyk (2001) indicates that there are many far-fetched theories about the origin of AIDS. Korber (2000) highlights a view, which is known to be generally more accepted by scientists, namely, that HIV crossed the species barrier from primates to humans at some time during the twentieth century. HIV is seen to be related to a virus called SIV (simian immunodeficiency virus), which is found in primates such as chimpanzees, and African green monkeys. According to scientists "the virus probably crossed from primates to humans when contaminated animal blood entered open lesions or cuts on the hands of humans who were butchering SIV-infected animals for food. While the initial spread of HIV was probably limited to isolated communities who had little contact with the outside world, various factors such as migration, improved transportation networks, socio-economic instability, multiple sexual partners and an exchange of blood products. Ultimately caused the virus to spread all over the world" (Korber, 2000, p.34).

2.1.4. The HI Virus

The HI virus has a circular shape and it consists of an inner matrix of protein called the core, in which the genetic material (viral RNA) is housed. Like other viruses, HIV can only reproduce itself inside a living cell which it parasites for purposes of reproduction. HIV can therefore only live and multiply in human cells. Although all viruses possess this very same characteristic, HIV is dangerous in that the HI virus does something that no other virus known to humankind has ever done: it directly attacks and hijacks the most important defensive cells of the human immune system, the CD4 or the T-helper cells. As it does this, it slowly diminishes the total number of healthy CD4 cells in the body – thereby undermining the ability of the human immune system to defend itself against attack from exterior pathogens (Van Dyk, 2001).

2.1.5. The transmission of HIV

HIV can be transmitted by: sexual intercourse (vaginal, anal, oral) or through contact with infected blood, semen, or cervical and vaginal fluids. This is said to be the most frequent mode of transmission of HIV world wide, and can be transmitted from an infected person to his or her sexual partner. The presence of other STIs, especially those causing genital ulcers, increase the risk of HIV transmission because more mucous membrane is exposed to the virus. HIV can also be transmitted through blood transfusions. A third mode of transmission is from mother-to-child. This can occur during pregnancy, labour and delivery or as a result of breastfeeding. Injecting equipment such as needles or syringes, or skin piercing equipment, contaminated with HIV, is another mode of transmission.

2.1.6. The progression of HIV to AIDS

Infection by HIV begins when an HIV particle encounters CD4 cells. Many people do not develop any symptoms when they first become infected with HIV. However,

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some people have flu-like symptoms within a month or two after exposure to the virus. These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. More persistent or severe symptoms may not surface for several years after HIV first enters the body in adults. In children born with HIV infection this can occur within two years. This period of "asymptomatic" infection is highly variable. Some people may begin to have symptoms in as soon as a few months, whereas others may be symptom-free for more than 10 years. During the asymptomatic period HIV is actively multiplying, infecting and killing cells of the immune system. HIV's effect is a decline in the blood levels of CD4 cells – the immune systems key infection fighters. The virus initially disables or destroys these cells without causing symptoms. As the immune system deteriorates, a variety of complications begin to surface, resulting in the "symptomatic" phase. The term AIDS, applies to the most advanced stages of HIV infection. AIDS includes all HIV-infected people who have fewer than 200 CD4+ T cells. Healthy adults usually have CD4+ T-cell counts of 1,000 or more. Most AIDS-defining conditions are opportunistic infections, which rarely cause harm in healthy individuals. In people with AIDS these infections are often severe and sometimes fatal because the immune system is so damaged by the HI virus that the body cannot fight off certain bacteria and viruses (Virtual Book, 2000).
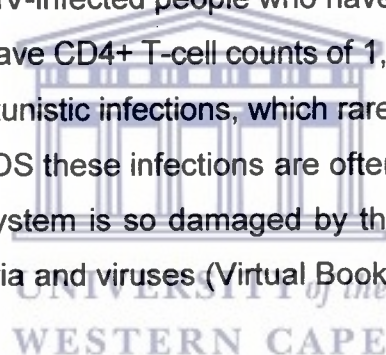
2.2. Psychosocial impact of HIV/AIDS

People living with HIV/AIDS (PLWHAs) face a complex set of psychosocial concerns and issues as they confront the reality of an HIV diagnosis. Because of the stigma attached to HIV/AIDS the implications of this illness causes much distress. The stigma can play a significant role in the individual's adaptation and response to an HIV diagnosis. Millions of PLWHAs are at risk of infecting their partners because of the stigma associated with the disease (Kalebbo, 1999).

Ng'weshemi et al. (1997) state that the psychosocial implications of AIDS are similar to those found in other chronic and fatal diseases. However, HIV/AIDS has

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certain distinctions that have extreme influences on how psychosocial support is provided. Ng'weshemi et al. highlight three distinctions. Firstly, many years may pass after the HIV diagnosis before the first opportunistic infection occur; even then, a person may live a full and productive life for years before full-blown AIDS develops. Secondly, as almost all HIV transmission occurs through sexual contact, the impact of AIDS is not limited to one individual. Thirdly, the behaviours that lead to HIV infection often provoke social and moral judgements, and subsequent discrimination against the infected person.

Ng'weshemi et al. (1997) furthermore adds that, "irrational fears of becoming infected through social contact, or through caring for the sick person, may also lead to ostracism and isolation of the infected person by family members or the surrounding community, including health care workers. Thus, HIV/AIDS is a condition laden with emotions of psychosocial distress, including denial, blaming others for the infection and feelings of hopelessness about the future" (p. 309). Knowledge of seropositivity triggers a variety of individual reactions including anguish, denial, repression and avoidance, as well as feelings of shock, sadness, shame and anger with self (Sittitrai & Williams, 1994).

Van Praag (1995) highlights that individuals often fear disclosing their HIV positive status. This, he says, is often due to denial of the medical diagnosis or either the fact that no cure is available. This fear leads not only to bypassing nearby clinics, but also to a prolonged period of searching for care or cure at private hospitals or from traditional practitioners. Fear of disclosure may also be related to fear of rejection by biological families, by their partners, their social support systems and employers. Discovery of HIV in a couples' life is often characterised by a feeling of guilt and unfair fate, which may provoke blame and suspicion (Lie & Biswalo, 1994).

Dilley, Pies and Helquist (1989) state that the stages of grief identified by Kubler Ross - including denial, anger, bargaining, depression and acceptance- can all be experienced by the person with HIV/AIDS. They also highlight, that people

diagnosed with HIV/AIDS face multiple losses throughout their illness including the loss of previous sexual behaviours and intimate relationships, damaged self-image, changes in employment pattern and loss of self-esteem. These multiple losses may leave individuals living with HIV feeling disempowered and with a lack of control over their lives. HIV/AIDS has an enormous impact on already poor communities. A large part of the family income is spent on health care for the infected and eventually funeral costs as a result of AIDS. This impact should be seen in the context of vast unemployment, where each breadwinner has to support many dependants. Sometimes family members, mostly women, must give up paid employment to look after the sick. Children facing such dire circumstances are affected in their health, mortality, education and overall quality of life. Discrimination against people living with HIV/AIDS and their family often makes an already unbearable situation worse. In rural, areas a lack of access to even meagre health services compounds the problem (Gender News, 2000).

2.2.1. Impact of HIV/AIDS on women

Women are increasingly affected by HIV/AIDS, representing 43% of those infected globally and more than 55% of those infected in sub-Saharan Africa, 30% in Asia, and 20% in Europe and the USA. In 1999 more than 5 million adults were newly infected with HIV, of whom nearly half were women. More than 90% of new infections are spread through unprotected sex, and women, especially young women, are biologically more vulnerable to HIV and other sexually transmitted infections (STIs) than men (Population Council, 2000). De Guzman (2001) highlights the role of social vulnerability in the spread of infection. Many presenting for testing are women infected with HIV or unable to protect themselves from the possibility of infection due to the lack of social and economic status.

Gender News (2000) and Nursing Update (2000), look at additional factors that make women more vulnerable to HIV. Firstly, with sexually transmitted infections (STIs), women are at least four times more vulnerable to infection. The presence

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of untreated STI's is a risk for HIV infection because more mucous membrane is exposed to the virus.

A second factor relating to women's vulnerability to HIV, is economic dependence. Financial dependence on men results in many women having to exchange sex for material favours for daily survival. In many poor settings, this is many women's only way of providing for themselves and their children. Similarly, Serote (1998) points out that in South Africa, "casual partners are often women's only form of support and many women are ignorant of their rights. It was pointed out that women will only be able to refuse support from men (in exchange for sex) if they (a) have access to education, and (b) have resources to fall back on. It was noted that it is not always the case that men have denied their role as husbands/partners - high unemployment, economic collapses, or wars have been major contributing factors in destabilising formerly stable cultural norms " (p11).

