THE DESIGN, IMPLEMENTATION AND EVALUATION OF AN HIV COUNSELLING SKILLS PROGRAMME FOR LAY COUNSELLORS

by

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Thesis submitted in fulfilment of the requirements for the degree

PHILOSOPHIAE DOCTOR (Psychology)

in the

Department of Psychology, Faculty of the Humanities

at the

UNIVERSITY OF THE FREE STATE

Date of submission: November 2020

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DECLARATION

I, Lerato Mmusi-Makhele, declare that the thesis submitted by me for the Philosophiae Doctor (Psychology) degree at the University of the Free State is my own independent work and has not previously been submitted by me at another university/faculty. In addition, I cede copyright of this thesis in favour of the University of the Free State.

30 November 2020

Lerato Mmusi-Makhele **Date**

ACKNOWLEDGEMENTS

This has been a long journey, God. Thank you for your constant presence and undying love. Once you open a door, no one can close it.

Words of gratitude to my parents: Thank you, papa, for everything. Mrs. Titi Mmusi, (mistresse) thank you for making me believe 'I can'. You have been my rock throughout everything. I thank God every day for you. To the person with whom I started this journey, Ntate Ntsienyane Makhele, ha ke na mantswe. My son, Buta Makhele, you are amazing. Thank you for the hugs and for telling me I will finish 'this'. Monyadiwa Mmusi, you lead me to God. Mpho, thank you for your generous heart and Mapule for brightening my days. To Refiloe, so much is coming. My Rakgadi Kwasi, my nieces, nephews, cousins, uncles and aunts and my in-laws, thank you.

This research study would not have reached this level has it not been for my former supervisor for whom, I will forever be grateful, thank you, Dr. Henriëtte van den Berg. My supervisor Dr. Edwin du Plessis, thank you for your willingness to see this to the end. The support from my co-supervisors Dr. Lindi Nel and Prof. Karel Esterhuyse, was amazing.

Many thanks to:

- The Vice-Rector for Research (UFS), the Faculty of Humanities (UFS) and the University of the Free State, for allowing me an extension and sufficient time to finish this research study.
- The Psychology Department (UFS) for their support and Health Sciences (UFS) for giving my study ethical clearance.
- National Research Foundation for financial assistance. [Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the NRF.]
- Department of Health in the Free State Province for permission to conduct the research.
- People who have continued to make this PhD exist, Portia Ngxangane (my research assistant), Lineo Seselinyane (my training facilitator), Helene le Roux

(my technical editor), colleagues, friends and family, who have been with me throughout. Thank you!

- To the passionate lay counsellors, I have worked with some of you for many years. You are truly ‘Unsung Heroes’, and the patients who allowed me to be part of their HCT journey… we are getting there.

This study is dedicated to my father Mr. Joseph Raletebele Mmusi

'Morolong wa ga Modiboa. Rona re bana ba ga 'Mastlhodiana bana ba tshipi ya moshogadi ga e tjhwarwe ga o sena shoke lephea. Re bina phiri, ha re bona phiri e ntjho, re ke moloi, makhowa a bone cheese ka rona'

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV- T	Anti-retroviral treatment
BCEA	Basic Conditions of Employment Act
BSS	Behavioural Surveillance Survey
CBT	Cognitive Behaviour Therapy
CDC	Centres for Disease Control and Prevention
CHW	Community Health Worker
CICT	Client-Initiated Counselling and Testing
CHCT	Couples HIV counselling and testing
CT	Counselling and Testing
DoH	Department of Health
EBF	Exclusive Breast Feeding
FBO	Faith-Based Organisation
FP	Family Planning
HBC	Home-Based Carer
HCBC	Home and Community-Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
MCP	Multiple concurrent partnerships
MDG	Millennium Development Goal
MI	Motivational Interviewing
MSM	Men who have Sex with Men
MTCT	Mother-to-Child Transmission
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
NHI	National Health Insurance
NSP	National Strategic Plan for HIV & AIDS and STIs
NQF	National Qualification Framework
OI	Opportunistic Infection

PC	Person-centred
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PITC	Provider-initiated testing and counselling
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PrEP	Pre-exposure Prophylaxis
RPL	Recognition of Prior Learning
SANAC	South African National AIDS Council
SLA	Service Level Agreement
STI	Sexually transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations HIV & AIDS Programme
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WBPHCOT	Ward Based Primary Health Care Outreach Team
WHO	World Health Organisation

ABSTRACT

Lay counsellors provide the majority of public health with HIV counselling and testing services in sub-Saharan Africa, including South Africa. Although lay counsellors are not formally employed, these volunteers provide a variety of basic healthcare services both in facility and community-based programmes. Lay counsellors are not professionally trained, and challenges have been identified in their counselling skills and competence. The study aimed to develop, implement and evaluate an HIV counselling skills training programme for lay counsellors in the Mangaung Metropolitan Municipality in the Free State Province, South Africa.

An experimental approach through a concurrent triangulation mixed-method design was utilised. Using a pretest-posttest non-equivalent method, 107 lay counsellors were selected through multi-stage non-probability purposeful sampling. Structured interviews, focus group discussions, and the observation of counselling sessions were employed to collect quantitative and qualitative data. The UNAIDS Tools for evaluating Voluntary HIV counselling and testing and the Maslach Burnout Inventory were used to measure the variables in the study. Quantitatively, a cross-sectional, correlational, and criterion-group design was used, while thematic content analysis was used to analyse the qualitative data.

The results indicated that lay counsellors had inadequate counselling skills and displayed limited competence, especially in pre-HIV test counselling, TB and PMTCT interventions. These results indicate that lay counsellors found it difficult to manage sensitive situations with patients. However, the Mann-Whitney test compared the differences between the experimental and the control groups and indicated no statistical difference in HIV content-based elements. No statistical difference on the competence-based elements in pre- and post-intervention were found for the experimental group. In addition, the participants reported a significant level of emotional exhaustion and work and systemic challenges such as lack of support, supervision, formal employment opportunities, and limited time to conduct counselling and unsafe working environments.

However, the MANOVA showed no statistical difference in the emotional exhaustion subscale of the MBI amongst the experimental group.

The study indicates gaps in the execution of HIV counselling within HCT services, although the HIV counselling skills training programme was unable to address these discrepancies. The study did reveal systemic and work-related indicators that impact HIV counselling provided by lay counsellors. The need for further counselling training is an arguable one, which should allow for a longer time frame, evaluation and monitoring to meet the needs of HCT services. Future studies should consider longitudinal research, and given the implications of work-related conditions reported, studies can include systemic variables, service users and measures that would address these aspects. In practice, counselling skills and competence are reinforced through regular supervision and on-going training, and this should be standard. Also, reorganising recruitment practices and creating employment opportunities should be prioritised to promote the selection of suitable candidates as lay counsellors.

Keywords: HIV counselling, lay counsellors, counselling skills, competence, burnout, training, mixed-method research

CHAPTER 1
INTRODUCTION

‘A problem shared is a problem halved’ (Cambridge Dictionary, n.d.). This is, in essence, what counselling entails. Counselling refers to assistance and guidance offered in various settings to assist in understanding and resolving personal conflict and problem situations. It can be dated back to ancient times when people came together to share experiences. As civilisation took its course, more formalised counselling methods began to emerge in religious settings and healthcare, for example. This thesis presents an experimental study that focuses on counselling within HIV counselling and testing (HCT) services in public healthcare. Initially, HCT was referred to as Voluntary HIV counselling and testing (VCT), although it is a process and strategy that intends to offer not only HIV testing but is also considered an important entry point in HIV prevention, management and care services (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2000; National Department of Health, 2015; World Health Organisation [WHO], 2015a). However, with the growing and changing facets of Human Immunodeficiency Virus [HIV]/Acquired Immune Deficiency Syndrome [AIDS] in the last four decades, aspects of personal risk to HIV, prevention, medical, emotional and social factors related to an individual’s HIV test results have been included (UNAIDS, 2000, 2019; WHO, 2015a). Today, counselling plays a significant role in HCT services (National Department of Health, 2015). With this in mind, this study entails the design, implementation and evaluation of an HIV counselling skills programme for lay counsellors.

In this introductory part of the thesis, the researcher outlines how the research topic was derived based on preliminary reading and work experience and how the research question, problem statement and rationale were formulated. The design and research methods will be mentioned briefly, including ethical considerations and key terms, concluding the chapter with an outline of the thesis's layout.

1.1. Background of the Research

Acquired Immune Deficiency Syndrome (AIDS), the epidemic that has caused global devastation and struggles for more than 39 years, has claimed many lives since its onset in the 1980s (UNAIDS, 2019). The HIV epidemic has been transmitted and has infected more than 78 million people and caused more than 32.7 million deaths globally (UNAIDS, 2019). The provision of Anti-Retroviral Treatment (ARV) as prophylaxis, especially amongst population groups of people at increased risk for mortality, has been a critical breakthrough in accelerating the fight against HIV/AIDS (UNAIDS, 2019). The increase in ARV treatment coverage across the world, especially in sub-Saharan Africa, has led to a decline in AIDS-related deaths (UNAIDS, 2020; WHO, 2014). The AIDS-related mortality has declined by 39% since 2010, the year which incurred the most HIV/AIDS-related deaths (UNAIDS, 2019). In South Africa, AIDS-related deaths decreased from 267 417 in 2007 to 126 805 in 2019, with an estimated 7.97 million people living with HIV/AIDS in 2019 (President's Emergency Plan for AIDS Relief [PEPFAR], 2019). By February 2019, South Africa alone had nearly 4.57 million people on ARVs, the most extensive treatment programme in the world and Africa (PEPFAR, 2019). Despite the scaling up of ARV treatment, it is not the only recommended treatment and management option for HIV/AIDS. Health programmes that support medical interventions, as in HIV/AIDS, include counselling and other supportive care (Bekker et al., 2016). In its nature, HIV counselling and testing should be able to provide preventative care options such as risk assessment for the most vulnerable populations (National Department of Health, 2015).

For those that test HIV positive, counselling can serve as a treatment maintaining factor (Kanekar, 2011) and contribute positively to retention in care (Fatti et al., 2012). Entry into and retention in care are significant contributors to the successful increase in treatment coverage for pregnant women living with HIV/AIDS (Knettel et al., 2018; United Nations Children's Fund [UNICEF], 2016). Through community service-delivery models and network support for women living with HIV/AIDS, prevention of mother to child transmission/parent-to-child-transmission (PMTCT) service delivery have been particularly valuable in providing support through counselling, HIV testing and diagnosis, treatment adherence and education on reproductive rights (UNICEF, 2015; WHO, 2010). UNAIDS reported that at the end of 2015, more than half of the countries in sub-Saharan Africa were utilising community health workers to provide the services mentioned earlier and support essential HIV services, including PMTCT (UNAIDS, 2016).

In their review, the WHO (2015b) reported that a study in rural Malawi, which involved a group of lay counsellors (LCs) that provided HIV testing, showed a significant decline in the portion of clients testing positive from 36% to 16 % following this task-shifting exercise.

Similarly, the South African government launched the national HCT campaign in 2010 (UNAIDS, 2010b), which entailed HIV counselling, where LCs were used as human resource strategies to increase HCT uptake. The HCT campaign raised the use of LCs in the provision of these services, and as a result, even today, the majority of HIV counselling remains the main task of LCs (Médecins Sans Frontières [MSF], 2020; National Department of Health, 2015). This task-shifting process is a human resource attempt to expand HCT services through a rational redistribution of health care delivery from higher-level health providers to cadres on a lower level (WHO, 2008) to provide entry-level HCT services (WHO, 2013a, 2014).

Arguably in any healthcare service delivery system, adequate training and support need to be available and provided to healthcare workers. Therefore, LCs' ability to provide adequate care and support within HCT services also requires sufficient training and support (Cataldo et al., 2015; Dewing et al., 2013; Mwisongo et al., 2015). With the evolving nature and varying dimensions of HIV/AIDS, including treatment services, the increase in ARV treatment access also implies that the LCs' training needs need to meet best practices and standard HCT services. In a study by Cataldo et al. (2015), caregivers in Zambia who provide home-based HCT services indicated training needs across various topics. The training areas included counselling for adherence to ARVs, monitoring of medication administration, tracing of non-compliant patients, as well as working with referral systems. Similarly, data from a study conducted by Thurling and Harris (2012), which evaluated training needs of South African community healthcare workers (CHW) at a tertiary hospital who provide PMTCT services, also revealed that the CHWs group indicated training needs in home-based care, tuberculosis (TB) knowledge, grief counselling and practical nutrition information for PMTCT interventions.

Challenges expressed in counsellors' training needs have also included general counselling skills (Ma et al., 2013; Mohlabane et al., 2015; Mwisongo et al., 2015). As raised in the study of Ma et al. (2013), in addition to general medical training on Sexually Transmitted Infections (STI), the Chinese counsellor group reported that they could benefit from further training on communication skills, psychological counselling, as well as the benefit of support groups with fellow counsellors.

Similarly, in a study by Mwisongo et al. (2015), participants selected from more than 73 HCT sites across South Africa expressed difficulty in the execution of counselling skills, especially in dealing with situations involving a patients' HIV test result, working with discordant couples and working with certain age groups.

The consensus is that LCs find it challenging to manage emotionally demanding counselling situations (Mwisongo et al., 2015; Van Dyk, 2007; Visser & Mabota, 2015). In addition to managing patients' emotional responses and needs, LCs in the City of Tshwane clinics, South Africa, reported in a study by Visser and Mabota (2015) to also have high levels of emotional exhaustion and depression due to the emotional load as a result of their HCT work. Some of the challenging work situations include inadequate support for HIV counsellors and lack of appropriate supervision coupled with substantial job-related stress, reportedly impacting counsellors' work participation and ability to execute HIV counselling duties effectively (Mavhandu-Mudzusi et al., 2007; Mkhabela et al., 2008). Also, lack of mentoring and debriefing opportunities was earmarked as indicators that impacted LCs' delivery of HIV counselling services in a study by Peltzer and Davids (2011). Therefore, it is essential to address the need for adequate training, continuous support and supervision for LCs (Dewing et al., 2015; Mohlabane et al., 2015; Mwisongo et al., 2015) to equip them with skills to manage challenging work situations.

At the core of this study's aims, the training needs are to develop an HIV counselling skills training programme. All essential components pertaining to the individual aspects to be considered in the design, implementation and evaluation of the training programme will be discussed in detail in the literature review.

1.2. Problem Statement

HIV remains incurable despite the availability and increased access to ARV treatment. Previous research that led to the development of policy frameworks that govern the implementation of crucial national HIV programmes in South Africa, such as the HCT policy of 2010 (revised in 2015) (National Department of Health, 2010a, 2015) and the National Strategic Plan 2012-2016 and 2017-2022 (South African National AIDS council [SANAC], 2011, 2017) identified several determinants of HIV.

The critical behavioural, social and structural determinants of HIV in South Africa specifically identified sexual debut, multiple sexual partners, condom use, age-disparate sexual relationships, alcohol and substance use, gender roles and norms, sexual abuse and intimate partner violence, as well as mobility and migration as driving forces in the HIV pandemic (Shisana et al., 2014; Simbayi et al., 2019; SANAC, 2017). Furthermore, biological risk factors such as co-infection with bacterial and viral STIs and low rates of male circumcision, also mitigate the impact of the AIDS epidemic among the general population in South Africa (Shisana et al., 2014). These key determinants have been outlined as entry points in the provision of quality HCT services (Simbayi et al., 2019).

Since the expansion of ARV treatment services in South Africa (UNAIDS, 2010b), the LC cadre has been a significant provider of ARV-support and various HCT-related services (Petersen et al., 2014). Those who provide HIV counselling and testing relieve the workload that many under-resourced healthcare services in developing countries experience (Sanjana et al., 2009). For instance, LCs are lay healthcare workers trained to provide essential support of medical, emotional, and social nature (Lewin et al., 2010). Furthermore, in South Africa, they undergo ten days of entry-level training, including HIV/AIDS, assessing patient risk and promoting good health and wellness (Mwisongo et al., 2015). Although most of the training is provided by non-governmental organisations (NGO's), LCs work in healthcare is in both facility- and community-based services. Initially, LCs within HCT services were a responsibility of the Department of Health and the Department of Social Development. However, in the last decade, the South African government has integrated HCT service provision to be a joint effort incorporating other governmental departments. Through the 'Expanded Public Works Programme,' the roll-out of community health workers has been a supported initiative through a coalition with other governmental departments (National Department of Social Development, National Department of Education, & National Department of Health, 2004). Also, it is during this period that the Primary Healthcare (PHC) Reengineering programme was developed, which saw LCs being placed in more communities to provide door-to-door outreach services (Mohapi & Basu, 2012). The LCs and other categories, formerly known as Directly Observed Treatment for TB (DOT) supporters, community caregivers (CCG) and home-based carers (HBC), are now referred to as Community Healthcare Workers (CHW). However, for this study, the term lay counsellor will be used.

There has been positive feedback on LCs' ability to provide adequate counselling (Kigozi et al., 2011; Meehan et al., 2015). Research regarding the services that LCs provide has focused mainly on assessment by conducting surveys and other investigations of factors facilitating HCT uptake, which subsequently identified counsellor variables such as lack of professional recognition, career path and remuneration (Duncan et al., 2017; Woolman et al., 2009), lack of appropriate counselling space and privacy (Mohlabane et al., 2015; Mwisongo et al., 2015) and even patients' accounts on lack of awareness of patients' needs (Papanna et al., 2012) by LCs. Some of the research on HCT services provided by LCs has also assessed patients' perspectives and indicated LCs' lack of provision of basic medical information, confidentiality and the inability of LCs to create an appropriate counselling environment (Daftary et al., 2007; Ginwalla et al., 2002). Lack of basic HIV/AIDS knowledge was also expressed in an evaluation study of 67 HCT facilities across South Africa (Mohlabane et al., 2015). Previous research on LCs' perceptions of their role within HCT services revealed that they expressed concern over their scope of practice and position within the healthcare system (Heunis et al., 2009; Lehmann & Sanders, 2007; Schneider et al., 2008). Furthermore, they indicated that their role expands beyond their experience and training. These include an inability to assist with patients' initial emotional expressions following a positive HIV test result, while some reported feeling inadequate when handling couples' counselling situations (Mwisongo et al., 2015; Richards & Marquez, 2005; Visser & Mabota, 2015). To date, there have been only a few studies that have sought to address these concerns. Amongst others, the psychological needs of patients seem to be an area which LCs feel ill-equipped to handle, and these ranged from management of conflict between couples (in session), depressive and suicidal patients, as well as underage (children) patients (Peltzer & Davids, 2011).

Furthermore, even in situations where counsellors could refer patients, referral systems are not in place (Haffejee et al., 2010). Beyond question, HIV counselling and testing services by LCs, which initially focused on pre- and post-HIV testing (Van Dyk, 2010) suggest that current needs have to encompass other psychological and counselling skills; areas where LCs have not received adequate training. Literature also highlights that LCs are expected to handle patients with deteriorating health, those who are dying and victims of sexual and domestic abuse, which counsellors deem to be stressful (Peltzer & Davids, 2011). Their inability to cope with these work situations, therefore, puts their mental health at risk. Egan (1975) stated that counsellors need to be aware of perceived barriers to counselling in themselves, their clients and the counselling conditions. This statement applies, especially in the context of HIV/AIDS.

Through various research studies, there has been an appeal for the standardisation of training for LCs, and the opportunity for further training and occupational development (Duncan et al., 2017; Peltzer & Davids, 2011). The lack of refresher or update courses that was addressed in an assessment of PMTCT training by Thurling and Harris (2012) indicated that LCs' training is inconsistent, thus questioning how sufficient the entry-level training in HCT services for LCs is. Since the development of the 10-day entry-level training, HCT services had to adapt to the emerging and evolving presentation of HIV/AIDS, including catering for counselling services in Voluntary Medical Male Circumcision (VMMC) situations, Men who have sex with other men (MSM) (National Department of Health, 2015; President's Emergency Plan for AIDS Relief [PEPFAR] (2019), among others.

At the onset of this study, there was limited research that comprehensively addressed HIV counselling refresher training for LCs, including HIV/AIDS-related knowledge and psychological counselling components, which this study aimed addressed. However, some researchers (Dewing et al., 2015; Diiorio et al., 2008; Golin et al., 2006) developed training techniques to address some of these gaps in HIV counselling, which focus on ARV research and ARV-adherence training. These training techniques seem to have improved LCs skills (Dewing et al., 2015; Diiorio et al., 2008; Golin et al., 2006). Similarly, a study in Zambia evaluating the effectiveness of a 2-day refresher HIV counselling training course for LCs found significant improvement in participants' levels of HIV/AIDS knowledge and satisfactory demonstration of counselling skills (Msisuka et al., 2011). Furthermore, according to Msisuka et al. (2011), these components were deemed crucial in sustaining LCs' motivation.

The current study endeavoured to address gaps in LCs training. Firstly, through a concurrent triangulation mixed-method assessment of existing counselling skills, competence and burnout, secondly, developing a training programme aligned to the needs of the LC who provides HIV counselling. Thirdly, to implement the training programme and lastly, to evaluate the training, as proposed by researchers. The aim is, therefore, to address the knowledge gap to improve the quality of HIV counselling provided by LCs.

1.3. The rationale of the research

At the time of conceptualising the study, the estimated HIV prevalence in South Africa was approximately 12.2 % of the total national population (Shisana et al., 2014). Currently, HIV prevalence stands at 20.4 % (UNAIDS, 2020). In 2016, the estimated total number of people living with HIV/AIDS in South Africa was around 7.03 million (Statistics South Africa, 2017). In the Free State Province, South Africa, where this study was conducted, HIV prevalence stood at 14.0% (Shisana et al., 2014). With the introduction of Primary Healthcare Reengineering (Mohapi & Basu, 2012), LCs were expected to provide community-based services. However, in their study, Heunis et al. (2013) found that more than half of the community healthcare workers that provided HCT services in some parts of the Free State Province received no basic counselling training. The aim, scope and challenges of HCT indicate that it does not assist in the prevention of HIV acquisition and transmission only. It is a process that can actively change HIV negative individuals' behaviour through risk reduction counselling, which incorporates behavioural modification information and skills such as a decrease in the number of sexual partners, increased and consistent condom use and management of sexually transmitted infections; aspects that should be addressed in the HIV counselling processes. In the field of psychology, these psychological processes of behaviour change are primarily based on psychological models.

Training in counselling within HCT services draws from a foundation of behavioural change that is embedded in many psychological counselling approaches. For example, Egan's 'The skilled helper', Person-centred (PC) approaches, Motivational interviewing (MI) and Cognitive behavioural approaches (CBT) (National Department of Health, n.d.) are used in the training of lay counsellors. A few studies have evaluated the use of these psychological models and principles in the execution of HIV counselling related duties (Dewing et al., 2013). In their study of ARV adherence services provided by LCs in the Western Cape, the researchers found many inconsistencies and contraventions of counselling principles (Dewing et al., 2013). Basic client-centred approaches were violated, such as the demonstration of positive regard and respect, based on LCs' ARV-adherence training and Egan's principles. What reflected was that counsellors resorted to traditional patient-provider relationship. Building on the findings mentioned earlier, Dewing et al. (2015) implemented an MI ARV-adherence training programme and reported that training and continuous supervision of LCs positively impacted their ability to adhere to counselling practices.

The study also revealed that counselling interventions with a problem-solving feature, which is in line with CBT approaches, reflected improved ARV adherence amongst patients. This study provides evidence that necessary counselling, communication skills and therapeutic training improved LCs' practices (Dewing et al., 2015). The Department of Health's (n.d.) *Minimum Standards for counselling and training: Selection and training of counsellors,* which is the foundation of LCs' HIV counselling training, together with the National Qualification Framework (NQF) set training and ethical guidelines, which include basic counselling strategies, providing support, promote good health and wellness of patients, amongst others. Unfortunately, this training curriculum cannot be left to the duration of 10 days because it has to be further developed to address professional needs in terms of knowledge, counselling skills and competencies, as well as the ability of counsellors to manage personal and emotional needs that might impact their interaction with patients during effective HIV counselling.

To improve the quality of HIV counselling services, the development, implementation, monitoring and evaluation of such a programme needs to be relevant and research-based. This experimental design study will explore the result of an HIV counselling skills training programme based on the *Model of Counseling Competence* (Ridley et al., 2011b) as a guiding theoretical framework. The pre- and post-intervention investigation will utilise the knowledge and skills base sets drawing from numerous psychological models that guide counselling to enhance counselling knowledge, skills, and competence. This will be accomplished following the steps outlined in the methodology chapter.

1.4. Research Aims and Objectives

This research study aimed to assess the current level of counselling skills, key competencies and level of burnout and address any deficiencies by developing, implementing and evaluating an HIV counselling skills training programme for LCs in Mangaung Metropolitan Municipality, Free State Province. The objectives of the study are as follow:

1. Firstly, to assess the current level of counselling skills, key competencies and burnout.
2. Secondly, to adequately inform counselling skills through the development in type, content, mode, as well as the duration of an HIV counselling skills training programme.
3. Thirdly, to implement the training programme.
4. Lastly, to evaluate the effectiveness of the training programme.

The study's objectives were achieved following the steps below:

a. Synthesising how LCs execute and perform HIV counselling duties and activities following the skills and competence acquired thus far by assessing the level of skill and key competencies the LC possess.
b. Assessing the level of burnout among the LC group to adequately equip them with skills to manage work-related burnout.
c. Comparing the relevant and adequate acquisition of skills and competencies using best practice guidelines.
d. Addressing any deficiencies or gaps by developing a counselling skills training programme within the understanding and training of counselling skills using the *Model of counselling competence* (Ridley et al., 2011b) as a guideline.
e. Evaluating the influence the counselling skills programme had on how LCs execute, perform, and manage HIV counselling duties, activities and burnout.

1.5. Defining of Key Concepts

To assist the fluency of the reading, the following definitions must be taken into cognisance:

AIDS	Acquired Immune Deficiency Syndrome caused by HIV (Human Immunodeficiency Virus). HIV destroys the body's ability to fight infection and disease and can ultimately lead to death. AIDS is the last (4^{th}) stage of HIV infection.
ARV/T	A comprehensive management and treatment plan that includes the use of anti-retroviral (ARV) medicines, counselling, psychosocial support and other medical healthcare and management of HIV.
Burnout	A state of emotional, physical, and mental exhaustion in long-lasting emotionally demanding work situations.

Community Health Worker	Any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial well-being and provide ongoing care and support to individuals and families vulnerable to chronic illness and indigent living circumstances.
Counselling knowledge, skills and competence	Counselling knowledge and skills are sets of actions that counsellors use to facilitate and guide clients' therapeutic processes. They are acquired through training. These counselling actions or practices also received through counselling practice lead to expertise (gained through continuous experience and further professional development). Counsellor or counselling competence is described as the determining, facilitating, evaluating, and sustaining intended counselling outcomes (Ridley et al., 2011b). It is a comprehensive and complicated process, which requires the use of acquired knowledge, skills, practices, and expertise to reach the desired counselling outcome.
Counselling	A process between counsellor and client/patient that facilitates problem-solving, exploring options for the client/patient to gain insight, challenge their thought processes and change behaviours to achieve a result that benefits the client/patients' psychological, physical and general well-being.

HIV Counselling and Testing	HIV Counselling and Testing (HCT) processes involving pretest counselling, HIV testing and posttest counselling and follow-up counselling. May include voluntary counselling and testing (VCT) and provider-initiated testing and counselling (PITC).
Lay counsellor	Lay counsellors (LCs) are healthcare providers who perform duties and functions related to healthcare delivery. They have been trained to deliver specific services but have not/did not receive any formal professional or paraprofessional or tertiary qualification (Lewin et al., 2006; WHO, 2015a). Within the South African HCT context, these lay counsellors may be referred to as community healthcare workers, community caregivers, assistant nurses (basic counselling background).
Skills training programme	Skills training and development programme aims to develop the skills of a particular group or workforce to improve the quality of services rendered by these workers, improve productivity in the workplace and the workers' prospects of work.

1.6. Outline of Chapters

CHAPTER 1: Introduction

This chapter encompasses a short description of the purposes and necessity of the current study and an outline of the study objectives. Key concepts that are relevant to the study are also defined.

CHAPTER 2: Counselling, HIV counselling and counselling approaches

The chapter explores the different needs, expectations, as well as objectives of counselling in general.

Counselling in healthcare services, particularly HIV counselling and processes, are defined and explored. The chapter also discusses the theoretical counselling approaches and frameworks underpinning the psychological and human behaviour in the context of HIV/AIDS.

CHAPTER 3: The Lay Counsellor, HIV/AIDS in the African context and HCT Programme development, implementation, and evaluation

This chapter entails a description of the background, perspective, and current scope on the role of the lay counsellor according to education, selection, training, and skills. An analysis of the geographical determinants of HIV/AIDS in Africa and South Africa is provided, and a discussion included concerning the theoretical perspectives on HIV counselling skills programme development, implementation and evaluation.

CHAPTER 4: Methodology

In this chapter, the research design, measures and details of data collection and generation and analysis methods of the problems are discussed. The chapter presents the theoretical perspective on the research design, data collection methods, stages, and processes of conducting the research study. Also included are details relating to measures to ensure the quality of the research and ethical considerations.

CHAPTER 5: Results

The research data is reported in pre-intervention (baseline) data, mixed-method analysis and post-intervention data. Both pre-intervention quantitative and qualitative findings are presented, followed by an analysis of the pre-intervention data through a triangulation process of both methodologies. The outcome generated the development of the counselling skills training programme, which was informed by the *Model of counselling competence* (Ridley et al., 2011b). The structure and mode of counselling skills training are discussed. The third section presents the post-intervention quantitative and qualitative findings specifically on comparisons between the experimental and control groups. The chapter is concluded with a summary of the key findings in the evaluation of the programme.

CHAPTER 6: Discussion

The findings are discussed in this chapter.

CHAPTER 7: Conclusion, Limitations and Recommendations

This chapter explores the conclusion and the limitations of the study. Academic recommendations are made for future research, including practical recommendations for HIV counselling provided by LCs in healthcare settings.

References and Appendices

A list of references and resources consulted and utilised in the development and execution of the research study is tabled.

In conclusion, this introductory chapter summarises how the research study was informed in terms of empirical evidence and how the research hypothesis was formulated, and research questions developed. The next chapter focuses on counselling in general and in healthcare settings, specific to HCT services. Furthermore, to enable the reader to better understand the psychological processes that aid in counselling, including a discussion about the theoretical approaches utilised in HIV counselling.

CHAPTER 2
COUNSELLING, HIV COUNSELLING AND HIV COUNSELLING APPROACHES

In this chapter, counselling, in general, is explained. Secondly, the chapter focuses on the different practices and implementation of counselling services within healthcare settings. Thirdly, this chapter will critically explore what informs the HIV counselling processes, including a discussion about the goals and conditions required in HCT service provision. Lastly, psychological models and approaches that inform HIV counselling processes will be addressed.

2.1 Counselling

Psychological counselling is defined as a process in which a counsellor uses specific skills in facilitating the development of self-knowledge, emotional acceptance, emotional growth and personal resources within a framework of a helping relationship with a patient/client (Gillis, 1994; Sikkema & Bissett, 1997). Counselling comprises many conversations using different techniques over some time to assist patients/clients in changing their behaviours and adopting and maintaining helpful behaviours (Amanullah & Firdos, 2018). Furthermore, this professional relationship between counsellor and patient/client is characterised by applying one or more psychological approaches, utilising a recognised set of communication skills, and modified by experience, intuition and other interpersonal factors (Corey, 2012). These skill sets are used to address the patient's/client's intimate concerns, problems, and aspirations, and it is a facilitated process rather than advice-giving and coercion (Colledge, 2002). It may be short or long term and may overlap with other services such as medical services and personal welfare matters. All counselling processes require a specific set of elements to be present and roles to be identified (McLeod, 2009). In this study, the term patient is used to refer to counselling service users, and the term patient will be used to refer to counselling service users.

The following section will describe counselling in terms of four components: the role of the counsellor, the role of the patient, goals of counselling and the stages of counselling.

2.1.1 The role of the counsellor

In *The skilled helper* (Egan, 1975, 2002), Egan states that counsellors and qualified helpers alike should be able to commit to both assisting patients to achieve growth and goals in some regions of their lives and have the ability to grow as well. Respect, genuineness or congruence are some of the primary attributes required for counsellors (Rogers, 1959). With these elements, a counselling environment is created that facilitates counsellors' knowledge regarding the expected counselling behaviour (Ridley et al., 2011b). Patients are empowered to take self-responsibility in the counselling process if such conditions are present. The intention of counselling is not to assist patients to solve their problems or prescribe a treatment, but instead, it is to focus on what options and choices patients can make to facilitate the change required (Ellis & Dryden, 2007). Confidentiality and counsellors' ability to respect patients' information and psychological processes foster positive counselling relationships. Counsellors need to have an identified mechanism of questioning, advice-giving and confrontation (Logren et al., 2017). Also, it is essential that counsellor's beliefs about their patients' perceptions regarding counselling and their attitudes towards counselling, as well as what can and should be achieved in a counselling process, should be realistic and feasible, and should consider the patients' context and individuality (Ridley et al., 2011b). Furthermore, counsellors need to be aware of perceived barriers to counselling, in themselves, their patients and the counselling conditions (Egan, 2002; Ridley et al., 2011b).

2.1.2 The role of the patient

For counselling to be effective, counselling service users (patients) need to have a sense of autonomy and control in pursuing health changing behaviours (Corey, 2012; Logren et al., 2017). Patient participation is vital in successful counselling, and counselling must always be based on what the patients require (Amanullah & Firdos, 2018). For instance, in HIV/AIDS, the counselling process needs to facilitate change in various areas of a patient's life (WHO, 2015a), as HIV/AIDS is not a condition that exists in isolation.

HIV/AIDS is a health condition that requires management from various aspects of a person's functioning (National Department of Health, 2015). It requires an integrated management and care structure that would support the person in totality (WHO, 2015a).

2.1.3 Counselling goals

Realistically, patients will have different goals. Goals in counselling can be remedial or developmental, depending on what the patient has identified as important/significant to them (Colledge, 2002). Helping in a counselling process is about making constructive change and achieving a level of significant difference in the life of a patient (Van Dyk, 2010). According to McLeod (2009), the counselling process draws from various theoretical approaches. It is viewed as a collaborative process that aims to increase the patient's insight, leading to increased ability and capacity to have an informed and rational perspective and control over thoughts, feelings and actions. This cognitive and behavioural process of systemic change entails a replacement of problematic beliefs, thoughts and patterns of behaviour that introduces a change in the self and how other social systems such as relationships should operate (Ellis & Dryden, 2007; Ridley et al., 2011b). Once patients become aware of these malicious forms of thoughts, feelings and behaviours that have hindered their coping mechanisms, they can develop a positive attitude towards self and an elevated positive interaction with others (Ellis & Dryden, 2007). Also, patients can be empowered through psychological education and understanding and change their behaviour through practical problem-solving skills and behaviour modification (Amanullah & Firdos, 2018). The transformation of these aspects can lead to a movement towards fulfilling their potential and integrating parts of self previously in conflict (Prochaska & Norcross, 2007). This, in turn, can lead a patient into developing a sense of generativity, the desire to share the changes and the capacity to influence others positively (Prochaska & Norcross, 1999).

2.1.4 Stages of the counselling process

Counselling should be a process of problem management and change (Van Dyk et al., 2017). In this section, counselling processes will be described according to four stages, as proposed by Van Dyk (2010). Although these stages are within the context of HIV counselling, they can be applied within various forms of psychological counselling processes.

These generic stages are guided by psychological approaches to understand a patient's changes in how they think, feel and behave. The method of counselling, including skills utilised, is as follows (Van Dyk, 2010):

- **Establishing a counselling relationship with the patient**

  The main components in this initial stage of counselling require establishing rapport with the patient and creating a relationship built on trust and mutual respect (Rogers, 1959). The basic skills in counselling can be used to assist in feeling more at ease, to be open and share intimate aspects about their private life. Listening, observing, attending, tracking, summarising, paraphrasing and reflecting on what the patient brings are components of counsellor skills that can facilitate trust-building within the counselling relationship (Ridley et al., 2011b).

- **Helping the patient to tell their story**

  Helping patients tell their story requires the use of counselling skills such as empathy, genuineness, and respect, as well as being concrete (Rogers, 1959). The counsellor needs to start probing at this stage and question the patient to better understand how the patient feels and what has led to those feelings (Amanullah & Firdos, 2018). Ideally, behaviours and thoughts will be revealed at this stage. By demonstrating the necessary counselling skills of empathy, for example, can make the patient feel understood (Egan, 1975).

- **Analysing and developing an understanding of the problem situation**

  Change can be facilitated by summarising, and using advanced empathy, clarifying, questioning and providing feedback to assist patients in exploring alternative thoughts, feelings and actions (Ellis, 1957). Considering options is essential within the context of what the patient values most. Once these options are examined, the alternative, positive and effective options are chosen for the patient to explore further outside and beyond the counselling sessions (Beck, 1967; Ridley et al., 2011b).

- **Formulating options, intervening and taking action**

  Counsellors can use directive and non-directive skills for problem-solving, goal setting and assisting the patients' action plan (McLeod, 2019).

Furthermore, the counsellor avails the counselling relationship as a form of support and explores various mounting methods that the patient can utilise to facilitate and maintain change (Ridley et al., 2011b).

Since the current study is within the medical condition context of HIV/AIDS, the next section focuses on special considerations in providing counselling in healthcare.

2.2 Counselling in Healthcare Settings

In healthcare, counselling aims to help individuals resolve personal and psychological problems (Brain et al., 2003). Depending on the nature of the medical issue, and the presenting healthcare situation, healthcare providers implement various health-based counselling interventions aimed at targeting specific health behaviours (Logren et al., 2017; Radoja, 2015). These counselling interventions are often based on health psychology, a discipline of psychology in which health behaviours are seen from the perspective of individual psychological elements of behaviour and lifestyle choices that affect an individual's health (Brennon et al., 2014). In addition, health psychology aims to promote and enhance health, prevent and treat diseases, identify health risk factors, improve healthcare systems and shape the public's opinion on health matters (Brennon et al., 2014).

Health psychology gained popularity during the 1970s and 1980s (Kaptein & Weinman, 2004), resulting from an understanding that health and illness treatment was more effective when medical interventions were used in combination with psychological interventions (Karademas, 2009). Health maintenance and health promotion interventions were increasingly utilised for effective treatment and symptom management for patients (Karademas, 2009). Thus, the role of health counselling in healthcare gradually became more critical.

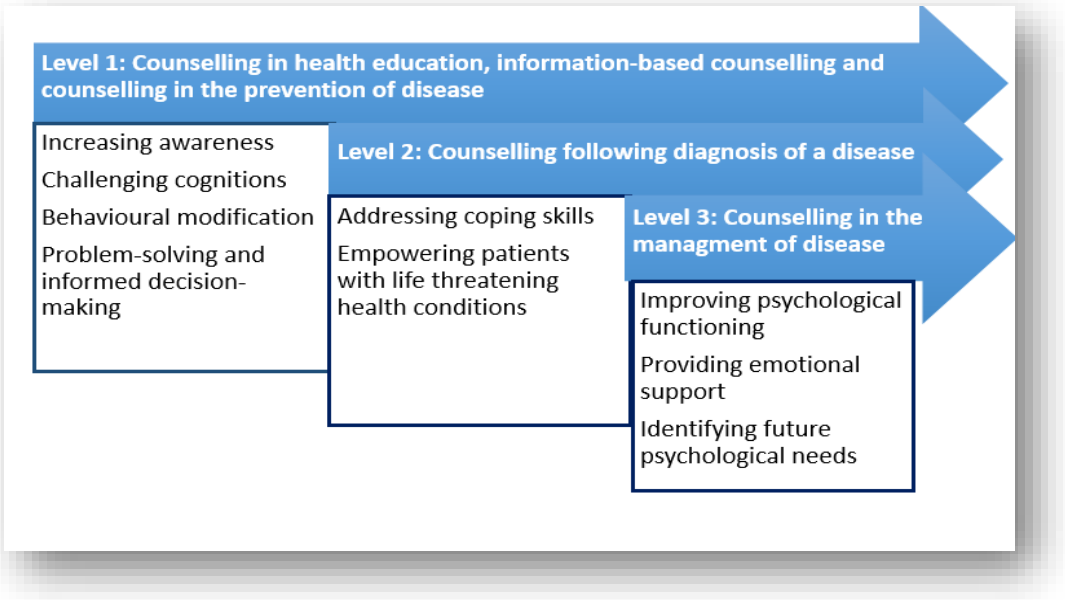
The role of counselling in healthcare settings is especially relevant in preventing and managing severe illnesses as it attempts to influence an individuals' attitudes and behaviour (Logren et al., 2017). The counselling process in healthcare settings typically involves a professional relationship between the counsellor and client/patient and is generally person-to-person, but might include more than one client/patient (Amanullah & Firdos, 2018; Radoja, 2015).

In this relationship, a patient is offered an opportunity to understand and clarify individual opinions of an emotional and interpersonal nature, learn ways to reach their goals through meaningful problem-solving skills and make informed choices (McLeod, 1998).

Based on the literature, the following section outlines basic healthcare counselling processes and interventions. Figure 2.1 illustrates counselling in the form of levels and main intervention components to aid in understanding the flow and structure of counselling in healthcare. These counselling interventions are informed by patients' healthcare counselling needs and contexts and do not necessarily follow in the order in which they are presented in the figure, as well as in the next section.

Figure 2.1

Counselling in healthcare



The levels of counselling interventions administered in healthcare settings are presented in both purposes and the predicted outcome of each intervention. Firstly, the primary level counselling processes that are educative and information-based, and inclusive of both preventative and assessment of the risk of developing a medical condition/disease (Karademas, 2009), will be discussed.

Secondly, the secondary level comprises counselling processes that follow a diagnosis of a disease and the psychological management thereof (Amanullah & Firdos, 2018; Logren et al., 2017). The third level is a tertiary level of counselling, which is offered to assist patients/clients

manage medical diseases better by addressing psychological concerns and issues that may accompany and/or arise from the presence of a medical illness (Amanullah & Firdos, 2018). Furthermore, this level of counselling is also offered to support adherence, compliance and maintenance of treatment (Amanullah & Firdos, 2018). This section will explore different counselling needs and psychological aspects of each level in healthcare counselling interventions.

2.2.1 Level 1: Counselling in health education, information-based counselling and counselling in the prevention of disease

Counselling plays a significant role in health education and information-based medical interventions. In healthcare, counselling greatly emphasises the patient's autonomy, experiences and choices without being instructive (Amanullah & Firdos, 2018; Corey, 2012). It is believed that patients can alter health behaviours to achieve good health, which can be demonstrated through many health and behavioural choices patients make. Different psychological aspects influence individuals choices when it comes to their health. These include an increase in awareness, challenging cognitions, behavioural modifications and problem-solving.

2.2.1.1 Increase awareness

Counselling provides an opportunity for individuals to gain information that can influence how and what kind of decisions they make. Although awareness or increasing awareness does not necessarily translate to ones' ability to adopt behavioural changes that may improve or reduce the risk of illness, it does infer that availability of health-related information can contribute to better health choices (Karademas, 2009). This understanding can be better explained by the dissemination of certain types of information to the public. For example, tobacco package warning messages are a marketing effort intended to enhance awareness of cigarette smoking's effects. However, their effects of increasing awareness and reducing unhealthy life choices have been debated (Soames, 1988).

Advances in medicine have shown that risk assessment and early detection of medical illnesses can alter an individuals' perception and improve health-related behaviours, thereby increase awareness. Keller et al. (2008) reported on the beneficial effects of such interventions. In the investigators' report following affected and unaffected patients in Germany with familial

colorectal cancer (CRC), data revealed that both affected and unaffected patients experienced decreased psychological distress after being informed that their cancer was likely due to an inherited condition and that their offsprings might not necessarily inherit it (Keller et al., 2008). In the study Keller et al. (2008) conducted, the participants also learnt that their risk of CRC could be effectively reduced through regular colonoscopy.

2.2.1.2 Challenging cognitions

Treatment availability, and how this contributes to changing individuals' perceptions and beliefs about the uptake of health assessments and treatment, contributes significantly to challenging ones' cognitions (thought processes). Thought processes involve mental activities such as reasoning, imagining different situations and scenarios based on information presented and problem-solving, which may include making judgments about situations (American Psychiatric Association [APA] Dictionary, n.d). Similar evidence was presented in a Palestinian study by Naalweh et al. (2017), which reported improved and positive therapeutic outcomes for the patients who had received counselling and education on haemodialysis. Comparably, Tanser et al. (2013) presented information on motivating factors that positively demonstrated increased HCT uptake in their study on HIV acquisition in rural KwaZulu-Natal, South Africa. In their report, the authors showed that individuals were willing to consider undergoing HIV testing due to ARV treatment availability (Tanser et al., 2013). The study indicates that treatment options and availability may positively influence patients' willingness to undergo or receive further medical treatment.

2.2.1.3 Behavioural modification

Human beings learn through many behavioural processes. In behavioural modification, behaviours are changed to avoid undesirable outcomes. Through this process, change occurs through a series of different procedures. For example, in healthcare, one of the most common risk behaviours is smoking.

Smoking is a behavioural risk factor and plays a role in predisposing a person to many illnesses and developing cardiovascular diseases (Brennon et al., 2014). Since smoking remains one of the leading contributors to cardiovascular deaths across the world (Akanbi et al., 2019; Lindson et al., 2019), quitting smoking is an intervention that can be implemented through a counselling programme. Support for this premise was also found in a systematic review and meta-analysis

study by Bartlett et al. (2014). In their analysis, the investigators reported that specific behavioural change techniques for smoking cessation such as action planning, self-recording, giving advice on methods of weight control, as well as advice on the use of social support proved to be useful for people with chronic obstructive pulmonary disease (Bartlett et al., 2014).

2.2.1.4 Problem-solving and informed decision-making

As described above, in general, patients have greater autonomy over environmentally pre-determined lifestyle choices. However, the case of genetic predisposition is somewhat different. One being biologically predisposed to a chronic medical illness may present significant psychological distress as this is less of a choice for the affected individual. Studies (Keller et al., 2008; Ramani & Kathriarachchi, 2011) on medical counselling interventions and education have shown that patients can still exercise some level of psychological autonomy and choice in their behaviours in managing their medical conditions. Keller et al. (2008) conducted a study among suspects of familial colorectal cancer (CRC) and found a decline in the indicated levels of anxiety, distress specific to familial CRC and general worry over cancer, following a multidisciplinary risk counselling programme. This finding reports the role counselling has as an opportunity for patients to evaluate options and make informed decisions. Through counselling, practical problem-solving possibilities are generated for patients to explore. These psychological processes attempt to resolve and minimise psychological distress, and may contribute positively to effective coping with a chronic illness.

Apart from the personal benefits of counselling to patients suffering from a health condition, counselling can increase the support family and significant others provide to patients. This is especially the case for HCT interventions, specifically post-HIV testing, where patients and counsellors engage in the process of evaluating the availability of support resources to facilitate disclosure, promote adherence and compliance (National Department of Health, 2015).

2.2.2 Level 2: Counselling following the diagnosis of a disease

Knowing what awaits one when they are diagnosed with a severe illness is important for initiating treatment and adherence of patients on therapy. In diagnosing a health condition, the information given may assist the patient in preparing for the diagnostic results. This may also

facilitate practical problem-solving and patients' ability to draw from available resources to cope with the medical diagnosis.

2.2.2.1 Address coping skills

In counselling, personal resources and various other external sources of support allow individuals to avoid and minimise stress (Brennon et al., 2014), which may be beneficial, particularly when one is diagnosed with a severe illness. Coping skills are sets of strategies that can be cognitive or behavioural that individuals utilise to reduce any possible adverse outcomes resulting from a challenging situation (APA, n.d.). Skoogh et al. (2013) provided evidence on psychological distress experienced at diagnosis of their Swedish testicular cancer survivors. Notably, two-thirds of the study population reported not being informed and not given information on psychological reactions such as in crises and possible stress reactions (Skoogh et al., 2013). Furthermore, the study concluded that 61% of its participants would have liked to have been offered counselling at diagnosis. Such interventions can assist patients in taking charge and being responsible for the management of their health condition.

2.2.2.2 Empowering patients with life-threatening health conditions

The same principles described above of providing information, conducting a risk assessment and utilising evidence-based interventions with patients should apply to severe, if not all, medical conditions. In a research review of diabetes management, there was a report of positive self-management behaviours by patients (Steed et al., 2003). In these studies, changes in behaviour over time occurred more among the intervention groups that received counselling interventions compared to the control groups. The differences noted were in diet and exercise improvements among these patients, both of which are significant components in managing this chronic and potentially life-threatening illness (Steed et al., 2003).

The findings of these studies suggest that counselling strategies that equip patients with opportunities to be empowered and choose effective disease management methods could improve patient care. In addition, one of the benefits of counselling interventions can be found in self-help and management strategies (Werth et al., 2008), where patients, with the assistance of counsellors, learn better ways to manage symptoms related to illness and by continuing to engage in those behaviours can alleviate, for example, pain and other physical symptoms.

2.2.3 Level 3: Counselling in the management of a disease

Evidence shows the considerable efforts of counselling to promote good health in patients with chronic health issues (Amanullah & Firdos, 2018). Psychological interventions, including counselling, have been shown to improve emotional well-being and contribute positively to better coping mechanisms, as well as the survival of patients with chronic diseases (Brennon et al., 2014; Smith et al., 2005). Furthermore, through patients' psychological support (National Department of Health, 2015), future psychological needs can be identified to assist patients throughout their medical illness (Amanullah & Firdos, 2018).

2.2.3.1 Improving psychological functioning

In a study of cancer patients, counselling interventions were shown to target psychological issues such as depression and anxiety and led to the inclusion of such interventions in integrative and comprehensive oncology services (Brennon et al., 2014; Smith et al., 2005). Smith et al. (2005) reported that mindfulness as a psychological intervention was a useful tool in patients living with cancer. In mindfulness, patients are guided through a process that encompasses relaxation to increase awareness of their perceptions and negative thoughts (Shapiro & Carlson, 2009). Through this practice, patients are encouraged to concentrate on these thoughts objectively. Through this process, the individual can gain insight into how they see the world and manage their unpleasant and disturbing thoughts effectively. In managing chronic diseases, patients require support and guidance in learning to adapt and adjust their life accordingly given the presence of impaired functioning, most chronic illnesses bring.

2.2.3.2 Providing emotional support

Stress, which is a common psychosocial complaint of users in general healthcare, is a component that impacts the psychological health of patients diagnosed with severe medical conditions (Amanullah & Firdos, 2018; Karademas, 2009) and may impair functioning. Although this component has not been given enough attention in many medical practices (Karademas, 2009), it has been linked, among others, to increasing the risk of mortality in patients with coronary heart disease (CHD), as reported by Pogosova et al. (2015). In their conceptual research, Pogosova et al. (2015) analysed psychosocial risk factors related to CHD. They proposed that psychological support should be a component of these services as stress and poor psychological health of patients with CHD are associated with adverse clinical outcomes of these patients (Pogosova et al., 2015). This kind of intervention and support for patients utilising chronic healthcare services may be especially relevant in follow-up care.

2.2.3.3 Identifying future psychological needs

Patients diagnosed with severe medical conditions may require further ongoing psychological management (WHO, 2015a). Depending on the nature of the medical condition and its severity, psychological counselling should be considered in all patient care (Amanullah & Firdos, 2018; Kaptein & Weinman, 2004). Psychological needs in follow-up and future care of patients are essential, not only to better manage chronic and severe diseases but also to provide patients with opportunities to address and improve the quality of their lives (WHO, 2015a). Counselling interventions play a central role in risk reduction and the improvement of patient emotional well-being, regardless of the severity of an illness (Amanullah & Firdos, 2018). For example, in HCT, the availability and initiation of ARVs, which is often accompanied by follow-up counselling, have also proved to lead to ARV-induced behavioural changes, as observed in individuals who have decreased sexual risk-taking behaviour due to optimism related to access to ARV treatment and its long term benefits (Tanser et al., 2013). Such ongoing counselling and support can also assist the patient in adopting a positive attitude to living life with HIV (UNAIDS, 2014a).

Thus far, the discussion indicates that counselling contributes to adequate healthcare provision within the prevention, diagnosis and management of medical and health conditions.

What this highlights is the applicability of counselling not only to one level of healthcare but throughout health conditions and illness. Of importance is the careful consideration of the desired outcomes, particularly the inclusion of counselling within healthcare interventions. Although briefly mentioned in the previous discussions, the next section will focus on counselling processes provided by LCs within HIV/AIDS services.

2.3 The HIV Counselling Process

Counselling in HIV is a process between a patient and a counsellor, intending to enable the patient to gain information, make informed decisions regarding their medical care, management and support. In HIV services, counselling is incorporated with HIV testing. Although at the outset, counselling was a minimal process in VCT services (WHO, 1994), it soon became an establishment of dialogue between patient and counsellor aimed at preventing HIV transmission and for provision of psychosocial support to those affected by HIV (Richter et al., 1999). In practice, counselling provided by LCs in the context of HCT is unidirectional (Dewing et al., 2013) and takes the form of information-giving as opposed to being problem-focused and client-centred (Richter et al., 1999). In the following section, the conditions, structure and aspects of HIV counselling are discussed. Although the focus of the current study is on the LC as the primary provider of HIV counselling within public healthcare, the counselling interventions to be discussed are general and not specific to any healthcare worker/provider.

2.3.1 The goals of HIV counselling

Formally known as Voluntary HIV Counselling and Testing (VCT), HCT is a process that was initially used as a strategy to offer HIV testing and is now an intervention that is considered necessary in entry point HIV prevention and care services (UNAIDS, 2000). HCT is intended to determine the individual's HIV status (National Department of Health, 2015). Furthermore, HCT helps to prevent HIV acquisition and transmission (National Department of Health, 2015). It is a process that can activate change in HIV uninfected individuals through risk reduction counselling, which incorporates behavioural modification information and skills such as a reduction in the number of sexual partners, increased and consistent condom use, safer injecting practices and management of sexually transmitted infections (WHO, 2015a).

At the outset, counselling was a minimal process in VCT services (WHO, 1994, 1997), but is now recognised as an essential aspect that facilitates the processes in HIV diagnosis, management and treatment of HIV/AIDS (National Department of Health, 2015; UNAIDS, 2017a; WHO, 2015a). Counselling is a psychological process that requires more than one session where the patient's needs should be a priority (WHO, 2015a). Furthermore, counselling standards require a comfortable environment and space to encourage and facilitate counsellor-patient interaction (Meehan et al., 2015).

2.3.1.1 Conditions of effective and quality HIV counselling

In HCT services, healthcare facility-based counselling and testing are still the more preferred and common choice of the counselling environment, although it has its advantages and disadvantages (Meehan et al., 2015). Services offered in these settings may pose challenges, such as providing counselling with full confidentiality (Harichund et al., 2019). However, these formal settings, which include clinics, hospitals, and health centres, continue to be a common location for receiving HIV test results (MacCarthy et al., 2014). In the last two decades, there has been an increase in the accessibility of HCT services in pre-urban and rural areas through providing and offering the service in non-formal environments such as people's homes, mobile clinics and other far and hard to reach populations and settings (Naidoo et al., 2018).

Barriers in the facility, as well as community-based HCT services, have been reported (Bukenya et al., 2020, Harichund et al., 2019; Mulongo et al., 2011; Naidoo et al., 2018) interventions. In 'Project Accept (HPTN 043)', the authors (Khumalo-Sakutukwa et al., 2008) reported fear of being labelled as HIV positive by community members and losing support from loved ones as one of the barriers to the study's community-level HCT service. The findings are consistent with those from Mulongo et al. (2011). Also, the risks home-based HCT pose to women, particularly, is the possibility of the violent consequences they might face in the hands of their partners should they come to know the women's risk or HIV status (Mulongo et al., 2011). In comprehensive HCT processes, patients who benefit from on-going community-based care still need to access nearby facilities. In developing countries such as South Africa, HCT services face challenges of being inaccessible due to patients' inability to travel to nearby healthcare facilities due to financial costs and time.

From a scientific programme implementation strategy (Harichund et al., 2019), community-level HCT can increase HCT coverage of services (Bukenya et al., 2020; Naidoo et al., 2018). In this case, financial costs for travelling could be a potential barrier, coupled with the patients' fear of being stigmatised. As a result, patients may choose to use facilities far from geographical areas where they could potentially be identified by fellow community members (Bogart et al., 2017; Naidoo et al., 2018), leading to increased financial constraints. Furthermore, counselling, as part of HCT services, has been extensively used. It has proved to be a useful tool in addressing the social structures that inform how community and group norms and behaviour regulate social practices (Naidoo et al., 2018) that influence an individuals' decision to engage in risky sexual behaviour (Young et al., 2010). For instance, HIV counselling has been used as a platform that allows an opportunity to challenge social norms, including morals, taboos, beliefs and laws (Khumalo-Sakutukwa et al., 2008; Young et al., 2010). A noticeable strength of community-based HCT services is its ability to reach and be highly acceptable among key populations, as Govindasamy et al. (2015) found in the study they conducted. Furthermore, community-based HCT has been able to identify those in earlier stages of HIV infection, which has improved linkage to care (Govindasamy et al., 2015; Mabuto et al., 2014). Mabuto et al. (2014) highlighted a higher uptake of HCT among men in their community-based HCT urban mobile units study.

When providing HCT services, it is also essential to understand the multi-disciplinary structures that form part of HCT services. Availability and access to appropriate systems of referral are therefore required. For the benefit of the patient and their HCT process, counsellors often have to refer patients to service providers with special/expertise skills (National Department of Health, 2015, 2016a). This, however, still requires maintaining confidentiality and keeping patient records private. Additionally, LCs need to have access to work-related supervision and support to identify situations where patients might require specialised care. In most healthcare professions, continuous supervision and guidance are necessary to ensure healthcare workers remain within the required ethical boundaries (Act No 56 of 1974). Aspects of ethical behaviour might include establishing relationships with patients outside the counselling relationship and self-disclosure (Ridley et al., 2011b). Self-disclosure is a controversial issue. According to Okun and Kantrowitz (2007), self-disclosure guidelines must first and foremost ensure that the counsellor's self-disclosure should be for the patients' benefit.

Thus, the counsellor should not burden the patient with his/her problems but need to regulate the quality and timing of the self-disclosure to assist the patient to focus more on his/her concerns and to encourage exploration and understanding of the situation (Ridley et al., 2011b).

Following what has been presented on the goals and conditions required in HIV counselling, the next section will explain the HIV counselling stages.

2.3.2 Stages of the HIV counselling process

HIV counselling comprises prevention counselling, pre-HIV test, post-HIV test and follow-up or on-going counselling. The different levels do not sequentially follow each other but are provided according to patients' needs.

2.3.2.1 Preventative and information-based HIV counselling

Counselling for HIV prevention should not be confused with HIV prevention. In HIV prevention services, the aim is to provide biomedical approaches to prevent acquisition and transmission of HIV (UNAIDS, 2016b). Biomedical programmes may include, for example, PMTCT, Pre-exposure Prophylaxis (PrEP) (Bekker et al., 2016) for individuals at risk of contracting HIV, VMMC (Kaufman et al., 2018), condom distribution and needle-syringe programmes for drug users (UNAIDS, 2010a). Counselling in HIV prevention aims to provide HIV information and risk management. Group designed programmes targeted at masses, and groups of individuals have shown improvement in behavioural changes related to sexually risky behaviour amongst different individuals and communities (Coates et al., 2014). Also, counselling for prevention basis augments HIV/AIDS education by making it personally applicable and relevant (UNAIDS, 1997). In many countries, including South Africa, HCT programmes have vigorously promoted and disseminated information through mass media (e.g., radio, television, billboards and posters). Mass media has increased HCT in the short term (Vidanapathirana et al., 2005). These services should be age-appropriate to ensure comprehension depending on conditions and availability of resources. HIV information can also be presented in waiting areas in health and community-based facilities (WHO, 2015a). Although HIV testing has become a simple, quick and affordable process (Harichund et al., 2019), it is not always readily available.

Even with the unavailability of HIV testing services in some resource-poor settings, counselling for HIV prevention purposes can still produce a desired behavioural modification in individuals at risk of contracting HIV (UNAIDS, 2000). In addition, assessing the need for testing, developing an HIV risk reduction plan and implementing behavioural interventions prescribed for pre-HIV test counselling can be achieved in preventative services (UNAIDS, 2016b). In their investigation of more than 8 961 participants, Cawley et al. (2014) found moderate associations between VCT use and reductions in some sexual risk behaviours among HIV negative participants. These encouraging findings reported that participants reduced the number of sexual partners and moved to safer types of partnerships (Cawley et al., 2014). Due to the needs and demands of HIV services, this might not always be possible. Coates et al. (2008) explained limitations to HIV prevention as being limited in form, the number of sessions and taking the form of an information-based approach instead of engaging with the patients. Despite this, some countries have consistently applied a combination of HIV prevention strategies that include counselling, subsequently implementing various behavioural, biomedical and structural packages explicitly tailored for crucial populations (UNAIDS, 2016b). For example, in high prevalence countries, counselling for prevention among young people has included behavioural interventions such as the use of preventative measures (condoms), sexuality education and access to sexual and reproductive services without prohibitive barriers (e.g., parental laws) (WHO, 2015a). A combination of these interventions has been reported to positively contribute to HIV information and HCT accessibility amongst the youth populations (UNAIDS, 2016b).

