

An Analysis of the Content and Social Representations of HIV in Voluntary Counselling and Testing (VCT) Training Manuals in the Gauteng Public Health System

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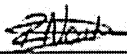
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DECLARATION

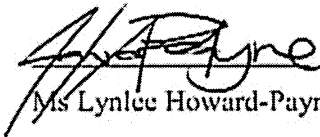
I, Rakhee Naik, declare that this research report is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university. All citations, references and borrowed ideas have been duly acknowledged using the APA format of referencing. Furthermore, I acknowledge and accept that plagiarism is wrong.



Miss Rakhee Naik

15 February 2013

As the candidate's supervisor, I have approved this research project for submission.



Ms Lynlee Howard-Payne
Supervisor

15 February 2013

*“Education is the most powerful weapon which you can use to change
the world.”*

— Nelson Mandela



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ABSTRACT

Voluntary Counselling and Testing (VCT) has been developed as an early and international response to the Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) primarily as a prevention intervention. The training manuals lay the foundation for the implementation of a quality service. However, a poorly-structured training process and the included materials may severely hinder the quality of service provided, enhancing the associated stigma and discrimination. Thus far, no research is available in South Africa regarding the training manuals as a key aspect of training VCT counsellors. Therefore, this research aims to gain a broader and deepened understanding of the content and social representations of HIV in selected VCT training manuals in the Gauteng public health system, through exploration of the content of seven English-based VCT training manuals, developed by both local and international non-governmental and governmental organisations. These VCT training manuals were obtained from local VCT organisations and the internet, which were analysed using a thematic analysis pursuing a social representations theory underpinned by the social constructionist interpretive paradigm. Social representations theory states that images are created through daily discourse assisting in enhanced effective communication. In this way, the impact of social representations of HIV on the way lay individuals think about the virus, the influence of this on how counsellors are trained, and in turn the impact on the service provided, was explored. Five categories representing the content covered in the training manuals were identified, namely: (1) HIV transmission, (2) HIV prevention, (3) risk factors, (4) HIV treatment and (5) counselling. Within these content categories, HIV is socially represented, among others, as: a sexually transmitted infection (STI); an agent of war; punishment for sexual impurity; and a death sentence. The findings indicate that a bio-medical approach to HIV and VCT is primarily emphasised. Such social representations play a continued role in enhancing the associated stigma and discrimination for those infected and affected by HIV/AIDS.

As a result of the ways in which HIV is socially represented, the manuals lack focus with respect to training counsellors in the psychological skills needed in effectively addressing the client's psychological well-being throughout the VCT process. The training manuals also often fail to address contextual concerns, and when doing so, relate to prevalent gender inequalities, which

strengthen the view of the sexual male and subordinate, passive female in sexual relations further entrenching an unequal gendered society.

Overall, the findings speak to a need to reconsider the training manuals used to provide VCT-counsellors with the bio-psychosocial skills training required to equip them in assisting clients presenting for VCT. This research study lays the foundation for a more critical way of thinking regarding VCT and VCT training manuals as providing a quality service and thus impacting the spread of the virus.

Keywords: AIDS; HIV; public health system; social representations theory; training manuals; VCT

ACRONYMS AND INITIALISMS

AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CDC	Center for Disease Control and Prevention
FHI	Family Health International
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
NDoH	National Department of Health
NGO	Non-governmental organisation
OIs	Opportunistic infections
PEPFAR	Presidents Emergency Plan for AIDS Relief
PITC	Provider initiated testing and counselling
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations program on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World health organisation

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CHAPTER 1: INTRODUCTION

1.1. Introduction

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is one of the most prevalent and demanding public health challenges that South Africa is currently facing. According to the Joint United Nations program on HIV/AIDS (UNAIDS), at the end of 2010 approximately “34 million people were living with HIV worldwide”, with adults accounting for over 85% of those infected (The Henry J. Kaiser Family Foundation, 2010; UNAIDS, 2011a, p.6). This represents a 17% increase in world-wide HIV infections over a period of 9 years (UNAIDS, 2011a). More noteworthy, 68% of these infected individuals live in Sub-Saharan Africa, with approximately 5.6 million infected people (over 10%) residing in South Africa (Statistics South Africa, 2011; UNAIDS, 2011a). This accentuates the utmost urgency required by the global community to aid in reducing the spread and impact of the HIV pandemic.

The World Health Organisation (2005, p.2) (WHO) defines a pandemic as the “increased and sustained transmission in general population”. The HIV/AIDS pandemic has produced multiple devastating impacts, severely hindering many aspects of the South African nation; this includes the psychosocial challenges faced by those individuals infected and affected by HIV/AIDS. The psychosocial impact of HIV/AIDS includes the considerable stigmatisation and discrimination experienced by those infected and affected due to the various formulations of meaning attached to these individuals. This psychosocial impact commences with individuals presenting for Voluntary Counselling and Testing (VCT), which may have tremendous psychological implications, regardless of the outcome of the test (testing as HIV positive or negative). VCT services, an early and international response to the large scale challenge, has been developed to respond to the HIV/AIDS crisis primarily as a diagnostic and prevention strategy. VCT, includes a pre - and post-test counselling session and an HIV test (UNAIDS & WHO, 2004). Through this process, it has been envisaged that the counselling aspect of the service, and the psychological approach taken towards clients presenting for VCT, assists in mitigating the impact of the

psychosocial element on individuals. However, those individuals who access the VCT service as well as the VCT counsellors; encounter and experience many difficulties on a daily basis (Angotti, 2010; Bharat & Mahendra, 2007; Kruger, Greeff, Watson, & Fourie, 2009). There is limited research on the challenges and difficulties surrounding the foundation of the VCT service, and the content of VCT training manuals. Furthermore, there is no research available on these training manuals as a key aspect of training VCT counsellors. Therefore, the current study will qualitatively examine seven VCT training manuals, designed primarily for an adult population, utilised in the Gauteng region.

1.2. Research Rationale

The severity of the HIV/AIDS pandemic within South Africa warrants urgency for further research into all pandemic related facets - from the bio-psychosocial aspects of HIV/AIDS to the conception and implementation of VCT services among other prevention campaigns. The South African health system is comprised of both private and public health services, with the majority of people living with HIV primarily utilising the latter due to the high financial cost of these services. One of the earliest services offered as an entry point to HIV treatment and care is VCT. This service, and consequently the training manual, as a starting point for anyone being tested, should therefore cater to those who may also be HIV negative, thus, permitting the counsellor to adequately counsel these individuals on how to remain uninfected.

VCT refers to a three-stage client-initiated voluntary and confidential procedure, which aims to educate and support individuals infected and affected by HIV/AIDS (UNAIDS & WHO, 2004). VCT has demonstrated its significance through its focus on secondary prevention, or the possibility of preventing an infected party from infecting another (Hyodo, Tanaka, Kobayashi et al., 2000 as cited in Reproductive Health Matters, 2000). However, according to Swanepoel (2010), VCT campaigns have failed their purpose in efficiently engaging with individuals who practice particularly high-risk sexual behaviours, such as unprotected penetrative vaginal and/or anal intercourse. Although VCT is highly endorsed in many developing nations, such as countries within Africa, this intervention has proven costly (Reproductive Health Matters, 2000). Therefore, implementation within South Africa, an already poverty-stricken nation, is

problematic, without fully considering every aspect of the VCT process. Implementation of a poorly-structured and managed VCT programme may severely hinder the adequate psychological support required by individuals presenting, and may exacerbate the already rampant stigma and discrimination experienced by those infected and affected by HIV/AIDS. As a result, the implementation of an effective and efficient VCT service has been limited and plagued by a multiplicity of factors (Ali, 2009; Kruger et al., 2009; Lalthapersad-Pillay, 2009; Madise, Zulu, & Ciera, 2007; Petros, Airhihenbuwa, Simbayi, Ramlagan, & Brown, 2006; Swanepoel, 2010).

VCT, as a diagnostic and prevention intervention, is located within the public health model and is grounded in the training of people who deliver VCT. The VCT process, ranging from prevention, care and treatment to research, is managed through the establishment of a variety of non-governmental organisations (NGO's) which envisage a reduction in the severity of the HIV/AIDS pandemic (Aids Foundation South Africa, 2010). The public health model follows a largely bio-medical approach, focusing on societal control and prevention as key aspects in addressing disease (Woodside & McClam, 2010). The public health model essentially refers to identifying and defining the problem at hand, allowing the development and implementation of strategies, which take into consideration the social, environmental and biological factors that play a role in disease (Woodside & McClam, 2010). However, HIV/AIDS has implications beyond the bio-medical realm and includes issues, which pertain to psychological and social concerns. A purely bio-medical model treats concerns as primarily medical and autonomous of any related psychosocial factors (Engel, 2004). However, the psychosocial component is a fundamental aspect of any HIV/AIDS intervention, as it plays an important role in furthering understanding of the underlying factors which influence the bio-medical aspects of the virus (Engel, 2004). In this way, a purely bio-medical approach is not representative of the complex nature of diseases excluding the human element from the virus (Engel, 2004). Therefore, the training manuals should have additional information dedicated to the non-biomedical components which may improve the service provided.

In South Africa, VCT training manuals, generated by various national and international NGOs and utilised in the public health care system are in abundance (National Department of Health,

2010). These training manuals are developed as the outcome of various national and international policies, which aim to guide the development and implementation of VCT services (WHO, 2005). The training manuals developed seek to provide VCT counsellors with basic VCT-related knowledge (Family Health International, 2004a). The National Department of Health (NDoH) and various NGO's have produced training manuals, which provide a yardstick for counsellors, with each province accountable for implementation within its region (Kenyon, Heywood, & Conway, 2001). This study aims to analyse selected manuals, developed by both national and international NGO's, which are utilised within the Gauteng public health system.

Some of the training manuals utilised within the Gauteng region include those generated by New Start, UNAIDS, HIVSA, WHO, Right to Care, Family Health International (FHI), the Centre for Disease Control and Prevention (CDC) and Health Systems Trust. Despite increasing access to VCT and VCT-training, the number of training manuals utilised in the South African public health system begs questioning as to the efficacy of each manual, and the similarity and differences of the training received by VCT counsellors. The main aim of the VCT service is to educate individuals and prevent the spread of HIV while providing support to the clients who use the service (NDoH, 2010). Therefore, ideally, the training manuals used for VCT-training should educate counsellors in adequately carrying out these aims. However, literature indicates inadequacy of the VCT service in catering to these main components (Angotti, 2010; Bharat & Mahendra, 2007; MacPhail, Pettifor, Coates, & Rees, 2008; Van Dyk & Van Dyk, 2003). Despite occasionally addressing the two components when training counsellors adequately, VCT services often prioritise the educative-component and neglect the supportive-component of VCT, thus overlooking the emotional needs of the client. There is also a clear lack of studies evaluating the content, quality and adequacy of VCT training manuals. Therefore, the training manuals developed and utilised may be inappropriate and unsuitable in achieving the service's aims, which contribute to reducing the impact and spread of HIV/AIDS in South Africa. Furthermore, education and support are fundamental features in alleviating the current HIV situation.

Through a quality VCT service, it is envisaged that individuals presenting for VCT will benefit medically, through the initiation of treatment, and psychologically, through counselling received. This will assist in generating positive social representations, thus limiting the stigma and

discrimination associated with HIV/AIDS and VCT, and in turn commencing the process towards lessening the current status of the pandemic.

As limited research can be found to this effect, this study aims to begin an exploration into the content and social representations of HIV of the training manuals utilised within the Gauteng region. This study notes the information addressed in the manuals and the information expected to be covered as based on the bio-psychosocial model and subsequently, based on the National Policy Guidelines and literature which address what should ideally be covered in the training manuals, what information has been omitted (Aidsbuzz, 2010; Angotti, 2010; Boswell & Baggaley, 2002; Evian, 2000; Goldberg, 2011; Grant-Stuart, Livingstone, & Mngadi, 2006; National AIDS Control Organisation, 2004; NDoH, 2010; Silverman, 1997; Swanepoel, 2010). Swanepoel (2010) maintains that to efficiently rectify the problem at hand requires a satisfactory prevention, care, support and VCT programme. However, VCT training manuals, as tools for prevention and behaviour change, are not designed for psychological purposes where the mental health or psychological distress experienced by the individual is often neglected.

The current study encompasses both theoretical and practical implications. The focus of the training manuals suggests inadequate attention to addressing the psychosocial issues. It is therefore necessary to examine the training manuals pursuing the social representations theory with the aim of increasing the focus on the psychological issues surrounding HIV and VCT. The knowledge gained from this study is intended to increase awareness regarding the drawbacks of the manuals and to aid in the improvement of the training provided to VCT counsellors, if required.

It is envisaged that suggesting improvements to the content of the VCT training manuals, will aid in addressing (and ultimately eradicating) the challenges experienced by both counsellors and people living with HIV. This, subsequently, may shed some insight into the current HIV/AIDS policy and VCT procedure, which would assist NGO's in increasing the proficiency of the services provided at VCT centres. It is anticipated that this will alleviate the dire situation regarding HIV/AIDS as it currently stands. Previous research indicates the unsatisfactory link between the policies and implementation of these policies through the training manuals and

challenges experienced (Bharat & Mahendra, 2007; Goldberg, 2011; Mphaya, Roos, & Ehlers, 2008; National Planning Commission, 2011; Olley, Zeier, Seedat, & Stein, 2005; UNAIDS, 2009; Kipp et al., 2001 as cited in Van Dyk & Van Dyk, 2003). It is therefore vital to understand if the challenges experienced in relation to VCT lie in the implementation of these policies. An analysis of the content and social representations of HIV in VCT training manuals in the Gauteng public health system would make an important contribution to understanding this issue.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The following chapter locates the current study in literature and previous studies conducted around HIV/AIDS and VCT. An overview of the pandemic and the need for VCT is presented as a precursor to an account of the VCT process. As the VCT counsellors are the users of the training manuals being analysed in this study, and given that the counsellor is a vital component to any VCT process, the role of the VCT counsellor will be discussed, as well as the training undertaken in this capacity. The VCT training manual will be discussed with regards to the type of content that the manuals should ideally contain in considering the value of the bio-psychosocial approach to the VCT process. Lastly, the theoretical perspective of social representations theory and its role in how information regarding HIV/AIDS is represented and exchanged is described. It is argued that HIV is socially represented in ways that promote stigma and discrimination furthering those issues that hinder successful implementation of VCT.

2.2. Overview of the Pandemic

The HIV/AIDS pandemic is a major global concern; with South Africa being one of the most infected and affected nations (Ali, 2009; Avert, March 2011; Statistics South Africa, 2011; UNAIDS, 2011a). HIV/AIDS has multiple implications at various levels of society, severely hindering a healthy and stable nation. A national response to the high prevalence rates of HIV/AIDS within the country has led to the development of VCT, a key prevention strategy (Republic of South Africa, 2010).

Recently, the term VCT, a term used by the NDoH, has been replaced by HIV Counselling and Testing (HCT). Research in the public health sector commonly aligns its terminology to that of the NDoH and is therefore, typical in its application. The main difference between VCT and HCT is the voluntary nature surrounding the testing procedure, with HCT referring to a broader setting, utilising a variety of interventions, with a recent focus on providers initiating the

counselling and testing process (WHO, 2005). The HIV/AIDS field is currently at a juncture with the change of terminology, resulting in much of the available literature referring to VCT rather than HCT. Further, the manuals utilised for analysis in the current study were written when this process was still referred to as VCT. Therefore, for the purposes of this study, the term VCT will be employed, due to the focus on VCT training manuals in particular.

The National Planning Commission (2011) identifies and acknowledges the significance of social determinants of risk factors in contributing to the increase of HIV/AIDS infection. These social determinants include individuals' daily living conditions and the structural inequality, which perpetuates the social determinants of risk (National Planning Commission, 2011).

Given the widespread nature of the factors contributing to HIV-risk, scaling-up universal access to HIV/AIDS prevention, care and treatment is vital (UNAIDS, 2009). However, deterioration in the level of knowledge surrounding HIV/AIDS within the population, and the management of the health system being vulnerable to opposing factors, such as a shortage of skilled staff, make it challenging to scale-up access to VCT (UNAIDS, 2009).

Despite the various obstacles to containing the spread of the HI virus, some factors regarding the containment of the virus have been addressed. The public health model, with its emphasis on the control and prevention of pandemics in the interest of the public's health, highlights the importance of societal risk factors in containing the pandemic (National Planning Commission, 2011). However, societal risk factors such as poverty are more challenging to control and overcome compared to individual risk factors, such as increased condom usage. An increase in the number of individuals being tested for HIV, the development and progress of provider-initiated counselling and testing, the establishment of the male circumcision programme and enhanced levels of political leadership are societal factors which have been addressed to some degree in assisting to contain the HI virus (Republic of South Africa, 2012). Further, a decrease in unsafe sexual practices such as the increase in the use of condoms, particularly among the youth, has resulted in a decline in the number of new infections (National Planning Commission, 2011; UNAIDS, 2012). However, the lack of knowledge regarding condoms and the use of condoms severely hinder behaviour change practices, particularly for females, in a number of

high prevalence countries (UNAIDS, 2012). Therefore, an increase in knowledge and promotion of condom use in HIV and VCT campaigns is a vital component in establishing a sustainable culture of condom usage.

On the other hand, the increased availability and accessibility of ARVs for those infected have significantly contributed to an improved quality of life (National Planning Commission, 2011; UNAIDS, 2012). This has resulted from the decrease in the cost of treatment and the increased availability to ARVs in turn lessening the associated stigma and discrimination and a greater awareness of safer sexual practices. Further, the augmented collaboration between HIV and TB programmes has resulted in a decline in “TB-related deaths among people living with HIV” worldwide and an increase in the number of individuals being tested for HIV (UNAIDS, 2012, p.58). Therefore, with an increased availability of ARVs, there is a lessened likelihood of HIV positive individuals acquiring TB (UNAIDS, 2012). These achievements, although not exclusive, have demonstrated the ability to feasibly reduce the number of new infections by addressing societal and individual risk factors. This assists in lessening the impact of the virus at all levels of society, affording some hope regarding the possibility of lessening the severity of the pandemic.

A key aim of the National Strategic Plan is “to create a social environment that encourages more people to test voluntarily for HIV and, when necessary, to seek and receive medical treatment and social support” (Republic of South Africa, 2010, p.30). Although not necessarily indicating an increase in the uptake of VCT, some success has been offered with available VCT services provided in public health facilities expanding to over 90% (UNAIDS, 2009). Public health facilities, within the South African context, are classified according to the services provided (Health Systems Trust, 2012). VCT is offered in a number of public health facilities; these include: hospitals, clinics, non-profit organisations such as New Start and Right to Care, private hospitals and laboratories, mobile VCT centres and corporate companies offering the VCT service to their employees (Aidsbuzz, n.d.). Hospitals, clinics and non-profit organisations provide counselling and testing to those presenting for VCT, with the majority of these facilities providing the service for free (Aidsbuzz, n.d.). This is to encourage individuals to test for HIV thus working towards lessening the pandemic. Similarly, corporate companies also provide free HIV testing to their employees (Aidsbuzz, n.d.). On the other hand, private hospitals and

laboratories provide the VCT service primarily based on the doctors referral (Aidsbuzz, n.d.). Individuals getting tested through a private hospital or laboratory pay for the service whereby the referring doctor performs and manages the pre- and post-test counselling (Aidsbuzz, n.d.). On the other hand, mobile VCT facilities aim to expand access to VCT in deprived or under-served communities thus providing access to the large number of individuals with limited access to a VCT facility (Aidsbuzz, n.d.). These facilities aim to provide the VCT service to the South African community thus aiming to be accessible to individuals from all socio-economic backgrounds. Therefore, through training of VCT counsellors, the objectives stipulated in various national policies enable the establishment of the service, furthering the aims of policies to motivate the uptake of VCT.

2.3 The Need for VCT

The high HIV/AIDS prevalence-rate in South Africa, in combination with the various benefits that may be experienced when presenting for VCT, results in an insistent need for an effective VCT service. VCT provides various bio-psychosocial benefits, which will be discussed in further detail in the following section. The benefits gained from presenting for VCT, influence the perceived efficacy of the service by those presenting for VCT. The efficacy and benefits of the service, however; are largely a result of VCT policy at a national and international level. The following section will discuss the need for VCT in a South African context.

2.3.1. Benefits of VCT

Despite the abundance of literature on the challenges of VCT, there are many advantages and benefits in presenting for VCT, and knowing one's HIV status. VCT helps in acknowledgement of the individual's sero-status, encourages early management of the virus and associated problems, assists in referral to appropriate services required, lessens the stigma the person feels towards HIV/AIDS and VCT, and develops the individual's knowledge, allowing for preparation for the future (such as the reality of death and his/her families future) (FHI, 2003). Further, knowledge of one's HIV-status will enable behaviour change. Previous research indicates that

education and knowledge assists in providing an increased understanding of the risk factors to HIV infection (Rindermann & Meisenberg, 2009). In this way, individuals who are more educated are more likely to understand their behaviour and the associated consequences therefore being able to make better informed decisions regarding their behaviour. In this way the individual is able to decrease their risky sexual activities in the future so as to prevent infection if testing, or avoid infecting others if testing positive (Aidsbuzz, 2010). Despite increased knowledge reducing the level of risk an individual may have, multiple strategies collectively function towards decreasing an individuals' level of HIV risk such as the lessening of stigma and the changing of attitudes (Coates, Richter, & Caceres, 2008).