Furthermore, certain cultural beliefs as well as socialisation in terms of gender roles in society are also seen as contributing factors in women's vulnerability to HIV. For example, women are not expected to discuss or make decisions about sexuality. They cannot request, let alone insist on using a condom or any form of protection. If they request condom use, they often risk abuse, as there is a suspicion of infidelity. The many forms of violence against women mean that sex is often coerced which is itself a risk factor for HIV infection (De Guzman, 2001; Nursing Update, 2000). Watts, Ndlovu, Njovana and Keogh (1997) highlight that the inequalities between men and women help perpetuate violence against women which are central features driving the HIV epidemic world-wide.

2.3. HIV/AIDS Counselling

The provision of counselling has come to be regarded as a vital part of the services offered to those who are involved in the area of HIV/AIDS or who are living with HIV or developed AIDS (Green & McGreaner, 1990). Kalebbo (1999) however states that stigma discourages the infected and affected people with HIV and their families

from seeking counselling. Kalebbo also states that, "eliminating the stigma must be central. It is about breaking the silence and breaking silence means breaking secrecy not confidentiality" (p.8). With the high level of HIV, infections a large number of people currently require or will require care and counselling. This then relates to the importance of HIV/AIDS counselling programmes in order to train health care workers to provide counselling to persons infected as well as affected by HIV. Therefore, it is important to meet both the clinical care and the emotional needs of people living with HIV/AIDS.

Lie and Biswalo (1994) define counselling as a process of helping someone accept and use information for coping with a problem. It may also be described as a process of helping someone make a decision, plan how to solve a problem or develop skills to cope with a problem. This is regarded as a 'client-centred approach in the non-directive' tradition. Similarly, the World Heath Organisation's Global Programme on AIDS has produced a comprehensive definition of what constitutes HIV counselling, namely, "an on-going dialogue and relationship between client and counsellor with the aims of preventing HIV transmission and providing psychosocial support for those affected, directly and indirectly by HIV" (Coyle & Soodin, 1992, p. 217). Bor, Miller and Goldman (1992) highlight several reasons why counselling should accompany an HIV test, even though many other tests are carried out without the patient's explicit consent. They argue that HIV infection, unlike some other conditions, can be passed on sexually; from mother to child perinatally, during delivery and postnatally through breast-feeding; through blood and other body fluids. Counselling provides an opportunity to educate people about the risks of transmission and to promote behaviour change that will prevent the further transmission of HIV. Bor et al. (1992) furthermore highlights that, "counselling can help people to make informed decisions by considering the advantages and disadvantages of being tested for HIV. They may also be better prepared emotionally for some of the possible personal and emotional consequences. Before a decision is made about testing, it is important to know how the patient perceives

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the advantages and disadvantages of having the test" (p. 62). Similarly, Krabbendam et al. (1998) describe the goal of counselling as a way to help people in dealing with the results of the HIV test.

Carballo and Miller (1989) define HIV counselling similarly to Coyle and Soodin (1992). They also note that in order to achieve the above- mentioned objectives, counselling seeks to encourage and enhance self-determination, to boost self-confidence, and to improve family and community relationships and quality of life. It concentrates specifically on emotional and social issues related to possible or actual infection with HIV and to AIDS (UNAIDS, 1997). Thus, the counselling process should include pre- and post-test counselling. Pre-test counselling is given with a voluntary HIV test and includes discussion about the implications of the test and the outcome. It also involves a discussion of sexuality, relationships and prevention of the infection. The discussion helps to correct misinformation around the subject of AIDS. The client is then able to make an informed decision. This is followed by post-test counselling in order to discuss the test results, provide information, support and referrals if necessary. Ng'weshemi et al. (1997) state that counselling after a positive result not only involves breaking the bad news to the individual, but also assessing understanding and emotional acceptance of the result. It helps them plan their lives in order to cope with the consequences of HIV. Ng'weshemi et al. (1997) also argue that post-test counselling should include an opportunity for the client to explore the challenges of living with HIV infection. In view of the usefulness of counselling, Kalebbo (1999) adds that stigma prevents people from taking control of their lives through counselling. He says, "if they do not go for counselling then we have lost valuable opportunities to prevent further transmission" (p. 9).

Silverman (1997) highlights two features, which may distinguish HIV counselling from counselling in other environments. Firstly, HIV counselling is delivered to people who have not specifically requested it. The counselling is part of the 'package' if an HIV test is requested. The clients of HIV counsellors may not have

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brought 'problems' that they wish to talk about and so may often adopt a more 'passive' role. The second distinctive feature of HIV counselling is the medical environment in which it takes place, in terms of the blood taking involved in an HIV test.

In order to satisfy the aims of pre-test counselling the client needs to be able to give informed consent based on the correct information and the possible personal, medical, social, psychological and legal implications of the diagnosis. In brief, the *pre-test counselling format* should include:

i.   Confidentiality

ii.   Reason for testing

iii.   Risk assessment

iv.   Knowledge about HIV/AIDS

v.   Implications of anticipated result

vi.   Test procedure

vii.   Informed consent

The aims of the *post-test* counselling session are dependent on the result of the test. In brief, the following should be included:

Negative test result

i.   Result given to client personally and promptly

ii.   Window period rechecked

iii.   Safer sex information reinforced

Positive test result

i.   Results given to the client personally and promptly

ii.   Opportunity for the client to express feelings provided

iii.   Immediate concerns explored

iv.   Support offered

v.   Follow-up arranged (Bor et al., 1992; Carlyle, 1998; Evian, 2000; Van Dyk, 1999).

The above constitutes the basis of what should happen in pre- and post-test counselling. However, to manage the process effectively, the counsellor needs to be trained in a counselling model and to have adequate counselling skills. The National Directorate's minimum standards recommended either the TASO model (developed in Uganda) or Egan's three stage model be taught. This so that counsellors have the knowledge and skills to explore, understand and engage in problem solving with their clients. Counselling skills such as listening, empathy, appropriate questioning (Bor & Meursing, 1994; Egan, 1998), clarifying, summarising, prioritising and helping a client reach a course of action, (Egan, 1998) are essential. Furthermore, a skilled counsellor should be able to respond to the client's needs "with an attitude of non-judgemental empathic attentiveness (which) is more important than doing or saying specific things" (Macfie, 1997 in Van Dyk, 1999, p.148).
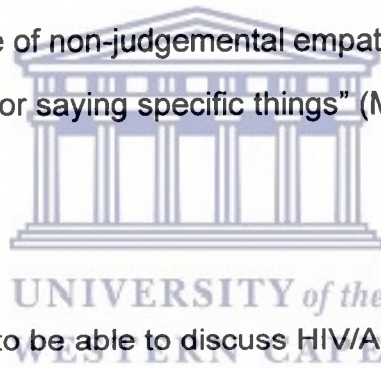
2.4. HIV/AIDS Counsellors

All health care workers need to be able to discuss HIV/AIDS with their patients in the context within which they work. However, the nature of HIV/AIDS counselling requires the employment of individuals whose main task is to counsel. Carballo and Miller (1989) state that effective pre- and post- test HIV counselling as well as ongoing counselling are time consuming and as such cannot be added to the burden of existing health care workers. Carballo and Miller (1989) feel that although there is a role to be played by volunteer counsellors, a sustainable programme depends on paid individuals. Whilst professionals such as social workers and psychologists are ideally placed to offer a quality counselling service, there is a shortage of trained personnel in South Africa. Financial constraints and a rapidly

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expanding epidemic preclude their full time employment. Paid non-professional, lay counsellors are the mainstays of the Department of Health's VCT service. Besides the fact that this generates employment opportunities and skills development, the use of lay counsellors has distinct advantages. Counsellors are selected from the communities in which they are to work on the basis that they are respected members of that community. Furthermore, they speak the same language and have the same cultural background as their clients (Brugha, 1994). This is vital given the cultural diversity in South Africa.

In order to be effective, counsellors need to possess certain personal qualities. These include the ability to communicate information clearly and simply, be non-judgemental, respectful and a good listener (Bor & Meusing, 1994). The ability to create a trusting and confidential relationship as well as comfort in discussing sex and sexuality are also requirements (Van Dyk, 1999). Further qualities include patience, understanding and the capacity to serve as role models for the community (Grinstead & Van Straten, 2000). Due to the nature of the work, it is essential that counsellors should be able to handle strong emotion such as anger and aggression (Bor, Miller & Johnson, 1991). Emotions such as shock, fear, despair and grief may also be directed at counsellors.

2.5. Theoretical approaches to HIV/AIDS counselling

According to Newman and Scott (1988), there are no comprehensive theories relating directly to the training process. Instead, general theories of counselling and psychotherapy have provided the constructs applied in the training context.

It has been argued that the behavioural theory of counselling provides a limited therapeutic intervention. This does not satisfy all of the counselling needs associated with the HIV/AIDS pandemic. Behavioural counselling complemented the awareness campaign by giving advice and information regarding the prevention of infection, but as noted the spread of HIV infection continued. It is furthermore noted that the continued spread of infection was exacerbated by the fact that the

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emotional correlates were not well understood and did not always appear to be influenced by logical and rational argument (Balmer, 1993).