2.3.2.2 Pre-HIV test counselling

This form of counselling applies to those that have never tested for HIV, have no knowledge of their HIV status or/and tested HIV negative previously and have come for a follow-up HIV test post the window period (Van Dyk et al., 2017). In pretest counselling, the WHO (2015a) proposed the five Cs (**C**onsent, **C**onfidentiality, **C**ounselling, **C**orrect test results and **C**onnection) as foundational components for all HCT service approaches. Pre-HIV test counselling is the initial point to access individualised and personal HIV counselling services. Counsellors and all healthcare professionals providing HIV counselling should ensure patient confidentiality (WHO, 2015a). Information can be shared with significant others, with the patient's consent, especially if it is beneficial for the patient (WHO, 2015a) and in a safe and private environment (Mabuto et al., 2014).

Pre-HIV test counselling focuses on HIV/AIDS information/knowledge, behavioural (sexual health, including the risk of sexually transmitted infections) risk assessment, the HIV test (explaining the HIV test and how it is done), its benefits and the management thereof should a test indicate an HIV positive result (National Department of Health, 2015). The latter can also be discussed in posttest counselling. An assessment of other situational determinants can also include the use of alcohol and recreational drugs when engaging in risky sexual behaviours (WHO, 2015a). The details provided in the pre-HIV test counselling should be concise and transparent, and the information should include the benefits of counselling, the meaning of an HIV negative and positive result, the potential of a false HIV result for those on ARV treatment, sexual partner testing, confidentiality, disclosure, stigma, how not testing will not affect access to other healthcare services and an opportunity to ask the counsellor questions (WHO, 2015a). Also, pre-HIV test counselling remains an intervention with an objective of behavioural risk assessment (Kanekar, 2011), which may lead to incorporating behavioural modification interventions. Upon identifying other risks, Baral and Phaswana-Mafuya (2012) proposed the need to move beyond individual risks in acquiring HIV. In their conceptual HIV risk model, they suggested that individuals should include the social-sexual risks, community norms and values, as well as public policies. The individuals could be MSM, with the social and sexual risks being sexual networks; the bigger the system, the more opportunities exist for exposure. Community norms and values could include stigmatised same-sex practices that lead to a lack of access to HCT services. Finally, public policies include the criminalisation of homosexuality and MSM practices. Nonetheless, pre-HIV test counselling would still need to offer patients an opportunity to assess whether they have exposed themselves to situations that put them at risk of contracting HIV (National Department of Health, 2015).

Opportunities to discuss ways in which an individual can cope with their HIV status and correcting myths and misinformation about the subject of HIV/AIDS are some of the topics addressed in pre-HIV test counselling (UNAIDS, 1997). Tanser et al. (2013) argued that one of the motivating factors for increased HCT uptake in their study could have potentially been the availability of ARVs to participants. Information about the availability of ARVs and its benefits as a long-term treatment option is usually provided and discussed with the patient during pre-HIV test counselling and further strengthened upon receiving positive HIV test results (WHO, 2015a).

Phakathi et al. (2011) found a mutually reinforcing relationship between HCT and ARV treatment, offering insights on how patients' perceptions, views, meanings about ARVs as treatment for HIV/AIDS could have led to their decisions regarding getting tested for HIV. Assessing the level of support and availability of support for patients upon receiving their HIV test results is essential (UNAIDS, 2000). Establishing the presence of these systems can further assist the patient in identifying significant others to whom they would most likely disclose their HIV status (UNAIDS, 2000). With the patients' consent, counselling can incorporate family interventions where spouses, sex partners and family members are invited based on shared confidentiality (UNAIDS, 1997). This can address issues related to perceived stigma and access to support from these systems (Naidoo et al., 2018), thus facilitating appropriate coping mechanisms and improving psychological functioning.

2.3.2.3 Post-HIV test counselling

This form of counselling concludes an HIV test process. In the post-HIV test counselling session, the counsellor prepares the patient for their test result (UNAIDS, 1997). The posttest details and format focus on communicating the HIV test results, and UNAIDS (1997, 2015a) recommends that when the patient receives the test results, it should be combined with counselling. The counselling should respond to the patient's personal needs and circumstances. This form of counselling should be client-centred; a form of counselling that focuses on understanding the needs and concerns of the patient (WHO, 2015a). The counsellor provides information related to the patient's HIV test result and, if required, referral to other care systems (UNAIDS, 2000, 2015a). In cases where individuals have tested HIV negative, the possibility of a window period is discussed with them, highlighting the need for an individual to re-test after a certain period (UNAIDS, 2000). The recommended WHO guidelines stipulated 12 weeks or three months as a reasonable time frame to retake an HIV test (WHO, 2015a). This recommended retesting is for individuals thought to be in the window period and who reported recent HIV risk encounters (WHO, 2015a). Counselling for those who test HIV negative should always include a clear description and explanation of the results, education on preventative methods (e.g., condoms, lubricants), emphasis on the importance of knowledge about sexual partners' HIV status and the availability of couple HIV counselling and testing (CHCT), as well as referral and linkage to other relevant preventative services (VMMC for HIV negative men, Post Exposure Prophylaxis (PEP) and PrEP for those with on-going risk) (WHO, 2015a).

When an individual's HIV test results are positive, the posttest counselling interaction and conversation between counsellor and patient should focus on the counsellor providing emotional support and identifying future psychological needs (Van Dyk et al., 2017). The type of information discussed should focus on prevention (for HIV negative test results) and on an individual's capacity to make an informed decision regarding protection. The counsellor can discuss condom-use and family planning (reproductive health matters) as part of prevention and protection techniques (UNAIDS, 2000). This counselling focuses on forms of treatment, care and management (Van Dyk et al., 2017). Everyone who tests HIV positive, including couples where only one or both are diagnosed HIV positive, should receive post-HIV test counselling (WHO, 2015a). This type of counselling offers an opportunity for an individual to address some of the psychological concerns the news of an HIV seropositive result may bring. Counselling can be beneficial for the patient. Marum and Baggaley (2013) reported post-HIV counselling to moderately affect patients' sexual behaviour change. The authors encourage intensive counselling and a follow-up for patients who test HIV positive to initiate treatment and care timeously. The main elements of post-HIV test counselling also need to include giving the patient time to cope with the news; in the case of psychological distress, a follow-up counselling session might be offered (National Department of Health, 2015). Addressing patients' concerns, providing information on ARV treatment and its benefits in management and preventing HIV transmission to partners and unborn child/infants (in cases of pregnant and breastfeeding women) and making referrals (WHO, 2015a), also form part of this intervention.

2.3.2.4 Follow-up or on-going counselling

This form of counselling addresses issues that ongoing communication about HIV test results. Those who tested HIV negative can receive assistance from a counsellor in how to adopt and maintain new, safer sexual behaviour practices (UNAIDS, 1997, WHO, 2015a). Once an individual tests HIV positive, further medical investigations need to be administered (WHO, 2015a), which includes referrals of the HIV-infected patients to healthcare professionals to assess their HIV infection stage and to determine their suitability for ARV treatment initiation (National Department of Health, 2015). Also, follow-up counselling and counselling that forms part of ARV treatment services can affect stigma positively (Fatti et al., 2012; Tanser et al., 2013). Observed in their study's participants, Phakathi et al. (2011) reported how the restoration of health as experienced by HIV positive individuals who were expected to die could have led to stigma reduction, a phenomenon previously reported by Roura et al. (2009).

The availability of ARVs increased VCT uptake and reduced stigma by normalising HIV/AIDS (Roura et al., 2009). Furthermore, disclosure, its benefits and disadvantages can be discussed, which will help alleviate the perceived stigma-related stress that accompanies the HIV positive results and assist patients in drawing support from loved ones, thus increasing adherence to ARV treatment (Fatti et al., 2012).

The counselling process requires that counsellors understand the different needs to engage patients in understanding their HIV/AIDS service requirements and how to manage their HIV/AIDS condition adequately. The next section details the different needs and forms of counselling within HCT services.

2.3.3 Forms of HIV counselling

Counselling outcomes are predetermined and guided by patients' needs (Ridley et al., 2011b). Variables such as patients' age, problem/context and other special needs inform the type of HIV counselling to be administered.

2.3.3.1 Voluntary counselling and testing

An ideal counselling process involves only the counsellor and patient (Karademas, 2009). In HCT, this counselling should be voluntary and provided in a non-stigmatised environment where HCT services include pre-HIV test counselling, informed consent for HIV testing and post-HIV test counselling (UNAIDS, 1997, WHO, 2015a). This type of counselling without informed consent and confidentiality is discouraged by UNAIDS (1997) and WHO (1993) as it is a violation of human rights (UNAIDS, 1997; WHO, 1993). Also, individual counselling may be influenced by patients' expectations and their preferences within the context of HCT services (National Department of Health, 2015).

2.3.3.2 Provider-initiated testing and counselling

Counselling should not be a forced procedure in healthcare. With provider-initiated testing and counselling (PITC), the WHO (2007a) set out guidelines to encourage and increase HCT services' uptake among patients and populations at risk.

However, with the challenges HCT services face, PITC is now offered to all patients who present with STIs, viral hepatitis and TB, including children under the age of five years who are utilising immunisation, malnutrition services and women making use of antenatal services. Notwithstanding the prevalence of HIV in any given geographical setting, PITC is recommended as an effective and efficient way of increasing HCT operations. As set out in the WHO Provider Initiated Testing and Counseling Guidelines (2007a), it can also improve HCT services.

2.3.3.3 Individual HIV counselling and testing

Generally, there should be mutual trust, genuineness, congruence and respect in a professional counselling relationship (Rogers, 1957). These elements help to create a helping environment in this particular counselling relationship. It is important to remember that in counselling, even in HIV counselling, individuals need to be provided with a comfortable environment that will help explore their beliefs, knowledge and values. Because this process may leave patients exposed and vulnerable, individual sessions might lessen their vulnerability. Holmes and Kivlighan (2000) compared individual and group psychological interventions. Their findings indicated that emotional awareness, which increases insight and problem definition and change, was more prominent in the individual process compared to group processes (Holmes & Kivlighan, 2000). Nonetheless, the concepts of counsellor effectiveness and competence (Ridley et al., 2011b), which will be discussed later in the thesis, should universally apply to any form of counselling, be it individual or group.

2.3.3.4 Group HIV counselling and testing

Counselling more than one individual puts confidentiality and the ability to allow patients to go through their emotional states in private in jeopardy. Due to the nature of HCT information and processes, group counselling might not always be feasible, as the group context may influence the dynamics of a counselling interaction. However, when providing counselling for education purposes and in contexts other than HCT, group counselling should be considered. In a study about youth at risk of Type 2 diabetes in Finland conducted by Logren et al. (2017), the group members' questions and participation in a health education programme influenced group interaction and positively directed and guided the counselling process.

The group of youth participants received health education from teachers who focused on participation, empowerment, and agency as processes of support in successful health promotion (Logren et al., 2017).

2.3.3.5 Couple HIV counselling (CHCT)

HIV/AIDS is unique from other medical conditions discussed thus far, as it carries with it the sexual form of transmission. Counselling for HIV that is offered to couples and individuals in sexual partnerships is effective (Allen et al., 2007). It promotes mutual disclosure of HIV status and increases the adoption of prevention measures, especially in discordant couples (one HIV-positive and one HIV-negative partner). Furthermore, HCT for couples can provide benefits such as a reduction in STIs and unplanned pregnancies among couples (Eyawo et al., 2010). In their study, Eyawo et al. (2010) evaluated the counselling setting for couples (patients). They found that counsellors were engaged and created a discrete environment that facilitated and eased the conversations around fear, stigma and sexual health concerns of the couples. In CHCT in South Africa, there are a few aspects to consider, given that the majority of HIV infections in South Africa are transmitted through heterosexual sex (Shisana et al., 20l4; Simbayi et al., 2019). Partner risk, HIV knowledge, prevention and engaging male partners are the key aspects discussed in the section that follows.

2.3.3.5.1 Partner risk assessment

With HCT, sexual partner risk assessment forms part of the HCT service (WHO, 2015a).
This form of counselling opportunity allows the individual partners to assess their risk when they engage in sexual and other behaviours that pose a risk of contracting or transmitting HIV (WHO, 2012). Furthermore, counselling services can be highly beneficial to couples and people in partnerships who engage in high-risk sexual and drug-related behaviour (UNAIDS, 1997). The advantages of couples HCT apply to all couples, whether they have the same HIV test results (seroconcordant) or different HIV test results (serodiscordant) (WHO, 2012). Couples undergoing HCT together can be assisted in addressing misunderstandings related to who contracted the HIV first and with issues that might arise, such as multiple sexual partnerships. This could be beneficial, especially for female partners who might have to face the consequences such as violence from their male partners.

The couple testing (or sharing their HIV tests results in a facilitated and controlled counselling process together) can be supported in making informed decisions about HIV prevention, access to treatment and the role ARVs plays in preventing HIV amongst serodiscordant couples (WHO, 2012).

2.3.3.5.2 Partner knowledge of HIV status

Previous data indicate a large proportion of new HIV infections in generalised epidemics, especially within serodiscordant relationships (UNAIDS, 2016a). Individuals in these partnerships are unaware of their HIV status and therefore pose a transmission risk to their HIV uninfected partner (WHO, 2012). In a Zambian study conducted by Allen et al. (2003), the transmission of HIV to a partner in a stable relationship was reported to account for 87% of new HIV infections in the HIV negative partner. Sub-Saharan Africa remains an area with the highest HIV concentration in the world (UNAIDS, 2014b, 2016a, 2019), with three-quarters of individuals aged 20-49 years reported to be in cohabiting relationships (Eyawo et al., 2010) and with the largest number of HIV serodiscordant couples (Chemaitelly et al., 2012). This information proposes that HIV knowledge amongst partners in a relationship should be important and addressed. The lack of knowledge of one's HIV status puts one in a vulnerable position. People who know their HIV status are likely to adopt preventative behaviours, and couples who undergo HCT processes together are more likely to adopt beneficial behaviours that can protect themselves and their partner than those who test alone (WHO, 2012).

Provision of ARVs to the HIV positive partner can significantly decrease the risk of HIV transmission to the negative partner, and provision of ARVs to the negative partner (pre-exposure prophylaxis) can potentially prevent HIV acquisition (Bekker et al., 2016). A study involving 1 219 young heterosexual Botswana men and women showed that the daily oral drug regime of PrEP prevented HIV infection among heterosexual men and women (Thigpen et al., 2012). Also, knowledge of each partners' HIV status and sharing the results can benefit the partnership, and the support within the relationship can increase the need to access and adhere to ARV treatment, as well as increase the use of interventions in preventing mother to child transmission (PMTCT) (WHO, 2012).

2.3.3.5.3 Partnership preventative measures

Partners and couples can benefit from counselling, which would help them consider all options when using preventative measures such as consistent and correct use of male and/or female condoms. This was reported in a study by Rosenberg et al. (2013). They found CHCT increased consistent condom use from baseline levels of 71% of unprotected sex to one-month post-evaluation levels of 26% following an HIV uninfected partner learning their HIV status. Furthermore, initiating lifelong ARV use for the HIV negative partner can potentially raise concerns regarding one's health, and this is an issue that could be addressed in couples counselling. Failure of serodiscordant couples to initiate ARV as a prevention method has been documented in a Kenyan study by Kahn et al. (2012). Some of the barriers identified in their research included perceived adverse effects of ARV use by the HIV negative partner, regular clinic attendance, and perceived stigma. Similar findings have been reported by Patel et al. (2016). Furthermore, healthcare providers were concerned that such strategies could potentially lead to an increased risk of sexual practices (Kahn et al., 2012).

2.3.3.5.4 Engaging male partners

HCT for couples aims to increase the involvement of male partners in health-related issues, as it tends to be low (Peltzer & Davids, 2011). In HCT services, male involvement is shown to positively contribute to the PMTCT of HIV (Morfaw et al., 2013). Furthermore, CHCT can increase the participation of men in HCT programmes and address gaps and delayed health management, including ARV initiation experienced by this group. This could increase life expectancy and decrease the high mortality rates reported in findings such as the 'Mass HIV Treatment and Sex Disparities Surveillance' (Bor et al., 2015) amongst HIV positive men. In addition to engaging men in the HCT services, such operations also incorporate services for specific groups and specialised interventions, which will be discussed in the following section.

2.3.3.6 Counselling for special circumstances and populations

WHO (2015a) recommends that healthcare settings provide inclusive, individualised and non-discriminatory HCT for critical populations and specialised interventions.

2.3.3.6.1 Prevention of mother to child transmission (PMTCT) counselling

Females who are within their reproductive years and planning to fall pregnant and/or are pregnant can benefit from HCT services. Those that plan to have a child might decide against it once they know their HIV status. In South Africa, pregnant women could benefit from considering termination of pregnancy where it is legal, available and possible. (National Department of Health, 2015) The earliest UNAIDS (1997) policy guidelines on PMTCT encourage counselling that provides pregnant females and those that have given birth with information on reproductive and infant feeding options, including the use of ARVs to reduce vertical transmission of HIV to the child (UNAIDS, 2000). Where possible and with their consent, a female patient should be encouraged to involve their male partner. Male partner involvement in female patients' HCT processes was also shown to increase the women's ability and motivation to access PMTCT interventions (WHO, 2012), which further encourages CHCT in antenatal and PMTCT care services.

2.3.3.6.2 Voluntary medical male circumcision (VMMC) counselling

In many countries where circumcision is a practice, VMMC is a strategy that has yielded positive HIV prevention results. South Africa is one of the African countries that has adopted VMMC to address HIV/AIDS (Shisana et al., 2014; SANAC, 2011). This followed numerous studies which indicated VMMC to be a useful measure in reducing HIV transmission (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). Male sexual health has been an issue that carries concerns. In their study, Humphries et al. (2015) highlighted this finding and also found that masculinity and male sexual identity are social and structural factors that can be addressed in counselling men, as they can be potential barriers to VMMC and HCT (Humphries et al., 2015).

2.3.3.6.3 Counselling children

HIV/AIDS has had devastating effects on infected adults and their loved ones, including children. Children who have been affected by and infected with HIV might require special counselling.

The emotional trauma that may accompany the child's emotional state and readiness, their willingness and understanding of why they have to undergo an HIV test can be challenging for the counsellor. These children could have possibly witnessed their parent(s) ill health and possibly death due to HIV. As such, they might have faced being discriminated against by other children and adults and now have to possibly face challenges and worries about their health (UNAIDS, 1997). Adolescents might require more comprehensive HCT services, which need to include sexual and reproductive health care (United Nations Children's Fund [UNICEF], 2015). HIV prevalence amongst children remains proportionally high (UNAIDS, 2016a), and structures are needed to implement clear guidelines considering the needs of children, some of who might be orphaned and under guardianship (UNICEF, 2016). Kranzer et al. (2014) highlighted the need for HCT services to promote PITC services, train counsellors and increase awareness of the risk of HIV infection among asymptomatic children. Also, Brouwer et al. (2000) suggested the inclusion of counselling guardians/caregivers of HIV-infected children and providing psychological support to this population as an element of HCT services for HIV infected children.

2.3.3.6.4 Counselling for injecting drug users and commercial sex workers

Population groups in society are affected differently by the HIV epidemic. In individual communities, certain groups are vulnerable to HIV for various reasons and may require individualised HCT strategies. These groups include injecting drug users and sex workers. These population groups are identified as critical populations that need special HCT services (UNAIDS, 2016a). Biological, behavioural and socio-structural factors contribute to the low uptake of HCT amongst these key populations (UNAIDS, 2016a). Ameyan et al. (2015) conducted a study on female sex workers in Addis Ababa, Ethiopia and identified several barriers, such as not being in possession or owning an identity card. In Guatemala, some barriers identified in the uptake of HCT included social norms and certain perceptions of male and female sexuality despite increased awareness of the risk of HIV among female sex workers (Lahuerta et al., 2013). Globally, HIV prevalence differs in demographics. For example, in countries where injecting drug users (IDU) are vulnerable to HIV-infection, the focus of HCT has been on providing options that would protect and manage the HIV epidemic amongst this population (UNAIDS, 2016a). The most prevalent of these strategies reported in studies include needle exchange and HCT home service practices (Wodak & Cooney, 2006).

From the literature presented thus far, LCs require specific skills and competencies that are based on an understanding of human behaviour. Psychological theoretical frameworks that inform human behaviour in the context of HIV/AIDS will be the focus of the next section.

2.4 Theoretical Approaches Utilised in Counselling

Theories in counselling are organised according to sets of ideas and concepts that inform how counsellors should work with patients (McLeod, 2009). Theoretical models explain behaviour, behavioural change and implications relating to changing behaviour (Prochaska & Norcross, 1999). Theoretical models assist counsellors by providing information to formulate a hypothesis about patients' health behaviour, which, in turn, guides the process of counselling by understanding elements and conditions that promote behavioural change (Karademas, 2009). The use of theoretical model guides is translated into the application of counselling approaches. Counselling approaches can be applied in different contexts and levels of counselling, for example, in the prevention, management and treatment of diseases and in identifying factors that place patients at risk of developing certain medical conditions (Amanullah & Firdos, 2018).

Psychological counselling approaches that are similar in characteristics are grouped into schools of counselling (Nelson-Jones, 2015). According to Colledge (2002), psychological approaches in counselling need to comprise four elements to be effective.

- Firstly, a fundamental assumption of patients' health behaviour underpinning the theory.
- Secondly, an explanation of various aspects of human behaviour that explains the acquisition of helpful (protective) and unhelpful (detrimental) behaviours.
- Thirdly, an explanation of factors that maintain and perpetuate helpful and unhelpful behaviours.
- Fourthly, an explanation and understanding of how to assist patients in behavioural modification and consolidate and adopt the gains post the counselling intervention (Colledge, 2002).

Furthermore, the emotional, social and economic impact of a medical illness such as HIV on a person's everyday functioning can lead to various psychological problems, adding to and exacerbating pre-existing psychological difficulties.

Amongst the most common psychological and mental illnesses found in people living with HIV and AIDS (PLWHA) are depression and anxiety (Chibanda et al., 2017; Kidia et al., 2015; Petersen et al., 2014). The use of counselling approaches such as interpersonal therapy (Petersen et al., 2014) and problem-solving (Chibanda et al., 2017) interventions have proven to alleviate mental health problems that PLWHA presents with. The following section outlines counselling approaches most commonly used in HCT services. These are based on theories mostly from humanistic, cognitive and behavioural schools.

2.4.1 Humanistic theory and counselling approaches

The humanistic theory assumes that human nature is good and human beings have an inherent quality to maintain healthy and meaningful relationships and make choices in the interest of self and others (Prochaska & Norcross, 2018). Drawing from the works of Carl Rogers (1957), Maslow (1943), Frankl (1988), for example, the focus on humanistic theories adopts a holistic approach to human existence by focusing on positive human potential (Prochaska & Norcross, 1999). Humanistic approaches utilise a wide variety of counselling interventions to conceptualise clients' case, formulate therapeutic goals and employ intervention strategies to increase clients' awareness and self-understanding. Various humanistic approaches are utilised in medical and health care services. The person- or client-centred approach is by far the most common form of humanistic counselling approach used across a wide range of health care settings, especially within HIV/AIDS services (Quiroga-Garza et al., 2018; National Department of Health, n.d.).

2.4.1.1 Person (patient/client)-centred counselling approach

Person-centred (PC) counselling holds the premise that patients have an inherent capacity for responsible self-direction (Rogers, 1959). Qualities of the therapist focus on allowing time and opportunity for the patient to present their main concerns. The counsellor attempts to create a therapeutic relationship and environment that is warm and accepting. The patient is seen as the expert of their life, and the aim is to facilitate self-actualisation. Congruence, empathy, a warm, positive and accepting attitude, and unconditional positive regard are the main elements used in the patient-therapist interaction to facilitate change. Furthermore, these counselling processes assume that growth and change occur in sessions, as well as outside the counselling meetings.

Some fundamental methods and techniques in PC counselling include '*Setting clear boundaries, Active listening, being non-judgmental, Genuineness, Accepting negative emotions'.*

In HIV/AIDS, voluntary counselling and testing refer to a patient-initiated process where a client would present themselves for HCT services based on their perceptions of HIV risk (Joglekar, 2015). These approaches allow patients to be the main drivers of the process. In such services, it is expected that strategies should be centred on exploring the patient's health and lifestyle, and while being in a mutual relationship with the counsellor, patients can be assisted in problem-solving and decision-making processes regarding their HCT journey (Quiroga-Garza et al., 2018). Lowther et al. (2018) reported a PC holistic approach used for PLWHA in Kenya to allow patients more time with counsellors. The results revealed an increased understanding and insight regarding HIV health matters in patients and offered them an opportunity to reflect (Lowther et al., 2018). Patients reported that they felt listened to and understood (Lowther et al., 2018), which, in essence, is what client-centred counselling aims to achieve (Rogers, 1959). Patients also indicated the guidance they received addressed their emotional, social and educational needs.

In South Africa, the training of LCs who provide HCT, conducted by various trainers accredited by the National Department of Health (n.d.), is mainly embedded within the PC approach (National Department of Health, 2010a, 2015). However, the ability to provide client-centred counselling remains a challenge in spaces lacking resources in facilities, staff shortages and limited consultation times (Church & Lewin, 2010; Lowther et al., 2018). This is further exacerbated by task-oriented procedures such as taking blood, drug prescriptions and routinised HCT services that often accompany HCT services (Church & Lewin, 2010). Such obstacles, in turn, limit the counsellor-patient relationship and the PC process in terms of inadequate attention to individualise and attend to patients' experiences regarding their HIV-related needs. Although widely used in HCT services (Church & Lewin, 2010; Pantelic et al., 2018; Quiroga-Garza et al., 2018), PC approaches have been criticised (Eremie & Ubulom, 2016) to have an overly optimistic view of people and that people are inherently good (Hergenhahn, 1984; Prochaska & Norcross, 2007).

Counsellors are thought to be non-directive and have limited opportunity to obtain sufficient information from patients (Corey, 2012). Nonetheless, PC approaches effectively yield better health outcomes (McMillan et al., 2013) and address the needs of patients seeking HCT services (Church & Lewin, 2010; Pantelic et al., 2018; Quiroga-Garza et al., 2018).

2.4.1.1.1 Motivational interviewing counselling approach

Motivational interviewing (MI) is a client-centred approach used to assist clients in achieving healthy behavioural changes (Miller & Rollnick, 2013) and has gained popularity in healthcare settings as it targets lifestyle changes and the management of chronic illnesses. Furthermore, MI is guided by principles similar to client-centred counselling. Counselling processes are embedded in the principles of asking a client for permission before providing information (advice), empathy and compassion, emphasising and respecting the client's autonomy, affirming the client and stressing the client's responsibility for change. Counsellors who provide MI counselling have background training in client-centred and directive approaches.

The counsellor's role is to support, encourage and direct clients in exploring issues, managing ambivalence, and enhancing motivation for behavioural change. MI is one such approach that is collaborative and encourages growth (Östlund et al., 2015). Also, MI utilises various counselling strategies to elicit and strengthen client's motivation to change targeted behaviours. These include '*Expressing empathy, developing discrepancy between clients' current behaviour and envisaged goals, eliciting motivation* (through statements of an expressed intend and need for change (change talk), *Avoiding confronting resistance* and *Supporting clients' efficacy'*.

Specific health behaviours in the treatment and management during any course of health conditions can be targeted using MI as an effective approach (Pengchit et al., 2011; Pollak et al., 2011; Copeland et al., 2015) and in HCT services (Flickinger et al., 2013; Dillard et al., 2017; Hart et al., in press; Petersen Williams et al., 2020). With access to ARV, adherence to treatment remains a challenge for the management of HIV. Motivational interviewing has proven to be a health behaviour change model of choice in ARV adherence (Dewing et al., 2015; Mokhele et al., 2019), and LCs have demonstrated that they can effectively deliver MI counselling within HCT services (Hart et al., in press; Petersen Williams et al., 2020).

As with a diagnosis of any chronic illness, an HIV diagnosis can lead to a range of problems related to the challenges the disease brings. In their study, Petersen Williams et al. (2020) highlighted that the impact of such a diagnosis could lead to mental health problems (e.g., alcohol abuse and depression) and that these can be managed through MI interventions. Although this study did not specifically target ARV adherence, it focused on possible barriers to effective ARV compliance and adherence. The young women from the Western Cape that participated in this intervention delivered by LCs found the MI-problem solving therapy beneficial (Petersen Williams et al., 2020).

Even in health communication and information-based interventions, MI effectively addresses behaviours that increase risk (Penghict et al., 2011; Hart et al., in press). In their investigation in two metropolitan areas in Canada, Hart et al. (in press) reported a significant decrease of sexual behaviours that increased risk behaviours among gay, bisexual and other men who have sex with men. This health promotion MI intervention suggests that counselling methods of this nature could be valuable, especially for high risk and vulnerable populations (Hart et al., in press). It is important to note that LCs also provided the interventions in this community-level study.

Evangeli et al. (2011) proposed that HIV counsellor training interventions, irrespective of their theoretical approach, should be followed up. In their study, the counsellors' skills in MI showed an improvement, which was attributed to factors such as individual motivation factors (e.g., staff that remained longer in their positions as HIV counsellors were more motivated to improve their MI skills continuously) and positive organisational support (Evangeli et al., 2011). Another challenge in counsellor training and practice is changing to a collaborative counsellor, which is a prerequisite in MI counselling as opposed to the traditional methods of authority and information-giver counsellor. This has also been reported in other LC studies (Dewing et al., 2015). Furthermore, this was demonstrated in a study by Östlund et al. (2015), where lack of time to practice new skills in their HCT interventions proved to be a limitation in their study sample.

Although MI has received criticism regarding its applicability in counselling (Hodgen et al., 2012; Mutschler et al., 2018), it works best with patients that participate fully. For example, it might not be effective in patients who present with depression, as these patients might have limited control over specific symptoms such as motivation and energy levels.

This may limit MIs effectiveness in such situations, as patients might not fully engage. Furthermore, MI can be a confrontational approach that can alienate patients that might not be ready to implement behavioural changes (Hodgen et al., 2012). For instance, after receiving news of a positive HIV diagnosis, patients might need time to process the information. Therefore, timing and time constraints, which include knowing when to move to the next level in the counselling process, may also need higher levels of clinical skills (Hodgen et al., 2012; Ridley et al., 2011b) and might not be feasible in HCT services provided by lay counsellors.

2.4.2 Egan's skilled helper counselling approach

Among the counselling approaches that have foundations in humanistic theories is the 'Skilled Helper' model, as proposed by Egan (1975). The model proposes that clients can explore various personal coping alternatives when they face problem situations. As with many approaches within this school of thought, there is a collaborative relationship between client and counsellor (helper); there are foundational values of respect, empathy and genuineness (Egan, 2002). As defined by Egan (1975), the process of counselling or helping entails problem-solving, which occurs through three stages. These include the exploring stage (clients focus on the current situation and key problem issues), the understanding stage (clients can start formulating goals and strategies that can be employed to achieve goals), and the action stage (plans need to be implemented to achieve change). There are various techniques and methods of application within this model. Some of them are: '*Dialogue, Empathic listening, listening to words, processing what you hear, listening to oneself, responding skills, Probing and summarizing*'.

In HCT services, Egan's skilled helper model has been used in counselling (Dewing et al., 2013). Egan's (2002) model is the foundation of LC training provided by ATTIC (one of the many NPOs that provide HCT training for LCs in South Africa), especially in ARV services. In their study, Dewing et al. (2013) analysed session recordings of 30 ARV adherence counsellors in Cape Town, South Africa. The results revealed that LCs failed to provide counselling in line with Egan's model and resorted to the traditional patient-provider role. Furthermore, client-centred core principles were also not adhered to. These findings suggest that the use of Egan's skilled helper in HCT by LCs might require more training (Dewing et al., 2013).

As proposed by the authors, the use of this approach might be more beneficial if it incorporates culturally sensitive interventions that are applicable to diverse populations (Dewing et al., 2013). Cultural sensitivity considered, HCT services need to be diverse and in line with patients' needs. Being able to remain within the set stages and tasks, according to Egan (1998), a counsellor needs to have time and an opportunity to be able to move with the patient in the realisation that they are capable of change. This process might take a day to a year, or even more, to progress. This might be feasible on a long-term basis; however, the current HCT environment calls for brief interventions. Therefore, Egan's (1998) approaches would have to be incorporated into existing services, which have prevailing time constraints.

2.4.3 Cognitive behavioural therapy and related-counselling approaches

Cognitive Behavioural Therapy (CBT) is a general classification of counselling theory that integrates cognitive and behavioural theories. It assumes that how we think (cognitions), how we feel (emotions) and how we act (behaviours) are interrelated, and all interact together. Furthermore, CBT is, in fact, an umbrella term for various classifications of CBT interventions that share some common elements (Prochaska & Norcross, 2018). The foundation of CBT is embedded in two of the earliest forms of CBT, namely Rational Emotive Behaviour Therapy, developed by Albert Ellis (1957) and Cognitive Therapy developed by Aaron T. Beck (1967) (McLeod, 2019; Prochaska & Norcross, 2018). CBT comprises a variety of procedures. Various approaches encompass CBT, such as the therapist is a trainer and helps the patient identify and focus on current problems. In this case, the therapist's role is to increase clients' ability to handle their issues. The counsellor challenges the patient, their dysfunctional thought processes and how to adapt problematic behaviour to more acceptable forms of behaviour. Current problem behaviour and the thoughts and feelings associated with the behaviour are targeted through different techniques/procedures such as '*Cognitive restructuring, Stress management training, Problem-solving, Skills training, Relaxation training,* and others.

Cognitive Behavioural Therapy aims to change what the patient does and thinks. *Functional analysis of the problem* is conducted and attainable counselling goals established and contracted on. The counselling process seeks to address the most pressing concerns and individualises patients' cognitive processes (McLeod, 2019).

There is continuous *encouragement of use, training and review of coping skills*, and practising skills learnt within sessions. *Maintaining change through the prevention of 'relapse'* situations encompasses the counsellor's ability to help the patient gain more self-efficacy, which forms part of the counselling process. The main behavioural techniques of CBT in counselling include *Relaxation training*, *Systematic desensitisation*, *Behavioural rehearsal*, *Assertiveness training* and *Reinforcement* and *Flooding* techniques. Most of the methods described above may require intense counsellor training. They might not be feasible in most HCT care settings due to the level of training and skills of a counsellor (National Department of Health, n.d.) and other structural barriers. In HCT services, CBT plays a major role across different processes. In ARV adherence, many factors have to be considered to yield good clinical outcomes for PLWHA.

In the management of chronic illness, adherence depends on taking medication and is affected by cognitive aspects such as knowledge, attitude, perception and motivation, which mediate behaviour and skills required for behavioural change (Adefolalu, 2018). When combining ARV adherence with CBT treatment for depression, depressive symptoms declined, and adherence improved (Safren et al., 2016). This is an important finding and recommended practice, as depression is often associated with poor ARV adherence among PLWHA. It is important to bear in mind that behavioural change is usually the main goal in HCT services and not necessarily a chosen counselling practice method. Therefore, other approaches, such as problem-solving therapy (PST) that focus on problem management, have yielded positive outcomes (Chibanda et al., 2017). For instance, PST adapted for local settings is an acceptable means of delivering services aimed at alleviating mental health issues among PLWHA (Chibanda et al., 2011, 2017; Mynors-Wallis, 2005). As with many cognitive-based approaches, problem identification, exploring the problem, devising an action plan, implementing the plan and following up on results are the main elements that this approach targets (Mynors-Wallis, 2005).

The CBT and related approaches described above focus mainly on the here and now and the individual patient's capacity to change their thoughts, feelings and behaviours (Petersen et al., 2014). These approaches do not address any broader problems in systems or families that often significantly impact a patient's health and well-being. In the context of South Africa, other methods of care are essential in HCT due to the socio-economic status of the population (Simbayi et al., 2019).

The HCT guidelines (Department of Health, 2015) stipulates that social aspects such as intimate partner violence, multiple concurrent sexual relations and transactional sexual encounters need to be addressed for patients to make the necessary changes. This indicates that current problems and specific issues addressed through CBT interactions need to consider these external factors that may impact the patient's ability to change. These factors are discussed in detail in Chapter 3.

To address external aspects that patients might present with, an alternative to CBT is Interpersonal Therapy (IPT), which has been found as an effective treatment for affective disorders, and its value has been shown in HCT settings (Petersen et al., 2011; Petersen et al., 2014). Interpersonal psychotherapy began as an experiment that led to a new addition to psychotherapies developed by Gerald L. Klerman and Myrna M. Weissman (Markowitz & Weissman, 2012). It is based on the assumption that the patient's psychological, biological and social context influence how they manage the psychological distress caused by adverse life events (Petersen et al., 2011). Interpersonal therapy was influenced by CBT and psychodynamic approaches as it is time-limited and structured (CBT). Also, its focus is on patients' distorted thinking concerning their significant others (Markowitz & Weissman, 2004). A randomised control trial investigation showed that ITP offered at resource-stricken facilities yielded positive results as it reduced depressive symptoms amongst the participants (Petersen et al., 2014). This treatment group-based process provided by LCs, targeted stigma and motivation and improved support amongst PLWHA receiving care at a health facility in Durban, South Africa (Petersen et al., 2014).

In addition to the significant theoretical foundations that inform counselling within HIV/AIDS healthcare services, other perspectives on approaching and viewing patients from a holistic position must be present. A multi-cultural perspective offers this view and is explained in the next section.

2.4.4 Multicultural counselling approach

One's culture and development are informed by cultural norms, values and events that determine what patients present as problems in counselling interactions. The multicultural theoretical approach is based on the premise that there is no single, universal theory of personality (Prochaska & Norcross, 2018).

The multi-cultural concept values that as populations continue to change and evolve, problems need to be contextualised to patients' circumstances (Collins & Arthur, 2010; Prochaska & Norcross, 2018). In addition, the definition of culture must expand to include other dimensions of personal identity, which do not remain static (Collins & Arthur, 2010). In the multicultural context, a counsellor endeavours to reveal his or her values and allows the client to relate to them as a person (Prochaska & Norcross, 1999). This approach enables individual patients to build their strengths and inner resources toward higher self-esteem and personal empowerment.

Cultural sensitivity and multiple perspectives are used to understand and assist the patients in managing their problem. Same-culture counsellors are seen to influence the success of counselling. In multi-cultural counselling, fundamental principles exist that need to be met to facilitate behavioural change and the individual uniqueness of every patient (Prochaska & Norcross, 1999). These principles include: *A flexible and respectable* approach that incorporates religious and spiritual elements, *Collectivism and dependency* aspects of human behaviour, *Power imbalances* that lead to discriminatory practices amongst groups, *Language*, *Support systems*, *Openness* about racial and cultural issues and *counsellors' awareness* about themselves and *willingness to learn from patients*.

The multicultural approach usually offers the patient an opportunity to find a counsellor that they are comfortable with, especially concerning their culture and aspects of their identity. The counselling practice requires considerable training and knowledge of the counsellor, particularly a counsellor that is knowledgeable and able to use diverse contextual and individualised skills to help patients achieve change. This ideal scenario, however, requires an educational experience that generates sensitivity and appreciation of the history, current needs, strengths and resources of the individual patient's population group that the counsellor are working with (Prochaska & Norcross, 1999). Such approaches could be beneficial in specific contexts, such as the diverse South African patient population. However, counselling training programmes and practices cannot offer and know all the details of each specific race, gender and social-determined structures. Nevertheless, opportunities for sensitivity and diversity work in counselling training need to be available to encourage societal and individual growth, including the well-being of patients (Ridley et al., 2011b).

In summary, the theories discussed thus far have relevance to HIV/AIDS, and they have been applied in counselling interventions within HIV/AIDS services.

2.4.5 Conclusion

This chapter highlighted the relevance and importance of counselling in general, in healthcare and HCT services. Such interventions need to ensure patients' autonomy, the right to be informed about processes in their HIV healthcare and options and resources available. All of these are key to the successful management of HIV/AIDS. It is important to note that counselling, though embedded in theory, the practice thereof requires much more than theoretical knowledge. It is also a skill set. In the next chapter, a historical and present-day exploration is provided regarding the provision of HIV counselling services by LCs. The chapter will also highlight HIV in the context of Sub-Saharan and the South African region. The chapter will conclude with a discussion about HIV training programme evaluation and its implementation.

CHAPTER 3

THE LAY COUNSELLOR, HIV/AIDS IN AFRICA AND HCT PROGRAMMES

This chapter will start with a brief history of lay counselling provided by lay health workers. This will be followed by a discussion of the background and status of LCs' training, counselling skills and competencies in line with the *Model of Counselling Competence* (Ridley et al., 2011b). This section will also include an analysis of global and local LC work conditions through task shifting, a strategy employed in delivering HCT services in high burdened, low income, and under-resourced countries, such as South Africa. The third part of the chapter focuses on the socio-economic facets that have mitigated the spread and presentation of HIV/AIDS in Sub-Saharan Africa, including the South African context. Lastly, the chapter will conclude with a brief outline of critical aspects to consider in programme development and evaluation of utilising Patton's (1980) Utilisation-Focused Evaluation.

3.1 Lay counselling and the lay health worker

Lay healthcare workers (LHW) perform duties and functions related to healthcare delivery and are trained to deliver specific services but have not received any formal professional, paraprofessional, or tertiary qualifications (Lewin et al., 2005). These LHWs, barefoot doctors, home-based carers, LCs, HIV counsellors or community health workers, depending on the context and service programme, have made considerable achievements in the field of healthcare service provision (Bhutta et al., 2010; Lehmann & Sanders, 2007; Lewin et al., 2005; National Department of Health, 2010a; Rifkin, 2008; WHO, 2007a, 2007b). Lewin et al. (2005; 2010) systemic reviews on LHWs interventions provided positive evidence on the promising benefits LHWs have in promoting certain healthcare behaviours, improving treatment outcomes, and reducing morbidity and mortality due to illness (Lewin et al., 2005; 2010)

Lay health workers are mostly volunteers, who through their initiative, pursue community- or facility-based healthcare volunteering opportunities (Lehmann & Sanders, 2007). This makes it possible for LHWs to be accessible to patients as they can reach recipients in their natural settings, such as in communities (Hodgins et al., 2016; South et al., 2012; WHO, 2005) as their services are provided in and outside healthcare settings. The strength of the work of LHW lies in the effectiveness of how healthcare interventions provided by LHW address health issues that contribute significantly to the burden of diseases, especially in middle- and low-income countries (Lewin et al., 2005; Lewin et al., 2010; Petersen et al., 2014). As a result of these achievements on LHWs' role within healthcare systems, a variety of generic job categories of less qualified and lower-paid healthcare staff providing counselling in healthcare settings have been created (WHO, 2008). Lay counselling refers to a form of psychological intervention that LHWs offer (Lewin et al., 2010; WHO, 2008). Lay health workers can deliver peer-led interventions that provide information and teaching skills to clients and patients (Bhutta et al., 2010).

As counselling is based on psychological principles embedded in the science of human behaviour (Corey, 2012; Nelson-Jones, 2015), service providers in the field of counselling, including LHWs, should have a foundational knowledge and skills base that is rooted in psychological sciences. Depending on the type and area of training, occupation and expertise that counsellors possess, counsellors might utilise various psychological approaches in their application of counselling. Within these services, providers trained in their speciality field may receive additional training in counselling to meet the psychological needs of patients' needs that have increased over time (Chibanda et al., 2011; Karademas, 2009; Kidia et al., 2015). Lay health workers that provide counselling through education and support of clients/patients are often referred to as LCs (Department of Health, 2015; WHO, 2015a)

3.2 The lay counsellor

The increased HIV/AIDS prevalence, which has overburdened health systems, especially in middle and low-income countries, has seen the growth of LCs as a primary healthcare provision category/strategy (Lewin et al., 2010; UNAIDS, 2010b; World Health Organization, President's Emergency Plan for AIDS Relief, & Joint United Nations Programme on HIV/AIDS, 2007).

Terms that are synonymous and used to describe this category include ‘Lay healthcare worker or counsellor’, ‘Community caregiver’, and ‘Community health worker’. To have uniformity, this thesis will refer to the category ‘Lay counsellor (LC)’ as a general term to describe trained lay workers that specifically provide HCT services within the public healthcare system.

Over the last three decades, the response to HIV care, support, and management needs have escalated the need for the services to be provided not only in healthcare facilities but also within communities (Lehmann & Sanders, 2007; Lewin et al., 2005; National Department of Health, 2010a). This is currently one of the main functional areas of the LC cadre in Sub-Saharan Africa (Bhutta et al., 2010; Chibanda et al., 2017; National Department of Health, 2010b; Schneider et al., 2008). Voluntarily or as selected by communities, LCs have taken it upon themselves to provide support through community-based care initiatives supported mostly by NGOs or community-based organisations (CBO) (Mohlabane et al., 2015; Mwisongo et al., 2015).

3.2.1 Historical background of lay counsellors

Literature suggests that there are more than 60 years of documented history since the first community-based programme started, in which healthcare workers went into communities to provide services (Lehmann & Sanders, 2007; Lewin et al., 2010; Schneider et al., 2008). Lay counsellors’ primary area of focus and strength lies in community development, bridging the gap between communities and formal health services, as well as being advocates and agents of social change (Lehmann & Sanders, 2007). Testing services and HIV counselling services in Southern Africa are provided mainly by LCs (National Department of Health, 2010a; Simbayi et al., 2019), who work in healthcare services but are coordinated NGOs. At the time of conducting this study, the LC group comprised of an HCT roving team (nurses with basic nursing training), community healthcare workers, and community care givers, as well as “these LCs form the majority of HCT service providers in healthcare facilities and communities within the Free State (FS) Province, South Africa” (T Stofile, Free State Health HCT coordinator, personal communication, January 26, 2015).

A single approach or model might not be enough to address patients’ psychological needs and expectations in HCT services because HIV/AIDS presents various dimensions requiring patient management on different levels.

Therefore, the *Model of Counselling Competence* (Ridley et al., 2011b) was utilised as a conceptual framework in this study as it draws from most of the psychological concepts and approaches discussed so far. Different counselling approaches are used to guide the counsellors' training (Ridley et al., 2011b), and therefore, the model served as a framework in this study to understand the educational background, counselling skills, competence, and training needs of LCs who provide HIV counselling in healthcare. The model is discussed in the next section.

3.2.2 The model of counselling competence

The counselling approach or model, *Model of Counselling Competence* (Ridley et al., 2011b), is embedded in counsellor competence. Unlike the counselling approaches already discussed, this approach is a skill and competence-based framework that addresses counsellor skills and competencies formulated from major psychological counselling approaches (Ridley et al., 2011a). These psychological approaches are accepted or acknowledged sets of rules of action or conduct that provide a foundation for defining counsellor competence and translating theory into practice. In essence, the model is an application framework model as opposed to a theoretical model. Most of the principles that govern counselling interventions are set on a foundation of an implicit understanding of psychological elements and form the basis of counselling as a practice (Ridley et al., 2011b).

Firstly, as currently constructed, the model of counselling competence specifies an explicit outcome orientation, which entails the determining, facilitating, evaluating and sustaining of counselling outcomes. This orientation can be interpreted as an extension of Van Dyk (2010)'s stages of the counselling process. Secondly, the competence model operates multi-dimensionally and consists of two levels of competencies, namely superordinate and subordinate, including an integrated deep structure and micro-skilling. Thirdly, the model addresses counsellors' cognitions, behaviours and affect as components of competence by embracing the idea of collaboration, co-learning and shared decision-making between counsellors and patients. The fourth principle is built on a multilevel clustering of these operations. The fifth principle is based on culture and diversity as integral competencies and actions used in developing a therapeutic alliance, setting counselling goals, employment of counselling interventions and termination of counselling.

The sixth principle focuses the model on the training of facilitation of counselling and psychological change. Seventh, this model is amenable to evaluation, which requires coordination and integration of all operations, as well as performance on the outcome orientation. Lastly, this is a new conceptual framework that still requires extensive research and rigorous scientific testing. However, due to its diverse focus on skill and competence, it was deemed ideal as it highlights practical use in counsellor training and is appropriate to address the aim of the current study.

Generally, in counselling, counsellors are expected to have reasonable knowledge to plan their approach to establish a counselling relationship with the patient and skills to move the patient to desired goals. Using the guidelines as set out in this model, evaluation of the process of counselling should be based on universal principles guiding psychological counselling from the perspective of what is deemed necessary qualities and elements of a counsellor. The following are the main elements of the model:

1) Counsellors need to *determine which information and data are relevant.* Counsellors need to have the ability to interpret the patient's data within the context of the stages of change.
2) Counsellors need to learn to *address cognitions and affect* using different training techniques such as journaling, assessments, self-reports, and questions to promote metacognition, emotional self-monitoring and management and critical thinking.
3) An *increasing self-awareness of counsellors* will help understand their intentions, motivations, and tendencies and how this affects their counselling processes with patients. Acknowledging these thoughts, feelings and behaviours that might hinder the counsellor's interaction with the patient better equips the counsellor. It also provides an opportunity to evaluate the progress of counselling and improvement towards counselling goals.
4) Counsellors are *encouraged to* use *self-exploration* as a process of reflection of their own biases, motivations, hesitations, complex, multifaceted, multicultural identities, and unfinished businesses. Counsellors need to be encouraged and motivated to seek personal therapy or significant others' perception of *counsellors' values, beliefs, knowledge, and skills*. The use of higher-order cognitive skills, including selection, sequencing, and timing, is essential, and the ability to combine these according to the patient's needs is important. *Self-evaluation* is crucial as it relates to competence, and counsellors need to have concrete self-evaluating methods.

Counsellors need to use this model as a challenge and acknowledge the investment in time, money, and effort as a way of *occupational development*.

3.2.3 Education and selection

To understand the requirements and qualities LCs in HCT services need to possess, the educational training and selection background before delivering HIV counselling need to be evaluated. In many employment positions, literacy based on one's academic exposure and experience is a prerequisite. With LCs, studies found that this employment category should have some form of secondary education (Dewing et al., 2013; Dewing et al., 2015; Lehmann & Sanders, 2007; Mwisongo et al., 2015) and a primary level or no tertiary education (Jansen van Rensburg, 2008) at all. In HCT services, gender plays a significant role (this will be discussed further in Section 3.4) due to societal norms and practices that may influence individual gender beliefs. Although the sex of LCs varies across different programmes and services, studies reported a sizeable female number compared to males (Lehmann & Sanders, 2007; Mwisongo et al., 2015; Schneider et al., 2008; Jansen van Rensburg, 2008).

As reported earlier, LCs come from the communities they serve (Atif et al., 2016; Lehmann et al., 2004), either as volunteers or recruited and selected through NGOs and their involvement in the local primary healthcare facility (Schneider et al., 2008). Similar to many counsellors in healthcare, LCs need a certain level of capacity to relate to patients. Therefore, it is vital to acknowledge that LCs may come from the same communities as their patients, and assuming that language and cultural backgrounds are similar, the interactions counsellors have with clients could be enhanced by these similarities. In essence, this was witnessed in the era of HIV/AIDS, where many people living with HIV and AIDS have formed a large portion of volunteers and LCs who provide HCT services, which might have been a motivating factor for some. This aspect of identifying with the work LCs do is acknowledged in a study by Schneider et al. (2008), who reported that LCs who also identified as PLWHA were positively driven in their supportive role because of their personal experiences.

Lay counsellors are primarily volunteers, and their selection into LC programmes might pose challenges. However, the South African National Community Health Workers Policy developed in 2004 (National Department of Health, 2004) gave more guidance into the work and conditions of the LC programmes, with the following critical aspects of the policy stated below:

- Volunteers should be selected from and reside in the communities they serve
- LCs should be affiliated with and be part of an NGO/CBO
- LC training should be done through accredited learnership programmes
- LC volunteering work should only be for a few hours per week and will have no remuneration but will be supported with a stipend through government-NGO partnerships (National Department of Health, 2004).
- LCs can be both generalists or serve single-purpose roles

Additionally, with the availability and access to ARVs, the work of ARV treatment counsellors has been structured, with the expectation that LCs should meet the *Minimum Standards for counselling training: Selection and training of counselling* (National Department of Health, n.d.), and be trained by an accredited counsellor training provider, receive on-going supervision, as well as further training and feedback (National Department of Health, 2015). Despite this, LCs still do not form part of formal employment structures within the public service in South Africa. Lay counsellors work under the Department of Health, including in facilities and communities, but their volunteering opportunities are coordinated mostly by NGOs (Mwisongo et al., 2015).

The worker versus volunteer aspect could overshadow the contribution this group makes in realising public health outcomes (Duncan et al., 2017; Naidoo et al., 2018). Lay counsellors expressed viewing themselves as volunteers and reported receiving little to no recognition at all (Peltzer et al., 2011; Woolman et al., 2009), especially from the formal healthcare authorities. Furthermore, they regard themselves as an exploited labour force without employment benefits and rights such as leave, maternity benefits or pensions (Schneider et al., 2008). Even though the Department of Health funds NGOs and contribute towards the LCs' monthly stipends (Health Systems Trust, 2011; Schneider et al., 2008), this is still a cause for concern because it implies that every province and programme has its structure (Duncan et al., 2017), which is not nationally regulated through standard procedures.

3.2.4 Training and career opportunities

3.2.4.1 Entry-level training

The world has responded to HIV and AIDS by establishing programmes and institutions that initiated policy development and guidelines to inform HIV treatment, care and support globally. Globally, LCs are at the forefront of delivering HCT services in facilities and communities. In South Africa, an LC is a trained individual who has completed an HIV counselling course prescribed in the *Minimum Standards for counselling and training: Selection and training of counsellors* (Duncan et al., 2017; National Department of Health, n.d.). In this prerequisite, first entry-level and compulsory training, HIV counselling training is allocated ten days. The training curriculum consists of 19 core modules, of which counselling, HIV counselling and counselling components account for 13 modules, which are allocated 64 hours. Also, two supervised counselling sessions are recommended as practice following the training. This training compares differently to professional counsellor training programmes, which require a minimum of four years of tertiary education qualification, six months' on-the-job site practicum, and a 70% pass in the national board examination (Health Professions Council of South Africa [HPCSA], 2019). It appears that lay counsellor training programmes might yield poor execution of counselling, as reported by Kagee (2013). The 18-hour training programme received by lay counsellors had some level of effectiveness in the training of skills such as encouraging, a reflection of content, paraphrasing, summarising and questioning, but was insufficient in yielding satisfactory execution of complex counselling skills (e.g., confronting the patient's incongruities, exploring logical consequence and identifying patients' positive assets) (Kagee, 2013). These two counsellor categories discussed above are not the only ones available in the provision of healthcare counselling in South Africa. There are various other counselling categories with sets of requirements, qualifications, and scope of practice. However, the two mentioned are more similar due to their entry-level counselling provision in their respective work classes and are suitable for healthcare services.

It is essential to contextualise the difference to understand the training needs and the job demands, including the competencies required in counselling for HIV/AIDS purposes in South Africa. Table 3.1. lists the differences between an LC and an entry-level professional counsellor training and their scope of practice.

Table 3.1

Comparison in Training and Scope of Practice of Entry-Level Categories Counsellors Who can Provide HIV Counselling Within the South African Public and Private Sector (HPCSA, 2019; National Department of Health, n.d.).

Lay Counsellor	Registered Counsellor
Qualification	
• Grade 12 senior certificate	• An academic Honours qualification at an NQF Level 8 as a requirement
Academic training includes the following courses, skills, or core competencies:	
• Minimum: An HIV counselling and testing course	• Psychopathology • Developmental Psychology • Therapeutic psychology • Research psychology • Psychometric and psychological assessment • Personality psychology
Professional training includes but is not limited to, the following:	
• Basic counselling skills • HIV/AIDS information • TB information • ARV initiation and adherence	• Basic counselling skills • Development of preventative and developmental programmes • Conceptualisation skills, bio-psychosocial and systems theory as appropriate for community interventions • Structured trauma counselling • Community understanding and intervention • Cultural beliefs and diversity • Language sensitivity • Psycho-educational skills • Ethical Code, the Bill of Rights and other relevant legislation
Practicum or internship	
• None	• A full-time 6-month practicum • The practicum should be formulated based on the model of training (School or Community counselling) • Pass board exam

Lay counsellor	Registered counsellor
Scope of practice (includes but are not limited to the following)	
• The first line of facility and community-based HIV prevention and treatment services • Pre-test counselling • HIV finger pricking • Testing • Post-test counselling • Follow-up counselling • Counselling on psychosocial matters relating to HIV/AIDS • ARV treatment support	• The first line of community-based psychological support • Provide preventative and developmental counselling services • Perform supportive psychological interventions to enhance emotional functioning and mental well-being • Perform basic psychological screening for mental health as a preliminary screening tool to refer appropriately • Provide counselling in conjunction with interdisciplinary support • Report writing and providing feedback to clients on interventions

Furthermore, HCT services have been under scrutiny, as there seems to be a lack of clear guidelines and uniformity in the training of LCs. In 2006, the South African Department of Health created the possibility of career pathways and structure by registering four community health qualifications following the National Qualifications Framework (Schneider et al., 2008). The framework policy formulated economic and social standardisation of LC programmes. According to the South African National HCT Policy Guidelines (National Department of Health, 2010a), healthcare providers include any individual providers providing the service according to the Allied Health Professions Act of 1982 (Act No. 63 of 1982), the Health Professions Act of 1974 (Act No. 56 of 1974), the Nursing Act of 2005 (Act No. 33 of 2005), Medicines and Related Substances Act of 1965 (Act No. 101 of 1965) and the Pharmacy Act of 1974 (Act No. 53 of 1974). These legal and policy principles prescribe the minimum requirements in training, skills, competencies, and delivery of health care services within the healthcare sector in South Africa. However, the LC category does not feature in these guidelines. These concerns are not only found amongst the LC services within South Africa. A review of the 90-90-90 targets, as set out by UNAIDS (Bemelmans et al., 2016), indicates that in 2016 many countries in Sub-Saharan Africa did not have a framework or a working process to sustain LCs in their staff establishments, and neither did they meet LCs' needs through professional training and professional associations.

3.2.4.2 Further training

In South Africa, HCT services are hindered by a shortage of professional healthcare staff resulting in human resource constraints (Lehmann & Sanders, 2007; Simbayi et al., 2019). However, task sharing or shifting has been implemented and is being used to address this. Task shifting is a process within Health Systems (HS) developed to reach and address the needs of HIV burdened areas, especially in low and poor resourced areas (WHO, 2010). It refers to task redistribution and delegation from higher-level to lower-level healthcare providers, and it has been used in many settings to reach individuals and communities. This process may facilitate more effective use of human resources available in a location to ensure the delivery of a wide variety of services, thus freeing the time of other healthcare providers (National Department of Health, 2010a). At the forefront of these developments and their implementation are the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO. Different NGOs assist the National Department of Health in South Africa to train LCs and deliver HCT services across communities. These have been very influential in developing strategies to alleviate the HIV/AIDS burden on the National Department by proving HCT services. Most of these NGOs that are part of the service have a clear programmatic focus and have HIV/AIDS as an integral part of their operations.

In addition to general follow-up training, the changing nature of HIV/AIDS, together with context-specific elements such as human resource capacity, has necessitated the need to train LCs on additional aspects in the care and management of HIV/AIDS. The course structure over the last decade, depending on the context and community needs, has included but is not limited to, HIV testing (WHO, 2015a), risk reduction (Kalichman et al., 2011), couples counselling (CDC, 2017), ARV adherence (Dewing et al., 2015) and common mental health conditions (Chibanda et al., 2011, Chibanda et al., 2017; Kidia et al., 2015; Petersen et al., 2014). Therefore, the work of LCs has expanded beyond the general HIV counselling process, and it now requires skills to match current needs. Evidence provided has shown that additional training for context-specific HCT services is beneficial and improves the services provided by LCs (Dewing et al., 2015).

The current needs in HCT were demonstrated by Cataldo et al. (2015), where specialised training and instructions on managing clients on ARVs (following up on clients, counselling them to adhere to treatment, checking that they took the drugs as prescribed, referring new patients to the clinics, and tracing those who did not attend appointments) contributed in strengthening the skills of home-based workers that provided lay counselling services in the study. For this group, the training motivated them to continue improving the services they were delivering (Cataldo et al., 2015). As already mentioned, the training of LCs is often provided by NGO/NPOs, supporting LCs efforts and work within HCT services in South Africa. Some NGOs have developed their training, either separate from complementing or building on the counselling skills of the LC cadre. For the Lifeline LHW in Jansen van Rensburg's (2008) study, the training was offered by Lifeline, while another training was through the various institutions such as the University of South Africa (UNISA), and the Family and Marriage Society of South Africa (FAMSA), for example. In this study, the training courses varied from advanced counselling, HIV and AIDS and trauma (Jansen van Rensburg, 2008). For Médecins Sans Frontières / Doctors Without Borders (MSF), the LC cadre receives formal refresher training one to two times a year on topics that address the needs and guidelines of HCT services (MSF, 2020). In addition, MSF LCs have access to a senior counsellor and up to four weeks of mentorship and supervision (MSF, 2020).

Interacting with mentors, supervisors and senior counsellors/colleagues plays a critical role in ensuring that counsellors have access to opportunities to consult, gain information and further their professional development. The supervision of LCs varies across South African provinces, where some LCs reported that they were accountable to clinic staff and identified LC supervisors. Working hours, work activities and task allocation were under the nurses' control (Schneider et al., 2008). This availability and provision of on-going support, including mentoring, supervision and monitoring (Dhadwal et al., 2009), also necessitated the call to follow up HIV counsellors training with refresher courses. Lay counsellors have identified a training need in supervision to strengthen their skills in the evolving nature of HIV/AIDS (Sanjana et al., 2009; Suri et al., 2007). Furthermore, supervision as a standard in community health workers in South Africa is lacking, indicating the failure of human resources to adequately provide what necessitates quality care (Assegaai & Schneider, 2019).