The fear of being stigmatised and discriminated against presents a considerable challenge for presenting individuals from the beginning of the VCT process (Goldberg, 2011). The above mentioned benefits of presenting for VCT aims to deter many of the individual's fears, facilitating a positive thought process. However, through pre- and post-test counselling, the presenting individual is provided with knowledge and the necessary skills to adequately comprehend, cope and manage their HIV status. When a presenting individual tests positive for HIV, VCT allows the opportunity for the presenting individual to evaluate their level of risk and establish realistic strategies in modifying their behaviour and developing realistic and practical goals to ensure progression to a stable and positive mental and physical state (Swanepoel, 2010). Furthermore, individuals testing positive for HIV are able to be referred to other available resources to assist them physically and psychologically in turn allowing them an opportunity to adequately plan their future (Swanepoel, 2010). In this way, knowing one's positive status may relieve anxiety as individuals are able to obtain the necessary information and plan accordingly. On the other hand, individuals testing negative may also reduce any psychological distress they may have been experiencing through increasing their knowledge thus being better informed of risky practices that place them at risk for HIV (Swanepoel, 2010). However, a range of contextual and personal factors may influence an individual's willingness to present for VCT such as accessibility to a VCT centre and stigma among others. According to Swanepoel (2010), an individuals' intention to receive an HIV test, which is primarily based on their beliefs, is the strongest indicator for individuals presenting for VCT. Therefore, it is vital for VCT campaigns to explore and appeal to an individual's beliefs regarding HIV and VCT.

The multiple contextual and personal barriers and the associated implications surrounding one's HIV status such as violence and disclosure to family, friends and one's sexual partner highly influences an individual's willingness to present for VCT. Therefore, encouraging sexual partners to present oneself for VCT is vital in reducing the individuals and couples anxieties. Research indicates that couples presenting for VCT are more likely to modify their risky behaviour preventing transmission of HIV from one partner to another or preventing new infections (Glick, 2005; MacPhail et al., 2008). Research findings reiterate this point indicating that couples presenting for VCT have shown to transcend through concerns of disclosure to one's partner and any related fears thus reinforcing trust in one's sexual relationships (Macphail et al., 2008). In this way, knowing one's HIV status relieves anxiety, and reinforces trust in sexual relationships (Mabunda, 2006).

Through widespread and significant gender inequalities, females are socially at increased risk of contracting HIV contributing both directly and indirectly to their vulnerability to HIV (Lalthapersad-Pillay, 2009). Females are more likely than males to be uneducated due to their traditional cultural and social roles where it is expected that they will provide care to their family (Lalthapersad-Pillay, 2009). In this way, females are more likely to leave school to ensure that their traditional roles are fulfilled (Lalthapersad-Pillay, 2009). However, this lack of education increases their vulnerability to a host of concerns, one being increased risk to HIV. Uneducated females are less likely to understand the risks involved in their behaviour, particularly those contributing to HIV risk, such as engaging in transactional sex, and are less likely to be aware of ways to protect themselves limiting their ability to negotiate safer sexual practices (Lalthapersad-Pillay, 2009). Further, their perceived subordination to males subject them to power imbalances further contributing to their limited negotiating power which may result in violence and abuse, particularly when a strong belief in female inferiority is present (Lalthapersad-Pillay, 2009).

The traditional care-giver role assumed of female's limits their ability to obtaining further education thus placing them at increased risk for economic inequality with their male counterparts, making them increasingly dependent on others (Lalthapersad-Pillay, 2009). However, the VCT process, through providing education and information on HIV/AIDS

promotes safer sexual practices and the ability to reduce the prevalent gender inequalities through providing an increased power balance with male partners thus reducing the spread of the virus. Furthermore, through weakening the power imbalances prevalent, females who receive an education are more likely to be economically empowered thus increasing their independence, lessening their likelihood of engaging in transactional sex and reducing the spread of the virus (Lalthapersad-Pillay, 2009). Therefore, VCT has the ability to equalise and empower men and woman, thus moving towards the eradication of gender inequalities (Lalthapersad-Pillay, 2009). However, the cycle of poverty limits the opportunities to receiving an education (Lalthapersad-Pillay, 2009). Therefore, it is vital for VCT campaigns to prioritise providing information to females regarding HIV/AIDS and the contributing social factors. While not all benefits are discussed here, the benefits of VCT are manifold and diverse, having many implications for lessening the impact of the HIV/AIDS pandemic.

2.3.2. Limitations to VCT

There is an abundance of literature around the various challenges and limitations to the VCT process that hinder the uptake of VCT in South Africa. The challenges and limitations present include both client and service related factors. These factors are discussed throughout the current chapter in further detail and will therefore only be briefly discussed below.

The client related factors limiting the uptake of VCT include: the limited knowledge and high levels of illiteracy in the country, the negative attitudes towards HIV and VCT, poverty and the related contextual barriers, the psychological trauma attached to the VCT process and the impact of disclosure of one's HIV positive status to family and friends which may lead to stigma and discrimination of the infected individual and those closest to them.

Knowledge, a key factor in assisting understanding of HIV related aspects is a vital component in the uptake of VCT. However, historical racial inequalities influencing the quality of education received severely thwarted the literacy levels within the country. This not only hinders uptake to VCT but also the likelihood of individuals comprehending the implications of practicing risky

behaviour's. The lack of knowledge and understanding, in combination with people's negative views and attitudes on HIV limits positive behaviour change and the uptake to VCT.

A second client related barrier to the uptake of VCT is poverty. Poverty is considered to be one of the major limitations and challenges to the uptake of VCT. Poverty-stricken individuals are more likely to experience contextual and environmental barriers such as having limited access to the necessary requirements to present for VCT and support themselves economically if testing positive (Swanepoel, 2010). Further, these individuals often have limited access to transport and finances to obtain quality health care. Therefore, if testing positive, these individuals often do not have the resources to obtain adequate treatment and other necessary services they may require.

The VCT process can also be psychologically distressing, particularly when testing positive (Goldberg, 2011). Therefore, the anxiety and fear often felt hinders uptake to VCT so as to avoid knowing and having to deal with the consequences such as the stigma and discrimination associated with HIV/AIDS. Despite the counselling component of the VCT process available to assist individuals overcome their anxieties, many individuals do not present for VCT thus impeding the benefits they may have gained. In addition to the psychological distress experienced, the associated stigma and discrimination often obstruct individuals from disclosing their status in turn limiting the support they receive from family and friends. This is exacerbated by the negative social representations of HIV (discussed later in the chapter) which contribute to the stigma and discrimination of HIV, frequently resulting in violent and non-violent abuse, particularly against females.

Over and above the client related barriers, service related factors may also limit the uptake of VCT. The limited accessibility and availability of VCT centres and follow-up care, including treatment and support, particularly for those individuals who are poverty stricken, limit the uptake to VCT. In addition, the psychological skills taught to counsellors who have not received more in depth training in counselling, limit their ability to implement the skills learnt in turn decreasing the quality of the service and limiting the uptake to VCT. Previous literature indicates that ethical dilemmas whereby counsellors believe that by not disclosing an individual's status to family or friends in the community could place others at risk, may find discontent with

confidentiality requirements (Angotti, 2010). Further, the daily challenges experienced by counsellors including long hours, a lack of staff and the psychological impact on the counsellor result in the diminished quality of the VCT process (Angotti, 2010). This hinders uptake of VCT as individuals often feel increasingly intimidated by the process thus opting to not present for VCT. The above-mentioned factors which include the availability and accessibility of VCT centres, the ethical dilemmas experienced and the daily challenges experienced by counsellors may reduce the quality of the VCT process in turn limiting the uptake of VCT.

The above mentioned client and service related factors limit the uptake to VCT. This may have multiple implications to lessening the pandemic and decreases the benefits that individuals may gain when presenting. However, addressing these limitations to VCT through media campaigns, policy and adequate monitoring and evaluation of the process may assist in increasing the uptake of VCT.

2.3.3. Risk factors and implications of HIV/AIDS

The promotion of health in relation to HIV/AIDS within South Africa is multi-faceted. There are various bio psychosocial factors which contribute to positioning individuals at increased risk of being infected with HIV. Over the years it has been widely established that the psychosocial factors contributing to increased risk of HIV infection is fundamentally intertwined with an individuals' health and largely impacts on the containment of the virus. These risk factors have multiple implications both directly and indirectly at various levels of society which consequently hinder a healthy and stable nation.

Poverty is considered to be one of the major risk factors of HIV worldwide. Transactional sex, where sex is exchanged for basic needs, is often a result of individuals not being able to afford basic needs to survive on a daily basis (Ali, 2009). Poverty-stricken individuals often engage in riskier behaviour, sexually and otherwise, to ensure survival. Moreover, the historically inferior positioning of females in society further exacerbates their vulnerability to HIV. This results in females more likely engaging in transactional sex to gain economic security for themselves and their family (Ali, 2009). Moreover, woman in poverty are more likely to have multiple sexual

partners to assure them of economic stability and daily survival; however this places them at increased risk of being infected with HIV (Booyesen & Summerton, 2002). This gender inequality and the resulting power imbalances, where females are seen as inferior to males often results in the former receiving unequal access to opportunities such as receiving a good quality education (UNAIDS, 2012). This lack of knowledge, the associated skills and their unstable living circumstances, provide males with increased power over sexual practices thus further limiting females ability to negotiate safer sexual practices, such as the use of condoms, and in turn protecting themselves from being infected with HIV (Booyesen & Summerton, 2002).

On the other hand, an increase in the “pursuit of modernity” has also resulted in females engaging in transactional sex for material belongings (Fox, 2010, p.18). In this way, females engage in sexual activity to gain gifts, often from wealthier and older men, to attain increased mobility and social status (Fox, 2010). Additionally, with the prevalent gender inequalities present, males who have multiple sexual partners are more likely to be viewed as demonstrating “their sexual prowess and social status” (Fox, 2010, p.19). This increases the risk of contracting HIV for both males and females. Therefore, poverty and transactional sex are one of the major drivers of increased risk for contracting HIV, particularly for females.

The above mentioned risk factor has multiple implications impacting the individual and household level. The power disparities evident among males and females where the latter are more likely to engage in transactional sex for economic stability and material gain may result in the discrimination and abuse of females. Females who are expected to be primary carers of the household and those within it, are discriminated against and viewed as immoral when partaking in transactional sex or when having multiple sexual partners (Wojcicki & Malala, 2001). However, when either the male or female become infected with HIV, the household becomes vulnerable to further adversity. Contextual factors and environmental barriers such as limited access to required resources including treatment, transport and access to a health care institution negatively impact on the psychical and psychological health of the individual. Further, these individuals often present at resource constrained VCT centres, in turn negatively impacting on the health care system as counsellors become over-worked resulting in a decline in the quality of care provided. On the other hand, poverty-stricken individuals are often less likely to present for

VCT due to challenges experienced including a lack of transport and proximity of a VCT centre further aggravating the status of the pandemic (Swanepoel, 2010).

When a male, often the breadwinner in a family, becomes infected, the burden often falls on the family to ensure economic stability in the household. This may result in the females of the household resorting to behaviour that increases their risk of HIV infection. On the other hand, when a female is infected with HIV, other females in the household, most often younger school-going females or elderly females, take on the care-giving role to other family members disadvantaging younger females in their education or resulting in elderly females having to return to work. Further, infected individuals place an added burden on the household resources as they require access to care and treatment. As the virus progresses, their productivity decreases thus further impacting their poverty-stricken household resulting in a continuous cycle of poverty (Arndt & Lewis, 2000). In addition, the decreased productivity of the individual has an indirect effect on the economy, particularly when large numbers of infected individuals are unable to work thus contributing to an unhealthy and unstable nation. The VCT process, through educating and informing, positively contributes to the lessening of power imbalances and gender inequalities thus empowering both men and women, consequently reducing the number of infected individuals and the subsequent implications.

Knowledge is a key factor contributing to an individual's level of HIV risk. The historical racial inequality under the apartheid regime in South Africa has resulted in many, primarily non-white individuals, receiving an inadequate education. This has resulted in South Africa still aiming to narrow the gap in the education system. However, knowledge plays a vital role in individuals making informed decisions relating to their sexual practices. Previous research conducted indicates that more educated individuals, due to an increased understanding of the risks involved, have shown an increased likelihood of practicing safer sex (Ali, 2009). On the other hand, behaviour change, in addition to relying on the level of knowledge an individual has, also involves the attitudes towards sexual practices and HIV, which in turn is influenced by the individuals' contextual factors such as normative beliefs (Obiajulu & Clark, 2009). However, with inadequate knowledge, attitudes often remain the same and risky sexual practices continue. Therefore, knowledge as a risk factor contributing to the rise in HIV infection impacts on and

limits positive behaviour change. In this way, knowledge as a key component of the VCT process plays a mitigating role in the fight against the pandemic.

In addition to the above, stigma and discrimination is both a factor contributing to HIV risk and a major implication of being infected with HIV. Stigma refers to the negative attitudes of the public towards an individual “who possesses an attribute that falls short of societal expectations” (Goffman, 1963 as cited in Gilbert & Walker, 2010, p.140). The negative connotations and social representations of HIV/ AIDS and VCT contributes to the stigma and discrimination associated with HIV and VCT (discussed in further detail in Section 2.10.2). This primarily refers to HIV being socially represented as equivalent to death, immorality and contamination among other representations. However, this associated stigma and discrimination surrounding HIV limits the likelihood of individuals who have placed themselves at risk to present for VCT due to the possible consequences that may follow, in turn deterring themselves from receiving essential treatment (Gilbert & Walker, 2010). In this way, individuals who do test positive run the risk of being discriminated against in all aspects of their life (Gilbert & Walker, 2010).

Over and above stigma contributing to HIV risk, it also has multiple implications on the impacted individual. HIV closely associated to immorality perpetuates the associated stigma thus leading to the physical and verbal violence of those infected (UNAIDS, 2012). This often causes challenges in disclosing of ones HIV status to family and friends in fear of being rejected and discriminated against thus resulting in a lack of support, when needed most, for the infected individual (Kruger et al., 2009). However, when infected individuals have not disclosed their status to those closest to them, this often severely hinders the uptake and adherence to their treatment regimen (Patel & Langa, 2009). Further, the stigma experienced from those around the infected individuals severely impact on their mental well-being subsequently resulting in a decline in their quality of life (Van Dyk & Van Dyk, 2003; Young et al., 2010). The stigma experienced from other individuals may also be experienced by the infected individual themselves. This stigmatisation of the self causes the individual to feel guilty and shameful leading to a further decline in their mental well-being (UNAIDS, 2012; Worthington & Myers, 2003).

The psychological distress experienced by individuals when testing positive increases the likelihood of a range of negative feelings such as guilt, anxiety and more severely, depression and post-traumatic stress disorder among others (Goldberg, 2011; Grant-Stuart et al., 2006; MacPhail et al., 2008). This deterioration of an individuals' mental well-being increases the likelihood of worsening their physical condition thus fuelling the progression of the virus. This further impacts on the infected individuals support structure, including family members and friends who essentially become helpless thus heightening their psychological distress and lessening their ability to positively influence the infected individual (Van Rooyen, 2008). In this way, the VCT process emphasising the counselling aspect increases the possibility of sustained behaviour change and an improved quality of life for the individual presenting for VCT and those closely associated.

Poverty, knowledge, attitude and stigma and discrimination are psychosocial factors contributing to HIV risk which have multiple implications on infected and affected individuals. With the large number of infected individuals, organisational demands and limited resources, the South African public health system is positioned with the burden of allocating and utilising resources effectively and in a sustainable way. However, with the attention drawn to successfully implementing programmes to assist in lessening the impact of HIV, the limited resources available in the public health system are inequitably distributed with majority of the resources, including personnel, going towards the HIV response thus in turn weakening the remainder of the health system (Chopra et al., 2009). Nevertheless, staff shortages often result in high rates of attrition resulting in a further shortage of staff impacting on the quality of care provided (Avert, 2010). The shortage of staff consequently result in an increase in workload and working hours thus fuelling the pressure placed on personnel impacting their psychological health and mental well-being (Bharat & Mahendra, 2007). The deterioration of the mental well-being of the health worker impacts on the quality of care provided deterring individuals from presenting for VCT or other HIV related aspects such as treatment or counselling thus fuelling their risk to HIV infection. In this way, the contributing factors to HIV risk and the multiple implications of the virus is cyclical in nature.

The factors contributing to risk include poverty, knowledge, stigma and discrimination among others discussed later in this chapter. These contributing factors encompass and highlight the multiple implications of HIV. However, the benefits of VCT and its encompassing features such as counselling contribute to mitigating the bio psychosocial consequences of the pandemic in South Africa.

2.3.4. Client mental well-being

VCT is primarily aimed at prevention and behaviour change to safer sexual practices. Increased focus is placed on providing clients with information about the various aspects of HIV/AIDS in anticipation that this information will be used to directly alter behaviour. According to Swanepoel (2010, p.6) “HIV-testing is never a goal in itself, but clearly motivated by prevention and care and support goals”. Over and above the benefits described, the VCT experience is psychologically challenging and has a significant impact on the mental well-being of an individual, particularly as a result of the major implications of the test result and perceptions by others (Goldberg, 2011). This potential psychological distress, which inevitably impacts on quality of life, severely hinders the uptake of VCT (Goldberg, 2011). It is therefore fundamental that a good quality support and counselling service is provided, to ensure that the mental well-being of individuals is managed in an appropriate and adequate manner.

According to Goldberg (2011, p.4), an individual presenting for VCT commences a psychological journey, which “by its nature is complex and extremely sensitive”. When testing positive, HIV/AIDS not only psychologically impacts the client, but also those in close interaction with the client, such as family, friends and VCT counsellors (Van Rooyen, 2008). This raises the need for counselling and support services for all those directly or indirectly involved in the process (Van Rooyen, 2008).

Research has indicated the increased risk of people living with HIV/AIDS to mental disorders (Freeman, Nkomo, Kaffar, & Kelly, 2008). High levels of anxiety when presenting for VCT, further exacerbated by a lack of availability of treatment, is a major hindrance to the uptake of VCT (MacPhail et al., 2008; Worthington & Myers, 2003). Studies conducted have indicated

how, when receiving a positive result, individuals may exhibit and experience symptoms of post-traumatic stress disorder (Mphaya et al., 2008; Olley et al., 2005). An uncertain future may cause individuals to lose hope, thus resulting in a further decline in the mental well-being of the client, with an increased risk of depression and possible thoughts of suicide (MacPhail et al., 2008).

The psychological impact of learning one's HIV status varies for each individual. Disbelief, denial, guilt, relief and a sense of immunity may be possible reactions to either a positive or negative result (Grant-Stuart et al., 2006). Although receiving a positive result may have a more significant impact on a client's mental health, reactions to a negative result are just as important, and VCT counsellors must be able to assist a client to further understand and appropriately manage his/her result. Kamb et al. (1998 as cited in Van Rooyen, 2008) describe the importance of counselling in the VCT process to enhance behaviour change and risk-reduction. However, Van Dyk and Van Dyk (2003) emphasise the need for long-term support if lasting behaviour change is required. Consequently, VCT counsellors should be trained in appropriately managing client's reactions to his/her HIV-status, thus enhancing the mental well-being of the individual. This reflects the need for counselling in the VCT process.

In addition to the psychological impact, Prince et al. (2007 as cited in Freeman et al., 2008), provide evidence of direct neuropsychiatric difficulties, which cause a decline in brain-functioning (Freeman et al., 2008) and impact cognitive, behavioural and motor functions (Nath et al., 2008). This is further aggravated by mental disorders and opportunistic infections (OIs), which increase the difficulty of treatment and care, thus intensifying the advancement of HIV (Cournos, McKinnon, & Wainberg, 2005, Smart, 2009 as cited in Haffeejee, Groeneveld, Fine, Patel, & Bowman, 2010; Odiase, Ogunrin, & Ogunniyi, 2006). Deterioration of mental and psychological well-being increases the complexity of, and adherence to, treatment and behaviour-change, thus enhancing the need for psychological support and the urgency of addressing psychological factors in the training of VCT counsellors. However, despite the importance of counselling in the context of VCT, and the positive impact it may have, the mental well-being of the client has still been largely neglected within research and HIV-interventions (Kelly, Freeman, Nkomo, & Ntlabati, 2008, Smart, 2009 as cited in Haffeejee et al., 2010).

The mental and physical impact of a positive diagnosis, impacts behaviour change, thus justifying the importance of counselling, over and above providing educational information, in VCT, in assisting clients to adequately cope with the virus. Research has indicated “counselling as a means of behaviour change”, which further affirms the need for counselling in VCT services (Rachier et al., 2004, p.176).

The need for trained professionals within the country is vital in assisting in the struggle against HIV/AIDS. This is further reiterated in the South African national policy, which emphasises the great need for professionals and trained individuals in various fields. While the increased use of lay counsellors assists in the shortage of staff within the country, these counsellors may not possess the professional skills to adequately counsel clients. It is therefore imperative that VCT counsellors are trained in meeting the psychological needs of those presenting for VCT.

2.3.5. Efficacy of VCT

The psychological impact of VCT and conversely, the benefits acquired through presenting for VCT, emphasise the need for VCT and the counselling component. The main aim of VCT is the prevention of HIV/AIDS and behaviour change, primarily through education (Aids Foundation South Africa, 2010). However, the focus on education has not offered the clear outcome expected, with individuals still engaging in risky behaviour, resulting in an increase in the number of infections (Aids Foundation South Africa, 2010). There is an abundance of research on the efficacy of VCT in assisting the decline of the HIV/AIDS crisis. However, the efficacy of VCT may be measured in multiple ways with the findings dependent on how efficacy is measured. The efficacy of VCT may be measured in terms of the educative or supportive components of VCT, either separately or in combination. While in some instances effectiveness may be measured through behaviour change, in others the efficacy of VCT may be measured in terms of the number of people utilising the service and are gaining awareness of their sero-status.

Research focusing on the level of risk and risk-reduction in measuring the efficacy of VCT, portrays the service as an effective tool in reducing risk and enabling behaviour-change (Boswell & Baggeley, 2002; Denison, O'Reilly, Schmid, Kennedy, & Sweat, 2008; Ekanem &

Gbadegesin, 2004; UNAIDS, 2000, VCT Efficacy Study Group, 2000 as cited in Van Dyk & Van Dyk, 2003). Therefore, VCT is represented as effective in decreasing the likelihood of individuals partaking in risky sexual behaviour (Denison et al., 2008) and in increasing people's likelihood to present for services, which would benefit their physical and mental well-being (UNAIDS, 2001 as cited in MacPhail et al., 2008). In contrast, this efficacy seems primarily in relation to certain groups of people. HIV-positive individuals and sero-discordant couples have been found to be the most responsive to VCT, and the most likely to engage in behaviour change (Bassett & Walensky, 2010; Glick, 2005). Therefore, "the target population itself seemed to be an important factor in success" (Public Health Agency of Canada, 2006, p.59).