In a study done by Garber and Seligman (1980) they argue that the behavioural approach is not appropriate for the individual already infected with HIV. The results from the study indicated that individuals could do little for themselves, which led to learned helplessness and this was detrimental to their well-being. Balmer (1993) suggests that a unified theory for counselling would give direction and momentum to interventions aimed at alleviating the excess of the pandemic. It is recommended that the focus for a unified theory for counselling is to provide a person-centred approach that explores the psychosocial and epidemiological concomitants of the pandemic. The unified theory includes axioms from the behavioural, psychoanalytical and humanistic theories of counselling. The unified theory uses the self-concept as a central axiom and this encourages a person centred rather than a disease centred approach.

Humanistic counselling arose out of humanistic psychology, which has it roots in humanism. The main theoreticians of humanistic counselling are Moreno (1940), Rogers, (1957), Maslow (1962), Perls (1976), Berne (1961) and Egan (1986). Humanistic counselling emphasis the essential elements of human experience and concentrates upon the feelings of the individual (Balmer, 1983). The theory of humanistic counselling is based upon axioms that include:

- the self-concept provides the main focus for counselling;
- people have the ability to solve their own problems provided they
- have psychosocial support;
- self actualisation is the basic drive of human beings and it motivates them in the direction of growth and inner harmony;
- people have the ability to determine their own future.

Humanistic counsellors maintain that everybody has the capacity to solve their own problems and if they cannot, something is blocking their self-actualising drive. Then

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the task of the counsellor is to help the individual remove the block so that s/he can become self-actualising again (Balmer, 1993). Therefore, the role of the counsellor is to facilitate the client's problem solving and crises resolution and not to attempt to take charge of his or her life. This facilitation occurs when counsellors use their active listening skills to help clients explore and understand their problems, as well as the related feelings, thoughts, beliefs, and behaviours (Brammer, Abrego & Shostrom, 1993). In the HIV/AIDS context, the most relevant aspect of humanistic counselling is the person-centred approach. More effective changes in behaviour can be achieved if more attention is directed towards the individual as a singular and unique human being (Balmer,1993).

Unlike psychoanalytical and behavioural counselling, humanistic counselling explores the qualities that counsellors need to posses if their interventions are to be therapeutic. Research studies have established that the core qualities of genuiness, human warmth, empathy and concreteness are critical (Rogers, 1957; Traux & Carkhuff, 1967). If counsellors posses these qualities, and approach their clients as singular and unique individuals, the outcome is invariably therapeutic.

Traux and Carkhuff (1967) took this theory and studied professional and non-professional 'helping' relationships to determine what skills and processes are necessary to help a person in need. Carhuff discovered that when a client gets help from counselling, six core qualities are exhibited by the counsellor, regardless of his or her theoretical orientation or professional background. In other words, an analytically -oriented doctor, a behaviourally-oriented social worker, or a good friend can all be successful helpers if they exhibit these core qualities. These core helper qualities, according to Carkhuff, can be taught to anyone willing to learn them, regardless of educational background or previous training. These core qualities are accurate empathy, respect, warmth, genuineness, immediacy and concreteness (Gazda, 1980).

Balmer (1993) states that research studies have shown that counsellors found that any one theory taken singly does not always provide a satisfactory basis for

counselling. This has led to the emergence of an eclectic model where counsellors combine axioms from two or all of the theoretical approaches in determining a practice, which suits them personally. Adapting this eclectic model to HIV/AIDS counselling, it is proposed to combine selected axioms from the three theories into a unified theory, which is capable of initiating and sustaining behaviour change.

Similar to Carkhuff's theory, Van Dyk (1992) maintains that AIDS counselling may be done by anyone who has the necessary knowledge and commitment to help prevent the spread of AIDS. He furthermore outlines that effective counselling entails a good working knowledge of AIDS and the ability and interest to keep up with developments in a rapidly changing field; feeling comfortable when speaking to people about sexuality and sex; the ability to communicate with anyone; a non-judgmental attitude towards people of different lifestyles, such as homosexuals or drug users and to be able to engender trust and maintain confidentiality.

Granie (1991) identifies additional qualities required for effective counselling which relate to the proficiency of the counsellor to manage common problems arising from HIV infection such as shock, guilt, poor self-esteem and fear. The counsellor should also be committed to working and communicating with a wide range of other professionals, especially in the medical and social sciences as well as in occupational settings.
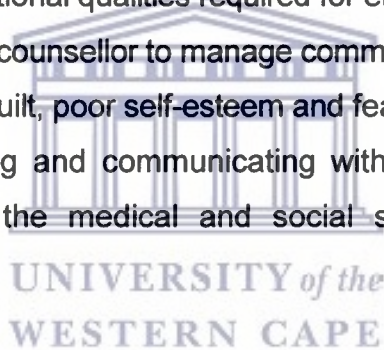
The diversity of thought portrayed in the above theories reflect the fragmentation and complexity that characterises counsellor training.

2.6. Training in HIV/AIDS counselling

A growing body of literature recognises counselling as an integral part of services for people infected by HIV/AIDS (Vollmer & Valadez, 1999). For example, UNAIDS (1997) reported on a study in Rwanda, in 1992, which examined the impact of preventive counselling. It was shown that for women whose partners were also tested

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and counselled, the annual incidence of new HIV infections decreased from 4.1% to 1.8%. As a result of these findings, counselling was recognised as a mainstream intervention and the funders of the study then established a project for counselling. Similarly, an evaluation of the AIDS Service Organisation (TASCO) in Uganda has shown that counselling helps people accept and cope with the knowledge of being HIV-positive. It also encourages acceptance from families and communities.

The anticipated increase in the number of people with HIV infection and AIDS places extra demands upon clinical and counselling services. To meet these demands, a wide range of health care staff have and will have to continue acquiring counselling skills especially since HIV/AIDS counselling has been noted to be effective. Lay counsellors have also been recognised as a vital source of assistance in dealing with HIV/AIDS, particularly given the enormity of the problem and the lack of alternative resources (Haworth, 1993; Brouard, Goldstein & Tallis, 1993; Higson-Smith, 1994 in Adendorff, 1995).

Rushton and Davies (1991) state that the growing demand for counsellors in different settings have seen a rapid increase in the number of short-term, accelerated training courses for non-professional practitioners. Matazarro and Patterson (1986) argue that successful counselling need not be dependent upon specific professional training. It is furthermore noted that relatively short courses can be sufficient to help a diverse group of trainees to, improve the target skills, the ratings of general counsellor skills, as well as multicultural awareness and attitudes. In a study done by Bor and Elford (1992), evaluating a 2-day intensive HIV/AIDS counselling course in Zimbabwe in 1989, it was found that trainees positively evaluated the course. The majority of the trainees felt the course met their expectations and indicated that they gained confidence in counselling patients about HIV/AIDS. The course consisted of

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two full days teaching, equally divided between theory and practice of HIV/AIDS counselling. The main objective of the course was to develop skills for communicating with and managing patients with HIV infection and AIDS. These skills included techniques for addressing patients worse fears, breaking bad news, handling confidentiality, bereavement counselling and engaging family and other social support. The practical component in the training course included group exercises and role plays to illustrate pre-and post-test counselling and family counselling techniques. Whilst it was clear that the course was positively evaluated by trainees, it was found that some of the trainees had difficulty in relating the theory of counselling to practice as many did not have the clinical experience of managing AIDS-related problems. Feedback from some of the trainees also indicated that although the course provided a framework for counselling and problem-solving, further clinical experience was needed in order to apply and test this framework. Bor and Elford (1992) further agree that intensive training provides an opportunity for skills development, practice and review. Some trainees indicated that the input on counselling *per se* could have been included in the content of the course. It was therefore the assumption that all the trainee previously aquired some general counselling skills.

A study done at the Western Cape ATICC evaluating "general" counselling courses during 1993 and 1994, found that trainees appreciated and benefited from the course. The majority of the trainees (60%) however, highlighted a need for ongoing training and supervision, in order to keep pace with new developments in the field and "real life" demands of the counselling situation. Training needs identified included, regular updating of knowledge, input on counselling HIV positive clients and the management of clients' depression and anxiety, sharing and discussing of

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problems and feelings relating to counselling, coping with stress and burnout and providing information regarding referral sources. Trainees' ideas for improving the courses were to include more role-plays, workshops and practical skills training (Bok & Gillespie, 1995).