3.2.5 Skills and Competence

Currently, WHO and UNAIDS inform best practice guidelines to guide HIV services (WHO, 2015a). This includes information and counselling during pre- and posttest counselling, linkage and access to appropriate HIV prevention, care and treatment services, as well as clinical support services, including quality HIV testing, accurate test results, diagnosis and coordination with laboratory services to support quality assurance. Since most of these services are at the centre of tasks provided by lay counsellors and encompass skill sets that LCs need to demonstrate, the issue of competence needs to be addressed. The ability to predict and ensure that counsellor competence is a complex phenomenon that requires continued work. Some authors (Murdoch et al., 2015) have shown significant differences in the acquisition of psychological literacy and experience among different healthcare providers, such as nursing, social work, medicine and both counselling and clinical psychology. This strengthens the argument that it would not be different in acquiring counselling skills amongst the LC group. Furthermore, researchers and counsellors alike have been identifying and researching aspects that influence counsellor competence (Ramalepe et al., 2014; Ridley et al., 2011a; Ridley et al., 2011b).

According to Ridley et al. (2011b), counsellor or counselling competence is a comprehensive and complex process, which requires using acquired counselling knowledge and skills (acquired through training), counselling actions or practices (acquired through counselling) and expertise (acquired through continuous experience and further professional development) to reach the desired counselling outcome. Nationally, counsellor competence, specifically registered counsellors' accountability, ethics, and professional development, are issues that the HPCSA is addressing through the Continuing Professional Development (CPD) programme. The HPCSA has implemented this programme, requiring every practitioner to accumulate a minimum of 30 Continuing Education Units (CEUs) per twelve-month period, with five of the units required to be on ethics, human rights or health law for registered counsellor practitioners. Healthcare and allied practitioners have a responsibility to continually update their professional knowledge and skills to benefit the clients they serve (Health Professions Council of South Africa, 2017) or otherwise face professional de-registration with the council.

However, the issue as set out in the HPCSA's national regulations and conditions does not apply to LCs, as they are not registered counsellors and do not follow national qualifications programmes that were outlined for professional counsellors in Table 3.1. It will be challenging to address counsellor and counselling competence amongst this group as there is limited regulation in terms of their training, their scope of practice and utilisation of their skills. What is, however, not highlighted in the training structure and scope of practice as set out in the *Minimum Standards for counsellor training: Selection and training of counsellors* (National Department of Health, n.d.), is the counsellor's personal and psychological being concerning the work they do. This is because emotional well-being plays a pivotal role in the execution of counselling duties, performance and competence. Visser and Mabota (2015) found that a below-average performance score on emotional well-being was reported from the LC group. This included aspects that would generally determine whether a counsellor would effectively cope with the counselling tasks, especially in assisting patients with a chronic illness and potentially numerous psychosocial stressors (Visser & Mabota, 2015).

Lay counsellors need to utilise different systems of counselling based on theoretical approaches. Other theories of change are employed to help patients identify psychological problems and learn practical ways to manage them to alleviate psychological distress. However different, these systems have strengths and weaknesses in terms of counsellor specific skill sets and competencies. For example, in psychodynamic approaches, psychotherapy is typically expected to be 12-40 sessions (Prochaska & Norcross, 1999), while more constructivists therapies such as brief solution-focused therapies may require 4-5 sessions. Another issue that might play a role in counsellor competence is the counsellor's characteristics and development. For example, humanistic counsellors might be more inclined and expected to display warmth (Wheeler, 2000).

From a public healthcare perspective, concerns have been expressed regarding LCs' acquisition and level of counselling skills and how these might affect healthcare service delivery. Studies investigating the factors facilitating HCT uptake, particularly among the TB population, have identified counsellor variables as factors that negatively influence HCT uptake (Heunis et al., 2009). The motivation for LCs remains a challenge, especially amidst the conditions of their employment or 'volunteerism'.

In Schneider et al. (2008), LCs reported that working as an LC could create formal employment opportunities, although some had said to be working in their respective facilities/communities for more than five years without any career progress. Furthermore, LCs enjoy minimal employment opportunities (Assegaai & Schneider, 2019; Naidoo et al., 2018). There is an expectation for them to comply with regulations as fully employed individuals, although their status is relatively lower than other healthcare workers (Schneider et al., 2008). LCs also express concerns regarding their scope of practice support from the healthcare system and professional development (Heunis et al., 2009; Lehmann & Sanders, 2007). One way to manage this would be to integrate the LCs into the existing structures of employment (Naidoo et al., 2018)

At the time of this study (2014-2017), the Free State (FS) Province had developed paths for learnerships and entry-level formal training. From personal communication with the Free State Health HCT coordinator, Ms. T. Stofile (personal communication, January 26, 2015), in 2011, the former LHWs and LCs had been trained in basic nursing, specifically within the Motheo District, where they were deployed as HCT nurses in communities and facilities to provide HCT and other necessary medical assessments. However, at the end of this study, only 21 of the 107 LCs participating in the study had received this training. With the current state of primary healthcare reengineering, LCs need to display appropriate skills and competencies to meet the needs of patients both at facility and community service points. Furthermore, these two main delivery approaches to HCT services are highly recommended by the WHO/UNAIDS (UNAIDS, 2017a). There are, however, differences in both these service point approaches. For example, in facility-based HCT services, LCs provide HCT services in addition to other primary health tasks, such as medical screenings. Community-based HCT services provide door-to-door/home, mobile outreach and workplace-based services and serve as patients' linkage to healthcare facilities.

Lay counsellors mainly fulfil roles of educational and emotional support in the field of HIV/AIDS (Jansen van Rensburg, 2008). These healthcare workers provide HIV counselling, which is a psychological service. Such psychological interventions are both practical and cost-effective ways of addressing psychological distress (Murdoch et al., 2015), especially in the field of health conditions such as HIV/AIDS. Lay counsellors in HCT services are trained in listening, asking supportive questions, discussing options, and encouraging clients to make informed decisions (National Department of Health, 2010a; Van Dyk, 2010.

Lay counsellors provide information and may suggest follow-up sessions (Benita, 2012). Additionally, LCs may provide HCT-related services such as VMMC, which includes comprehensive HIV prevention, sexual and reproductive health. Although it is preferred that healthcare workers such as nurses provide VMMC services in health facilities, due to shortage of human resources, some of the counselling-related services of VMMC are delegated to trained LCs (National Department of Health, 2010a, 2015).

It appears that the use of LCs within the healthcare system in delivering HCT services has improved and strengthened primary care. It is also a significant human resource benefit that has addressed HIV/AIDS from a community-level perspective (Naidoo et al., 2018; Taegtmeyer et al., 2011). Apart from the valued contribution LCs make on the HCT service continuum and the strong support for LCs to provide patients with emotional and psychosocial support related to living with HIV (Torpey et al., 2008), lay counsellors serve as a link between the individual patients and their health system (Cataldo et al., 2015; Schneider et al., 2008; UNAIDS, 2017a). Therefore, counselling services, especially HIV-related counselling within HCT services, are vital in HIV and AIDS programmes. Given this context, it is also essential to consider the HIV counselling skill sets and competencies of HCT service providers. In the context of this study and South Africa, in particular, the service providers of HIV counselling are LCs. The current HIV counselling within HCT services can be evaluated to effectively address gaps identified in this specific workgroup, and of importance is whether there is a need to invest in the improvement of these services. The answer perhaps lies in the global and local effect HIV/AIDS has had.

The section that follows analyses Sub-Saharan African specific determinants. Sub-Saharan Africa remains one of the most hit regions globally (UNAIDS, 2019) while not forgetting South Africa and the Free State Province, where the current study was conducted (Simbayi et al., 2019). In this examination of HIV/AIDS by the numbers, a discussion about general and group-specific characteristics of HIV/AIDS in these high disease-burdened countries and regions will be included.

3.3 HIV/AIDS in Africa: The Sub-Saharan African Context

HIV/AIDS is characterised by certain psychosocial, economic, and political factors that negate the pandemic. In understanding the spread and prevalence-related issues of HIV/AIDS in burdened areas, the focus will be on context-specific aspects that have given rise to Sub-Saharan individual and societal determinants. In South Africa, the increased HIV prevalence is related to factors such as lack of employment, poverty, gender-based violence, traditional norms and cultural practices that promote, amongst others, multiple concurrent and intergenerational sexual relations (Shisana et al., 2014; Simbayi et al., 2019; UNAIDS 2014a). With this in mind, HCT services offered by LCs should address the influence of these determinants in their interventions with patients.

3.3.1 Mobility and migration

As with many epidemics, HIV has been linked to mobility. Mobility in Sub-Saharan Africa is synonymous with truck drivers, mineworkers, mobile farmers, and traders. With limited employment opportunities, many countries in Sub-Saharan Africa had an increase in the mining of natural resources (Corno & de Walque, 2012). Although such has brought financial and economic opportunities to many (International Organisation for Migration, 2010), it has also increased HIV/AIDS cases (Campbell, 2003; Ginwalla et al., 2002). Generally, such migration keeps men away from their partners and families for lengthy periods; this absence makes them vulnerable to sexual exposure, alcohol, drug use, and limited access to HIV prevention and treatment care (Campbell, 2003). In rural KwaZulu-Natal, where a proportion of men were migrants, 34% of young pregnant women were HIV positive (Ramjee & Gouws, 2002). This study further highlighted the HIV-status-discordancy rate among migrant couples, which was three times more likely than in non-migrant couples (Ramjee & Gouws, 2002). Across national borders, Corno and de Walque (2012) reported that the probability of HIV infection increased for Swaziland and Lesotho nationals employed in South African mines. They further argued that miners' migration into South Africa increased HIV/AIDS transmission to its bordering countries. Although these and many other studies have found mobility to be a structural driver in the spread of HIV (Iliffe, 2006), the role of migration in the earlier stages of the spread of HIV was more critical and relevant than in the recent decade or two.

Nonetheless, HCT interventions by LCs need to incorporate how mobility and migration increase HIV risk when working with migrant labourers and their partners. As set out in the WHO (2012), guidelines for couple HCT services and support for couples are offered by providing a safe space and process, where through the guidance of a health worker, couples can test, receive their HIV results and be encouraged to disclose their status to each other mutually. Options on prevention, treatment and support can then be discussed and decided upon together, depending on each partner's HIV status (WHO, 2012c). This was highlighted in a pilot study conducted by McGrath et al. (2010), which showed that couples-focused interventions could be key in improving testing numbers and reducing HIV transmission and eliminating the impact migration has on these populations (McGrath et al., 2010).

However, this can only be accomplished through the rigorous involvement of sexual partners who have been left at home and partners that migrants encounter on their work travels. Furthermore, in a study conducted by Deane et al. (2016) among mobile farmers in Tanzania, it was found that risky behaviours of mobile individuals were influenced by sexual norms and practices around sex and exchange. These transactional sexual interactions indicate unequal gender and economic relations issues. They also highlighted that though mobility was a factor, the roles of gender and societal norms took a central position in explaining their findings (Deane et al., 2016). Thus, there are sexual risk behaviours that men and women in migrant relationships engage in (Corno & de Walque, 2012; Ramjee & Gouws, 2002; Deane et al., 2016). However, it would be difficult to isolate this as the only causal factor in the HIV epidemic in Sub-Saharan Africa, primarily since HIV prevalence transmitted mostly through heterosexual contact, is high (Shisana et al., 2014) and is further mitigated by other equally crucial factors, which are discussed further in this section.

3.3.2 Poverty vs. wealth

The relationship between HIV and poverty seems to be one of the most well-documented variables in the study of HIV/AIDS (Bor et al., 2015; IOM, 2010; Long & Deane, 2015; Magadi, 2013; Poulin et al., 2016). In an analysis survey conducted by Magadi (2013) on 20 Sub-Saharan African countries indicated that the urban poor showed higher odds of HIV infection than their urban non-poor counterparts when considering urban poverty.

The link between household wealth and HIV prevalence in urban settings was higher among the urban poor than the rural poor (Magadi, 2013). This study further observed certain societal norms and behaviours such as sexual behaviour, education level, unemployment, discrimination, gender disparities and violence. Also, the positive relationship between poverty and the number of HIV infections can be ascribed to economics because the perspective of one's view of the future of living in poverty is more likely to increase the readiness to take risks today (Holmqvist, 2009). It has been shown that CBT (Adelfolalu, 2018) and behavioural interventions (Coates et al., 2014) can improve the HIV-related choices that patients make. Therefore, one's perception of the likelihood of HIV risk can address individual choices and be targeted through different counselling approaches that are at the disposal of LCs.

The dynamics of poverty vs wealth have been reported (Long & Deane, 2015; Poulin et al., 2016). In rural Malawi, wealth was significantly and positively associated with HIV infection (Poulin et al., 2016). Here, wealth is determined by rural standards, which are the main drivers of wealth in rural areas, and these range from farming, livestock, land and goods that can be produced and sold to the public. Poulin et al. (2016) found that in rural Malawi, men in the upper quintile of the wealth distribution had nearly twice the chance of being HIV positive than men in the lower wealth and economic distribution. The rise in HIV incidence as men age was also found to be attributed to an increased ability of men to earn money over their life course; it also increased opportunities for sexual encounters with multiple and casual partners (Poulin et al., 2016). With men being more likely to die from AIDS than women, men's lower use of HIV services and low level of health-seeking behaviour also attributes to this disparity (Bor et al., 2015). When it comes to HIV testing, Long and Deane (2015) propose that testing and wealth should be treated with caution. In their study among men in Tanzania, east of Africa, they found that wealthy men have higher rates of HIV and are likely to refuse a test compared to the men in lower wealth quintiles (Long & Deane, 2015).

Furthermore, risky sexual behaviour has been linked to the level of education, which also relates to wealth (Gummerson, 2013). The more educated one is, the safer the sexual behaviours they engage. Additionally, education has been associated with more protective behaviours, such as condom use and increased HIV testing among this group (Gummerson, 2013).

Poor people are less likely to be educated or literate, limiting their access to HIV prevention and information material, which is distributed through the media (e.g., newspapers, television, and radio). It would be premature to take the relationship between wealth and poverty and HIV prevalence as a singular driver in the HIV epidemic as it presents differently across different settings. Poverty as a driver in HIV/AIDS was mentioned in 2000 when the former president of South Africa, Mr Thabo Mbeki, issued a statement where he gave his analysis that HIV did not lead to AIDS; instead, socio-economic factors such as poverty contributed to individuals developing AIDS (Fassin & Schneider, 2003). This further indicated that HCT should encompass such components into their service.

Poverty (lack of food and shelter) in Africa is a reality and one of the biggest challenges South Africa has had to deal with; together with sexual needs, it also forms part of the lowest level on the hierarchy of needs. According to the motivational theory of Abraham H. Maslow (1943), the ability to be motivated to grow in different aspects of one's being, requires fulfilling basic physiological needs for food, water and shelter. An individual's need for food, water and shelter must be met before advancing to the next level in the hierarchy (Maslow, 1943). Therefore, if any of these physiological needs are missing, individuals will not be motivated to grow and attain other necessities such as safety (the feeling individuals get when no physical, mental or emotional harm will befall them) and security (the feeling individuals get when their fears are low). The level of sexually risky behaviour, which often accompanies poverty, places individuals in harm's way and increases their chances of contracting HIV.

3.3.3 Social norms, stigma and perceptions related to HIV/AIDS

It is the fundamental right of every person to attain the highest standard of health, a right that can discourage people from using services to protect their health and well-being (UNAIDS, 2017b). In HIV counselling and testing services, specific social determinants affect individuals' decisions, behaviours, and outcomes. From a social psychology context, social norms direct an individual's chosen behaviour that reflects and embodies cultural values and systems. These values are ideals that individuals hold about what is good or bad, what is proper, desirable, and permitted within and from their cultural or group's perspective.These basic constructs are also related to stigma and perceptions held by individuals within their groups, affecting HIV prevention, care and management strategies.

Both internalised stigma (i.e., an HIV infected person's internalised view of HIV), and fear of stigmatisation (i.e., the fear of being discriminated against based on one's HIV status), serve as barriers to HCT services (Young et al., 2010). HIV stigma can affect people's decision-making, behaviours and outcomes. It can also affect if one chooses to participate in HIV prevention, counselling and testing. Furthermore, stigma can interfere with health behaviour adaptation and treatment adherence. Concerns may arise regarding fear of rejection from a partner and society, sexually protective behaviours such as condom use may be undermined by stigma-related experiences. However, stigma can differ by demographics and culture. For instance, in Sub-Saharan Africa, where most HIV transmissions occur among heterosexual couples, shame regarding ones' sexual activity may influence an individual's experiences of possible disapproval and discrimination and lessen their motivation to disclose their HIV status and their ability to maintain optimal health. HIV testing studies show that most people who have tested for HIV are less likely to hold negative attitudes and beliefs about people living with HIV/AIDS (Mall et al., 2013; Young et al., 2010). Also, those who have negative attitudes are more likely not to have received HIV tests (Young et al., 2010).

Studies in South Africa have shown that a decrease in HIV/AIDS-related stigma resulted in increased HIV counselling and testing (Haffejee et al., 2018; Kalichman & Simbayi, 2003). This can further be attributed to increased numbers of individuals accessing HIV-related information, widespread availability of HCT services and high ARV treatment coverage. The availability of home-based HIV testing services has also been linked to reduced stigma and increased testing rates, as seen in a Ugandan study by Wolff et al. (2005), who found a 36% increase in HIV testing compared to standard testing services among rural Ugandans. HIV is perhaps one of the public healthcare system's highly contested debates regarding the social aspects of the disease, as it presents an enormity in terms of the deeply intimate social practices involved in HIV transmission. When one looks at evidence-based findings on preventative measures that have produced policy-making data, undeniably biomedical and social standards form the majority, as well as the most researched and tested interventions.

On a preventative note, VMMC, a debate about social norms, is a biomedical intervention that has effectively lowered female to male biological transmission of HIV. Male circumcision has shown to reduce the transmission of HIV by 60-73% in the heterosexual male population (Tobian et al., 2015). However, with any preventative method, caution should be applied.

This can also be argued from a perspective of modified or protective sexual behaviours that those who have been circumcised engage. Despite this, the comprehensive counselling package offered during VMMC interventions has been shown to provide information to male patients on the benefits of VMMC, offering partial protection from contracting HIV (Kaufman et al., 2018). It is also important to note that similar to any HIV preventative strategy, most VMMC programmes are accompanied by follow-up visits, which offer health and counselling care and management, an opportunity where sexual behaviour can be further addressed by LCs when they provide counselling services. Voluntary medical male circumcision has been encouraged as part of HIV prevention. In 2007, WHO and UNAIDS (WHO & UNAIDS, 2007) issued a joint statement that led to policy development in promoting VMMC as an additional strategy for the prevention of heterosexually acquired HIV infection in men. Today, VMMC is regarded as a successful prevention strategy in providing quality HCT services (UNAIDS & WHO, 2019).

3.3.4 Heterosexual behaviour and women's vulnerability to HIV

Specific behavioural risk factors that lead to the concentrated HIV epidemic amongst populations in Sub-Saharan Africa (Baral & Phaswana-Mafuya, 2012, Shisana et al., 2009; Simbayi et al., 2019), specifically the general heterosexual population, have reportedly led to an increased HIV incidence (UNAIDS, 2010a & 2018). Risk factors such as unprotected sexual intercourse, the occurrence of STIs, the number of sexual partners, and the consequent HIV incidence localised in that region are some of the factors that attribute to the high HIV rate (Baral & Phaswana-Mafuya, 2012; Shisana et al., 2014). In addition, biologically, the presence of STIs may increase the probability of HIV transmission (National Department of Health, 2010a; Shisana et al., 2014). Therefore, entry-level HCT services should include processes that assess the biological risk to decrease the occurrence of STIs (National Department of Health, 2015).

In clustering prevalence and incidence of STIs, Ramjee and Wand (2014) found that their study's geographical areas overlapped with areas where HIV prevalence was high. In addition, their study participants shared the same characteristics: younger age groups, not married or cohabiting and multiple sexual partners. Noteworthy is that both HIV and STIs share common demographic, social and sexual behavioural risk factors (Ramjee & Wand, 2014).

Furthermore, the gender-specific risks of heterosexual transmission of HIV in Sub-Saharan Africa have drawn attention to the high HIV rates among women (Simbayi et al., 2019). Thus, biological vulnerabilities put girls and women at a physiological increased risk of contracting HIV compared to boys and men (Shisana et al., 2009). In Africa, poverty and powerlessness are core issues that place women in positions of exchanging sexual favours for economic and other resources (Jewkes et al., 2003).

HIV in Sub-Saharan Africa and elsewhere have indicated the relationship between diverse contextual, socioeconomic factors and vulnerability of women to HIV (UNAIDS, 2010a). As discussed in the preceding section, systemic wealth and socioeconomic dependence of women on men highlights women's lack of sexual autonomy, inability to negotiate safer sexual practices, and limited choices in a relationship (Shisana et al., 2009 & 2014). Young women reported that the primary incentive in becoming sexually engaged with older partners is mostly for financial and material gain (Longfield et al., 2004). Although relationship dynamics could be argued in terms of who holds power and exerts their influence in such relationships, this study does indicate one of the prominent driving forces behind HIV prevalence as economic gain. In addition, a review of more than 45 studies showed evidence in support of an increased HIV prevalence in existing relationships between young women and older male partners in Sub-Saharan Africa (UNAIDS, 2015a). Other than the 'sugar-daddy' stereotype- relationships between younger women and older men, there are other general heterosexual relationship factors. Gender discrepancies, which are linked to gender inequality, are some of the many social aspects of HIV in Africa where women are at risk of intimate partner violence and at risk of contracting HIV (Poulin et al., 2016, Shisana et al., 2009).

Another compounding finding made by Magadi (2013) regarding poverty concerns women's vulnerability to HIV that increases due to transactional sex, also associated with gender-based violence and being socio-economically disadvantaged. Dunkle et al. (2004) further reiterated this in their study where South African women who had a history of violence from their partner had a 50% increased risk of being HIV positive. Gender inequality is a reality that is intimately linked to perceptions about masculinity, which is generally related to violence against women. Also, lack of access to education and social protection are some of the inequities that adolescent girls and young women face in their pursuit to protect themselves from HIV and access to sexual and reproductive healthcare services (UNAIDS, 2014b).

In a review of HIV prevalence and incidence amongst adolescent girls and young women in Sub-Saharan countries, Birdthistle et al. (2019) reported a consistently high rate among females compared to males, regardless of the setting. Although ARV treatment has been scaled up in these high-prevalence areas, there are still no significant reductions in HIV incident amongst this female age group (Birdthistle et al., 2019). The adolescent and young adulthood phase are also significant childbearing years, which in South Africa have been reported to have yielded a high number of pregnancies (Mchunu et al., 2012).

In the provision of antenatal care for pregnant women, PMTCT forms part of primary health facilities (National Department of Health, 2010a & 2015). This HCT intervention, if offered and utilised early, can be beneficial for both the mother and the unborn child by reducing HIV risk for both (National Department of Health, 2015). With the changes in the economic landscape, gender relations in many regions in Sub-Saharan Africa have changed. More women have economic opportunities, and men are no longer able to provide for families (StatsSA, 2019). This has led to women no longer considering marriage as a means of support or life choice. Within the South Africa relationships, environment marital commitments have declined, and non-cohabitation has increased (Shisana et al., 2014). This is further exacerbated by multiple sexual partnerships in relationships and how frequently these encounters and relations occur (Shisana et al., 2014). Furthermore, AIDS as the leading cause of death among adult men in Sub-Saharan Africa, together with poor health-seeking behaviour among men (UNAIDS, 2013), can severely impact a household's family income (Holmqvist, 2009).

As the epidemic progressed, some of the traditional African customs of keeping the widow within the family, a concept known as levirate, are continuing (Kimanga et al., 2014). Widowhood in many Sub-Saharan countries, has shown the vulnerability that women have in the HIV epidemic (Kimanga et al., 2014). With the limited number of men alive and the possibility of such practices diminishing over time, young widows might be left vulnerable to sexual exposure and HIV (Kimanga et al., 2014; Lopman et al., 2008). Taking the general population of men and women into consideration, a study conducted in 1998-2000 in Manicaland, Zimbabwe, of a cohort of widowed men and women, indicated the highest prevalence of HIV amongst this group, in comparison to those who were not widowed with figures of 64 % and 58 % respectively (Lopman et al., 2008).

A range of sociologically plausible factors needs to be drawn to understand and intervene on individual, societal and universal mechanisms of influence. Within this climate of a combination of social determinants, it remains imperative that sexual behaviour remains one key aspect that still has a tremendous impact on HIV in Sub-Saharan Africa and a key element in HCT services provided by LCs. However, this becomes difficult in any situation. Behavioural change is motivated by many factors, and in the case of HIV, understanding what motivates health behaviour in the developing world is essential. Therefore, LC interventions need to consider the aspects of human behaviour, as proposed in frameworks such as cognitive-behavioural, persuasive communications, peer education and behavioural science approaches; these have been at the forefront of behavioural strategies employed in HCT services to reduce the transmission of HIV. Furthermore, knowledge, stigma reduction, access to HCT services and sexual behaviour practices (e.g., delaying sexual debut, condom use, decreasing the number of sexual partners) are some of the behavioural approaches that can be integrated within HCT approaches in the prevention, treatment and management of HIV. This study's literature review will concentrate on the state of HIV/AIDS in South Africa.

3.4 The South African HIV/AIDS Context

When the current study was conducted, South Africa had one of the largest numbers of people living with HIV/AIDS (UNAIDS, 2016). According to UNAIDS (2016), in 2014, South Africa was one of the ten countries, including Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Uganda, United Republic of Tanzania, Zambia and Zimbabwe, that accounted for 81% of this Sub-Saharan population of people living with HIV/AIDS. Half of the 81% was found in two countries, Nigeria and South Africa (UNAIDS, 2016). The estimated HIV prevalence in South Africa was approximately 14 % of the total national population in 2019 (Simbayi et al., 2019), with an estimated 19.07 % of the adult (15-49 years) population being HIV positive (Statistics South Africa, 2019).

The total number of people living with HIV/AIDS in South Africa was estimated at 7,97 million in 2019 (Statistics South Africa, 2019). The AIDS epidemic in South Africa was initially marked by a political stance (Govender, 2009), which set in motion AIDS activism through civil society, which resulted in establishing a movement by civil society organisations such as the Treatment Action Campaign.

Today, South Africa is an exceptional case where NGOs such as CAPRISA, MSF, and the Desmond Tutu HIV Foundation have established and are operating HIV programmes that are integrated within the public health HCT service. HIV prevalence differs substantially across different provinces in South Africa. In 2012, Kwa-Zulu Natal had the highest HIV prevalence in the country, at 16.9 % and the Free State Province at 14.0%, making it the third-highest in the country (Shisana et al., 2014). The figures in the Free State remained relatively static in the last few years, with the prevalence in the province currently being 14.62% (McDonell & Low, 2019).

The national survey of 2012 (Shisana et al., 2014) also indicated a difference in HIV prevalence between people who lived in informal urban areas and those living in the other locality types. In South Africa, informal urban areas are often referred to as squatter camps or informal settlements. They are generally under-resourced, and lack necessities such as formal housing, water, sanitation and have limited healthcare services. Most people in these settlements are from different backgrounds and geographical locations, such as migrant labourers and unemployed individuals, who have settled near urban areas that offer better economic opportunities. These areas are vital targets for the national primary healthcare (PHC) reengineering programme (National Department of Health, 2010b).

In 2012, HIV prevalence in the metropolitan municipalities (hereafter referred to as metro) showed that eThekwini Metro in Kwa-Zulu Natal had the highest HIV prevalence at 14,5% and Mangaung Metro in the Free State Province had a 7,9 % HIV prevalence (Shisana et al., 2014). By the end of 2017, the Mangaung Metro, which includes Bloemfontein, Botshabelo and Thaba Nchu, had an HIV prevalence of 10,7 % (National Department of Health, 2017). There are statistically significant differences in HIV prevalence among the different race, age and gender groups within PLWHA (Mabaso et al., 2019). Amongst these groups, the black African females generally have the highest HIV prevalence, and the majority is found among the productive and reproductive age groups, especially for those with limited educational backgrounds and those residing in low- and middle-income households (Mabaso et al., 2019). These trends have been observed and reported for the last decade. Young girls and women between the ages of 15 and 19 years had an HIV prevalence of 13,7% in 2009, which increased to 14 % in 2010 (National Department of Health, 2011). In 2012, South African females had a 14,4% HIV prevalence, higher than the males at 9,9% (Shisana et al., 2014).

Correlating with UNAIDS global statistics (UNAIDS, 2013), HIV infection rates among South Africa's young females was eight times higher than among young men of the same age. Approximately one-fifth of South African women in their reproductive ages were HIV positive in 2014 (Statistics South Africa, 2016). Young pregnant girls and women in South Africa have been reported as a key population requiring attention (Abdool Karim et al., 2012). The fifth South African National HIV Prevalence, Incidence, Behaviour and Communication survey concluded in 2017, reported a 24,4 % HIV prevalence amongst the 25-49 years' age group, with a 33,3 % amongst females as compared to 19,4 % of males of the same group (Simbayi et al., 2019).

In South Africa, women are disproportionally affected by HIV. UNAIDS (2020) data report indicated that of the 7,5 million adults living with HIV in South Africa, 4,7 million are women with rapidly rising infections among adolescent and young women of ages 15-24 years. Research that led to the development of policy frameworks governing the implementation of critical national HIV programmes in South Africa, such as the HCT policy of 2010 (National Department of Health, 2010a) and the National Strategic Plans (SANAC 2011 & 2017), reported several determinants (already discussed in the preceding section). The findings revealed sexual debut, multiple sexual partners, condom use, age-disparate sexual relationships, alcohol and substance use, gender roles and norms, sexual abuse and intimate partner violence, as well as mobility and migration as the main factors influencing the distribution of HIV in South Africa (National Department of Health, 2015; Shisana et al., 2014; Simbayi et al., 2019; UNAIDS, 2020). The policies and plans referred to serve as operational structures towards achieving global goals such as the Millennium Development Goals and the 90-90-90, measurable targets with specific guidelines aimed at addressing many challenges the worlds' poorest people face. In these plans, HCT services are highlighted as one of the key components in addressing the HIV/AIDS epidemic.

The expansion of HCT services and treatment in South Africa has increased the public's dependence on the government's resources, expanding the scope of what the government can provide.The 'roll-out' of treatment called the national government to increase its capacity (National Department of Health, 2010a), which will include expanding the skills of the LCs. Despite the role of LCs in HCT services, it is also essential to consider how HIV counselling services can be supported in their efforts and address challenges that affect the skills, competencies and opportunities of further development in HIV counselling.

To ensure and improve HIV counselling services, the development, implementation, monitoring and evaluation of HCT programmes need to be relevant and research-based. The next section aims to direct the conversation towards the essential elements that need to be in place, to ensure quality HIV counselling within HCT services in public healthcare.

3.5 HIV Counselling Skills Programme Development, Implementation and Evaluation

3.5.1 HCT programme background

In theory, many forms of theoretical perspectives, as described in this chapter, can form the foundation of counselling skills training programmes. However, it is important to note that even though some of these skills might be universal and generic, they might not always apply to all geographical contexts, to all settings and all population groups (WHO, 1995).

Globally, UNAIDS and WHO require health ministries and departments to develop a comprehensive HIV programme plan, which includes HIV prevention, management, and care services. In South Africa, the primary sources of policy development are guided by frameworks set out in the National Strategic Plan (NSP) on HIV, STIs and TB for 2012-2016 and 2017-2022 (SANAC 2011 & 2017), the *Minimum Standards for counselling training: Selection and training of counsellors* (National Department of Health, n.d.), and the HCT policy (National Department of Health, 2010a), for example. These national guidelines explicitly state that HIV counselling services should be used in combination with other healthcare interventions to target gaps, optimise care and enhance HCT services. Mwisongo et al. (2015) emphasised that HCT counselling and testing services face challenges such as inadequate counselling skills for specific populations. Dewing et al. (2015) also reported similar findings and recommended additional training and supervision. Furthermore, LCs perform other auxiliary and administrative duties, impeding their HIV counselling duties. At the time of this study, the National Department of Health in South Africa was in the initial stages of implementing primary healthcare (PHC) reengineering. This approach is focused on strengthening the interaction between healthcare services and users, and the lay counsellor (referred to as Community Healthcare Worker (CHW) per amended regulations) is the primary service provider (National Department of Health, 2010a). Through this community-based programme, which focuses on health promotion and preventative care, CHWs deliver services to households and families.

These services are provided for early detection and prevention, especially for individuals at risk of medical and health illnesses and those with chronic conditions. The health promotion, awareness and screening services provided include HIV, as well as TB, maternal and child health. In addition, CHWs are expected to provide ARV adherence support, supportive counselling and refer and receive referrals from other healthcare practitioners (National Department of Health, 2010a).

3.5.2 The role of training

When government employees first enter any job or work, they are trained in the content, behaviours and skills required to perform the expected job tasks. Training is fundamental to any workforce as it offers the opportunity to learn what is related to the work. It improves workers' knowledge, skills and attitudes and advances their services (Marquardt, 1996). Training is an organised and methodical process to modify or promote knowledge/skill/attitude through a learning experience (Buckley & Caple, 2004). It can be done for numerous purposes, including monitoring and evaluating expected goals, improving services to meet the demand and changing nature of the service or acquiring or developing new tools and techniques for the workforce (Ahmad & Din, 2009). Training should be seen as an investment as it is indispensable for the organisation's benefit and effectiveness. Additionally, Ahmad and Din (2009) believe that training can increase employees' confidence in their ability to perform their duties.

The healthcare sector's service delivery needs depend on employees' previous work and/or educational training experiences. In healthcare, training offers the employer the ability to acquire employees who would be able to provide, maintain and increase the service being provided to survive healthcare services. These employees would have to fulfil human resource requirements in skill, knowledge, and competence. However, it is the government's responsibility to improve employees' ability to perform duties more efficiently and effectively. The human resource development of employees requires a needs analysis to be conducted, identifying the role of the healthcare worker and how it impacts service delivery, evaluating the benefits training might bring, assessing performance management and development, promoting as well as developing the healthcare worker's distinct roles

3.5.3 Evaluation and development of training

Every training programme has indicators that are sets of information used to collect data on a programme's success and failures. Evaluation of training is a measure that should be built in at the onset of the development of the training programme (Ahmad & Din, 2009). This systematic collection of information for assessment purposes is utilised to inform training needs decisions on how best to use available resources to achieve organisational goals. These corporate goals focus on problems and challenges, resulting in inadequate and failure to perform. The Public Service Act of 1994 (Act 103 of 1994) of South Africa details the standard functions of the Department of Public Service Administration (DPSA). This office in government regulates and coordinates the development and implementation of policies and guidelines to ensure compliance, improve service delivery and strengthen monitoring and public service evaluation. Through this national department, public servants' training, wellness, conditions of service, and code of conduct, for example, are used as key performance functions (Public Service Act 103 of 1994). These functions also serve as indicators to assess whether the DPSA can meet its goals. Similarly, in healthcare, some indicators measure patients' care through the administration or delivery of healthcare processes/services and the resulting outcomes. With LCs, clinical indicators can be assessed through various means in their counselling work, such as using self-report, observation of counselling sessions and interviews with service users (patients) (UNAIDS, 2000).

The clinical indicators in HIV counselling services are counselling skills and competencies such as 'establishing rapport', 'providing information', 'demonstrating empathy' and 'making use of referral systems'. The outcome of the evaluation as an assessment can inform training and evaluate the value of a training programme. Needs analysis conducted on LCs providing HCT services have indicated a need for structured guidelines in training and continued development of the LC cadre (Dewing et al., 2015; Duncan et al., 2017; Mohlabane et al., 2015; Mwisongo et al., 2015). However, the shortage of staff, lack of resources (e.g., budget for materials, time and expertise) are some of the challenges encountered in low resource settings. For this reason, a practical approach to programme development and evaluation was used.The Utilisation-Focused Evaluation (Patton, 1980) is a complex, dynamic, and adaptive system that provides a programme evaluation engagement process and interaction between the evaluator and intended user by realising the dynamics of implicit programme development and evaluation process.

In HCT, such evaluations are crucial in informing training requirements and assessing whether the services provided are in line with best practices. The planning steps utilised are explained in the next section.

3.5.4 Utilisation-Focused Evaluation (UFE)

Developed by Michael Q. Patton (1980) with numerous revisions, the Utilisation-Focused Evaluation (UFE) is a multi-method approach based on the proposition that the usefulness and intended outcomes for the users should be the primary goals for an evaluation (Patton, 2008). The findings of an assessment and the evaluation process itself must be able to inform decisions and improve performance. For this to be achieved, evaluations should be organised and effectively managed. UFE has two main elements. Firstly, since UFE provides an overall decision-making process, continuous attention should be placed on ensuring the products and techniques are used. Secondly, evaluators cannot be decision-makers. This means that UFE evaluators work with intended users to determine priority and the intended user assumes ownership over the development and implementation of the evaluation. Patton (2008) argues that research on evaluation demonstrates that if intended users drive the process, this increases the likelihood of the intended user using the outcomes because they have a better understanding and feel ownership of the evaluation process and findings. Furthermore, this increases the chance of the evaluations having the desired impact. UFE methods and data collection measures are informed by the outcomes of the Key Evaluation Questions (KEQS), which are generated by users.

The UFE framework (Patton, 2013) initially entailed five steps, with the most recent version having 17 steps. The steps are described below to provide contextual factors that informed the counselling skills programme development and evaluation in this research study based on the UFE framework. It is important to note that this programme evaluation framework considers not only the content and the training and the trainee, but also the trainer needs to demonstrate programme development abilities from an academic and practical standpoint. The methodology chapter (Chapter 4) will describe the evaluation and implementation of the HIV counselling skills training programme in more detail.

The 17 Step UFE Framework (Patton, 2013)

1. Assess and build programme and organisational readiness for utilisation-focused evaluation

   A commitment was commissioned from the Department of Health: Free State, and funding for the research study sought from the National Research Foundation. A review of essential documents such as the *NSP 2012-2016* (SANAC, 2011) *Minimum standards for counsellor training: Selection and training of counsellors* (National Department of Health, n.d.) and *UNAIDS Tools for evaluating VCT* (UNAIDS, 2000) was conducted. Interviews with key stakeholders (Free State HCT coordinator and Mangaung Metropolitan Municipality HCT coordinator) were held.

2. Assess and enhance evaluator readiness and competence to undertake a utilisation-focused evaluation

   The researcher assessed their professional practice knowledge, inquiry, analysis and project management skills in consultation with the study supervisor. Interpersonal, reflective practice and cultural competencies were also reflected upon. Commitment and knowledge were adapted as the process unfolded through various training opportunities that the researcher attended. These academic research training opportunities were offered by UFS Postgraduate school. The researcher attended and presented papers related to the current study topic at various conferences. These included presenting a poster at the Higher Education and Training HIV/AIDS Programme (HEAIDS) Conference in 2012, attending the Southern African HIV Clinicians Society Conference in 2014 and presented a paper at the Southern African Association for Counselling and Development in Higher Education (SAACDHE) Conference in 2016. The researcher was considered appropriate to be the only evaluator based on professional competencies in counselling skills and HIV through these various opportunities.

3. Identify, organise, and engage primary intended users: the personal factor

   Participants for the study were selected from three towns, namely Bloemfontein, Botshabelo and Thaba Nchu, as described in the sampling process in Chapter 5 (cf. Section 5.3.2). The researcher explained the role participants would play and organised and involved participants and stakeholders throughout all steps/processes. There was continuous monitoring of availability and interest in participation by lay counsellors. The study ensured that there was no disruption in HCT service delivery.

4. Situation analysis conducted jointly with primary intended users

   The researcher examined their own experience in a previous study conducted as part of the MAC-AIDS Fund Leadership Initiative (MAFLI, 2012) to identify factors that support and facilitate the current evaluation. Barriers such as accessibility of participants, transport, appropriate research environment and conditions were identified. Resources were determined, such as support and openness of team leaders and HCT coordinators to ensure participants' availability. This ensured that the research adhered to the set timeline. The researcher also had to understand the political context affecting the work of LCs as volunteers and not employed by the Department of Health. In addition to continuous consultation with the research supervisor, the researcher remained objective by employing the help of a research assistant who had experience in community research and a Master's degree in Community Development.

5. Identify and prioritise primary intended uses by determining priority purposes

   The researcher considered and continuously reviewed the contribution the evaluation would have on HCT services. Accountability, objectivity, and monitoring were continuously emphasised. The researcher prioritised her purpose by ensuring ethical conduct and not having conflicting roles as both researcher and clinical psychologist, especially in managing research-based counsellor-patient interactions that had a negative psychological effect on patients.

6. Consider and build in the process uses if and as appropriate

   The researcher evaluated thinking and its relation to HCT service organisational culture and whether the evaluation would enhance shared understanding. Support was sought by encouraging participants to use supervision and peer support to reinforce the intended objectives of the HCTP intervention. The researcher considered the possible increase in HIV counselling skills, knowledge, confidence, self-determination, and sense of ownership of lay counsellors in the delivery of HIV counselling following the HCTP intervention. A review of positive and negative effects, as well as prioritising research processes, was conducted throughout.

7. Focus priority evaluation questions

   The criteria for the right UFE questions (KEQS) were evaluated. Focus group discussions (FGD) provided an opportunity to sufficiently answer research questions to complement and corroborate quantitative data. Measures such as audio recordings and transcripts were used to capture participants' responses.

8. Check that fundamental area for evaluation inquiry are being adequately addressed: implementation, outcomes, and attribution questions

   Options for implementation evaluation were considered by addressing the effort and input of the assessment. Process evaluation, component evaluation and intervention duration were conducted throughout the process. Evaluation outcomes in terms of what results were generated from HCTP intervention, how participants changed, to what extent the programme's goals were achieved, any unanticipated outcomes, and to what extent the participants' needs were met by the programme were considered.

9. Determine what intervention model or theory of change is being evaluated

   The *Model of Counselling Competence* (Ridley et al., 2011b) as the theoretical framework of the evaluation was utilised to conceptualise and develop the HCTP intervention. The evaluation design (mixed methods) and measurement approach (different phases and tools) of the programme intervention were carefully selected.

10. Negotiate appropriate methods to generate credible findings that support intended use by intended users

    Mixed method design offered a selection of methods to answer participants' priority questions (what LCs identified as training needs) to have credible results and meet the objective (to enhance counselling skills, competence and management of burnout). Methods and tools were appropriate for the research question, translated to accommodate language barriers, and they were cost-effective, ethical and in line with best practices. Threats to data quality, credibility and utility were managed with the use and in consultation with a statistical team's appointment.

11. Make sure intended users understand potential methods controversies and their implications

    Both quantitative and qualitative measures were used to achieve methodological purity in this experimental design with multi-stage randomisation. Internal versus external validity and generalisations versus context-sensitive extrapolations were considered.

12. Simulate the use of findings

    Measures and activities remained the same in the pre-and post-intervention phases. Participants' commitment to proceed regardless of costs was continuously monitored.

13. Gather data with ongoing attention to use

    Effective management of data collection for quality assurance and credibility was done through assigning participants a unique number for confidentiality purposes, the use of recordings, attendance registers and safekeeping of completed questionnaires. Only the

agreed-on research activities were implemented. Participants were continuously informed on data collection processes and feedback provided to participants and stakeholders.

14. Organise and present the data for interpretation and use by primary intended users: analysis, interpretation, judgement, and recommendations

    Findings are reported in Chapter 6, as well as a discussion provided in Chapter 7. Results were triangulated, and various interpretations and explanations explored. Different kinds of recommendations, costs, benefits, challenges and actions for implementing are explained in Chapter 8 of this thesis. Additionally, implications from various perspectives are also outlined in the chapter.

15. Prepare an evaluation report to facilitate use and disseminate significant findings to expand influence

    The research study is reported in the form of this thesis. A summary report was presented as a research paper at the Free State Research Day (2019). More avenues for further and broader formal and informal dissemination will be explored.

16. Follow up with primary intended users to facilitate and enhance use

    Following the implementation and evaluation of the HCTP intervention, participants both in the experimental and control groups were offered counselling skills training notes and resources.

17. Meta-evaluation of use be accountable, learn, and improve

    A systematic reflective practice about the evaluation was conducted by engaging in personal reflective practice. This was achieved through consultation with the research study team to support on-going professional development.

3.6 Conclusion

This chapter extensively addressed the LC group and dynamics related to the education, selection, training, and skills of LCs. The literature shows extensive gaps in the provision of quality HIV counselling within HCT services in South Africa. Furthermore, the systems in place to address the HIV/AIDS epidemic in South Africa seem to be driven by many social factors. Thus, HIV counselling needs to include a comprehensive process that will be able to incorporate these socio-economic factors.

The LC group seem to have a challenging task at hand, and the statistics and effect of the epidemic have shown that, although significant achievements have been made, barriers are still present. Perhaps these barriers can be addressed and intended objectives achieved in the current study utilising the programme evaluation method, as discussed in the preceding sections. The next chapter comprises the construction of the study plan, methods, and tools. Careful planning went into how the study was designed, considering what has been emphasised in the literature.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

This chapter outlines the study's methodological orientation and research paradigm. It will provide a theoretical background regarding the research design and the processes undertaken in developing the research methods. The sample, measuring instruments, the research question, data-gathering process, data analysis and statistical procedures will also be discussed. The chapter concludes with aspects concerning ensuring the quality of the research as well as ethical considerations.

The research methodology and design were based on the aim of this study stipulated in Chapter 1, namely to assess the current level of counselling skills, key competencies and burnout of lay counsellors and address any deficiencies by promoting best practices in the field through the development and evaluation of a counselling skills programme.

The main objectives include:

- Firstly, to assess the current level of counselling skills, competence, and levels of burnout among lay counsellors.
- Secondly, to adequately inform counselling skills through the development in type, content, mode, and duration of a skills training programme.
- Thirdly, to implement the training programme.
- Lastly, to evaluate the effectiveness of the training programme.

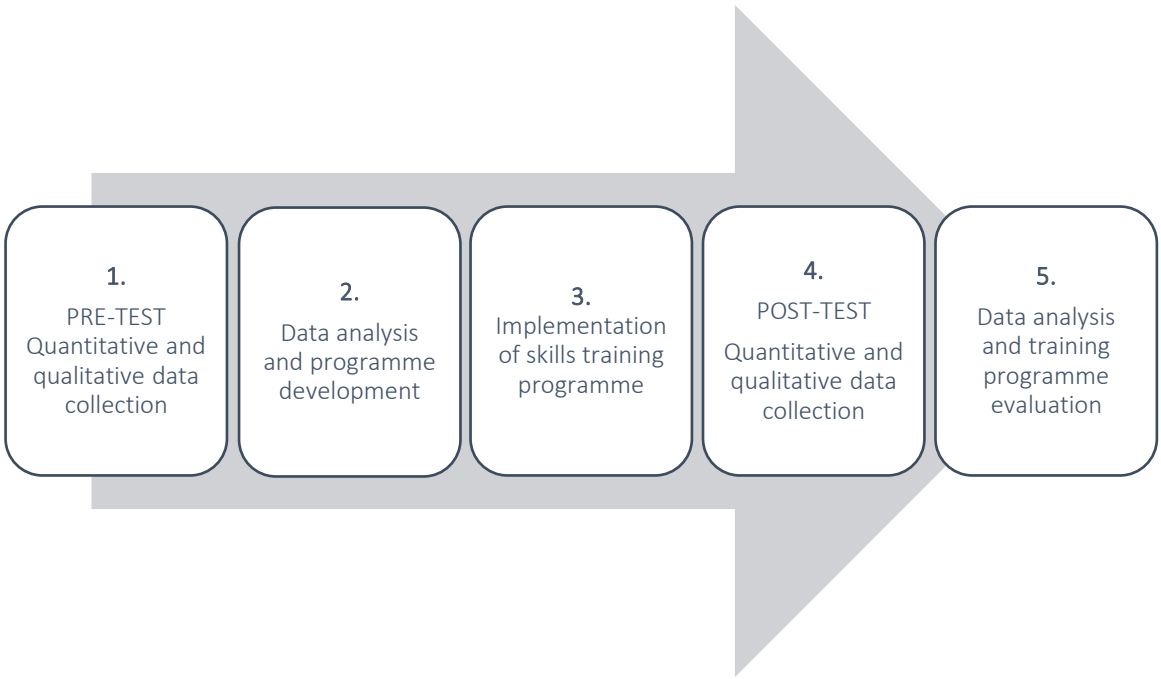
The study used a concurrent triangulation, also known as the convergent parallel design (Creswell et al., 2003; Greene, 2007; Teddlie & Tashakkori, 2009). As illustrated in Figure 4.2, the process of data collection and analysis for both the quantitative and qualitative research strands are outlined, including the triangulation (merging data sets) process. These steps were conducted for both the pre- and post-intervention phases.

This chapter also includes motivations and explanations on the choice of the mixed-method design used and discussions about quantitative and qualitative processes in terms of theoretical stance and general characteristics. The research entailed a controlled, open, experimental evaluation design, including pretest and posttest analysis with randomised experimental and control groups. The level of skill, competence, and burnout of the LCs in the qualitative section of the study form the dependent variable, while exposure/non-exposure to HIV counselling skills training programme (HCTP) forms the independent variable. This uses an experimental intervention, which justifies this research as experimental (Stangor, 2011). The study comprised of five phases, as shown below in Figure 4.1. and in more detail, in Figure 4.3. Figure 4.1 illustrates the main phases of the research study, from the assessment and analysis of pre-intervention data (phase 1 & 2), the implementation of HCTP (Phase 3), and the evaluation and analysis of post-intervention data (phase 4 & 5).

**Note:* Adapted from Concurrent Triangulation Mixed Methods (Cresswell & Plano-Clarke, 2011)

Figure 4.1

Five Phase Mixed Method Steps



The theoretical background on the research design and the process undertaken in developing the research methods is described in the next section.

4.1 The Research Design

A research design is a detailed formulation of a programme of action and method of execution of research. As Yin (2003) explains, "it is an action plan for getting from *here* to *there*, where 'here' may be defined as the initial set of questions to be answered and 'there' is some set of (conclusions) answers" (p. 20).

4.1.1 The theoretical perspective of research design

Based on general principles in research design, as provided by Patton (1990), Cresswell et al. (2003) and Tashakkori and Teddlie (2003), the mixed-method research design was chosen for various reasons. These include the following:

- Firstly, a fixed mixed-method design was selected where the use of quantitative and qualitative methods was predetermined and planned at the start of the research course. This allowed for the research processes to be implemented as planned.
- Secondly, in designing this mixed-method study, a typology-based approach seemed more appropriate as it is a classification system that allows for the selection and adaptation of a particular design to a study's purpose and questions. When considering the nature of the research study's aim, both qualitative and quantitative strand had to run parallel to allow simultaneous data collection, allowing both forms of methodologies to provide data that could yield strengths that either of the methods would.
- Thirdly, a single method alone includes one data source, and that is often insufficient. Adding a second method offers an opportunity to study a problem through multiple stages of research by including numerous types of methods. In this study, no single method took priority over the other.
- Lastly, the triangulation and integration (mixing) of the data was conducted following data analysis. In the current study, it was important to follow this plan, as it was appropriate in meeting the objectives of this experimental study that had both assessment (pretest) and evaluation (posttest) phases.

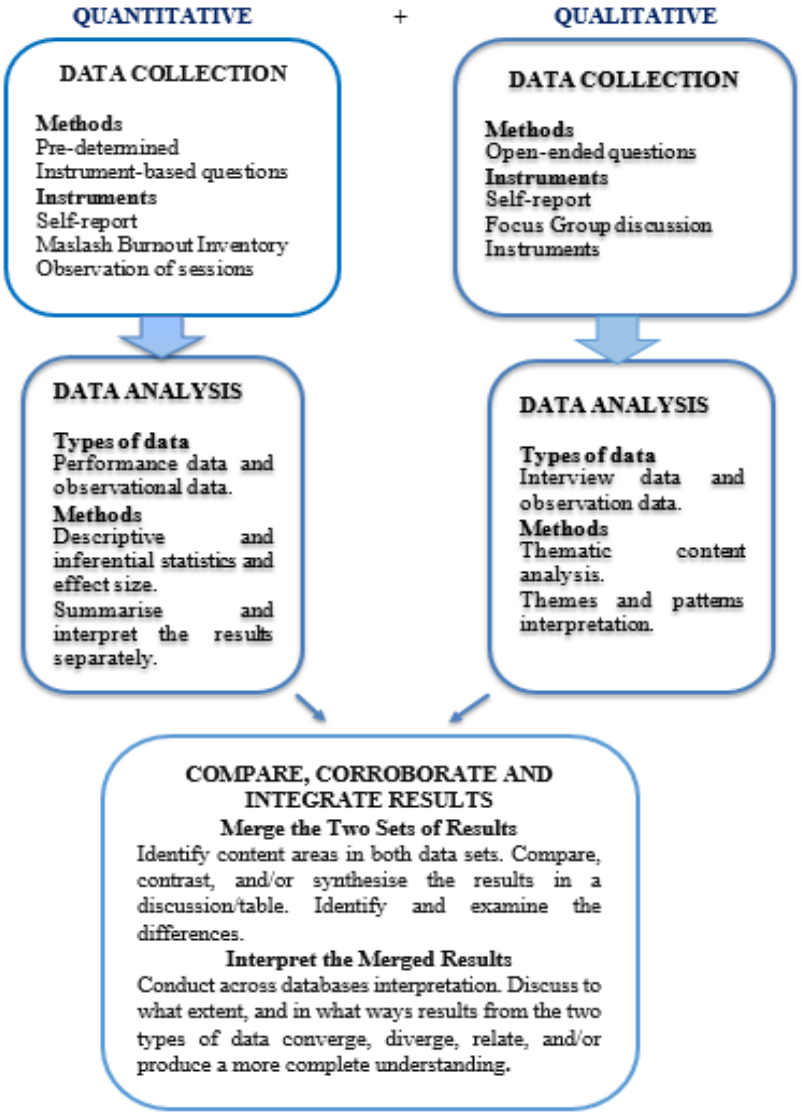
Bryman's (2006) general framework, which expanded from the work of Greene and colleagues (Greene et al., 1989) was utilised in informing the choice of 'mixing' that occurred by

integrating findings at the results stage. The rationale was to address the study's objective in collecting data that are complementary, credible, expandable, explainable and provide diverse views that are context-specific. Additionally, collect data that can provide a 'complete' analysis of the phenomena under study, considering offsets (strengths and weaknesses of each method). The concurrent mixed-method approach was applied in both the pre-intervention (phase 1 & 2) and post-intervention (phase 4 & 5) phases of the study.

Figure 4.2

Concurrent Triangulation Mixed-Method Design

(adapted from Creswell & Plano-Clark (2011)



4.1.2 The mixed-methods research design

In research, philosophical assumptions are central to research inquiry. Upon investigating the research phenomena, the researcher sought a balance between subjectivity and objectivity throughout the investigation. This is, in essence, what 'Pragmatism" offers (Tashakkori & Teddlie, 2003). This paradigm proposes that reality is best understood through multiple outlooks (Creswell & Plano-Clark, 2011). Therefore, this 'worldview' was deemed well-suited for guiding the research work by merging the two approaches into a broader understanding.

The current study followed the **Four Decisions for Mixed-Method Designs** (Creswell et al., 2003) in its order of conducting the study.

1. From the onset, the implementation sequence of data collection was based upon the conditions of concurrent methods where the qualitative and quantitative data are collected simultaneously.
2. There was an independent level of interaction between the quantitative and qualitative strands. Therefore, the research questions, data collection, and analysis were treated and conducted as separate activities and processes.
3. No specific method took priority; both the quantitative and qualitative strands had equal importance.
4. Following the qualitative and quantitative data analyses separately, the researcher merged the findings in the interpretation phase, with both strands weighing equally. This degree of interaction between the two methodologies ensured that the results stage sought to meet the complementarity conditions, namely, *using* one method to elaborate, illustrate, enhance, or clarify the results from another.

The process (Creswell & Plano-Clark, 2011) is illustrated in Figure 4.2.

4.1.2.1 The quantitative strand

The positivist paradigm's perspective informs research approaches that are associated with quantitative methods, which place great emphasis on accuracy, generalisability, reliability, and replicability (Johnson & Onwuegbuzie, 2004).

This objective, standard and deductive reasoning methods are a way to eliminate biases and help researchers remain objectively uninvolved with the objects of study to justify their stated hypotheses (Creswell, 2008) empirically.

In the current study, the quantitative phase investigated counselling skills, competencies, and burnout among the LC participants. A two-group, pretest, posttest experimental design (Struwig & Stead, 2001) was used for this component of the mixed-method study.

4.1.2.1.1 Quantitative data collection

At pre- and post-intervention, the quantitative leg investigated counselling skills, competence, and burnout. Regarding Figure 4.2, information on education level, work experience, training, current work practices, workload and stress were collected to describe participants. In addition, the variables in this study about counsellor skills, competence, and burnout of the lay counsellor group were assessed. A self-report (Annexure 5) and observation of counselling sessions (Annexure 8) measures derived from the *UNAIDS Tools for evaluating VCT*: *Tool 3, 4 and 5* (UNAIDS, 2000) were used with the addition of the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981) (Annexure 6) for burnout.

4.1.2.1.2 Quantitative data analysis

The quantified data recorded numerically was analysed to get an indication of the distribution of the data. Descriptive statistics, inferential statistics and non-parametric tests were also conducted.

4.1.2.2 The qualitative strand

Qualitative purists support a constructivist paradigm that assumes that reality is constructed intersubjectively through the meanings and understandings developed socially and experientially (Creswell & Plano-Clark, 2011). Within this method, it is assumed that the investigator and the object of investigation are linked. The investigator relies on the participants' views and opinions, developing subjective meanings of the studied phenomena (Johnson & Onwuegbuzie, 2004). Qualitative research designs involve understanding the meaning that individuals and groups ascribe to certain situations and conditions.

Furthermore, the process of qualitative research involves emerging questions, themes and procedures with data typically collected in the participant's setting. This inductively builds from particular to general themes, and the researcher can make interpretations about the meaning of the data (Onwuegbuzie & Combs, 2011).

4.1.2.2.1 Qualitative data collection

At pre- and post-intervention, the qualitative leg explored counselling skills, competence, and burnout. To clarify and increase the depth of the quantitative data, qualitative entities in the study were collected using open-ended data that was collected from *UNAIDS Tools for evaluating VCT: Tool 3* (UNAIDS, 2000) (Annexure 5), as well as a focus group discussion tool (Annexure 7).

4.1.2.2.2 Qualitative data analysis

The qualitative data was analysed using procedures of theme development and those specific to the qualitative approach. Thematic analysis was utilised to find common themes to explain the various meanings of the studied phenomena (Struwig & Stead, 2001). The analysis of the qualitative data will be discussed in detail under Section 4.2.8.4.2 in this chapter.

In summary, the current study's choice of a mixed-method approach entailed using different methods, some overlapping, and some informing the nature and course of the research study. In the next section, the research study is described in detail.

4.1.3 Research study

This part of the thesis focuses on the research study components, including participants, measuring instruments, methods of investigation, data collection processes of both the quantitative and qualitative strands.

4.1.3.1 Aim of the study

The research study aimed to 'assess the current level of HIV counselling skills, key competencies and burnout of LCs and address any deficiencies by promoting best practices in the field through the development and evaluation of a counselling skills programme'. This was to be achieved through a concurrent triangulation mixed-method design illustrated in Figure 4.2 and following the five-phase process shown in Figure 4.1.

4.1.3.2 Sampling and Participants (Quantitative and Qualitative)

A nonprobability purposive sample comprising of N=107 lay counsellors whose primary tasks is the provision of HIV counselling and testing services in clinics and hospitals within the Bloemfontein, Botshabelo and Thaba Nchu areas was selected. The researcher purposefully selected participants in the desired settings (Public HCT service points) for this phase to maximise understanding of the underlying studied phenomenon. Information on the participants was obtained from the Free State HCT coordinator, and meetings with participants organised to orientate and obtain consent.

> **Inclusion criteria**: Lay counsellors with 10-day HIV counselling and testing training provided by the Department of Health or an accredited/affiliated non-governmental organisation (NGO), currently working in public health HCT services.
> **Exclusion criteria**: Professional counsellors (with counselling degree/diploma) working in public health HCT services.

Furthermore, multistage, purposeful, random sampling methods were followed according to the multi-phase process of the mixed-method investigation. Multistage sampling divides large populations according to different stages of the study to make the process of sampling more practical (Onwuegbuzie & Collins, 2007). Therefore, the 107 participants that were part of the first assessment (self-report) were assigned a number. This number and sampling were adhered to throughout the different stages and phases of the study (i.e., Participant 3 in the pre-intervention phase remained Participant 3 in the post-intervention phase). A random number generator was used to randomly select participants for the next stage of the assessment phase by selecting random cases or choosing a desired number of individuals for the total (N=107) to participate in the next stage of the study.