Equally, studies have also indicated the inefficiency of VCT in reducing the risk-behaviour of all those presenting for VCT (Van Dyk & Van Dyk, 2003). Studies have indicated less success in changing the behaviour of those who test negative, those receiving counselling with no HIV test (Weinhardt, Carey, Johnson, & Bickham, 1999 as cited in Van Dyk & Van Dyk, 2003), or even some HIV-positive individuals who engage in high-risk behaviour (Kipp et al., 2001, Weinhardt et al., 1999 as cited in Van Dyk & Van Dyk, 2003). Infection with HIV/AIDS and high-risk behaviours are intimately linked to contextual factors, which have a significant influence on an individual's behaviour. It is therefore vital to understand these contextual factors, which contribute to people's behaviour, before attempting to modify the behaviour itself (Swanepoel, 2010). Long term counselling and support should be provided to further understand contextual factors, and modify individual behaviours for a more effective and lasting change (Van Dyk & Van Dyk, 2003).

Results of the efficacy of VCT remain mixed and are largely determined by the target audience considered and the definition and measure of efficacy. However, it is clear that VCT is more effective in secondary-prevention, assisting HIV-positive individuals in changing their behaviour so as to decrease the likelihood of infecting another (Solomon et al., 2004). In essence, a culture promoting behaviour-change, whereby individuals reduce their risky behaviour, which results in a decreased risk of infection, is vital in successfully lessening the HIV pandemic (Aids Foundation South Africa, 2010). Moreover, the "adoption of a psychological lens adds depth to

an understanding of the efficacy of the intervention” and is therefore fundamental in the fight against HIV/AIDS (Goldberg, 2011, p.4).

2.4. VCT Policy- The Fundamentals

The conceptualisation and implementation of VCT is fundamentally based upon national and international policy. There are currently a number of national and international guidelines and policies available to direct VCT practice and service-delivery (Bharat & Mahendra, 2007). Despite VCT counsellors playing a crucial role in implementing policies on the care and treatment of HIV-infected individuals, “the lack of appropriate and suitable policy frameworks to support service delivery can compromise provider’s roles” (Bharat & Mahendra, 2007, p.94). A policy should preferably, in a systematic manner, address political, economic, social, legal and health issues (WHO, 2005).

2.4.1. International policy

The UNAIDS and the WHO, dominant international organisations, have generated an HIV testing policy-statement (WHO, 2005). This policy statement is one of the key documents on which many governments and NGO’s respectively base their policies and training manuals. According to the policy-statement, prevention of HIV/AIDS is the primary objective of VCT (WHO, 2005). The guiding principles include: universal access to VCT and encouragement of VCT-uptake; superior quality of VCT; increasing awareness of the benefits when presenting and thus reducing stigma and discrimination; the inclusion of HIV positive individuals in planning and implementing VCT; and utilising standardised and ethical procedures from a client-centred approach (WHO, 2005). The policy-document further identifies three foundational principles which HIV-testing should follow. These principles include consent, confidentiality and counselling, and are based on a public health rationale and implementation of international human rights standards (Angotti, 2010). These guiding principles are of great importance and should be implemented with rigour so as to improve VCT services world-wide.

2.4.2. National Department of Health policy

The South African policy guidelines regarding VCT have been established in alignment with international standards (NDoH, 2010). The NDoH have, over recent years, adopted several responses to HIV/AIDS, developing and expanding on multiple policies, guidelines and reports, to facilitate in decreasing the current crisis surrounding the pandemic (Republic of South Africa, 2010). Health policy within South Africa has traditionally been the focus area of academics. However, this is shifting, with professionals in the field taking interest in, and contributing to, the nation's policy on HIV/AIDS (National Planning Commission, 2011).

The commitment towards reducing the current crisis surrounding HIV/AIDS has been incorporated into various policies (NDoH, 2007; NDoH, 2010). Current HIV/AIDS policy focuses on prevention as the approach to help positively shift the HIV prevalence rates (Department of Basic Education, 2010). This lays the foundation for the National Planning Commission, National Strategic Plan and the National VCT Policy Guidelines.

VCT counsellors must have the ability to relate available guidelines to the national policies in operation within South Africa and to implement the objectives (Bharat & Mahendra, 2007). The primary aims of the strategic plan for HIV/AIDS within South Africa is to decrease the rate of infection by half and guarantee treatment of at least 80% of those infected by 2011 (NDoH, 2010). Moreover, the strategic plans for 2009-2014 include fighting against HIV/AIDS, as one of the four strategic outcomes (National Planning Commission, 2011). This demonstrates government's awareness of the challenge that the country is currently facing. The Department of Basic Education (2010), in conjunction with the National Strategic Plan, also plays a fundamental role in prevention of HIV/AIDS through the encouragement of educating youth with information on HIV/AIDS related aspects in school. The main focus of the South African government is to: promote universal access to a high-quality affordable VCT service; encourage the uptake of VCT; promote support and voluntary disclosure of an individual's status; and to encourage and facilitate referral, access to treatment, care and support (NDoH, 2010).

The South African health system is established on two ideas, which assist in providing health care to the public, namely: primary health care and utilisation of a people-centred approach, which strengthens the aim of prevention (National Planning Commission, 2011). Primary health care refers to the utilisation of a person-centred as opposed to a disease-focused approach to health care and services within the country (National Planning Commission, 2011). The person-centred approach hints at a seemingly psychological-approach to patient care within the country. Therefore, it is assumed that VCT, a component of the health system, has been established on the notion of primary health care. Consequently, the notion of primary health care is an essential component in South Africa's drive towards "universal access to HIV prevention, treatment, care and support" (Republic of South Africa, 2010, p.12).

High prevalence rates have prompted the government and various organisations, towards the development and enhancement of services available within the country. However, despite numerous attempts at reducing the rate of infection within the country, a reduction in the severity of the epidemic has not yet been accomplished (Department of Basic Education, 2010). This may be due to a failing health system, which consequently results in the inability to adequately cater for the needs of the country (National Planning Commission, 2011). According to the National Planning Commission (2011), the disproportional capability of the nation, resulting from a complex interaction between factors, results in unbalanced operations at varying levels of government. These factors include a shortage of staff and supervision, which hinder service delivery in the health sector, and variable government funding for training, which further aggravates the shortage of staff and supervision (National Planning Commission, 2011). Furthermore, by not prioritising clients and failing to develop a working relationship with them, the underlying notion of primary health care deteriorates and this hinders policy implementation (National Planning Commission, 2011). The instability of the health sector persists as a result of hasty resolutions to challenges and the diversion of focus from priorities such as lack of skill within the country (National Planning Commission, 2011). Nevertheless, the South African government has recognised the failing health system and has pledged to work towards a more efficient system, which adequately caters to the needs of the South African society (National Planning Commission, 2011).

Appropriate training of VCT counsellors may improve services provided, and consequently may contribute to the reduction of the current pandemic. The National Planning Commission (2011, p.319) echoes this, stating that “to implement policies that are more appropriate to the health and health care needs of South Africa, there needs to be a massive and focused investment in training health personnel”. Furthermore, collaboration among the NDoH, various partners and organisations, and between the different government departments and sectors, furthers the goal of lessening the crisis (National Planning Commission, 2011). Collaboration with traditional healers, who play a vital role in many sectors of South African society, may further assist in achieving the aims (National Planning Commission, 2011). Therefore, a focus on best practices, through concentrating on training and collaboration, and balancing requirements of governmental policies with those of the citizens, health sector and VCT service, may enable greater success (National Planning Commission, 2011).

The current National Development Plan outlines health related aims for 2030. These goals include a reduction in HIV/AIDS rates, an improvement in the quality of the health care system and VCT, and training of health personnel (Republic of South Africa, 2010). These goals are to be achieved through: universal availability of services and an increase in the number of HIV-positive people receiving treatment; a system based on evidence; dividing of policy and operations; managing backlogs with increased use of technological developments; and the initiation of health care teams (Republic of South Africa, 2010). It is further envisaged that with increased training capacity, training counsellors will enable filling posts with skilled, committed and competent individuals (Republic of South Africa, 2010).

In addition to the above policy aims, the NDoH has developed the National HCT Policy Guidelines (NDoH, 2010). These policy guidelines, built upon the foundation of primary health care, have been developed based on previous government documents and international practices and offer guidance for VCT service implementation (NDoH, 2010). The guidelines aim to provide an outline of the VCT services for adults and children in both the private and public sectors in South Africa, and emphasise quality assurance (NDoH, 2010). These guidelines are envisaged to assist in: scaling-up prevention and treatment; increasing awareness of HIV among

South Africans; enabling accurate assessment of risk; and increased utilisation of the available services (NDoH, 2010).

The development of policies is only adequate when put into practice (Bharat & Mahendra, 2007). This is highly problematic in a South African context. Many VCT counsellors are unaware of the relevant policies, and thus must work from his/her own experience and interpret the situation in relation to their own background of knowledge (Bharat & Mahendra, 2007). This lack of awareness may result from a lack of formal training of VCT counsellors, particularly in disadvantaged communities, where staff shortages may be most prevalent. In these situations those in authority, such as policy-makers, should allow the counsellors the freedom to use their best judgement in relation to their particular context (Angotti, 2010). However, this begs questioning as to whether their best judgement is adequately suitable in implementing the policies available. Furthermore the diversity of policies and guidelines created by government and multiple NGO's may include conflicting information (Bharat & Mahendra, 2007). It may, therefore, be necessary to have training manuals based on a single guiding policy. Based on the numerous challenges experienced by counsellors, investing more in VCT training programmes is fundamental in improving the service provided (Bharat & Mahendra, 2007). Nevertheless, these policy objectives are vital in improving the current status of the pandemic and should ideally be conveyed to the NGO's, who are currently the main distributors of the VCT service in South Africa.

2.5. The VCT Process

In a nation where many are unaware of their sero-status, VCT is a necessity. VCT is a counselling and testing procedure, which includes a pre- and post-test counselling session and testing for HIV (NDoH, 2010). This three stage process is vital in providing individuals with support and information to make informed choices regarding both testing and their current sexual behaviour. Client-initiated VCT, where individuals seek and present for VCT due to their own personal risk-assessment, has been the primary model of delivery for people seeking HIV testing (Njeru, Blystad, Shayo, Nyamongo, & Fylkesnes, 2011; WHO, 2007). However, with many unaware of their status, provider-initiated VCT, where health personnel assess a client's risk and

routinely refer for VCT, is becoming increasingly prevalent (Njeru et al., 2011; Public Health Agency of Canada, 2006; WHO, 2007). Following is an outline of the various aspects of the VCT process, in which VCT counsellors should ideally be trained, and thus focus on in the VCT process. However, it is important to be cognisant that training organisations implement policies in various ways thus influencing the emphasis placed on certain content areas within the various training manuals. Further the information reviewed here is not an absolute in relation to VCT training, but rather incorporates perspectives from literature and the NDoH guidelines.

2.5.1. Pre-test counselling

The pre-test counselling session is broadly undertaken to assess the individual's reason for presenting, the level of risk associated with that person and his/her attitudes and beliefs about HIV (Swanepoel, 2010). Furthermore, it allows for providing information regarding HIV and the testing procedure (Swanepoel, 2010). Hence, the main aim of the pre-test counselling session is to balance between the educative and supportive components of VCT - providing information, assessing the individual's risk and adequately catering to the emotional needs of the individual (NDoH, 2010).

When an individual presents for VCT, ideally, the counsellor should: begin by discussing the confidential nature of the VCT process; gain an understanding of why the person has presented; and establish a level of understanding around the various common concepts and knowledge of HIV/AIDS and the VCT process (Grant-Stuart et al., 2006). Although confidentiality refers to the privacy of information between the counsellor and client, the client must be notified that this may involve other VCT counsellors or medical practitioners so as to provide an adequate service to the client and ensure optimal health (NDoH, 2010). The counsellor then assesses and discusses the level of risk that the person has engaged in (Goldberg, 2011). Further, the counsellor should discuss risk-reduction; correcting any pre-conceived or mistaken information that the client may have (NDoH, 2010). This involves discussion about abstinence and the use of condoms (Boswell & Baggaley, 2002; NDoH, 2010). The counsellor should emphasise the confidential and voluntary nature of the process, and should attend to any questions the client may have. This aims to alleviate anxiety, and increase trust around the testing procedure.

The counsellor should then prepare the client for both negative and positive test results; providing an explanation of the window period, and information regarding care and treatment if testing positive (NDoH, 2010). When providing such information, the counsellor must be aware of the level of support to which the individual has access, and any fears the individual may have regarding any aspect of the VCT process (Boswell & Baggaley, 2002). This is a particularly vital aspect of the session whereby the counsellor should take time to discuss how the client may be feeling regarding his/her results, whether positive or negative (Grant-Stuart et al., 2006). The information and discussion at this point provides the foundation of informed consent; allowing the individual to make an appropriate decision regarding whether or not they want to proceed with the second stage of the VCT process (Goldberg, 2011). The decision to proceed to the next stage of the VCT process should always be the client's decision, and should be fully informed and on a voluntary basis (NDoH, 2010). Once a decision has been made, the counsellor should obtain informed consent in writing (NDoH, 2010). Lastly, counsellors should be cognisant of the emotional well-being of the client, and should verify the client's understanding of all that has been discussed; allowing clients the opportunity to ask anything if need be (Boswell & Baggaley, 2002).

2.5.2 Testing for HIV

Testing for HIV may occur in a variety of settings ranging from VCT centres to hospitals and mobile VCT sites. Currently, there are multiple modes of HIV testing, which can be employed to ascertain the sero-status of the individual presenting for VCT. Different HIV-tests are utilised depending on where the test is performed. There are three broad categories of HIV tests; namely antibody tests, rapid tests and home tests (Avert, April 2011).

The HIV-antibody tests are able to detect antibodies linked to the HI virus in blood, saliva or urine (Avert, April 2011). Rapid HIV-tests, operate similarly to the antibody tests, and produce results within twenty minutes, and can be performed outside of a laboratory and do not require trained personnel (Avert, April 2011). Rapid tests are highly advantageous in South Africa where distances and access to VCT centres, are major factors preventing many from testing for HIV

(Mabunda, 2006). Furthermore, within the South African context there is a substantial shortage of skilled staff and expensive equipment (Kassler, Dillon, Haley, Jones, & Goldman, 1997). An individual should ideally undergo more than one HIV test to account for the window period, which refers to the period of time between infection and being able to detect the HIV antibodies in body fluids (NDoH, 2010). Counsellors must be continuously vigilant to the emotional needs of the client constantly reminding the client of the voluntary and confidential nature of the VCT process. It may also be viable to provide a comprehensive overview of the testing procedure, thus decreasing the level of anxiety and possible confusion resulting from this particular stage of the VCT process.

2.5.3. Post-test counselling

The final stage of the VCT process is a post-test counselling session, which, once again, involves an educative and supportive component. Ideally, the counsellor should begin by reinforcing the confidential nature of the VCT process. This further instils trust and may lessen the anxiety and fear of receiving their test results. According to Boswell and Baggaley (2002), content areas covered in the pre-test counselling session should be restated and explored if necessary, particularly if the post-test session does not occurring on the same day.

The educative component of this stage includes providing an explanation of, and information regarding, HIV test results. Whether positive or negative, the counsellor should confirm the client's understanding of the test result, and should inform the client of the possible reactions and various emotional responses he/she may experience and the effect this may have on his/her well-being (NDoH, 2010). When testing negative, the counsellor should discuss what the result may mean if the person has engaged in any risky behaviour after taking the test, reiterating the window period and the need for follow-up tests (NDoH, 2010). More importantly, the counsellor should provide information regarding prevention of HIV, risk-reduction and condom usage (NDoH, 2010). On the other hand, when testing positive, the counsellor should recommend a second HIV-test be done to confirm the results, and should provide additional education about the virus, and various physical and mental coping mechanisms (Aidsbuzz, 2010; Swanepoel, 2010). The counsellor should discuss issues surrounding safe sexual practices and issues and

implications of HIV-status disclosure (Swanepoel, 2010). It is vital that disclosure be addressed as the implications can be a hindering factor in disclosing their positive status. It is also important to assess the resources available to the client to help him/her to adjust, and, if necessary, any of future assistance that may be required (Goldberg, 2011). Furthermore, issues surrounding treatment, care and, if necessary, counselling, should be discussed and, if possible, a viable route for the client should be established (NDoH, 2010).

The supportive component of this stage refers to the importance of counselling skills in the VCT process. According to Goldberg (2011), both pre and post-test counselling must occur with sensitivity and caution, with the counsellor possessing skills in detecting the verbal and non-verbal behaviour of the individual. Therefore, the counsellor must be cognisant of the manner in which questions are phrased, how the client is addressed, and subtleties like body language in the interaction (Goldberg, 2011). Essentially, the counsellor must be able to make the individual feel comfortable and maximise the quality of the session (Goldberg, 2011). This will provide the counsellor with a wealth of information thus allowing appropriate steps to follow. Furthermore, the counsellor must be aware of, and take into consideration, the client's cultural values and norms regarding HIV and VCT (Goldberg, 2011). This is extremely important in a South African context in which there is significant diversity which impacts the views that individuals hold.

When testing positive the emotional experience of the individual should be of utmost importance. Therefore, the counsellor should provide the results in an environment where in the client does not feel threatened in any way (Goldberg, 2011).

The VCT process encompasses both an educative and supportive component ensuring a comfortable environment for the client to adequately assess their level of risk and thus in turn aim to change their behaviour towards a healthier way of living, lessening their risk of contracting HIV/AIDS. As described above, the pre-test counselling session is focused more towards educating the client, whereas the post-test counselling session emphasises the supportive component. These processes are based upon national policies, which are translated into training VCT counsellors. The challenges experienced by people living with HIV/AIDS and VCT counsellors are discussed below.

2.6. The VCT Counsellor

The main aim of counselling is to encourage the client to become self-reliant, self-sufficient and comfortable with the test result they receive (Angotti, 2010). HIV counselling is a collaborative and interactive process in which a trained professional assists an individual in managing his/ hers HIV/AIDS related problems, predominantly focusing on behaviour-change (Evian, 2000; National AIDS Control Organisation, 2004). In this way, the counselling process is an establishment of a socialised foundation entrenched within the contemporary society (McLeod, 2003), whereby the counsellor is seen as enabling the client to advance understanding of themselves and in effectively managing and coping with challenges in their life (Silverman, 1997). As a result, HIV counsellors aim to increase the client's confidence in making appropriate decisions for themselves and becoming self-sufficient in adequately coping in the future (Ministry of Health [Malawi], 2007 as cited in Angotti, 2010).

Bharat and Mahendra (2007, p.93) state that “a trained health service workforce is critical to ensuring good quality service delivery to people with HIV”. It is thus imperative that VCT counsellors are adequately trained in providing a high-quality service. The National HCT Policy Guidelines provide an indication of the minimum educational requirements necessary for all VCT counsellors. These quality assurance measures comprise having all training completed by an accredited service provider, with all counsellors having met the national minimum standards for counselling (NDoH, 2010). These standards are assessed by the South African Qualifications Authority (2006). Despite this, the skills of VCT counsellors largely differ in the degree of quality provided across the numerous VCT centres (Bharat & Mahendra, 2007). Disparate quality is aggravated by the basic experiences and challenges faced among health care workers.

The training received by VCT counsellors largely impacts the quality of counselling provided. A study conducted by MacPhail et al. (2008) indicated young people's concerns regarding how they are treated at VCT centres. Many of the participants in this study mentioned that they are often shouted at, discriminated against and publicly chastised for wanting an HIV test at such young ages (MacPhail et al., 2008). This form of discrimination and lack of a supportive attitude, from counsellors hinder presentation at VCT centres and deter individuals from being open and

honest with counsellors when presenting. This is particularly problematic in the case of youth, where the prevalence of HIV is increasing at a rapid rate. This study suggested that VCT counsellors are ill-equipped and not trained adequately in meeting the emotional needs of the client (MacPhail et al., 2008).

In addition, previous studies have found that VCT counsellors, at times, lack in adequate knowledge regarding basic concepts of HIV (Bharat & Mahendra, 2007). A lack of clarity and difficulty in providing information in an adequate and easily understandable way further deteriorates the quality of VCT (Bharat & Mahendra, 2007). A study conducted by Chopra, Doherty, Jackson and Ashworth (2005) demonstrated that despite having the appropriate communication skills, the level of information provided to HIV-infected mothers is inadequate and incomplete, hindering the uptake of VCT. In addition, clients often do not receive an adequate explanation of their HIV-test results. Counsellors at the National AIDS helpline often receive calls from clients presenting for VCT but not understanding their test results either due to a lack of, or inadequate, explanation (Birdsall, Hajiyanis, Nkosi, & Parker, 2004). This may be a result of a power-dynamic whereby counsellors feel it unnecessary to provide all information to clients, as they are unable to fully comprehend the information and that this may further enhance anxiety around HIV testing (Bharat & Mahendra, 2007).

These basic experiences demonstrate the significance of the educational requirements in becoming an HIV counsellor. Ideally, counsellors should be trained in basic HIV knowledge, and taught how to adequately convey this information. Furthermore counsellors should be trained to deal with all individuals in a caring and supportive manner.

2.7. The Role of the VCT Training Manual

The VCT training manuals and guidelines utilised within South Africa are developed from both national strategies and international practices (NDoH, 2010). According to the WHO, the government of a country should be responsible in ensuring that the citizens of that country have access to quality health care (Sait, 2001). In South Africa, the NDoH (2010) ensures and guides VCT policies in being adequately and suitably implemented within the country, and provides

oversight to the training requirements, thus ensuring that high quality assurance measures are implemented to safeguard a high quality service.