A study done in Britain, investigating whether the training counsellors received equipped them to cope with the issues arising during HIV counselling, found that counsellors, who had not received any formal training or who had undergone short counselling courses (2-3 days), experienced difficulties in dealing with death and bereavement issues, as well as higher stress levels (Coyle & Soodin, 1992). Based on the findings it was recommended that HIV counsellors should have adequate training and/or experience in general counselling. Coyle and Soodin (1992) argue that ongoing training is a prequisite to ensure knowledge remains up to date as well as to teach skills to deal with more stressful aspects of the work. These include suicide, death and bereavement. O`Keeffe and Sims (1998) agree that in order to care effectively for people with HIV/AIDS, health workers require access to appropriate training. Training should include a sound knowledge of HIV/AIDS as well as STIs and TB. A counselling model should be taught (Scottish Health Education Group, 1989) as well as counselling skills.

Brouard (1998) argues that counsellors are only as good as the training they receive. He notes that in South Africa the level of training varies. This depends on the capacity of each province, with bigger and better resourced Provinces having greater access to trainers of quality and experience. He highlights a lack of understanding of the intensity and difficulty of counselling training, claiming that there is a superficial commitment to minimum standards, which stipulate that counsellors must be selected, properly trained, evaluated and supervised (ibid).

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O`Keeffe and Sims (1998) further highlight that in resource limited settings it is essential that training has a multiplier effect which reaches all cadres of the health system. In light of this, Mildmay International has developed an innovative approach to training senior health care professionals that creates successful cascading educational programmes. Since 1991 Milday has developed training programmes on the Care and Management of people with AIDS in Kenya, Uganda and Tanzania. The two-week training courses offered an holistic approach to care at hospital and community level. The programme content included factual information regarding the study, 190 senior health care professionals completed the Milday courses and they have subsequently trained over 7000 individuals and groups. The trainees' evaluation of the course indicated positive results.

A study conducted by Adendorff (1995) evaluates a 10-day counselling course at the Aids Training, Information and Counselling Centre in Pietermaritzburg. The study investigated whether the course in basic pre- and post-test counselling was having a positive impact on trainees. A variety of methods were used to assess a sample of 90 trainees, before and after training, and in a 10-12 month follow-up, over a period of 19 months. Assessment instruments included a questionnaire, video-taped role-plays, the California Personality Inventary (CPI) and the Carkhuff Empathy Scales. The results indicate that although the training was effective, follow-up scores indicated some deterioration in skills. The course consisted of 18 modules, which were covered in 10 days, including both theoretical and practical training. The content of the course included various issues. These were, attitudes and myths associated with AIDS and HIV, medical facts; paediatric AIDS; legal and ethical issues; basic counselling skills; death and dying and pre- and post-test counselling skills. The trainers using video-recorded role-plays evaluated the trainee counselling skills. Self-

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and peer-ratings were also conducted. Trainees indicated confidence in their abilities. Trainees' performance in the role-plays was noted to improve significantly between pre- and post-training. Improvements were found in what was considered to be the most important counselling skills as measured by the rating scale, via; empathy, acceptance and warmth.

According to Sherr, Christie, Sher and Metz (1989), "by providing education for health care workers they will be in a position to disseminate what they have learnt and thereby amplify the impact of education for prevention of HIV infection and AIDS in the South African community in general" (p. 361). Neglect of patient well-being and the failure to obtain co-operation of HIV infected individuals in reducing the spread of HIV are likely to result from prescriptive advice giving rather than counselling. This situation is likely to arise as a result of "insufficient training and undeveloped counselling skills as well as insufficient time" (Brugha, 1994, p.130). Thus the quality of counsellor training as well as both psychological and logistical support for the counsellors has an important role to play in the quality of the counselling services in the various communities.

In view of the above literature, it is evident that counselling training courses have been effective in terms of improving knowledge and counselling skills in HIV/AIDS. The literature, however, particularly highlights studies evaluating short-term counselling courses. There appears to be a lack of studies evaluating the impact of clinic-based counsellor training on trainee counselling skills. Various literature searches were conducted, including an AIDSearch (May 2001) at the Medical Research Council, affirming this limitation.

CHAPTER 3

RESEARCH METHODOLOGY

3.0 Introduction

This chapter focuses on the methodology for the present study. The methodological framework, research design, instruments utilised, and the outline of the clinic-based counselling course is also described. Finally, the research procedure, the methods of data analysis and the ethical concerns are discussed.

3.1. Methodological Framework

The present study employs a combination of qualitative and quantitative research methodology. According to Leedy and Ormrod (2001), both research designs are appropriate for answering different kinds of questions. "We learn more about the world when we have both quantitative and qualitative methodologies at our disposal than when we are limited to only one approach or the other" (p.101).

In comparing a qualitative and quantitative study, Leedy and Ormrod (2001) highlight that a quantitative study usually ends with confirmation or disconfirmation of the hypotheses that are tested. Whereas, a qualitative study is more likely to end with tentative answers or hypotheses about what was observed. These tentative hypotheses may be used in future studies of a quantitative nature designed to test the proposed hypotheses. In this way both approaches are said to represent complementary components of the research process.

Quantitative methods are used to answer questions about relationships among measured variables with the purpose of explaining phenomena. Thus qualitative methods are used to answer questions about the complex nature of phenomena,

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with the purpose of describing and understanding phenomena from the participants' point of view (Leedy & Ormrod, 2001). It is also believed that in qualitative research the multiple perspectives held by different individuals each have equal validity, or truth. Therefore, the goal of a quality study is to reveal the nature of these multiple perspectives (Creswell, 1998; Guba & Lincoln, 1988 in Leedy & Ormrod, 2001).

The combination of qualitative and quantitative research methodology in the present study makes use of multiple data collection methods to look for common themes that appeared in the data and to check the validity of the findings. This process is referred to as triangulation (Denzin, 1978; Leedy & Ormrod, 2001). Both qualitative and quantitative data based upon trainees' feedback about the training courses were used. According to Mouton and Marais (1990), the inclusion of multiple sources of data collection in a research project is likely to increase the reliability of the observations. Leedy (1997) highlights that similar themes noted in data collected from a variety of sources enhances the credibility of the interpretation.

3.2. Trainees

The trainees were nominated by the Cape Metropolitan Council to attend the six-month HIV/AIDS counselling training course at ATICC (August 1998 - January 1999). The trainees of the study constituted a sample of seven trainees. Six of the trainees were female who at the time of the study were married and one single male. Their ages, at the time of the study, ranged from 30-56 years old. Five of the trainees were employed as professional nurses at clinics and community health centres. Their duties included family planning, HIV/TB/STD counselling and health education talks. The remaining two trainees were housewives at the time of the study, with past experiences in nursing. Both were involved in HIV/AIDS awareness

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programmes at their churches, following the training they returned to work at their respective clinics.

3.3. Research Design

Evaluation is now considered a necessary part of health programming because of increased demands for accountability. Dignan and Carr (1992) mention that "evaluation is needed for monitoring the efficacy of programmes, to aid in the planning of future programmes, and to provide defensible evidence of the value of current programmes" (p.14). Consequently, evaluation methodology is now a well-established methodology. This is widely used to determine the efficacy of intervention programmes. Impact evaluation was utilised to assess the effectiveness of the training course, using the existing data collected from the focus group and questionnaires. The objective of an impact evaluation is to determine the extent to which the goals and objectives of the programme have been reached. It also focuses on the impact of the programme of the trainees functioning within their work setting (Dignan & Carr, 1992). Windsor, Baranowski, Clark and Cutter (1994) also highlight that the evaluation of an existing programme should primarily focus on internal validity of programme results, via the effectiveness.

The present study made use of existing data from the evaluation of a six-month counselling training course at ATICC. The study was therefore archival. As a research intern at the time of the training course the present researcher collected this data which was not analysed at the time. Therefore, in the present study primary analysis was applied to the archival data.

The archival data was obtained through the use of both a focus group and a questionnaire-based survey. The focus group was conducted with trainees after completing the theoretical section of the counselling course (on 3 December 1998). The purpose was to obtain information of a qualitative nature regarding their attitudes toward and perceptions of the theoretical course content. Windsor et al. (1994) highlight the advantages of focus groups by arguing that this method allows

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for more detailed information than is possible from other methods. Open-ended, in-depth questions are asked. The presence of multiple respondents stimulates thoughts about the topic of discussion. As it is also important to highlight the disadvantages of this method, Kruger (1988) states that one person can dominate the focus group, making it difficult to obtain the opinions and perceptions of all group members. Kruger also maintains that this method may become a problem with a large sample size, as the researcher would need to conduct the necessary number of focus groups. A further concern in conducting several focus groups is the inconsistency of the questions asked across the groups, thus the responses may reflect answers to substantially different questions (Kruger, 1988). In the present study only one focus group was conducted as the trainee population consisted of only seven people and thus the last two concerns are not applicable.