This process generated the number of participants that would participate in the focus group discussions. To avoid bias, the process conducted would ensure that every participant had an equal chance to be selected as part of the sample for the specific activity (Onwuegbuzie & Collins, 2007). The FGD sample procedure was further followed by random sampling from the total (N=107) for the observation of sessions. As each sampling method resulted in several participants, the allocation will be discussed under each method of study (i.e., sample for focus group discussions). Nonetheless, the qualitative sample would ensure that participants provide in-depth information about the studied phenomena and the site of investigation. Furthermore, the demographic characteristics of participants will be described in Chapter 5, with the study results.

4.1.4 Research tools and measures

The *UNAIDS Tools for evaluating VCT* (UNAIDS, 2000) was used to evaluate voluntary HIV counselling and testing services (Ginwalla et al., 2002; Ma et al., 2013; Papanna et al., 2012; Ramalepe et al., 2014). The tools consist of a series of measures of specific aspects in evaluating V/HCT and were designed to develop and improve the services. The tool consists of eight sections (tools) listed below, which monitor and evaluate V/HCT services.

UNAIDS Tools for evaluating VCT (UNAIDS, 2000)

- **Tool 1**: National preparedness and VCT commitment and implementation
- **Tool 2**: Evaluation of operational aspects of the sites and services
- **Tool 3**: Counsellors' requirements and satisfaction
- **Tool 4**: Evaluation of counselling quality (Tool 4a) and content (Tool 4b)
- **Tool 5**: Counselling for special interventions
- **Tool 6**: Group counselling/ Group work
- **Tool 7**: Client satisfaction
- **Tool 8**: Costs of VCT

For this study, only Tools 3, 4 and 5 (highlighted) were utilised. According to UNAIDS (2000), the tools are feasible to be utilised by countries in their national V/HCT programmes, at public HIV sites and institutions, independent sites, in serving special groups, as well as in community and NGOs that provide HCT services (UNAIDS, 2000).

Additionally, to explore key components that affect HIV counselling services offered by LCs, the burnout section in Tool 3 was omitted. Instead, the Maslach Burnout Inventory (Maslach & Jackson, 1981) was used as it has been proved to be useful in understanding burnout among healthcare professionals (Dubale et al., 2019) and offers more statistical reliability (Kantas & Vassilaki, 1997; Kokkinos, 2000). Furthermore, the FGD tool was developed as guided by components of the UNAIDS (2000) tool. In the last section, a description is provided of the HCTP evaluation self-report measure, which was utilised to evaluate the skills training received by the intervention (experimental) groups.

4.1.5 Quantitative study

In this mixed-method study, the quantitative process entailed assessing skills and competence using components in the *UNAIDS Tools for evaluation of VCT* (UNAIDS, 2000).

4.1.5.1 Self-report measure

A self-report measure is a type of interview that can be structured or semi-structured. Such a measure aims to allow the researcher to understand the respondents' perspective and is largely dependent on the interviewer. Merriam (2009) describes a structured interview as a standardised form of quantitative data collection where the wording and order of questions are predetermined. In quantitative studies, this form of reporting is used to obtain demographic data such as age, gender, ethnicity, and education (Merriam, 2009). Self-report tools can also be assessment tools used to obtain certain information, as in the case with psychometric and diagnostic tools in healthcare services.

4.1.5.1.1 UNAIDS self-report

The *UNAIDS Tools for evaluating VCT* (UNAIDS, 2000) (Annexure 5) self-report measure was utilised. Most items, except for item 34-42 from Tool 3, were selected. These consisted of a list of questions (items 1-13) on biographical information on LCs' age, ethnicity, and place of residence. Item 13 was a qualitative question where participants had to respond to the question "*Are you part of a community club or society*?' and, if *Yes, please elaborate*.

Job selection and training background (item 14-22) enquired about occupational background, with questions posed such as '*How were you selected to be an LC*?' '*Training you received?*' '*Needs for additional training*?'. Item 16 was a qualitative question where respondents had to answer '*Do you feel that you have been pressurised into doing counselling*? *For example, is counselling something you feel comfortable doing, or do you feel it is a strain, or that you have to do it as part of your job? Please elaborate*. Questions 16,17,19-22 also required the participants to respond qualitatively. Items 25-27 on support and supervision required respondents to answer questions such as '*How many hours do you work*?' *Do you have a counsellor support group*?' '*Do you have support from a designated supervisor*?' etc. Stress and burnout questions related to items 29-33, which qualitatively enquired about the participants' ability to manage stress. However, burnout assessment (items 34-42) was omitted. Participants were also asked to indicate their workload and time spent with each patient (item 44) . For example, '*How many years have you been counselling*?' *How many hours per day do you do counselling*?'

4.1.5.1.2 Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI; Maslach & Jackson (1981) (Annexure 6) is the most widely used and accepted measurement tool of stress and burnout. The MBI is a 22-item questionnaire designed to assess the three subscales of burnout, namely emotional exhaustion, depersonalisation and decreased sense of personal accomplishment. In the development of the MBI tool, samples from various human service provision occupations were used in item selection and different samples from the same occupational categories in testing reliability (Maslach et al., 1996). The MBI generated Cronbach's alpha reliability coefficients of 0.90 for the Emotional Exhaustion subscale, 0.79 for Depersonalisation and 0.71 for Personal Accomplishment on these original samples (Maslach et al., 1996). In South Africa, the overall scale has demonstrated Cronbach's alpha of 0.86 (Visser & Mabota, 2015).

The 22 total items of the MBI are divided into three subscales: items 1, 2, 3, 6, 8, 13, 14, 16 and 20 relating to emotional exhaustion (Section A), items 5, 10, 11, 15 and 22 relating to depersonalisation (Section B), and items 4, 7, 9, 12, 17, 18, 19 and 21 relating to personal accomplishment (Section C). The participants choose items, which are rated on a frequency and intensity scale. The frequency scale ranges from zero (never) to six (every day).

The intensity scale ranges from one (never) to six (very strong). The measure indicates high levels of burnout if a participant scores high on the first two sub-scales (section A and B) and low on the last one (Section C)**.** The instrument has been used widely amongst mental health professionals (Dubale et al., 2019; Mashego, 2018) and healthcare workers providing HIV care (Kim et al., 2018, Qiao et al., 2016; Roomaney et al., 2017; Visser & Mabota, 2015) and have demonstrated good construct validity in many countries (Kantas & Vassilaki, 1997; Kokkinos, 2000). The MBI was included to explore further and expand the data relating to aspects of counsellor variables that impact their work.

4.1.5.2 Observation of counselling sessions

Observation of counselling sessions is a feasible data collection measure, especially in the training, evaluation and monitoring of such services (UNAIDS, 2000). Merriam (2009) states that a researcher in an observation capacity can assume different roles. As an observer, they can be a complete participant or have one participant serve as an observer or be a complete observer. There are advantages and disadvantages of these different roles. Firstly, through complete participation in research activities and what is being studied, the researcher conceals their identity from the group to not disrupt the natural activity of the group, which, however, has questionable ethics.

If the researcher assumes the role of a participant-observer or an observer as a participant, they can potentially affect the information revealed and shared within the group. However, with a complete observer, one who is hidden away from the group, observing through one-way mirrors or from a distance, can add value as they have limited influence on the overall observation activity. However, the role of a researcher is found to run over a continuum, in that researchers often find themselves in varied roles of both participant and observer (Merriam, 2009). To effectively manage this, various options of observations are available. These alternative counselling session assessments include but are not limited to audio and video recording of counselling sessions, one-way mirrors, using dummy patients and role-play sessions.

4.1.5.2.1 UNAIDS Observation of sessions

The *UNAIDS Tools for evaluating VCT* (UNAIDS, 2000) (Annexure 8) consists of Tools 4a and 4b. Tool 4a is designed to evaluate counselling skills, competence-based and content-based elements. Interpersonal relationship, gathering information, giving information and dealing with special circumstances are the main competence elements (UNAIDS, 2000). The competency elements are rated on a three-point Likert rating scale, with 1 being least competent, 2 indicating average competence and 3 being fully competent. The evaluator assesses the counselling skill sets and competencies and rates the LC based on this scale. However, it should be emphasised that the UNAIDS tools evaluation is not a pass/fail test of competence, but rather a way of enhancing performance and highlighting strengths and weaknesses in the service to improve them (UNAIDS, 2000).

Tool 4b is for evaluating content-based elements that cover content related to pretest HIV counselling, posttest HIV counselling, and counselling where HIV testing is unavailable. Questions are asked where an observer/evaluator needs to assess the LCs' interaction with the patient and evaluate whether the LC addressed questions and content related to this type of counselling. The evaluator assesses the counsellor by rating their counselling skills/content either a Yes or No. In addition, Tool 5 includes HIV counselling aspects relating to special interventions and specific groups. These are interventions for patients with TB (TBTP) and HIV counselling for pregnant female patients or females with infants, referred to as mother-to-child-transmission (MTCT). Using the tool for evaluating counselling content for TBPT, the observer/evaluator can assess the LCs' inclusion of TB-related information in their interaction with the patient and make special reference to TB.

Similarly, this applies to content associated with MTCT counselling interventions. In the MTCT counselling process, the HIV counsellor needs to address the information related to the biological risks mothers pose to unborn babies or infants. Tool 5 requires that the session observer/assessor evaluate the counsellor using a Yes, (if the content was included) or No (where the content was not included) assessment rating. The observation of the session tool is attached as Annexure 8.

4.1.6 Qualitative study

In this mixed-method study, the quantitative process was complemented by an additional data gathering process to explain, expand or complement the data. The focus was specific to issues that could answer the research question.

Also, these measures are deemed necessary components in the *UNAIDS Tools for evaluation of VCT* (UNAIDS, 2000) as they offered an opportunity to gather more details on LCs' training and work through various roots. For example, for the component assessing the counselling skills and observation of counselling sessions was employed (tools 4 and 5), more information was sought to explain the quantitative results. The FGD measure developed is described in the section that follows.

4.1.6.1 Focus group discussion (FGD)

According to Rennekamp and Nall (2006), the goal of an FGD is to promote self-disclosure among participants. Wilkinson (2004) describes this qualitative method of investigation as a means to collect data by engaging in a small group of people in an informal discussion focused on a set of issues. For this study, FGDs are guided and facilitated discussions on a clearly defined topic to gather insights, responses, perspectives and opinions regarding a specific topic. The use of such discussions is to explore how individuals describe a topic. The findings could be used to develop quantitative data collection instruments or, in the current study, complement, supplement or enhance the data collected.

4.1.6.1.1 Focus group discussion (FGD) tool

The *Focus Group* questions were developed from the UNAIDS tools 3, 4 and 5 and literature study. Before the FGD tool could be developed, an analysis of the counselling components in the UNAIDS tool related to lay counsellors' skills and competencies was conducted to corroborate and compile a list of components. These main components of each of the tools were grouped and combined with data from the literature in a list of the type of questions/components that were included in the FGD. The FGD tool is attached as Annexure 7.

4.1.6.1.2 UNAIDS Self-report (Qualitative questions)

The *UNAIDS Tools for evaluating VCT* (UNAIDS, 2000) (Tool 3) has qualitative components relating to counsellors' working conditions (cf. 4.2.5.1.1).

These questions focus on the selection and training of lay counsellors (e.g., *Do you feel that you have been pressurised into doing counselling: For example, is counselling something you feel comfortable doing, or do you feel it is a strain, or that you have to do it as part of your job*?), peer and mentor support (e.g., *Do you attend a counsellor support group, If YES, in what way is the group helpful or not helpful*?) and supervision from supervisors and managers and workload (e.g., *Are you given adequate time in your job to carry out your counselling duties?*)

4.1.7 HIV counselling skills training evaluation self-report

The *Training Evaluation Self-report* was compiled and administered at the end of the training. The tool contains both quantitative and qualitative questions. Questions 1-5 used a Likert-scale with responses ranging from 1 = Very dissatisfied, 2 = Dissatisfied, 3 = Unsure, 4 = Satisfied, 5 = Very satisfied. These questions covered general aspects of the implementation and process of training. Questions 6-7 were qualitative questions, which asked participants whether the training aspects were enjoyable and not enjoyable. Questions 8-12 were qualitative questions covering the content of the training, specifically the main objectives of each module, such as determining counselling outcomes, facilitating counselling outcomes, evaluating counselling outcomes, and sustaining therapeutic outcomes. The evaluation is attached in the training manual (Annexure 1.4.) For example, *After the training: Can you establish/assess what the client needs from you*? *After the training: Do you have skills to evaluate if your counselling benefited the client*?

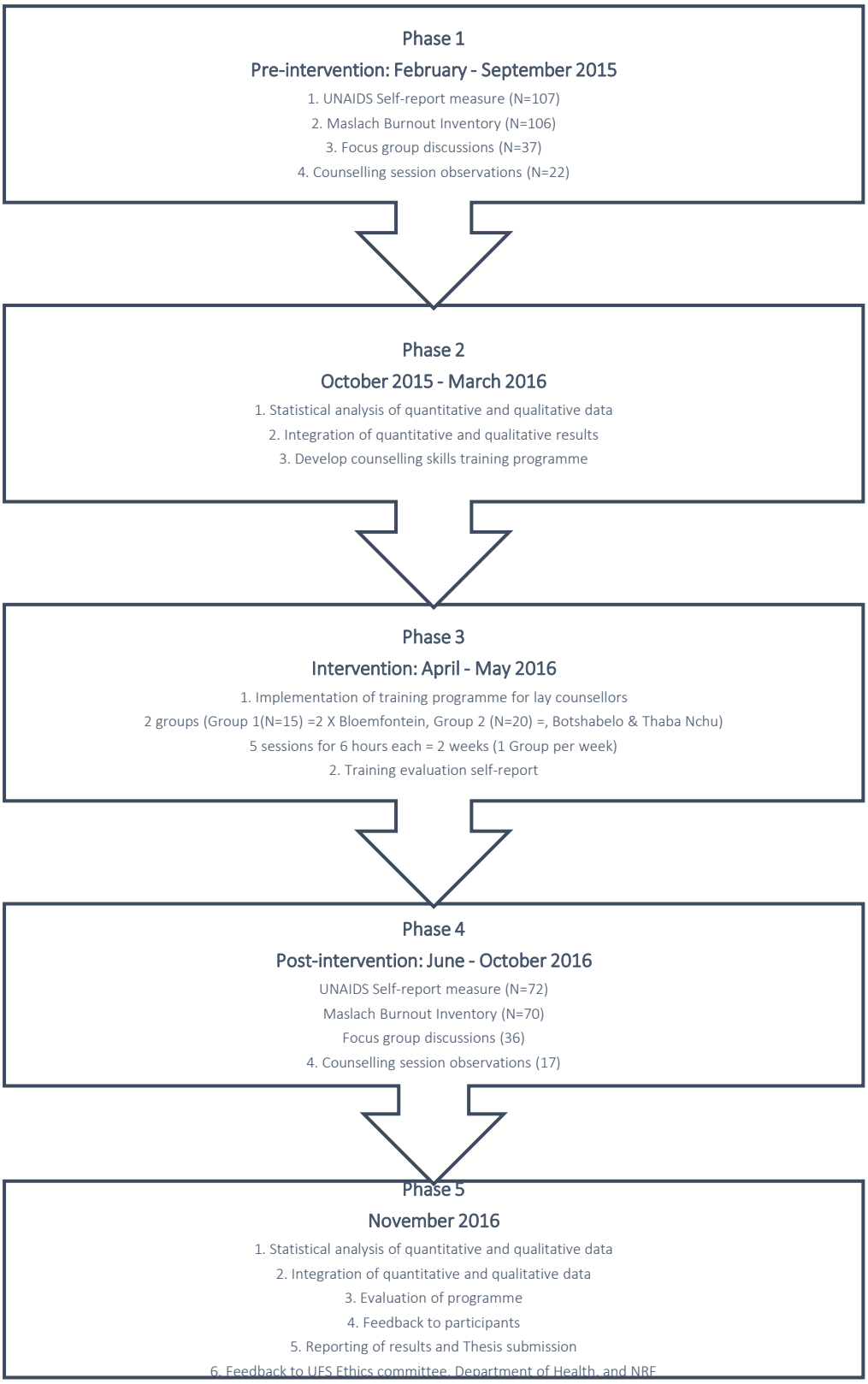
4.1.8 Data collection process

The following section details the multi-step data gathering process, including the techniques, used. The three data collection techniques used in this research study were self-report measures (UNAIDS self-report and MBI), FDGs and counselling session observations.

No one method constituted a single, most important and valuable source of information, but all activities and methods combined were equally important. In Figure 4.3, the five-phase research process is illustrated, from the assessment (pre-intervention phase) to the evaluation (post-intervention phase). All steps are indicated regarding activities and sample sizes.

Figure 4.3

Research Study Flow Chart



Quantitative research hypotheses

The following research hypotheses were formulated for the quantitative part:

- *Lay counsellors who underwent the CTP programmes' counselling skills will differ from those who were not exposed to the programme*
- *Lay counsellors who underwent the CTP programmes' competence will differ from those who were not exposed to the programme*
- *Lay counsellors who underwent the CTP programmes' levels of burnout (emotional, depersonalisation, personal accomplishment) will differ from those who were not exposed to the programme*

4.1.8.1 Qualitative research questions

The following research questions are formulated for the qualitative part:

- *How do LCs perceive their current level of counselling skills, competence, and burnout?*
- *What are the LCs' perceptions on the acquisition of counselling skills, competence, and management of burnout?*

4.1.8.2 Phase 1: Pre-intervention data collection

The pre-intervention assessment process was conducted between February 2015 and September 2015.

4.1.8.2.1 Quantitative section

All LCs present on the day of the first data collection period provided consent to participate in the study and completed the assessments. The assessments used had been translated to Sesotho, and all measures were made available in both English and Sesotho versions. This assessment process was twofold; it included the UNAIDS self-report measure (UNAIDS, 2000) and the Maslach Burnout Inventory (Maslach & Jackson, 1981). From the onset, the LCs were assigned randomly to the experimental and control groups.

Following the initial self-report measure, LCs participated in the rest of the research activities following multi-stage sampling procedures. The quantitative part also included the observation of the session tool from the UNAIDS measure. The section that follows details the quantitative data collection processes.

4.1.8.2.1.1 Self-report (UNAIDS self-report and MBI) data collection

This section will discuss the sampling and administration of the quantitative aspect of the pre-intervention phase of the study.

4.1.8.2.1.1.1 Sampling and Participants

After the nonprobability random sampling procedure (Onwuegbuzie & Collins, 2007), the total sample available for the pre-intervention phase self-report was N=107. The total group had been divided according to geographical location and area of service (Bloemfontein: 2 groups = District and Community, Botshabelo and Thaba-Nchu). The researcher travelled to the LCs' geographical location. Interviews were conducted at the clinics and hospitals where the participants work, as to not interrupt the delivery of public HCT services.

4.1.8.2.1.1.2 Administration

The data collection of the self-report measures entailed administering the measures to participants. The administration was two-hours long, and it was conducted in Sesotho, Setswana and English. This process included administering the UNAIDS self-report (N=107) followed by the Maslach Burnout Inventory (N=106). The translated self-report measures (annexure 5 & 6) were utilised. The researcher was present and available throughout the administration process and conducted all research activities with a research assistant's help. Both the researcher and assistant are fluent in Sesotho and Setswana. Participants from each group completed the assessments; therefore, in total, the administration entailed four separate data collection sessions in the four geographical regions.

4.1.8.2.1.2 Observation of sessions' data collection

Following the FGDs, the LCs counselling sessions were observed by the researcher.

4.1.8.2.1.2.1 Sampling and Participants

A multi-stage purposeful random sampling procedure was used (Onwuegbuzie & Collins, 2007). A sample of N=22 of the participants was randomly selected to participate in the session observations, with each group having an equal chance of representation. The qualitative sample would ensure that participants provide in-depth information about the studied phenomena at the site of investigation

4.1.8.2.1.2.2 Administration

The observations' guidelines were explained to the LC and the patient before they considered participating. After obtaining consent from both, the researcher observed, in person, the individual counselling sessions without interfering with the counselling process. The researcher was the only one involved in this part of the study. During the session, the researcher had to assess and rate the counselling skills and competencies of the LC using the UNAIDS Tool 4a, 4b and 5 (Annexure 8). The sessions occurred at the LCs place of work (i.e., clinics, health facilities and in communities through door-to-door services). Community-based service points included places such as patients' homes and patients' workplaces. The LCs conducted counselling sessions with patients in Setswana and Sesotho; the researcher is fluent in both these languages. The counselling sessions and observations were scheduled for 30 minutes, but the time varied depending on the patient's needs. The least time spent was 15 minutes and the most one hour.

4.1.8.2.2 Qualitative section

Following the self-report data collection, LCs participated in the qualitative process discussed below.

4.1.8.2.2.1 Focus group discussions' data collection

This section will discuss the sampling and administration of the qualitative aspect of the pre-intervention phase of the study.

4.1.8.2.2.1.1 Sampling and Participants

A sample of N=37 participants was chosen through multi-stage purposeful random sampling (Onwuegubuzie & Collins, 2007) to take part in the FDGs. There was equal representation of all four groups.

4.1.8.2.2.1.2 Administration

The discussions were conducted and facilitated in Sesotho and Setswana.

Open-ended and flexible questions were posed to participants, with follow-up questions and probing to elicit more information (Bryman & Bell, 2007). The research assistant made field notes on the participants' responses. To document all information for analysis, all FGDs were audio-recorded, a practice that was followed throughout the study. The researcher, with the assistance of the research assistant, transcribed all responses. The 'verbatim transcription' documented word-for-word what the respondents shared (Bailey, 2008), with the research assistant writing down field notes.

4.1.8.3 Phase 2: Pre-intervention data analysis

The purpose of the pre-intervention phase was to assess the level of counselling skills, competence, and burnout. The section that follows details the data analysis of the baseline assessment.

4.1.8.3.1 Quantitative data analysis

The quantitative data from the UNAIDS self-report and MBI were analysed first. Data was validated, edited, and coded; where necessary, consultations with a statistical consulting firm and an assigned statistician took place during the different stages of data gathering and data analysis. The SPSS version 23.0 Statistical Package (IBM, 2015) was utilised for quantitative analyses.

4.1.8.3.1.1 UNAIDS self-report data analysis

Numerical codes were assigned to the categories before the data was captured together with responses to close-ended questions. Means, median, mode, range, frequencies, and percentages were produced per the research hypotheses. Quantitative data pertaining to biographical and work-related information was generated.

4.1.8.3.1.2 Maslach Burnout Inventory data analysis

Following the assigned codes as per participants' responses, scoring was according to the three aspects of burnout, which followed the scoring criteria (Maslach & Jackson, 1981) described below.

- **Section A**: Emotional exhaustion (items 1, 2, 3, 6, 8, 13, 14, 16, 20), a total score of 17 or less on these items indicates low-level burnout. A total score between 18 and 29 inclusive indicates moderate burnout. Scores of over 30 indicate high-level burnout.
- **Section B**: Depersonalisation (5, 10, 11, 15, 22), a total score of 5 or less on these items indicates low-level burnout, while any total score between 6 and 11 inclusive shows moderate burnout.
- **Section C**: Personal Achievement (4, 7, 9, 12, 17, 18, 19, 21), a total score of 33 or less indicates high-level burnout and a total between 34 and 39 inclusive indicates moderate burnout. A total greater than 40 indicates a low-level burnout.

Case mean substitution, at the subscale level, was used to replace missing data. Thus, each missing data point was replaced by the mean of the items for that question that the particular person did answer. This practice of dealing with missing data is sufficient for psychological tests with Likert-type scales (Fox-Wasylyshyn & El-Masri, 2005). The data generated means, mode, median, range, frequencies and percentages.

4.1.8.3.1.3 Observation of session data analysis

Data analysis for the observed sessions from Tool 4 (UNAIDS, 2000) with assigned codes generated descriptive statistics on the set counselling skills that form part of each of the four competence components. For example, as illustrated in Table 4.1, the competence 'Interpersonal relationship' comprises of counselling skills such as 'greeting client' and 'introducing self'.

Table 4.1

Scoring of Skill and Competence in Observation of Sessions

Competence	Counselling skill	Rating		
Interpersonal relationship	• Greets clients	3	2	1
	• Introduces self	3	2	1
	• Engages client in conversation	3	2	1
	• Listens actively (both verbally and non-verbally)	3	2	1
	• Is supportive and non-judgemental	3	2	1

Additionally, the content-based components in Tool 4b and 'Specific intervention' content components in Tool 5 were also assigned numerical codes before the data was captured. Descriptives were produced according to the research aim (i.e., assessing the level of counselling skills and competence).

4.1.8.3.2 Qualitative data analysis

Qualitative data gathered during data collection was from the qualitative questions in the UNAIDS measure (Annexure 5) and the FGDs (Annexure 7). The data analysis performed separately for both measures followed the processes explained in the next section.

4.1.8.3.2.1 Focus group discussion and UNAIDS self-report (QUAL) data analysis

Qualitative data from open-ended questions in the UNAIDS self-report (UNAIDS, 2000) and FGDs included interview transcripts and written notes, which were analysed systematically through iterative and repeated re-reading. This made it possible to gain an increasingly profound understanding of each interviewee's viewpoint and perspective, of links and contradictions within and across interviews, of complex contextual factors emerging from the interviews mentioned above and of the many relationships between the relevant concepts (Bailey, 2008). During the fieldwork, the crosschecking mechanisms for the data on each question were evolutionary; the questions were clarified and also refined during the process of gathering data.

The researcher checked the results of the analysis by reviewing transcriptions, including the audio recordings of the FGDs. The data analysis was guided by Creswell and Plano-Clark's (2011) mixed-methods approaches. Once the data was cleaned, Braun and Clarke's (2006) 6-step thematic analysis steps were followed, as listed below.

1. Researcher and statistician familiarised themselves with the data by re-reading the transcripts.
2. Preliminary codes were assigned by the researcher and statistician, separately and compared. The codes were used to describe the content. This was in accordance with the research question.
3. Patterns or themes were identified in the codes across the different FGD interviews; this also included reviewing the coded data for similarity and overlapping.
4. Themes were collaboratively reviewed by researcher and statistician.
5. Themes were defined and named, and furthermore, categories and subcategories were created.
6. A report was generated on themes.

4.1.8.3.3 Triangulation: Integrating quantitative and qualitative results

In following the research objective 1: ***Assess the current level of counselling skills, competence, and burnout***', data was integrated.

An interactive strategy of merging was used to bring the two data sets together through a combined analysis (Cresswell & Plano-Clark, 2011). The researcher compiled a matrix to facilitate comparisons and interpretations. Table 4.2 illustrates the integration of quantitative and qualitative components, and the specific content and variables will be detailed in the results chapter (Chapter 5).

Table 4.2

Triangulation: Integration of Quantitative and Qualitative Data (Adapted from Cresswell & Plano-Clark, 2011)

Variable	Quantitative	Qualitative	Mixing
Counselling skills	Descriptives generated from session observations	Themes generated from FGD and QUAL questions from UNAIDS self-report	Identify, compare, corroborate and explain
Counselling competence	Descriptives generated from session observations	Themes generated from FGD and QUAL questions from UNAIDS self-report	Identify, compare, corroborate and explain
Burnout	Descriptives generated from MBI	Themes generated from FGD and QUAL questions from UNAIDS self-report	Identify, compare, corroborate and explain

The last step involved a discussion about how and to what extent results from the two types of data converged, diverged, related, and/or produced a more complete understanding. A list of categories was drawn up as the final product of data and interpreted. The categories comprised of sets of constructs based on the identified gaps in counselling skills, competence, and burnout. These were domains that informed the objectives of the skills programme.

Through this process, the researcher could contextualise the findings to draw a wider picture and conceptualise guidelines of lay counsellors' skills training programme. The programme content (themes, categories, and sub-categories) are outlined in Chapter 5 (cf. Table 5.8)

4.1.8.3.4 Development of intervention programme based on the results

This phase of the mixed-methods study involved presenting a matrix (cf. Table 5.8), which contains merged results generated from the data analysis and integration of quantitative and qualitative data. This forms part of the results section. The results data will be discussed and indicate how themes and categories were grouped into constructs that form the basis of the skills as stipulated in the research question, namely '***Counselling skills, key competencies and management of burnout of HIV counsellors can be enhanced through the design, implementation and evaluation of an HIV counselling skills training programme,'*** subsequently developing a counselling skills training programme. The HCTP intervention is attached as Annexure 9.

4.1.8.3.5 Phase 3: Implementation of the HCTP intervention programme

The purpose of Phase 3 was to implement a counselling skills programme that was developed based on the gaps identified during Phase 1.

4.1.8.3.5.1 Sampling and Participants

The experimental design included randomly allocating participants (using random tables) to the experimental group and control group. The total number available for the full duration of the training and who participated were N=37. The rest of the participants formed part of the control group who did not receive the intervention. The training involved five sessions of six hours each, scheduled over one week. The first group comprised the two groups from Bloemfontein (Group 1), and the second was a combined group of Botshabelo and Thaba-Nchu (Group 2) participants. At the end of the training, participants were asked to evaluate the skills training programme using the HCTP self-report evaluation (Annexure 9).

4.1.8.3.5.2 Administration of the training programme

The results of the pre-intervention phase are reported in Chapter 6. The training implementation was conducted from April-May 2016. The training implementation followed the 17 steps of the Utilised-Focused-Evaluation Framework (Patton, 1980, 2013) (cf. Section 3.5.4.). The training programme (see Annexure 9) was implemented according to the scope of counselling training following procedures and processes necessary in accountable and effective counsellor training. In any training of skills, various teaching mechanisms and equipping participants with the skills needed and being able to achieve competence are used. The training used various methods adapted from a review study by Martin et al. (2013), such as explaining concepts related to counselling, demonstrations, role-plays, group discussions, debating, questioning, lectures, videos, case studies, homework tasks, reflective practices and journaling.

4.1.8.3.5.3 Training evaluation self-report

Evaluation of skills training was conducted on the last day of the implementation of the training programme.

4.1.8.3.5.3.1 Administration

The tool developed for the programme evaluation was based on the objectives of the counselling skills schedule (Annexure 9). The data collection of the evaluation measure entailed administering the measure to participants. The administration lasted 15 minutes, and was conducted in both Sesotho and English. The researcher was available throughout the administration process.

4.1.8.3.6 Phase 4: Post-intervention data collection

Following the training programme's implementation, the post-intervention assessment process was conducted between June and October of 2016. Pre-intervention phase research guidelines and procedures were duplicated and used in the post-intervention phase. The purpose of the post-intervention phase was to assess the level of counselling skills, competence and burnout and utilise the results in determining whether differences existed between pre- and post-intervention phases.

4.1.8.3.6.1 Quantitative section

All LCs present on the day of the post-evaluation data collection period provided consent to participate in the study and completed the self-report assessments.

4.1.8.3.6.1.1 Self-report (UNAIDS self-report and MBI) data collection

This section will discuss the sampling and administration of the quantitative aspect of the study.

4.1.8.3.6.1.1.1 Sampling and Participants

For the nonprobability random sampling procedure (Onwuegbuzie & Collins, 2007), the total sample available for the baseline self-report was N=72.

4.1.8.3.6.1.1.2 Administration

The data collection of the self-report measures entailed administering the measures to participants following the same steps as in the pre-intervention phase. This process included administering the UNAIDS self-report (N=72) followed by the Maslach Burnout Inventory (N=70).

4.1.8.3.6.1.2 Observation of sessions' data collection

Following the FGDs, LCs counselling sessions were observed.

4.1.8.3.6.1.2.1 Sampling and Participants

A sample of the participants randomly selected to participate in the post-evaluation session observations (N=17) using the multi-stage purposeful random sampling (Onwuegbuzie & Collins, 2007) procedure participated in the observations.

4.1.8.3.6.1.2.2 Administration

The researcher conducted the observation following the same procedure as in the pre-intervention phase. The sessions occurred at different locations, including clinics, health facilities, patients' homes, and places of work.

4.1.8.3.6.2 Qualitative section

In addition to the quantitative data collection process, LCs participated in the qualitative process discussed below.

4.1.8.3.6.2.1 Focus group discussions' data collection

This section will discuss the sampling and administration of the qualitative aspect of the study's post-intervention phase.

4.1.8.3.6.2.1.1 Sampling and Participants

A sample of N=36 participants was chosen through multi-stage purposeful random sampling to participate in FGDs.

4.1.8.3.6.2.1.2 Administration

As previously stated, the focus group tool, which was developed for the pre-intervention phase, was used in the post-intervention phase. All research activities of FGD data collection followed the same process as in the pre-intervention phase.

4.1.8.3.7 Phase 5: Post-intervention data analysis

The purpose of the post-intervention phase was to assess the level of counselling skills, competence and burnout following the implementation of the HCTP. The section that follows details the data analysis of this post-intervention assessment.

4.1.8.3.7.1 Quantitative data analysis

Data processes followed the analysis procedures, as described in the next section.

4.1.8.3.7.1.1 UNAIDS self-report, MBI and Observation of session data

Following the steps as stipulated in the quantitative data analysis in the pre-intervention phase, the three listed tools and data collection methods were processed accordingly. Data analysis procedures from the pre-intervention phase were repeated for the self-report, MBI and observation of sessions. Descriptive statistics were generated on all the variables as measured by the different tools.

4.1.8.3.7.2 Qualitative data analysis

Data processes followed the analysis procedures, which will be described in the next section.

4.1.8.3.7.2.1 Focus group discussion and UNAIDS self-report (qualitative questions)

Qualitative data from open-ended questions in the UNAIDS self-report and FGDs followed the same steps as in the pre-intervention phase.

4.1.8.3.7.3 Triangulation: Integrating quantitative and qualitative results

In this part of the study, research objective 1, ***Assess the counselling skills, competence, and burnout in the post-intervention phase,*** is discussed. This phase followed the same process as reported in the pre-intervention phase, which is the last step and entails merging the two data sets, namely discussing how and to what extent results from the two types of data converge, diverge, relate, and/or produce a more complete understanding of the studied phenomena. A list of categories was drawn up as the final product of data and interpreted. The results of this process will be presented in the results section (Chapter 5) as summarised themes and categories. These results compare the pre-intervention results (in themes, categories and sub-categories, if applicable) to determine a difference in LCs' counselling skills, competence and level of burnout.

4.1.8.3.7.4 Evaluation of the training programme

Following integrating the post-intervention data, the fifth phase also included evaluating the HCTP intervention by incorporating a process of comparison in the identified differences established before the training intervention and after the intervention.

4.1.8.3.7.4.1 Mixed-method study evaluation

A list of categories was drawn up from the merged quantitative and qualitative data from the post-intervention phase. The categories consisted of sets of constructs based on the identified counselling skills, competence, and stress management skills to address burnout. These were domains that informed the objectives of the skills programme. Through this process, the researcher compared the pre- and post-intervention findings and contextualised the difference in the findings before and after the HCTP intervention.

4.1.8.3.7.4.2 Quantitative evaluation

The process of evaluating the programme involved additional quantitative statistical analysis methods, as detailed below.

4.1.8.3.7.4.2.1 Non-parametric tests

To investigate the second research hypothesis,

> *Lay counsellors who underwent the CTP programme levels of competence (interpersonal relations, gathering information, giving information, and handling special circumstances) will differ from the lay counsellors who were not exposed to the programme.*

A non-parametric technique will be followed. During the investigation, a complete set of information was obtained from 11 respondents in the experimental group and nine respondents from the control group.

Due to the limited information, uncertainty exists regarding the assumptions of normality and homogeneity scores, and therefore, it was not possible to investigate the formulated statistical hypothesis using the parametric statistical technique. In practice, it was, however, not possible to obtain larger groups due to the dropout rate during the intervention phase. This reduced the number of participants in both the experimental and control group. Additionally, the sample size was not sufficient to carry out parametric tests. This will further be expanded in the limitations and recommendation chapter (Chapter 8) of the thesis. To determine the post-scores of the two groups (experimental and control) regarding their competency-based elements, the Mann-Whitney U test was used.

4.1.8.3.7.4.2.2 Multiple Analysis of Variance (MANOVA)

To investigate the third research hypothesis,

> *Lay counsellors who underwent the CTP programmes' levels of burnout (emotional, depersonalization, personal accomplishment) will differ from those who were not exposed to the programme.*

The statistical procedure that was followed to investigate the formulated research question will be discussed next. Regarding the reformulated research question, it is clear that one independent variable (exposure/non-exposure to HCTP) and several dependent variables (three scales of burnout) are the points of discussion. According to Howell (2013), the one-directional multiple analysis of variance (One-way MANOVA) seems the most appropriate statistical method of analysis in this case. If a significant result (*F-value*) using the MANOVA is found, it will be followed by an analysis of variance (ANOVA) for each dependent variable.

4.1.8.3.7.4.3 HCTP intervention evaluation by participants

Furthermore, the skills training evaluation self-report that was administered to participants following the training was analysed.Thematic analysis was conducted for the qualitative section of this evaluation, as the content of the questions related specifically to counselling processes and operations contained in the *Model of counselling competence* (Ridley et al., 2011b).

The results provided in the next chapter contain feedback from participants regarding the value the training had and their level of HIV counselling skills, competence and management burnout.

4.1.8.3.7.5 Feedback to participants

Feedback for participants who were not part of the intervention phase was provided in stress management techniques and counselling skills notes and resources. This was a brief interaction and did not form part of the study. The provision of information was in line with good research ethical conduct.

4.1.9 Research quality

The research quality of the mixed-method study was ensured by addressing various aspects, which are discussed in the next section.

4.1.9.1 Mixed-method research quality

To ensure quality, the mixed-method study followed criteria (Cresswell et al., 2011; Lavelle et al., 2013) that entailed the use of rigorous approaches. The study team comprised of researchers with both quantitative and qualitative expertise. From the onset of the investigation, the assumptions, methods of data collection and analysis of each strand were respected (i.e., what is applicable in quantitative and qualitative research); this will be discussed in the sections that follow. The investigation entailed different investigation methods, thus utilising different sample sizes using multistage purposeful random sampling. The two strands were conducted separately at every stage of the process. The integration phase entailed merging the two data sets, and data were interpreted to yield, guide and formulate the design and evaluation of the counselling skills programme.

4.1.9.1.1 Quantitative research quality

Quantitative research relies on measures such as reliability and validity through statistical analysis methods.

The precise measurements utilise structures and validated instruments for data collection. To generalise findings and apply to other contexts and populations, this research study utilised methods that were analysed through comparisons, objectivity and statistical inferences.

4.1.9.1.1.1 Statistical reliability and validity of measuring instruments

4.1.9.1.1.1.1 Translations

The UNAIDS self-report (UNAIDS, 2000) and MBI (Maslach & Jackson, 1981) were translated into Sesotho. Translation needs to meet ethical standards to promote trust, accountability, mutual respect and fairness. The overall translation of tools had to ensure that the translated measures needed to be faithful and accurate to the source text entailing limited or no subjectivity. In this research, hiring a translator was an option selected to take precautions to avoid bias. The employed translator had experience as a Sesotho-teacher and sufficient expertise to ensure dedication to a quality product. A process of re-translation (Tyupa, 2011) of the translated questionnaires back to English was conducted by the researcher, and, in consultation with the translators, subsequent comparisons were done, and final documents agreed upon

4.1.9.1.1.1.2 UNAIDS tool self-report

The *UNAIDS Tools for evaluating VCT* (UNAIDS, 2000) has been deemed feasible in some studies to be an effective operational tool in evaluating HIV counselling and testing services (Ginwalla et al., 2002). Although studies (Ginwalla et al., 2002; Ma et al., 2013; Papanna et al., 2012; Ramalepe et al., 2014) have been conducted using the UNAIDS (2000) tool for V/HCT evaluations, there are presently no studies that have conducted validity and reliability on this measure.

4.1.9.1.1.1.3 Maslach Burnout Inventory

The researcher explored internal consistency for the different subscales used in this investigation. For this purpose, the Omega coefficient was calculated as reported in Table 4.3. This was calculated for the LC participants in this study.

Table 4.3

Omega Coefficients

Subscales	Omega coefficients	
	Pre-score	Post-score
Maslach Burnout Inventory:		
Emotional	.80	.80
Depersonalisation	.58	.52
Personal accomplishment	.59	.60

Due to the sample size (N = 58), the instability that occurs in measurements can exert a relatively large influence on the reliability index. The reliability index ranges from 0.52 to 0.80. Even though the subscales did not report a highly satisfactory internal consistency, it was decided to use all analysis that followed. The results should, however, be interpreted with caution.

4.1.9.1.1.1.4 Observation of sessions

Following the internal consistency where the different subscales of the MBI are measured, the Omega coefficient was calculated (see Table 4.3). However, the same could not be done for the counsellors' competency instrument as insufficient information from respondents was available. As previously indicated, the reliability-index of the counsellors' competency instrument cannot be determined, which implies that the results, in this case, need to be interpreted with caution.

4.1.9.1.2 Qualitative research quality

Various aspects need to be considered in ensuring quality in qualitative research. Qualitative research seeks to explore, explain, and gather meanings on a subject, and therefore, the subjective nature of the inquiry needs to meet scientific standards. To ensure the quality of the FGDs and the UNAIDS self-report (qualitative questions), the qualitative study's trustworthiness was addressed by employing processes discussed in the following section.

4.1.9.1.2.1 Trustworthiness

Trustworthiness is defined as “the degree of confidence that the researcher has that their qualitative data and findings are credible, transferable and dependable” (Andrew and Halcomb (2009). Trustworthiness refers to rigorous and control measures employed in qualitative research. Lincoln and Guba (1985) proposed and set out four criteria to evaluate and determine the trustworthiness of qualitative research. This criterion comprises credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985), which will be described below.

4.1.9.1.2.2 Credibility

Credibility, which is deemed one of the most important components in qualitative research, is a key criterion in scientific studies that explores the congruency of qualitative findings (Merriam, 1998). In pursuit of this, researchers often employ triangulation to show that the research findings are credible. The researcher was familiar with the culture and nature of the work of the research participants. Other measures included the degree to which the total sample was represented. This was addressed through random sampling measures, which gave each participant an equal chance to participate in the research activities. What proved to be a control measure in terms of the depth and breadth of the research data allowed for different methods as a means to collect data. Through the process of triangulation, different data could be verified against others. This process also offered confidence in being able to reach data saturation, as the sample and its distribution was sufficient for the phenomenon being studied.

The nature of the research and the conditions surrounding ethical conduct of the study, allowed for debriefing sessions. The researcher’s experience as an investigator was also weighed against the foundation of her professional capacity, training background and qualifications.

4.1.9.1.2.3 Transferability

Transferability demonstrates trustworthiness by generalising or illustrating that findings apply to other contexts. An inquiry audit is one method of ensuring that a research study can be replicated.

However, given issues around transferability, it is important to note that in investigations that explore a regularly changing phenomenon, such as healthcare services (e.g., HIV counselling services), results need to allow for context-based understanding.

4.1.9.1.2.4 Dependability

Dependability entails the review and examination of a particular research study. The transcripts from the audio recorded FGDs, and UNAIDS qualitative measure was checked by both researcher and research assistant to make sure there were no mistakes in the responses. The coding process also entailed not losing definition and measuring codes by revisiting the research question and its variables.

4.1.9.1.2.5 Confirmability

Confirmability is another factor that may utilise an inquiry audit to determine the research study's degree of neutrality. This is to try to eliminate any biases that the researcher could have had.

4.1.9.1.2.6 Flexibility

The flexibility of the research design should allow the focus group facilitator to understand which topical areas to pursue more than others or the specific follow-up (probing) questions to interject. A participant-observer, in this case, a research assistant, has little control over the activities of the observed. Thus, the assistant's goal is to be as unobtrusive and flexible as possible to capture the reality of the observed events.

4.1.9.1.2.7 Reflexivity

The reflexivity process pertains to the “analytic attention to the researcher's role in qualitative research” (Gouldner, 1971). It is both a concept and a process that refers to a certain level of consciousness. Reflexivity entails self-awareness, which means being actively involved in the research process. It is about recognising that researchers are part of the social world that they study (Ackerly & True, 2010; Palaganas et al., 2017).

Reflexivity is a process of introspection on the role of subjectivity in the research, which was addressed as a means of quality control. The researcher exercised her ability to capture the essence and convey her experience from a personal and professional stake by reflecting after every session through journaling and consultations with stakeholders (e.g., the research assistant and the study supervisor/s).

4.1.9.2 Ethical Considerations

As the current research study utilised human participants, ethics in research had to be considered.

4.1.9.2.1 Approval of the research study

Permission was granted by the Free State Department of Health (Annexure 2) following the approval granted by the Department of Psychology's Research Colloquium (UFS) on 24 March 2014. The study was approved ethically by the Health Sciences Research Ethics Committee (UFS) and registered as ECUFS NR 136/2014 (Annexure 3) on 14 July 2014. Written informed consent was requested from all participants in the study. The researcher coordinated the processes of data gathering and programme development, implementation, and evaluation and was available to debrief all participants after completing the activities. The confidentiality of all collected data was maintained, and recordings were marked using a code to protect the participants' identities. By not linking their HIV status to their real identities safeguarded the confidentiality of patients' HIV status. Compensation for all LC participants (experimental and control groups) was provided in notes regarding counselling skills. Transport and meals were also supplied to participants.

4.1.9.2.2 Informed consent of participants

Informed consent for all research activities was requested from the LCs. Confidentiality and privacy of information, as an important issue in behavioural HIV research, were emphasised due to the intrusiveness of such research. The right to consent also highlighted that the research subjects' participation was entirely voluntary.

Furthermore, they could exit the study at any time, without experiencing any consequences or loss of benefits should they decide to withdraw from the study. Each participant had a unique number assigned to them to identify them in all research activities, including questionnaires. The attendance register with participants' names was kept separate from the questionnaires. All personal information remained confidential and was not revealed to any staff member of the healthcare facility. Debriefing of subjects was offered after every activity. The LCs received transport and food during the self-report and focus group.

The intervention training could only be held in Bloemfontein; thus, the participants had to be transported from other towns. The patients were treated as individuals, considering their social, emotional, psychological, and physical factors. This relates to the physical incapacity and loss of mental capacity as characterised by the progression of the HIV disease that might influence the patient's ability to exercise their right to autonomy during the study. Patients that participated in the observation of sessions could not derive any immediate personal benefit from participating in the research. However, patients undergoing HIV counselling could experience some psychological discomfort. Since HIV-infected individuals are a vulnerable population, care and support were offered to ensure that patients did not suffer any effects from participating in the study. Both debriefing and individual psychological support were offered to all patients who participated in the research.

4.1.9.2.3 Adverse effects

All LC participants received feedback. When a patient tested HIV positive and/or experienced serious psychological discomfort during the process, the researcher availed her and provided a confidential and private psychological assessment as a registered Clinical Psychologist. Such patients were also referred to relevant healthcare professionals for further management.

4.1.9.2.4 Exclusion of research participants

None of the participating LCs in the study formed part of any additional counselling skills, developmental or refresher training other than the current investigation for the duration of the study. Patients and LCs were informed on confidentiality matters. Research participants did adhere to these matters, no participants were eliminated from the study.

4.1.9.2.5 Researchers' expertise and role conflict

The researchers' work experience and expertise added value to the study. As a clinical psychologist with more than 14 years of work experience in psychology, mental health and counselling, the researcher provides mental health care services to communities most afflicted by HIV/AIDS.

Notably, the researcher was awarded a MAC-AIDS Fund Leadership Initiative (MAFLI) grant in 2010, which entailed developing a skills training programme for LCs who work in the public health care HCT services. Here, the researcher explored HIV counselling in healthcare. In any research study where conflict could arise between the researcher's roles (e.g., a researcher provides physical or psychological care during an interview), the results will be biased. Subsequently, generalisation will be difficult, and therefore, the researcher and/or research team should determine if a harmful situation appears imminent and requires the intervention of the researcher. According to the declaration of Helsinki (World Medical Association, 2009), 'the interest of the individual should prevail over the interests of society of science'. This can solve some of the ethical dilemmas a researcher could experience. Even if situations are not life-threatening, any conflict that could potentially result in adverse effects of participating in the research study is a possible conflict. Burns and Grove (2005) suggest that if support from the researcher is required, it should be given, but the subjects should be excluded from the research. Recommendations for an alternative, such as seeking assistance from other professionals to proceed with the data collection, should be made. Nevertheless, no matter how skilled they are in supportive techniques, most health professionals will provide some care if they feel that it is needed in a certain case. However, the researcher should only intervene if "a harmful situation appears imminent". This statement and a professional counsellor's commitment to caring may create conflict between the researcher's and clinician's role.

4.1.9.2.6 Conditions for prolonged research study period or suspension of study

The key target population were already volunteering as LCs, community health care workers and community caregivers at their various health care facilities and PHC outreach teams. Therefore, their participation in the study had to ensure that their work obligations and responsibilities would not be affected for the duration of the research.

However, in the later stages and phases of the research, this did affect the study period due to the unavailability of some of the individuals and group. This will further be discussed in Chapter 6 (Results and Discussion). Due to the nature of the topic, breaching the code of conduct by any research participant, team member or any other individual affiliated with the research study would have constituted suspension and possible termination of the study. These breaches (e.g., disclosing confidential information of an LC or a patient participant, which might lead to psychological harm to the individual involved) did not occur.

4.2 Conclusion

The research design, methodology and research data gathering processes detailed in this chapter outlined how the study was conducted. Both quantitative and qualitative measures of the study were explained. Data analysis measures were described, including how they were employed, producing results to be discussed in Chapter 5. The compilation of the skills training programme was briefly mentioned concerning the specific components of the training programme. Components to ensure the research quality, that is, pertaining to quantitative and qualitative research were outlined. Ethical considerations and the protection of participants were also highlighted. The study was conducted in a rigorous and structured manner, and the results of the data analysed in the pre- and post-intervention will be discussed in Chapter 5.

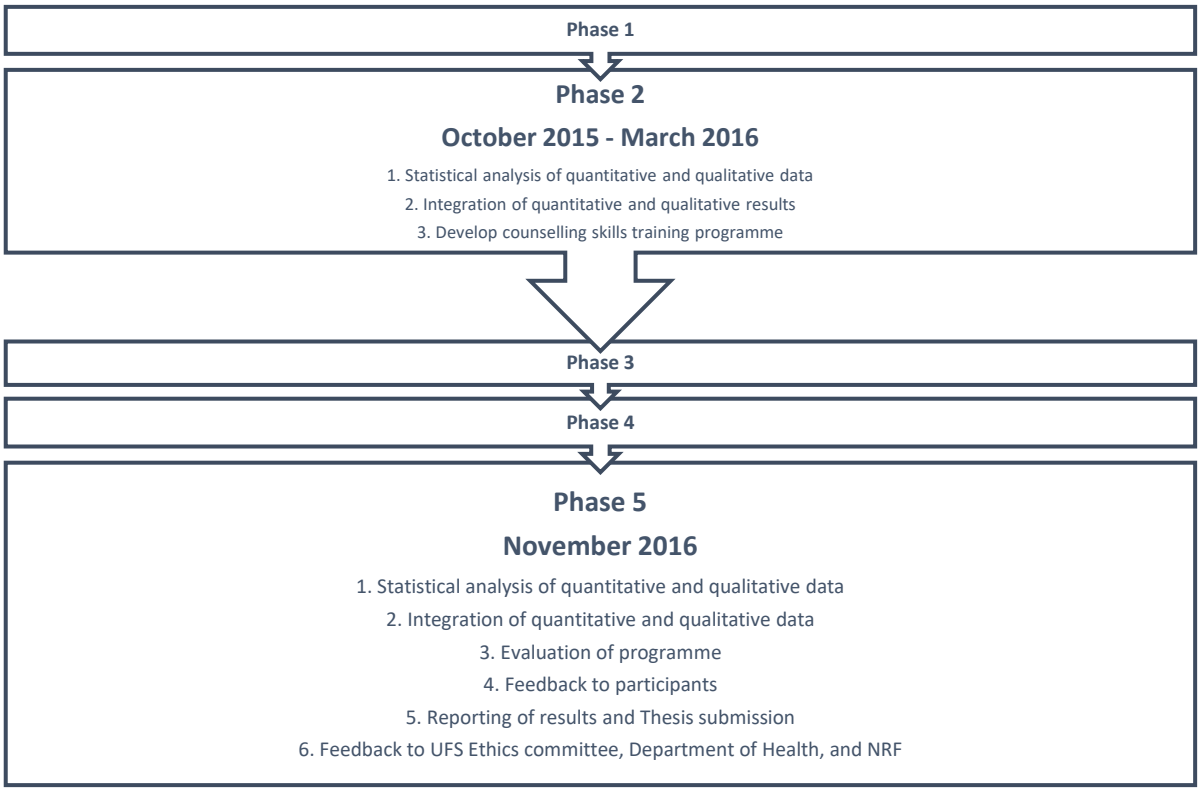
CHAPTER 5

RESULTS

This chapter reports on the data analysis and results generated from the research processes. The results presented will follow the format in which the study was conducted (i.e., pre-and post-intervention phases). The report will also refer to measuring tools and analysis methods utilised, as explained in Chapter 4. Figure 5.1, which was adapted from Figure 4.3: Main study flow chart, illustrates the main focus of this chapter, namely Phase 2 (step 1-3) and Phase 5 (step 1-3) of the research process. The illustration entails a process of data analysis for the assessment (pre-intervention) phase, triangulation and the development of the HCTP intervention. Furthermore, Phase 5 reports on results generated from the evaluation (post-intervention) phase and research activities of this objective.

Figure 5.1

Pre- and Post-Intervention Data Analysis and Triangulation



Data reported in this chapter is in line with the research question, '*Can counselling skills, key competencies, and management of burnout of lay counsellors be enhanced through the development, implementation, and evaluation of an HIV counselling skills training programme?'*

The following research hypotheses were formulated for the quantitative phase:

Lay counsellors who underwent the HCTP programmes' levels of counselling skills (content-based elements) will differ from the lay counsellors who were not exposed to the programme.

Lay counsellors who underwent the HCTP programmes' levels of competence (interpersonal relations, gathering information, giving information, and handling special circumstances) will differ from the lay counsellors who were not exposed to the programme.

Lay counsellors who underwent the HCTP programmes' levels of burnout (emotional exhaustion, depersonalisation, personal accomplishment) will differ from the lay counsellors who were not exposed to the programme.

The following research question was formulated for the qualitative phase:

- *How do LC's perceive their current level of counselling skills, competence, and burnout?*
- *How do LC's perceive the acquisition of counselling skills, competence, and management of burnout?*

5.1 Reporting of results

In line with Figure 5.1, the findings from the pre-and post-intervention will be presented first. In the first section, the pre-and post-intervention findings from the UNAIDS self-report are presented. This part of the quantitative results will only focus on the demographics of the LC group participants. The qualitative data reported in the second part of this section contains data gathered from the UNAIDS self-report (qualitative) and covers pre-intervention counselling work conditions.

The second part reports on counselling skills, competence, and burnout of the lay counsellor participants. This analysis of pre-intervention data is reported for the quantitative and qualitative methods separately. The analysis is followed by a triangulation process, as set out in concurrent triangulation mixed-method designs (Creswell & Plano-Clark, 2011). The results, which informed the HIV counselling skills training programme content, are reported in themes, categories and subcategories. The training components are presented in line with the elements of the *Model of Counselling Competence* (Ridley et al., 2011b) (cf. Table 5.8).

The third section presents the analysis of the post-intervention quantitative and qualitative data. The analysis is reported separately for both methodologies and followed by a triangulation process (cf. Figure 4.2.) (Creswell & Plano-Clark, 2011). This process will specifically focus on whether the generated data (reported in themes, categories and subcategories) can provide sufficient evidence on whether differences occurred by comparing pre- and post-intervention data.

The fourth and final section reports on quantitative analyses for both the experimental and control groups' performance during the pre-and post-intervention phases conducted using statistical tests. These results provide data on the evaluation of the HCTP, as stipulated in the research hypotheses. Additionally, results from the evaluation measure used to gather the experimental groups' response to the HCTP intervention received will also be provided. In addition, Table 5.1 summarises the data collection process and reporting of results by outlining the research variables and measures employed in answering the research question. The chapter concludes with a summary of the key findings.

Table 5.1

Format of Data Collection and Reporting of Results

Research variables/ components	**Summative research questions/investigations**	**Quantitative tools**	**Qualitative tools**
Demographics (Age, Race, Training Occupation, etc.)	How are LCs selected? What is their educational background? What is their occupation?	UNAIDS Self-report Tool 3	
Counselling work conditions (Training and selection, support and supervision, motivation and stress and work conditions)	What HIV counselling training have the LCs received? What conditions do they work under (e.g., nature of work, supervision, and workload)?	UNAIDS Self-report Tool 3	UNAIDS Self-report Tool 3 FGD
Counselling skills	What counselling skills do LCs possess?	UNAIDS Tool 4	FGD
Competence	What is the level of the LCs' competence?	UNAIDS Tool 4 & 5	FGD
Burnout	Does LCs suffer from burnout due to their work?	MBI	

Research variables/ components	Summative research questions/investigations	Quantitative tools	Qualitative tools
Evaluate HIV counselling skills programme	Is there a difference in LCs' skills, competence and burnout for the experimental and control groups between pre- and post-intervention phases?	UNAIDS Tool 4 & 5 MBI	FGD

5.1.1 Sample population

For this study, 107 LCs were recruited through nonprobability purposive sampling (Onwuegbuzie & Collins, 2007). Multi-stage purposeful random sampling method was used to generate the sample size according to the different data collection stages. There were marked differences in the sample size between the pre- (N = 107) and post-intervention (N = 72) phases. In the section that follows, LC participants' demographics are reported.

5.1.2 Pre- and post-intervention results

This section applies to the data from the *UNAIDS Tools for evaluating VCT* Tool 3 (UNAIDS, 2000).

5.1.2.1 Quantitative and qualitative data

The self-report measure of the *UNAIDS Tools for evaluating VCT* Tool 3 (UNAIDS, 2000) was used to gather demographic information on the LC sample during the pre- and post-intervention phases.

5.1.2.1.1 Statistical procedure

Quantitative and qualitative data were collected through the UNAIDS measure (UNAIDS, 2000). The data was cleaned by changing text into a numerical format and categorising the data. Data were entered into a Microsoft Excel® sheet and analysed using a Statistical Package for the Social Sciences (SPSS®, IBM Corp., 2015, Version 23.0) for Windows®. The statistical methods were applied to obtain a complete numerical analysis that generated the desired outcomes (measures of frequency, central tendency, dispersion, and position).

The mean, median, modus, standard deviations, maximum and minimum values for each demographic attribute results were generated. These are presented in the next section.

5.1.2.1.1.1 Demographic characteristics of participants

5.1.2.1.1.1.1 General demographics

All the participants in both pre- and post-intervention phases identified themselves as black South Africans. The sample age distribution ranged from 23 to 67 years, with a median age of 38-39 years. From Table 5.2, females comprised more than 91.6 % of the sample size in both the pre- and post-intervention phases, and almost half of the participants' home language was Sesotho. Sesotho is a major language spoken in the Free State Province and the three towns where the study was conducted. The Sesotho language is similar to Setswana, and most people fluent in any of the two can communicate in both.

Table 5.2

Gender and Language Distribution of Participants

		Pre-intervention		Post-Intervention	
		Frequency	Percentage	Frequency	Percentage
Gender	Male	9	8.4	6	8.3
	Female	98	91.6	66	91.7
	Total	107	100.0	72	100.00
Language	Sesotho	52	48.6	34	47.2
	Setswana	38	35.5	26	36.1
	IsiXhosa	14	13.1	12	16.7
	Zulu	2	1.9	0	0
	Missing	1	0.9	0	0
	Total	107	100.0	72	100.0

5.1.2.1.1.1.2 Employment and work demographics

The demographics presented in Table 5.3 show that the majority of the LCs who were part of the pre- and post-intervention study classified themselves as community health workers (44.9 – 51.4 %), with a few classified as assistants and enrolled nurses, community caregivers and HIV counselling and testing officers. The results reflected that 66% of the pre-intervention and 12.5 % of the post-intervention group were self-motivated to become lay counsellors, while 34 % of the pre-intervention and 87.5 % of the post-intervention group were proposed by a senior colleague. Employment status indicated that many LC participants (72.9 – 79.2 %) reported that they were volunteers within NGOs, and 18.1 – 26.2 % were formally employed as public health servants.

The study also showed that many LC participants had a high school education and had a Grade 12/matric certificate. The minimum high school education obtained was Grade 10, which applied to 20.8 – 29.9 %, while the highest qualification (Grade 12/matric certificate or higher) applied to 70.1 – 77.8 % of the participants. These discrepancies could be attributed to participants' misunderstanding of the question. Regarding the HIV counselling training, the majority (57.9 – 63.9%) of LC participants reported that they felt that the counselling training they received was 'very good' compared to 29 – 30.6 % who reported it was 'good'. Counselling seems to constitute most of the tasks that LCs perform daily. Most LCs reported that they provide HCT services five times a week and that the number of hours spent per week on counselling activities ranged from two to 40 hours, with an average of 22 hours. Lay Counsellors reported that they spent, on average, five hours per day doing counselling. Most of the counselling time reported is spent on counselling about HIV-related matters. The results also indicated that participants spent about 73% of their working lives on counselling activities.