The role of VCT is invaluable in lessening the prevalence of the HIV pandemic. VCT has shown to have many benefits ranging from empowerment and healthy living to secondary-prevention (FHI, 2003; Lalthapersad-Pillay, 2009; Reproductive Health Matters, 2000). The training manuals that seek to achieve the above mentioned benefits are therefore, a vital component in the HIV/AIDS field.

Good quality training permits multiple benefits, which enhance the quality of the service provided when it is implemented (National Planning Commission, 2011). Over and above the development of skills, training permits a space which enhances the unbiased reflection where counsellors are able to examine and discuss the difficulties they may experience when working within the VCT field (National Planning Commission, 2011). Training also assists in creating a community of individuals who share a common understanding of a particular field and the importance of their work (National Planning Commission, 2011). Furthermore, capacity-building through training further permits the “strengthening of organisations and systems, and establishing and supporting linkages and networks” (WHO, 2005, p.42). It is therefore vital to ensure good quality training to assist in increasing the quality of service provided.

The National Planning Commission, in conjunction with the South African NDoH, aims to prioritise and increase the capacity of trained professionals or lay counsellors with specialised skills, through training and research and development, to assist in the HIV/AIDS crisis and improve the quality of care provided at VCT centres (NDoH, 2010; National Planning Commission, 2011). It is envisaged that the development of skills within the country, will enable South Africa in constructing a proficient and quality public service that permits a greater capable and competent nation (National Planning Commission, 2011). Training of VCT counsellors should ideally be conducted in relation to the minimum standards required for counselling and testing with increased collaboration across the various government departments, between governmental and non-governmental organisations, and all stakeholders in the South African health system, particularly the VCT sector (NDoH, 2010; National Planning Commission, 2011).

This unified support in decreasing HIV/AIDS prevalence rates and improving the quality of the VCT service provided will ensure “delivery of standardized, high quality and ethical HIV counselling and testing services” (NDoH, 2009, p.28-29).

High quality training facilitates a passage to an improvement to the quality of service provided. Previous research indicates that peer-education, and use of techniques such as role-playing, are efficient methods of training VCT counsellors. These ways of training enable VCT-trainees to gain knowledge from colleagues who may have more experience in dealing with various challenges, and allow them to practice simulated situations, increasing their confidence and quality of the service (Bharat & Mahendra, 2007; Thurling, 2011). In addition, it is essential to ensure that training focuses on the VCT counsellors training requirements and is tailored to the group holistically to adequately form a shared understanding of the content taught (National Planning Commission, 2011). This may also assist in increasing counsellors motivation and add personal value to the service they provide (National Planning Commission, 2011). It is however essential, as indicated in previous research, to provide VCT counsellors with refresher courses and updates on the knowledge they gain, so as to maintain and improve their skills and knowledge level (Thurling, 2011).

Despite the above frameworks, VCT training manuals have not sufficiently encompassed these goals and objectives. The disparity in the number of VCT counsellors in public versus private hospitals, owing to better working conditions and financial reward, often leaves the public health system under-resourced and lacking in trained personnel. An investment in training personnel in the public health sector is recommended to increase the quality of health care provided by the public health care system (National Planning Commission, 2011).

These concerns are further intensified by a lack of satisfactory leadership from those in authority, primarily national government (Kenyon et al., 2001). There is a “lack of synergy between the national DoH’s policy and the implementation thereof in the respective provinces” (Sait, 2001, p.2). This is particularly problematic as it indicates that the training manuals, the vehicle via which policies are implemented, are inadequate. This is reiterated by Kenyon et al. (2001) who argue that, despite aiming to implement the policies, the prevalence of HIV is steadily

increasing; indicating that implementation of the policies has not been satisfactory. Therefore, ensuring that policy is implemented, in collaboration with the various stakeholders, with standardised messages, is a challenge (WHO, 2010). This includes the inability to consent to quality indicators, which would be used to monitor and evaluate the implementation of the policy (WHO, 2010). These challenges add further value making certain that government recognises the long-term commitment and focus required on training VCT counsellors, thus planning the training requirements of the future (National Planning Commission, 2011). This is particularly essential for those previously disadvantaged individuals in assisting to redress the inequalities of the past and in fighting against HIV/AIDS (National Planning Commission, 2011).

Monitoring and evaluation play a vital role in effective implementation of policies (SANAC, 2011). Despite the multiple efforts in improving the quality assurance component, establishing a capable nation is guided by multiple interrelated strategies (Republic of South Africa, 2010). It is therefore necessary to build a culture of monitoring and evaluation practices with regard to policies being implemented (Republic of South Africa, 2010). Consequently, an increase in research is required to guide policy, with monitoring and evaluation in turn guiding the research required (SANAC, 2011). The Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa (2002) offer internal and external techniques for assuring quality. Supervision, group meetings and refresher-courses for counsellors are some techniques for ensuring the internal quality of the VCT service (Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa, 2002). On the other hand, surveys, sharing of experiences through forums, and control-checks are techniques, which could be used as monitoring and evaluation tools externally (Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa, 2002). The complexity and scale of the crisis requires a multiplicity of interventions and quality assurance measures to ensure an effective and high-quality service, which is able to adequately control and lessen the prevalence rates of the pandemic (Bertrand, Holtgrave, & Gregowski, 2009).

2.8. The Ideals of the VCT Training Manual

The scaling-up of VCT services is envisaged to increase the number of people who know their HIV status thus, decreasing individuals' risky sexual behaviour and promoting early treatment (Kiene et al., 2009). According to the WHO (2003, p.2), VCT must become the "standard practice wherever they are likely to enhance the health and well-being of the individual" thus, increasing the number of people benefitting from the service. VCT is primarily aimed towards individuals who partake in high-risk sexual behaviour. Therefore, the assessment of an individual's level of risk is vital in understanding the uptake of VCT.

The vital role that risk plays in transmitting HIV increases the need for VCT counsellors to fully comprehend the various aspects of internal and external risk associated with HIV/AIDS and VCT. Therefore, it is vital for VCT counsellors to understand how HIV is transmitted and which behaviours and psychosocial barriers place an individual at increased risk of infection and concomitantly decrease their willingness to present for VCT.

Culture and the use of traditional healers within South Africa play a central role in providing primary medical care to the majority (Aids Foundation South Africa, 2010). Easier access and respect for those presenting result in an unwavering trust in herbal medication provided by traditional healers consequently leading to many not accessing the appropriate medication (Kruger et al., 2009; Peltzer & Mngqundaniso, 2008). Traditional healers are neither trained nor knowledgeable regarding HIV, and this exacerbates misinformation and may increase the level of risk to which individuals expose themselves (Aids Foundation South Africa, 2010). As they are often the first port of call for health needs, the training of traditional healers in caring for HIV clients and lessening the HIV crisis is essential (Peltzer & Mngqundaniso, 2008).

The acknowledgement and understanding of risk factors in relation to culture and tradition, which are important aspects of the lives of many South Africans, lays the foundation towards a quality health service. It is, therefore; fundamental for VCT training to encompass these aspects over and above those mentioned in the VCT procedure described above.

2.8.1. Psychological impact of VCT- Counselling for VCT

The psychological impact that VCT may have, renders counselling one of the most important aspects of the entire VCT process. However, the focus placed on the bio-medical approach often results in the counselling component being partially acknowledged and only moderately established (Rachier et al., 2004).

Despite utilisation of varying counselling models, the client-centred model is the most adopted approach within South African VCT centres. The client-centred approach focuses on assisting the client in moving towards their self-defined goals and principles, thus basing its premise on the self-striving individual (McLeod, 2003). This approach, emphasises the relationships within the client's life, including the counselling relationship, and focuses on the current state and experiences of the client. Furthermore, the importance on empathy, hospitality and authenticity portrays unconditional positive regard for the client (McLeod, 2003; Rachier et al., 2004). However, according to Carkhuff (1969, p.27 as cited in Rachier et al., 2004, p.181), "counselling is never a neutral intervention; it either has a positive or negative effect". It is therefore vital for counsellors to actively work towards providing a positive experience for the client through a high-quality service. However, it must be noted that the client-centred approach towards counselling, may not be as suited to provider-initiated counselling due to the limited time (Kiene et al., 2009). However, the possible reluctance of clients in provider-initiated testing and counselling (PITC) contexts makes consideration of using the client-centred model vital.

McLeod (2003) states that certain skills necessary for a counsellor to effectively conduct a counselling session include: interpersonal skills (ability to listen effectively, be aware of non-verbal behaviour, use of language etc.); the ability to accept and be sensitive towards the client's beliefs and attitudes; to understand the client's position and assist with problem solving skills; awareness of the self as neutral in the counselling relationship; the ability to effectively utilise their skills; understanding of a client's social systems; and an interest in the client's experiences and the openness to help. These verbal and non-verbal skills are necessary to effectively conduct a counselling session (Goldberg, 2011). Further, it is imperative that a counsellor is contextually sensitive, assisting in creating an environment, which is optimal to the well-being of the client

(Goldberg, 2011). It is crucial for counsellors to understand that counselling is not an advice-giving session, but rather aims to develop and enhance the client's ability to cope, with present circumstances and in the future (Evian, 2000). Despite the various approaches to, and emphasis on, differing aspects of counselling, it is important to ensure the flexibility of the counselling session, thus enabling the client-counsellor relationship and permitting increased exploration of the client's concerns relevant to his/her well-being (McLeod, 2003). Although not a comprehensive overview of counselling skills, it is vital for counsellors to be adequately trained in these skills to ensure high-quality counselling.

Despite requiring adequate learning's to ensure a high quality service, skills learnt by the counsellor may become problematic when practically applied. Confidentiality, a crucial feature in the VCT procedure, plays a central role in people's willingness to present for VCT (Ekanem & Gbadegesin, 2004). The potential detrimental consequences of being HIV-positive and causes concern regarding the confidentiality of the VCT procedure. According to participants in MacPhail et al.'s study (2008) health workers often negatively converse, and breach the contract of confidentiality by discussing people's status among themselves. Clients often fear that their status may be revealed to others, leading to discrimination and stigmatisation by medical personnel or those within their community (Van Dyk & Van Dyk, 2003).

On the other hand, other medical staff attending to a client may require personal information revealed in the VCT process, which cannot be provided due to the importance of confidentiality (Rachier et al., 2004). Despite aiming to protect clients, not providing information to these medical personnel may impede the client from receiving quality care and treatment for HIV.

A study conducted by Angotti (2010) described counsellors' discontent with confidentiality requirements; suggesting that it is hindering, rather helping, the aims of the VCT process. Counsellors often felt that they were placed in an ethical predicament where, by not revealing a person's HIV status, they were placing others at risk (Angotti, 2010). A study conducted by Nulty and Edwards (2005) also elaborates on this, as many counsellors recognise the difficulty in maintaining confidentiality, and in convincing clients to disclose their status. It is therefore crucial to make counsellors aware of when it may be appropriate and advantageous to reveal test

results, without violating the client's human rights. Furthermore, in clarifying the role of confidentiality and shared confidentiality; clients may feel less anxious, and more trusting, when presenting for VCT. Therefore, training counsellors to attend to the emotional requirements of the individual helps increase trust, allowing certainty in the confidentiality of the VCT process.

Also of concern, is the voluntary nature of VCT based on the individual's informed consent. This condition may be violated by counsellors, particularly when the value and success of their work is measured in terms of the number of clients undergoing HIV-testing (Angotti, 2010). These criteria for evaluating counsellor performance may result in health care workers pressurising clients to take an HIV-test, thus blurring the lines between informed consent and inducement (Angotti, 2010).

Although VCT counsellors are trained to focus on conveying their knowledge and utilising the skills and principals taught, they are not prepared for all the possibilities, with which they may be confronted (Angotti, 2010). Training manuals should ideally encourage the importance and practical significance of confidentiality and counselling so as to improve the quality of the VCT procedure. Despite training providing theoretical knowledge, it does not provide counsellors a practical reference from which they can work. It is therefore vital in training of VCT counsellors, to take into consideration real-world challenges and apply these to practical exercises in training in order to improve the quality of service provided. This is particularly crucial regarding stigma and discrimination as they are major hindrances to the uptake of VCT and have detrimental consequences, causing a decline in a person's mental well-being.

Counselling skills may differ in depth and quality depending on the type of training received (Bharat & Mahendra, 2007). However, it is important for counsellors to acknowledge their ability and limitations to increase the quality of the service provided. According to Bharat and Mahendra (2007), the ability to refer, when unable to assist, often lacks. Despite the large mental health impact on the client, counsellors (most often lay counsellors with limited, or no, medical professional training) often have difficulty in adequately assisting the client with the mental impact of their experiences, much less acknowledge their limitations and identify the psychological needs of the client for referral. Consequently, psychological support and

supervision for counsellors plays an important role in enhancing the quality of psychological support provided to clients presenting at VCT centres.

2.8.2. Psychological impact of VCT- On the counsellor

Despite the tremendous psychological impact of VCT on a client, and the multiple challenges experienced by people living with HIV, VCT counsellors similarly experience a multiplicity of challenges on a daily basis. VCT counsellors are, expected to provide both information and care for those presenting for VCT (Evian, 2000). While necessary to learn the above skills, the rapid rise in the number of infected individuals per year, intensifies the need for health care workers to respond to the increasing needs of infected individuals (Bharat & Mahendra, 2007). However, practical considerations, such as time and space constraints, may result in a diminished quality of counselling provided (Angotti, 2010).

Studies have indicated that in South Africa, counselling sessions are often conducted with sensitive and more personal issues being avoided, due to the distress experienced by the counsellor in discussing sexual matters, the inadequate time specified for counselling sessions and the low pay received by counsellors for the work they perform (Bharat & Mahendra, 2007). In addition, the counsellors, due to increased contact with HIV-positive clients, have an increased risk of contracting the virus (Evian, 2000). Therefore, counsellors must be continuously aware and must take all necessary precautions to prevent accidental infection. These precautions include the safe use and handling of needles, discarding used needles into solid containers, the use of gloves and other protective materials such as eye glasses and mouth protection when handling blood and other bodily fluids, and washing hands with antiseptic soap (Evian, 2006). However, in resource constrained settings, these necessary requirements are often lacking, which places counsellors at significant risk of infection. This places increased pressure on counsellors, often leading to high attrition rates. Further, the extreme shortage of health care workers in certain contexts may result in counsellors sometimes having to counsel previous or current sexual partners (Angotti, 2010). Counsellors should therefore be trained in dealing with these matters professionally and flexibly, and be able to deal with their feelings of embarrassment and discomfort to improve the quality of the VCT process.

The tasks required of counsellors including informing clients of positive HIV results, organisational demands, and the counsellor's personal concerns surrounding HIV may, with other factors, contribute to a demanding work role, which consequently leads to a decline in counsellor mental well-being. According to Bharat and Mahendra (2007, p.93), "an adequately informed, skilled and motivated health workforce is critical to meeting the needs of HIV positive people, but unless they too are supported, they may become a major systems constraint in scaling-up of services".

Support and supervision for counsellors are critical in the VCT sector. Supervision and support facilitates a decrease in burnout and thus increases the quality of the service provided, enabling counsellors to meet the psychological needs of clients (Haffeejee et al., 2010; Rachier et al., 2004). Burnout, as defined by Pines and Maslach (1978 as cited by Collins & Long, 2003, p.420) is a "state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations". Burnout, characterised by low motivation and fatigue, may have a significant influence on how clients are counselled and cared for, thus decreasing the efficiency and quality of the service received (Goldberg & Howard-Payne, 2010; Patel & Langa, 2009). Supervision will also assist in motivating counsellors and maintaining quality standards (WHO, 2010). Support and supervision can take various forms, including: group meetings, individual meetings, in-service training and stress management (Bharat & Mahendra, 2007; Miller & Bor, 1988; Nulty & Edwards, 2005). Despite lay counsellors often receiving limited support and supervision, it is vital to emphasise this component in policy and training (Richter, Van Rooyen, Solomon, Griesel, & Durrheim, 2001). Therefore, adequate training and psychological support for counsellors are valuable in providing and maintaining a high quality VCT service.

2.8.3. Social impact of VCT

Psychosocial and environmental barriers can severely hinder the quality of the service provided to individuals. Neglecting these issues, and thus failing to inform counsellors of these concerns

in the training manuals, will inevitably decrease the quality of service provided because the counsellors may be unable to address these challenges.

Psychosocial barriers, such as poverty and the desperate need to survive, influence an individual's level of risk. Extremely poverty-stricken individuals often suffer on a daily basis due to the extreme lack of basic needs. This influences engagement in risky sexual behaviour as a means to attain these basic needs, and thus increases risk of infection (Ali, 2009). Furthermore, infected individuals place an added burden on poor families who must now care, and access treatment, for those infected, with the limited resources available. As the virus progresses, infected individuals often earn less due to their decreased level of productivity (Arndt & Lewis, 2000) thus positioning themselves and their family in a continuous cycle of poverty (Avert, 2010). This is further aggravated by the gender inequalities prevalent in society, whereby women are more likely to engage in transactional sex to receive basic necessities and security for both themselves and their families (Ali, 2009). Previous research highlights the issue of females having multiple sexual partnerships with wealthier males to obtain basic needs for survival (Zulu, Dodoo, & Ezech, 2002, Akwara, Madise, & Hinde, 2003, Dodoo, Zulu, & Ezech, 2007 as cited in Madise et al., 2007). Females, culturally placed in an inferior position in society, more often suffer from illiteracy and are more likely engaged in transactional sex. This results in discrimination and abuse of females, and deters the uptake of VCT (Lalthapersad-Pillay, 2009). This inferiority of females provides increased ability to males to make decisions regarding sexual-practices, thus limiting females negotiating power regarding unsafe sexual practices (van der Straten et al., 1995, Ulin, 1992 as cited in Glick, 2005). In a study conducted by Mabunda (2006) participants felt that men place woman at increased risk due to the greater likelihood of them having multiple sexual partners, their superior status and females' inferior, uneducated position, which lessens the likelihood that they will negotiate sexual practices.

In addition, environmental barriers, including the availability and proximity of VCT centres and the cost of both transport and the VCT process, is highly problematic in South Africa, with the majority of the population only able to afford presenting themselves at resource constrained VCT centres (Swanepoel, 2010). Being aware of, and having knowledge regarding the environmental barriers, and practical considerations such as time, which impact on the likelihood

of individuals returning for their results, may allow counsellors to cater to client needs and improve VCT services. Post-test counselling may increase the value of the supportive component of the VCT process where counsellors may further understand an individual's situation and empathise with clients, thus improving the quality of VCT. It would therefore be valuable to include information with regard to the environmental barriers that individuals might experience, in the VCT training manuals.

VCT counsellors often work in challenging conditions and are continuously exposed to the HI virus. This high-risk environment, in addition to the multiplicity of challenges evident, has detrimental effects on the quantity and quality of service provided. Organisational demands and limited resources place a great burden on the counsellors and health care system. The public health care system often suffers from poor infrastructure and a lack of basic supplies including needles, gloves and other medical equipment (Bharat & Mahendra, 2007). This places clients' and VCT counsellors' health at risk, often resulting in the exclusion of certain procedures carrying a higher risk of infection, or an increase in referrals (Bharat & Mahendra, 2007). Skipping certain procedures may be a safer option for counsellors, but does not enhance the quality of VCT services within South Africa, and is a hindrance to the fight against HIV/AIDS. Furthermore, although referral to a more sufficiently equipped clinic may be a more viable and practical option for counsellors, this could negatively impact the uptake of VCT. Preferred, and more sufficiently equipped, clinics may be much further away resulting in clients incurring additional costs and overcrowding of centres (Aids Foundation South Africa, 2010). This, in combination with counsellors who are already infected, directly impacts his/ her work, instilling fear of contracting HIV or infecting the client (Avert, 2010). Furthermore, many VCT counsellors are not highly paid, with salaries often being delayed or not being received at all (Bharat & Mahendra, 2007). These challenges frequently result in VCT counsellors leaving the profession completely, or moving to other countries, thus impacting the already tremendous shortage of health care workers within South Africa (Avert, 2010).

In addition to increased risk of contracting the virus, counsellors are required to perform emotionally taxing tasks, which place them at increased risk for decreased mental well-being. This is particularly so when providing clients with positive test results (Azwiangwisi,

Mavhandu, Vhonani, Netshandama, & Mashudu, 2007 as cited in Kabamba & Rabe, 2009). Furthermore, appropriately dealing with client's emotions and encouraging disclosure may place greater strain on the counsellor as this requires longer counselling sessions (Kabamba & Rabe, 2009; Nulty & Edwards, 2005). The physical and emotional work demands placed on counsellors lead to a declined mental well-being and thus increases the rate of attrition (Aids Foundation South Africa, 2010). Consequent staff shortages result in an increased workload and longer working hours for remaining counsellors, which can place great pressure on counsellors and be emotionally exhausting (Bharat & Mahendra, 2007).

A shortage of staff, high volumes of individuals presenting for VCT, and a limited amount of time to conduct pre- and post-test counselling with clients, may lead to clients not receiving the care they require. Studies have indicated that, owing to these factors, counsellors may experience feelings of guilt and failure in being unable to complete their tasks adequately (Nulty & Edwards, 2005). This is further exacerbated when counsellors are over-involved, particularly so when the counsellor is infected themselves or has family members or friends who are infected, resulting in high levels of stress from being unable to adequately assist infected clients (Aids Foundation South Africa, 2010; Bharat & Mahendra, 2007). Previous studies have indicated that inattention to the above concerns by management result in experiences of a lack of positive regard and approval hastening the deterioration of counsellor mental well-being (Israel, 2001; Nulty & Edwards, 2005). In addition, a lack of referral skills and inadequate training may aggravate counsellor's feelings, thus hastening the decline in mental well-being. Therefore, Bharat and Mahendra (2007) recommend VCT training that emphasises counsellor self-reflection, thus increasing counsellor's ability to detach their work from their personal situations.