A second method of evaluation is by means of a self-completion questionnaire constructed by researchers at ATICC. The self-completion questionnaires were handed to the trainees towards the end of the training course (28 January 1999). It may thus be important to highlight the advantages and disadvantages of self-completion questionnaires. Windsor et al. (1994) maintain that this method is the most convenient and frequently used method of data collection for programme evaluation. It is also time and cost effective. Almost all types of measures can be assessed by the self-completion questionnaire. All people are exposed to the same instrument. Windsor et al. (1994) also highlights the disadvantages of the questionnaire. Respondents can easily fall into role selection when answering questionnaires because no one is present to observe, clarify, or challenge their role taking. The phenomenon of response sets was originally identified using this questionnaire. Other problems noted by Windsor et al. (1994) are as follows: (i) the questionnaire promotes change; (ii) changes may occur in the respondents' understanding of the questionnaire; (iii) limits may exist on the phenomena to which

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a questionnaire can be applied. To limit these problems in the present study the trainees were given the questionnaires at the training venue and were asked to complete them before they left the venue. Provision was made regarding the time to complete the questionnaires. The researcher was also present to clarify any concerns the trainees may have had at the time. The researcher then collected the questionnaires after the trainees were completed.

3.4. Research Instruments

Two instruments were employed to assist with the original data collection. These were a questionnaire and a focus group guide as discussed below.

3.4.1. Questionnaire

The self-completion questionnaire (see Appendix A) consisted of both rating scales and structured open-ended questions to provide an overall assessment of the course and to assess it's future development. The rating scales from 1-10 rated specific weekly topics. The open-ended questions allowed trainees to comment on the usefulness of both the theoretical and the practical components of the course. Furthermore, recommendations for improving the programme were elicited. Trainees were also asked to comment on changes in the way they counsel at their work as a result of the training they received over the 6 month period.

3.4.2. Focus Group guide

The focus group discussion aimed to evaluate the impact of the four-month theoretical training, on the trainees counselling skills at the respective clinics, in order to gain as complete and rich an understanding as possible of the impact of the training course. Specific questions were formulated to guide focus group

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discussions (see Appendix B). The questions focused on the changes in the way trainees work as a result of the training, the reasons for these changes and it's relation to the training course.

3.5. The clinic-based counselling course at ATICC
3.5.1. Development of the course

In an effort to facilitate the provision of adequate health education and counselling at the primary care level, a small 6-month pilot project at a peri-urban predominately lower socio-economic residential suburb was piloted in the mid-nineties. This involved health educators concerns from these clinics. The people concerned had no counselling experience except for having completed the basic HIV/AIDS awareness courses at the centre.

The Director of the Health Service of the Cape Metropolitan Council was then invited by ATICC to select Health Educators and Nurses who were involved in health education and counselling in their local clinics to complete the 6-month training course. Eight health educators and Nurses were selected to complete the six-month training at ATICC from June-December 1997. A pilot study was conducted by the researcher to investigate the impact of the training course on the trainees` counselling skills. The study highlighted the importance of learning the appropriate counselling skills in dealing with HIV/AIDS patients. The training course was reported to impact primarily on trainees' confidence in their counselling skills. Favourable reports on the skills development prompted the expansion of the project.

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3.5.2. Purpose of the course

In an effort to develop skills at the primary care level and equip staff to handle the patients' counselling needs, the Western Cape ATICC aims to train clinic-based staff in health education and counselling skills and thereby to provide the selected staff with skills in counselling HIV/AIDS, STD and TB. The training courses aim for a comprehensive understanding of the ethical and practical implications with which these diseases challenge our society as well as skills transfer to selected learners whose daily work involves the provision of counselling and health education to a range of clients and communities.

3.5.3. Programme description

The Clinic-based counselling course was conducted once a week for 6 months. It consisted of 4 months of theoretical input and 2 months of practical work (see Appendix C). The theoretical part of the training was offered from August - December 1998 and the practical one from 10 December - 28 January 1999. Clinic-based counsellors were provided with skills in counselling for HIV/AIDS, STD and TB, which was translated into the theoretical input concentrated around skills and techniques.

In the first 5 weeks of the course trainees were provided with input on the qualities of a counsellor, format for engaging and the importance of confidentiality. Communication exercises and active listening skills such as paraphrasing, reflection, empathic responses, were also reviewed. In the sixth to the ninth week of the course the theoretical input concentrated on stages in therapy (in a helping relationship). Trainees were given input on the TASO model for counselling (Egan's 3 stage model). The training course also included input on supportive work for partners of people with AIDS. In addition, input on HIV counselling and women, counselling and pregnancy and counselling re: breastfeeding was given. The

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training course also included information on medical re: HIV/AIDS including input on TB and STIs as well as legal and ethical issues relating to HIV/AIDS.

In the remainder of the theoretical section, input on pre- and post- HIV test counselling was presented including a counselling format that served as a general guide. Trainees were given an opportunity to practice pre- and post-test counselling formats by using the Egan's model. Trainees were also provided with skills in dealing with an HIV-positive diagnosis. They were made aware of the emotional impact of an HIV-positive diagnosis. Input on crisis management, suicide counselling and family counselling were also addressed, as well as input on caring for the carer to prevent burnout.

The practicum included observed counselling role-plays during which observation checklists were completed by the facilitator in order to evaluate the trainees counselling skills and knowledge regarding HIV/AIDS. In addition, face- to- face counselling behind a one-way mirror with audio/vocal guidance took place. This was followed by unobserved counselling sessions at ATICC and in the respective clinics. The teaching method included charts, videos and overhead transparencies. A wide range of methods such as lectures, role-plays, small group excises and peer reviews were used.

The course also involved weekly supervision sessions, monitored by a clinical psychologist at ATICC, during the practical section of the training course. The supervision entailed feedback from the trainees to the supervisor regarding their counselling at their work sites. Management of difficult cases were also discussed.

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3.6. Original Procedure

The focus group was conducted on the last day of the theoretical sessions (December 1998). Permission was sought from trainees to utilise data from the focus group. Arrangements were made with the trainers and the trainees about the date and time for the focus group. Permission was obtained from the trainees to tape record the discussion in order for the researcher to obtain the complete richness of the discussion transcribed. Evaluation questionnaires were given to trainees at the end of the training course (January 1999), they were asked to complete this the same day. Sufficient time was allowed for trainees to complete the questionnaire, the researcher was present at the time in order to clarify any concerns about the questionnaire.

3.7. Data Analysis

Both qualitative and quantitative analyses were conducted. The data from the open-ended evaluation questions in the questionnaire as well as from the focus group were analysed by using thematic analysis. In order to accomplish this, the focus group discussions were transcribed verbatim by the researcher. Categorisation of themes followed this whereby data was analysed for general and specific themes and direct quotations were used to illustrate the emerging views. The purpose of identifying and extracting themes from the data are relevant in the evaluation of the counselling training course and the frequency of responses constitute a means of assessing the impact of the training course on the trainees' practice at the respective clinics. The data from the rating scales in the questionnaire was analysed by noting the mode (i.e., most frequently occurring values rated on the scale from 1-10).

3.8. Ethical Considerations

Although the present study is based on archival data, the researcher adhered to the following ethical issues. The trainees in the study were informed about the nature of the study as well as their freedom of choice to participate. Anonymity of trainees and confidentiality of the information were also assured. Feedback regarding the results of the study will be given to both ATICC and the trainees via a report highlighting the summary of the findings.

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CHAPTER 4

RESULTS

4.0. Introduction

This chapter presents the results and interpretation of the data obtained from the questionnaires and the focus group conducted with the trainees. The first section presents analysis of the trainees' evaluation of the training course. Data on the trainees' impressions of the course and the trainers, their views on the content presented and the shortcomings in the course are provided in this section. The second section focuses on aspects pertaining to perceived gains and changes in the trainees' counselling skills following the training. It includes changes as a result of both theoretical and practical input received during training.

4.1. EVALUATION OF THE TRAINING COURSE CONTENT

4.1.1. Quantitative data

Table 1 presents the trainees ratings of each of the areas covered in the course in relation to its usefulness. The most frequently occurring values are between 8 and 10, thus indicating the usefulness of all the areas covered. It appears that the trainees found the following sessions to be the most useful: discussing confidentiality, listening skills, pre-and post- test counselling and the stages in HIV counselling. Each gave of these sessions.

4.1.2. Qualitative data

4.1.2.1. Course in general

The trainees overall perception of the course appeared favourable. When asked to describe the course, all their responses were positive. The following responses illustrates this:

> "The training was an eye opener to me, I learnt a lot about myself and others."