Table 5.3 (a)

Days per Week Spent on Counselling

	Pre-intervention		Post-intervention	
	Frequency	Percentage	Frequency	Percentage
Occupation				
Community healthcare worker	48	44.9	37	51.4
Assistant nurse	24	22.4	16	22.2
Enrolled nurse	5	4.7	2	2.8
*Other	30	28.0	17	23.6
Total	107	100.0	72	100.0
Selection				
Proposed by senior colleague	35	34.0	63	87.5
Self-motivated	68	66.0	9	12.5
Missing	4	7.0	0	0.0
Total	107	100.0	72	100.0
Employer				
Free State Department of Health	28	26.2	13	18.1
*NGO	78	72.9	57	79.2
*Other	1	0.9	1	1.4
Missing	0	0	1	1.4
Total	107	100.0	72	100.0
Highest formal education level				
Secondary school (gr. 10 and 11)	32	29.9	15	20.8
Matric/Grade 12 or higher	75	70.1	56	77.8
Missing	0	0	1	1.4
Total	107	100.0	72	100.0
Training				
*Very Good	62	57.9	46	63.9
*Good	31	29.0	22	30.6
*Adequate	7	6.5	3	4.2
*Inadequate	7	6.5	1	1.4
Total	107	100.0	72	100.0

**Please note some of the participants selected more than one option on certain items*

Table 5.3 (b)

	Pre-intervention (cont.)		Post-intervention (cont.)	
	Frequency	Percentage	Frequency	Percentage
	Days			
2-4	10	15	11	15.3
5	92	86	60	83.3
*Other	5	6	0	0
Missing	0	0	1	1.4
Total	107	100.0	72	100.0
	Hours			
1-3	16	15	10	13,9
4-8	88	82.3	49	6.1
*Other	1	0.9	11	1.2
Missing	1	0.9	2	2.8
Total	107	100.0	72	100.0

**Please note some of the participants provided unspecified information on certain items*

The data for the pre-intervention phase will be reported in the next section.

5.1.3 Pre-intervention results

This part of the pre-intervention results first reports on the qualitative data obtained from the UNAIDS self-report, and the second part on the quantitative data from the UNAIDS observation of sessions, and MBI. Lastly, the qualitative data from the focus group discussions are reported.

5.1.3.1 Qualitative data

The UNAIDS self-report measures (Tool 3) the qualitative components related to various components in the counselling tasks and work conditions of lay counsellors. These responses were grouped into themes, categories, and subcategories.

5.1.3.1.1 Analysis procedure

To supplement the quantitative process in this mixed-method study, a qualitative inquiry into participants' perceptions, ideas and thoughts around issues pertaining to their work in HCT was conducted. The information gathered was subjected to a qualitative analysis process utilising thematic analysis (Braun & Clarke, 2006). The qualitative process entailed consistency, frequency, patterns, and categories grouped into themes and linked to the research question. Once the data was cleaned, Braun and Clarke's (2006) 6-step thematic analysis was applied by the researcher, as follows.

1. Familiarise self with the data by re-reading the transcripts.
2. Assign preliminary codes, separate and compare. Use codes to describe the content in line with the research question.
3. Review identified patterns or themes in the codes and the coded data for similarity and overlapping.
4. Conduct a collaborative review of the themes (this was done by the researcher and statistician).
5. Define and name themes by creating categories and subcategories.
6. Generate a report on themes.

5.1.3.1.1.1 Counselling work conditions

The following are key themes that emerged, as indicated in the UNAIDS self-report: training (period, content, and training needs of participants), support and supervision, motivation, stress and burnout, and time spent on counselling.

5.1.3.1.1.1.1 Training

Qualitatively, many of the LC participants revealed that they received entry-level training between 2012 and 2016. The major topic covered during this training was HIV counselling. Many of the LC participants reported that they received follow-up training on the following topics: other diseases and infections (TB, Oral Thrush, and STI's), couple testing and counselling, and advanced counselling. Many LC participants reported that they require additional training on 'couples (CHCT/CHC) and family HIV counselling and testing'.

Additionally, training on ‘treatment’, ‘Anti-Retro Viral Therapy (ARV)’ information,’ CD4 Count’ information, including how to use the PIMA machine (for viral load and CD4 count) and ‘ARV drug readiness and Adherence’ were also identified as training needs.

5.1.3.1.1.1.2 Support and supervision

When asked about other sources of support received, they mentioned receiving support from their ‘supervisor/ clinic manager/ team leader/ sister (nurses) in charge’. Many participants reported that they have access to counselling supervisors for support. Supervisors, clinic managers and team leaders were the most frequently mentioned sources of support for lay counsellors. An equal number of participants stated they did and did not receive supervision at work. The most frequently mentioned source of supervision was from a supervisor or clinic manager.

5.1.3.1.1.1.3 Motivation, stress and burnout

Many participants stated being self-motivated to become an HIV counsellor.

The participants’recurrent reasons for becoming HIV counsellors were that they had a relative or friend living with HIV/AIDS and had a passion for counselling. When asked about their feelings towards their job, participants reported that they had positive feelings. Participants frequently reported that they enjoyed the job and were satisfied/ happy with their job. Many participants said they would continue with counselling in the future because ‘there will always be a need for HIV counselling / they are contributing something’ and ‘they enjoy the job / counselling’.

5.1.3.1.1.1.4 Time spent on counselling

Frequent mention was made of concerns about statistics (reaching targets), having a limited scope of practice and a heavy workload. Most participants felt that they were given adequate time for their counselling duties. Those who felt not having enough time mentioned how they were rushed to produce statistics (to reach their targets) and had to focus on testing rather than counselling and felt as if that was the only concern from their supervisors.

Participants mentioned that this made them rush through their work, leaving little or no time to provide adequate HIV counselling.

The section that follows provides the results of the pre-intervention quantitative data.

5.1.3.2 Quantitative data

In a review of the research objectives, an assessment of the current level of HIV counselling skills, competence and burnout among lay counsellors was conducted. These skills and competence variables were measured by the same tool (*UNAIDS Tools for evaluating VCT* Tool 4 & 5) (UNAIDS, 2000) and conducted by observing counselling sessions of LCs and patients (Annexure 2.4.). Burnout was measured using the Maslach Burnout Inventory (Maslach & Jackson, 1981) (Annexure 6).

5.1.3.2.1 Counsellor skills and competence

The researcher evaluated the counselling sessions by drawing from her experience as a Clinical Psychologist working in a clinical setting as both a clinician and in a training capacity. The quality and content of the counselling session and the counsellor-patient interactions were also evaluated. The sample size for this process was N=22. The statistical procedure employed is discussed in Section 5.2.2.1.1.

5.1.3.2.1.1 Competence-based elements

The competence-based elements (e.g., competence and skills items that make up each competence results) are reported. To test the study's hypothesis, only skills and competencies found to be insufficient or deficient formed part of this report. The rating scale for this measure is indicated by 1-Poor, 2-Moderate and 3-Best performance (previously discussed in Section 4.2.5.2.1 and Table 4.1. The descriptive statistics for the 'Interpersonal relationship', 'Gathering information', 'Giving information' and 'Handling special circumstances' competencies are reported in Table 6.4.

Table 5.4

Descriptive Statistics for the Competence-Based Elements

Competencies	N	Mean	Median	Mode	Std. Dev	Range
Interpersonal Relationship	22	1,8818	2,0000	2,00	,43930	1,60
Gathering Information	22	1,7348	1,6667	2,00	,41359	1,50
Giving Information	22	1,9015	2,0000	2 & 2.17	,39728	1,33
Handling special circumstance	22	1,5114	1,5000	1,00	,45954	,211

5.1.3.2.1.1.1 Interpersonal relationship (IR)

For the ‘interpersonal relationship’ competence, the average score given is 1.88, indicating that the counselling sessions were adequately handled. When considering the five skills items that make up this competence, the lay counsellors’ execution of the skills seems to have been ‘moderately’ performed.

5.1.3.2.1.1.2 Gathering information

For this competence, an average score of 1.7 is reported, which indicates adequate handling of the counselling sessions. When considering the six skills items that comprise this competence, an individual item analysis indicates that the lay counsellors’ execution of two of the skills seemed to have been ‘poorly’ rated for almost half of the participants. The ‘Uses silence well to allow for self-expression’ was not well executed by 10 (45.5 %) of the participants, and ‘Avoids premature conclusions’ was also not well executed by 11 (50 %) of the participants.

5.1.3.2.1.1.3 Giving information

For the ‘giving information’ competence, the average score given is 1.9, indicating that the counselling sessions were adequately handled. When considering the individual item analysis, the lay counsellors’ execution of these skills seem to have been ‘moderately’ performed. In the pre-intervention, lay counsellors spoke the same language as their patients. Thus, the item ‘Accommodates language difficulties’ item was excluded from the mean calculations for HSC.

In addition, ‘Manages clients’ distress’ applied to only two patients as most patients were not tested for HIV or already HIV positive or had received a negative HIV test result. Subsequently, it was excluded from the descriptives. The ‘Flexible in involving partner’ was also excluded on the basis that only a few patients (N=3) had brought a partner into the counselling session. The descriptive statistics for the ‘Handling special circumstances’ competence are, therefore, reported for four of the seven skills items and is illustrated in Table 5.4.

5.1.3.2.1.1.4 Handling special circumstances

‘Handling special circumstances’ competence received an average score of 1.5, which indicated adequate handling of the session. When considering the individual item analysis, lay counsellors performed poorly on three of the seven skills that make up this competence. For ‘Talks about sensitive issues plainly and appropriately to the culture’, 15 (68%) of the respondents were evaluated ‘poorly’. For the skill ‘Uses silence well to deal with difficult emotions’, 14 (64%) of the lay counsellors performed ‘poorly’, and the ‘Prioritises issues to cope with limited time in short contacts’ was also not well executed where 11 (50%) of the participants were evaluated ‘poorly’. As some of the ‘Handling special circumstances’ individual items were only applicable to a few of the observed sessions, and therefore, the analyses for this competence must be interpreted with caution. One of these items, ‘Managing patients distress or emotional reaction’, was evaluated ‘poorly’ as the LCs in the two observed sessions failed to execute this skill adequately.

5.1.3.2.1.2 Content-based elements

In this section, only content deemed insufficient, deficient or absent formed part of this report. Using this tool, content-based skill elements were grouped into 1: pre-HIV test, 2: post-HIV test, 3: counselling where HIV testing is not available (UNAIDS tool 4), and 4: special interventions- TB and MTCT situations (UNAIDS tool 5). The scoring and data analysis process is explained in Section 4.2.5.2.1. Due to the variation in the presentation of patients’ needs, the data reported pertains to sessions that focused only on the specified HIV-related content. For example, for patients whose HIV status were not known, HIV testing was offered, and they received both pre- and post- HIV counselling, which was evaluated.

5.1.3.2.1.2.1 Pre-HIV test counselling content

This section was applied to 17 sessions; a few patients (N=5), those who were HIV reactive and already on ART, had been excluded from the analysis. Of the total observed sessions for the pre-HIV test counselling sessions evaluated, the results indicated that LCs failed to include and address content related to 'Misconceptions corrected' for 13 (76.5%) of the respondents. 'Assessment of personal risk profile' was not carried out for N=17 (100%) of the patients. A substantial number N=11 (64.7%) of LCs failed to 'Discuss potential needs and availability of support' for patients. A 'discussion of a personal risk-reduction plan' was not addressed for N=16 (94%) of patients, and no 'Follow-up arrangements' were discussed with N=14 (82.4%) of the patients.

5.1.3.2.1.2.2 Post-HIV test counselling based content

This section applied to a total of 15 sessions; seven of the other sessions were situations where HIV tests were not available (N=2) or patients were already HIV reactive and on ART (N=5), as mentioned in Section 6.3.3.2.1.2.1. These were subsequently excluded from the analysis. Lay counsellors performed 'poorly' by not 'Discussing a personal risk-reduction plan' with N=10 (66.7%) of the patients. Lay counsellors were unable to 'Check availability of adequate immediate support' for N=12 (80%). 'Discussion of follow-up care and support' was not conducted for N=12 (80%) of the patients. No 'Options and resources were identified' (13-86.7%), 'Immediate plans, intentions and actions were not reviewed' (12-80%) and 'Follow-up plans and referrals where necessary were not discussed' with N=12 (80%) of the patients.

5.1.3.2.1.2.3 Counselling-based content where HIV testing is unavailable

In the observation of sessions, counselling was still offered to patients who were not tested for HIV. The content was only applicable to a few counselling sessions (N=4) in the pre-intervention phase. The data was transformed by converting quantitative data into narrative data presented in theme, categories, and sub-categories. All counsellors failed to address the content displayed in Table 5.5.

Table 5.5

Content where HIV Testing is not Available

Counselling-based content where HIV testing is unavailable	
Category	Subcategory
What is HIV?	• Symptoms and course of illness reviewed and discussed • Review of knowledge about HIV, including transmission and prevention • Misconceptions corrected and information given
Preventing HIV	• A personal risk assessment carried out, concerning sexual and drug-injecting behaviour, and history of blood contact • Further discussion of possibility/certainty of HIV-related diagnosis combining risk profile, symptoms and clinical state
Management and treatment of HIV	• Discussion of the meaning of the diagnosis for the client • Discussion of a personal risk-reduction plan • Checking availability of adequate immediate support • Immediate plans, intentions and actions reviewed

5.1.3.2.1.2.4 Counselling-based content for TB interventions

Table 5.6 reports on the number of LCs who screened patients for TB in their sessions. Only one patient had, before the counselling session, been screened for TB. Thus, the evaluation was conducted for N=21 patients. The respondents who included the content were assigned ‘Yes=1’ and those who did not ‘No=0’. Only the ‘No’ responses are reported.

Table 5.6

TB Screening

Symptom	Frequency	Percentage
Cough	11	52.4
Productive	18	85.7
Fever	10	47.6
Weight loss	9	42.9
Family contact with TB	20	95.2
Total	21	100.0

It appears that 20 LCs (95.2%) failed to ask whether patients have had contact with a family member diagnosed with TB. Patients were also not asked whether they had a 'productive' cough (coughing up blood or sputum or phlegm from deep inside the lungs); this applied to N=18 (85.7%) and N=11 (52.4%) were not asked if they had a cough.

5.1.3.2.1.2.5 Counselling-based content for MTCT interventions

Counselling was only applicable to N=3 sessions for female patients attending maternity services. For LCs who addressed content related to the needs of this group of patients, the quantitative data was transformed into qualitative data. All counsellors failed to address the content as displayed in Table 5.7. The data is presented in theme, categories, and subcategories.

Table 5.7

Content in MTCT Services

Category	Subcategory
Pregnancy	• Client's views on pregnancy explored • Discussions around the benefits of testing together with her partner/her baby's father • Explaining that testing is not mandatory and that she will not be denied access to antenatal care or other services if she chooses not to be tested • Options for termination of pregnancy (TOP) (if available legally and safely) • Information on family planning
HIV positive	• Implications of an HIV-positive result for her baby • Implications of an HIV-positive result for future children • Planning for the future (including emotional, spiritual and legal support • Options for a referral if required
HIV treatment	• Previous ARV use • Contraindications and cautions to current regimes discussed • Drug reactions • Other medicines being taken • The regimen explained • The need to take medicines continually according to the regimen and the dangers of taking the regime erratically • The possible side-effects and when to seek medical help

In summary, it appears that many aspects of content-based counselling for HIV deemed necessary among the investigated lay counsellor group were not addressed.

5.1.3.2.2 Burnout (MBI)

In this section of the results, LCs' self-assessment on the Maslach Burnout Inventory (Maslach & Jackson, 1981) is reported. The items are categorised into three elements: emotional exhaustion, depersonalisation, and personal accomplishment.

First, the Cronbach's alpha for each theme was interpreted, expecting the values to range from 0 to 1, where $\alpha \geq 0.7$ values indicated an acceptable reliability. From the total sample (N=107) that participated before the training intervention, only 1 participant did not complete the MBI.

5.1.3.2.2.1 Emotional exhaustion

Cronbach's alpha value for Emotional Exhaustion was $\alpha \geq 0.795$ (acceptable); this reflects a good internal consistency. The generated results showed that the sample had a mean of 29,5 (SD = 11.59) for the pre-intervention phase. Many participants reported a high level of emotional exhaustion (49,1%), usually associated with burnout (Maslach & Jackson, 1981).

5.1.3.2.2.2 Depersonalisation

For Depersonalisation, the Cronbach's alpha (α) had a value of 0.432 ($\leq$0.70), which indicated that the Depersonalisation sub-scale had low reliability. This low level of internal consistency reliability deemed this subscale as poor reliability of burnout on the MBI. For this purpose, the Depersonalisation subscale is omitted from the results.

5.1.3.2.2.3 Personal accomplishment

For the same reason as reported for the Depersonalisation scale, Cronbach's alpha with a value of 0.489 ($\leq$0.70) for the Personal Accomplishment subscale is unacceptable as it indicates poor reliability of burnout on the MBI. For this purpose, the Personal Accomplishment subscale is omitted from the results as well.

Based on the above, the reliability of the MBI was inconsistent, showing that the measure could not be deemed a good indication for measuring burnout overall within this study's sample. A possible reason could be that the items tap into multiple factors, rather that a single dimension.

5.1.3.3 Qualitative data

The focus group discussion data were reported using themes from the counselling work conditions (identified from the UNAIDS self-report measure), as well as the competence and content-based elements (observed sessions).

These formed a foundation to conceptualise through an inductive process, the presentation of the results. In this section, key themes and topics that were regarded as important in meeting the objectives of the concurrent triangulation method are discussed, with verbatim excerpts from the FGDs. An additional category about work environment was also added.

5.1.3.3.1 Counselling work conditions

In this section, key themes and topics that were regarded as important in clarifying the quantitative components are discussed, with verbatim excerpts from the FGDs.

5.1.3.3.1.1 Training

Many participants reported that ongoing training could be beneficial to increase knowledge and skills.

5.1.3.3.1.2 Support and supervision

Lay counsellors frequently mentioned concerns about statistics (reaching targets) and having a limited scope of practice.

TB HC 3: '*The government wants statistics. They do not even come to us. They keep posting our area statistics on boards and emphasise when we have not met our targets.*

BC HC 9: *HCTs sometimes do not do proper counselling because they are after statistics. I went for my HCT training a month ago and found that one of my clients was not counselled properly.'*

5.1.3.3.1.3 Motivation, stress and burnout

Participants mentioned that factors such as receiving positive feedback, acknowledging their work or feeling they contributed, keep them motivated to be HIV counsellors.

BC HC 7: *We love our work. We are willing and want to help our country, but the Department of Health is failing us. Waking up in the morning is an effort. Sometimes you feel discouraged. We feel that our work is not valued and recognised. We hope to get permanent positions. Money will motivate us, as well.*

5.1.3.3.1.4 Time spent on counselling

The heavy workload was also mentioned as a problem and an ineffective working referral system.

BD HC 1: *Going with a colleague is not possible because of getting statistics and covering as many households and people as possible.*
We want to cover many … I feel I need to do more as a team leader, but I can't do anything.

5.1.3.3.1.5 Working environment

There was mention of working in a dangerous working environment without security or protection. Frequent mention was also made of the actions that counsellors employ to counter their safety concerns. The most frequently mentioned action was that they report incidents. However, they also often mentioned that reports are not followed up.

TB HC 1: '*We need a referral system that works. They take patients back and forth. Between doctors and social workers and their reports never correspond.'*

BD HC 1: *Other people have danger allowance; we work separate because we want to cover statistics and we are exposed. There is no immunity; if you are a team leader, you are just as exposed. ... Others must cover other streets, for example, if we are ten, two per street. It's not HCT that is going to be raped. We have no emergency numbers or protocol in instances of danger. Sometimes as a team leader, I feel the same.*
The report writing does not help. You are told to write it, but there is no follow-up. You have to remove the team leader title and think as a woman who could be raped, and you feel for your colleagues.

Overall, lay counsellors seem to be faced with many challenges in delivering HIV counselling services, including work conditions and systems problems.

5.1.3.3.2 Counselling skills and competence

This information is presented in the same format as the counselling skills competence tool (Observation of session) to present the qualitative data in an intelligible and interpretable manner; Competence (Interpersonal relationship, Gathering and Giving information and Handling special circumstances) and Content (Pre-, Post-HIV test, follow up and counselling for TB and MTCT).

5.1.3.3.2.1 Competence and competence-based skill elements

5.1.3.3.2.1.1 Interpersonal relationship

Lay counsellors shared how they normally conduct their counselling sessions. Most seemed familiar with basic counselling skills (e.g., introducing themselves and allowing the patient to ask questions and speak). Most LCs reported that they often had to be friendly and welcoming to make patients comfortable even when they encountered language difficulties.

BD HC 2: *'I greet and introduce myself. I use different languages because I am not fluent in Sesotho. I ask for permission. I haven't encountered any language problems yet. I agree language is a barrier in some instances. There are times where I had to call my colleagues to come interpret.'*

BC HC 8: *'I allow a person to ask questions and do not dominate the conversation.'*

Lay counsellors indicated that their role also includes being respectful to patients. Many LCs agreed that an important element was to uphold confidentiality, but some still felt it was their place to give them advice.

BC HC 1: *'You are not there to judge. I will not judge patients'*

BO HC 4: *'Especially those that we see when we do door-to-door, they volunteer easily as compared to those that are referred by a nurse. They are afraid to test at the clinic, and door-to-door enforces confidentiality initially, and at the clinic, people will see them.'*

5.1.3.3.2.1.2 Gathering information

Lay counsellors acknowledged that patients might have negative opinions or experiences regarding issues concerning HIV, and they tried to ask questions that would elicit rich responses, attempting to communicate empathy to patients.

BO HC 1: *'We ask questions to understand what they feel because some do not have reasons why they want to test. My work is to be there for them but not to advice.'*

TB HC 1: *'Probe and do not just ask questions that require only a yes or no answer.'*

5.1.3.3.2.1.3 Giving information

Lay counsellors agreed that beginning with a neutral conversation to put the patient at ease and make them feel comfortable was an important way to show support, encouragement and provide information.

BD HC 6: *'Look at the patient whether it is a young person or older. Get to their level to win their confidence and use examples. Check if the person will relate well or not. Ask a question or comment.'*

5.1.3.3.2.1.4 Handling special situations

Lay counsellors seemed to understand their ability to manage special situations where patients bring sensitive issues to the process. Additionally, LCs acknowledged the implications that the HIV status of patients might have on their romantic/sexual relation (partner). There are also implications of dealing with patients' emotional reactions in the session. LCs made frequent mention of having to deal with sensitive issues, different cultures, family traditions, religion, sexuality, sexual practices, gender, domestic violence, gender-based violence and poverty situations. Furthermore, frequently raised issues included religious and cultural differences. Lay counsellors expressed these as interferences that posed limitations to their counselling work.

BD HC 6: '*We do posttest counselling while we are waiting for the results. You use the time to explain, so it depends on the results. The patient could be crying.'*

TB HC 8: *With couples, you explain cordant and discordant couples and that CD4 count for the ones who are positive must be taken, and the negative ones need to test again. This also causes relationship problems for couples.*

BC HC 2: '*Sometimes when their pastors tell them they are negative, it's very difficult for you to get them to believe the other tests that they could do in the clinic. ... There is nothing we can do. ... Religion and culture pose a problem. It's not easy to communicate and encourage such patients. They will tell you I am not going to take these pills, etc ... .They would not take ARVs because of my family; even family planning is not part of my culture. We try, but some will say leave me alone. We are trying, but we do not win some days.'*

BO HC 1: '*If you take treatment, your CD 4 count goes high, and the person may test negative, and they think the virus is cured. In our clinic, we inform them there is no cure, and they must not test in many facilities and stop taking their treatment. We have a problem with traditional healers. We know have included them in committees in clinics, and we have health talks with the traditional healers. We urge them to encourage their patients to test and not stop taking treatment.'*

With regards to ethical dilemmas, concerns were raised about confidentiality issues such as disclosing HIV results to significant others, especially when working with initiation schools that bring teenagers for testing. Furthermore, LCs reported being expected to work out of their scope of practice and report cases, as well as patients who do not adhere to medication. Economic situations (poverty) of their patients seemed to affect LCs ability to assist their patients effectively. Lay counsellors reported on issues around transport to and from the clinics, a problem experienced by many patients as some clinics were far from their homes. Participants also reported that patients have poor living conditions and that their patients live in danger.

BD HC 4: '*In cases where there is a couple, the woman wants to test, and it is better to also ask the man and the issue of disclosing the results to a partner who did not test, is not part of my responsibility ... In most instances, I try to test both parties. ... I avoid being involved in their issues of why the other does not want to test ... I once tested a woman who did not want to disclose her status to her man and said she came alone. During the positive posttest she*

revealed the man is outside. When she came in, she discloses, but I feel my presence made it easy for her to do so. Last week we tested a couple, and they started fighting because the woman said it's the man who gave her the virus. You don't want to be responsible for causing a fight between a couple. We never followed-up.'

Despite the concerns raised, lay counsellors maintain that they continued to act in the best interest of their patients by respecting their choices by providing support to test, continue treatment and educating patients (through community-based HCT campaigns).

5.1.3.3.2.2 Content-based skill elements

5.1.3.3.2.2.1 Pre-HIV test counselling based content

In the discussion about the counselling process, counselling reasons were frequently mentioned as practices performed during sessions. When doing pretest counselling, the most attention is paid to providing information related to safety and prevention, as well as testing.

BO HC 6: '*I assess how much I know about HIV and AIDS and how one gets infected. The difference between HIV and AIDS, and I let them tell me. They normally talk and think they test for AIDS. In pretest, I also give information.'*

5.1.3.3.2.2.2 Post-HIV test counselling based content

When doing posttest counselling, the emphasis is on giving feedback on results, especially if the patients test HIV positive, and providing information and education.

TB HC 9: '*Post-test counselling should include discussion of test results, what negative or positive HIV results mean, and that a positive one means one has the virus. You explain the lines on the test kit. You discuss how to stay negative for those that test negative, the window period and use of condoms.'*

Mention of doing posttest counselling was made more frequently than pretest counselling. Lay counsellors reported that they check for availability of support for patients and issues around disclosing ones' status to significant others. Participants mentioned that they talk about HIV-related matters (specifically providing the information) with clients during post-HIV test counselling sessions.

TB HC 9: '*And explain that they cannot disclose on the phone. You need to encourage them to disclose 'face-to-face'. If a patient cries in your presence, you can't even hug them. It's like our hearts are getting hardened.'*

5.1.3.3.2.2.3 Counselling based on content-based for PMTCT interventions

Lay counsellors indicated that when attending to pregnant women, they provided information for childcare before and after birth and conducted TB screening and treatment information.

BO HC 2: *'When/if women test positive and they are pregnant, we refer to nurses to initiate ART.'*

TB HC 9: '*Explain that at 6 months, the exclusive breastfeeding can be stopped. They can test the child at 6 weeks after breastfeeding using the PCR test. This is done by the nurses. At 18 months again with a rapid test. We also suggest breastfeeding to patients because they drop the kids' bottles in the clinic, and the kids get diarrhoea due to many infections and also for economic reasons. They sometimes don't have money for formula and go buy fresh milk.'*

The counselling sessions' main focus with patients, as reported by the LCs, seemed to be building interpersonal relationships and fostering the relationship through support and understanding and by providing information.

5.1.3.4 Summary of pre-intervention results

The pre-intervention results are reported concisely and extensively, as these results informed the nature of the HIV counselling skills programme. By creating an opportunity to view each construct with the main themes and categories, one can generate a thorough picture of the training components.

The pre-intervention results indicated that counsellors seemed to possess adequate counselling skills in relationship building, gathering and providing information to patients. However, competence-related aspects such as handling special circumstances, ethical issues and incorporating HIV-related content in TB and MTCT interventions were still lacking. Lay counsellors reported a high level of emotional exhaustion, which is also reflected in the counselling work-related components reported in this section. The triangulation results are reported in the next section. Triangulation is among the most important objectives of mixed-methods research as it allows different analysis and perspectives on a studied phenomenon (Bentahar & Cameron, 2015).

5.1.4 Integration of pre-intervention quantitative and qualitative results (Triangulation)

In this study, the mixed-method steps were carefully considered and followed, particularly in collecting and analysing data, leading the researcher to arrive at the overall aim and objectives of the study. Before reporting on the results of the triangulation, the methods used in the 'mixing' of the quantitative and qualitative data will be discussed.

5.1.4.1 Steps of 'mixing'

Before choosing the most plausible method of mixing, first consider the **Study Design**: *Concurrent triangulation* mixed-method and the **Aim of triangulation**: *To validate findings using quantitative and qualitative data sources*.

The two types of data can provide validation for each other, resulting in a core base for drawing interpretations and conclusions about the studied phenomena (Wisdom & Creswell, 2013). Mixed analyses involve several phases and steps of mixing. In this study, several methods of integration were identified.

These methods were based on Greene's (2007) 'mixing' methods, which stipulated four steps: (a) data transformation, (b) data correlation and comparison, (c) analysis for inquiry conclusions and inferences, and (d) using aspects of the analytic framework of one methodological tradition within the analysis of data from another tradition.

In an attempt to have a comprehensive 'mixing' strategy, Onwuegbuzie and Teddlie's (2003)

seven-step process of the method of integration was considered: (a) data reduction (i.e., reducing the dimensionality of the quantitative data and qualitative data), (b) data display (i.e., describing the quantitative data and qualitative data visually), (d) data correlation (i.e., correlating quantitative data with quantitated data or correlating quantitative data with qualitative data), (e) data consolidation (i.e., combining both quantitative and qualitative data to create new or consolidated variables or data sets), (f) data comparison (i.e., comparing data from the quantitative and qualitative data sources), and (g) data integration (i.e., integrating both qualitative and quantitative data into a coherent whole).

The following steps were arrived at: (a) data were analysed separately, (b) data were transformed (quantitative data was converted into themes and categories and presented in a narrative), (c) jointly displaying both forms of data, for example, qualitative data to assess lay counsellors' counselling work conditions that negatively impact on stress while also comparing it to quantitative data from burnout scores (MBI), (d) assessing information using parallel constructs for both types of data, (f) side-by-side comparison was conducted in the form of a discussion with the research team. This interactive strategy of merging was used to bring together the two data sets through a combined analysis (Creswell & Plano-Clark, 2011; Wisdom & Creswell, 2013).

5.1.4.2 Pre-intervention triangulation matrix

The visual presentation that follows illustrates the integrated data of the mixed methodologies and the results that emerged from this process. In addition, training components on what was considered important content for the intervention are also included in the matrix.

Table 5.8

Pre-intervention Triangulation Matrix

Quantitative Results	Training Components	Qualitative Results
	Counselling Skills	
• Talks about sensitive topics plainly and appropriately to the culture • Uses silence well to deal with difficult emotions • Prioritises issues to cope with limited time in short contacts • Innovative in overcoming constraints • Uses silence well to deal with and allow for self-expression • Avoids premature conclusions • Managing patients distress or emotional reaction	• Diversity and multicultural sensitivity • Understanding and managing own beliefs • Consulting other sources • Refer for difficult cases • Structuring the counselling process • Drawing up a session plan • Flexibility • Providing an 'emotionally' safe environment for patients • Managing own emotions • Ethical conduct • Couples HIV counselling and testing	• LCs admitted they struggle with patients who fail to comply with treatment because of cultural and religious beliefs: They are discouraged by this • LC reported they do not have time to conduct adequate and quality counselling as they need to rush sessions to meet the daily targets • LC reported they do not have time to conduct adequate and quality counselling as they need to reach targets • LC find it difficult in maintaining confidentiality in couples counselling
	Competence-Based Elements	
• Handling special circumstances	• Diversity and multicultural sensitivity • Understanding and managing 'own' beliefs • Consulting other sources • Refer difficult cases • Ethical issues • Good practice conduct • Understanding limitations in skills sets and competence	• LCs do not deal well with religious, cultural and other sensitive issues; they cause interference in counselling and pose limitations to the service/assistance they can provide to clients • LCs find it difficult dealing with disclosure • LCs reported difficulty in working with patients' with other social problems (socio-economic status - poverty)
• Gathering information	• Providing an 'emotionally' safe environment for patients • Managing own emotions	

Quantitative Results (cont…)	Training Components (cont…)	Qualitative Results (cont…)
	Content-Based Elements	
	Pre-HIV test counselling	
• No discussion on HIV: Misconceptions/myths on HIV • Risk assessment/profile • Potential needs and availability of sources of support • Follow-up arrangements	• Discussion of specific issues for individual and assessment of individual risk, risk reduction and the window period should patients test HIV negative. • Discussion of prevention strategies, including delayed sexual debut, abstinence, and regular use of condoms. • Discussion on the way forward and management options, including TB screening, clinical staging, CD4 count, pre-antiretroviral treatment (ARV) management and healthy lifestyle, should the patient test HIV positive. • Discussion on partner involvement and referral for testing. • Discussion of the option to refuse to test. • Obtaining written or verbal informed consent for HIV testing.	• HIV information · Medical conditions · Treatment TB Oral thrush · STI's · ART · ART drug readiness · ART Adherence
	Post- HIV test counselling	
• Personal risk reduction plan • Availability of adequate and immediate support • Follow-up care and support • Immediate plans and actions • Referrals	• HIV-negative patients: should be offered a comprehensive posttest counselling • Prevention package includes information and advantages of MMC, TB screening, risk reduction and correct and regular use of condoms. • They should be encouraged to repeat the test three months after exposure to exclude the possibility of the window period. The window period should be explained. • HIV-positive patients: must be given their test results and counselled posttest about their HIV status only after the second confirmatory test is also positive. • Patients who test positive should be informed and counselled about possible emotional responses (e.g., denial and anger), and they should be guided as to when and how they can manifest and what impact these emotions can have on adherence to healthy lifestyle choices.	• HIV negative patients · Prevention · Risk assessment · Personal risk reduction plan • Follow-up plans

Quantitative Results (cont…)	Training Components (cont…)	Qualitative Results (cont…)
	No HIV testing	
• HIV information-knowledge and misconceptions • Personal risk assessment and discussion • HIV diagnosis implications • Availability of adequate support • Review plans and actions	• The same information as in pretest counselling	
	Counselling for specific groups/populations	
• Thorough assessment of TB signs and symptoms • Maternity services · HIV positive pregnant women · HIV positive breastfeeding (and infant feeding for) mothers · HIV positive mothers on ART and implications for future pregnancies and management	• Dealing with special situations • Keeping practice standards (through reading, training, and revising work-related information) • Understand one's scope of practice • Refer and consult in difficult cases	• Counselling for specific groups/populations · Thorough assessment of TB signs and symptoms · HIV positive pregnant women · HIV positive breastfeeding (infant) feeding mothers · Couples HIV counselling and testing · Family HIV counselling and testing
	General counselling conditions	
	• Understand scope of practice • Refer to other sources • Seek supervision and support	• Minimal counselling and the focus of sessions is providing information
	Burnout	
• High Emotional Exhaustion	• Refer and consult • Understand your coping mechanisms • Create external sources of support • Create internal sources of support	• Heavy workload (73% of work is on counselling activities: 22 hours per week) • Not enough time for counselling (15 minutes per session • Rushing to reach statistics (daily targets) • Many other work tasks • Focus on testing rather than counselling • Unsure of what is the scope of practice

5.1.4.3 Development of the HIV counselling skills training programme

According to the *Model for Counsellor Competence* (Ridley et al., 2011b), the process of counselling requires counsellors to sufficiently progress in the counselling operations of determining, facilitating, evaluating, and sustaining counselling outcomes for clients/patients. In this study, there is a report of some skill deficits indicated in the LC groups' inability to purposefully move through this process of 'competence', as explained by Ridley et al. (2011b). As reported thus far, LCs poorly executed critical skills and competencies, for example, structuring the therapy, surmounting obstacles, and managing special situations/populations. These fundamental skills and competencies of the LC group were addressed through a 5-day HIV counselling skills training programme developed and implemented to address these variables. Only the experimental group participated in this part of the study.

5.1.4.3.1 Content of the HIV counselling skills training programme

To adequately inform the HIV counselling skills training programmes' (Annexure 9) development in type (basic counselling skills and key competence), content (*Model of Counseling* Competence and HCT-related content*),* mode (use of different training techniques) and duration (5-day HCTP to supplement the 10-day compulsory HCT training of LCs), the components of the training as per the *Model of Counseling Competence* (Ridley et al., 2011b), will be discussed in the next section. The training schedule developed following the *Model of Counseling Competence* (Ridley et al., 2011b) was structured to purposefully improve the counselling skills and competencies of LCs that provide HCT through following the superordinate foundational principles of determining, facilitating, evaluating and sustaining counselling outcomes for patients. In addition, subordinate competencies, the integrated deep structure, as well as micro skills, were incorporated to achieve overall competence. The section that follows provides a basic description of these aspects concerning the research groups' results, which informed the development of the training programme.

5.1.4.3.1.1 Superordinate competencies

Superordinate competencies are essential in indicating the level and presence of competence among counsellors, as they offer a foundational base for competence.

According to the *Model of Counseling Competence* (Ridley et al., 2011b), these competence actions are integral in the undertaking of all other competencies (Ridley et al., 2011a).

5.1.4.3.1.1.1 Determining counselling outcomes

Lay counsellors failed to individualise outcomes and review goals as patients brought in new information. Outcomes seemed not to be individualised for each patient, as LCs stuck to the 'script' and could not adequately manage sessions, especially when patients became emotional. Lay counsellors would go back to the 'script' specifically with HIV counselling content. They, therefore, could not manage or revise outcomes and goals as new information (i.e., emotional response in session) from patients emerged.

5.1.4.3.1.1.2 Facilitating counselling outcomes

It appeared as if lay counsellors did not employ various strategies in reaching patients. According to the LCs, training in counselling was limited, and there was little refresher counselling training. The counselling skills employed were mainly on information and health education-based levels. Participants often mentioned having to deal with sensitive issues in all four of the research sites/groups. The most frequently raised issue concerned religious and cultural sensitivity/limitations/interferences. Patients who had defaulted on treatment or patients refusing to test was a common problem. Regarding ethical dilemmas, LCs raised concerns about issues pertaining to confidentiality, especially with disclosing results to significant others, which led to LCs feeling that they were expected to work out of their scope of practice. In the session observations, it was found that the majority of the counsellors (68%) did not deal well with talking about sensitive issues plainly and appropriately to the specific culture of the patient.

5.1.4.3.1.1.3 Evaluating counselling outcomes

Lay counsellors were not able to create an opportunity to review the sessions or counselling process with patients.

Most LCs reported that reaching daily and weekly statistics targets were an issue, which they felt hindered delivery of quality counselling, as they had to rush through counselling sessions. In the observed sessions, there were few opportunities utilised by LCs to check if patients had adequate opportunity and the freedom to express needs or ask questions. Therefore, LCs could not acknowledge or correct any of the errors they might have miscalculated in the process. The only measurable strategy, as expressed by LCs, was the recording of statistics. Lay counsellors also expressed little support and supervision to address or evaluate counselling goals and deal with any challenges encountered with the help of a supervisor. The participants who reported access to support stated that they received the most support from supervisors/clinic managers and team leaders.

5.1.4.3.1.1.4 Sustaining counselling outcomes

The LCs did not effectively address referral processes during their interactions with patients. They did not indicate the referral system to patients, especially as reported from the observation evaluation checklist: 'Checking availability of adequate immediate support', 'Discussion of follow-up care and support', 'Options and resources identified' and 'Immediate plans, intentions and actions reviewed'; these were some of the aspects not sufficiently addressed during sessions. These are measures to assess if patients could translate gains from counselling processes into their everyday life choices and behavioural changes.

5.1.4.3.1.2 Subordinate competencies

Counsellors coordinate and integrate subordinate competencies intending to determine, facilitate, evaluate and sustain counselling outcomes purposefully. These competencies as skills are specific to patients' needs and counselling processes. Although counselling depends on the distinctive requirements of determining and facilitating positive counselling outcomes, some of the competencies are specific to counselling processes. For example, as mentioned in the competence-based element of interpersonal relationship or building a counselling alliance with the patient (as stipulated in the model), this is deemed a counselling-specific competence.

5.1.4.3.1.2.1 Self-appraisal/self-evaluating

Self-appraisal and self-evaluating are an opportunity for counsellors to examine their counselling strengths and weaknesses, understand their boundaries, and continually assess their work. This aspect did not seem to receive enough opportunity as LCs reported feeling rushed to do their work and could not effectively reflect on their performance during their engagements with patients. Also, LCs have limited support in addressing their concerns, especially within a supportive environment, which, if needed, personal therapy or adequate supervision should be provided.

5.1.4.3.1.2.2 Structuring the therapy

Structuring counselling has its benefits, such as providing safety, comfort and acceptance for patients and respective cultures of the patient. The LCs did report that there are challenges faced within the multicultural context in which they provide HCT services.

5.1.4.3.1.2.3 Building a therapeutic alliance

The LCs actively co-created an enduring, collaborative, supportive relationship with the patients by demonstrating empathy, respect, and approachability in sessions. The LCs, however, were still unable to manage emotional situations with patients effectively.

5.1.4.3.1.2.4 Applying a conceptual map of therapeutic change

Counsellors in this study seemingly did not possess the skills to draw up a coherent conceptual map with adequate skills to guide the complex nature of counselling change processes patients often require/need. When patients presented with emotional difficulties in sessions, it was uncomfortable for the LCs to adequately understand and use skills in guiding counselling interventions for patients.

5.1.4.3.1.2.5 Using therapeutic techniques

The LCs only perused information-based interventions and expressed the need to learn various counselling interventions to accommodate their diverse patient populations'

needs. This was addressed by introducing different psychological theoretical perspectives and the sciences of behavioural change. Each model, presenting its own theoretically sound and applicable technique, would provide information for consideration as prescribed for each patient's need.

5.1.4.3.1.2.6 Self-correcting

There was limited time and opportunity to use micro-skills to evaluate counsellor performance and client improvement. Limited and perhaps non-expertise supervisory feedback also contributed.

5.1.4.3.1.2.7 Surmounting obstacles

These obstacles included confidentiality and other ethical issues that LCs reported to be challenging, such as managing different belief systems about culture, traditional beliefs, as well as life principles and values.

5.1.4.3.1.2.8 Leveraging opportunities

In HCT services, the LCs' limited scope and 'rushed work' often hampers an opportunity for learning and growing; counselling skills and competence often is a result of opportunities available. In this study, particular system challenges required more attention than what the study had available. These challenges and concerns are incorporated in the conclusion section of the thesis.

5.1.4.3.1.2.9 Managing special situations

As mentioned earlier and also in some sessions, as observed by the researcher, the LCs were inexperienced in effectively handling special circumstances of a sensitive nature.

5.1.4.3.1.2.10 Working with other systems of care

LCs faced challenges such as the door-to-door work and working with other systems of work. This was expressed in the FGD as LCs reported to have referred patients to other systems (e.g., social workers), but only to get a report from the patient of not being assisted.

5.1.4.3.1.2.11 Consulting other sources

Using referral sources also seemed to be an aspect that the LCs reported that is not managed well.

5.1.4.3.1.2.12 Terminating therapy

Transferring gains of the counselling process are further hampered by system challenges posed to LCs in HCT services.

5.1.4.3.1.3 Integrated deep structure and micro-skills

The LC group had many challenges with executing some of the required skills and competencies. In the metacognitions competencies that form part of the integrated deep structure, LCs came across as intrinsically motivated to their job. However, concerns regarding support, working environment and career prospects seemed to be an issue that affected their motivation. They also struggled with the metacognitions of purposefulness, selection, sequencing and timing. Furthermore, LCs had no opportunity between sessions to reflect deeply and utilise supervision. Consultation was not always available, and when was available, not in the form of counselling expertise. The LCs did not have an array of interventions and could not adequately select the ones that could yield positive counselling outcomes. Their training needs were clearly expressed and indicated in the various activities utilised to assess their counselling skills and competencies. Counselling sessions could not be monitored, and timing was an issue. This was evident in how the LCs managed the emotional situations of patients.

The researcher acknowledged the use of critical micro skills in the LCs' interactions with patients. These were some of the positive reports from the assessment. However, demonstrating empathy, providing a positive environment for patients and engaging in active listening are micro skills that cannot independently facilitate change in a counselling process. Thus, no single competency is sufficient to achieve the outcomes as described in the *Model of counselling competence* (Ridley et al., 2011b).

In summary, the results provided incorporated into the *Model of counselling competence* (Ridley et al., 2011b) provided a framework in developing the training intervention.

The training as described in an outline of the content discussed in Section 5.3.4, was implemented. The next part of the results report will be on the changes and differences, if any, in the counselling skills, competence and level of burnout among the research group because of the training intervention.

5.1.5 Post-intervention results

In the review of the research objectives, following the implementation of the HIV counselling skills programme, an assessment of the level of HIV counselling skills, competence and burnout was conducted. The skills, competence and burnout variables were measured using the same format as in the pre-intervention phase. The aim was to provide data to compare with pre-intervention in line with the research question. In this section, the quantitative data is presented first, followed by the qualitative data. The same tools, namely *UNAIDS Tools for evaluating VCT* Tool 3, 4 & 5 (UNAIDS, 2000), the Maslach Burnout Inventory (Maslach & Jackson, 1981) and the focus group discussions were used.

5.1.5.1 Quantitative data

The results will be presented in a summary format and only reporting on aspects of the variables that the lay counsellor participants performed differently on.

5.1.5.1.1 Counsellor skills and competence

The counsellors' sessions were evaluated by the researcher. The quality and content of the counselling session and the patient–counsellor interaction were evaluated. The sample size for the post-intervention session observation process was N=17. The statistical procedure employed is discussed in Section 5.2.2.1.1. The results are presented as competence-based elements and item analysis of skills making up each competence.

5.1.5.1.1.1 Competence-based elements

The following results report how the participants performed and executed counselling by using counselling skills and how the combination and execution of these skills determined a specific competence.

5.1.5.1.1.1.1 Interpersonal relationship

The counsellors' mean score for the five items and skills making up interpersonal relationships seem to have increased (from 1.8 to 2.3) between the pre-intervention and post-intervention phases. Counsellors improved in all of the following skills: 'Greets client', 'Engages client in conversation', 'Listens actively (both verbally and non-verbally)' and 'Is supportive and non-judgemental'.

5.1.5.1.1.1.2 Gathering information

The counsellors mean score for the six items and skills making up 'Gathering Information' increased from 1.7 to 2.2 between the pre-intervention and post-intervention phases. Counsellors improved on most but not all the skills making up this competence (i.e. 'Uses appropriate balance of open and closed questions', 'Uses silence well to allow for self-expression', 'Avoids premature conclusions', 'Probes appropriately', 'Summarises main issues'). The 'Seeks clarifications about information' skill among the lay counsellor group increased in 'poor' rating during the post-intervention compared to the pre-intervention phase.

5.1.5.1.1.1.3 Giving information

The counsellors mean score for the six items and skills making up 'Giving Information' increased from 1.9 to 2.4 between the pre-intervention and post-intervention phases. Counsellors improved on some of the skills making up this competence (i.e., 'Gives client time to absorb the information and respond', 'Has up-to-date knowledge about HIV' and 'Repeats and reinforces important information'). The 'Gives information in clear and simple terms', 'Checks for understanding/misunderstanding' and 'Summarises main issues' skills among the lay counsellor group increased in 'poor' rating during the post-intervention in comparison to the pre-intervention phase.

5.1.5.1.1.1.4 Handling special circumstances

The 'Handling special circumstances' individual items were only applicable in a few of the observed sessions and could not yield sufficient data for consideration.

The counsellors mean score of the four items (three items were excluded) and skills making up ‘Handling special circumstances’ increased from 1.5 to 2.23 between the pre-intervention and post-intervention phases. This item list on its own posed challenges since it requires client/patients’ circumstances to be individualised. Therefore, it was difficult to quantify, and additional information had to be recorded qualitatively to better explain and evaluate the observed interaction. This will further be addressed in the qualitative report of the study.

5.1.5.1.1.2 Content-based skill elements

5.1.5.1.1.2.1 Pre-HIV test counselling content

On average, during the post-intervention phase, LCs were effective in addressing HIV-related content in their interaction with participating clients. These included: ‘Reasons for attending discussed’, ‘Knowledge about HIV and modes of transmission explored’, ‘Misconceptions corrected’, ‘Assessment of personal risk profile carried out’, ‘Capacity to cope with HIV positive results’, ‘Discussion of personal risk-reduction plan’, ‘Informed consent/Dissent given freely’ and ‘Follow up arrangements discussed’. However, of the total observed sessions in both the pre- and post-intervention phases evaluated, the results show a few LCs failed to include what would be deemed important content in pre-HIV test counselling, amongst others. This discrepancy is indicated in the failure to increase the number of important and expected content in the post-intervention phase. Content related to: ‘Information concerning the HIV test given (e.g., the process of testing, meaning of possible test results, window period)’, ‘Discussion of the meaning of HIV-positive and HIV-negative results and possible implications’ and ‘Discussion of potential needs and available support’. Thus, in some of these sessions, LCs were rated ‘NO-content not included’. The same items also showed decreased ‘YES-content included’ responses in the post-intervention phase. In addition, however small, in one of the sessions where the client-patient was underage, the HCT session failed to address most of the content related to and stipulated for HCT.

5.1.5.1.1.2.2 Post-HIV test counselling based content

For items 1-4 on the post-HIV test counselling the following content was addressed with all patient-clients in the pre-intervention phase: ‘Results given simply and clearly’, ‘Time allowed for the result to sink in’, ‘Checking for understanding’ and ‘Discussion of the meaning of the result for the client’. Although addressed, these items showed decreased ‘YES-content included’ responses (highlighted in green) in the post-intervention phase. In addition, however small, in one of the sessions where the client-patient was underage, the HCT session failed to address any content related to and stipulated for HCT in post-HIV test counselling. On average, LCs were effective in addressing HIV-related content in their interaction with participating clients. These items and content included: ‘Discussion of a personal risk-reduction plan’, ‘Options and resources identified’, ‘Immediate plans, intentions and actions reviewed’ and ‘Follow-up plans discussed and referrals where necessary’. However, of the total observed sessions in both the pre- and post-intervention phases evaluated, the results highlighted in red show a failure by a few of the LCs to include what would be deemed important content in post-HIV test counselling, amongst others. This discrepancy is indicated in the failure to increase the number of important and expected content in the post-intervention phase. The content relating to ‘Discussion of the personal, family and social implications including who, if any, to tell’ was not addressed in some sessions. In addition, however small, in one post-intervention phase session where the client-patient was underage, the HCT session failed to address most of the content related to and stipulated for post-HIV test counselling.

5.1.5.1.1.2.3 Counselling based content where HIV testing is unavailable

The content was only applicable to a few counselling sessions. The data was transformed by converting quantitative data into narrative data presented in theme, categories and subcategories. All counsellors failed to address the content displayed in Table 5.9.

Table 5.9

Content where HIV Testing is not Available

Category	SubCategory
What is HIV	• Symptoms and course of illness reviewed and discussed • Review of knowledge about HIV, including transmission and prevention • Misconceptions corrected and information given
Preventing HIV	• Personal risk assessment carried out, with respect to sexual and drug-injecting behaviour, and history of blood contact • Further discussion of possibility/certainty of HIV-related diagnosis combining risk profile, symptoms and clinical state
Management and treatment of HIV	• Discussion of the meaning of the diagnosis for the client • Discussion of a personal risk-reduction plan • Checking availability of adequate immediate support • Immediate plans, intentions and actions reviewed

5.1.5.1.1.2.4 Counselling based content for TB interventions

Observed sessions in which patients were screened for TB are reported in the table below. There seems to be an increase in the number of relevant TB information enquired and discussed with patients compared to the pre-intervention data.

Table 5.10

TB Screening

Symptom	Frequency	Percentage
Cough	11	64.7
Productive	11	64.7
Fever	10	58.8
Weight loss	10	58.8
Family contact with TB	11	64.7
Total	17	100.0

5.1.5.1.1.2.5 Counselling based content for MTCT interventions

The data on MTCT interventions is presented in Table 5.11 and indicates that LCs still failed to address most of the content required for this particular patient group.

Table 5.11

Content in MTCT Services

Category	Subcategory
Pregnancy	• Client's views on pregnancy explored • Implications of an HIV-positive result for future children • Explain about discordancy
HIV treatment	• Information on ARV's if available • Information about treatment, care and support services available and referral • ARV Not a cure • Need to attend maternity services • Need to take ARV's as prescribed. The regimen explained • The need to take medicines continually according to the regimen and the dangers of taking the regime erratically • The possible side-effects and when to seek medical help • Previous ARV use • Contraindications and cautions to current regimes discussed • Drug reactions • Other medicines being taken
Mother and infant feeding support	• Information about the care of the child (including nutritional advice and seeking early treatment for illnesses) • Information on family planning • Planning (including emotional, spiritual and legal support) • Options for a referral if required

5.1.5.1.2 Burnout (MBI)

5.1.5.1.2.1 Emotional Exhaustion

The Emotional Exhaustion subscale showed adequate internal consistency reliability (Cronbach's alpha = 0.802). Only two items, if deleted, would have increased alpha. Emotional exhaustion in the post-intervention phase decreased, as the sample reported low levels of burnout (24.3%), with only a third of the sample (35.7%) reporting moderate levels. However, a significant number of emotional exhaustion (40%) was still reported.

5.1.5.1.2.2 Depersonalisation

The depersonalisation subscale showed a low level of internal consistency reliability (Cronbach's alpha = 0.437). None of the items, if deleted, would have increased Cronbach's alpha. In the post-intervention, a large number of the sample still reported low scores (72.9%) on Depersonalization, indicating low levels of burnout, while moderate levels and high levels of burnout were reported by 20.0% and 7.1% of the sample, respectively.

5.1.5.1.2.3 Personal accomplishment

The personal accomplishment subscale showed a low level of internal consistency reliability (Cronbach's alpha = 0.458). Only three items, if deleted, would have increased Cronbach's alpha. In the post-intervention, a large number of the sample still reported low scores (80%) on Personal Accomplishment, indicating low levels of burnout. In comparison, moderate levels and high levels of burnout were reported by 14.3% and 5.7% of the sample, respectively.

5.1.5.2 Qualitative results

The focus group discussion data and the UNAIDS self-report measure (Tool 3) qualitative components are in the same format as reported in the pre-intervention, except that a summary is provided for the results section of this part of the report.

In this section, key themes and topics that were regarded as important in clarifying the quantitative components, with verbatim excerpts from the FGDs.

5.1.5.2.1 Counselling work-related aspects

The responses were grouped into themes, categories and subcategories. The following are key themes that emerged from the UNAIDS self-report (qualitative): training needs of participants, support and supervision, motivation, stress and burnout, and poor working conditions.

5.1.5.2.2 Counselling skills and competence

This information on the observation of sessions was analysed, and themes emerging from the post-intervention phase ordered in the same manner as the pre-intervention phase: Competence (Interpersonal relationship, Gathering and Giving information and Handling special circumstances) and Content (Pre-, Post-HIV test, follow up and counselling for TB and MTCT). Most LCs seemed familiar with basic counselling skills when they shared how they normally conduct their counselling sessions. However, the majority of LCs found it challenging to manage special situations. Counsellors reported that they include all information deemed necessary as per the HIV counselling process (pre- and posttest counselling and counselling in MTCT interventions).

5.1.5.3 Summary of post-intervention results

From the post-intervention results, LCs do have adequate counselling skills. However, competence-related aspects such as handling special circumstances, ethical issues and incorporating HIV-related information, especially in PMTCT interventions, were still lacking. The LCs reported a high level of emotional exhaustion; this is also reflected in the additional counselling work-related components reported in this section.

In the following section, the key areas identified in the post-intervention phase are presented. The majority of the key areas did not change between the pre- and post-intervention phase.

5.1.6 Integration of quantitative and qualitative results (Triangulation)

Following the triangulation steps in Section 5.2.4.1, the quantitative and qualitative data were merged. In this study, the mixed-method steps were followed carefully to arrive at the overall theme and purpose of the study. As previously stated, the quantitative and qualitative results, including the descriptive statistics, provided more detail about the participants' counselling and occupational background, employment, education, selection and training; this was not expected to change from the pre-intervention to the post-intervention phase. However, the drop-out rates in the post-intervention phase led to sampling variations. Therefore, the report on post-intervention data will mostly focus on the hypothesis. The post-intervention data is only reported in the form of comparison tables.

5.1.7 Evaluation of HIV counselling skills training programme

Three processes were undertaken to evaluate the training programme. In this section, the results of a comparison of both pre- and post-intervention results are compared.

5.1.7.1 Comparison of pre- and post-intervention merged data

The triangulation results of the pre- and post-intervention were compared to determine if there was a difference between the pre- and post- intervention.

5.1.7.1.1 Counselling skills

Table 5.12

A Comparison between Pre- and Post-Intervention Merged Data: Counselling Skills

Pre-intervention Results	Post-Intervention Results
Overarching themes: The main focus of the counselling sessions was to provide information and build interpersonal relationships. This was reflected in both the focus groups and the video assessment observations; both these components had a rating of "moderately handled".	Overarching themes: The main focus of the counselling was to provide information and build interpersonal relationships. This was reflected in both the focus groups and the video assessment observations; both these components had a rating of "moderately handled".

5.1.7.1.2 Competence-based elements

Table 5.13

Comparison between Pre- and Post-Intervention Merged Data: Competence-Based

Pre-intervention Results	Post-Intervention Results
Overarching themes: The main focus of the counselling sessions was to provide information and build interpersonal relationships. This was reflected in both the focus groups and the video assessment observations; both these components had a rating of "moderately handled". Although counsellors frequently mentioned needing to deal with sensitive issues related to cultural differences, they did not seem to be very adept at doing just this.	Overarching themes: The focus of the counselling sessions was to provide information and build interpersonal relationships. This was reflected in both the focus groups and the video assessment observations; both these components had a rating of "moderately handled". Although counsellors frequently mentioned needing to deal with sensitive issues related to cultural differences, they did not seem to be very adept at doing just this.

5.1.7.1.3 Content-based elements

Table 5.14

A Comparison between Pre- and Post-Intervention Merged Data: Content-Based

Pre-intervention Results	Post-Intervention Results
Overarching themes: In both participants' own admissions and from the video assessment, more training is required in a number of areas.	Overarching themes: In both participants' own admissions and from the video assessment, more training is required in a number of areas.

5.1.7.1.4 Burnout

Table 5.15

A Comparison between Pre- and Post-Intervention Merged Data: Burnout

Pre-intervention Results	Post-Intervention Results
Overarching themes: Burnout is mostly due to the stressful working environments of the participants. The frequently mentioned emotionally draining nature of the work was confirmed by the high-level burnout reported by participants on the Emotional Exhaustion subscale of the Burnout Inventory.	Overarching themes: Burnout is mostly due to the stressful working environments of the participants. The frequently mentioned emotionally draining nature of the work was confirmed by the high-level burnout reported by participants on the Emotional Exhaustion subscale of the Burnout Inventory.

5.1.7.2 Statistical analysis

The section encompasses reports on the statistical analysis conducted to test the three-research hypothesis. The report starts with the content-based skills, followed by the competence elements and concludes with burnout analysis.

5.1.7.2.1 Research hypothesis 1

Lay counsellors who underwent the HCTP programme levels of counselling skills (content-based elements) will differ from the lay counsellors who were not exposed to the programme

The Mann-Whitney U test was run for various components of the observed session. This was only run on the observed session that had a large enough sample size. It is important to note that the mean and median were higher for the intervention than for the control group. The low sample size would have influenced the statistical significance scores.

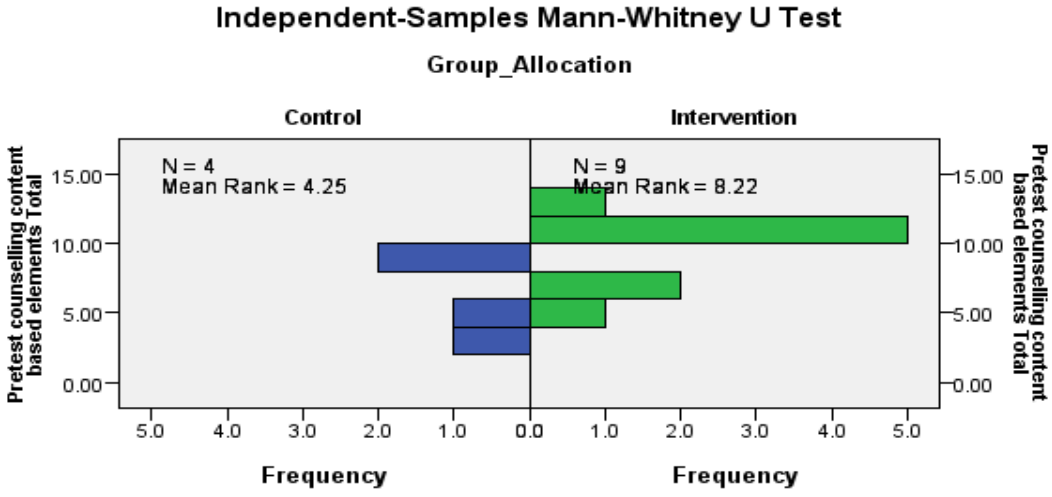
5.1.7.2.1.1 Content-based skill elements

A Mann-Whitney U test was run to determine if there were differences in the total pretest content-based counselling scores between the intervention and control group after the intervention occurred.