In the context of severe staff shortages, lay counsellors play a significant role assisting in the implementation of VCT in South Africa. This is extremely vital, particularly so in resource constrained contexts (Patel & Langa, 2009). This is invaluable when aiming to provide a high quality service, which "may strain already weak health care infrastructures" (Denison et al., 2008, p.363). However, lay counsellors do not hold the skills-set received from professional training that is received by qualified counsellors. This results in the need for supervision of counsellors, so as to provide support, prevent burnout and allow professional growth thus

ensuring a higher quality service provided to clients (Rachier et al., 2004). In under-resourced settings, job related, organisational and personal demands, in combination with inadequate support, leave counsellors over-whelmed severely impacting their mental well-being, hastening burnout and decreasing the quality of care they are able to provide (Aids Foundation South Africa, 2010; Haffejee et al., 2010). Therefore, the VCT training manuals should ideally contain bio-medical facts, the psychological impacts of VCT and HIV/AIDS and should address the various social impacts and barriers that may be experienced when conducting VCT. This information is vital when aiming to provide a quality service.

2.9. The Bio-psychosocial Approach

The South African health care system is located within and emphasises the public health model in its practices. The public health model primarily focuses on controlling and preventing pandemics from worsening in the interest of the public's health (Taber, n.d.). The primary focus of the public health model is the encouragement of the populations' health as opposed to focusing on the individual (Munthe, 2008). In this way, the public health model promotes the improvement of infrastructure and proficiencies which assist in advancing the health care system of the country intended for the good of the public (Munthe, 2008).

Through aiming to lower the public's risk of and thus focusing on prevention of the transmission of the infection, the public health model places emphasis on health protecting behaviour. Therefore, the public health model concentrates on implementation of public policy and prevention services based on the interests of the population (Phillips & Coates, 1995, Strode et al., 2005, Yeatman, 2007 as cited in Van Rooyen, 2008). VCT, located within this model, has been largely established to prevent the rise in the number of HIV infected and affected individuals. The implementation of VCT is aimed to control the current HIV crisis through the identification of HIV positive individuals followed by prevention, through counselling. This is intended to encourage people, on an individual level, to adopt safer practices and behaviour to limit the spread of the virus thus ensuring the good health of the public.

This model encompasses a four step process to ensure that the primary goal of the model is met. The first step of understanding and defining the problem at hand assists in gaining a descriptive assessment of the current health status of the population (Dahlberg & Krug, 2002). Further, the factors that play a role in placing people at risk for the problem or alternatively shelter an individual from infection are vital to understand to ensure that the strategies in place effectively address the concerns and promote the protective factors (Dahlberg & Krug, 2002). The understanding of the HI virus including who it affects, how one is infected and the behaviours and associated factors influencing risk to infection supported the development of VCT, a prevention strategy that was established in response to the virus. The development and testing of this prevention strategy forms a vital component of the public health model. In this way, the evaluation of this strategy enables implementation for the public good (Dahlberg & Krug, 2002). The fourth and final step of this process is the implementation and adoption of the strategy (Dahlberg & Krug, 2002). The implementation of VCT has resulted in a shift in focus from the individual to the South African population.

The South African public health system, entrenched in the inequalities generated through the apartheid system has made major transformations post-apartheid, working towards redressing these inequalities. The South Africa Department of Health, through utilising the public health model, bases its premise on primary care, which takes into consideration the bio-medical and psychosocial aspects of health in the country. Social determinants are central to understanding health and disease (Gilbert, Selikow, & Walker, 1996). These determinants impact varying levels of a disease, ranging from an individual having an increased likelihood of infection, to having the ability to access the services required for prevention, care and treatment (Gilbert et al., 1996). Therefore, a balance between the bio-medical and psychosocial approach is required to adequately meet the needs of the country in responding to the HIV/AIDS crisis.

Despite policy being located within the public health model, determinants in prevention of disease and VCT continues to lack a psychosocial component, prioritising the bio-medical approach and educating the presenting individual. Emphasis on increasing the number of people who are aware of their status, disregards the essential and necessary need of prevention at an individual level (Van Rooyen, 2008). The bio-psychosocial approach to VCT is intended to be

the primary health approach adopted by developed and developing nations. It is therefore imperative that HIV-prevention and behaviour change through utilisation of VCT services is aimed towards balancing the educative and psychological components (Van Rooyen, 2008).

In addition, through focusing on the collective population, the individual needs, which essentially lead to the health of the majority, may be understated (Munthe, 2008). The public health model, through its primary goal, may essentially lose focus of the individuals concerns. On the other hand, taking into consideration the individual as opposed to the collective may also become problematic when one assumes “that the individual takes the initiative to seek out and use opportunities for preventing health problems” (Munthe, 2008, p.41). This is particularly problematic in South Africa where contextual factors, both social and infrastructure and services, play a vital role in contributing to the HIV pandemic. Therefore, not taking into consideration those factors influencing an individual’s level of risk and their willingness and ability to present for VCT can be a hindrance to the successful implementation of VCT.

The public health model holistically assesses the factors which influence an individual’s risk of contracting a virus (Taber, n.d.). Therefore, through utilisation of this model, efficient processes in prevention and suppression of HIV should be determined and established so as to implement an efficient service, which furthers the aims of the model (Taber, n.d.). However, with a continuously changing environment, behaviour modification and prevention strategies are required to constantly shift, to match the needs of the public (Taber, n.d.). In spite of this, a lack in resources amongst other factors may hinder the development of the service to match the needs relevant in the public sphere.

The public health model, focusing on prevention and education, aims to promote health-related behaviour and to improve public health (Gilbert et al., 1996; Taber, n.d.). Therefore, the model focuses on educating the public in obtaining support towards further control of the epidemic (Taber, n.d.). However, the numerous limitations experienced within the public health system hinder the application of the model. One of the major limitations is the lack of available funding (Chopra et al., 2009). This lack of funding suggests limited available training to up skill personnel working in the field, a negative impact on the number of health personnel being able to

work within the field and limits the accessibility of necessary equipment which demonstrates the most up to date technology available in the medical field essentially limiting the advancement of the public health care system.

The inequalities evident during apartheid are still portrayed, to some extent, in the current South African health system. The inadequate education received by non-white individuals and racial segregation of the medical field resulted in a limited number of non-white medical professionals (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Consequently, lack of personnel and further a lack of skilled personnel working in the field prevails. This severely compromises “the ability to deliver key programmes” with an adequate level of quality (Coovadia et al., 2009, p.830). Further, the implementation of policies often lacks in efficiency and adequacy due to a shortage of adequate governance, often exacerbated by the lack in personnel (Coovadia et al., 2009). This results in the inefficient use of limited resources and “has resulted in a failure to ensure that some of the fundamental facets of primary health care are in place, such as community involvement” (Coovadia et al., 2009, p.831). These concerns, in addition to the challenging working environment frequently create low morale among health care personnel thus further hindering the delivery of quality care (Chopra et al., 2009). The public health model, in its entirety, does not take into consideration contextual limitations that may be experienced in ensuring the good health of the public. However, as seen particularly within the South African context, this may lead to the detriment of the good health of the public.

2.10. Social Representations Theory

Social representations theory permits an understanding of social facts and ideas, which are shared by a community, that enhance effective communication (Augoustinos & Walker, 1999 as cited in Howard-Payne, 2010). Social representations theory, formulated by Moscovici, explains that social representations are “a system of values, ideas and practices” (Moscovici, 1973 as cited in Flick, 1998, p.24). The primary functions of this theory is understood as the values, ideas and practices that individuals hold to assist in establishing an order which facilitates individuals to adequately familiarise and adapt to their social environment subsequently enabling

communication between individuals within society by providing a system for social exchange (Moscovici, 1973 as cited in Flick, 1998).

Moscovici, a key theorist, portrays human communication and interaction as requiring a “system of common understanding of concepts and ideas” to communicate in an effective way (1984, as cited in Howard-Payne, 2010, p.107). This theory emphasises the processes of interpersonal interaction as influencing the arrangement and content of the principles thus providing a practical plan in communicating with others (Breakwell, 1993; Howarth, Foster, & Dorrer, 2004). In this way, social representations theory intends to understand and describe the idea that is associated to every image and vice versa (Moscovici, 2000).

Social representations theory utilises the 'taken for granted' and seemingly natural perceptions and understandings of the world, focusing on the images constructed through daily discourse, which are conveyed in daily interactions (Breakwell, 1993; Wagner, Elejabarrieta, & Lahnsteiner, 1995, p.673 as cited in Goodwin et al., 2003; Schoeneman, Schoeneman-Morris, Obradovic, & Beecher-Flad, 2010). This theory permits an understanding of how individuals may make meaning of unfamiliar concepts and experiences, based upon previous socio-cultural influences, thus, furthering understanding of how individuals comprehend and make significant meaning of their world (Breakwell, 1993). This is achieved through combining “a semantic knowledge and a belief that is rooted in the culture together with the practices that people live by” (Moscovici, 2001, p.24). Consequently, social representations theory examines the common sense and taken for granted knowledge and its accompanying systems, ideas and practices of social constructions of a lived experience (Flick & Foster, 2008).

2.10.1. Theoretical development of Social Representations Theory

Social representations theory, formulated by Moscovici in the 1960's, has been a contributor to many disciplines within the field of psychology, particularly social, discursive and social cognitive psychology. Social representations theory, initially a response to the difficulty within social psychology in defining the focus of the discipline, drew upon a number of existing theorists work in the development of the theory (Flick & Foster, 2008). Durkheim's concept of

collective representations played an important role in the theoretical development of Moscovici's social representations theory. Collective representations, as defined by Durkheim, refers to the shared systems in the conception, reasoning and evaluation of social reality (Hoijer, 2011). In this way, Durkheim dichotomised the individual and the collective where a single representation identified by a group, over other similar or dissimilar representations, predominates thus leading to representations having an invariable nature (Moscovici, 1988). In relation, Moscovici aspired to construct common sense knowledge as significant in its daily purpose thus continuously changing through social interaction (Flick & Foster, 2008; Moscovici, 1988). In this way, the significance of common sense knowledge is acknowledged as being seen as inferior to other forms of knowledge such as expert knowledge (Flick & Foster, 2008). However, social representations theory focuses on individuals utilising common sense knowledge as the foundation to comprehending, interpreting and in turn communicating about the various aspects within the world (Moscovici, 1973 as cited in Flick & Foster, 2008).

Moscovici, who focuses primarily on the social interaction individuals are engaged in, states that "representing is a social process, that is undertaken by individuals within a social group, in order to create and maintain a shared code" (Moscovici, 1973 as cited in Flick & Foster, 2008, p.197). Therefore, social representations are not novel nor individualistic constructions but rather are produced by individuals who employ and make use of shared knowledge to construct and co-construct social representations (Flick & Foster, 2008). Social representations, once established, become taken for granted knowledge which signifies reality thus developing into the concept understood by society as opposed to a representation of a particular object (Markova, 1996 as cited in Flick & Foster, 2008). In this way, the individual is seen as autonomous and active in producing and altering representations (Moscovici, 1988). Further, these representations socialise individuals within society thus influencing the thoughts and behaviour's towards various concepts (Moscovici & Hewstone, 1983 as cited in Flick & Foster, 2008). Therefore, through the theoretical development of social representations theory, Moscovici positions common sense as "knowledge shared by society as a whole, interwoven with our language, constitutive of our relations and our skills" with these representations utilised to organise human interaction (Moscovici, 2000, p.146). Additionally, social representations, through the active participation of individuals, powerfully infiltrate society in that it progresses into reality itself (Moscovici, 2000).

Social psychology, with its focus on social knowledge, asserts the cognitive processes such as perception and information gathering as interacting “to provide the actual knowledge within a social context” which is influenced by external factors such as experiences, culture and relations with others (Moscovici, 2001, p.9). According to Moscovici (2001), individuals require a system of common representations to aid in assisting to establish a bound society where shared rules are obeyed. In this way, social representations facilitate interactions in society consequently resulting in societal organisation (Moscovici, 1988). As stated by Moscovici (2001) in his formulation of social representations theory, common sense knowledge forms the basis of human interaction and situates an effective arrangement which permits the interaction. Further, in constructing new representations, individuals are enabled to further understand a variety of daily concerns which permits the comparison of representations across differing groups (Moscovici, 1988). These representations, once developed and established in a particular setting, become common sense knowledge and are incorporated into daily interactions (Moscovici, 1988). Therefore, social representations theory is fundamentally intertwined with social psychology, impacting on and comprising of social interactions (Howarth, 2006).

The formulation of social representations theory in social psychology became a vital and unifying aspect of cognitive psychology (Moscovici, 1988). Social cognitive psychology relates to the “mental processes that underlie behavior and action” focusing on the common sense knowledge that people retain to effectively function in a social interaction (Ormerod & Ball, 2008, p.555). In this way, social representations theory is intricately linked to social cognitive theory with the fundamentals of both fields concerned with common sense knowledge. However, according to Moscovici, common sense is the foundation of cognitive processes that occur due to its ability to furnish and provide the knowledge that is encompassed by individuals (Moscovici, 2000). Social representations theory, as related to social cognitive psychology associates cognitive processes to the content that is most extensively accepted by a social grouping (Moscovici, 1988). Therefore, similarly to social psychology, social representations theory as a component of social cognitive psychology asserts that representations are constructed to feature into what is already known thus transforming social representations into reality (Howarth, 2006).

In addition to social and social cognitive psychology, discursive psychology is centered with the viewpoint that people are “social and relational” beings (Wiggins & Potter, 2008, p.73). In this way, social representations theory and its association to discursive psychology is fundamentally based on the language utilised in social interaction. According to Wiggins and Potter (2008), discourse is linguistically constructed and utilised to represent particular accounts of the world which in turn are the outcome of the interaction itself. It is further positioned in a progressive setting where conversation is understood based on prior discourse (Wiggins & Potter, 2008). In this way, social representations theory has primarily focused on discourse within social interactions and the constructed representations (Flick & Foster, 2008). Social representations theory considers representations as objects and view thinking and knowledge as inner experiences with communication seen as an outer experience (Flick & Foster, 2008). Therefore, social representations in relation to discursive psychology takes a “critical stance against social cognition research but it avoids its shortcomings regarding knowledge and thinking” (Flick & Foster, 2008, p.199). Consequently, social representations are constructed accounts of the world which impacts on individuals and their perspectives (Wiggins & Potter, 2008).

Social representations theory as related to discursive psychology share fundamental commonalities in how discourse is viewed. However, there are a number of differences that highlight the variations between social representations theory and discursive psychology. A fundamental difference is that discursive psychology looks at social interactions as representing meaning whereas social representations theory predominantly relies on the individuals’ cognition which enables meaning making thus facilitating understanding of the world (Potter & Edwards, 1999). Further, discursive psychology views conversation as insufficient in aiming to understand social interaction whereas social representations theory views conversation as the device used to construct representations (Potter & Edwards, 1999). Further, social representations theory relies more on the cognitive aspect of interaction by regarding representations as a cognitive structure which permits the understanding of the world whereas discursive psychology views cognition “as a feature of participants’ practices, where it is constructed, described and oriented to as people perform activities” (Potter & Edwards, 1999, p.449). Through these fundamental differences, social representations theory, as utilised in this study, focuses on its association to social and social cognitive psychology as opposed to discursive psychology.

The current study aims to explore the content of VCT training manuals through the social representations of HIV allowing for an increased understanding of VCT training. The link between social and social cognitive psychology and social representations theory is comparable in its association to the representation of common sense knowledge as significant in permitting social interactions to take place. Social representations theory as related to social and social cognitive psychology fundamentally believe in the construction of representations which through interaction become taken for granted thus giving individuals the power in constructing and co-constructing representations. However, social representations theory in relation to discursive psychology focuses on the language utilised in social interaction to represent a particular version of the world with representations being constructed through conversation. In this way, discursive psychology relies on more than just conversation in the understanding of social interaction and the constructed representations. The current study aims to examine the topic areas covered in the training manuals through understanding of the social representations of HIV and the implications of the representations on the behaviour of individuals and in turn the fight against the pandemic. Therefore, the current study primarily focuses on utilising social representations theory in its analysis as related to social and social cognitive psychology thus focusing on furthering the aim of the study. Consequently, despite social representations being related to discursive psychology, the current study, through its association to social and social cognitive psychology initiates the conceptualisation of the social representations of HIV and the implications this may have ahead of an in-depth account of the complexities of social interactions which would result from a discursive analysis.

2.10.2. Anchoring and objectification within Social Representations Theory

Social representations theory encompasses two cognitive mechanisms which assist in the construction of social representations. Anchoring and objectification allow individuals to transform the unfamiliar into the familiar thus incorporating the social representations into daily reality (Schoeneman et al., 2010).

According to social representations theory, as formulated by Moscovici, anchoring is the first mental process which assists in generating a social representation and in turn making the unfamiliar, familiar. Anchoring refers to the process whereby the unknown is compared to the social representations that are already known by an individual (Hoijer, 2011). In comparing the unknown to more familiar representations, the unfamiliar becomes familiar through incorporation of new social representations to previous ones and the modifying of previous representations to accommodate new knowledge (Hoijer, 2011; Moscovici, 2000). Through this process the unfamiliar becomes related to more recognised representations and forms a part of “the collective frames of reference of a society” (Hoijer, 2011, p.7). According to Moscovici’s formulation, the notion of thought and reasoning without anchoring is disregarded (Moscovici, 1984, p.36 as cited by Laszlo, 1997, p.157).

Literature explaining the process of anchoring elaborate on the anchoring mechanisms utilised to make the unfamiliar familiar. The first and most common mechanism is naming an unknown concept thus locating it within an existing culture (Hoijer, 2011). The HIV/AIDS virus, initially an unknown and unfamiliar concept, through naming, developed from an unfamiliar virus into a recognisable frame of reference of illness and death. On the other hand, through naming the virus, particularly with its negative associations, it strongly relates the virus to stereotypes and the representation of the other being most vulnerable (Hoijer, 2011). A second mechanism assisting in the anchoring of concepts is where a concept is closely associated to particular emotions, referred to as emotional anchoring (Hoijer, 2011). This is particularly established in relation to the language used or by the imagery portrayed in relation to the concept (Hoijer, 2011). Further, thematic anchoring refers to unfamiliar concepts being anchored through themes, often seen as taken for granted knowledge (Hoijer, 2011). Anchoring in antinomies assumes the active participation of individuals in creating representations where opposing ideas on certain representations create tensions by thinking individuals thus allowing new representations to be created (Hoijer, 2011). Lastly, anchoring may also be linked to metaphors which compares the representation to something else legitimating the concept itself (Hoijer, 2011).

HIV/AIDS and its closely related negative associations which portray feelings of fear and danger gradually become related to themes and antinomies of life and death. Through these associations

of anchoring the concept to familiar representations, HIV/AIDS is gradually established to negative emotions, imagery, themes and metaphors which increasingly become taken for granted knowledge. However, these associations, once becoming taken for granted, become challenging to negate having a large impact on people's attitude and behaviour towards infected and affected individuals and the risky practices that may result in infection. Therefore, exploring HIV/AIDS through social representations theory, taking into consideration the anchoring mechanisms utilised by individuals, the researcher is able to gain an in-depth account of the representations that are associated to HIV and the implications that this may have on peoples' practices.

The second mechanism of objectification refers to the process of making "the unknown known by transforming it into something concrete" which can be recognised and experienced through an individuals' senses (Hoijer, 2011, p.12). In this way, objectification represents abstract concepts as concrete elements which are in existence in reality (Hoijer, 2011; Moscovici, 2000). According to Moscovici, the objectification process is a more active process than anchoring which occurs automatically when concepts are presented (Hoijer, 2011). The process of objectification occurs when a familiar representation is used to characterise a particular concept (Moscovici, 1988). Through this transformation from concept to object, objectification results in social representations becoming taken for granted and common sense knowledge (Moscovici, 1988). HIV/AIDS, as portrayed in the media in particular, demonstrate HIV infected individuals with degenerated bodies and visible signs of illness. In this way, HIV is objectified and transformed from an abstract concept into something concrete that is closely associated to illness and helplessness.

Through comparing and associating unfamiliar concepts with the familiar (anchoring), and transforming these into common-sense, and often taken-for-granted notions (objectification), individuals from differing social and cultural backgrounds are able to interact and communicate on a daily basis (Augoustinos & Walker, 1995 as cited in Schoeneman et al., 2010). In this regard, social representations theory presumes that understanding, foreseeing and controlling are the key motives for individuals (Schoeneman et al., 2010). Consequently, utilisation of the social representations theory will permit further understanding of how social representations withstand time in response to multiple and conflicting representations.

2.10.3. Social Representations Theory and HIV/AIDS

HIV testing encompasses a multifaceted variety of social, cultural and political factors (Worthington & Myers, 2003). This is intimately linked to many of the challenges experienced by individuals either wanting to present for VCT or already infected. Presenting for VCT “is the behavioural end-point of a range of converging contextual and personal influences” (Swanepoel, 2010, p.9). In South Africa, it is these very influences that severely impede the success of VCT. This is reiterated by Mabunda (2006) who maintains that the culture of testing for HIV has still not been adequately established. It is therefore vital to provide individuals with messages of hope and the importance of knowing their HIV status, such that they are able to more readily accept and understand the current crisis (Brockway, 2007). These positive messages thus aim to convert negative social representations into knowledge commonly shared, thus enabling a culture of testing.

Perception of risk, HIV and VCT lays the foundation for many of the psychosocial barriers people contend with. The perception that people hold of themselves and others is closely linked to the judgement they make regarding their own risky sexual behaviour (Swanepoel, 2010). However, this perception is highly subjective and not necessarily accurate, encompassing many systematic biases (van der Pligt, Otten, Richard, & van der Velde, 1992). Therefore, individuals often overestimate, or underestimate, their level of risk in contracting the virus (Van der Pligt et al., 1992). This is particularly problematic, as those most in need of the service do not present, believing they have no reason to do so. However, modifying people’s thoughts to a more accurate level of risk is an extremely challenging issue, whereby individuals who often underestimate their levels of risk partly do so to protect their identities and their beliefs of who they are as people (Swanepoel, 2010). A study conducted by Mbengashe (1996 as cited in Howard-Payne, 2010) portrays how social group membership and social representations of HIV impact on individuals’ awareness of their risk to HIV.