Table 1 : Trainees evaluation of the theoretical input of the course

COURSE CONTENT	MODE(S)* OF RATING
Group Contract	10
Who Am I?	10
Values	8,10
Relationships	10
Qualities of a Counsellor	10
Communication Exercises	10
Format for engaging	10
Confidentiality	10
Listening Skills Exercise	10
Paraphrasing, Reflection & Open Questions (theoretical)	9,10
Paraphrasing, Reflection & Open Questions (practical exercises)	9,10
Empathic responses in counselling	10
Stages in Therapy (in a helping relationship)	10
Stages in HIV counselling	10
HIV counselling and Women	10

COURSE CONTENT	MODE(S)* OF RATING
Counselling and Pregnancy	8
Counselling and Breastfeeding	10
TB and its Link to HIV	10
STD and its Link to HIV	10
Support for Partners of Paws	8,10
pre-test Counselling	10
post-test Counselling	10
Dealing with an HIV positive diagnosis	10
Crisis management	10
Depression, Fear and Anxiety	8,10
Suicide Counselling	8,10
Counselling Families	8,10
Caring for the Carer (Preventing Burnout)	10
Create your own Pre- and Post Test format	8,10
Face to Face counselling with observation input	10

* Where two modes are provided, the distribution of frequencies was bimodal.

"The course gave me a lot of confidence in many areas, professionally and personally. It was very empowering."

"I would like my colleagues to come onto the course, to experience what I experienced. Everything about the course was great."

It appears the course provided the trainees with positive insight into their professional as well as personal lives.

In response to the question "How were the concepts explained?", all the trainees provided positive feedback. The responses indicated that the concepts were "well understood". One participant highlighted that "there was lots of space to clear questions that I had".

4.1.2.2. Specific areas of the course found to be useful

In addition to rating each of the areas covered in the course, trainees were given an opportunity in the questionnaire and in the focus group to highlight and elaborate on areas in the training course that were found to be useful.

The exercises used to highlight the importance of listening skills in counselling were found to be most useful. Trainees found the input on legal and ethical issues, factual information on HIV/AIDS and referrals important. The majority of the trainees found the role-plays to be very useful. It was noted that the role-plays prepared them to deal with the actual clients in the clinics. One trainee commented that the role-plays helped her "apply the theory easily".

Two of the trainees identified input on values as useful, highlighting the importance of how counsellors should be aware that "people have different values and the need to respect this" which in turn relates to the counsellor's attitude towards the clients. For one participant the input on living positively with AIDS was important as illustrated in the following response:

"People would normally say 'ah, so I have AIDS now what's the point of me having to practice safer sex and after all, this is a death sentence'. I

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have since learnt that what's important is the quality of life, and that one can lead a normal life despite being infected with HIV."

The initial perception of the participant may be seen as a common perception of people affected and infected with HIV. Once there was a clearer understanding of the stages of HIV, it was realised that being diagnosed with HIV does not mean immediate death. Another participant found the input on counselling families useful as illustrated in the following response:

"We tend to think that clients come from a vacuum, but they come from families and their families should also be cared for."

4.1.2.3. Relevance to work at clinics

In relation to their work, all trainees found the course to be very useful and relevant to their jobs. It was evident from the responses that their views around the issues mentioned have changed. It was however pointed out by two of the trainees that due to the heavy workload at their clinic and the time restraints, it becomes difficult to cover all aspects, in counselling patients sufficiently.

4.1.2.4. Supervision

Trainees commented on the weekly supervision they received at ATICC. Overall, the supervision was found to be useful. It was also described as a learning experience in gaining insight into their clients' problems and management thereof. The positive feedback by the trainees regarding the supervision highlights the importance of these sessions for persons involved in counselling.

4.1.2.5. Shortcomings in course

Trainees were also asked to comment on any shortcomings in the course. Trainees felt that all the training input was very useful, it was however highlighted that more time be allocated for the practical training section of the course. Trainees felt they needed more contact with ATICC clients, as they were expecting to see more

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clients than they did. Upon investigation regarding this matter, it should be noted that the limited number of clients was as a result on the amount of appointments made by the clients. This fluctuated on a daily basis.

4.1.2.6. Facilitators/staff

The trainees described the staff at ATICC as "friendly", "helpful", "caring" and "supportive". The following response illustrates these themes: "The staff were always willing to help and assist in every way."

4.1.2.7. Perceived gains and changes

Trainees were asked in a focus group discussion to comment on changes in their counselling skills before and whilst in training. They conducted pre- and post- test counselling sessions at their respective clinics throughout the training course. Trainees were also asked to highlight the theoretical input they found to be most significant. When the trainees discussed the impact of the theoretical training on their counselling skills the following seven themes emerged:

    (i)   improved listening skills;

    (ii)   non-judgemental attitude towards persons living with HIV;

    (iii)   personal growth;

    (iv)   increased self-confidence;

    (v)   improved communication skills;

    (vi)   setting personal limits and

    (vii)   follow-up sessions.

The themes are presented in more detail below:

(i) Improved listening skill

A significant theme, which emerged regarding changes in the trainees counselling skills was that of, improved listening skills. Trainees reported that prior to the training they would often interrupt their clients during the counselling session. They

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reported being impatient and thereby not allowing the client to 'tell their story'. As a result they were not able to explore the problems adequately. The training, however, equipped them with effective counselling skills, creating awareness regarding the importance of attentive listening.

The following responses illustrate these changes:

"I learnt listening and patience. With the listening skills when somebody used to talk I used to jump in and not get the whole story from the person and that wouldn't be good enough for me to help with the person's problem. So in this course I learnt that one has to listen and show interest when a person is talking."

"I improved on my listening skills, before I wouldn't give the patient time to finish speaking, now I allow them to finish."

"Before I would be very impatient, you would want to finish the sentence for him so that he can get done, but I've improved on that."

One participant indicated that she was prone to giving clients advice, rather than allowing the clients to find their own solutions. Similar concerns were raised by the remaining trainees. It was highlighted that the input on the training course improved these shortcomings. Thereby trainees were more open to listening to their clients, rather than interrupting by giving advice. This is illustrated in the following responses:

"Before I would not allow the person to finish their story, the person might have said three words and I would just go on to interrupt and finish the person's story. But I leant that if you listen and try and get the whole story that's better. I also stopped giving advice, this course helped me realise that it's best that the client learns solutions for their own problems and don't try to change things for them."

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"Before I wouldn't listen properly, but if you listen you get to the mind of the person ... with paraphrasing one has to be sure of what the person is saying, this is different from the way I used to counsel before. Before I would suggest and tell the person how I perceive things, I would give advice. Now I would listen and paraphrase to show listening."

"Listening skills changed, now I give a person a chance to speak. What is good is, don't give solutions, get that from the client."

(ii) Non- judgemental attitude towards persons living with HIV

A significant theme found across the responses of the seven trainees was their improved attitude towards HIV+ persons. It was felt that the input on the training course provided them with a change in attitude, to be less judgemental of HIV+ persons. The following responses highlight these views:

"The course helped me to have a different attitude towards people with HIV/AIDS. Before I always used to take it as if these people were prostitutes, they didn't behave well, that's because I didn't know the mode of transmission."

"Before I would be judgemental in a way that I would think that patients would be ignorant and just be sleeping around but now I understand more because I have more knowledge."

"The course taught me not to judge people and not to carry your views onto other people, to respect people in how they see things and not to try and change things."

These responses highlight common judgements regarding HIV, thereby generalising and relating the diagnosis to promiscuous behaviour. However, once trainees

gained more knowledge about HIV there appeared to be a change in their perceptions.

The following responses also highlight the importance of taking all factors into account when dealing with HIV and thereby being sensitive to individual needs and circumstances:

> "We use to think people got it because they wanted to, we usually forget that there are circumstances that push them to acquire HIV, even if they know they can get it. So I learnt to feel empathy, to be empathic with them."

> "I have leant to understand the fact that no two people are alike, that we got to treat clients as they come with understanding that they have individual needs ... understand that they have different levels of understanding and backgrounds, that's important."

(iii) Personal Growth

Trainees gained more insight into their personal lives. This in turn helped in understanding other people. Thus trainees related their self-awareness to the change in their attitudes towards people living with HIV. These issues are illustrated in the following responses:

> "I learnt to understand myself more, so by understanding myself helped me understand other people, to show respect, to accept them as they are, used to be judgmental, now not anymore."

> "When doing the slot on listening skills, we spoke a lot about ourselves and that was useful, to learn about myself, this was important also in dealing with other people."

"In the beginning of the course we looked at ourselves first, this changed a lot of my views."

"There was a tendency before not wanting to look into yourself trying to shy away from some aspects in your life, that has improved with attending these sessions. It's about understanding yourself so that you can understand the other person better, listening, accepting the person as they are, not wanting to do and say things for them."

(iv) Increased self-confidence

The training input provided trainees with more guidance around their counselling skills thereby enhancing their confidence. This is shown in the following responses:

"Things improved a lot with my counselling, I feel more confident."

"After I gave results, I didn't know what to say. I improved a lot, especially by understanding the emotions around HIV."

"Since I'm on the course I feel good about my counselling, because I'm really practicing what I learnt here. Now I feel like I'm really doing what I'm suppose to do."

(V) Improved Communication Skills

Two of the trainees felt that as a result of the training course, their communication skills improved. The following response highlights this improvement which was considered an advantage in the workplace:

"We had social workers and we would share and it helped with communication difficulties, now I'm used to it."