5.1.7.2.1.1.1 Pre-HIV test counselling content

Figure 5.2

Mann-Whitney U test for pre-HIV Test Counselling Content



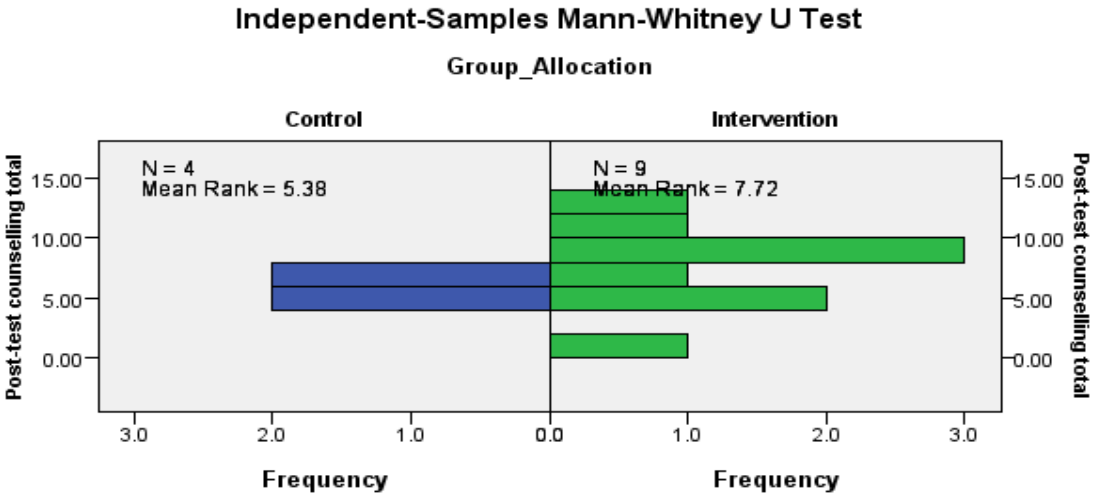
Distributions of the total pretest content-based counselling scores for the intervention and control groups were not similar, as assessed by visual inspection.

There was no statistically significant difference in the total pretest content-based counselling scores between the intervention (mean rank = 8.22) and control (mean rank = 4.25) groups, $U = 7.0$, $p = 0.106$, using an exact sampling distribution for U.

5.1.7.2.1.1.2 Post-HIV test counselling content

Figure 5.3

Mann-Whitney U test for post-HIV Test Counselling Content

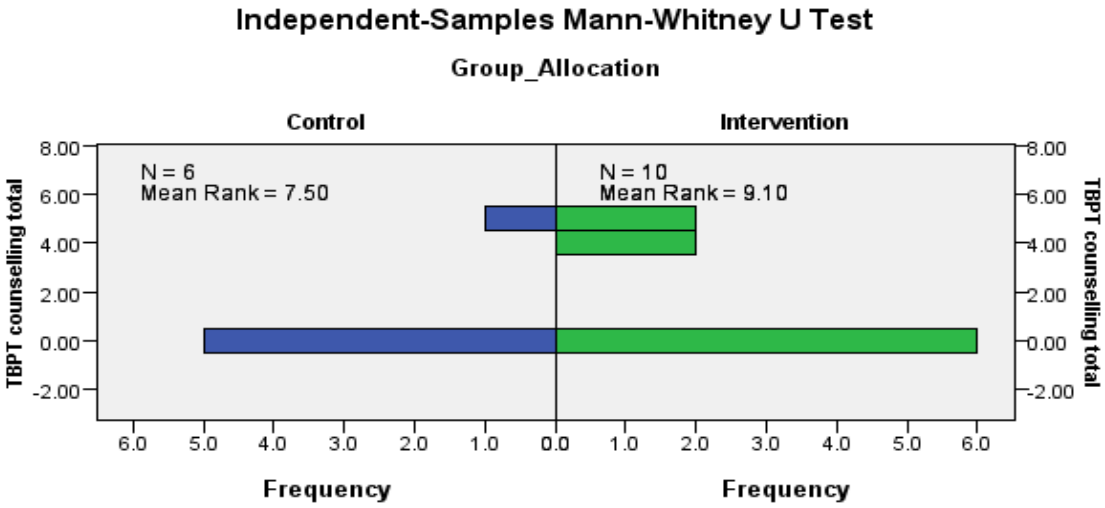


A Mann-Whitney U test was run to determine if there were differences in the total posttest counselling scores between the intervention and control group after the intervention took place. Distributions of the the total posttest counselling scores for the intervention and control groups were not similar, as assessed by visual inspection. There was no statistically significant difference in the total posttest counselling scores between the intervention (mean rank = 7.72) and control (mean rank = 5.38) groups, $U = 11.5$, $p = 0.330$, using an exact sampling distribution for U.

5.1.7.2.1.1.3 Counselling-based content for TBPT

Figure 5.4

Mann-Whitney U test for Counselling-based Content for TBPT



A Mann-Whitney U test was run to determine if there were differences in the total TBPT counselling scores between the intervention and control group after the intervention took place. Distributions of the total TBPT counselling scores for the intervention and control groups were not similar, as assessed by visual inspection. There was no statistically significant difference in the total TBPT counselling scores between the intervention (mean rank = 9.10) and control (mean rank = 7.50) groups, $U = 24.0$, $p = 0.562$, using an exact sampling distribution for U.

5.1.7.2.2 Research hypothesis 2

Lay counsellors who underwent the HCTP programme levels of competence (interpersonal relations, gathering information, giving information and handling special circumstances) will differ from the LCs who were not exposed to the programme

To investigate the second research hypothesis, a non-parametric technique was followed.

During the investigation, a complete set of information was obtained from 11 respondents in the experimental group and nine respondents from the control group.

Due to the limited information, there was uncertainty regarding the assumptions of normality and homogeneity scores, and therefore it was not possible to investigate the formulated statistical hypothesis using the parametric statistical technique. In practice, it was, however, not possible to obtain larger groups due to the multi-stage sampling procedures employed. To determine the post-scores of the two groups (experimental and control) regarding their competency-based elements, the Mann-Whitney U test was used. Since all the dependent variables (competence-based elements) are measurable on the interval scale, it was appropriate to consider the Mann-Whitney U test due to it being a non-parametric test that compares the central tendency between two independent groups. The test statistic for the said test is as follows:

$$U_A = n_A n_B + \frac{n_B(n_B + 1)}{2} - T_B$$

$$U_B = n_A n_B - U_A$$

Where T_B = the sum of the ranking order of sample B and

U = the smallest between U_A of or U_B.

The decision rule regarding a two-sided test (as is the case here given that the alternative hypothesis is non-directional) is as follows:
If observed $U \leq U_{1-\alpha/2}$, for n_A and n_B, reject H_0.

In testing the second hypothesis, the Mann-Whitney results were calculated (see Table 5.16).

Table 5.16

Mann-Whitney-test Results for Competence (interpersonal relations, gathering information, giving information, and handling special circumstances)

Phases of concern	U-value	p-value+
Interpersonal relations	17.5	0.122
Gathering information	20.5	0.216
Giving information	21.0	0.256
Handling special circumstances	21.0	0.256

+ corrected for equal ranking orders

Not one of the calculated U-values was smaller than 23, thus not significant at the 5% level of significance. Consequently, the null hypothesis cannot be rejected for one of the four competency-based elements to assume that a significant difference in the average post-scores for the two groups is present. As a result, the application of the HCTP programme was unable to make a statistically significant contribution to changes in competence/behaviour of the LCs who were part of the experimental group.

5.1.7.2.3 Research hypothesis 3

Lay counsellors who underwent the HCTP programmes' levels of burnout (emotional, depersonalization, personal accomplishment) will differ from those who were not exposed to the programme

To determine the possible effect of the programme on burnout among the LCs (emotional exhaustion, depersonalisation and personal accomplishment), it was necessary to establish if no significant differences existed before the intervention between the two groups regarding levels of burnout. Consequently, the average scores of the three variables' pre-scores were compared. If no statistical differences for the two groups can be found, the averages of the post scores should be compared. If statistical differences are reported on the pre-scores, the average score difference between the pre-and-post scores for the two groups needs to be compared.

Regarding the practical importance of the statistically significant result, it was necessary to calculate effect sizes (*f*-values), as indicated in the last column of Table 5.16. During the comparison of two or more population averages, as in this case, the effect sizes were determined as follows (Steyn, 1999):

$$f = \sqrt{k-1/N-k} \cdot \sqrt{F}$$

Where k = number of populations

To assist in interpreting the effect sizes, the following guidelines can be used:

$f = 0.1$: small effect

$f = 0.25$: medium effect

$f = 0.4$: large effect

The effect sizes can only be calculated if significant results are reported from comparisons. The 1% as well as 5% levels of significance were included in this study. The results were calculated with the aid of the SPSS-computer programme package (IBM SPSS, 2017).

5.1.7.2.3.1 Descriptive statistics

The descriptive statistics (means and standard deviations) for the MBI scale are reported in Table 5.17.

Table 5.17

MBI: Average, Standard Deviations, Skewness and Kurtosis for the Total Group

Variables	$\overline{X}$	sd	Skewness	Kurtosis
Emotional – pretest score	29.54	11.11	-0.178	-0.447
Emotional – posttest score	25.55	11.46	-0.074	-0.837
Depersonalisation – pretest score	4.81	4.56	1.075	0.609
Depersonalisation – posttest score	4.06	4.18	1.406	1.672
Personal accomplishment – pretest score	41.39	5.80	-1.305	2.262
Personal accomplishment – posttest score	41.99	5.37	-1.646	3.235

To determine the skewness and kurtosis values, the following guideline values were used: For skewness, a range between -1 and +1 indicated slight skewness, values between -2 and +2 indicated moderate skewness (Peat et al., 2008) and for kurtosis, normal distribution was between -3 and +3 (Brown, 1997). From Table 5.17, it is clear that except for the posttest scores for personal accomplishment, the values produced fell within the acceptable range of skewness, as well as kurtosis. This indicates that the data obtained in the present study could be further analysed.

Table 5.18

Means and Standard Deviations for the MBI Subscale Score for Experimental and Control Groups

MBI subscales	Experimental group			Control group		
	N	$\overline{X}$	sd	N	$\overline{X}$	Sd
Emotional – pretest score	32	29.62	10.91	26	29.47	11.44
Emotional – posttest score	32	25.16	11.72	26	25.87	11.43
Depersonalisation – pretest score	32	4.93	5.16	26	4.72	4.08
Depersonalisation – posttest score	32	3.57	4.11	26	4.46	4.26
Personal accomplishment – pretest score	32	42.19	4.94	26	41.73	6.42
Personal accomplishment – posttest score	32	42.51	5.31	26	41.57	5.48

5.1.7.2.3.2 Results of the variance analysis

There are several assumptions if a MANOVA is being used. One of the most stringent assumptions is the independence of observations. To control correlations among observations, a more stringent alpha level (e.g. $p < .01$) should be used, especially when determining the significance of MANOVA calculations. When dealing with the normality of scores, each of the dependent variables should be normally distributed within groups. Outliers should be removed before a MANOVA is performed. The third assumption deals with homogeneity of variances. This assumption assumes that the dependent variables exhibit equal levels of error variance across the range of independent variables. The Levene's Test can be used to test for homogeneity of variances.

The last assumption deals with the homogeneity of covariances, and the Box Test can be used to investigate whether the observed covariance matrices of the dependent variables are equal across groups. The last two assumptions may be violated without greatly affecting the level of significance or power. However, it is also important to pay attention to unequal sample sizes. If the difference in sample size is significant, we should use the Pillai's trace should be used as the multivariate test statistic rather than Wilk's Lambda (Tweedy & Lunardelli, 2016).

The homogeneity of covariances and variances of the dependent variables will first be investigated. The Box Test and Levene's Test were used to investigate the homogeneity of covariances and variances of the pretest scores of the different dependent variables. The results of the Box Test (Box's M = 12.118; $F_{(6;20189)}$ = 1.900; p = 0.077) indicate no significant differences in the covariances matrices while the results of the Levene's Test also indicate no significant F-values (Emotional = 0.040; p = 0.842; Depersonalisation = 1.143; p = 0.290 and Personal accomplishment = 0.626; p = 0.342), which indicate no significant differences in the variances of the dependent variables. The data for the pretest scores comply thus to all assumptions, and the analysis proceeded with a One-way MANOVA analysis. Table 5.19 presents the results of the one-way MANOVA to determine if there were significant differences in the average pretest scores for the MBI between the experimental and control groups.

Table 5.19

Results of the Oneway MANOVA for the Pretest Scores of the Three MBI Subscales for the Experimental and Control Groups

	Experimental group		Control group	
MBI subscales	$\overline{X}$	sd	$\overline{X}$	sd
Emotional – pretest score	29.47	11.44	29.61	10.91
Depersonalisation – pretest score	4.72	4.08	4.93	5.16
Personal accomplishment – pretest score	41.73	6.42	42.29	4.94
F = 0.335				
p = 0.800				
f = 0.018				

From Table 5.19, the reported *F*-value (according to Hotelling-Lawley Trace) of 0.335 ($\nu = 3; 54$) is not significant on the 1% level ($p = 0.800$). Therefore, it can be concluded that there are no statistically significant differences in the averages of the pretest scores for the three measuring scales (emotional exhaustion, depersonalisation, and personal accomplishment) reported. Consequently, the average posttest scores of the three measuring scales for the two groups (experimental and control) were compared using a one-way MANOVA. In this case, the researcher tested the assumptions and the posttest scores. The Box Test and Levene's Test were used to investigate the homogeneity of covariances and variances of the posttest scores of the different dependent variables. The results of the Box Test (Box's M = 2.737; $F_{(6;20189)} = 0.429$; $p = 0.860$) indicate no significant differences in the covariances matrices while the results of the Levene's Test also indicate no significant *F*-values (Emotional = 0.003; $p = 0.953$; Depersonalisation = 0.024; $p = 0.877$ and Personal accomplishment = 0.060; $p = 0.807$), which indicate no significant differences in the variances of the dependent variables. The data for the posttest scores complies with all assumptions, and thus the calculation of the average posttest score was done by a one-way MANOVA analysis. Table 5.20 reports the results of the one-way MANOVA, which was used to determine if there were significant differences in the average posttest scores of the MBI between experimental and control groups.

Table 5.20

Results of the One-way MANOVA for PostTest Scores of the Three MBI Subscales for the Experimental and Control Groups

MBI subscales	Experimental group		Control group	
	$\overline{X}$	Sd	$\overline{X}$	sd
Emotional – posttest score	25.87	11.43	25.16	11.72
Depersonalization – posttest score	4.46	4.26	3.57	4.11
Personal accomplishment – posttest score	41.57	5.48	42.51	5.31
$F = 0.377$				
$p = 0.770$				
$f = 0.021$				

From Table 5.20, it appears that the *F*-Value of 0.377 (ν = 3; 54), as calculated according to Hotelling-Lawley Trace, was not found significant at the 1% level of significance ($p = 0.770$). Accordingly, it can be deduced that no statistically significant differences exist for the average posttest scores for any of the three measuring scales (emotional exhaustion, depersonalisation, and personal accomplishment).

It can therefore be concluded that the HCTP indicated no significant effect on the levels of burnout for lay counsellors.

5.1.7.3 Training programme evaluation by participants

The HIV counselling skills training programme was evaluated using a training evaluation measure (Annexure 9) developed by the researcher. This scale has a 5-point Likert-scale, which addresses general training aspects, including a qualitative enquiry on the basic process operations and micro-skills, as indicated in the *Model of Counselling Competence* (Ridley et al., 2011b), thus concluding the results section.

5.1.7.3.1 Quantitative evaluation (Likert scale)

Overall, most of the experimental LC group reported that the training was good in many aspects. Punctuality and professionalism (80.6%), effective use of training materials and techniques (86,1%) accounted for some level of satisfaction among participants. Most (88.9%) of the LCs indicated that the presenter was knowledgeable about the topics presented and that the HCTP course was informative and applicable to 86.1% of the intervention group.

5.1.7.3.2 Qualitative evaluation

5.1.7.3.2.1 Which part was beneficial?

Overall theme: The majority of the LC group reported they would like more sessions to improve their knowledge and more than five days for training.

EC 18: '*More training to gain knowledge.'*
EC 12: '*Counselling is an interpersonal dynamic communication process between patient and counselling.'*

EC 17: '*Training was so important to me, we need more than 5 days*
EC 24: '*I would like to encourage you for more time to me five days was not enough. I suggest one-year course or six months.'*

On content relating to the work the counsellors do, the group reported they would like marriage counselling as part of the professional support they receive from their workplace.

EC 35: '*What I need is marriage counselling training and every year we must have advance, and I'm asking (de-briefing) because as a counsellor we have a lot weight on our shoulders.'*

5.1.7.3.2.2 Which part was not beneficial?

1. Self-management N=11 (30, 6%)

EC 15: '*No counselling without you ('U')'*
EC 27: '*Stress management. Self-care and preventing burn out.'*

2. Counselling skills N=8 (22, 2%)

EC 19: '*Conceptual map counselling process.'*
EC 23: '*Counselling skills and activity*.'

3. Role play N=8 (22.2%)

EC 2: '*When we do the activities in counselling skills*.'
EC 18: '*Role plays and Discussions*.'

5.1.7.3.2.3 Preference and usability of skill set

1. Communication N=31 (86, 1%)

EC 5: '*I will use the skill of body language to make my patient satisfied by using body language, I did not know that body language is a part of showing someone welcome*.'
EC 15: '*Listening skill. Open and close questions. Body language.'*

2. Interpersonal traits N=25 (69.4%)

EC 9: '*Self-control. Self-awareness. Confidentiality. Communication.'*
EC 16: '*Journal. Aspects. Counselling skills. Self-care*.'

3. Empathy N=16 (44.4%)

EC 8: '*Respect my patient's feelings and listen to them.'*
EC 11: '*Empathy and be more patient to my patients understand that our level of understanding or thinking is not the same.'*

5.1.7.3.2.4 Skills, competence, and burnout

5.1.7.3.2.4.1 Determining counselling outcomes

The majority N=34 (94.4%) of the lay counsellor group indicated that they had gained skills in determining counselling outcomes. In total, communication N=8 (22.2%) was still an important factor, and also, LCs reported that they had learnt different skills and application of counselling skills from the training. This was reported by N=12 (33.3%) of the group.

As expressed in their own words:

EC 8: '*To teach them they can solve their own problems.'*
EC 11: '*Yes, they just need me to listen and help them to tell their story and show them they have an ability within themselves to find solutions for their problems*.'

5.1.7.3.2.4.2 Facilitating counselling outcomes

The majority (N=35 / 97.2%) of the lay counsellor group indicated that they had gained skills in facilitating counselling outcomes. In total:

- Communication (N=13 / 36.1%)
- Interpersonal traits (N=11 / 30.6%)
- Listening (N=8 / 22.2%)

5.1.7.3.2.4.3 Evaluating counselling outcomes

Most respondents reported that they had learned skills to evaluate the counselling process (N=35 / 97 %), especially about follow-ups (N=9 / 25%) of clients.

On these questions, participants responded with:

EC 5: '*Yes, I will make sure that my patient gets from point A to B or by seeing that he or she coming back to me by saying you helped me a lot*.'
EC 11: '*Yes, because I can now observe body language, feedback, see if there is change, but in so doing, I'll be able to measure if I reached the patient.'*

5.1.7.3.2.4.4 Sustaining counselling outcomes

Most respondents reported that they had learned skills to sustain counselling outcomes. Follow-ups were reported by 52.8 % (N=19) of the group, and educating patients also seemed to be an important component in ensuring patients translate gains beyond the counselling process. On average, N=11 (30.6%) of the lay counsellor group are confident about the role educating patients play. Providing information and tools were another valid benefit as N=66 (16.7%) of the LCs felt it would benefit patients. Encouraging patients was reported by N=6 (16.7%) of the participants.

On these questions, participants responded with:

EC 2: '*Taking responsibility. Adhere in their treatment.'*
EC 10: '*By making follow-ups and see the happiness to the eyes of my patients and my patient decided to move on to the new step.'*
EC 27: '*With the knowledge I have, I'll be able to approach my patient t. If the nothing I can do for them, I'll refer them to get better, not more help.'*

5.1.7.3.3 Summary of results

Despite counsellors reporting being satisfied with the training, it is evident that the research participants' counselling skills, competence and burnout did not change, and no statistical difference was noted between the pre- and the post-intervention phases for both the experimental and control groups' performance among the investigated variables. The study was able to identify gaps in the execution of skills, displaying of key competencies and measuring the level of stress components within this group, and this formed the basis of the training intervention. Despite this, and the fact that various tools and data collection and analysis measures were employed, assessing the level of counselling skills, key competencies and burnout among the study's participants did not yield the desired results. To address the possible reasons for the results reported, a discussion on the results and what could have impacted the findings is undertaken in the next chapter. This will take into consideration all elements that inform such evaluation and development of counselling training programmes.

CHAPTER 6

DISCUSSION

In this chapter, the main findings from the research study will be discussed. The discussion will be in line with the literature and the research questions. Firstly, the chapter will start with the first objective devised: to assess the current level of HIV counselling skills, competence, and burnout among lay counsellors. The discussion of the results is presented according to the triangulation process for both the quantitative and qualitative legs. The process of triangulation involved the combination of the two sets of data to enhance the credibility of the research investigation. The assessment considered other contextual factors significant in the execution of HIV counselling by lay counsellors. Therefore, in addition to skills, competence, and burnout, the first part of the chapter explores counsellor demographics and counselling work conditions. The second part of the chapter addresses the fourth objective: to evaluate the HIV counselling skills training programme. In this post-intervention (evaluation) phase, a discussion is presented following the triangulation process for both the quantitative and qualitative parts. The evaluation's purpose was to determine if any similarities or differences exist between the pre- and post-intervention results. In addition, this segment of the chapter will encompass results from the statistical analyses conducted for the post-intervention quantitative part, including the HCTP evaluation administered to participants following the training intervention.

6.1 Discussion of the pre-intervention results

This section explores the pre-intervention assessment findings, which addresses Objective 1: *Assess the current level of counselling skills, competence and burnout among the lay counsellors.*

The discussion presented follows the format used in the results presentation in Chapter 5. Therefore, contextual factors pertaining to LCs demographics are presented first, followed by skills, competence, and burnout. The discussion of the results is presented in themes and categories based on the findings from the triangulation process. The findings discussed in the part that follows is organised in two sets, as lay counsellor variables and counselling work-related variables.

6.1.1 Lay counsellor demographics (selection, educational background and entry-level training)

In this study, participants reported that their selection as lay counsellors was based on criteria that require a basic school education background. What the current study found was that lay counsellors had, at the most, a matric certificate. Compared to entry-level professional counselling positions in healthcare, which, at a minimum, require a university degree, as illustrated in Chapter 3 (cf. Table 3.1.); lay counsellors only require a high school education. The entry-level education criteria as set out in the National Department of Health HCT guidelines (National Department of Health, 2015) stipulate a matric qualification as a requirement. However, this study, similar to others in South Africa (Dewing et al., 2015; Duncan et al., 2017; Mwisongo et al., 2015), has reported at least a high school education; thus, not all lay counsellors have a matric qualification.

The role of education in the execution of intellectually demanding activities is an important aspect of learning (Parisi et al., 2012). The question can rightfully be asked whether the current study participants' level of education influences the cognitive ability required to undergo the training proposed. Depending on the learning ability and style of the counsellor trainee, counselling training may be easier when it comes to learning observable skills. These skills, which encourage rapport and relationship building between counsellor and patient, may include paraphrasing and asking open-ended questions, and these are skills that are often demonstrated during training (Bryant-Jeffries, 2017). However, there are more complex skills that require a certain level of cognitive ability; these may include conceptual aspects such as being able to interpret what the patients' needs are, identifying patients' positive assets and assisting patients in exploring alternative options (Hill et al., 2017).

As reported in the results, the current study's participants lack skills and competence elements that require conceptual cognitive ability. The findings reported lay counsellors not being able to meet patients' needs in counselling situations where sensitive and/or issues of an emotional nature were present. Despite this finding, the lack of skills necessary to ensure competence amongst the lay counsellors in this study does not necessarily imply or question the study participants' intellectual ability. In explaining the findings, an attempt is made to discriminate between skills that are easily learned and those that are challenging to apply in HIV counselling provided by the lay counsellors.

All participants in this study had undergone an entry-level 10-day training programme in HIV counselling and testing (HCT), as set out in the *Minimum Standards for counselling and training: Selection and training of counsellors* following their recruitment (National Department of Health, n.d.). This requirement is standard training practice and criteria in selecting lay counsellors in South Africa (National Department of Health, 2015; Mwisongo et al., 2015), as it addresses the acquisition of basic counselling skills. The skills, amongst others, include: 'establishing rapport with patients' and 'being non-judgemental', both skills draw from the person-centred counselling approach.

Additionally, participants also reported having received the entry-level training between the years 2012-2016. It would be expected that some of the lay counsellors might have had adequate opportunity for exposure and experience in HIV counselling. The probability of having gained sufficient work experience would also be expected to increase the participants' level of demonstrating adequate skill and competence. However, participants struggled to adjust and be flexible in their counselling processes with patients.

Ridley et al. (2011b) describe this aspect of metacognition as 'timing', which proposes that competent counsellors need to adjust the direction of the counselling process as new information presents. In such counselling situations, counsellors may need to generate and use appropriate problem-solving techniques to achieve predetermined counselling outcomes.

For the current study participants, the use of the aforementioned skills, at the level proposed and expected based on the *Model of counselling competence* (Ridley et al., 2011b), might not necessarily be feasible. The model of Ridley et al. (2011b) is customised primarily for professional counsellor training and evaluation. As indicated in the comparison of training between lay counsellors and professional counsellors, the training and execution of counselling by lay counsellors still require a certain level of accessibility of the described skills for the study participants.

When examining the concept of work experience versus effective work tasks execution, the participants in the current study did not seem to perform the counselling tasks at an expected level given the work experience reported in the findings. Although work experience was not a variable controlled for in the current study, the results suggest that there might be other aspects to consider in counsellors' ability to perform counselling duties to achieve competence. In view of work experience, Ridley et al. (2011b) considered various perspectives that may inform counsellors work performance. What the authors deliberated on is that experience alone might not meaningfully improve counsellors' judgement, and drawing from contrasting positions, the authors arrived at an understanding that certain interactive sets of cognitive and affective components referred to as metacognitions, inform counselling outcomes (Ridley et al., 2011b).

An additional variable that could have influenced lay counsellors' evaluation of performance on skills and competence in the current study is further training. Findings of the current study indicate that the majority of participants reported satisfaction with the entry-level training received. However, participants reported that additional training was needed as the entry-level training was not sufficient in meeting the evolving nature that determines the current demands of HIV counselling within HCT services. Similar findings are reported by Dhadwal et al. (2009).

As in its nature, HIV/AIDS is a continuously changing medical condition with continuously changing healthcare needs, therefore, this necessitates a requirement for lay counsellors to be trained and evaluated regularly. Such training would assure that lay counsellors keep abreast with new HIV/AIDS trends.

The current study participants reported having received additional training on different HIV-related areas, which covered medical topics such as TB, ART initiation, etc. However, the scope of the current study did not include examining in detail, how these trainings could have affected the level of skills and competence displayed by the participants. These findings suggest that the additional training received might not have been able to meet the HIV counselling needs of the participants. This could perhaps explain the lay counsellors lack of adequate counselling skills and competence. Furthermore, lay counsellors in the current study reported a need for further HIV counselling training. Similarly, this finding was reported by Mwisongo et al. (2015) on their evaluation of HIV counselling services in South Africa. Seemingly, an improvement in HIV counselling skills of lay counsellors has been reported following counsellors undergoing refresher and additional training (Msisuka et al., 2011; Sarker et al., 2009).

In considering what has been presented thus far, it is important to note that the level of educational background relates to cognitive processing and that the selection of lay counsellors is an aspect that has a bearing on the trainability of this particular healthcare provider. Kagee (2020) indicated that in South Africa, currently, no recruitment screening measures have been developed to distinguish between counsellors who do or do not become effective in their work after receiving the entry-level training. Therefore, as a natural principle, the development of the current study's HCTP was planned and structured at the level that would be pertinent, given the educational background and qualifications of the participants. With all processes considered, the overall performance and response of the lay counsellor group to the training will determine the attainability of the intended study outcomes. Furthermore, it important to consider other aspects which lay counsellors reported as having a negative impact on their work in HIV counselling. These counselling work variables are discussed in the next section.

6.1.2 Counselling work conditions (employment opportunities, time spent on counselling, support, and supervision)

A major aspect that is reported by the participants is the lack of opportunities for formal employment and integration into the healthcare work system. Lay counsellors expressed dissatisfaction with working as volunteers.

Working under unsatisfactory employment conditions may be impairing lay counsellors' ability to deliver effective counselling services. Issues about employment status, career progression and remuneration of lay counsellors have been a long-standing debate and issue in HCT services (Duncan et al., 2017; Heunis et al., 2013; Lehmann & Sanders, 2007; Schneider & Lehmann, 2016). Africa shares the same sentiments as some countries who lack healthcare resources, where poor working conditions of lay counsellors, have been reported as an issue that impacts job satisfaction and retention (Bott et al., 2014; Schneider, 2019). Dissatisfaction with work was indicated for approximately 80% of the lay counsellor participants in a multi-country study on HCT across Burkina Faso, Kenya, and Uganda, which was mainly attributed to non-financial rewards (Bott et al., 2014).

In South Africa, lay counsellors' integration into the health system and other state entities is still a contentious issue. Many of the reviewed literature states that the employment status of lay counsellors is a function that relies solely on the support and coordination of community-based organisations (CBOs) and/or NGOs (Bemelmans et al., 2016; Duncan et al., 2017; Schneider, 2019). These organisations are mostly supported through internationally funded operations. It would be expected in sub-Saharan Africa that, country to country specifications would apply, and in South Africa, these would include province to province stipulations. This finding indicates the lack of uniformity in the employment status of lay counsellors in HCT in South Africa (Duncan et al., 2017; Schneider, 2019). Issues around the employment status of lay counsellors, as reported in the current study, is a national government administrative issue and one that seems to be an additional barrier encountered by lay counsellors in the delivery of HCT services.

Given work conditions barriers, the lay counsellor group in the current study reported still being keen and motivated to perform and deliver HCT services.

The study participants' motivation is a variable that forms part of lay counsellors ability to manage stress and burnout and will be discussed further in the thesis. Work condition barriers reported by the lay counsellors in the current study also included personal safety issues, which, according to the study participants, is a source of concern.

Most HCT services, when the current study was conducted, were mainly provided through community-based programmes as part of primary healthcare (PHC) reengineering. The PHC reengineering services provided by lay counsellors are conducted door-to-door, where lay counsellors provide the service at the patients' place of residence or work (National Department of Health, 2010b, 2015). Such conditions would put pressure on the quality of one's counselling, especially if lay counsellors' ability to focus on the task at hand can easily be interrupted by concerns or safety issues.

In addition, lay counsellors raised a 'high workload' and not being afforded adequate time on counselling duties, as other hindrances to the provision of quality HIV counselling. These results echo findings from other South African studies (Haffejee et al., 2010; Mwisongo et al., 2015; Peltzer & Davids, 2011) where lay counsellors' dissatisfaction with working conditions impedes their ability to provide adequate HCT services. The workload and inadequate counselling time highlighted in the studies reflected an on-going problem in South Africa, as the current study still reflected the same results. Similarly, a high workload and insufficient time for counselling were reported in an evaluation of HCT in India by Papanna et al. (2013), which proposed that such work conditions attributed to poor quality in HIV counselling services.

Lay counsellors in the current study also indicated feeling rushed to reach the set daily statistical targets as a concern, which is a reported work-related concern that has been previously reported in the assessment of counselling and support for PLWHA conducted by Peltzer and Davids (2011). In view of counselling competence, the researcher argues that counsellors should be able to recognise and skillfully employ a variety of interventions that would be efficient under situational circumstances that impact adequate time for counselling.

As much as HCT is a manualised and structured intervention, time constraints and other systemic issues call for lay counsellors to customise interactions to reach predetermined counselling outcomes. The interventions proposed to maximise counselling interactions in HCT are perhaps suggestive of what Kohrt et al. (2018) and Kagee (2020) implied as predispositions of lay counsellors not being inclined to comprehend what fitting measures would be ideal under such constraints.

Dissatisfaction among lay counsellors on the level of support and supervision offered by supervisors and managers was reported amongst the study participants. Support and supervision for counsellors should accompany counselling training and ongoing counsellor development (Assegaai & Schneider, 2019; Dhadwal et al., 2009; Schneider et al., 2008; UNAIDS, 2000).

Supervision on its own is an important factor in counselling work and has been reported in various studies as a hindrance if not regularly provided to lay counsellors providing HCT work (Boeke et al., 2018; Corey, 2012; Haffejee et al., 2010; Ridley et al., 2011b). In considering the results of this study, support and the extent to which lay counsellors experience supervision, or the lack thereof, is one of the factors that can potentially account for a considerable degree on the execution of quality counselling, resulting in lay counsellors not being able to apply counselling skills appropriately. Mwisongo et al. (2015) reported similar results and indicated that support is essential in assisting lay counsellors to manage stress.

The lay counsellors in the current study expressed frustrations with the lack of access to consistent referral points, as also reported by Haffejee et al. (2010) as a barrier to quality HCT services. This is especially important as healthcare services is an integration of different disciplines that require constant communication and referral to appropriate care. Although this was deemed a negative factor from the perspective of the lay counsellor participants, it does provide a valuable outlook on the use of other systems of care as an indication of the lay counsellors' awareness of limitations of the scope of practice.

This finding proved to be encouraging, as it supports the notion expressed by Ridley et al. (2011b), that competent counsellors can recognise their limitations in knowledge, skills and expertise. From the findings in the current study, participants seem to be aware of their role within the broader HCT care system.

It was important in this study to consider the individual and structural impeders in the planning of the HIV counselling skills training programme. A few points of referral can be drawn from the discussion presented on the aspects that affect HIV counselling practice as carried out by lay counsellors in HCT in public health settings.

Firstly, the ability of counsellors to manage situations outside the counselling set-up and process with patients indicates the level of competence a counsellor possesses. Secondly, the success of the HCTP intervention is, therefore, dependent to some extent on counsellors' ability to negate through challenging work conditions. Thirdly, the training development and outcomes had to be specific and appropriate to the lay counsellors' expectations and within the threshold of what would be feasible and realistic to their everyday provision of HIV counselling services. In light of the demographics and work-related conditions, the next part of the discussion presents the assessment of skills, competence and burnout.

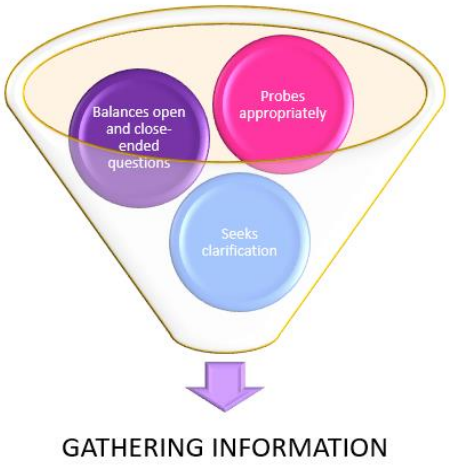
6.1.3 Counselling skills and competence

6.1.3.1 Competence-based elements

In the current study, as outlined in Chapter 4, lay counsellors were evaluated on individual counselling skills items that comprise a certain competence and on the competence itself. As seen in Figure 6.1, the key competence 'gathering information' consists of counselling skills such as 'balances open and close-ended questions, seeks clarification and probes appropriately'.

Figure 6.1

Gathering information competence and the associated counselling skills



The discussion that follows reports on the evaluation and quality of the counselling process, including the skills and competencies and the content of the HCT sessions.

In working to attain competence, the lay counsellor group in this study struggled with basic skills. However, by effectively utilising other counselling skills such as active listening and providing an emotionally warm and supportive environment, for example, participants were able to fulfill some of the expected outcomes in executing skill sets related to the first competence, '**interpersonal relationship**' and the third competencies, '**giving information**'. Overall, participants adequately displayed these two competencies. However, participants did not adequately manage skills for the second competence, '**gathering information**' and '**handling special' circumstances**'. For these purposes, only these two competencies and the skills related to them will be discussed.

On individual items making up the '**gathering of information'** competence, the lay counsellor group seemed to find it challenging to '**use silence well to allow for self-expression**' skill in their interactions with patients.

The lay counsellor group in the current study reported that they are often rushed for time and do not have an opportunity to allow pauses and silence in counselling interactions with patients. Limited counselling time means that there is limited time for allowing the process of 'silence' in meeting the patients' needs for self-expression. This impedes the natural counselling process, as dealing with patients' difficult emotions might not be possible. When there is silence in a counselling session, the patient may be processing information and making connections as silence can touch on the deepest part of emotions (Barber, 2009). According to Rogers (1942), silence is an element in counselling that could be beneficial in achieving predetermined counselling outcomes. In an initial interview, Rogers (1942) proposes that long pauses or silence are likely to be embarrassing rather than helpful. However, with subsequent contacts silence on the part of the counsellor may be a most useful device if fundamental rapport is good (Rogers, 1942).

Silence, if used adequately, can communicate to a patient that 'this is a safe environment'. Silence encourages patients to explore themselves, gives patients a sense of autonomy and offers counsellors a chance to gather their thoughts and feelings (Barber, 2009; Rogers, 1942). The silence between a patient and counsellor can facilitate and further encourage a connection between two people at a deeper human level. However, on its own, silence can be uncomfortable for anyone, especially inexperienced counsellors but what is important is how lay counsellors in the current study managed such situations.

Opposite to silence in the competence, '**gathering information**', is a process that involves engaging patients in conversations. In the case of the current study, lay counsellors were not effective in utilising the skill of '**avoids premature conclusions**. 'Avoids premature conclusions' refers to patients not only providing information but rather, they are engaged in a process that allows them to share information. Adhering to these required counselling skills facilitates the process of reaching predetermined counselling outcomes (Ridley et al., 2011b). This process is vital to gathering information in counselling as it allows counsellors to clarify information and patients' expectations (UNAIDS, 2000). Competent counsellors need to evaluate if patients understand the information provided. Similar results were reported by Mohlabane et al. (2015), where lay counsellors' sessions were more educative and hindered the process of gathering information from patients. Mohlabane et al. (2015) found that the participants in their study were not interactive and did not engage with their patient, thus restricting the process of adequate counselling. The skill of engaging patients in conversations could be ideal in HIV counselling situations where patients voluntarily request HCT services. Dewing et al. (2013) reported that lay counsellor participants in their study who provide ART adherence support services failed to meet the requirements as set in Egan's (2002) stage 2, where the counsellors' task is to assist the patient in exploring issues related to the problem. In their study, although patients were undergoing follow-up counselling for adherence and offered it as a mandatory practice, the lay counsellors mainly used information giving and advice for addressing patients' non-compliance to ART (Dewing et al., 2013). This contradicts the counselling objectives for patients with chronic conditions, especially when considering the same was shared by Haffejee et al. (2010) in their criticism of the model of 'information-giving' in HCT.

Patients going through life-changing experiences such as being diagnosed with a chronic illness require more than information (Haffejee et al., 2010). Processes at the stage of one living with a chronic illness differ from preventative and information-giving counselling, which forms part of health education counselling. Patients on ARV treatment may require strategies to improve psychological functioning, and counsellors must provide emotional support, both, which require patients engage in conversation and lay counsellors to obtain as much information as needed to meet the predetermined counselling objectives.

The fourth competence, '**Handling of special situations**' and counselling skills related to this competence, proved challenging to achieve for the current study participants. Lay counsellors in the study performed inadequately on the skill '**talks about sensitive issues plainly and appropriately to the culture**'. Many of the study participants expressed being aware of sensitive issues such as poverty, religion, sexuality, gender, cultural and traditional practices; however, the lay counsellors in the current study expressed not being comfortable in managing these situations.

Counsellors in the current research study frequently mentioned being confronted with sensitive issues related to cultural differences. In the observed sessions, counsellors did not seem to be very adept at doing this. Furthermore, by counsellors' own admission, multi-cultural aspects are considered 'interferences' in counselling and posing 'limitations' to counselling work. This admission could indicate lay counsellors inability to manage situations where patients present with new information that deviates from what the lay counsellor was expecting based on the HIV counselling needs of the patient. According to Hill et al. (2017), counsellors need to understand the patient and their problems from a high conceptual perception. Interpersonal dynamics and the patient's context are higher-order skills that are far more complex than the micro-skills (e.g., listening actively and probing). Apart from the training and education-related context of the current study's participants, Kagee (2020) reported that training of these higher-order skills requires more opportunities and time, as these skills are difficult to attain. Furthermore, the LCs in the current study's inability to incorporate patients' differing views violate the conditions expected in HIV counselling situations that foster respect and acceptance, as in the case with person-centred approaches.

The lack of appropriate management of sensitive issues was also indicated by lay counsellor participants' own expression of feeling helpless, especially when patients that are on ARVs default their treatment and uses alternative medicines and treatment options. This is similar to what Dewing et al. (2013) reported. In the ART adherence support service, the authors reported lay counsellors used confrontation inappropriately, as it conveyed judgement to patients (Dewing et al., 2013). Although non-compliance and non-adherence to ARV treatment would compromise treatment and complicate the patients' HIV/AIDS condition, lay counsellors' failure to adhere to concepts of person-centred approaches (e.g., respect and being non-judgemental), impedes the intended outcomes of the HIV counselling process. This raises concern, as advances in HIV/AIDS indicate that counselling is recommended as standard practice in ART services (Bekker et al., 2016).

The study participants encountered more challenges in the 'handling special situations' competence, which was evident from failure to '**prioritise issues to cope with limited time in short contacts**' skill. Being able to select appropriate strategies to use in quick contacts with patients, especially in HIV where there are retention and poor linkage to care concerns for people diagnosed with HIV and on ART (Asiimwe et al., 2015; Bukenya et al., 2020; Haffejee et al., 2010), is important. However, in such instances, it is important to note 'time available for counselling' and 'time spent on counselling' as it is critical and should be sufficient to allow for counselling objectives to be achieved. Lay counsellors in the current study were unable to sufficiently manage these obstacles during limited counselling session durations. Peltzer and Davids (2011) also reported the same findings when lay counsellors in their counselling support study reported not being able to adequately provide PMTCT interventions due to lack of sufficient counselling time.

According to Ridley et al. (2011b), 'sequencing' describes the ability to select goal-directed strategies in such demanding situations. Sequencing offers pacing and timing that allows counsellors to remain focused on the outcomes of their interventions, and to achieve competence, counsellors use effective communication and questioning in a timed and strategic manner to maximise the chance of achieving counselling outcomes (Ridley et al., 2011b).

On the other hand, 'timing' is an indication that the counsellor is aware of the patients' readiness for the next level of the intervention, thus adjusting the intervention to meet the needs of the patient (Wilkinson et al., 2015). In the current study, participants failed to use sequencing and timing. However, in a study conducted by Ramalepe et al. (2014), participants were able to use effective questioning such as open-ended questions to elicit and gather information from patients in time-limited and challenging situations. This indicates that these skills and counselling strategies are feasible and achievable by lay counsellors that provide HIV counselling. Furthermore, in the current study, monitoring of the counselling process and progress appears to have not been responded to appropriately. For instance, in one of the observed sessions with a patient who had received an unexpected HIV positive result, the counsellor did not prioritise the patients' emotional needs following the diagnosis.

Such instances indicate that lay counsellors do not use counselling guidelines to monitor and evaluatie counselling outcomes. In the current study, it was observed in the evaluation of counselling sessions that the study participants did not use a measuring tool (e.g., a checklist) to ensure they have addressed pertinent aspects of the HIV counselling session. It is within good practice and ethical grounds for counsellors to ensure patients' acceptance of HIV results and assess the potential risk associated with denial or other negative emotions experienced by patients (National Department of Health, 2015; WHO, 2015a) in such instances. Evaluating counselling outcomes enable counsellors to ascertain whether they have helped patients achieve the desired change or outcome (Fairburn & Cooper, 2011; Ridley et al., 2011b). Evaluating counselling outcomes, as explained by Ridley et al. (2011b), is measurable and can be applied in any situation regardless of the theoretical or counselling intervention used. In Cognitive Behaviour Therapy (CBT), for example, a rating scale such as the Cognitive Therapy Rating Scale (CTS) (Young & Beck, 1980) is used to evaluate the content and quality of the counselling session. It is recommended that monitoring and evaluation should be incorporated as a regular practice in HIV counselling processes.

One of the findings in the study was the inability of counsellors in using the skills in '**managing patients distress and emotional reactions**', which also forms part of the 'handling special circumstances' competence.

Although this was only applicable to a few of the observed sessions were lay counsellors were confronted with emotionally charged responses from patients, lay counsellors were ineffective in handling these special situations. In these sessions, patients had emotional responses either following testing positive for HIV or due to a distressing life situation. Regardless of the context, these situations seemed challenging for counsellors to manage. Dealing with distressing or bad news can be a daunting task for counsellors and an aspect in counselling that can either encourage or discourage patients' level of engagement. Buckman (1992) provides six steps in how to convey bad news. These steps are similar to what is addressed in pre-HIV test counselling. Amongst the steps, Buckman (1992) proposes the sharing of information or making an opportunity for a patient to consciously bring a distressing topic to their awareness.

In essence, what counselling intends to do is help patients manage present concerns, which can be managed on a conscious level. As previously stated, participants made reference to the limited time available for counselling, which could explain why there was ineffective management of patients' distress. Several authors (Ginwalla et al., 2002; Mohlabane et al., 2015; Peltzer & Davids, 2011) have reported time constraints in the delivery of HIV counselling services as one of the work-related concerns that affect achieving predetermined counselling outcomes, such as attending to patients' emotional needs.

The lay counsellor group did not adhere to certain counselling skills and competencies, thus assuming that this reflects the counselling skills training needs of lay counsellors in the current study. The next section focuses on content specific to HIV processes.

6.1.3.2 Content-based elements

Counselling outcomes are depended on the type of counselling process conducted. In HIV, the content of the HCT intervention includes pre- and post-HIV test counselling and follow-up counselling (National Department of Health, 2015). HIV content specific to certain populations and interventions (i.e., TB and PMTCT), as outlined in Chapter 3, also forms part of HCT interventions. In the next part of the discussion, lay counsellor participants' results on the inclusion of HIV content in their interactions with patients are discussed.

6.1.3.2.1 Pre-HIV test counselling

The discussion on the findings of the pretest counselling process pertains to sessions where HIV testing was conducted, as well as where no testing was performed. Pre-HIV test counselling has several objectives, which include obtaining patients' consent, ensuring confidentiality and discussing the advantages and disadvantages of undergoing HIV testing (WHO, 2015a). HIV information regarding HIV acquisition, transmission and HIV-related information on TB, MTCT, VMMC and MSM is provided during pretest counselling (National Department of Health, 2015). The HIV testing process and HIV prevention are also explained. Additionally, TB screening and a risk assessment need to be conducted (National Department of Health, 2016b; WHO, 2015a). Pre-test counselling, as set out in the South African HCT guidelines (National Department of Health, 2015), is intended to be an interactive process where counsellors provide information, engage a patient in discussing the relevant issues and ascertain if patients understand and are prepared to undergo the HCT process. In light of pretest counselling's aim and objectives, lay counsellors need to include as much content as possible as this process serves as preparation for getting tested and receiving the HIV test results.

The findings in the current study indicate that the majority of the participants failed to '**provide adequate HIV-related information**' and did not '**address myths and misconceptions'** patients' might have had about HIV. Counselling is an opportunity to challenge patients' cognitions (Tanser et al., 2013) and encourage evaluating options and helping patients make informed decisions. Similar results are reported by Ramalepe et al. (2014), where less than half of their study participants did not enquire or have discussions with patients regarding knowledge of HIV transmission. Ramalepe et al. (2014) and the current study's participants were unable to provide such opportunities and therefore influenced the outcome of counselling for patients. Furthermore, as seen in our previous discussion on lay counsellors skills, participants in the study did not engage patients in appropriate 'gathering of information'. Asking patients relevant questions helps determine patients' understanding of HIV as an HIV positive result carries psychological, legal and social implications (Ramalepe et al., 2014).

Additionally, all the lay counsellors in the current study did not conduct 'risk assessment'. Such assessment of personal risk profile helps identify patients that have been exposed to HIV (Bekker et al., 2016) and perhaps these patients might be more willing to use opportunities in discussing HIV risk reduction plans.

Lay counsellors in the current study did not conduct 'Risk profiling'. Together with risk assessment, risk profiling, as well as risk reduction, are key HIV prevention strategies to reduce HIV acquisition and transmission (WHO, 2015a). Since ART accessibility and availability has substantially increased over the years (Bekker et al., 2016; Bemelmans et al., 2016; UNAIDS, 2019), biomedical interventions in HIV prevention have been modified and adjusted to address HIV infection and transmission among uninfected individuals. These medical interventions use Pre-exposure prophylaxis (PrEP) and prescribe ongoing and follow-up counselling in their services (Bekker et al., 2016; CDC, 2016). Combination prevention methods use strategies such as motivational interviewing to elicit and improve patients' motivation in changing certain behaviours. Additionally, counselling offers patients access to pre-HIV test counselling and motivates patients to understand the importance of continuing with PrEP to maximise the benefit of HCT services (Bekker et al., 2016; CDC, 2016). Such interventions add value in reducing the negative impact that socio-economic determinants place on vulnerable populations (UNAIDS, 2020).

Given the studied sample, lay counsellors did not engage patients in a '**discussing a risk reduction plan**'. In risk reduction, patients' sexual practices and behaviours are evaluated to identify risky practices to come up with options and agree with lay counsellors, which would be best fit for the patient to undertake given their situation (Bekker et al., 2016; CDC, 2016). The value of risk reduction has yielded positive reports on sexual behavioural changes in patients who undergo HCT. Cawley et al. (2014) acknowledged this and found conclusive associations reported by participants who tested HIV negative. The results provided evidence of the relation in the use of HCT and an observed decrease in the number of sexual partners (Cawley et al., 2014). This study and many others (Clark et al., 2019; Flickinger et al., 2013; Hart et al., in press) indicate the value of lay counsellors developing a risk reduction plan to influence patients' sexual behaviour positively.

In preparing patients for their HIV test results, participants in the current study did not explore if patients had '**potential support sources available**' following their HIV test results outcome. Papanna et al. (2013) evaluated HCT services and indicated that a majority of their sample failed to assess if patients had adequate support. One of the main objectives in counselling interventions for patients undergoing medical investigations is to ensure that patients will seek support from significant others (Pogosova et al., 2015). This is an important component as it facilitates dealing with disclosure and potential concerns around stigma (Department of Health, 2015). Support for patients undergoing HCT interventions is an important matter to include, especially in Sub-Saharan Africa, where there is still persistent stigma (Boeke et al., 2018) of PLWHA. Lay counsellors' ability to provide a comfortable environment for patients could open up ways to discuss patients' perceptions of self and HIV and possibly minimise stigma. Additionally, patients' preference of testing place also plays a role in how stigma affects the delivery of HCT services. Patients at times prefer not to use facility-based HCT services and opt for community services provided at their places of work or residence.

Nonetheless, as much as this option can be made available, a study in Soweto by Young et al. (2010) indicated that stigma was likely to decrease when HCT content included talking about norms and perceptions about HIV. Therefore, addressing myths, challenging cognitions and misconceptions, provide LCs the opportunity to engage patients in counselling processes that could lead to informed decision-making. Furthermore, addressing stigma and other socio-economic factors that influence patients' retention in care was reported as a positive finding by Bukenya et al. (2020), which re-emphasised the move of healthcare provision from facilities to communities.

Lay counsellors in the current study reported that in addition to assisting patients by alleviating patients' fear of being stigmatised when using healthcare facilities, community-based programmes also address poverty-related socio-economic factors (e.g., accessibility of healthcare to the poor). Access to healthcare has also been reported as a factor that leads to lay counsellors' dissatisfaction with work conditions, as reported in Peltzer and Davids (2011); participants in the study reported feeling emotionally drained by these other compounding factors that patients present with.

The option of door-to-door services for patients seemed to be highly encouraged by the current study's participants and will be discussed further under Section 6.2.3.2.3. The findings presented in Chapter 5 reported that lay counsellors in this study focused more on post-HIV counselling than pre-HIV counselling. This finding has possible reasons: firstly, lay counsellors reported high workload, insufficient time for HIV counselling, and feeling rushed to reach daily targets.

These circumstances could possibly imply that lay counsellors rush through the pre-HIV test counselling to get to the test results on time, thus having time to allocate to patients who test positive for HIV. Secondly, lay counsellors indicated that limited staff capacity and lack of supervision and support hinders their ability to explore other HIV counselling interventions and options with patients. With adequate support from supervisors, lay counsellors could potentially invest in other aspects of their work, including HIV prevention strategies such as risk assessment and risk reduction plans with patients. In turn, this could serve as an occupational development opportunity and contribute to the motivation of LCs regarding their skills and competence in HIV counselling. These are only a few aspects that could explain why lay counsellors are unable to ensure adequate pre-HIV test counselling. The discussion on post-HIV test counselling results is presented in the next section. It will hopefully provide more information on the inclusion of content-based elements in HCT provided by lay counsellors.

6.1.3.2.2 Post-HIV test counselling

Post-test counselling's main objective is to communicate the HIV test results and provide emotional support for patients who test HIV positive (disclosure and healthy living) (National Department of Health, 2015). A risk reduction plan is further discussed for HIV positive and HIV negative patients (National Department of Health, 2015). In addition, patients who test HIV positive are encouraged to consider partner involvement (and testing) (WHO, 2015a). ART initiation and medical treatment of opportunistic diseases are also discussed (WHO, 2015a).

Considering health psychology and the role of counselling in health, it is important to understand that the diagnosis and management of chronic illnesses may require different counselling skills and/or different level of applying these skills compared to what has been discussed in the preceding sections. For example, a risk reduction plan for patients who test HIV positive and in sexual relationships is re-emphasised at this point (Bekker et al., 2016; CDC, 2016). Different techniques, such as motivational interviewing and CBT, and using techniques to address patients' behavioural choices in situations where they might expose themselves or others to HIV. The behavioural changes addressed in post-HIV test counselling for patients who test HIV positive relies on counsellors' abilities to assist patients in transferring gains from counselling interactions into every-day life decisions and behaviours.

In the current study, '**follow-up plans**' with patients who tested negative for HIV were not discussed, and arrangements not made. According to Ridley and Shaw-Ridley (2010), a discussion of follow up plans is one of the ultimate tests of counsellor competence, which is referred to as 'sustaining counselling outcomes' as described by Ridley et al. (2011b). In HCT, these plans encompass discussing the 'window period', among other information. Discussing the 'window period' would ease pressure on patients with limited risk and highlight the need to follow-up for a re-test for those who have increased risk based on assessment. Therefore, it is required of counsellors to understand how all of these aspects are related to one another and omitting one part may influence the outcome of the HIV counselling process.

In the present study, participants failed to '**check availability of adequate immediate support**' for patients during post-HIV test counselling. This translates into counsellors not recognising these opportunities and employing them to enrich counselling for patients. In the event of an HIV positive outcome, counselling requires that the counsellor evaluate the availability of support following the set HCT guidelines (National Department of Health, 2015). To competently assist the patient, Ridley et al. (2011b) propose that counsellors leverage opportunities. Unanticipated circumstances that counsellors encounter can be used for the benefit of the patients, and competent counsellors need to recognise these opportunities to enrich the patients counselling process.

Some of the plans discussed with patients who test positive for HIV are disclosing to significant others. Although disclosure might not necessarily be an unanticipated situation in HCT, however, given individual patient needs, it could be an opportunity that enriches a patient's life by drawing support from significant others, thus improving psychological functioning. Disclosing one's HIV status is an aspect of counselling that carries ethical weight, such as confidentiality and beneficence. Competent counsellors should be aware of the implications of disclosure and work with patients' systems of care, such as incorporating family or significant other systems without compromising patients' safety. Disclosure should be carefully planned, and counsellors need to execute counselling skills that would lead to achieving outcomes. Disclosure is one of the components that have led to patients using other systems of care in South Africa, such as ARVs and social welfare, which has benefited around 7.97 million people living with HIV\AIDS (Statistics South Africa, 2019). People infected with HIV and those living with AIDS have accessed treatment and care through early ART initiation, before severe disease progression, which has yielded improved outcomes for patients (Bekker et al., 2016).

Following the patient receiving their HIV test results, '**options and resources were not identified and discussed**' with patients who tested negative for HIV and a few who tested positive. Options go hand in hand with actions, which the participants in the current study also failed to address. Therefore, patients' immediate plans were not reviewed. These types of missed opportunities affect ART initiation, education and counselling. If adapted in HCT settings, treatment resources improve patients' readiness to initiate ART (Wilkinson et al., 2015). Over and above normal ART regime, patients' dropout rate can be due to patients who require more than the routine ART treatment (Asiimwe et al., 2015) In addition to adherence support and health education, access to social pensions and grants improves the households' economic status (Fatti et al., 2012) and may increase retention in care.

In addition, '**follow-up plans, care and support were not discussed**' with patients who tested HIV negative, however surprisingly, the lay counsellors were able to provide information and discuss, to a certain extent, some plans with patients who tested positive for HIV. These follow-up plans included referring patients to the ARV treatment healthcare services for ART education and initiation.

These findings are positive and hold promising value. They indicate that LCs provide much-needed information in the posttest counselling processes, which aligns with policies set in the South African HCT guidelines (National Department of Health, 2015). Referrals for ARV treatment are essential, as demonstrated in Fatti et al. (2012) in evaluating community-based follow-up care where patients receiving follow-up care and support had better ART adherence and compliance outcomes. The community-based ART programmes not only provided confidentiality, subsequently decreasing the impact of barriers associated with facility-based ART follow-up care, but were also cost-effective and increased the uptake of HCT follow-up services (Fatti et al., 2012).

Although '**Referrals**' were used in services for patients that tested positive for HIV, especially in linking them with ARV treatment and care, it was reported that patients who presented with additional healthcare needs, such as psychological needs, were not referred. These would be patients who might have benefitted from psychological counselling based on their response to being presented with HIV positive results. In the current study, the lack of lay counsellors to appropriately manage emotional responses of patients following positive HIV test results suggests that this might have a bearing on patients' use of follow-up care, especially timely ART initiation. Readiness to start ART depends on patients understanding and acceptance of their HIV status. As Wilkinson et al. (2015) stated in their report, early ART initiation entailing comprehensive HIV counselling produced better outcomes for patients newly diagnosed with HIV. Also, adherence and compliance of patients who tested positive for HIV seemed to be a concern that participants in the current study reported. Lay counsellors in the study reported not being equipped to deal with sensitive issues of a cultural nature that non-compliant patients on ART present with. Lay counsellors in the current study could have possibly addressed this through supervision and support from work supervisors. Similar results were reported by Boeke et al. (2018), who also linked poor staff supervision and counsellor motivation to the lack of appropriate utilisation of referral systems for patents who required additional care. The findings in the current study and reported by Bott et al. (2014), indicate that lack of support as a work-related condition for lay counsellors present challenges in the provision of HCT services as it leaves lay counsellors with insufficient guidance on how to assist patients beyond their scope.

In the current study, there were counselling sessions observed where HIV testing was not done due to the unavailability of testing kits. Such limitations in any work situation can hinder one's ability to provide services that are required and necessary, especially in the field of HIV and AIDS. Such system-related restrictions may be a reason for work-related strain in lay counsellors' ability to provide quality counselling.

6.1.3.2.3 Follow-up counselling

In the current study, posttest counselling was the focus of the content-based elements among the studied sample, as compared to other content-specific interventions. '**Follow-up**' in both pre-HIV test counselling was not adhered to; however, post-HIV test counselling yielded better results. Follow-up ensures that timely and immediate support for patients who test positive for HIV be available as it increases linkage to care and support in a timely manner (Asiimwe et al., 2015; Boeke et al., 2018). For example, the 'test and treat' campaign in South Africa initiated and implemented in 2010 (UNAIDS, 2010b) has improved patients' access to care and HIV management. Additionally, PHC re-engineering (Department of Health, 2010b) has made this process feasible.

One of the significant findings in the current study was lay counsellors' ability to make '**use of referral systems**' for patients who tested positive for HIV. Implementation models supporting ARV treatment initiation and adherence indicate that the times between the posttest counselling, ARV readiness contact, ARV initiation and other follow-up appointments should be reduced to ensure speedy ART initiation (Wilkinson et al., 2015), which the studied sample addressed. Lay counsellors followed up patients who tested HIV positive with referral to healthcare professionals, mostly nurses, to link patients to ARV treatment services. This finding has been corroborated in a recent study conducted in Uganda by Bukenya et al. (2020), which showed that follow-up counselling improved linkage to healthcare. In their study, some of the patients could address intimate partner violence and self-perceived stigma through the follow-up counselling interventions they received (Bukenya et al., 2020), indicating that HCT services also need to consider patient demographics.

Similarly, patient demographics in a study on linkage to care of patients in Uganda observed that youth and the male sex seemed more likely to drop-out of ART care than other patients (Asiimwe et al., 2015). In follow-up care, motivational interviewing appears to be the most utilised approach in ART services as it offers patients with intention and behavioural and action strategies of change (Wilkinson et al., 2015). However, this model, as feasible as it is, has been under scrutiny due to lay counsellors abilities to execute the skills and components as prescribed in the model (Wilkinson et al., 2015). Additionally, other models such as CBT (Adefolalu, 2018) and the trans-theoretical model of change (TTM) (Genberg et al., 2013) have also been applied in ARV treatment services. Although this study did not focus on ART adherence, it is also important to note that lay counsellors in adherence services have been reported to be more traditional in their approach to counselling, as opposed to interactive, as reported by Dewing et al. (2013). However, this should not be considered as a barrier, as follow-up counselling is often accompanied and supported by individualising patients' needs (Bukenya et al., 2020), such as providing community-based follow-up care and continuous linkage and referral to other systems of care depending on the patients' needs. The uniqueness of HIV/AIDS has shaped HCT services to be inclusive to various populations with different needs. The next section discusses some of the interventions with key populations.