A contributing factor towards people’s perception of their level of risk is fuelled by the common misconceptions surrounding HIV/AIDS. Myths hinder the uptake of VCT, exacerbating thoughts that nothing can be done to help or that continuing their risky sexual behaviour (such as sleeping

with a virgin to be cured) can only be advantageous (Kruger et al., 2009). A study conducted by Ekanem and Gbadegesin (2004) reiterates this conception, finding that more educated individuals, as compared to those with a lower level of education, felt more at risk. This is particularly problematic in South Africa, where, under the apartheid regime, many received inadequate education. This is reiterated by Sandoy, Michelo, Siziya and Fylkesnes (2007 as cited in Ali, 2009) who found increased condom usage among more educated individuals. In this way, social representations seemingly have the power to change individuals' perceptions of their risk, thus being more likely to present for VCT. Individuals perceiving VCT as a beneficial process are more likely to present. Therefore, VCT campaigns should emphasise the benefits of the service thus reframing the social representations, through lessening the stigma associated with undergoing VCT.

Social representations of HIV, AIDS and VCT are developed and communicated through interactions with others, which influence their behaviour (Howard-Payne, 2010). A lack of trust in the public health care system often deters individuals from attending VCT sites or from receiving the appropriate care and treatment they require (Arthur et al., 2000, Pool et al., 2001 as cited in Van Dyk & Van Dyk, 2003). HIV testing should be conducted only when informed consent has been obtained and is decided upon voluntarily by the client (WHO & UNICEF, 2010). However, problems often arise when putting these concepts into practice. Counsellors often attempt to coerce clients by convincing and encouraging them to take the test (Angotti, 2010). This is further complicated when counsellors have a more personal relation to the client whereby testing guidelines are often dishonoured (Angotti, 2010). A study conducted by Angotti (2010) indicates a counsellor who, during her daughter's pregnancy, requested for the placenta to be tested for HIV. These unethical practices require investigation and prevention. However, an individual unaware of his/her sero-status, despite medical personnel believing the individual to be of high-risk, produces much debate leaving a deep lack of trust in the public health system (Angotti, 2010). This deep lack of trust highly influences the individual's willingness to present for VCT, despite perceptions of his/her level of risk. It is, therefore; of utmost importance to address social representations of the various aspects surrounding HIV/AIDS and VCT.

In this way, social representations are embedded in “social and collective products of communication, which perform ideologically by vindicating and legitimising the existence of stereotypes and prejudices within society” (Abdool Karim & Abdool Karim, 2005, Winskell, Obyerodhyambo & Stephenson, 2011 as cited in Howard-Payne, 2010, p.16). Stigmatisation and discrimination are the largest barriers to the uptake of VCT. HIV/AIDS, has, in many respects, been characterised as equivalent to “death, plagues, evil, punishment of immorality, sexually transmitted diseases, homosexuality, war, crime, rural areas and contamination” (De Rosa & D’Ambrosio, 2002, Flynn & Murray, 2005, Gilman, 1988, Howard-Payne & Kiguwa, 2008, Winskell et al., 2011 as cited in Howard-Payne, 2010, p.17). Furthermore, those associated to the disease, through infection, have often been distinguished as a ‘victim’, perpetrator or just as the vague ‘other’ (De Rosa & D’Ambrosio, 2002, Flynn & Murray, 2005, Gilman, 1988, Howard-Payne & Kiguwa, 2008, Winskell et al., 2011 as cited in Howard-Payne, 2010). These representations, with the unavailability of a cure and treatment, have resulted in the ‘exceptionalism’ of AIDS (Bayer, 1991 as cited in Van Rooyen, 2008, p.14). This produced a fear of contracting the virus, developing and enhancing stigma and discrimination of HIV/AIDS (De Cock et al., 2002, 2003, 2006 as cited in Van Rooyen, 2008). AIDS exceptionalism continues to fuel the stigma and discrimination associated with HIV/AIDS. Therefore, HIV is socially represented in ways that promote stigma and discrimination.

Stereotypes surrounding HIV/AIDS have severely fuelled the discrimination of groups of people expected to be of high risk. The blaming of other races and religions for spreading the virus is a common problem in the South African context (Petros et al., 2006). This occurs most frequently towards the black racial group who were marginalised under the apartheid regime (Petros et al., 2006). In Sub-Saharan Africa approximately 61% of adult woman are infected, with black women being more prone to infection than men (Ali, 2009). The high prevalence rate may be intensified due to the gender inequality regarding education, where men are prioritised; resulting in woman making uninformed choices concerning sexual practices, and the negotiation of condom usage (Ali, 2009).

Presenting for VCT and testing positive may result in dire consequences, which influence an individual’s decision to present for VCT and thus increases his/her level of risk for contracting

the virus. VCT counsellors are trained to encourage disclosure of an individual's status to all sexual partners, family and friends, to curb further infection and allow support and assistance in care and treatment when needed. However, the belief that they are sexually unacceptable, leading to a lack of support when needed most, results in many not wanting to disclose their status, for fear of being rejected or possibly abused by family members or sexual partners (Kruger et al., 2009). Moreover, the very nature of presenting for VCT creates perceptions of being judged (MacPhail et al., 2008). Many believe that presenting for VCT creates suspicion among family and friends that one is either HIV positive or sexually promiscuous (Swanepoel, 2010). Exacerbating this issue is stigmatisation of the self, where infected individuals feel guilty and shameful, resulting in a loss of power and control over their situation (Worthington & Myers, 2003).

Social and cultural connotations associated with being HIV-positive, permit high levels of anxiety and fear of rejection and abuse (Van Dyk & Van Dyk, 2003). This severely hampers an individual's mental well-being, particularly when victimised. A study conducted by Patel and Langa (2009) found that HIV-positive individuals often decided to not disclose their HIV status, which influenced adherence to their treatment regimen. The barriers to disclosure occur most often with females, who are more prone to abuse from their male sexual partners (Gielen et al., 1997 as cited in Boswell & Baggaley, 2002; MacPhail et al., 2008). Previous research has indicated the value of couple's testing in promoting behaviour change, considerably lessening the burden of disclosure (Glick, 2005).

Stereotypes regarding HIV and VCT are further worsened by connotations associated to condom usage. Condom usage, in stable partnerships and certain cultural practices, may be viewed as mistrust, thus thwarting efforts to increase the use of condoms and reduce risk (Avert, 2010). As portrayed "stigma has a profound effect on people's decisions, behaviours and outcomes" (Young et al., 2010, p.620). Advocating trust in the process may assist in normalising HIV testing, decreasing the stigma and discrimination associated with testing and a positive status (Birdsall et al., 2004).

VCT counsellors, due to the nature of their job, often experience secondary stigma from family, friends, and those within their community (Bharat & Mahendra, 2007). This may have an impact on the mental well-being of the counsellors which in turn may affect the quality of service provided. These health workers, encompassing a qualified voice, play a vital role in society and should be acknowledged, holding a high status within the community (Rachier et al., 2004). The issues raised above beg questioning as to whether the training manuals take into consideration the context within which the counsellors work. As is evident, HIV is represented in ways that promote stigma and discrimination which then cause further difficulty in the successful implementation of VCT.

The mass media play an essential role in producing and portraying social representations of HIV to the public, taking into consideration both lay and specialist explanations (Moscovici, 1961 as cited in Gibbs, 2010; Hepworth & Featherstone, 1998 as cited in Lyons, 2000). The mass media represent meaning through the use of written and spoken language which ultimately portray dominant representations which are continuously reinforced (Lyons, 2000). In this way, the media is a vehicle for socially representing HIV in particular ways. Similarly, the VCT training manual compares with the various forms of print media such as newspapers as an instrument that socially represents HIV/AIDS in particular ways, most often aligned to the dominant representations of a particular period in time. According to Faure (2008), the media represent and make sense of the world we live in by providing information and the related explanation. In this way, VCT training manuals portray information and explanations of HIV/AIDS to ensure understanding of the virus through a particular representation. However, individuals with limited knowledge or experience related to HIV/AIDS depend more heavily on the information provided by the media and similarly the VCT training manual (Faure, 2008). Therefore, the social representations presented by both require cautiousness in how HIV is presented and represented.

Techniques utilised by print media lay the foundation towards further reinforcing dominant representations of HIV/AIDS. In highlighting certain information and topic areas, the media is able to attach greater significance to a topic area (Faure, 2008). Further, media gatekeepers such as those organisations owning particular media, determine what information is made available and how it is portrayed thus influencing how lay individuals interpret the information provided

(Faure, 2008). The VCT training manual, in portraying certain information and emphasising on certain topic areas over others portray the significance of the topic area for that organisation. In addition, the HIV organisations developing the training manuals similarly determine what information is provided and how it should be portrayed through training thus influencing recipients of the information. According to Faure (2008), print media, through the explanations provided and sources used, assist in representing a particular perspective of a topic area. Further, print media, through its focus on written language concentrate solely on individuals who are literate and those able to afford that particular form of media (Faure, 2008). In the same way, the VCT training manuals, through providing information and reasoning through experts teaching on a particular topic area, concentrate on a particular audience who will essentially disseminate a particular view of HIV to those presenting for VCT. Therefore, a VCT training manual compares with various forms of print media as a vehicle for socially representing HIV in particular ways.

Social representations theory conveys perceptions of a knowledge system permitting interaction between individuals, which is by nature, consensual (Paez et al., 1991 as cited in Goodwin et al., 2003; Schoeneman et al., 2010). Social representations of concepts are often produced and developed over a large amount of time with multiple contributors (Breakwell, 1993). It is therefore vital to understand the processes involved in producing social representations and ultimately the social representations that form, and the significance of these to society. Utilisation of this theory does not provide an understanding of why representations exist in a particular manner (Breakwell, 1993). However, it does acknowledge the multiplicity of representations in relation to any specific concept or experience, without showing favour to any one particular representation over another (Howarth et al., 2004). Nevertheless, it is vital to note that contributors with power often have more of an influence in the uptake of social representations (Breakwell, 1993). Therefore, it would be assumed that VCT policy makers and distributors of VCT information, the VCT training centres, hold power to substantially influence social representations of VCT and aspects related to HIV/AIDS. Furthermore, international organisations, often viewed as having more power than local VCT centres, may also influence the social representations prevalent within South African training manuals, and in essence, the South African public. With the dire HIV/AIDS situation that is currently being faced in South Africa, planning for future health care needs is vital. Therefore, with the power held by VCT

centres, the social representations of aspects related to HIV/AIDS may assist in lessening the crisis.

2.11. The Bio-psychosocial Nature of HIV

The multi-faceted nature of HIV and HIV testing is closely associated and influenced by bio-medical, psychological and social factors (Worthington & Myers, 2003). In aiming to lessen the pandemic within South Africa, an increase in the number of individuals presenting for VCT and thus knowing their HIV status is vital. However, the negative social representations that surround HIV and VCT severely impede this aim. Nevertheless, without taking into consideration the psychological and social factors that influence the negative representations, HIV representations will remain negative.

The social and cultural context that embodies an individual and influences their behaviour “contributes to legitimising and giving meaning to the common assumptions, expectations and values that people hold in relation to their day-to-day activities” (Leclerc-Madlala, Simbayi, & Cloete, 2009, p.16). In this way, social representations that are generated by society and communicated and further developed through interactions function as a legitimising activity for the occurrence of negative representations (Howard-Payne, 2010).

Stigmatising and discriminating representations, which are influenced by sociocultural factors impede the success of VCT. The multiplicity of previous research indicates that negative HIV social representations are most often established due to psychosocial and sociocultural influences. Kruger et al. (2009) portrays the significance of family and an individuals’ support structure as being a vital reason for many not wanting to test for HIV or not wanting to disclose their status in fear of rejection or abuse. On the other hand, when not disclosing their status, individuals are less likely to maintain their rigorous treatment regimen (Patel & Langa, 2009). Research by Swanepoel (2010) also demonstrates the significance placed on presenting for VCT where VCT is represented as an individual already being infected with HIV thus generating concern that one’s family, friends and community may be suspicious that the person is being sexually promiscuous or engaging in other risky behaviour. Being infected with HIV, an illness

with no cure, results in negative consequences further exacerbating negative social representations of the virus. Previous research indicates that HIV/AIDS has been socially represented in a number of ways including being associated to death, punishment of immorality and contamination of the body among others (Howard-Payne, 2010). These social representations, which are closely associated to social factors of fear and primarily discrimination impact on the way HIV is socially represented and thus severely hinders the uptake of VCT (Van Dyk & Van Dyk, 2003). Therefore, without taking into consideration the psychosocial factors surrounding HIV and the uptake of VCT, social representations of HIV will be purely based on the bio-medical aspects thus resulting in negative social representations.

2.12. The Current Study

The HIV/AIDS pandemic is a global concern impacting all levels of society hindering a secure and stable nation. VCT, as a national response to the HIV/AIDS crisis is a key prevention strategy working towards reducing the impact of the virus. The identification of bio psychosocial factors contributing to the increase in HIV infection has resulted in the scaling up of universal access to prevention, care and treatment of HIV/AIDS. However, social determinants have been acknowledged as major contributors to HIV risk. The three step VCT process assists in addressing the bio psychosocial factors contributing to HIV risk encompassing an educative and supportive component thus working towards behaviour change. However, the psychological distress associated with the VCT process makes counselling, in working towards managing this distress, a vital component of the process. The conceptualisation and implementation of VCT is fundamentally based upon national and international policy which directs VCT practice and service delivery. The South African health system is located within the public health model which primarily focuses on controlling and preventing pandemics from worsening in the interest of the public's health taking into consideration the social determinants in contributing to the rise of HIV infection. These guiding principles and policies assist in the development of VCT training manuals and are of great importance in laying the foundation towards the development and enhancement of services available within the country. However, the implementation of good

quality training is vital in increasing the quality of the service provided thus working towards eradicating the virus.

The VCT training manual, a vehicle for socially representing HIV in various ways, influences the success of VCT. The social representations theory permits an understanding of how individuals make meaning of concepts and experiences which are then conveyed in daily interactions influencing behaviour. Perception of risk, HIV and VCT lays the foundation for many of the psychosocial barriers people contend with. Therefore, understanding the social representations of HIV and the associated aspects contributes to influencing behaviour change. As discussed and in response to the above chapter, the primary aim of this study was to explore the content of the VCT training manuals through the social representations of HIV, allowing for an increased understanding of VCT training.

CHAPTER 3: METHODOLOGY

3.1. Introduction

This chapter outlines the methodology used to conduct the current study. The research aims, questions, design, procedure of the study, and ethical considerations are presented in this chapter. In addition, an explanation of the training manuals used in the analysis, is described. The data analysis used to conduct this study is presented, providing an explanation of a thematic analysis, the process of conducting the analysis, advantages and disadvantages of this method, and the validity of the analysis.

3.2. Research Aims

This qualitative, idiographic, comparative research aspires to gain a broader and deepened understanding of the content of seven English-based VCT training manuals used in the Gauteng public health system. The primary aim of this study was to explore the content through the social representations of HIV, allowing for an increased understanding of VCT training.

This research study sought to explore the content of the training manuals in a number of ways. This study examines the social representations of the topic areas covered in the training manuals, namely the bio-medical, psychological and social content. Furthermore, this study, through examining the topic areas covered, assessed the extent to which the manuals provide bio-psychosocial content. Therefore, this study addresses the negative social representations that exist when HIV is explained solely as a bio-medical concern, which can be addressed through a bio-psychosocial model. By focusing on the training manuals, this research study did not explore or evaluate the service provided at VCT centres and thus, does not aim to make recommendations in this regard.

By examining the training manuals within a qualitative paradigm, it is anticipated that the findings will enable a greater understanding of the VCT training that is received within the

Gauteng region. Consequentially, this will permit the researcher to suggest recommendations on how the VCT material can be improved along the lines of existing social representations to move beyond the bio-medical standpoint, to including more psychosocial features.

3.3. Research Questions

3.3.1. Primary research question

- 1) What social representations are addressed in the content of the VCT training manuals, at the time of the study, used by VCT counsellors in the Gauteng region?

3.3.2. Secondary research questions

- a) What social representations, in relation to the bio-medical content, are addressed in the VCT manuals?
- b) What social representations, in relation to the psychological content, are addressed in the VCT manuals?
- c) What social representations, in relation to the social content, are addressed in the VCT manuals?
- d) What are the dominant social representations of HIV for each of these areas of content in the VCT training manuals?

3.4. Research Design

This research utilised a qualitative paradigm, where the researcher is positioned within the world that they are studying. This allows the researcher the opportunity to interpret and engage with the topic under investigation, using the social representations theory which is underpinned by the social constructionist paradigm. Social representations theory, as underlined by the social

constructionist paradigm, fundamentally examines the process of meaning-making, closely connected and influenced by social factors, which ultimately affects individual behaviour. This accommodated differing perspectives on how HIV/AIDS and various related information is represented in the training manuals and is subsequently disseminated to the public ultimately affecting human behaviour. According to Marshall and Rossman (2011, p.2) qualitative research is “pragmatic, interpretative, and grounded in the lived experience of people”. Qualitative research gave the researcher an opportunity to initially observe specific instances thus, further allowing general trends of the data at hand to emerge (Patton, 1980). Therefore, this paradigm allowed the researcher to conduct an inductive, ideographic analysis, whereby the results pertained to the specifics of the VCT training manuals utilised in the Gauteng region, thus aiming to effectively improve the VCT service provided. The data collected by the researcher was interpreted using the social representations theory (as discussed in chapter 2). A qualitative approach, in a social representations framework, permitted a greater in-depth understanding of the content of the training manuals, taking into consideration the contextual factors when implementing the service.

3.5. Training Manuals

This particular research study did not focus on human participants but rather utilised the training manuals that are developed to train VCT counsellors. Two of the seven training manuals sampled for this study were developed by international organisations (CDC and FHI). These manuals, although not necessarily utilised in the South African context, with the exception of the latter, form the basis for informing those manuals developed within South Africa. The other five manuals were obtained through organisations that have developed their own training manuals within South Africa (New Start, HIVSA, Right to Care, the Rural AIDS and Development Action Research Health Systems Development Unit and the Health Systems Trust).

There are several NGO's within South Africa that provide training to personnel working within the field. Some of the major HIV/AIDS NGO's that provide VCT training include WHO, New Start, CARE, the Reproductive Health Research Unit, Right to Care and the HSRC among others. The NGO's providing training for VCT either provide a trainer and trainee manual or a

single manual utilised by both the trainer and trainee. When providing a trainer and trainee manual for training, it enables differentiation between how to educate trainees and the key elements that a trainer should be made aware of and essentially have on hand when implementing their knowledge. Further, the greater level of depth provided in a trainer manual would be particularly beneficial towards standardising the training provided within the country thus working towards increased collaboration between different NGO's and their material. On the other hand, providing one training manual for both trainer and trainee may assist in providing greater depth of information to the trainee, which would traditionally not have been provided.

In addition to the above mentioned types of manuals provided by NGO's, guidelines and toolkits may be available to supplement the learning material used in training providing a practical element to the information taught. The guidelines provide information on the key elements of the information taught. It is therefore easily referable for trainees, which is particularly important for those working in the field for the first time. Further, toolkits provide additional and greater in-depth information to either the trainers or trainees. Toolkits provided to trainers offer a variety of methods to teaching the content in various ways thus allowing trainers the opportunity to increase the trainees understanding based on the level of knowledge and skills they encompass. On the other hand, if provided to trainees, it is beneficial as they are then able to advance their knowledge and understanding of HIV beyond what is taught during training. The severe nature of the virus requires VCT personnel to fully comprehend the implementation of the knowledge to successfully provide VCT to individuals and positively impact on their behaviour. Therefore, incorporation of the guidelines and toolkits, as supplementary tools to training, is a vital component to VCT training.

The seven VCT training manuals utilised for analysis, developed by various NGO's and international organisations, were primarily selected based on the availability of the training manuals to the researcher. Approximately 15 institutions/organisations (all located within the VCT field within South Africa) were contacted telephonically by the researcher to inform them of the nature of the study, and to request a copy of their VCT training manuals. However, of the organisations contacted, only four willingly provided copies of their training manuals to the researcher. Reasons provided by other institutions/organisations for not providing the training

material included that they: (1) did not have a VCT training manual to provide, (2) did not provide any VCT training and, (3) had to refuse access due to undisclosed reasons and logistical setbacks (such as the training manager being unavailable to grant the researcher permission to access the VCT training manuals). The remaining three manuals were publically available and accessed through the internet through the respective organisations' webpage's. Further, it was not viable, nor desirable, for the researcher to attempt to analyse every possible VCT manual currently being utilised by various public health facilities that offer VCT services, such as Right to Care, New Start and HIVSA among others. However, the researcher sought to obtain access to those training manuals, which are promoted by the NDoH and are widely used thus, allowing an opportunity to evaluate the content of the manuals most recently utilised in the public health system. In addition, the researcher sought a broad range of training manuals from different organisations, so as to gain a general sense of the types of manuals made available to VCT counsellors within the public health system.

Currently, all the training manuals, utilised for analysis, are provided to counsellors and becomes a document, which they are then able to refer to at any time, during or after their training. The training manuals are a part of a comprehensive strategy where counsellors receive facilitated training sessions. Therefore, counsellors, in conjunction with the facilitators of the respective training organisations, jointly work through the training manuals in preparation for working in the VCT field. The training manuals are then intended to become a source which counsellors, at their discretion, are able to refer to.

A brief description of the organisations from which the training manuals analysed in this study is provided below. These descriptions provide a context in which a further understanding of the training manuals can be achieved.