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(vi) Setting personal limits

Two of the trainees also felt that the input on the training course helped them realise the importance of limit setting, as a way to prevent burnout. The following response illustrates this:

> "I learnt that as a counsellor you have limits, before I went out of my way and felt helpless if I couldn't do anything for the client. I learnt that I shouldn't feel that way otherwise I'm going to continue to blame myself."

(vii) The importance of follow-up sessions

One of the trainees indicated the awareness for the need for follow-up sessions as a result of the input given on the course. The following response highlights the importance of considering follow-up sessions:

> "Another thing that impressed me is the follow-up appointment that should be given. I was counselling but I didn't take notice of the follow-up care. You just think about what you doing in the session, forgetting about tomorrow, and next week."

The above mentioned comments highlight significant improvements in trainee's counselling skills as a result of the course. The training also seemed to have an impact on the personal lives of the trainees.
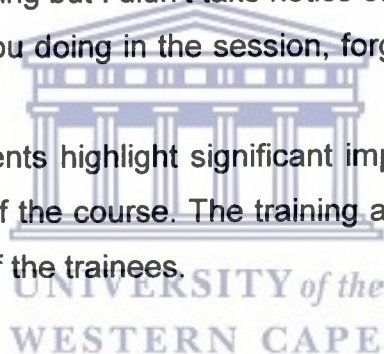
CHAPTER 5
DISCUSSION AND CONCLUSION

5.0. Introduction

This chapter presents the discussion of the results highlighted in the previous chapter. The discussion will focus on both the trainees' evaluation of the training course as well as the impact of the training course on their counselling skills.

5.1. Summary of main findings

The results generally showed improvements in the trainees' knowledge and attitude about AIDS. Trainees attributed the improvement in their counselling skills to the theoretical and practical training they received at ATICC. The course was found to be empowering. Also described as "an eye opener", providing trainees with confidence in their personal and professional lives.

The input given on the course was rated favourably by trainees, specifically the input focussing on values, relationships, confidentiality, pre- and post-test counselling, listening skills and factual information about HIV/AIDS. The role-plays contributed to trainees' confidence in their counselling skills, preparing them for counselling clients at their workplace. The role plays also provided an opportunity for them to practice the theoretical input in the class and further at their place of work. The supervision received at ATICC was useful as trainees gained insight into their clients' problems. The supervision received also provided trainees with guidance to deal with difficult counselling cases. The staff was described as "warm" and "caring".

The course content identified by trainees as most useful related to the positive impact the course had had on their counselling skills. It was noted that prior to the course, counselling was defined as information -giving only, thereby focusing on giving the clients advice regarding their concerns. However, the input on counselling

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skills encouraged trainees to listen attentively to clients allowing them to explore their problems and identify solutions suitable to their needs.

The results also highlighted changes in common social and moral judgements about HIV. The changes in trainees' attitudes were related to their improved knowledge about HIV/AIDS. The training highlighted for the trainees the importance of taking all factors into account when dealing with HIV and thereby being sensitive to clients' individual needs and circumstances. Most clients who come in for testing have a reason related to a relationship issue. An HIV test always needs to be viewed in the context of a relationship and counsellors must always bear this in mind in the counselling session.

In addition to changes in knowledge and attitudes of AIDS, trainees also gained more insight into their own lives and relationships. The introduction of this material at the beginning of the course was found to be effective. The trainees found it useful to explore their feeling, thoughts and beliefs in various areas as a basis for ongoing input in HIV/AIDS. Mkuye, Schapink, Heimelmann and Masesa in Ng'weshemi et al. (1997) highlight that "training needs to address the beliefs, attitudes and prejudice of the workers themselves, their fears of infection, how to deal with sensitive topics and the workers' own personal problems" (p. 205).

Trainees also gained more confidence in themselves, which was reflected in their counselling skills. The levels of confidence in the counselling sessions were also attributed to the structured guidelines as well as knowledge of counselling techniques. Trainees were then better able to focus on their client's needs, exploring problems and showing empathy. As a result of improved knowledge around HIV/AIDS counselling skills trainees felt more confident in discussing case management issues with colleagues.

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5.2. Explanations of the present findings

5.2.1. The course in general

In describing the course in general, trainees felt empowered and confident about their abilities. The training equipped them with skills to cope with various issues arising in HIV counselling. Thus, the training course encouraged trainees to take into account the social and psychological factors in addition to the medical concerns of the client regarding HIV/AIDS. The course also provided trainees with improved self-awareness regarding areas relating to their professional as well as personal lives. In both the quantitative and qualitative data collected from the present study there was consistency regarding what the trainees perceived as useful.

5.2.2. Specific areas in the course found to be useful

The results indicate that all areas in the course were found to be useful. Trainees especially found the exercises on listening skills useful as well as legal and ethical issues and medical facts relating to HIV/AIDS. Much emphasis was placed on the usefulness of role-plays to illustrate pre- and post-test counselling techniques, as this allowed the trainees to put the theory they learnt into practice, thereby enhancing their confidence in counselling skills. Trainees also found the input on 'living positively' important as this provided increased knowledge regarding the management of HIV positive clients. The input on family counselling was also found to be useful as this encouraged trainees to be sensitive to family issues and influences when working with an individual in HIV/AIDS counselling, an understanding of a systems approach theory is important.

Feedback from the trainees also referred to the usefulness of the input on values as this equipped them with the knowledge to be sensitive to their client's values and beliefs. Jue and Kain (1995) highlight the importance of including input on cultural values in a training course. Counsellors need to be aware of how these values can influence behaviour. Through understanding and supporting sexual or ethnic differences, the counsellor can alleviate confusion, facilitate the breakdown of

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internalized negative stereotypes in the client, and help raise the client's self-esteem (Jue & Kain, 1995). They also highlight the importance of counsellors being made aware of how culture influences their own interpretation of behaviour and thus the outcome of counselling.

The results in the present study highlight that the training course equipped trainees with the knowledge and skills to manage the range of issues that may be presented in HIV/AIDS counselling. The study done by Coyle and Soodin (1992) emphasises the importance of an in-depth training course of this nature. The study highlighted the importance of counsellors receiving adequate training and/or experience in general counselling and for the counselling courses to include a range of issues not directly related to HIV/AIDS, such as relationship problems, suicide, and death, dying and bereavement. It was found that those who had not received any training or who had undergone short counselling courses (2-3 days) experienced difficulties in dealing with death and bereavement issues. Thus, the findings from the study suggested that the longer and the more in-depth the HIV counselling course, the less likely it is that the counsellor will find post-test counselling stressful. These findings are similar to those found by Adendorff (1995) who evaluated an in-depth 10 day counselling course, assessing trainees pre- and post test counselling skills and found that trainees were confident about their counselling skills, as the trainers noted improvements. Both Coyle and Soodin (1992) and Adendorff's (1995) study suggests that in-depth counselling training results in trainees feeling confident about their counselling skills. The results of these studies are similar to the findings of the present study referring to the confidence gained as a result of the knowledge and skills learnt throughout the intensive training course.

5.2.3. Perceived gains and changes

Much emphasis was placed on the improvement of counselling skills, with listening seen as the core quality of a counsellor. Input from the trainees suggested that their

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counselling was of a prescriptive nature prior to the training, which contributed to their poor listening skills. This was due to a lack of understanding of the process of counselling. There however appeared to be a shift from prescriptive advice-giving sessions to more balanced counselling sessions including both information and supportive counselling. As in the study done by Brugha (1994), it was highlighted that staff involved in counselling who had insufficient training and undeveloped counselling skills, as well as insufficient time may tend towards prescriptive advice about risk-reducing behaviour and consequently, neglect the psychological needs of the client. The provision of information and education is essential in managing the spread of the disease but there is recognition that this needs to be combined with traditional, supportive, non-directive counselling to ensure that clients feel supported in decision making affecting their lives and relationships (Bor, Miller & Goldman, 1993).

Trainees also highlighted a positive change in their attitude towards HIV positive individuals as well as sex workers and issues relating to homosexuality; it was felt that improved knowledge regarding the medical issues in HIV contributed to this change. The change to non-judgemental attitudes emphasises the importance of including input on attitudes in an HIV/AIDS training course with the aim of making trainees aware of the impact of negative and positive attitudes on the counselling process. The findings from the present study can be compared to what Van Dyk (1992), refers to as effective counselling which entails a good working knowledge of AIDS and a non-judgemental attitude towards people of different lifestyles, such as homosexuals or drug users and to be able to engender trust and maintain confidentiality.

The training was found to have impacted on trainees' personal lives creating self-awareness on different levels. The input presented on the beginning of the course was found to be useful, as these topics specifically focused on issues relating to self-awareness. The importance attached to self-awareness and the impact this had

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on trainees professional and personal lives highlight the importance of exploring these aspects in a training course of this nature.