6.1.3.2.4 Special populations and interventions for consideration (TB, PMTCT and VMMC)

Screening of TB such as '**assessment of contact with a known suspect or confirmed TB case**', a relative or someone living with a patient and '**assessment of the presence of a productive cough**' was not conducted by more than half of the study participants. TB still remains one of the most opportunistic diseases that lead to HIV/AIDS-related deaths (National Department of Health, 2016a; UNAIDS, 2019), and the studied sample did not adhere to the regulations as set out in the HCT guidelines proposed by the National Department of Health (2015). TB in healthcare services is also a stand-alone service, and the lay counsellors in the current study did not really focus on it.

TB still forms part of the integrated systems model that aims to decrease the waiting time and the number of consultations at health facilities where the lay counsellor is expected to address assessment and adherence to different treatments together simultaneously (MSF, 2015; National Department of Health, 2016a). Some of the participants in the studied sample reported they previously volunteered as Directly Observed Treatment (DOT) supporters, which suggest that they had TB knowledge and skills. Whether lay counsellors are prepared and able to fulfil the broader tasks of integrated TB/HIV functions was evaluated in a study by Heunis et al. (2013). The study conducted in the Free State Province indicated strong associations between training received among the different types of counsellors providing TB, HIV and community services (Heunis et al., 2013). Among these three types of counsellors, lay counsellors providing HCT were more likely than the DOT supporters not to receive training in TB and DOT support (Heunis et al., 2013). Besides the possibility that the studied sample might not have been trained in TB/DOT support, this does not take away the fact that HIV counselling and testing on its own is a challenging task. With additional work, lay counsellors might be placed in situations where they miss some of the stipulated HCT tasks due to heavy workloads and limited HIV time for counselling.

In considering content-specific interventions, the most commonly used HCT services in primary health are women who attend to maternity and ante-natal services. The participants in the current study failed to address some of the content related to PMTCT interventions. This finding is consistent with the results of an evaluation of counselling and support conducted by Peltzer and Davids (2011) that PMTCT services were impacted by a poor working environment, increased workload, limited time for counselling, staff shortages, lack of training and supervision. In their descriptive study, Thurling and Harris (2012) indicated lay counsellors providing PMTCT services benefited from supervision and support provided by professional nurses in their clinical areas. This finding supports the results of the current study, which suggest that lay counsellors execution of the necessary skills and competence can be positively influenced by access to supervision and support. It is also important to bear in mind that with the primary healthcare reengineering, lay counsellors who work in communities might not easily access this type of support, making the PMTCT work challenging in such settings.

PMTCT interventions provide an opportunity for counsellors to gather and provide as much information as possible pertaining to HIV risk and related matters for both mother and child. However, a positive finding in the current study is that lay counsellors were able to link pregnant women who tested positive for HIV with follow-up care and referral to ARV services. The current study provided evidence that makes this particular key population unique as most women are normally diagnosed with HIV during routinely conducted ante-natal services, as also reported by Boeke et al. (2018). Additionally, since the few patients who tested positive for HIV in the current study were women in ante-natal and maternity services, at the end of the post-HIV testing session, the female patients seemed to understand the implications. They were willing to initiate ARV treatment for the benefit of themselves and their unborn or infant child and were subsequently referred to ARV services. This finding is consistent with those of Boeke et al. (2018). A positive aspect of the evaluation of PMTCT in the current study shows lay counsellors adequately addressing these PMTCT needs.

Although voluntary medical male circumcision was not the focus of this study, in one observed session, which was for VMMC intervention, it was noted that the lay counsellor did not adhere to the order and content of the pre- and the post-HIV counselling content. Also, the evaluation tools utilised in evaluating HIV counselling did not include specific content for VMMC; however, with the increase in the use of voluntary medical male circumcision (VMMC) as a prevention strategy (Kaufman et al., 2018; UNAIDS & WHO, 2019) the findings motivate for this key population to be included in the evaluation of lay counsellors skills pertaining to this intervention. Similarly, Kaufman et al. (2018) reported that VMMC counselling showed gaps in content reported by adolescents in their study. Older-aged males received a completer and more comprehensive VMMC package compared to adolescent males (Kaufman et al., 2018). In South Africa, HIV counselling for VMMC may have implications for further training needs of lay counsellors as the VMMC programme has been instituted as a national programme (National Department of Health, 2015; WHO, 2015a); at the time of conducting the current study, the programme was administered to children aged 12. In general, the adolescent age group is reported as the most difficult to reach of the vulnerable populations (Boeke et al., 2018) and the age group 15 to 24 years are most affected with high HIV incidence (Simbayi et al., 2019).

Therefore, inadequate VMMC HIV counselling administered by lay counsellors could potentially add to issues that maintain and exacerbate HIV prevalence amongst the youth population. This aspect will be discussed further under the limitations section in the next chapter.

The current study provides evidence consistent with previous investigations undertaken, indicating that lay counsellors experience challenges in executing expected counselling skills and in displaying appropriate competence (Dewing et al., 2013; Mohlabane et al., 2015; Mwisongo et al., 2015; Papanna et al., 2013, Ramalepe et al., 2014). In particular, basic counselling skills prescribed in theoretical counselling models are not adhered to (Dewing et al., 2013; Papanna et al., 2013). Furthermore, assessment of counselling content specific to HIV interventions (Mohlabane et al., 2015; Papanna et al., 2013) and competence elements (Papanna et al., 2013) have also revealed gaps within these critical elements. This necessitates attention, as HIV counselling and testing are key entry-level interventions in HIV prevention, treatment and linkage to care (National Department of Health, 2015; Papanna et al., 2013) in primary healthcare settings.

Thus far, the discussion presented a reality on the state of HCT services in South Africa at the time of the study. It seems that lay counsellors might feel more comfortable providing information and education-based interventions. However, the discussion on the findings revealed that HCT requires more than just information-based interventions, but rather processes that call for effective counselling skills that would be able to address patients' needs and promote quality HCT services. In considering the provision of quality HCT services, the next section discusses burnout as a component to understand lay counsellors' response to the counselling work demands.

6.1.4 Burnout

High levels of emotional exhaustion were reported by the studied sample. Given the nature of their work, lay counsellors work under conditions that might be stressful. As already mentioned, dealing with uncomfortable situations that patients present with affects their ability to execute appropriate skills and thus might pose some pressure for the counsellors. This, in turn, has a bearing on their ability to manage stress.

Stress is a component that contributes toward burnout and has been studied amongst the professions that involve working with people. In helping professions such as teaching (Kokkinos 2000; Maslach et al., 1996), nursing (Engelbrecht et al., 2008; Roomaney et al., 2017), and psychologists and registered counsellors (Mashego, 2018), burnout has been a significant factor that affects the provision of adequate and quality services.

Lay counsellors in the current study reported that their working conditions made it challenging to execute some of their tasks. Workload, limited time spent on counselling, the pressure to reach daily targets, lack of support and safety concerns were the main concerns they raised. The same was reported in a study by Mwisongo et al. (2015), where emotional dissatisfaction expressed by lay counsellors stemmed from poor working conditions. In addition, upon reflecting on the role they play within the public healthcare system, lay counsellors' indicated that ineffective referral systems make it difficult to assist their patients in accessing other forms of care adequately, subsequently leading to feelings of helplessness. Therefore, self-reflection could be a positive indication of the lay counsellors' realistic perceptions of what they can deliver and recognise their limitations. Such self-awareness can help counsellors develop self-compassion and lead to better management of stress and burnout (Ledingham et al., 2019).

In comparison to similar work context of the studied population, there have been reports of increased levels of emotional exhaustion among healthcare workers in primary healthcare (Engelbrecht et al., 2008) and those that work in HCT services (Roomaney et al., 2017). Emotional exhaustion resulting in work-related chronic fatigue and other physical symptoms is an important factor to note in burnout situations. Despite these, another encouraging finding from the current study was the lay counsellors' motivation levels. They reported that they volunteered and were motivated to become a counsellor as they were living with HIV or had a significant other living with HIV. This finding is supported by evidence (Lie & Biswalo, 1994) that indicates that healthcare workers with these personal circumstances are more motivated to counsel and more likely to be empathetic and proficient counsellors.

Motivation plays an important role in counsellors' competence as it encompasses the degree to which professionals devote effort in the type and source in attaining predetermined counselling outcomes (Ridley et al., 2011b). It is expected that lay counsellors' level or degree of motivation would change when issues such as burnout, relational problems with patients and poor work conditions surface. This was, however, not the case in the current study. However, encouraging the participants' level of motivation in the context of counselling, could potentially compromise the lay counsellor's ability to effectively remain ethical and not seek or pursue their own agenda, but remain with their patient's process without clouding their judgement. This element, which Ridley et al. (2011b) described as self-appraisal/self-evaluating, allows counsellors to assess their performance, recognise their abilities and gain an understanding of their boundaries. This is integral to competence. By addressing their own concerns in a suitable format (e.g., in supervision or other forms of professional support), the counsellor is subsequently better able to work effectively with the patient. Nonetheless, regardless of the various hindrances experienced in their work, counsellors judge the rewards in their job by the satisfaction that comes with being able to see patients' health improving and helping patients. Bott et al. (2014) reported similar results.

Following the pre-intervention results, the HIV counselling skills training programme was developed, implemented and evaluated. In the next section, a discussion of the results of the evaluation is presented.

6.2 Post-intervention results discussion

The post-intervention evaluation was conducted in line with the fourth objective:
To evaluate the HIV counselling skills training programme.'

The aim was to assess whether the HIV counselling skills training programme implemented impacted each of the variables, namely skills, competence, and burnout for the lay counsellor group participants. The findings of the current study reveal that the HIV counselling skills training intervention had no impact on lay counsellors' skills, competence, and burnout for the experimental group. In the section that follows, the reasons to explain these findings are discussed.

6.2.1 Counselling skills and competence

At baseline, we found comparative gaps in counsellors' skills and competence, which were addressed through the HIV counselling skills training programme. Standard HIV-content did not change between pre- and post-intervention for the lay counsellor group. Lay counsellors failed to cater for diverse populations with diverse needs. This indicates a high possibility that the HCTP training did not meet the needs and expectations of the lay counsellor participants in terms of the work they perform daily.

Content-based elements specific to the everyday work lay counsellors conduct could explain that the skills training programme addressed counselling components more than HIV information, which the participants reported as a training need. Depending on the HCT needs when the study was conducted, the HCTP might have had limited scope regarding what lay counsellors deemed necessary. For example, the lay counsellor's inadequate management of challenging counselling sessions led to counsellors continuously reverting to the directive and information-giving role. Perhaps this is what the participants found comfortable.

Typically lay counsellors in South Africa have little secondary education, but the majority of counsellors taking part in the current study completed Grade 12. Thus, the recruitment practices alone could not explain the HCTPs ineffectiveness in improving skills. Although one cannot guarantee that counsellors in the intervention and control groups were equivalent in terms of counselling skills before the HCTP, the data suggests that they were in terms of those variables. Where counsellors differed in terms of counselling experience, it could be that counsellors become more directive and less client-centred over time as they experience burn-out or become frustrated by ongoing difficulties with patients that present with challenging situations and increased counselling demands. Alternatively, it is possible that lay counsellors in the control arm benefitted from more years of counselling practice and training. It is difficult to determine the extent to which the selection, recruitment and educational level of the counsellors in this study link to their ability to grasp the training and transfer gains into their everyday service delivery in HCT.

Findings from the current study support those of previous studies (Dewing et al., 2013; Mohlabane et al., 2015) that show that lay counsellors focus more on information and education-based interventions, which have a limited focus on patients' needs for emotional support and context-specific conditions. One way of interpreting this finding could potentially allude to the educational level and cognitive ability of the participants to comprehend the skills and competencies required. In the context of counsellor training for lay counsellors, the evaluation of Kohrt et al. (2018) regarding component and competence in community-based services postulated that lay counsellors might not be able to fully integrate counselling specific micro-skills in administering counselling to patients. Without standardised and effective practices that entail assessments or clinical judgment enforced by trainers during training, recruitment of lay counsellors who display at least minimal standards of competence (Kohrt et al., 2018) would impact the successful implementation of quality services. This view is also endorsed by Kagee (2020), who provided a perspective on the trainability of lay counsellors in public healthcare care settings in South Africa. Kagee (2020) provides recommendations on the recruitment of lay counsellors and how this process impacts the provision of evidence-based treatments, which are in line with good practice guidelines and professional ethics. In essence, the reality reflected raises the question of whether the job demands and expectations of lay counsellors are at the level of professional counsellor standards, which lay counsellors are not equipped with.

In addition, taking into account training in counselling skills as a process that requires different modes of training complemented by support and mentoring, the HCTP training served as a refresher course to build on the 10-day entry-level training. As in any form of development of a skills training programme, the HCTP content was informed by the baseline results. However, similar to the entry-level training, the HCTP did not include practicums and an assessment to evaluate specific components of the training, following its implementation. This aspect, as described in Chapter 3, is a comparison in requirements and practices between the lay counsellor and entry-level counsellors, indicating a vast difference, which could potentially put lay counsellors at a disadvantage in their counselling work. Comparatively, the lay counsellor group receives less time in the classroom, no practicums and no post-training assessment as commonly found in professional training programmes.

Therefore, on the surface, lay counsellors will not be able to match in skills and competence with entry-level professional counsellors. Standards in training and lack of development emerged, especially in the focus groups where lay counsellors raised concerns and reservations about both the Department of Health and stakeholders not offering opportunities for lay councellors to be formally employed, with access and equal opportunity for training and development. Despite the current study's training intervention offering an opportunity for lay counsellors to advance some of the skills, as stated by the experimental group following the intervention, reservations were raised by lay counsellors that lack of support from supervisors and work conditions do not allow them sufficient time to apply the acquired skills. It was evident in this study, especially in the evaluation of the training programme after implementation, that lay counsellors still listed HIV medical and ART-related information as the main training areas relevant to their areas of work. This finding again reiterates that lay counsellors provide more information-based counselling interventions, which require minimal use of counselling skills, especially skills required in emotional support and understanding of patients' situations.

Lay counsellors reported that more than 70% of their work is on counselling, particularly counselling on HIV matters. Thus lay counsellors consider their interventions to encompass, in totality, what counselling is. The level of intervention of lay counsellors' focus can further explain this. As explained in Chapter 2, lay counsellors in this study are focused more on the Level 1 category of healthcare counselling, which mainly consists of an educative and information-based nature in the prevention of diseases. Interventions at this entry-level of counselling aim to elicit some level of awareness and to challenge patients' views and perceptions on certain aspects. This is what generally informs pretest counselling. However, due to the participants failing to include the expected HIV content in their interactions with patients, important aspects that could have led to patients' psychological growth were not explored. Furthermore, behavioural modification and problem-solving are entities that form part of the entry-level counselling interventions and, judging from the findings in our study, participants did not address these aspects (e.g., risk reduction planning).

Perhaps the reported positive ratings on relationship building skills using skills such as ‘creating a warm environment’ and being able to ‘establish rapport’ with patients are considered as the main components of counselling, according to lay counsellors.

Lay counsellors in the study focused more on posttest counselling content than pretest content in both pre- and post-intervention phases. This content is informed by Level 2 interventions involving counselling in the diagnosis of an illness. Lay counsellors in the study could not manage special situations of an emotional nature, especially where patients expressed certain emotions. Coping skills and making follow-up plans were not attended to, and patients not offered an opportunity to learn skills and be empowered to manage the news of their HIV diagnosis and management thereof. This also illustrates that lay counsellors might not be able to manage crises and other situations of a legal and ethical nature. This is a requirement as counsellors are expected to follow protocols that extend beyond normal counselling interventions (Ridley et al., 2011b).

As reflected in the pre-intervention discussion, time constraints were still a continuing factor in lay counsellors’ opinions of insufficient opportunity to cater to the emotional needs of the patients. Such work conditions and systemic aspects were not the focus of the study, and therefore, the intervention solely focused on lay counsellors’ capacity to deal with these challenges. The majority of the lay counsellors reported that reaching targets impedes their counselling intervention. This reality, as reflected in the observed sessions, showed that even when lay counsellors attempted to provide comprehensive counselling during the observations sessions, content-specific skills and competencies were still lacking. The researcher also observed that some lay counsellors took more than the normal time they spend in sessions, which has been reported as 15 minutes. An hour would have provided ample time for lay counsellors to include most content specific to HIV and perhaps have an opportunity to utilise appropriate skills. Unsuccessfully the added time (for the sake of the evaluation) did not yield the desired outcomes. This reflects the reality of impaired counselling services and poor time allocation. It is important to bear in mind that the extent to which the current study’s sample represents the population of lay counsellors in South Africa, as the demographic profile of this cadre of health workers are unclear due to the changing nature of HCT services.

At the time of the study, the lay counsellor cadre was part of being merged into the healthcare system, which resulted in the redefinition of the scope of their work. There has been strong advocacy for CHW to be absorbed in the healthcare system (Duncan et al., 2017). These systemic issues reported on working conditions as a major factor in the satisfaction and motivation of lay counsellors in their work. Earlier works (Lehman & Sanders, 2007, Schneider et al., 2008) have indicated that this cadre's contribution in primary healthcare services was important, which was reiterated a decade later (Duncan et al., 2017; Mwisongo et al., 2015). Lay counsellors' ever-changing work in HCT, as already mentioned within the primary healthcare reengineering, is another aspect that could have impacted the findings of this study. Lay counsellors reported that the task shifting process had left them with additional duties, some of which they feel are not within their scope of practice. This also leaves limited room to use counselling skills if primary healthcare reengineering calls for the provision of other tasks such as obtaining demographical information and information about other illnesses, employment status and welfare issues. Therefore, opportunities were perhaps scarce, especially for the experimental group to practice and implement the skills learnt in the training intervention.

Furthermore, lay counsellors reported that the duration of the training intervention was short. The time frame between the training and the evaluation was three months. Within this period, no follow-up, mentoring or support was offered by the researcher/trainer. This indicates there was limited opportunity to 'check' on counsellors' use of skills learnt, and an opportunity to reinforce these skills was not made available. Again this could indicate the expectations placed on lay counsellors to perform counselling duties at the standards expected. The mixed-method nature of the study using multi-stage purposeful sampling limited statistical procedures that would have produced significant results. This was due to variations in sample size that was mainly attributed to dropout rates between the pre-intervention and post-intervention phases. Of the 107 counsellors who took part in the initial pre-intervention phase in February-September 2015, 35 dropped out during the study. This could have been due to participants anticipating the level of mental and emotional effort and motivation required, with continued participation. Another aspect could have also been the discouraging lack of occupational benefits that may accompany participation.

Levels of loss were, however, similar between control and experimental groups. The study was also limited in ability to describe or control what training or skills development was delivered during the pre- and post-intervention phases, which was a period of three months (see Figure 4.3 concerning the main study flow chart, which details the timelines). The counselling content and skills observed by a single trained evaluator to maintain uniformity through observers' bias cannot be ruled out, and the researcher identified this as a limitation of this study, which will be discussed in the next chapter. Nonetheless, this is a potential source of bias as there was only one rater both in the pre- and post-intervention phases.

6.2.2 Burnout

Counsellors participating in the intervention scored the same between the pre- and post-intervention phases on the burnout measures. As with the pre-intervention results, the emotional exhaustion subscale was the only one that showed good internal consistency and could be interpreted. How the lay counsellors' experienced emotional exhaustion could have been a factor that influenced or impeded how lay counsellors used new skills, and this may have led to lay counsellors reverting to 'old' ways of conducting counselling.

Retention of health care providers, including community volunteers, is crucial for the successful continuation of the existing programme. The motivation for volunteers involved in community health was reported by Downie et al. (2005) and is grouped into three categories: empathetic concern, contribution to community life, and life-course issues and personal development. The majority of the current study's participants responded that refresher training could be an intervention to sustain the motivation of lay counsellors. The same was reported by Msisuka et al. (2011). Furthermore, in this study, lay counsellors still reported sufficient levels of motivation in the post-intervention phase and maintained their commitment to the work they do.

6.3 Conclusion

Within the scope of what is expected of the lay counsellors, various social and systematic elements contribute to their dissatisfaction with certain conditions of their job. These indicators could be addressed with stakeholders, but the essence of this study was to incorporate counselling skills that the lay counsellor group can utilise to effectively manage the stress brought on by these systematic and social issues. However, with the reported results, the study could only provide extensive information on the state of counselling skills, competence and level of burnout among the lay counsellor group when this study was conducted, for this particular population of lay counsellors at this particular geographical location. Therefore, the results generated cannot be applied to other contexts, situations, populations and times. The current research however, does yield evidence on the potential need for refresher or supplementary counselling skills training for lay counsellors. For more significant results and better training programme interventions, the next chapter will provide a summary, limitations and recommendations for future research.

CHAPTER 7

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

This chapter presents final remarks on how counselling skills, competence, and the level of burnout of LCs were influenced by the HIV counselling skills training programme. The chapter begins with a summary of the literature and provides contributions to the study. Additionally, the limitations and recommendations for future research and practise will also be discussed.

7.1 Summary of literature

The literature review conducted on the research topic explored the role counselling plays in healthcare settings and specifically HIV/AIDS healthcare. An understanding of human behaviour as based on psychological theory was analysed. The analysis offered the researcher an opportunity to build on a predetermined theoretical base underpinning the acquisition of counselling skills, competence and management of burnout. Lay counsellors' skills and competence and how they are shaped by educational background, recruitment practices, entry-level training, and HIV counselling services they provide is a well-researched field. However, few studies have undertaken investigations on refresher and additional training and its impact on enhancing skills and competence amidst evidence of inadequate HIV counselling provision within HCT services.

A body of research on LCs' provision of HCT services in public healthcare has indicated that despite the scale-up in ART access as a biomedical treatment of choice in HIV/AIDS (Fatti et al., 2012; Patel et al., 2016; UNAIDS, 2019) and as a prevention strategy (Bekker et al., 2016), counselling still plays a pivotal role in HCT services (National Department of Health, 2015; WHO, 2015a).

The use of the lay counsellor cadre as a task-shifting strategy to minimise the burdened healthcare systems in under-resourced settings (Lewin et al., 2010; Sanjana et al., 2009; WHO, 2008; 2015b) has resulted in lay counselling services being overly stretched and not being able to keep up with the demands (Duncan et al., 2017) in the delivery of quality HIV counselling (MSF, 2020, Mwisongo et al., 2015). Assessment of the skills, competence and burnout from previous investigations undertaken indicate that lay counsellors experience challenges in executing ordinary counselling skills and in displaying appropriate competence (Dewing et al., 2013; Mohlabane et al., 2015; Mwisongo et al., 2015; Papanna et al., 2013, Ramalepe et al., 2014). In particular, basic counselling skills as prescribed within the frameworks of theoretical counselling approaches, are not adhered to (Dewing et al., 2013; Papanna et al., 2013). LCs are unable to competently determine, facilitate, evaluate and sustain counselling outcomes (Ridley et al., 2011b).

Furthermore, assessment of counselling content specific to HIV interventions (Mohlabane et al., 2015; Papanna et al., 2013) and competence elements (Papanna et al., 2013) have also revealed gaps within these critical elements. This necessitates attention, as HIV counselling and testing are key entry-level interventions in HIV prevention, treatment, and linkage to care (National Department of Health, 2015; Papanna et al., 2013, WHO, 2015a) in primary healthcare settings. Lack of standard and uniform training, recruitment and employment opportunities (Lehmann & Sanders, 2007; Schneider, 2019), as well as lack of refresher training (Msisuka et al., 2011) and the challenging work conditions (Mohlabane et al., 2015; Peltzer & Davids, 2011) of LCs, poses a threat to their ability to manage stress and burnout (Dubale et al., 2019; Roomaney et al., 2017; Qiao et al., 2016). Challenges posed by HIV/AIDS-specific behavioural and socio-economic factors that have influenced the patterns distinct to the presentation of HIV/AIDS in Sub-Saharan Africa and South Africa are still persistent (Shisana et al., 2014; Simbayi et al., 2019). These determinants unique to the South African HIV/AIDS context make the lay counsellor cadre ideal for community-based interventions that patients can easily access (Chibanda et al., 2017). Furthermore, service accessibility through primary healthcare reengineering (Mohapi & Basu, 2012) have shown an increase in HCT uptake by key populations and hard-to-reach areas (National Department of Health, 2016a).

However, despite the value added by LCs within the broader healthcare system, LCs find themselves in a working environment that is unable to provide appropriate supervision and support (Mwisongo et al., 2015; Peltzer & Davids, 2011) and lacks formal integration of the lay counsellor into the healthcare system (Schneider et al., 2008). The literature provided the researcher with a synthesis of contextual factors relating to the development and implementation of a counselling skills programme that would enhance HIV counselling skills, competence and management of burnout of LCs in HCT.

7.2 Summary of empirical findings

The research study's aim was to assess the current level of counselling skills, key competencies and burnout of LCs and address any deficiencies by promoting best practices in the field through the development and evaluation of HIV counselling skills training programme for LCs in the Mangaung Metropolitan Municipality in the Free State.

The formulated objectives set out to achieve the following:

- Firstly, to assess the current level of counselling skills, competence and levels of burnout amongst LCs.
- Secondly, to adequately inform counselling skills through the development in type, content, mode, and duration of a skills training programme.
- Thirdly, to implement the training programme.
- Lastly, to evaluate the effectiveness of the training programme.

Based on the mixed-method design, the pre-intervention assessment and post-intervention analysis yielded no difference between the three measured variables. Therefore, on the HIV counselling skills programme evaluation, it can be concluded that the HIV counselling skills training programme did not enhance LCs skills, competence and management of burnout. Nonetheless, a summary of the key findings will be presented. This will be per the formulated objectives 1 and 4.

7.2.1 Counselling skills

The triangulation process resulting from the thematic analysis and descriptive statistics conducted in both pre-intervention and post-intervention phases resulted in similar findings on the assessment of LCs in terms of skills. Based on what is deemed important in counselling, especially in HIV/AIDS in the South African context, where there are still persistent socio-cultural aspects that influence individual perceptions of 'HIV risk', the LCs failed to provide adequate and concise HIV/AIDS information to patients. Also, being faced with challenges in talking about sensitive issues plainly and appropriately to the culture influenced LCs to adequately address myths and misconceptions patients might have had about HIV/AIDS.

The essence of HIV counselling is to dispel preconceived ideas that influence patients' decisions to test for HIV. Upon testing HIV positive, the decision regarding being perceived negatively and fear of stigma jeopardises patients' ability to follow-up and comply with ARV treatment interventions. Lay counsellors' time constraints, although unavoidable, indicates that the lack of utilisation of skills needed to deal with prioritising important issues in a limited time suggests that the work conditions (e.g., lack of supervision and support and adequate training), leaves LCs in situations where opportunities of maximising an HCT intervention with patients are missed. Furthermore, LCs' emotional exhaustion could have led to counsellors not being 'emotionally' receptive and available to understand and meet the emotional needs patients presented with. Such lack of engagement negatively influences the counselling relationship and the predetermined counselling outcomes. Retention in care, follow-up and using external referral systems imply that in situations where patients' emotional reactions were not attended to resulted in LCs not being able to recognise the additional needs of patients.

Quantitatively, the cross-sectional and correlational analysis conducted with the Mann-Whitney test indicated that there were no differences in the pre- and post-intervention performance between the experimental and control group in terms of content-based elements. Lay counsellors had not adequately included information that is pertinent to HIV counselling. In terms of HIV prevention and transmission, risk assessment and reduction plans have value in decreasing prevalence and HIV incidence.

Key populations and marginalised groups (e.g., females who present for PMTCT interventions) benefit from such interventions, subsequently reducing the risk of vertical transmission of HIV, including the risk associated with inadequate infant feeding practices. One redeeming factor in the study's outcome was that all HIV positive cases received an immediate referral to nurses for medical attention and ARV treatment initiation; a positive aspect in the work LCs provide, thus indicating a well-coordinated effort by the HCT service. However, missed opportunities with patients who might have been at risk of contracting TB indicates that LCs do not have adequate training in TB information-based counselling, resulting in the provision of an inadequate service. Similarly, VMMC interventions are not focused on male youth, categorically one of the high-risk populations in South Africa.

7.2.2 Competence

Due to sample size variations, the outcome of regression and correlation analysis resulted in the use of the Mann-Whitney. It indicated that the application of the HCTP was unable to make any statistically significant contribution to changes in the competence-based elements (interpersonal relations, gathering information, giving information and handling special circumstances) for the experimental group. Additionally, when considering the skills that comprise the specific competences, gaps could be identified in two of the four competence-based elements. The competence of gathering information entails a counsellors' ability to use effective communication skills to obtain relevant information from patients. From the current study, we can deduce that time-constraints and other work-related unfavourable conditions might have led to these outcomes. The current study's findings are similar to what Mohlabane et al. (2015) reported, namely LCs 'inability to allow for an interactive process of information gathering evidently prohibits achieving competence. Competence is not only one component, but it is the sum of interrelated skills predetermined to achieve a certain goal. In the case of counselling competence, it is a variety of skills that counsellors use to achieve, for example, building a counselling relationship with the patient. Therefore, competence cannot exist in isolation or the absence of skills.

The current study also highlighted a gap and inadequate handling of counselling situations that presented the lay counsellor with high-order skills such as multi-cultural sensitivity, which the findings indicate was not achieved among the study population. The participants were also unable to 'meet the patients where the patients were, psychologically'. In instances where patients had a different opinion or need, LCs did not adequately maximise their interaction with patients. This can largely be attributed to a high workload and pressure to meet daily statistical targets that decrease the amount of time LCs spend on counselling patients presenting to HCT services.

7.2.3 Burnout

A one-way MANOVA was performed following descriptive statistics on the three elements of the burnout measure. A small-sized sample led to limited statistical analysis that could have been conducted with the burnout data. From the descriptives, the emotional exhaustion as one of the components of burnout indicates that LCs might experience an indifference or perceived lack of interest or concern for patients, and this can be deduced from the lack of displaying an appropriate emotional response in situations where patients presented with emotional needs and circumstances. This undeniably affects the counselling relationship and warrants support and supervision from work supervisors or even an intervention from other healthcare workers. However, LCs reported that due to ineffective referral systems, this is not always possible and increases the emotional pressure and perhaps even emotional exhaustion the participants reported. Despite these challenges, the current study indicated that LCs tend to be satisfied with their work. These counsellor variables could serve as protective factors and may explain the motivation counsellors still have regarding their work.

7.2.4 Counsellor variables

The study found that LCs are motivated despite experiencing a few adverse events when working in communities. Personal qualities of LCs, such as motivation and commitment to HCT work, are essential in facilitating and determining the counselling outcomes. These unique attributes may not be quickly learnt but could be the result of own or personal circumstances LCs have regarding HIV/AIDS.

Lay counsellors, who reported being infected and living with HIV or a significant other in the same situation, indicated that this served as a significant factor in their motivation and commitment to HCT work. However, it may not be right in assuming that LCs who do not have such personal situations lack motivation and commitment. Although some LCs displayed an inability to respond to patients' emotional needs during counselling interactions, it does not necessarily mean they are not suitable for HIV counselling work. Other potential reasons for lack of expected counsellor responses might be a way for the counsellor to detach from an environment that is found stressful and could also be an indication of emotional exhaustion and an inability to manage stress effectively. Similarly, educational background and entry-level training might not have prepared LCs for the emotional demands of their work in HCT services. Counselling requires, to some extent, the use of cognitive entities that assist counsellors in recognising and being able to utilise conceptual skills in complex counselling interactions. Lay counsellors in the study seemed to be inadequately equipped for interventions that required more than what the scope of HIV counselling, as stipulated in the entry-level training, entails. However, it is still within the LCs' ability to recognise such situations as a possible point of professional growth and to use supervision to achieve this. Using referral systems may also assist in the continuation of specialised care for patients. The entry-level training provided to LCs only focuses on basic skills. It does not explore the intricate depths of counselling processes that are commonly found in professional counsellor training and work.

7.2.5 Counselling working conditions

Unfavourable working conditions expressed by LCs are found to be barriers in the execution of appropriate HIV counselling. Lay counsellors reported that limited counselling time with patients and heavy workloads influences counselling outcomes. Lay counsellors also highlighted the critical role of supervision in enabling them to feel supported, motivated, and able to meet the various demands in their HCT work. However, in any training situation, opportunities need to be created for trainees to implement knowledge and skills learnt in training. In the studied population, this might not have been possible as working environments and conditions could have prevented LCs from practising skills learned in the HCTP intervention.

The findings have highlighted the need for refresher training but, more importantly, integration of the LC into the healthcare system. Formalised practices in labour, as well as employee development practices, would allow LCs the opportunity to undergo performance management evaluations, which would be an ideal opportunity to identify and address gaps in skills and competence.

7.3 Contribution of the study

In this mixed-method study, the pre-intervention data and results presented provided in-depth evidence on the state of counselling skills, competence, and burnout, as well as other work-related variables at the time of the study. The mixed-method design also added value by offering and producing complex views and interpretations of the phenomena being studied through the different qualitative methods employed. Also, the post-intervention data provided an overview of the main themes, including quantitative data pertaining to the fourth research objective. It provided evidence by using different measures employed in answering the research question. The mixed-method design seems to have been an acceptable option in this investigation. Simultaneously, the current study indicates research-derived evidence based on the experimental design utilised. The use of the design provides confidence in the pre-intervention assessment data obtained, including post-intervention evaluations, despite the HCTP not yielding the desired research outcomes.

Regarding the collection of data, the current study's assessment of counselling skills and competence also included focus group discussions as a qualitative element to explain the quantitative data from the self-report and observed session ratings. The study used real-life counselling sessions with patients. The results can be interpreted as a true reflection of the HCT counselling interactions in primary healthcare settings in the Free State Province. Having an observer sitting in a counselling session might have influenced the dynamics of the counselling session as counsellors could have put in more effort and shown "improved performance" for the evaluation.

However, the aim of the observations was explained to both counsellors and patients, as the evaluation was a way to assist counsellors in improving their counselling skills, rather than the evaluation being a test. Thus, it is hoped that the observation data, in some way, added value to achieving the objectives of the study. The study utilised the UNAIDS tool (UNAIDS, 2000) as a comprehensive measure that entails the main aspects of evaluating HCT. Additionally, a burnout measure, the Maslach Burnout Inventory (Maslach & Jackson 1981), was utilised in assessing the level of burnout experienced by LCs.

Regarding the intervention itself, the *Model of Counselling Competence* (Ridley et al., 2011b) was found to have good potential as an outline for a counselling training of LCs as it includes revised definitions and perspectives on the definition of counselling competence, theorises sound foundational principles and specifies competencies in detail. The model's main strength lies in its emphasis on counselling outcomes. Every competency and micro skill in the model directly relate to determining, facilitating, evaluating, and sustaining counselling outcomes (Ridley et al., 2011a, 2011b). Furthermore, the model can be applied in beginner training and for more advanced counsellors and existing professionals. Also, the model might prove functional in the real world and encourages the application of critical thinking at a more advanced level than is typically demonstrated by trainees in many skills-based training programmes. Considering this aspect, for HIV counselling skills training programmes to be at the standard that would ensure adequate execution of counselling skills and competence, the occupational status of the LCs needs to be on the same level as that of other healthcare workers who provide essential and critical services. In summary, the model provides a positive starting point from which the profession of counselling within HCT services can elaborate on and operationalise principles of counselling competence that are integral to best practices.

The evaluation helped in identifying the strengths and weaknesses of training needs and interventions for LCs. The evaluation revealed satisfactory results concerning understanding the levels of skills, competence, and burnout. Additionally, issues regarding infrastructure and staffing patterns were noted.

The emphasis made by participants that HIV-related information-based counselling is a training need further strengthened the fact that such information may be the main focus in HIV counselling interactions due to the reported limited counselling time.

Literature conducted on refresher training indicates less research and approaches to improve LCs skills, even though such has been recommended in many studies. The current study attempted to address this deficit to equip LCs with the necessary skills and improve competence, giving the primary healthcare reengineering programme greater support to meet the various needs of patients, including key populations that are a priority in HCT services. The research evidence already available on counselling skills refresher training for LCs and additional training on other aspects of HCT recommends that stakeholders, including the Department of Health, should offer additional training to meet the demands HIV/AIDS places on the healthcare system. From the discussion of the results, there is also evidence that limited training, particularly on HIV-related information-based counselling (content-based), may have impacted the quality of counselling delivered.

The findings of the study support the need for refresher HIV counselling skills training programme for LCs who provide HCT services in public healthcare.

7.4 Limitations

The study sample was not fully representative of all racial groups, and participants were from other districts and provinces. Despite efforts to ensure an adequately powered sample, the loss and dropout rate of the lay counsellor participants between the pre- and post-intervention resulted in a small sample size affecting the power of study results. This highlights the need to find ways to address the retention of study participants in experimental designs. Also, although the current study goes beyond a single site, all participating services were public healthcare HCT but excluded other HCT sites such as VMMC sites. Such services may be very different from those investigated and deserve exploration. This could have yielded more information about content that is specified for this particular group. Therefore, the results cannot be generalised to HCT services.

Additionally, other marginalised groups such as ‘men who have sex with other men’ (MSM) and commercial sex workers who might not be inclined to use HCT services, especially in facilities, were also not part of the study. Although comprehensive in its ability to evaluate V/HCT services, the UNAIDS tool (UNAIDS, 2000) was developed prior to other developments that have become standard procedures in line with best practices in HCT. For example, voluntary medical male circumcision (VMMC) was not standard procedure in HIV prevention services at the time of the tool's development. Therefore, the tool does not address pre- and post-HIV test counselling for males undergoing VMMC. In South Africa, traditional and cultural-based male initiation is still common practice, and HCT programming has since included VMMC programmes and involved traditional schools as a regulatory practice in scaling up HCT. However, Given the HIV transmission mode and rate in the South African context, information about the medical and sexual health behaviour aspects in VMMC could add value to the quality of HCT in such contexts. Therefore, as reflected in the VMMC observed session, the current study did not use VMMC HIV counselling guidelines. Nonetheless, VMMC, as a patient-specific demographic, did not appear to have a strong influence on the results and unlikely that it would explain the outcome of the HCTP.

In the observation of sessions, the current study only had one rater in both pre- and post-intervention phases. Practices in such evaluations propose using more than one rater/evaluator. Therefore, the outcomes of this study could have been compromised using one rater, effecting inter-rater reliability. Ginwalla et al. (2002) is one study that is similar in the assessment of skills and competence compared to the current study. The interviewer/observer bias was motivated by looking at it from the perspective that the same person observed all sessions and conducted all interviews, therefore ensuring a greater degree in the consistency of results. A further limitation was that there was no opportunity for engagement and follow-up on the usage of skills through supervision and support during the three-month period following the HCTP intervention and the start of the post-intervention evaluation process. The longer-term impact of the intervention on participants’ skills and competencies could have been positively influenced had this opportunity been available and used. This results in not being able to establish the longer-term impact on the participants’ retention and use of skills learnt in the intervention.

In addition, this might have also been influenced by the additional tasks that LCs are expected to perform, limiting the use of counselling skills learnt and having a limited impact on improving competence.

7.5 Recommendations

The list of recommendations pertaining to research and current practices in HIV counselling within HCT services is presented.

7.5.1 Future research areas

The researcher recommends that a mixed-method experimental approach is adopted to generate information that would inform a model or theory for the training of counselling skills, competence and management skills for burnout. It is essential to acknowledge that skills sets are not sufficient for ensuring competence.

To inform future needs of HIV counselling, the researcher recommends that research be conducted to explore the nature and processes of LCs and the employer relations regarding work conditions and occupational status and critically examine the impact these contextual factors have on HCT services. Additionally, the researcher recommends that in-depth measures be incorporated in such research to extend understanding gained from the current study of the drivers for this by including stakeholders (National Department of Health and NGOs) as participants or key informants. These collaborative strategies should utilise assessment of patients experiences undergoing HCT, which might help understand the skills and work-related dynamics. Such strategies may also help to address factors such as high patient load and pressure for counsellors to meet their daily statistical targets, as reported in this study. These indicators highlight the need to put structured labour measures in place. Counselling generally requires regulatory standards of what is feasible in terms of workload, as well as employee and service user (patient care).

7.5.2 Recommendations for practice

7.5.2.1 Address systemic and recruitment strategies

Although LCs provide many HCT services in primary healthcare, HCT programming and plans have featured surprisingly little in implementing policy. Furthermore, very little information has been provided regarding implementing plans beyond the HCT policy (Department of Health, 2015). It is also noted that the expansion of community-based services through primary health reengineering, especially in the many areas where few or no services are available, might provide patients with a greater choice on HCT services' availability and access. Thus, addressing systemic issues, such as conflicting roles and scope of practice LCs reported amidst primary health reengineering, could provide support and improve LCs ability to provide quality HIV counselling.

The study highlights that lack or limited use of human resource training and employee development practices, which are not regulated as the lay counsellor group is not formally employed, puts the improvement in HCT skills and competence at a disadvantage. The systemic issues regarding employment have been addressed in various studies, and in this study, it is further highlighted as a barrier to the execution of adequate HIV counselling. Also, it was not concluded that personality factors or attributes are characteristic of better execution of HIV counselling. Rather these qualities need to be incorporated into recruitment strategies that would promote and ensure ideal candidates are chosen for training as LCs. This practice is standard in professional counselling training where potential candidates undergo several stages of evaluation and assessment in line with the expected professional and personal attributes required to be a counsellor. Furthermore, the reported work-related indicators suggest a number of areas that are beyond the immediate scope of the current study. To develop and improve HCT strategies, it is also recommended that stakeholders and managers provide opportunities for peer support/mentorship and debriefing, professional consultations, address and reduce adverse events when conducting community-based services, enable LCs sufficient time and opportunity to conduct counselling, either through increasing staff or reorganisation of LCs working practices.

This aspect can be considered for practical adjustments in the current work and support offered to LCs in HCT. Additionally, future studies should include exploring internal sources of support and coping mechanisms. This aspect formed part of the current study; however, if more attention is given to the stress and burnout variables, there might be an opportunity to yield responses that are focused on enabling the counsellor to retain control and choice in how they manage stress. Addressing burnout and issues of positive emotional response to patients' situations should be a clear priority for future action to enhance practice and the positive experiences of patients substantially.

7.5.2.2 Align mode of training to best practices

Competence requires experiential learning of different case scenarios, work-related support and supervision. Therefore, training should incorporate the use of these training support measures. Ginwalla et al. (2002) recommended that the observation of counselling form part of the training or at least be conducted before counsellors started with counselling work. This is further recommended at such standards in training or onset of commencement of duties and could also serve as a baseline measure and be incorporated in further evaluations to monitor lay counsellor performance and encourage career development. Continuous evaluation to offer the opportunity for further development and training also needs to be considered. This additional recommendation should consider using an independent assessor as this may provide an objective assessment and provide comparative observations across different HIV counselling contexts.

7.5.2.3 Broaden the scope of training

Additionally, training content should be specific to HCT needs. As evident, HIV medical information and information-based counselling was a recurring theme throughout the reports from LCs and already reported in Ginwalla et al. (2002). If training is aligned to the ever-changing needs of the HCT service, it might result in a more flexible and diverse system that may be more likely to allow LCs an opportunity to adequately manage to deal with sensitive issues patients may present with.

Additionally, further training tailored to the needs of particular demographic groups may enhance the capacity of HCT services to deliver care tailored to the needs of individual service users.

The evolving nature of HIV/AIDS calls for interventions that would meet the demands of HCT services. Patients' needs have highlighted the need to utilise various HIV testing options. These options would have to adhere to WHO (2015a) testing guidelines in ensuring convenient and confidential counselling. Home HIV testing is one such option, which offers convenience and addresses some of the barriers encountered in healthcare testing (facility and community-based) (Venter et al., 2017). Home HIV testing offers anonymity and minimises travel and time expenses (Harichund et al., 2019). As Harichund et al. (2019) indicated that the absence of pretest counselling and the physical availability of social support that goes hand-in-hand with this service was reported as a concern among home testers, especially in the event of HIV positive test results. The authors acknowledge that home HIV testing does have a place in HCT, provided that it be tailored to the patients' needs in terms of supervised or semi-supervised by a trained HIV counsellor (Harichund et al., 2019). This report supports and encourages the value counselling adds to HIV testing services. Also, since most of the current study's participants focus more on posttest counselling, this is a potentially positive entry point for reaching non-healthcare HIV testing patients.

7.6 Conclusion

The evidence provided in this study makes the training of LCs an even greater challenge, one that goes beyond counsellor variables. Acknowledgement of other factors that affect HCT, especially HIV counselling services, signals a need to prioritise the role LCs play in the broader HCT service. In South Africa, where various cultural and socio-economic factors play a role in the HIV/AIDS pandemic, policies need to reflect the commitment of the government to provide healthcare services that align with quality service provision and best practices. With these in place, progress towards managing HIV by minimising transmission and providing treatment for active HIV/AIDS cases might be a feasible one.

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APPENDICES

ANNEXURE 1

Ethical Approval

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA
UFS UV

Research Division
Internal Post Box G40
☎(051) 4052812
Fax (051) 4444359

E-mail address: StraussHS@ufs.ac.za

Ms H Strauss

2014-07-30

REC Reference nr 230408-011
IRB nr 00006240

MS L MMUSI-MAKHELE
C/O DR HS VAN DEN BERG
DEPT OF PSYCHOLOGY
FACULTY OF HUMANITIES
UFS

Dear Ms Mmusi-Makhele

ECUFS NR 136/2014
MS L MMUSI-MAKHELE DEPT OF PSYCHOLOGY
PROJECT TITLE: THE DESIGN, IMPLEMENTATION AND EVALUATION OF A HIV COUNSELLING SKILLS PROGRAMME FOR LAY COUNSELLORS.

1. You are hereby kindly informed that the study was approved at the Ethics Committee meeting held on 22 July 2014.

2. Committee guidance documents: Declaration of Helsinki, ICH, GCP and MRC Guidelines on Bio Medical Research. Clinical Trial Guidelines 2000 Department of Health RSA; Ethics in Health Research: Principles Structure and Processes Department of Health RSA 2004; Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa, Second Edition (2006); the Constitution of the Ethics Committee of the Faculty of Health Sciences and the Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines.

3. Any amendment, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

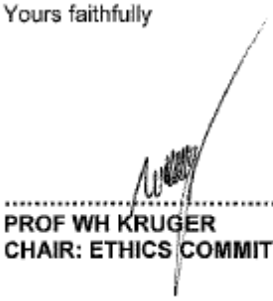
4. The Committee must be informed of any serious adverse event and/or termination of the study.

5. All relevant documents e.g. signed permission letters from the authorities, institutions, changes to the protocol, questionnaires etc. have to be submitted to the Ethics Committee before the study may be conducted (if applicable).

6. A progress report should be submitted within one year of approval of long term studies and a final report at completion of both short term and long term studies.

7. Kindly refer to the ETOVS/ECUFS reference number in correspondence to the Ethics Committee secretariat.

Yours faithfully



.....
PROF WH KRUGER
CHAIR: ETHICS COMMITTEE

Cc Dr HS van den Berg

ANNEXURE 2

Free State Department of Health
Permission to do Research

health
Department of
Health
FREE STATE PROVINC

07 August 2014

Ms L Mmusi-Makhele
C/O Dr HS Van Den Berg
Dept of Psychology
Faculty of Humanities
University of Free State
9300

Dear Ms Nokuthula

Subject: The design, implementation and evaluation of HIV counselling skills programme for Lay counsellors

The above mentioned correspondence bears reference.

- Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation must be voluntary.
- Written consent by each participants.
- Ascertain that your data collection exercise neither interferes with the day to day running of the health facilities nor the performance of duties by the respondents.
- Serious Adverse events to be reported and/ or termination of the study.
- Confidentiality of information will be ensured and no names will be used.
- Research results and a complete report should be made available to the Free State Department of Health on completion of the study.
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of Free State and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee of the University of Free State and to Free State Department of Health.
- Department of Health to be fully indemnified from any harm that patients and staff experiences in the study.

Trust you find the above in order.

Kind Regards

Dr D Motau
HEAD: HEALTH

Date: 6/8/2014

Head : Health
PO Box 227, Bloemfontein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfotein
Tel: (051) 408 1646 Fax: (051) 408 1556 e-mail:khusemj@fshealth.gov.za/fshealth.gov.za/chikobvup@fshealth.gov.za
www.fs.gov.za

ANNEXURE 3

Information document for all participants

Information document for all participants

INFORMATION DOCUMENT

The design, implementation and evaluation of an HIV counselling skills programme for HIV/lay counsellors

February 2015

Dear Sir/Madam

The PhD candidate; Lerato Mmusi-Makhele under the supervision of Dr. Henriette van den Berg – with the Department of Psychology, UFS – is conducting research to assess current HIV counselling skills and competencies of HIV counsellors. The information obtained from the study will eventually enable the researchers to inform the provincial HIV&AIDS counselling and testing programmes. HIV counsellors (HC) who provide HIV counselling services within the Motheo District (Mangaung Metropolitan Municipality) in the Free State will participate in the study. During the baseline process all HC participants will complete a self-report measure. Other assessments including focus group discussions and recording/observations of counselling sessions using the HC sample drawn from the total group will be conducted. The purpose of these measures is to gather baseline information on HIV counsellor's job selection, HIV counselling training; HIV/AIDS knowledge and attitudes, counselling skills and competence in respect of HIV counselling and testing of patients; stress tolerance; support and supervision and job satisfaction. A skills training programme for HIV counsellors will be developed and implemented. The designed training intervention will involve at least six sessions of 5 hours each, scheduled over a period of two weeks. This intervention will only be for the participants randomly assigned to the treatment group. Post-intervention evaluation will include all assessments that were used in the baseline to all participants following the intervention. Feedback will be provided to all HC participants and an opportunity for the control group to undergo the training. A personal development workshop will be offered to all HC participants. Breaching the code of conduct by any research participant, research team member or any individual who is affiliated with the research will constitute elimination of the study participant and in adverse events, suspension of the study. Such conduct could include revealing confidential information of a research participant that might cause psychological harm of the individual involved. It is expected that the study will be able to address deficiencies in counselling skills and competencies of HIV counsellors through the envisaged skills development programme. The planned study is likely to add value to existing literature on HIV counsellors' competencies and counselling programmes within the public sector management of HIV and AIDS in South Africa.

We herewith kindly invite you to participate in this research project. Before you decide whether to take part, kindly consider the following: The consent form and procedure, as well as the research schedule and the study project as a

whole, have been approved by the Department of Health (FS), Department of Psychology (UFS), the Ethics Committee: Faculty of Health Sciences (UFS). The project is funded by the National Research Foundation (NRF) and the University of the Free State (UFS).

Participation is voluntary, you may exit the study at any time, you will incur no losses and all information will be kept confidential.

For additional information: For questions about the research and reporting on research-related adverse effects, please contact Lerato Mmusi-Makhele at 051 401 2853.

For reporting of complaints/problems: **Ethics Committee of the Faculty of Health Sciences, University of the Free State** at 051 405 2812

ANNEXURE 4

Consent forms

Consent form for Lay counsellors: Self-report

Dear Sir/Madam,

RE: The design, implementation and evaluation of an HIV counselling skills programme for HIV counsellors

CONSENT FORM: HIV COUNSELLOR BASELINE AND POST-INTERVENTION SELF-REPORT MEASURE INTERVIEW

We herewith kindly invite you to participate in a research project aiming to assess the level of HIV counselling skills and competencies in order to develop and implement a training programme aimed at enhancing these skills. Before you decide whether to take part, kindly consider the information below. Should you consent to participate, please confirm this by signing this consent form on page 2. The consent form and procedure, as well as the research schedule and the study project as a whole, have been approved by the Ethics Committee: Faculty of Health Sciences of the University of the Free State. The project is funded by the National Research Foundation (NRF) and the University of the Free State (UFS).

Purpose of the study: The PhD candidate, Lerato Mmusi-Makhele under the supervision of Dr Henriëtte van den Berg – with the Department of Psychology, UFS – is conducting research to assess current HIV counselling skills and competencies of HIV counsellors. The information obtained from the study will eventually enable the researchers to inform the provincial HIV & AIDS counselling and testing programmes. The purpose of this interview is to gather information on HIV counsellors' job selection, HIV counselling training; HIV/AIDS knowledge and attitudes, counselling skills and competence in respect of HIV counselling and testing of patients and furthermore explore stress tolerance; support and supervision and job satisfaction.

Interview: A trained researcher will conduct the interview. The process will be completed in approximately one hour. Your participation is voluntary. You may stop the interview at any time or decide not to answer any particular question. You will experience no consequences or loss of benefits should you decide to do so. Your name is not indicated on the questionnaire and the consent forms (with names and signatures of respondents) are kept separate from the questionnaires. All personal information will remain confidential. It will not be revealed to any staff member at this clinic. Although you will not derive any immediate personal benefit from participating in the research, the information you will provide will help the researchers to inform the Free State Department of Health on the needs and experience of HIV counsellors providing HIV counselling and testing. Your participation can only be terminated by the investigator without your consent in cases where there is a breach of other study participants' confidentiality.

It is hoped and anticipated that this study will benefit all patients undergoing HIV counselling and testing and their counsellors in the end.

For additional information: For questions about the research and reporting on research-related adverse effects, please contact Lerato Mmusi-Makhele at 051 401 2853.

For reporting of complaints/problems: **Ethics Committee of the Faculty of Health Sciences, University of the Free State** at 051 405 2812

Kind regards,

_____
L Mmusi-Makhele
Principal Researcher

Consent/permission: I, ... [name in block letters] have had adequate opportunity to read and understood all the information given to me about my participation in this study. I was given the opportunity to discuss this information and ask questions. In the presence of a witness, I volunteer to participate in the interview. I have had sufficient opportunity to consider whether to participate and I did not experience any coercion or undue influence to make this decision. I confirm that I have received a copy of this consent form.

Signature of **research participant**	Date

Witness: I, ... [name in block letters] witnessed that the research participant read/was read to and understood all the information given to her/him about her/his participation in this study and was given the opportunity to discuss this information and ask questions. She/he volunteered to participate in the interview under the conditions stated above. She/he had sufficient opportunity to consider whether to participate and did not experience coercion or undue influence to make this decision. She/he was given the information in a language understandable to her/him. I confirm that she/he has received a copy of this consent form.

Signature of **witness**	Date

Consent form for Lay counsellors: FGD

Dear Sir/Madam

RE: The design, implementation and evaluation of an HIV counselling skills programme for lay counsellors

CONSENT FORM: LAY COUNSELLOR BASELINE AND POST-INTERVENTION FOCUS GROUP DISCUSSION

We herewith kindly invite you to participate in a research project aiming to assess the level of HIV counselling skills and competencies in order to develop and implement a training programme aimed at enhancing these skills. Before you decide whether to take part, kindly consider the information below. Should you consent to participate, please confirm this by signing the consent form on page 2. The consent form and procedure, as well as the research schedule and the study project as a whole, have been approved by the Ethics Committee: Faculty of Health Sciences of the University of the Free State. The project is funded by the National Research Foundation (NRF) and the University of the Free State (UFS).

Purpose of the study: The PhD candidate, Lerato Mmusi-Makhele, under the supervision of Dr Henriëtte van den Berg – with the Department of Psychology, UFS – is conducting research to assess current HIV counselling skills and competencies of lay counsellors. The information obtained from the study will eventually enable the researchers to inform the provincial HIV & AIDS counselling and testing programmes. The purpose of this interview is to gather information on lay counsellors' attitudes, counselling skills and competence in respect of HIV counselling and testing of patients and furthermore explore stress tolerance, support, supervision and job satisfaction.

Focus group discussion: Trained researchers and facilitators will conduct the focus group discussions. The process will be completed in approximately one hour. Your participation is voluntary. Guidelines will be provided in the group discussions. Questions will be asked and opened up for discussion. You may decide not to answer any particular question or discuss any particular issue. You will experience no consequences or loss of benefits should you decide to do so. Your name is not indicated on the group intake forms and the consent forms (with names and signatures of respondents) are kept separate from these forms. All personal information will remain confidential. It will not be revealed to any staff member at this clinic. Although you will not derive any immediate personal benefit from participating in the research, the information you will provide will help the researchers to inform the Free State Department of Health on the needs and experience of lay counsellors providing HIV counselling and testing. Your participation can only be terminated by the investigator without your consent in cases where there is a breach of other study participants'

confidentiality. It is hoped and anticipated that this study will benefit all patients undergoing HIV counselling and testing and their lay counsellors in the end.

For additional information: For questions about the research and reporting on research-related adverse effects, please contact Lerato Mmusi-Makhele at 051 401 2853.

For reporting of complaints/problems: **Ethics Committee of the Faculty of Health Sciences, University of the Free State** at 051 405 2812

Kind regards,

_____
L Mmusi-Makhele
Principal Researcher

Consent/permission:
I, ... [name in block letters] have had adequate opportunity to read and understood all the information given to me about my participation in this study. I was given the opportunity to discuss this information and ask questions. In the presence of a witness, I volunteer to participate in the focus group discussion. I have had sufficient opportunity to consider whether to participate and I did not experience any coercion or undue influence to make this decision. I confirm that I have received a copy of this consent form.

Signature of **research participant**	Date

Witness:
I, ... [name in block letters] witnessed that the research participant read/was read to and understood all the information given to her/him about her/his participation in this study. She/he was given the opportunity to discuss this information and ask questions. She/he volunteered to participate in the focus group discussion under the conditions stated above. She/he had sufficient opportunity to consider whether to participate and did not experience coercion or undue influence to make this decision. She/he was given the information in a language understandable to her/him. I confirm that she/he has received a copy of this consent form.

Signature of **witness**	Date

Consent form for Lay counsellors: Video recordings/Session observations

Dear Sir/Madam,

CONSENT FORM: LAY COUNSELLOR BASELINE AND POST-INTERVENTION VIDEO RECORDINGS/SESSION OBSERVATIONS

We herewith kindly invite you to participate in a research project aiming to assess the level of HIV counselling skills and competencies in order to develop and implement a training programme aimed at enhancing these skills. Before you decide whether to take part, kindly consider the following and should you consent to participate, please confirm this by signing this consent form on page 2. The consent form and procedure, as well as the research schedule and the study project as a whole, have been approved by the Ethics Committee: Faculty of Health Sciences in the University of the Free State. The project is funded by the National Research Foundation (NRF) and the University of the Free State (UFS).

Purpose of the study: The PhD candidate; Lerato Mmusi-Makhele under the supervision of Dr. Henriette van den Berg – with the Department of Psychology, UFS – is conducting research to assess current HIV counselling skills and competencies of lay counsellors. The information obtained from the study will eventually enable the researchers to inform the provincial HIV&AIDS counselling and testing programmes. The purpose of this video recording (session observation) is to gather baseline information on lay counsellor's counselling skills and competence in respect of HIV counselling and testing of patients.

In-session video recordings: In order to further assess other aspects of professional counselling skills and competencies, some sessions with patients will be video recorded (observed. **VIDEO**: The video equipment will be placed in such a way as not to hinder/obscure or interrupt the interaction between you and the patient. Your face on the video will be blurred. However, it is essential in counselling that non-verbal cues be visible as other verbal cues would be. These recordings will be kept by the researcher in a secured, locked cabinet in a safe office. No one other than the researcher will have access. **OBSERVATION**: The observer will be seated and will not hinder/obscure or interrupt the interaction between you and the patient and may not take part in your session.

Once the material has been analysed by the researcher for the purpose of the study, the video recordings will be destroyed will be destroyed 5 years after the study was conducted. Your participation is entirely voluntary. You may stop the session with the patient at any time and ask the researcher to disconnect the video equipment. You will experience no consequences or loss of benefits should you decide to do so. Your name is not indicated in the video recording and the consent forms (with names and signatures of respondents) are kept separate from the videos. Although you will not derive any immediate personal benefit from participating in the research, the information you will provide will help the researchers to inform the Free State Department of Health on the

needs and experience of Lay counsellors providing HIV counselling and testing. Your participation can only be terminated by the investigator without your consent in cases where there is breach of other study participants' confidentiality. It is hoped and anticipated that this will benefit all patients undergoing HIV counselling and testing and their lay counsellors in the long run.

For additional information: For questions about the research and reporting on research-related adverse effects, please contact Lerato Mmusi-Makhele at 051 401 2853.

For reporting of complaints/problems: **Ethics Committee of the Faculty of Health Sciences, University of the Free State** at 051 405 2812

Kind regards,

_____
L Mmusi-Makhele
Principal Researcher

Consent/permission: I, ... [name in block letters] have had adequate opportunity to read and understood all the information given to me about my participation in this study and was given the opportunity to discuss this information and ask questions. In the presence of a witness, I volunteer to participate in the video recording. I have had sufficient opportunity to consider whether or not to participate and did not experience any coercion or undue influence to do so. I confirm that I have received a copy of this consent form.

Signature of **research participant** Date

Witness: I, ... [name in block letters] witnessed that the research participant read/was read to and understood all the information given to her/him about her/his participation in this study and was given the opportunity to discuss this information and ask questions. She/he volunteered to participate in the video recording under the conditions stated above. She/he had sufficient opportunity to consider whether or not to participate and did not experience coercion or undue influence to do so. She/he was given the information in a language understandable to her/him. I confirm that she/he received a copy of this consent form.