3.5.1. Family Health International (FHI)

The training manual utilised by FHI, 'HIV Voluntary Counselling and Testing: Skills Training Curriculum – Facilitators Guide', was released in January 2005 (FHI, 2005). FHI receives

funding from the US agency for international development among other donors (FHI, 2005). The FHI VCT training manual includes the trainer and trainee manual and a reference guide offering an extension to the training curriculum (FHI, 2004b). Both manuals contain the same content, with the facilitator guide encompassing a greater depth of information. For the analysis of this study, the trainer manual was utilised due to the greater level of depth with a clearer indication of the training sessions through the instructions provided in the manuals. Despite being unclear on how the training manuals content is taught, the trainer manual provides an increased transparency into the training session with the greater depth of information provided. The greater depth of information provided to trainers on how to portray information to the trainees is therefore more evident in the manual utilised for analysis. The facilitator's manual aims to guide VCT trainers at varying levels, aiming to expand the VCT service within the country (FHI, 2004a).

3.5.2. New Start

New Start is a non-profit HIV testing program managed by the Society for Family Health organisation (New Start, 2009). The New Start initiative is funded by a number of donors and corporate sponsors including the presidents emergency plan for AIDS relief (PEPFAR), the CDC, global fund and Levis South Africa (New Start, 2009). Furthermore, New Start has numerous partnerships with the Mosamaria Aids Ministry, Faith and Hope Integrated Aids Program, Targeted Aids Interventions, Trinity health centre, Centre for positive care and Anglican diocese of Grahamstown (New Start, 2009). The training manual, 'HIV Counselling Training- Trainees' Manual', was developed in 2007 and significantly modified from the WHO 'HIV testing and counselling trainees manual- November 2005' and 'PSI/Zimbabwe's HIV preventative counselling participants manual- 2005' (New Start, 2007). New Start has a trainer and trainee manual, with the latter containing 15 modules encompassing a comprehensive overview of the VCT process. The trainee manual is utilised for analysis, primarily due to the availability of this manual. However, the trainee manual provides the key components of the VCT process holistically. In this way, the researcher was able to gain a comprehensive overview of the information taught to the trainees'.

3.5.3. HIVSA

HIVSA is one of the most recent HIV/AIDS centres acquiring full training accreditation in November 2007 (HIVSA, 2009). HIVSA is funded by the UNAIDS and PEPFAR, with training including a diploma qualification operating community outreach programs and professional development (HIVSA, 2009). HIVSA aims to “provide psycho-social support to those infected and affected by HIV/AIDs” providing services to those within the greater Soweto area and the Mpumalanga province (HIVSA, n.d., p.2). The training manual, ‘HIVSA- Provide pre and post HIV test counselling’ is one of the learner guides of a series of 22 modules. A trainer and trainee manual are available, with the former providing instructions on the activities to be achieved in the training session. Training is conducted by individuals who are already in the field of HIV testing and counselling, training those individuals who have different levels of experience. However, majority of those individuals presenting for training are often already employed within the field and are sent for training by the South African Department of Health. Therefore, this training manual is most likely expected to be the most aligned to national policy. Further, these counsellors are more likely to have greater say at policy level. The learner guides are utilised for analysis in this research study. The HIVSA manual used for analysis affords the researcher the opportunity to focus on the information aligned to the national policy which is being portrayed to the trainee’s. Further, the focus on the counselling aspect portrays, to some degree, the focus of the government in moving towards eradicating HIV/AIDS.

3.5.4. Right to Care

The Right to Care NGO is reasonably prevalent across some of the major hospitals within the Johannesburg region, reaching 136 651 clients in active HIV care and testing and 226 009 individuals at 184 outlets by the end of 2009 (Right to Care, 2009). Right to Care has numerous associations with both, the government of South Africa and other NGO’s (Right to Care, 2009). Right to Care supports the government in providing training in five provinces, providing services to over 170 sites, which range in every aspect of HIV/AIDS, from sexually transmitted infections (STIs) to HIV-related illnesses and treatment of HIV/AIDS (Right to Care, 2009; Right to Care,

n.d.). Furthermore, Right to Care also provides support to 19 NGO's within five provinces in South Africa (Right to Care, 2009). This organisation is partnered with the Clinical HIV research unit (CHRU), the AIDS Care, training, and support initiative (ACTS) Clinic, Witkoppen Clinic, Alexandra Clinic, Ndlovu care group, Topsy foundation, Hlokomela, and Amcare (Right to Care, 2009).

The Right to Care health services are funded by PEPFAR and the United States Agency for International Development (USAID) (Right to Care, 2009). The training manual, a single manual encompassing 25 modules, the 'HCT skills training for counsellors: Provide pre and post HIV test counselling – Training manual' was developed with the main aim of providing practical skills development of the pre- and post- test HIV counselling process encompassing theoretical aspects of this process (Right to Care, n.d.). Different topic areas are covered in different training sessions. The manual utilised for analysis focused on the psychological aspect of VCT including training on the VCT process itself. The psychological focus of the current study makes the manual applicable for analysis. The manual utilised for analysis is linked to a workbook required for completion of the course by trainees. For the purposes of the current research, the workbook was not analysed due to the focus of the research on the training manuals as opposed to any associated material.

3.5.5. Centre for Disease Control and Prevention (CDC)

CDC is an international organisation operating as a core component of the department of health and human services aiming to "create the expertise, information, and tools that people and communities need to protect their health- through health promotion, prevention of disease, injury and disability, and preparedness for new health threats" (CDC, 2012, para.1). The training manual, 'Voluntary Counselling and Testing (VCT) - Trainers manual', was developed in March 2003 with multiple United States based and international collaborators, including South Africa's ministry of health (CDC, 2003). There is a trainer and trainee manual, with the former being utilised for analysis due to the greater level of depth in the information provided. The manual utilised for analysis is applicable to the current study due to the greater detail in the manual thus

providing increased transparency and understanding of how trainers educate and inform the trainees. The CDC works closely with other international organisations providing vital information relating to the information provided by South African manuals.

3.5.6. Rural AIDS and Development Action Research (RADAR) - Health Systems Development Unit

The RADAR program is under the Health Systems Development Unit in the Limpopo province. The RADAR program is a partnership between the University of the Witwatersrand's School of Public Health and the London School of Hygiene and Tropical Medicine focusing on the development of "model approaches that are appropriate and relevant to the rural African context" (University of the Witwatersrand, 2000-2013, para.1). The training manual, a single manual encompassing five modules, 'Radar counselling skills manual', was utilised for analysis. The psychological focus of the current study makes a counselling skills manual applicable for this study. Further, this manual is developed and utilised locally thus providing a greater indication of the information disseminated to the South African community.

3.5.7. Health Systems Trust (HST)

Health systems trust is a not-for-profit organisation developed to assist the transformation of the South African health system post-apartheid (Health Systems Trust, 2011). The main aim of Health Systems Trust is "to contribute to building comprehensive, effective, efficient and equitable national health systems by supporting the implementation of functional health districts in South Africa and the southern African region" (Health Systems Trust, 2011, para.3). The training manual, 'provider initiated counselling and testing participant's manual' was developed with financial support from the CDC and the South African NDoH (Health Systems Trust, n.d.). The VCT training course is divided into 9 modules taught across a 24 hour contact time period (Health Systems Trust, n.d.). The current manual is the only provider-initiated manual utilised for analysis. The manual was selected based upon time constraints and logistical problems experienced with other organisations. Despite the problems experienced, the researcher

anticipated that this manual would be a valuable contribution to the current study due to the increased focus on provider-initiated VCT within South Africa. Provider-initiated VCT follows a slightly different process than client-initiated VCT. Therefore, the content provided would differ, thus providing broader and more generalisable findings. Further, it allows the researcher an opportunity to differentiate between the client-initiated and provider-initiated process which differ in how personnel address the client, having an impact on how content is socially represented to those presenting.

3.6. Procedure

Due to the nature of the research being conducted, permission from the non-medical human research ethics committee at the University of the Witwatersrand was not required to conduct the research study. Three training manuals had been found online. These training manuals were in the public domain and therefore did not require any ethics permission to utilise for analysis. However, some manuals (to be discussed in greater detail shortly), which brought immeasurable value to the current study and needed to be included, were not in the public domain. Permission to approach these organisations, requesting access to the organisations' training manuals was requested from the Human Research Ethics Committee of the School of Human and Community Development, at the University of the Witwatersrand. The permission request from the school ethics committee was approved and granted under the protocol number MRES/11/001 IH (Please see attached, Appendix C).

In order to meet the objectives of this study, it was essential that the researcher conduct some initial research into the manuals that are used within the Gauteng public health system. This was achieved by searching online. The researcher utilised the search engine, Google, using key words including VCT training manuals, HIV testing in South Africa, VCT training materials and training material for VCT counsellors to search for those manuals available online. Moreover, the researcher, where necessary, informally discussed and consulted with numerous health care workers and staff from VCT centres and hospital personnel within the Johannesburg region. This was achieved through appointments made with VCT managers and counsellors from VCT training centres. This face-to-face interaction and discussion allowed for a more in-depth

understanding of the training manuals utilised in various public hospitals located in or near the Gauteng region. This allowed the researcher to gain a better understanding of the training manuals used within the major public hospitals within the Johannesburg region thus, permitting exploration of those manuals utilised most often.

The researcher approached, in person, the relevant individual from each organisation requesting permission to utilise the manuals by providing a letter of request, explaining the nature of the current research study to the relevant person including the manager, training officer, training coordinator or trainer (Please see attached, Appendix D). The letter provided an understanding of the current research by explaining the aims and rationale of the study. Furthermore, it explained that granting permission to the researcher to utilise the training manual for analysis was both voluntary and confidential and that no identifying information would be revealed when reporting the findings of the study, as each training manual was coded and reported on as such. However, it was explained that the research report would include brief descriptions of the organisations that have developed the respective training manuals by name, in no particular order thus, decreasing the level of anonymity. Furthermore, the researcher also discussed key points with the relevant individual, clarifying any misunderstandings and answering any questions the individual had regarding the research project. The researcher was granted access and permission by the relevant individual, including the manager, training officer and training co-ordinator, to utilise and analyse four of the approached organisations' VCT training manuals.

A total of seven training manuals were gathered and analysed for this study. The researcher began by collating a content list of each of the seven training manuals for an initial comparison of the content of the training manuals. This allowed the researcher to familiarise herself with the training content across all seven manuals, and to gain an initial insight into the material provided to VCT counsellors within the Gauteng public health system. The researcher then generated a preliminary coding schedule based upon all seven training manuals and the National Policy Guidelines (Please see attached, Appendix E) to further understand the multi-faceted nature of the VCT process. The coding schedule generated by the researcher was based upon the contents list of the training manuals used for analysis and the National Policy Guidelines, thus giving a clearer indication of the broad spectrum of information that should ideally be included in the

training manuals. Coding of all seven training manuals utilised for analysis was completed using the Atlas.ti version 6.2 software programme. Once the data coding procedure was completed all data was analysed and interpreted. Atlas.ti is relatively flexible qualitative data analysis software programme that enabled the researcher to “manage, extract, compare, explore and reassemble meaningful segments of large amounts of data” (Atlas.ti, 2002- 2013, para.2). This software is practically and functionally viable permitting the researcher increased data management efficiency, particularly so when taking into consideration the numerous time constraints and scheduled deadlines.

3.7. Data Analysis

The current study explored the content of the training manuals through the social representations theory underpinned by the social constructionist interpretive paradigm. The social representations theory is fundamentally based upon the notion that an individual’s behaviour is intertwined with social factors (Winn & Skelton, 1992). Social representations are the “negotiated understandings that make up our socially constructed reality” thus permitting the comprehension of concepts and experiences based within social groupings, which are associated with and influenced by the knowledge systems, beliefs and values of that particular grouping (Petersen, Mason, Bhana, Bell, & McKay, 2006; Schoeneman et al., 2010, p.14). In essence, social representations theory is fundamentally based upon the way in which concepts and experiences are constructed and represented by lay individuals in society.

The social constructionist paradigm presumes that human behaviour is meaningful and contextually embedded (Bhana & Kanjee, 2001). Therefore, the focus on the meaning that is represented by human behaviour is of utmost importance (Bhana & Kanjee, 2001). In this context, the researcher assumes that people’s behaviour, particularly high-risk behaviour towards contracting and transmitting HIV/AIDS, and how the person generates meaning of their behaviour and various other aspects through interaction, are influenced by contextual factors. The construction of contextually embedded knowledge assumes that truth is generated through “consensus among informed and sophisticated constructors, not of correspondence with an objective reality” (Patton, 2002, p.96). In its entirety, the ontological stance of this approach is

that phenomena are produced in a particular form and understood because of the shared language and thus meaning-making that occurs in human interaction (Burr, 2003). Further, social constructionism views the nature of knowledge, or epistemological stance, as a construction of a specific viewpoint of the world through talk (Burr, 2003). Therefore, the training manuals, the vehicle for providing knowledge to others, are assumed to be generated through an understanding of a shared language and meaning-making. However, the social representation of this knowledge is what matters, in that the portrayal of information to those training as VCT counsellors, and consequently those presenting for VCT, essentially commences with the information relayed in the training manuals.

The social representations theory, underpinned by the social constructionist paradigm, is “concerned primarily with the process rather than the outcomes or products” (Bhana & Kanjee, 2001, p.143). This is a vital component in aiming to lessen the current HIV/AIDS crisis where an individual’s thought processes largely influences their behaviour. Therefore, the training manuals essentially represent the process which influences the outcome, aspires towards altering an individual’s thought process rather than behaviour, which is fundamental to understanding the way forward in lessening the pandemic.

The current research study applies a thematic analysis using a social constructionist paradigm towards the interpretation of the data. A thematic analysis is a qualitative method of data analysis, which exclusively examines the content of data (Riessman, 2008). Thematic analysis refers to the method for “identifying, analysing and reporting patterns (themes) within data” permitting the examination of “artefacts of social communication” (Berg, 1995, p.174; Braun & Clarke, 2006, p.79). This method of analysis aims to achieve a broad and compact interpretation providing knowledge and an understanding of a particular phenomenon, allowing the researcher to organise data in rich detail interpreting the content present, through the social representations of HIV (Braun & Clarke, 2006; Elo & Kyngas, 2008; Hsieh & Shannon, 2005). Therefore, thematic analysis allowed the researcher increased understanding of the content of the training manuals utilised in the VCT service through the consideration of how meaning-making is closely connected with social factors which ultimately impact on human behaviour. With a purpose of gaining a broader and deepened understanding of VCT training manuals in the Gauteng public

health system so as to explore the material within the manuals through social representations theory, the qualitative thematic analysis was determined to be the most viable research technique for the current study.

A qualitative data analysis employs the use of language, aiming to classify a substantial amount of text into categories, which adequately represent the meaning in text (Weber, 1990 as cited in Hsieh & Shannon, 2005). Therefore, the large amount of material (i.e. the content of the seven training manuals) may be reduced to categories and themes, which effectively represent the broad range of topic areas included. Essentially, qualitative thematic analysis allows subjective interpretation as a result of an efficient classification and coding system into relevant themes (Hsieh & Shannon, 2005). This permits the researcher to make inferences from the data to provide and extend current knowledge (Krippendorff, 1980 as cited in Elo & Kyngas, 2008). Therefore, qualitative thematic analysis allows the integrated examination and deepened understanding of a “social reality in a subjective but scientific manner” (Zhang & Wildemuth, 2009, p.1). Consequently, it permits the researcher to examine the implications of the training material included in the manual. Therefore, the current study made use of a thematic analysis using the social representations theory underpinned by a social constructionist paradigm.

Through utilisation of an interpretive perspective, the researcher was able to further understand the experiences of a situation and relate them to a “wider social, cultural, and perhaps even theoretical, context” (Larkin, Watts, & Clifton, 2006, p.104). Furthermore, this perspective allowed the researcher to view all data in an exploratory manner so that increased familiarity and insight of the manuals could be gained (Larkin et al., 2006). Consequently, within the current study, the researcher, utilising the interpretive approach, had the opportunity to analyse the VCT training manuals, thus taking into consideration the surrounding factors influencing the success of the VCT procedure. This allowed further understanding of the worth and shortcomings of the training material in the manuals.

3.7.1. Approaches to qualitative thematic analysis

Qualitative thematic analysis may be distinguished in various ways, with each approach encompassing slightly differing process of analyses. Qualitative data may be analysed using inductive or deductive reasoning (Elo & Kyngas, 2008). Inductive reasoning occurs when the categories transpire from the data (Zhang & Wildemuth, 2009). Therefore, the researcher aims to understand the data without inflicting their “pre-existing expectations on the research setting” (Patton, 1980, p.40). Inductive reasoning most often occurs whereby there is limited or disjointed former knowledge regarding a particular phenomenon (Elo & Kyngas, 2008). On the other hand, deductive reasoning occurs when a researcher derives the coding structure from previous knowledge or theory (Elo & Kyngas, 2008; Zhang & Wildemuth, 2009).

The current study relied on social representations theory to inductively identify the themes that had emerged from the thematic analysis. The researcher derived a preliminary coding schedule based upon each content list of all seven training manuals. This form of inductive reasoning assisted in providing the researcher the opportunity to familiarise herself with the data. Furthermore, the limited knowledge surrounding standards of the VCT process within a South African context further permitted the use of inductive reasoning. Additionally, the researcher utilised the South African National Policy Guidelines for HCT and former knowledge gained through reading articles published within the field to further add value to the preliminary coding schedule. This permitted the researcher to add prior knowledge onto the coding schedule and more importantly, some measure of government standards surrounding the VCT process, and what should ideally be taught to VCT health workers so as to improve on preventative measures, such as VCT services provided to the public. Moreover, the current study assessed the written documents on a content unit of themes or sentences. This permitted the researcher an understanding of the varying themes within the data, enabling further understanding of the general pattern of content provided.

3.7.2. Process of analysis

Qualitative thematic analysis began with the researcher aiming to attain immersion into the data. This allowed familiarisation with the data through active and repetitive reading and re-reading thus gaining an understanding of the content before coding. Through the process of attaining immersion, the researcher began looking for patterns, themes and any relationships that were evident. Aiding in the process of familiarisation and active reading, the researcher kept track of ideas and notes that aided in the analysis phase, generating initial codes for the data. According to Patton (2002 as cited by Zhang & Wildemuth, 2009, p.3) “the choice of content must be justified by what you want to know”. The current study aimed to explore the content of the VCT training manuals, through the social representations of HIV, within the Gauteng public health system. Therefore, the training manuals utilised for analysis had to include the VCT process and be utilised within the Gauteng public health system. However, two of the seven training manuals are from international organisations that were used for analysis. These manuals have been obtained from organisations within the Gauteng region and therefore indicate usage within this context, either directly or indirectly.

The researcher then defined the unit of analysis, which assisted in initial coding of the data. The unit of analysis refers to the most basic unit of the text to be classified, whereby in qualitative research this most often encompasses individual themes (whether a word, phrase or sentence) (Zhang & Wildemuth, 2009). The VCT training manuals are the population of interest with sentences utilised as the unit of analysis for interpretation.

The researcher then developed categories and a coding scheme. As indicated above, the development of categories was produced inductively. According to Zhang and Wildemuth (2009), the constant comparative method is suggested when developing categories inductively. This method systematically compares the content of the categories so as to gain a deepened understanding of the multi-faceted nature of each category (Zhang & Wildemuth, 2009). According to Weber (1990 as cited in Zhang & Wildemuth, 2009), the categories developed must be mutually exclusive to avoid problematic variables. This follows from Lincoln and Guba (1985 as cited in Zhang & Wildemuth, 2009, p.4) who state that the categories used “should be

defined in a way that they are internally as homogeneous as possible and externally as heterogeneous as possible”. Although challenging for categories to be completely mutually exclusive, the researcher aimed at achieving a holistic understanding of the VCT process to achieve mutually exclusive categories as far as possible.

The next step of analysis was to test the coding scheme developed on a fragment of the text so as to establish the consistency and validity of the coding scheme (Zhang & Wildemuth, 2009). When developing the coding scheme, the researcher generated a multi-level hierarchy thus enabling the researcher to visually view both codes and categories simultaneously. The researcher began making sense of the results by investigating the various elements of the categories and recognising and examining the relationships among the various categories present to the full text (Bradley, 1993 as cited in Zhang & Wildemuth, 2009). According to Hsieh and Shannon (2005), definitions of each category must be developed so as to further the audiences understanding. The field of HIV/AIDs and specifically the VCT process entails concepts, which have been developed and defined over years of research and are thus considered standard concepts within the field. These include concepts of STIs, condoms and anti-retroviral therapy (ART) among others. For this reason, the coding scheme of the current study did not indicate urgency around defining of categories (please see literature review for the definitions provided) or the development of new categories for coding. Inter-coder agreement on the categories to be coded for analysis was achieved by consulting with the supervisor, co-supervisor and a third lecturer at the university. The coding schedule developed was discussed with both supervisors dealing with any concerns surrounding categorisation of content. Furthermore, the consistency and validity of the coding scheme was a continuous process with both supervisors checking the consistency of the coding process until coding was complete.

Once complete, the researcher began coding all the data available. Coding the data involves identifying the “most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p.63 as cited in Braun & Clarke, 2006, p.88). The current study utilised a qualitative data analysis software programme, Atlas t.i., for the coding of all training manuals. A thematic analysis was utilised as the primary mode of analysis of all VCT training manuals. An interpretive lens permitted the

researcher to code the data, which would result in a comprehensive overview of the content of each of the training manuals. Through increased familiarisation of the data, the researcher began coding all data identifying patterns of the main components, which comprise each manual and consequently the topics that are lacking.