Trainees reported more confidence in their counselling skills as a result of the theoretical and practical input on the course. They gained up-to-date knowledge and the ability to communicate this information clearly. Their improved knowledge and sensitivity to the complex emotions regarding an HIV diagnosis enhanced their confidence in their counselling abilities. It is apparent that trainees had internalised the skills necessary for effectively counselling enhancing confidence. Brugha (1994) agrees that training in the basic skills and techniques of counselling, good knowledge of HIV and an understanding underlying principles and goals of counselling are prerequisites for effective counselling.

In addition to the counselling skills acquired, it was felt that the input on the training course helped the trainees realise the importance of setting limits as a way to prevent burnout. This also created for the trainees the awareness to be cautious about becoming to personally involved their counselling sessions.

The findings from the present study indicate that the trainees gained skills that impacted positively on their counselling skills at their workplace, these skills necessary for effective counselling. Similar results were found by a study done by Adendorff (1995) assessing trainees counselling skills before and after the training, showing improvements in their counselling skills. Improvements were found in what was considered to be the most important counselling skills, namely; empathy acceptance and warmth.

5.3. Limitations of the study

The current study was limited to the evaluation of a small number of counsellors, therefore the results cannot be generalised to other participants of courses of this nature. The researchers' objectivity regarding the evaluation could have been influenced by having been involved in working at ATICC as well as conducting the evaluation.

5.4. Future research

In future, research of this nature could include a larger number of counsellors as well as a 6-month follow-up evaluation of the trainees counselling skills to further assess the effectiveness of the skills acquired during the training. Furthermore, to ensure more objectivity, a researcher from outside ATICC not involved in training should ideally conduct the evaluation.

5.5. Recommendations

In view of the very few shortcomings in the course identified by the trainees, one of the recommendations is to extend the practical training section to allow for additional time at ATICC to counsel clients. Another recommendation that flows from this study is that to provide trained counsellor with follow-up refresher courses to up-date their knowledge regarding HIV/AIDS. Finally, there is a need to conduct similar evaluations of all training programmes run throughout the country starting perhaps with only those in the Western Cape to allow for comparisons among them to determine best practices.

5.6. Conclusion

HIV/AIDS has become a serious problem, a problem for which new knowledge is the most promising weapon. Mkuye et al. in N'gweshemi et al. (1997) highlighted the importance of training health workers in Africa on HIV/AIDS/STDs especially because of the different emotional issues which surrounds AIDS. Sherr et al. (1989) pointed out that by providing education for health care workers "they will be in a position to disseminate what they have learnt and thereby amplify the impact of education for prevention of HIV infection and AIDS in the South African community in general" (p.361).

In view of the ongoing need to train health care workers the input provided by ATICC can be seen as a contribution to the training needed. The present study

showed that the course was successful in a number of respects, enhancing trainees' confidence in their counselling skills resulting in effective counselling. Trainees also expressed their satisfaction with the course, commenting on how it has changed their attitudes towards clients at their place of work and in enhancing their understanding of the psychosocial impact of HIV. Both the theoretical and the practical components of the course were noted to be effective. The positive impact of the trainees counselling skills is a reflection of their progress. Impact evaluation confirms the usefulness of the clinic-based counselling course resulting in enhanced knowledge of counselling skills in HIV/AIDS/STD and TB.

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APPENDICES A

CLINIC-BASED COUNSELLING COURSE EVALUATION FORM

EVALUATION FORM (Part I)

Date: ………………………………………………………………………………

Name: ………………………………………………………(Optional)

On a scale from 1 – 10 (1 = least useful and 10 = most useful) please rate the course

WEEK 1 - 5

1. Group Contract ☐

2. Who Am I? ☐

3. Values ☐

4. Relationships ☐

5. Qualities Of A Counsellor ☐

6. Communication Exercises ☐

7. Format For Engaging ☐

8. Confidentiality ☐

9. Listening Skills Exercises ☐

10. Paraphrasing, Reflection And Open-Ended

    Questions (theoretical input) ☐

11. Paraphrasing, Reflection And Open-Ended

    Questions (practical exercises) ☐

Weeks 6 - 9

12. Empathic Responses in counselling ☐

13. Stages In Therapy (In A Helping Relationship) ☐

14. Stage in HIV Counselling ☐

15. HIV Counselling And Women ☐

16. Counsellng And Pregnancy ☐

17. Counselling re: Breastfeeding and HIV ☐

18. TB and its link to HIV ☐

19. Stds and its link to HIV ☐

20. Support For Partners of PWAs ☐

Weeks 10 - 13

21. Pre-Test Counselling ☐

22. Post-Test Couselling ☐

23. Dealing with an HIV positive diagnosis ☐

24. Crisis Management ☐

25. Depression, Fear And Anxiety ☐

26. Suicide Counselling ☐

27. Coping With Losses ☐

28. Counselling Families ☐

29. Caring For The Carer (Preventing Burnout) ☐

30. Creating One's Own Pre- & Post-Test Format ☐

Weeks 14 - 25

31. Face To Face Counseling With Observation input ☐

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EVALUATION FEEDBACK (Part II)

1.   What was most useful for you?

_____
_____
_____
_____

2.   What was least useful for you?

_____
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_____

3.   Please comment on the theoretical input

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4.   Please comment on the role-plays

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5.   Please comment on the weekly supervision

_____
_____
_____
_____

6.   How did you find the staff at ATICC?

_____
_____
_____
_____

7. What has changed in the way you work as a result of this training?

_____
_____
_____
_____

8. Do you think the length of the training was appropriate (e.g. too long, too short, about right?)

_____
_____
_____
_____

9. How could we improve the programme?

_____
_____
_____
_____

10. What would you want more of?

_____
_____
_____
_____

11. What would you want less of?

_____
_____
_____
_____

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APPENDICES B

FOCUS GROUP DISCUSSION QUESTIONS

1. How has the course change the way you counsel at your workplace?

2. Which part of the theoretical input was the most useful?

3. Where there any shortcomings in the course? If so, discuss.

4. How would you describe the course?

5. How well were the concepts explained?

6. How relevant to your job were the course objectives?

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WESTERN CAPE

APPENDICES C

WESTERN CAPE AIDS TRAINING, INFORMATION AND
COUNSELLING CENTRE
CLINIC BASED COUNSELLING TRAINING PROGRAMME

Welcome to the ATICC Clinic Based Counseling Training. We trust that you will enjoy the time we spend together over the next six months and that by the end of this training, you will have reached a stage of confidence concerning counselling in general and HIV/STDs and TB in particular.

Please note that the course will include tea and lunch breaks but these are not indicated on the programme. Below is the course programme over six months divided as follows.

WEEK 1 - 5

1. WELCOME, ICE BREAKER and GROUP CONTRACT
2. WHO AM I?
3. VALUES
4. RELATIONSHIPS (Part I and Part II)
5. QUALITIES OF A COUNSELLOR
6. COMMUNICATION EXERCISES
7. FORMAT FOR ENGAGING
8. CONFIDENTIALITY
9. LISTENING SKILLS EXERCISES
10. PARAPHRASING, REFLECTION AND OPEN-ENDED QUESTIONS
11. PARAPHRASING, REFLECTION AND OPEN-ENDED QUESTIONS (Practical)

WEEKS 6 - 9

12. EMPATHIC RESPONSES INCOUNSELLING

13. STAGES IN THERAPY (IN A HELPING RELATIONSHIP)

14. MODEL FOR HIV COUNSELLING (Adapted from Egan's 3 stage model)

15. HIV COUNSELLING AND WOMEN

16. COUNSELLNG AND PREGNANCY

17. COUNSELLING re: BREASTFEEDING AND HIV

18. TB AND ITS LINK TO HIV

19. STDs AND ITS LINK TO HIV (incl. MENTION OF SYNDROMIC TREATMENT)

20. SUPPORT FOR PARTNERS OF PWAs

WEEKS 10 - 13

21. PRE-TEST COUNSELLING

22. POST-TEST COUSELLING

23. DEALING WITH AN HIV POSITIVE DIAGNOSIS

24. CRISIS MANAGEMENT

25. DEPRESSION, FEAR AND ANXIETY

26. SUICIDE COUNSELLING INTERVENTION

27. COPING WITH LOSSES

28. COUNSELLING FAMILIES

29. CARING FOR THE CARER (PREVENTING BURNOUT)

30. CREATING ONE'S OWN PRE- & POST-TEST FORMAT

WEEKS 14 - 25

31. ROLE PLAY WITH OBSERVATION INPUT THROUGH ONE-WAYGLASS

32. FACE TO FACE COUNSELING WITH OBSERVATION THROUGH ONE-WAY GLASS (ONLY WITH WRITTEN PERMISSION FROM CLIENTS)

33. PRACTICAL FACE TO FACE COUNSELLING WITH MENTORING

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