Signature of **witness** Date

Consent form for Lay counsellors: Intervention

Dear Sir/Madam

CONSENT FORM: HIV COUNSELLOR INTERVENTION PARTICIPATION

We herewith kindly invite you to participate in a training programme aimed at enhancing HIV counselling skills and competencies of HIV counsellors. This forms part of a larger research project which focuses on HIV counselling skills and competence. Before you decide whether to take part, kindly consider the information below. Should you consent to participate, please confirm this by signing the consent form on page 2. The consent form and procedure, as well as the research schedule and the study project as a whole, have been approved by the Ethics Committee: Faculty of Health Sciences of the University of the Free State. The project is funded by the National Research Foundation (NRF) and the University of the Free State (UFS).

Purpose of the study: The PhD candidate, Lerato Mmusi-Makhele, under the supervision of Dr Henriëtte van den Berg – with the Department of Psychology, UFS – is conducting research to assess, develop and evaluate an HIV counselling skills and competence programme. The information obtained from the study will eventually enable the researchers to inform the provincial HIV & AIDS counselling and testing programmes. The purpose of this intervention programme is to train HIV counsellors in evidence-based counselling skills drawing from best practices. Furthermore, enhance their counselling abilities and competence through training on stress tolerance and around issues of support, supervision and job satisfaction.

Training Intervention: The principal researcher, who is also a practicing Clinical psychologists together with a facilitator will conduct the training. The groups have been selected according to appropriate representation from all the three research sites; Bloemfontein, Botshabelo and Thaba Nchu. The training is over a period of five consecutive days and participants are expected to be present for all five days. Permission from your work supervisors and coordinators has been requested. Transport to and from the venue (University of the Free State) will be provided. Participants are requested to be available from 07h30-16h00 each day of the training. Your participation is voluntary. You may decide not to answer any particular question or discuss any particular issue however you are requested to participate fully as the content of the training requires full participation through experiential learning. All personal information will remain confidential. Your participation can only be terminated by the investigator without your consent in cases where there is a breach of other study participants' confidentiality. It is hoped and anticipated that the information gathered from your participation will hopefully provide the researchers with critical aspects on the needs and experiences of counsellors providing HIV counselling and testing within the Free State Department of Health and that the overall research study will benefit all patients undergoing HIV counselling and testing.

For additional information: For questions about the research and reporting on research-related adverse effects, please contact Lerato Mmusi-Makhele at 051 401 2853.

For reporting of complaints/problems: **Ethics Committee of the Faculty of Health Sciences, University of the Free State** at 051 405 2812

Kind regards,

_____
L Mmusi-Makhele
Principal Researcher

Consent/permission:
I, ... [name in block letters] have had adequate opportunity to read and understood all the information given to me about my participation in this training. I was given the opportunity to discuss this information and ask questions. In the presence of a witness, I volunteer to participate in the training. I have had sufficient opportunity to consider whether to participate and I did not experience any coercion or undue influence to make this decision. I confirm that I have received a copy of this consent form.

Signature of **research participant**	Date

Witness:
I, ... [name in block letters] witnessed that the research participant read/was read to and understood all the information given to her/him about her/his participation in this training. She/he was given the opportunity to discuss this information and ask questions. She/he volunteered to participate in the training under the conditions stated above. She/he had sufficient opportunity to consider whether to participate and did not experience coercion or undue influence to make this decision. She/he was given the information in a language understandable to her/him. I confirm that she/he has received a copy of this consent form.

Signature of **witness**	Date

Consent form for patients: Video recordings/Session observations and exit interview

Dear Sir/Madam,

CONSENT FORM: PATIENT BASELINE AND POST-INTERVENTION VIDEO AND INTERVIEW

We herewith kindly invite you to participate in a research project aiming to assess the level of HIV counselling skills and competencies in order to develop and implement a training programme aimed at enhancing these skills. Before you decide whether to take part, kindly consider the following and should you consent to participate, please confirm this by signing this consent form on page 2. The consent form and procedure, as well as the research schedule and the study project as a whole, have been approved by the Ethics Committee: Faculty of Health Sciences of the University of the Free State. The project is funded by the National Research Foundation (NRF) and the University of the Free State (UFS).

Purpose of the study: The PhD candidate; Lerato Mmusi-Makhele under the supervision of Dr. Henriette van den Berg – with the Department of Psychology, UFS – is conducting research to assess current HIV counselling skills and competencies of lay counsellors. The information obtained from the study will eventually enable the researchers to inform the provincial HIV&AIDS counselling and testing programmes. The purpose of this interview is to gather baseline information on lay counsellor's HIV/AIDS knowledge and attitudes, counselling skills and competence in respect of HIV counselling and testing of patients.

Recording: The duration of the recording/observation of the counselling session will be determined by the length of the counselling session. Your participation is entirely voluntary.
VIDEO: You may choose and request the recording to be stopped at any time. You will experience no consequences or loss of benefits should you decide to do so. The video equipment will be set-up in such a way as not to hinder/obscure or interrupt the interaction between counsellor and patient. The video recorder will not face you. All personal information will remain confidential and will not be revealed to any staff of the clinic. The recorded data will be analyzed and assessed by a psychologist and once the necessary evaluation is complete the video will be erased immediately.
OBSERVATION: The observer will be seated and will not hinder/obscure or interrupt the interaction between you and the patient and may not take part in your session.
Although you will not derive any immediate personal benefit from participating in the research, the information you will provide will help the researchers to inform the Free State Department of Health on the needs and experiences of patients in respect of HIV counselling. It is hoped and anticipated that this will benefit all patients and lay counsellors in the long run.

Interview: A trained researcher will conduct the interview and the process will be completed in approximately 20 minutes.
Your participation is entirely voluntary. You may stop the interview at any time or decide not to answer any particular question. You will experience no

consequences or loss of benefits should you decide to do so. Your name is not indicated on the questionnaire and the consent forms (with names and signatures of respondents) are kept separate from the questionnaires. All personal information will remain confidential and will not be revealed to any staff member of this clinic. Although you will not derive any immediate personal benefit from participating in the research, the information you will provide will help the researchers to inform the Free State Department of Health on the needs and experience of patients utilising HIV counselling and testing services. It is hoped and anticipated that this will benefit all patients undergoing HIV counselling and testing.

For additional information: For questions about the research and reporting on research-related adverse effects, please contact Lerato Mmusi-Makhele at 051 401 2853.

For reporting of complaints/problems: **Ethics Committee of the Faculty of Health Sciences, University of the Free State** at 051 405 2812

Kind regards,

_____
L Mmusi-Makhele
Principal Researcher

Consent/permission: I, ... [name in block letters] have had adequate opportunity to read and understood all the information given to me about my participation in this study and was given the opportunity to discuss this information and ask questions. In the presence of a witness, I volunteer to participate in the interview. I have had sufficient opportunity to consider whether or not to participate and did not experience any coercion or undue influence to do so. I confirm that I have received a copy of this consent form.

....
Signature of **research participant/patient** Date

Witness: I, ... [name in block letters] witnessed that the research participant read/was read to and understood all the information given to her/him about her/his participation in this study and was given the opportunity to discuss this information and ask questions. She/he volunteered to participate in the interview under the conditions stated above. She/he had sufficient opportunity to consider whether or not to participate and did not experience coercion or undue influence to do so. She/he was given the information in a language understandable to her/him. I confirm that she/he received a copy of this consent form.

Signature of **witness** Date

ANNEXURE 5

Self-report measure

Self-report measure

SELF REPORT MEASURE FOR HIV COUNSELLOR

Questionnaire No ☐☐☐

HIV counsellor No ☐☐

Tekanyetso ya tshebetso ka bomong ya moithaophi wa tsa HIV (khanselara) / SELF REPORT MEASURE FOR HIV COUNSELLOR

DITAELO: Etsa sedikadikwe moo ho hlokahalang / **INSTRUCTIONS: Circle one option on all questions unless otherwise specified**

Dintlha ka mong **/Background information**

For office use only

1.	*Mosebetsi/* Occupation/	*Mosebeletsi wa bophelo ba setjhaba /* Community healthcare worker……1 *Mothusi wa mooki /* Assistant nurse……..2 *Mooki wa moithuti /* Enrolled nurses……..3 *Mooki /* Registered nurse……4 *O mong /* Other……5 *Hlalosa /* Specify ……..	1 ☐
2.	*Sebaka sa mosebetsi /*Town (where you work)	Bloemfontein ……..1 Botshabelo ……2 Thaba Nchu ……..3	2 ☐
3.	*Sebaka sa mosebetsi kapa sehlopha /* Ward or team	*Ngola lebitso la sebaka seo o sebetsang ho sona/* **Write name of ward or team** ……	3 ☐☐
4.	*Botjhaba /* Race	*Motho e motsho /*Black ……1	4 ☐

		*Lekhalate ka mmala/*Coloured ……2 *Mo-india/*Indian ……..…3 *Mosweu/ lekgowa /*White ……4 *O mong /*Other……5 *Bolela* Specify ……....	
5.	*Bong* / Sex/Gender	*Monna /*Male……..……1 *Mosadi /*Female……..……2	5 ☐
6.	*Dilemo* / Age at last birthday	*Ngola dilemo tsa hao/***Write age in years** ☐☐ Years	6 ☐☐
7.	*Puo ya lapeng* / Home language	Sesotho ……..1 Setswana……..…..…2 English……..……3 Afrikaans ……...4 *E nngwe / Other*……..……5 *(Hlalosa /* Specify)…… …… …… ……	67 ☐ ☐
8.	*Maemo lenyalong /* Marital status	*Ya aso nyalwe /* Single (never been married)……1 *Nyetse /* Married……..…….. ..2 *Hladiwe /* Divorced……..…… 3 *Mohlolo-hadi /* Widowed……..……..4	8 ☐

9.	*Na o na le bana kapa bao o ba hlokometseng /* Do you have children and/or dependants?	*Ba ba kae? /* How many? Palo / Number ☐☐	9 ☐☐
10.	*O hlahetse tulong/bakeng sefe? /* Where were you born?	Bloemfontein ……1 Botshabelo ……2 Thaba Nchu…… 3 *Baka se seng/* Other……..4 *(Hlalosa/* Specify)……	10 ☐☐
11.	*Bolela lengolo le phahameng la dithuto leo o le fumaneng /* What is the highest formal educational qualification that you have obtained?	*Ha o a kena sekolo* /No formal schooling……..……1 *Sekolo sa Poraemari* /Primary school ……2 *Sekolo se phahameng* /Secondary school……3 *Materiki/ sehlopha sa 12 kapa ho feta/*Matric/grade 12 or higher…… ……4	11 ☐
12.	*O sebeletsa mang? /* Who employs you?	*Lefapha le Bophelo Foreistata/* /Free State Department of Health…… ……1 *Mosebetsi o e seng wa mmuso* /NGO……..2 *(Hlalosa /* Specify) …… *E meng* /Other …… *(Hlalosa /* Specify) ……	12 ☐

13.	*Ana o setho sa mokhatlo wa setjhaba/society/kereke, jj. /* Are you part of a community club/society/church group, etc.	*Hlalosa /* Specify …… …… …… …… …… …… …… ……	13 ☐ ☐

Kgetho le boikwetliso / Selection and Training

14.	*Tsebo ya hao /* What is your background?	*Mooki /* Nurse ……...1 *Mosebeletsi wa tleliniki /* Clinical officer ……..……2 *Mosebeletsi wa setjhaba /* Social worker……..……...……3 *Motho ya nang le HIV kapa AIDS /* Person living with HIV or AIDS……..…… ……...4 *Tse ding /* Other…...……..…… ……..……5 *(Hlalosa* /Specify) ……	14 ☐ ☐
15.	*Hlalosa hore o kgethilwe jwang hoba mokhanselara /* How were you selected to be a counsellor?	*O kgethilwe keya o okametseng /* Proposed by senior colleague…… .....1 *Boithaopi /*Self-motivated (expand) *(Hlalosa ka ho totobala hore o nkile jwang qeto ya hoba mokhanselara,na ke ka lebaka la kamano ya hao ya HIV setjhabeng kapa na ke ka tsebo eo o nang le yona, kapa ho na le emong ya nang le tswaetso ya HIV motswalle/e mong /* For example, give reasons why you decided to train as a counsellor, e.g. "concerned about the impact of HIV in the community", "following personal experience" – e.g. have friend, relative with HIV, etc)…… 2	15 ☐

16.	*A na hona le motho ya o qobelletseng ho khansela?* /Do you feel that you have been pressurized into doing counselling? *Mohlala, na o nka mosebetsi wa bokhanselara o le boima, kapa karolo ya mosebetsi, kapa mosebetsi oo o kgonang ho o etsa* /For example, is counselling something you feel comfortable doing, or do you feel it is a strain, or that you have to do it as part of your job?	*Hlalosa* / Explain..	16 ☐
17.	*Qaqisa boikwetliso ba bokhanselara boo o bo fumaneng?* /Describe the counselling training you have received? *Mohlala. Dithuto kapa palo ya nako ya dithuto tseo* /For example, number of courses and duration of courses attended	*Hlalosa* / Explain..	17 ☐
18.	*O beha bokhanselara ba hao boemong bofe?* / How would you rate your counselling training?	*Hantle haholo* / very good ☐ ....1 *Hantle* / good ☐ ....2 *Bohareng* / adequate ☐ ....3 *Ha bo a lekana* / inadequate ☐ 4	18 ☐
19.	*Fana ka dintle le dimpe tsa boikwetliso ba hao* / What were the good things and poor things in your training?	*Hlalosa* / Specify...	19 ☐ ☐

20.	*Na ho na le karolo ya mosebetsi wa hao moo o hlokang boikwetliso? /* Are there any areas in which you feel you need more training?	*Hlalosa /* Specify …… …… …… …… …… …… ……	20 ☐☐
21.	*O bile le poeletso ya boikwetliso kapa boikwetliso bo ile ba tswelapele? /* Have you had follow-up or ongoing training?	*Ha o dumela, e hlalose /* If YES, describe the training …… …… …… …… …… …… ……	21 ☐☐
22.	*Ha o sa dumele, na o nahana boikwetliso bo tswellang pele ke kakanyo e nepahetseng ?/* If NO, do you think ongoing training would be a good idea?	*Ha o itse Ee, hlalosa hore boikwetliso boo bo o thusitse kapa ha ba o thusa /* If YES, describe how the training might or might not help …… …… …… ……	22 ☐☐

Tshehetso le bohlokomedi/Support and supervision

23.	*O nka dihora tse kae ka beke o etsa mosebetsi wa ho khansela?/* How many hours a week do you spend in counselling activities?	☐☐ *Dihora/* Hours	23 ☐☐
24.	*Ke karolo e kae ya nako eo o e sebeditseng ho khansela? /* What proportion of your working life is spent counselling?	☐☐☐% *Peresente/*Percentage	24 ☐☐☐
25.	*Na o tsamaya dihlopha/ dikopano tsa kgothatso le tshebetso? /* Do you	*Ha o itse Ee, hlalosa ka moo dihlopha tsa tshehetso di o thusang le ho sa thuse ka teng? /* If YES, in what way is the group helpful or not helpful? *(Hlalosa/*Specify) ……	25 ☐☐

	attend a counsellor support group?	…… …… …… …… …… ……	
26.	*Ha o itse tjhee, o ka fumana tse molemo kapa tse seng molemo? /* If NO, in what ways do you think you would benefit (or not benefit) from a support group	*Hlalosa / Specify* …… …… …… …… …… …… ……....	26 ☐☐
27.	*Na ho na le tshehetso ho tswa mafapheng a mang ho tswellisa mosebetsi wa bo khanselara? /* Do you have support for your counselling from other sources?	*Ha o itse Ee, hlalosa hore ke mang le hore o thua jwang /* If YES, explain whom and how does it help *(Hlalosa/*Specify) …… …… …… …… …… ……	27 ☐☐
28.	*Na o na le bokgoni ba ho fumana thuso ho bua ho mookamedi wa hao mabapi le bokhanselara tabeng ya botegniki? /* Do you have access to a designated counselling supervisor to provide you with support and technical back up?	*Ha o itse ee,ke mang a fanang ka thuso? /* If YES, who provides; *Tshehetso / Support* …… …… …… *Bookamedi / Supervision* …… …… ……	28.1 ☐ 28.2 ☐

***Kgatello ya maikutlo* /Burnout**

29.	*O ikutlwa jwang ka mosebetsi wa hao? /* How do you feel about your job?	*Hlalosa / Explain* …… …… …… …… …… ……	29 ☐ ☐

		…… ……	
30.	*Na o ikutlwa o le motho wa bohlokwa kapa tjhee?(hlalosa) /* Do you feel valued or undervalued by clients (explain in what ways)	*Hlalosa / Explain* …… …… …… …… …… …… …… ……	30 ☐ ☐
31.	*Na o ikutlwa o le motho wa bohlokwa ho basebetsimmoho le wena kapa tjhee?(hlalosa) /* Do you feel valued or undervalued by other staff (explain in what ways)	*Hlalosa /* Explain …… …… …… …… …… …… …… ……	31 ☐ ☐
32.	*Na o ikutlwa o le motho wa bohlokwa ho baokamedi ba hao? Ee kapa tjhee?(hlalosa)/* Do you feel valued or undervalued by your supervisor (explain in what ways)	*Hlalosa / Explain* …… …… …… …… …… …… …… ……	32 ☐ ☐
33.	*Na o fumana nako e lekaneng mosebetsing wa hao, ho ka tswellisa mosebetsi wa hao wa bokhanselara? /* Are you given adequate time in your job to carry out your counselling duties?	*Hlalosa / Explain* …… …… …… …… …… …… …… ……	33 ☐ ☐

***Lenane le bontshang boemo ba maikutlo /* Burnout inventory**

***DITAELO: Bolela hore ka ho ngola 'X' na o ikutlwa joang ka tse latelang /* INSTRUCTIONS:**

Please indicate with an 'X' how you feel about the following statements

*Dipotso /***Question**		*Hohang /***Never (0)**	*Makgetlo a seng makae /***Occasionally (1)**	*Kgafetsa /***Often (2)**	*Kamehla /***Always (3)**	
34.	*Maikutlo aka a nyahamiswa ke mosebetsi /* **I feel**					34 ☐

	emotionally drained by my work					
35.	*Mosebetsi wa ka o tletse kgatello ya maikutlo /* **My work is very stressful**					35 ☐
36.	*Mosebetsi wa ka o na le moputso /* **My work is very rewarding**					36 ☐
37.	*Sebaka seo ke sebetsang ho sona se na le kgathello ya maikutlo /* **My work environment is very stressful**					37 ☐
38.	*Ke ithuta ntho entjha tsatsi le leng le le leng mosebetsing wa ka /* **I learn something new in my work every day**					38 ☐
39.	*Ke ikutlwa ke le mong, mosebetsing wa ka /* **I feel isolated in my work**					39 ☐
40.	*Ke na le mathata ho bueng le basebetsi mmoho le nna /* **I have problems communicating with my colleagues**					40 ☐
41.	*Ke kgona ho thusa bakudi ba ka /* **I can help my clients**					41 ☐
42.	*Ha ke itshepe ho hang mosebetsing wa ka /* **I have no confidence in my clinical skills**					42 ☐
43.	*Hlalosa ka ho feta polelong tse fetileng (tse ka hodimo) /* **Please elaborate on any of the above statements**	....				43 ☐☐

		…… …… …… …… …… …… ……	

***Boima ba mosebetsi le nako eo o dulang le mokudi /*Workload and time spent per patient**

44.	*O bile lekhanselara dilemo tse kae?* How many years have you been counselling	☐☐ *Dilemo/* Years	44 ☐☐
45.	*O nka dihora tse kae ka letsatsi o khansela? /* How many hours per day do you do counselling?	☐☐ *Dihora/* Hours	45 ☐☐
46.	*Ha mosebetsi wa hao wa letsatsi o fetoha ,fana ka kakanyo ya nako ka dihora eo o e sebedisang bekeng /*If your daily schedule varies, please give an approximate indication of the time of hours, you spend each day of the week on the following;	*Puisano mabapi le mathata a HIV/*Counselling about HIV-related problems ☐☐ *Dihora/* Hours *Puisano ka mathata a mang /*Counselling about other issues ☐☐ *Dihora/* Hours *Mosebetsi o mong /* Other work ☐☐ *Dihora/* Hours *Hlalosa/*Specify ……	46.1 ☐ 46.2 ☐ 46.3 ☐ 46.4 ☐
47.	*O nka matsatsi a makae bekeng o khansela? /* How many days per week do you do counselling?	☐☐ *Matsatsi/* Days	47 ☐
48.	*Ka letsatsi o bona batho ba bakae? /*How many clients do you see per day?	☐☐ *Nomoro/* Number	48 ☐☐

49.	*Ke batho ba ba kae bao o ba bonang ba; /* What proportion of your clients are the following;	*Batjha (dilemo tse 12-18) /* Teenagers (12-18) ☐☐☐% *Ba baholo (Ho feta dilemo tse 18) /* Adults(Over 18) ☐☐☐%	49. 1 ☐☐☐ 49.2 ☐☐☐
50.	*Ke batho ba ba kae bao o ba bonang ba /* What proportion of your clients are the following;	*Bo ntate /* Male ☐☐☐% *Bo mme /* Female ☐☐☐%	50.1 ☐☐☐ 50.2 ☐☐☐
51.	*Ha mosebetsi wa hao wa letsatsi o fetoha , bolela palo ya batho e o e ebonang /*If your daily schedule varies, please give an approximate indication of the number of clients you see each day of the week;	*Batho ba nang le mathata a HIV /*Clients with HIV-related problems ☐☐ *nomoro/* number *Batho ba nang le mathata a mang /*Clients with other problems ☐☐ *nomoro/* number	51.1 ☐☐ 51.2 ☐☐
52.	*O bona bokamoso ba hao bo le joang mosebetsing o na wa hoba le khanselara/moithaupi /* How do you see your future in counselling? *(Mohlala, na o tla tswellapele ka mosebetsi ona wa bokhanselara le nako e tlang, kapa o a duba hoo o bonang ho iphumanela mosebetsi o mong? Sotho /* For example, "...will go on with my counselling job for the foreseeable future", "...find counselling too stressful/difficult and want to find a new job")	*Hlalosa/*Specify ……	52 ☐☐

Re lebohela honka karolo ha hao / **Thank you for your participation**

ANNEXURE 6

Maslach Burnout Inventory

ANNEXURE 1. 2. 1. 1. Maslach Burnout Inventory (Self-report)

Questionnaire No ☐☐☐
HIV counsellor No ☐☐

DITAELO: Bontsha kgetho ya hao ka ho ngola 'X' / **INSTRUCTIONS: Indicate your option with an 'X'**

*Dipotso /***Question**	*Hohang /***Never (0)**	*Makgetlo selemong /***A few time as a year (1)**	*Hangwe kgweding kapa hohang /***Once a month or less (2)**	*Makgetlo kgweding /***A few times a month (3)**	*Hangwe ka beke /***Once a week (4)**	*Makgetlo bekeng /***A few times a week (5)**	*Letsatsi ka leng /***Everyday (6)**	***For office use only***
1. Maikutlo a ka a nyahamis wa ke mosebetsi wa ka / I feel emotionally drained from my work								1. ☐
2. Ke ikutlwa ke sebeditse haholo letsatsing/ I feel used up at the end of the work day								2. ☐
3. Ke ikutlwa ke kgathetse hoseng mme ke tshwanela ho shebana le mosebetsi wa letsatsi / I feel fatigued when I get up in the morning and have to face another day on the job								3. ☐
4. Ke kgona ho utlwisisa								4.

maikutlo a bakudi / I can easily understand how patients feel about things								☐
*Dipotso /***Question**	*Hohang /***Never (0)**	*Makgetlo selemong /***A few time as a year (1)**	*Hangwe kgweding kapa hohang /***Once a month or less (2)**	*Makgetlo kgweding /***A few times a month (3)**	*Hangwe ka beke /***Once a week (4)**	*Makgetlo bekeng /***A few times a week (5)**	*Letsatsi ka leng /***Everyday (6)**	***For office use only***
5. *Ke ikutlwa ekare ke tshwara bakudi, e ka ha se batho /* I feel I treat some patients as if they were impersonal objects								5. ☐
6. *Ho sebetsa le batho letsatsi le letsatsi ho ang kgathatsa /* Working with people all day is really a strain for me								6. ☐
7. *Ke sebetsana le mathata a bakudi hantle /* I deal effectively with the problems of patients								7. ☐
8. *Ke ikutlwa ke fellwa ke matla ka mora mosebetsi /*								8. ☐

I feel burned out from my work								
*Dipotso /***Question**	*Hohang /***Never (0)**	*Makgetlo selemong /***A few time as a year (1)**	*Hangwe kgweding kapa hohang /***Once a month or less (2)**	*Makgetlo kgweding /***A few times a month (3)**	*Hangwe ka beke /***Once a week (4)**	*Makgetlo bekeng /***A few times a week (5)**	*Letsatsi ka leng /***Everyday (6)**	***For office use only***
9. Ke ikutlwa kena le tshusumetso e nepahetseng maphelong a batho ka lebaka la mosebetsi waka / I feel I'm positively influencing other people's lives through my work								9. ☐
10. Ke ikutlwa ke sa kgathalle maikutlo a batho , haesale ke nka mosebetsi ona/ I have become more callous towards people since I took this job								10. ☐

11. *Ke utlwa ekare mosebetsi ona o thathafatsa maikutlo /* I worry that this job is hardening me emotionally								11. ☐
12. *Ke ikutlwa ke le mafolofolo* I feel very energetic								12. ☐
13. *Ke a nyahama mosebetsing waka /* I feel frustrated by my job								13. ☐
*Dipotso /***Question**	*Hohang /***Never (0)**	*Makgetlo selemong /***A few time as a year (1)**	*Hangwe kgweding kapa hohang /***Once a month or less (2)**	*Makgetlo kgweding /***A few times a month (3)**	*Hangwe ka beke /***Once a week (4)**	*Makgetlo bekeng /***A few times a week (5)**	*Letsatsi ka leng /***Everyday (6)**	***For office use only***
14. *Ke ikutlwa eka ke sebetsa ka thata /* I feel I am working too hard on my job								14. ☐
15. *Ha ke kgathalle hore ho etsahala eng bakuding ba bang /*I don't really care what happens to some patients								15. ☐
16. *Ho sebedisana le batho ho tlisa*								16.

	kgatello maikutlong / Working with people directly puts too much stress on me								☐
17.	*Ke kgona ho bopa le ho etsa hore bakudi ba phutholohe /* I can easily create a relaxed atmosphere with my patients								17. ☐
18.	*Ke ikutlwa ke le motlotlo ke kgotsofala ha ke sebetsa haufi le bakudi /*I feel exhilarated after working closely with my patients								18. ☐
	Dipotso /**Question**	*Hohang* /**Never (0)**	*Makgetlo selemong* /**A few time as a year (1)**	*Hangwe kgweding kapa hohang* /**Once a month or less (2)**	*Makgetlo kgweding* /**A few times a month (3)**	*Hangwe ka beke* /**Once a week (4)**	*Makgetlo bekeng* /**A few times a week (5)**	*Letsatsi ka leng* /**Everyday (6)**	***For office use only***
19.	*Ke fihlelletse dintho tsa bohlokwa mosebetsing wa ka /* I have accomplished many worthwhile things in my job								19. ☐

20. *Ke ikutlwa eka ke qetellong ya ho fellwa ke matla /* I feel like I am at the end of my tether								20. ☐
21. *Mosebetsing waka ke rarolla mathata a maikutlo ka moya le pelo e imametseng /* In my work, I deal with emotional problems very calmly								21. ☐
22. *Ke ikutlwa eka ba bang ba bakudi ba bona eka ke baka amang a mathata a bona /* I feel patients blame me for some of their problems								22. ☐

Re lebohela ho nka karolo ha hao / **Thank you for your participation**

ANNEXURE 7

Focus Group Tool

Focus Group Tool

FOCUS GROUP DISCUSSION

Questions

1. What do you do in the beginning of the session to help patients to overcome their nervousness when they first meet you? What do you do to help understand what the patients experience is when he/she sees you during the first meeting? How do you show support and acceptance to the patients?

2. What kind and type of information do you give the patient during pretest counselling and posttest counselling? In special interventions counselling such as in patients who test positive for TB and/or females who are pregnant, what type of information and facilitation do you do? What kind of measures do you use in order to assess whether a patient understands and will use this information?

3. After communicating the information what else do you do to make sure that the patient has an opportunity to present any thought/s or feeling/s and the state that they are in, during the session? How do you address the following issues in your sessions: culture, family traditions, religion, sexuality, sexual practices, gender, relationship, domestic violence, gender-based violence and poverty? What key issues and elements do you look out for to determine the level of a patient's distress after they find out that they tested positive for HIV? And for those who test HIV negative what aspects do you focus on?

4. What types of ethical dilemmas do you normally encounter in an HIV counselling session? What types of measures to you take to resolve these ethical issues? How do you address and facilitate disclosure for patients who test HIV positive?

5. Is there anything else that you would like mention regarding your everyday work in HIV counselling and testing of patients in your clinic?

ANNEXURE 8

Video recording/Observation of session tool

Video recording/Observation of session tool

VIDEO/SESSION OBSERVATION ASSESSMENT CHECKLIST

Questionnaire No ☐☐
HIV counsellor No ☐☐☐ Patient No ☐☐

VIDEO RECORDING

SESSION ASSESSMENT MEASURE FOR HIV COUNSELLOR

Competency based elements

Function	Skills	Score	Comments	For office use only
1. Interpersonal relationship	1.1 Greets clients	3 2 1		☐
	1.2Introduces self	3 2 1		☐
	1.3 Engages client in conversation	3 2 1		☐
	1.4 Listens actively(both verbally and non-verbally)	3 2 1		☐
	1.5 Is supportive and non-judgmental	3 2 1		☐
2. Gathering information	2.1 Uses appropriate balance of open and closed questions	3 2 1		☐
	2.2 Uses silence well to allow for self-expression	3 2 1		☐
	2.3 Seeks clarification about information given	3 2 1		☐
	2.4 Avoids premature conclusions	3 2 1		☐
	2.5 Probes appropriately	3 2 1		☐

	2.6 Summarizes main issues discussed	3 2 1		☐
3.Giving information	Gives information in clear and simple terms	3 2 1		☐
	Gives client time to absorb information and to respond	3 2 1		☐
	Has up-to-date knowledge about HIV	3 2 1		☐
	Repeats and reinforces important information	3 2 1		☐
	Checks for understanding /misunderstanding	3 2 1		☐
	Summarizes main issues	3 2 1		☐
4.Handling special circumstances	Accommodates language difficulty	3 2 1		☐
	Talks about sensitive issues plainly and appropriately to the culture	3 2 1		☐
	Prioritizes issues to cope with limited time in short contacts	3 2 1		☐
	Uses silences well to deal with difficult emotions	3 2 1		☐
	Is innovative in overcoming constraints (e.g. space for privacy)	3 2 1		☐

	Manages client's distress	3 2 1		☐
	Flexible in involving partner or significant other	3 2 1		☐

TOOL FOR EVALUATING PRE-TEST COUNSELLING

Content based elements

During the session have the following occurred?

	Yes	**No**	**For office use only**
5.Reason for attending discussed			☐
6.Knowledge about HIV and modes of transmission explored			☐
7.Misconceptions corrected			☐
8.Assessment of personal risk profile carried out			☐
9.Information concerning the HIV test given(e.g. process of testing, meaning of possible test results, window period)			☐
10.Understanding checked for			☐
11.Discussion of meaning of HIV-positive and HIV-negative results and possible implications			☐
12.Capacity to cope with HIV-positive result			☐
13.Discussion of potential needs and available support			☐

14.Discussion of a personal risk-reduction plan			☐
15.Time allowed to think through issues			☐
16.Informed consent/dissent given freely			☐
17.Follow-up arrangements discussed			☐
18.Adequate time for questions and clarifications			☐

TOOL FOR EVALUATING POST-TEST COUNSELLING

During the session have the following occurred?

	Yes	**No**	**For office use only**
19.Results given simply and clearly			☐
20.Time allowed for the result to sink in			☐
21.Checking for understanding			☐
22.Discussion of the meaning of the result for the client			☐
23.Discussion of the personal, family and social implications including who, if any, to tell			☐
24.Discussion of a personal risk-reduction plan			☐
25.Dealing with immediate emotional reactions			☐
26.Checking availability of adequate immediate support			☐

27.Discussion of follow-up care and support			☐
28.Options and resources identified			☐
29.Immediate plans, intentions and actions reviewed			☐
30.Follow-up plans discussed and referrals where necessary			☐

TOOL FOR EVALUATING WHERE HIV TESTING IS NOT AVAILABLE

During the session have the following occurred?

	Yes	**No**	**For office use only**
31. Symptoms and course of illness reviewed and discussed			☐
32. Investigations and treatments reviewed and discussed			☐
33. Possibility/certainty of HIV-related diagnosis based on clinical presentation			☐
34. Review of knowledge about HIV including transmission and prevention			☐
35. Misconceptions corrected and information given			☐
36. Personal risk assessment carried out, with respect to sexual and drug-injecting behaviour, and history of blood contact			☐
37. Further discussion of possibility/certainty of HIV-related diagnosis			☐

combining risk profile, symptoms and clinical state			
38. Time allowed for news to sink in			☐
39. Understanding checked for			☐
40. Discussion of the meaning of the diagnosis for the client			☐
41. Discussion of a personal risk-reduction plan			☐
42. Discussion of the personal, family and social implications of the diagnosis for the client			☐
43. Dealing with emotional reactions			☐
44. Checking availability of adequate immediate support			☐
45. Discussion of follow-up care and support			☐
46. Options and resources identified			☐
47. Immediate plans, intentions and actions reviewed			☐
48. Follow-up plans discussed and referrals where necessary			☐

TOOL FOR EVALUATING COUNSELLING CONTENT FOR TBPT

Have the following questions about TB and TB treatment been covered?

		Yes	**No**	**For office use only**
49. Questions for TB screening (symptoms explored)	Cough			☐
	Productive			☐

	Fever			☐
	Weight loss			☐
	Family contact with TB			☐
50.Contraindications and cautions to TBPT discussed	Drug reactions			☐
	Other medicines being taken			☐
	Pregnancy			☐
	Past history of TB			☐
	Past history of TB medication			☐
51. Explanation of TBPT adequately given including	The regimen explained			☐
	The need to take medicines continually according to the regimen and the dangers of taking TBPT erratically			☐
	The possible side-effects and when to seek medical help			☐
	Understanding checked for			☐

TOOL FOR EVALUATING COUNSELLING CONTENT FOR MTCT INTERVENTIONS

In the counselling session have the following occurred?

		Yes	**No**	**For office use only**
52. In early pregnancy:	Client's views on pregnancy explored			☐

Have the following areas been adequately covered?	Full information about HIV in pregnancy and the risk of transmission to the infant given			☐
	Possible benefits of knowing her status and interventions available if the result is positive (including making it clear that ARV therapy cannot be given to women whose status is not known)			☐
	Implications of a HIV-positive result for her baby			☐
	Implications of a HIV-positive result for future children			☐
	Implications of a HIV-positive result for decisions about infant feeding			☐
	Implications of a HIV-positive result for her relationship with the baby's father			☐
	Discussions around the benefits of testing together with her partner/ her baby's father			☐
	Implications and benefits of sharing a HIV-positive result with her partner/her baby's father			☐
	Explaining that testing is not mandatory and that she will not be denied access to antenatal care or other services if she chooses not to be tested			☐
	Options for termination of pregnancy (TOP) (if available legally and safely)			☐

TOOL FOR EVALUATING POST-TEST COUNSELLING FOR HIV-POSITIVE WOMEN ATTENDING MARTENITY SERVICES

In addition to the general issues that should be covered in posttest counselling, counselling for pregnant women who are HIV seropositive should include:

	Yes	No	For office use only
53. Information on ARVs, if available			☐
54. Information on infant feeding options and the benefits and risks of breastfeeding			☐
55. Information on family planning			☐
56. Information about treatment, care and support services available and referral			☐
57. Discussion of potential benefits and risks of sharing information about their HIV status with partner, family			☐
58. Information about safer sex and using condoms to prevent transmission of HIV and STIs			☐
59. Information about care of the child (including nutritional advice and seeking early treatment for illnesses)			☐
60. Planning for the future (including emotional, spiritual and legal support)			☐
61. Options for referral if required			☐

62. Have specific questions about MTCT and ARV treatment been covered?

	Yes	No	For office use only
Previous ARV use			☐
Not a cure			☐

Need to attend maternity services			☐
Need to take ARVs as prescribed			☐
Contraindications and cautions to current regimes discussed; Drug reactions Other medicines being taken			☐

63. Explanation of current therapy regimes (e. g. FDC = TDF, FTC/3TC, EFV and AZT) for prevention of MTCT adequately given including:

	Yes	**No**	**For office use only**
The regimen explained			☐
The need to take medicines continually according to the regimen and the dangers of taking the regime erratically			☐
The possible side-effects and when to seek medical help			☐
Understanding checked for			☐

TOOL FOR EVALUATING POST-TEST COUNSELLING FOR HIV-NEGATIVE WOMEN ATTENDING MARTENITY SERVICES

	Yes	**No**	**For office use only**
64. Information about safer sex and using condoms to prevent infection (especially during pregnancy and breastfeeding)			☐
Explain about discordancy			☐

……END……

ANNEXURE 9

HIV COUNSELLING SKILLS TRAINING PROGRAMME

The development and evaluation of an HIV counselling skills programme for HIV counsellors in public healthcare settings in the Mangaung Metropolitan Municipality

Training manual (shortened version): Counselling skills

Investigator/Trainer: Lerato Mmusi-Makhele

Contents

Participants and training period
The training is over a period of five consecutive days and participants are expected to be present for all five days. Participants are requested to be available from 07h30-16h00 each day of the training.

Format of training
The facilitator(s) will use a variety of training methods, presented in both individual and group work such as:

- Formal presentations (computer based such as PowerPoint)
- Assessment tools
- Case studies
- Questioning
- Videos
- Discussions
- Role playing
- Mock counselling sessions
- Reflection and summarising
- Journaling

DAY 1

1. **Review of training objectives, expectations, goals and ground rules**

Objectives

- To establish clear expectations of what should be accomplished in the training
- To establish expectations for participants' behaviour during the training

Steps

Activity 1

Goals and objectives

MAIN GOAL: Though the medium of counselling the goal of this intervention is to integrate knowledge, skills and competencies into HCT services in order to:

Determine the purpose and goals in lending direction I the HIV counselling session/process

Assist HIV counsellors to identify and display appropriate knowledge, attitudes and skill sets in order to assist patients/patients in reaching their goals and in achieving change

Use broad range evidence-based interventions and be flexible in using these interventions

Have continuous acknowledgement and correction of professional errors

Evaluate the counselling process continuously

Assist patients/patients transfer gains and prevent relapse at post-treatment

Assist patients/patients in drawing on internal and external sources of support resources

THEMES

Self-appraisal and self-evaluation

Structuring counselling session/process

Building counselling relationship

Applying coherent conceptual counselling map

Using counselling techniques

Self-correction and counsellor evaluation

Surmounting counselling obstacles and overcoming barriers

Leveraging opportunities and working with possibilities

Managing special circumstances

Working in multi-disciplinary systems

Consulting other sources

Terminating counselling

Steps

Activity 2

- Hand out the rules sheet

Ground Rules

Many factors will contribute to success of the training. The facilitator(s) will strive towards creating a positive learning experience and exchanging environment by adhering to specific aspects of group interaction.

Respect one another

Respecting each participant is important. Show respect to one another by remembering and using fellow participants' names, encouraging them to contribute to discussions, and requesting feedback. Wait your turn to speak, do not interrupt and give each other a chance to speak and participate.

Be time conscious

Use the time allocated for each activity wisely and respectfully. These include the breaks for rest and refreshments, which will be scheduled and provided.

Challenge yourself to share but do not feel compelled or pressured

Although it is normal to feel nervous, anxious or uncomfortable in new and unfamiliar situations with unfamiliar faces, try to share your own experiences. This could include situations in which you were and were not successful. Such an engagement can increase your motivation and learning ability.

Be mindful of your interaction with others

Be constructive in your engagements and feedback with others to reassure other participants that their remarks are acceptable and appropriate. This may encourage overall group participation.

Engage fully in assessments, reflections and in-between sessions work

There will be time the beginning and end of each day to allow participants to share their learning insights and their assessment of what did and did not go well for them, that day. This assessment will enable adjustments, if needs be, in the agenda and give the participants the opportunity to comment on the way the training coursed is progressing.

The training curriculum is set and final

The curriculum is based on the data fathered during the baseline investigations (February-July 2015) conducted at all three research sites. There will be no adjustments to the curriculum. All-important content will be covered and sufficient time allowed for discussions, questions, etc. without compromising the quality of the training.

Theoretical and practical

Set objectives for each content aspects and chapters will be covered each day as set out in the programme. In the event of lack of time, the facilitator(s) might ask the participants to review some of the material in the text that evening or might note the topics that are problematic to follow-up.

Evaluations

End of workshop evaluations will be administered at the end of the training period as swell as a few weeks or months post the workshop, as part of the research study.

2. What is counselling?

Objectives

- To define counselling within the context of HIV

Steps

Activity 3

Counselling

Counselling is an interpersonal, dynamic communication process between patient and counsellor. This interaction tries to address and resolve personal, social and psychological distress and challenges that are affecting the individual, their significant others and society. In HIV counselling, counselling aims to prepare the patient and explore the patients' HIV knowledge, attitude and readiness to undergo an HIV test (pretest counselling). In post HIV test counselling the focus is on communication of results and discussing and evaluating the implication of the test outcome and planning around identifying ways of coping and resource mobilization. In the case of HIV negative results, exploring skills and behaviours around 'staying HIV negative', is the main objective.

Patients' needs: From diagnosis to acceptance

Initial phase
Shock, denial, anger, crying, numbness, etc.
Lasts hours to a week

What to do as a counsellor: Contain the situation. This phase requires time

Reality phase
The reality of being HIV positive
Life threatening
Social aspects such as stigma

What to do as counsellor: Provide information and bring in support. Consider ethics

Remembering phase
Who infected me?

What to do as counsellor: Help patient establish why they want find out and Assess level of responsibility towards sexual partners (past and present)

Rebuilding phase
Acceptance

What to do as counsellor: Teach and enhance coping skills

3. What are basic counselling skills and theories that govern them?

Objectives

- Patient-centred counselling, Motivational interviewing, Solution focused counselling, Information-based counselling

Steps

Activity 4

- Hand out 'Major theories in HIV Counselling' sheet

4. The helping process: Scope of practice HCT Counsellors vs. Registered Counsellor/Psychologist

Objectives

- Define and discuss the different scope of practice amongst the different counsellor categories

Steps

Activity 5

5. **The helping relationship: Who are you as the counsellor?**

Objectives

- To define the role and qualities of a counsellor

Steps

Activity 6

- Reflection work at home

Counsellor characteristics activity
List and explain five personal qualities you need, to become an effective counsellor?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

DAY 2

Review Day 1 Activity 6

Objectives

- To define the qualities, I bring to the counselling process and my role as a counsellor

Steps

- Hand out 'Counsellor characteristics' sheet

Counsellor characteristics'

The following terms are used in the literature to describe effective counsellor characteristics;

Patience: You need to be patient and give the patient time to express their needs before continuing with the process. Clarify and ask questions if you do not understand. Do not just assume
Good listening: Having a conversation that will effectively communicate to the patient your availability is essential. Being able to listen and hear messages that are not even said.
Observant: The key is also to interpret non-verbal behaviours and be able to explore what you observe form the patient
Warm: Showing acceptance, concern, understanding and genuineness communicate your warmth.
Knowledgeable: Your knowledge on counselling related subject matters should be relevant, current and evidence-based.
Having empathy: Put yourself in your patients' shoes
Maintaining counselling relationship with patient: Set boundaries and allow the patient to make their own decisions. Do not direct their choices, allow them chance to explore options.
Confidentiality: maintain information the patient shares with you a confidential manner
Personal Integrity: Maintain a level of personal integrity with patient and model behaviour that is appropriate.

6. **Facilitating counselling outcomes: Establishing a counselling alliance and building rapport**
   : Showing attention, interest and empathy
   : Paraphrasing and reflecting feelings
   : Summarising

Objectives

- To define the counselling skills required to establish a relationship with patient
- Using listening skills and how to ask questions
- Learn to express empathy, reflect and summarise the patients' feelings and situation

Steps

- Hand out 'Counselling skills' sheet

Oral Presentation
Out of Class Homework: Paraphrasing
Out of Class Homework: Summarising

Counselling skills

Active listening happens when you "listen for meaning". The listener says very little but conveys much interest. The listener only speaks to find out if a statement (or two or twenty) has been correctly heard and understood.

Body language takes into account our facial expressions, angle of our body, proximity of our self to another, placement of arms and legs, and so much more. Notice how much can be expressed by raising and lowering your eyebrows! You need to **monitor the tone of your voice** - in the same way that you monitor your body language. Remember, the person may not remember what was said, but they will remember how you made them feel!

An **open question** is one that is used in order to gathering lots of information – you ask it with the intent of getting a long answer. A **closed question** is one used to gather specific information - it can normally be answered with either a single word or a short phrase.

Paraphrasing is when you restate what the speaker said. Often different words are used and the listener may be using this to draw attention to a particular concern or aspect. Sometimes paraphrasing is used to clarify.

Summarizing is focusing on the main points of a presentation or conversation in order to highlight them. At the same time, you are giving the "gist", you are checking to see if you are accurate.

Note taking is the practice of writing down pieces of information, often in a shorthand and messy manner. The listener needs to be discreet and not disturb the flow of thought, speech or body language of the speaker.

3 steps of expressing empathy: Step 1: Create a safe and nurturing environment for the patient. This is both literal and figurative. The area should be uncluttered and private. The counsellor should be a calming presence Step 2: Use encouraging behaviours to prompt the counselling patient to share more information about his/her life circumstance. These include non-verbal cues such as open body posture and verbal cues such as "um," "I see," and "tell me more. Step 3: Truly listen to the patient's words and observe non-verbal cues. Every single ounce of attention needs to be focused on the patient. Try to see where the patient is coming from and what s/he is experiencing.

Reflecting on feelings allows the listener to reflect the speaker's experiences and emotional response to those experiences. It links the content and feeling components of what the speaker has said.

Objectives

- To practice skills essential in facilitating counsellors' interaction with the patient

Steps

Role-playing

Activity 7

Active listening Exercise

Speaker - You are to tell the listener all about something frustrating that happened within the last week or so. For example, being stuck in traffic, the neighbour who constantly plays music loud, etc.

Listener - You are not allowed to say anything more than two or three syllables long to keep her/him continuing ie "uh-huh", really!?", "tell me more", etc.

Out of Class Homework

Be very conscious of how well you listen

Steps

Role-playing

Activity 8

Encouraging / Discouraging Body Language Exercise:

Speaker - Talk to the listener about an interesting incident that happened to you over the past few days.

Listener - Systematically go down the SOLERF list, first using the positive BL. And then it's opposite.

For example, while the speaker is talking – the listener can lean a little toward the person – then slump into her/his chair. (Don't worry if you both end up laughing.)

Out of Class Homework

Be very conscious of how you treat people vis-a-vis your body language. Watch the gestures and mannerisms of others and note how it makes you feel?

Steps

Role-playing

Activity 9

Open and Closed Questions Exercise

Listener - Get ready to actively listen and get into your encouraging body language. Ask an OEQ like, "Was there anything particularly interesting that happened within the past few days?" You want them to go on at some length.

Speaker - Talk away! After a few minutes, the listener can try to constrain or redirect conversation by asking a CQ such as "Does this make you feel good or bad?" You are looking for an either/or answer.

Listener, ask another OEQ, followed by a CQ a few minutes later. **Speaker**, be helpful, ok? :)

Out of Class Homework

Be very conscious of asking questions - the kinds you ask and why you do so? Notice how you feel when asked an Open or Closed question?

Role playing (3 scenarios)

Activity 10

Expressing empathy case study 1:
Patient: I am here because my family thinks I need treatment, because I take 6 Adco-dol pills every day. I can barely get up in the morning without taking Adco-dol and I need to take it 3-4 times a day. I started taking it to control the pain I had when I was injured in a serious car accident 3 years ago. I am still having flashbacks of the car accident. It is always the same thing. The other car slams into our car in slow motion, glass flies everywhere, and I look over to see my husband unconscious and bleeding. I am scared because every little thing that happens in my life sends me into a panic. Yesterday, three teenagers ran in front of the taxi I was travelling in to cross the street. Luckily the driver had plenty of time to stop, but my heart was beating so fast I thought it would burst. The only thing that relieves me of this anxiety and pain is more Adco-dol.

Activity 11

Reflecting on feeling case study 2:
Patient: My life is going pretty well now that I have not used any dagga for a month. I have a new job and I have begun making some friends at work. Things with my wife are going much better and she seems happier and more trusting in me, especially after I got the new job. I am tired much of the time because I still am not sleeping very well. I think if I smoked just a little dagga at bedtime, it would help me sleep. However, I am fearful that if I started smoking dagga again, it could ruin all the progress I have made. I'm not sure what to do. I really need to get a good night's sleep.

Activity 12

Summarising case study 3:
Patient: My wife complains constantly that I haven't been a good husband because I don't make enough money and I spend money on alcohol. My children are always misbehaving and they talk back at me, even the youngest who is only eight years old. Furthermore, they always refuse to do their chores. They seem to take, and take, and take – and to never be satisfied or appreciative. Today I was very angry with my wife and children and I left the house and went to the tavern and drank all afternoon; afterwards, I felt guilty and started blaming myself. This situation must be my fault. If I had been a better husband and father, things would be better. If I didn't have all the stress and fighting I wouldn't need to use alcohol

7. Facilitating counselling outcomes:
Planning your counselling with your patient
Self-disclosure, self-correction and self-evaluation
Managing resistance and surmounting obstacles
Facilitating problem-solving
Coaching, modelling and rehearsing
Improving patients' self-talk

Reviewing patients' assumptions and improving patients' perceptions
Negotiating homework

Objectives

- To establish and practice advanced skills in counselling

Steps

Oral presentation
Ability to manage yourself in your work
Note about your patients/patients

Steps

Role-playing
Activity 13: Case study 1
Abigail came to see you for a follow up after testing HIV negative she is however worried about being in the window period and does not know whether to break up with her boyfriend since he admitted to cheating. You recently had a cousin with a similar situation who tested HIV positive. Would you share this information with Abigail? And how would you address this? Abigail suddenly breaks out crying and express feelings of anger and tells you in a rage that she does not feel like coming to the sessions anymore as she feels talking does not help her. She comes down and informs you she has had sex with another guy while drunk and she thinks they did not use condoms.

Role-playing
Activity 14: Case study 2: from the group

Role-playing
Activity 15: Case study 3: from the group

Key points for discussion
Seeking collateral information
Counsellors' self-disclosure: when is it appropriate to use personal information/examples
Counsellor's self-correction by requesting patients to evaluate their interaction
Using listening and appropriate basic skills and asking the right questions
Exploring external resources
Investigating patients' readiness for change
Being able to extract patients' internal resources
Focus on the solution not the problem
Use reflection to encourage homework in between sessions
Coaching, modelling and rehearsing
Improving patients' self-talk and reviewing patients' assumptions
Improving patients' perceptions

Day 3

8. Evaluating counselling outcomes: Monitoring and sequencing
Offering challenges, leveraging opportunities and feedback
The middle sessions
Managing special situations: Couples and family counselling
Multicultural and gender-aware counselling
Ethical issues
Professional support, supervision and consulting other sources

Objectives

- To build on counselling skills by learning to deal with challenging situations in counselling

Steps

Oral presentation

Activity 16: Case study 1/Role play: Ethics, Support, Counselling children and Gender aware counselling

A 14-year-old teenage boy named Thabo, who was prenatally infected with HIV shares with you he is using and selling 'nyaope' (a mixture of recreational drugs and ARVs) and he is engaging in risky sexual behaviour with other boys. He also reports he has not been taking his ARVs properly and he does not care what happens to him. One of his friends' Vusi, comes by a week later and tells you he has tested HIV positive at another clinic and Thabo told him you helped him before to deal with his status and he would like you to help. Vusi also reveals he has had sex with Thabo.

Activity 17: Case study 2/Role play: Ethics and consulting other sources

One of your patients who is on ART and has no income is unable to make ends meet with her food selling business. She tells you she has been going around the offices at the government departments pretending to sell food and wait for people to leave their belongings unattended and steals them. One of your cousins' laptop and purse has been stolen at her place of work and that is where your patient goes to sell her food.

Activity 18: Case study 3/Role play: Multicultural and couples counselling

Tshivhango sells household goods in your neighbourhood and you and her have become very close. She recently had a child and refused to tell you the fathers' identity. She

now tells you that the child's father is a married man and in Zimbabwe where she comes from if you want to keep another woman's man and make them yours your must have unprotected sex with them, make sure you bleed during sex by using detergent like 'Jik' so that the man can get hooked. She tells you this man is Jake Morafe. Jakes' wife Nono, is your patient and has recently started ART. A week later Nono brings her husband to come test and he is HIV positive and they both want you to give them follow-up couples counselling as they want another child. After the session you receive an 'sms' from Tshivhango saying she just found out she is HIV positive and has just bought rat poison to kill herself.

Activity 19: Case study 4/Role play: Multicultural issues and couples counselling

Abigail came to see you for a follow up after testing HIV negative she is however worried about being in the window period and does not know whether to break up with her boyfriend since he admitted to cheating. You recently had a cousin with a similar situation who tested HIV positive. Would you share this information with Abigail? And how would you address this? Abigail suddenly breaks out crying and express feelings of anger and tells you in a rage that she does not feel like coming to the sessions anymore as she feels talking does not help her. She comes down and informs you she has had sex with another guy while drunk and she thinks they did not use condoms. Abigail follows up and tells you that she feels useless. She believes if she goes through a traditional cleansing ritual it would her situation. She also expresses feeling uncomfortable with it and believes her family is forcing her to do it after she disclosed her situation.

Key points for discussion

Seeking collateral information, consent for adults and children
Counsellors' self-disclosure: when is it appropriate to use personal information and examples
Exploring external resources
Investigating patients' readiness for change
Being able to extract patients' internal resources
Focus on the solution not the problem
Use reflection to encourage homework in between sessions
Dealing with challenging situations

Objectives

- To establish tools you can use to determine, facilitate and evaluate counselling outcomes

Steps

Oral presentation

How do you measure your counselling outcomes?

HCT EVALUATION SESSION SHEET

DATE: _____

NAME:_____
SURNAME:_____
GENDER:_____ID NUMBER:_____
PHYSICAL ADDRESS: _____
CONTACT NUMBER: _____
WHAT MAKES YOU THINK YOU ARE INFECTED WITH HIV/REASON?
_____
SEXUALLY ACTIVE:_____NR OF SEX PARTNERS IN PAST YEAR: _____
AMOUNT OF SEX PARTNERS CURRENTLY: _____

PATIENT SECTION				
Do you know what HIV/AIDS is?	**Yes**		**No**	
Has it been explained to you how the test is done?	**Yes**		**No**	
Have the advantages of the test been explained to you?	**Yes**		**No**	
Have the disadvantages of the test been explained to you?	**Yes**		**No**	
Has it been explained to you how a positive test result will affect your treatment?	**Yes**		**No**	
Do you know what a negative result means?	**Yes**		**No**	
Has the window period been explained?	**Yes**		**No**	
Has it been explained what will happen if you are not tested?	**Yes**		**No**	
Do you want to know the results of the test?	**Yes**		**No**	
Do you consent that your blood be tested for HIV?	**Yes**		**No**	
Do you want the result to be made known to your spouse, partner, relative or a friend	**Yes**		**No**	

COUNSELLOR SECTION **Have you explained to the patient/patient:**				
What HIV/AIDS is?	**Yes**		**No**	
How the test will be done?	**Yes**		**No**	
What a negative result means?	**Yes**		**No**	
What the window period means?	**Yes**		**No**	
What the advantages of testing are?	**Yes**		**No**	
What the disadvantages of testing are?	**Yes**		**No**	
Why the information is needed?	**Yes**		**No**	
How a positive result will affect treatment?	**Yes**		**No**	
What will happen if the test is not done?	**Yes**		**No**	
Have you yourself explained the above?	**Yes**		**No**	
Has a translator been used to explain the above?	**Yes**		**No**	
Did the patient/patient give consent that a spouse, partner, relative or friend can be informed of his/her HIV status?	**Yes**		**No**	

COUNSELLOR:……
PATIENT:…….

DATE:……
DATE:……

Activity 20

- Reflection work at home

Evaluating counselling outcomes
List and explain how you would evaluate your counselling process with patient

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Day 4

9. **Sustaining counselling outcomes**

Terminating counselling
How to refer on if necessary and Referral Systems and working with other systems
Advocating for patients
Supervision and professional support
Self-discovery

Review Day 3 Activity 20

Objectives

- To define important aspects of evaluating a counselling session/process

Steps

- Pre-test, posttest and follow up issues

Objectives

- How to refer on and which systems to use

Steps

- Identify your stakeholders and referral systems

Objectives

- How to refer ask for help form supervisors and support form colleagues
- Advocating for your patients

Steps

Activity 21

- Gratitude exercise- write on board what you are thankful for and what you you're your advocacy can and gives the world

Objectives

- Self-discovery

Steps

- Ask participants to share their personality type, read off and provide information from the personality type information sheets retrieved on https://www.personalitypage.com/html/index.shtml

---

Day 5

10. Self-care: What are basic principles in self-care

Objectives

- To explain and identify 5 Principles of Self-care

Steps

- Provide hand-outs

Oral presentation

1. Rewards: Money coin

We will be known forever by the tracks we leave

2. Recognize the hazards: Magnifying glass/Pin

3. Thoughts: Take care of the mind: Blank cd

Epictetus:
"People are disturbed not by things, but by the views they take of them."

4. Take care of the Body: Bath salts/Body lotion

Activity 22
Relaxation exercise

Breathing exercise: CLOSE YOUR EYES TAKE A DEEP BREATH, VISUALISE THIS BREATH AS CALM, PURE Progressive muscle relaxation

5. Taking care of your feelings: Balloon with paper inside

Activity 23
Soul nurturing exercise

Balloon with piece of value list/3 important things (paper) inside Piece of paper: Identify 3 most nurturing people in your life: put it in the balloon and blow it, write on balloon something negative in your life currently that you need to let go of. Pop balloon and discard it/throw in bin. Keep paper in your purse. Look at it when you are feeling down

ADDITIONAL RESOURCES

Example of CONSENT FORM for HIV counselling and testing

I declare that I agree to receive pretest and posttest HIV counselling provided by HIV counsellors. I also understand that these health care workers who work under the supervision of registered professional nurses and medical staff and they will adhere to professional ethics and a code of conduct according to professional standards set out by the Health Professions Council of South Africa.

Confidentiality
In all cases, the identities of patients/patients and their self-disclosures are handled in a strictly **confidential** manner.

I understand that to provide me with HIV-related psychological services, the Department of Health represented by the healthcare facility/clinic or through community outreach (door-to-door or mobile clinics) will collect some personal information about me (e.g., name, age, address, etc.). I have been informed about the nature, conduct, risks and implications involved in an HIV test. I agree to be contacted by the HIV counsellor or contact the HIV counsellor should a follow-up appointment be deemed necessary, whether I test positive or negative for HIV.

Name: :_____
Address:_____
Gender:_____
Age:_____
Cellphone:_____

Signature: :_____
Place: _____Date:_____

Evaluation of training skills intervention

This questionnaire is anonymous and the information gained from it will be treated as confidential

Please rate the following qualities or statements on a scale of 1-5 and write it in the appropriate block.
(1 = Very satisfied, 2 = Dissatisfied, 3 = Unsure, 4 = Satisfied, 5 = Very satisfied)

Date: _____
Presenter: _____
Title: _____

The presenter was knowledgeable about the topic. ☐

The presenter was warm and friendly. ☐

The presenter made good use of material such as handouts, overheads, etc. ☐

The course was informative and applicable. ☐

The presenter was punctual and professional. ☐

What aspects of counselling skills did you learn and enjoy?

_____
_____
_____
_____
_____

Which part did you not enjoy?

_____
_____
_____
_____
_____

After the training: Can you establish/assess what the client needs from you?

_____
_____
_____
_____
_____

After the training: Do you have skills to facilitate counselling processes?

_____
_____

_____
_____
_____

After the training: Do you have skills to evaluate if your counselling benefited the client?

_____
_____
_____
_____
_____

After the training: How can you ensure your client maintains change in their life?

_____
_____
_____
_____
_____

Any other comments / suggestions:

_____
_____
_____
_____
_____

Letter of English Editing

This letter confirms that the thesis listed below was edited by one or more editors. The following issues were edited: grammar, spelling, punctuation, sentence structure and phrasing.

Thesis title:

THE DESIGN, IMPLEMENTATION AND EVALUATION OF AN HIV COUNSELLING SKILLS PROGRAMME FOR LAY COUNSELLORS

Authors:

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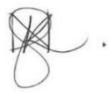
Date issued:

30/11/2020

Certificate number:

Flavia Kigozi



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February 2021

DECLARATION

I, Anneke Denobili, hereby declare that I did the language editing of the thesis of Lerato Mmusi-Makhele titled, *The Design, Implementation and Evaluation of an HIV Counselling Skills Programme for Lay Counsellors,* for submission purposes in fulfilment of the requirements of the degree **PHILOSOPHIAE DOCTOR (Psychology)** in the Department of Psychology, Faculty of the Humanities at the University of the Free State. All the suggested changes, including the implementation thereof, were left to the discretion of the student.

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