The data coding procedure consists of recognising particular words so as to explore the usage and preliminarily identify any patterns (Hsieh & Shannon, 2005). The coding of the data was initially based upon phrases or sentences. At a later stage in the research process, the researcher noted patterns and decided that themes would be of more value in serving the aims of the research. Therefore, a theme constituted phrases/sentences, which were prevalent across the training manuals. These phrases/sentences were based upon the content in the training manuals whereby the researcher coded these as relevant to the content area being taught in the manual. The researcher reviewed and refined all codes and themes thus, strengthening the reliability and validity of the analysis. When coding the data the researcher kept a track of thoughts around the data and coding, which permitted a more in-depth and satisfactory coding scheme to analyse the data (Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). In utilising this approach for the current study, the researcher was able to infer the meaning of certain words in relation to the context. Furthermore, the researcher was able to explore the underlying meaning of the content of the training manuals thus allowing consideration of the surrounding factors impacting the success of implementing the content of the training manuals. According to Zhang and Wildemuth (2009), once data is fully coded the researcher must re-check the consistency and validity of the coding scheme. This should be completed due to numerous reasons, such as the addition of new categories, and a better understanding of the data, which may change the way the researcher views each category (Miles & Huberman, 1994, Weber, 1990 as cited in Zhang & Wildemuth, 2009). This was achieved as each manual was coded with both supervisors and the researcher re-checking the coding so as to maintain the coding throughout all training manuals.

The next stage of the thematic analysis involved searching for themes (Braun & Clarke, 2006). The essential notion of the theme is to classify data, which will represent a particular idea or issue (Zhang & Wildemuth, 2009). By familiarity of the data, the prominent emerging codes noted in each manual was utilised as a foundation for identification of the main patterns and

themes across the data sets. Through this, the researcher was then able to draw conclusions from the data based on the coding scheme developed. According to Braun and Clarke (2006) a theme is decided upon based on the relation to the research questions asked. Furthermore, a theme “represents some level of patterned response or meaning within the data set” (Braun & Clarke, 2006, p.82). Generating themes from the data set involve organising the previously coded data into initial relevant themes, thus allowing the researcher to observe the relevance and significance of the data at hand (Braun & Clarke, 2006).

Once themes were generated, the researcher reviewed and refined all themes in relation to the previously coded data extracts and in relation to the entire training manual (Braun & Clarke, 2006). This involved the separation and collapsing of codes to more appropriately reflect the information in the manuals. This process continued until saturation of the data, which meant that the researcher did not observe any new information (Morse, 1995 as cited in Charmaz, 2005). This phase of the data analysis process aimed to ensure that each theme accurately reflects the content of the training manuals providing an opportunity for the researcher to code any data that had been previously left un-coded (Braun & Clarke, 2006). This phase occurred until a state of redundancy had been reached. Lastly, the researcher performed the last phase of the thematic analysis procedure. This involved defining and refining the themes so as to identify the key aspect of, and establish the fundamental nature of each theme (Braun & Clarke, 2006). Each theme was named and organised into a coherent manner with an accompanying analysis for each theme (Braun & Clarke, 2006). While the researcher paid attention to each training manual holistically, the themes selected for analysis and discussion are based upon those themes most prevalent within the manuals. Collapsing of codes to constitute the themes assisted in identification of the main themes. These themes therefore indicate those areas most prevalent within the manuals and the implications of the content provided further demonstrate the content areas most lacking.

Despite the procedure seeming relatively structured and linear, one must accept that this is not necessarily the case whereby the researcher must constantly move backwards and forwards across all phases so as to represent an accurate and reflective account of the document being analysed (Braun & Clarke, 2006). Further, qualitative data analysis is inherently subjective in

nature and therefore, highly influenced by many external factors. This subjectivity runs through the entire research process from coding the data to analysis and interpretation. For that reason, the findings discussed should be interpreted with attentiveness to the researcher's individual perceptions as opposed to more definite interpretation often afforded to quantitative analysis. The primary focus on the data through an interpretive lens, relying on thematic analysis and familiarity with social representations theory assisted in the analysis and reporting of the findings provided below.

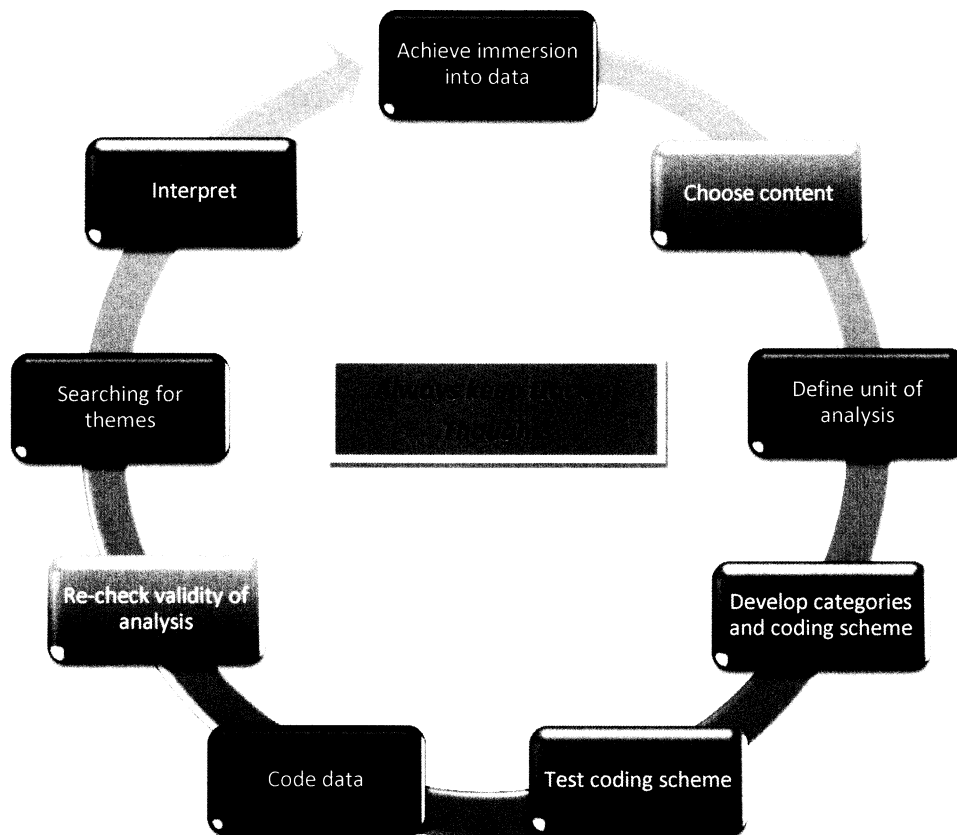


Figure 1: Process of analysis

3.7.3. Advantages and disadvantages of qualitative thematic analysis

Research methods and techniques entail both advantages and disadvantages. These are vital to acknowledge when utilising research methods so as to be aware of the limits when analysing. Thematic analysis is a flexible method of data analysis allowing usage across a variety of different data (Braun & Clarke, 2006). Furthermore, this method of analysis can be utilised so as to “reflect reality and to unpick or unravel the surface of reality” (Braun & Clarke, 2006, p.81). More importantly, the researcher is able to emphasise similarities and differences across different data set’s (Braun & Clarke, 2006). Thematic analysis is particularly informative with multi-faceted phenomenon and “is as easy or as difficult as the researcher determines it to be” portraying flexibility (Neundorf, 2002 as cited in Elo & Kyngas, 2008, p.108). Therefore, this is particularly advantageous for the current study where HIV/AIDs and the VCT process are multi-faceted. On the other hand, this method of analysis permits researchers to being more prone to failing to conduct any analysis at all (Braun & Clarke, 2006). Furthermore, one must be trained so as to avoid developing weak themes thereby not being able to appropriately distinguish between themes or whereby each theme is inconsistent (Braun & Clarke, 2006). Moreover, a lack of a stable definition and procedure both hinders and facilitates utilisation. A thematic analysis is often most useful when focusing on written documents (Berg, 1995). This however, does not pose a problem as the current study focuses on written documents.

Although the researcher cannot be concealed from the challenges arising from using the above mentioned research method, the acknowledgement of the limitations will improve the quality of the research conducted. Therefore, a thematic analysis, by means of inductive reasoning, was utilised to investigate the content in VCT training manuals, through the social representations of HIV, in the Gauteng public health system.

3.7.4. Validity of analysis

Qualitative analysis often receives much criticism for the elevated levels of subjectivity throughout the entire research process, as opposed to quantitative research. The validity of the thematic analysis can be evaluated by the credibility, transferability, dependability and

confirmability of the data produced (Lincoln & Guba, 1985 as cited in Zhang & Wildemuth, 2009).

The credibility of qualitative analysis refers to the sufficient representation of the categories being studied (Bradley, 1993 as cited in Zhang & Wildemuth, 2009). This enables the researcher to make valid and reliable inferences from the data (Weber, 1990 as cited in Elo & Kyngas, 2008). The credibility of results can be improved by extensive involvement in the field, examining and comparing interpretations against the original text, designing a transparent process and providing clear and precise definitions for the coding scheme and all categories used (Lincoln & Guba, 1985 as cited in Zhang & Wildemuth, 2009). The transferability of the data refers to generalisability and applicability of the researcher's hypothesis to another context (Zhang & Wildemuth, 2009). This indicates the depth of the findings, which will allow others to make their own judgments regarding the content of the manuals (Zhang & Wildemuth, 2009). According to Elo and Kyngas (2008), detailed descriptions should be provided of the research process indicating a clear and comprehensive relationship between the data and the results and inferences made. Furthermore, dependability refers to the consistency of the process of analysis whereas confirmability refers to the extent that the findings can be replicated or confirmed by others (Bradley, 1993 as cited in Zhang & Wildemuth, 2009). These are interlinked to the above with equivalent means of attaining these criteria. According to Kyngas and Vanhanen (1999 as cited in Elo & Kyngas, 2008, p.112), success of a qualitative analysis "requires that the researcher can analyse and simplify the data and form categories that reflect the subject of study in a reliable manner".

The credibility, transferability, dependability and confirmability of the current study has been achieved, by the researcher, in a number of ways. This includes the following:

- Conducting a thematic analysis allowed the researcher the opportunity to investigate the VCT training manuals, providing descriptions and interpretations of the content of the VCT training manuals. Furthermore, the researcher was able to explore the patterns within and across the training manuals making this analysis a suitable and appropriate method of data analysis, providing the researcher a richer interpretation of the training manuals currently used in the Gauteng region.

- The researcher had, in person, spoken to a number of individuals working in the VCT field at differing levels (i.e. a VCT counsellor, a VCT trainer and a VCT training manager). This had allowed the researcher the opportunity to gain some familiarity with the culture of the organisations and gain differing perspectives on the health care system and VCT training more generally.
- The researcher had kept track of her opinions and feelings towards the research process through a journal throughout the two year period. This journal had allowed reflection on the research process and project as a whole, providing the opportunity to detach herself from the process, to some degree, gaining greater objectivity in moving forward and perspective on how her thoughts and viewpoints had developed over the course of the work. This audit trail of the researchers' viewpoints and growth over time contributes to ensuring the confirmability and credibility of the findings of this study.
- Consistent contact with the researchers' supervisor throughout the process had assisted in ensuring reflection on those thoughts and opinions arising and recorded in the researchers' journal. Discussion of these thoughts and viewpoints supported the researcher in gaining a more objective stance on the topic at hand and allowed her to broaden her thinking thus ensuring that the multi-faceted nature of the field was taken into consideration. Further, this contact had allowed discussion of the researchers' interpretations of the data, which when problematic, was amended.
- In addition, when the need arose, the researcher consulted external people to the research, in addition to contact with the researcher's supervisor, to ensure that any bias was not reflected in her interpretation of the findings.
- The researcher had used seven manuals instead of one for her analysis. This method of triangulation assisted in the interpretation and verification of differing viewpoints on the same topic through providing more in-depth knowledge from different VCT centres thus increasing the credibility, confirmability and dependability of the results.
- All VCT centres approached had the opportunity to decline participation in this study. Through allowing this opportunity, the training manuals utilised for analysis are based on those centres that understand the nature of the study and the ethical considerations in providing their training manual to the researcher.

- The researcher had attended and presented her research at the 30th International Congress of Psychology Conference which had provided her with valuable feedback regarding her research project. This, once again, allowed the researcher the opportunity to view her research from a distance, taking note of parts of the process that required improvement.
- In describing the organisations that the manuals had come from, the researcher aimed to ensure that the context of the study was apparent, allowing the reader an understanding of the context which lays the foundation to understanding the findings. This further allows increased transferability as the reader is then able to make the transfer of knowledge based on the findings to other contexts similar in nature.
- The researcher has, in aiming to achieve transferability of this study, explained the number of training manuals utilised and where these manuals had been obtained and the challenges experienced during the data collection process. In this way, the researcher aims to achieve transparency permitting greater dependability and transferability of the findings of this study to a different context.
- The researcher has reflected on her beliefs, assumptions and possible influences to the study's findings (please see reflexivity section in Chapter 5). The acknowledgement of these limitations helps promote the credibility and confirmability of this study.

The above mentioned factors demonstrate the provisions made by the researcher to ensure the credibility, transferability, dependability and confirmability of the study thus increasing the validity of the findings and the research process holistically.

3.8. Ethical Considerations

Ethical considerations are one of the most crucial aspects of any research being conducted. The current study does not involve human participants in collecting or analysing data, thus decreasing the likelihood of being confronted with ethical issues. Nonetheless, ethical considerations are vital and should always be taken into consideration no matter the context of the research study. These ethical considerations have been undertaken as a responsibility of the researcher. According to the American Psychological Association's ethical principles, psychologists should

encourage accuracy and honesty when practicing within the field (Murphy & Davidshofer, 2005). This study has not reported on findings that are inaccurate or untruthful. Therefore, this study has not falsified or fabricated any information. Furthermore, this research aim's to promote fairness, providing a piece of research, which will add value to the information already available within the topic area. The researcher also aims to minimise bias as much as possible and report on findings, acknowledging possible personal biases in the interpretation and analysis of the data.

The current study has obtained informed consent from the relevant individuals of those training manuals not in the public domain. Informed consent refers to these individuals understanding the nature of the research and providing permission to utilise the training manuals they have developed, for the purposes of the current study (Whitley, 2002). This study obtained informed consent by providing letters to the relevant people of various organisations explaining the aims, rationale and nature of the study requiring a signed consent. Furthermore, the relevant individuals approached have been informed of the voluntary nature of providing the training manuals to the researcher. Therefore, if individuals felt that providing the training manuals to the researcher may, in any way, cause harm to themselves or the organisation with which they are affiliated, they were free to decline providing the researcher with the VCT training manuals.

The training manuals utilised for analysis has been numbered such that no identifying information has been presented when reporting the findings, thus maintaining the anonymity of each organisation's training manual. However, the research report does include brief descriptions of the organisations that have developed the training manuals utilised for analysis by name, in no particular order, thus decreasing the level of anonymity. All information and findings gained throughout the research process will be available for any interested party in the form of a research report or a brief summary of the results. A brief summary of the results will be provided to each organisation, from which permission was requested portraying the findings of the study and possible recommendations, after submission of the current research report. The researcher has a moral and ethical obligation to notify the relevant organisations when blatant errors regarding information in the VCT training manual are found. This will be achieved through providing a letter to the respective organisations and dealt with in the utmost professional

manner. All data collected will remain in the researcher's possession remaining confidential as per the letter provided to the organisations.

Despite not relying on human participants within this study, the researcher took into consideration various ethical principles where relevant and applicable. This research study aims to promote the urgency of research required within the field of HIV/AIDS and VCT and promote an improved VCT training manual for VCT counsellors thus improving the situation at an organisational and community level.

CHAPTER 4: RESULTS AND DISCUSSION

In this chapter, the findings of all the training manuals analysed in the study are presented. Training manuals are provided to counsellors to educate and inform them of the knowledge taught in each training session. Therefore, training manuals form a key component of successful training. The training manuals used for analysis were selected based on their use within the province. These training manuals present material utilised for VCT training within South Africa, particularly in the Gauteng province. These documents have been analysed using a thematic analysis through an interpretative lens and familiarity of the social representations theory. The contexts within which the counsellors work were taken into consideration, so as to validate the inferences made and, thus, to formulate recommendations on the content of the training manuals, which are appropriate for the current setting, to improve the VCT service. The findings are separated according to the themes identified through analysis and will be explored and discussed accordingly.

The themes aim to highlight the nature of the content most prevalent across the manuals and the social representations of the content provided, thus, accounting for the possible implications of the content. The themes are discussed, individually utilising quotes from the coding system generated, so as to support the arguments and discussion made. The themes are explored and discussed in the following sequence:

✎ Category 1: HIV Transmission

- Theme 1: HIV socially represented as a sexually transmitted infection
- Theme 2: HIV socially represented as a deserved consequence for IDUs
- Theme 3: HIV socially represented as an infection
- Theme 4: HIV socially represented as a plague
- Theme 5: HIV socially represented as the ultimate prankster

✎ Category 2: HIV Prevention

- Theme 1: VCT socially represented as the saviour to the HI virus
- Theme 2: VCT socially represented as a behaviour change mechanism in relation to risk reduction

- Theme 3: HIV socially represented as an agent of war
 - Theme 4: HIV prevention, through condom usage, socially represented as promiscuity – Prevalent gender inequalities in society
 - Theme 5: HIV prevention socially represented as an issue of trust
 - Theme 6: HIV prevention through condom usage socially represented as unnatural
- ✚ Category 3: Risk Factors
- Theme 1: HIV socially represented as a punishment for sexual impurity
 - Theme 2: HIV risk social represented as affecting ‘Others’
 - Theme 3: HIV socially represented as an unjust target for the poor
- ✚ Category 4: HIV Treatment
- Theme 1: HIV socially represented as a death sentence
 - Theme 2: HIV treatment (ARVs) socially represented as a saviour
 - Theme 3: HIV treatment socially represented as positive living
- ✚ Category 5: Counselling
- Theme 1: The counselling relationship socially represented as an enabling relationship
 - Theme 2: Counselling socially represented as empowering the client
 - Theme 3: The VCT counsellor socially represented as the shape shifter

4.1. Category 1: HIV Transmission

Comprehending how HIV is transmitted is a vital component of the training manual. HIV transmission is often associated with particular behaviours, and thus lays the foundation for VCT counsellors to understand those behaviours which place individuals at risk for HIV, and, in turn, to promote behaviour-change. All training manuals, with the exception of Training Manual 3 and Training Manual 4, make mention of the various ways of HIV transmission and non-transmission. The transmission of HIV is socially represented in a number of ways. This includes HIV as socially represented as an STI and as an infection, illness, disease and plague.

Theme 1: HIV socially represented as a sexually transmitted infection

The primary, and most common, mode of HIV transmission has been recognised as occurring through sexual contact (Gilman, 1988 as cited in Howard-Payne, 2010). This is conveyed in the training manuals, with a primary theme emerging from the data supporting the idea of HIV as primarily transmitted through sexual activity. In this way, HIV transmission is socially represented as an STI.

The concept of risk being sexually transmitted was discussed and explained across all training manuals at the pre- and post-test counselling stages. Training Manual 6 defined risk as the *“chances a person takes; in this case risks pertain to taking chances sexually and exposing oneself to the risk of contracting STI’s and HIV, consequences of this carries the risk for loss, injury and infection.” - Training Manual 6.* Thus, in this definition, the risk of HIV transmission has been explicitly conceptualised as occurring from sexual activity, with HIV being associated with and equated to STIs. In this way, training manuals may neglect to address or provide equal weighting to other modes of transmission and the influencing psychosocial factors. Historically, sexual activity has been closely associated with immorality, which has over time become increasingly conflated (Fischer, 2006; Joffe, 1996 as cited in Goodwin et al., 2003). This conflation of terms is greatly influenced by the surrounding culture in relation to sexual activity and immorality; further enhanced by the media’s portrayal of sex, often relating sex to corruption and immorality (Fischer, 2006). Sexual activity, particularly when related to disease, thus becomes closely associated to impurity through contamination and pollution, and immorality through guilt (Fischer, 2006). In this way, the above quote conceptualises risk of contracting HIV as occurring through improper sexual behaviour tying it to sexual norms, sanctioning blame on infected individuals. In this way, HIV, as represented as a sexual infection, is seen as a consequence of immoral sexual behaviour. Therefore, without taking into consideration the influencing psychosocial factors, HIV is negatively socially represented thus having negative implications on how counsellors may treat those presenting for VCT.

Previous research demonstrates that females are biologically at increased risk for contracting HIV (Lalthapersad-Pillay, 2009). Therefore, through describing HIV as occurring primarily

through sexual behaviour and thus, socially representing HIV as an STI, places increased emphasis on the bio-medical component of HIV. Training Manual 7 refers to viruses, bacteria and parasites. Here, STIs are represented as unclean and polluted (Lawless, Kippax, & Crawford, 1996). Moreover, STIs have also been anchored in promiscuity, as seen in the quote provided below, implying that only those with multiple partners are at risk for STIs (Lawless et al., 1996). In a study conducted by Lawless et al. (1996, p.1374), women with STIs were perceived as “out of control, manipulative, and not deserving of the care of health professionals”. If counsellors view STIs in this light, without taking into consideration why females may be engaging in such activity, the consequences could hinder adequate health care, and lead to possible further transmission of STIs with direct impact on HIV transmission as presenting individuals may feel unsupported and increasingly stigmatised.

STIs are caused by viruses, bacteria and parasites - Training Manual 7

Reduce number of partners - Training Manual 7

Having multiple sexual partners is a recognized HIV risk. Therefore, reducing the number of sexual partners is a worthwhile HIV prevention strategy - Training Manual 6

The predominant mode of transmission of HIV is sexual contact; however, this is not the sole mode of transmission (UNAIDS, 2011b). The training manuals discuss factors to HIV transmission through abstinence, knowledge level and attitude, the level of a virus, needles, risk perception, sexual activity, STIs and drugs. It is, however; apparent that the training manuals provide counsellors with more information regarding HIV transmission through sexual contact. All manuals, except Training Manual 3 and Training Manual 4, provide counsellors with information on HIV transmission. The manuals provide to counsellors the primary modes of transmission as blood, semen, vaginal fluids and breast milk. In this way, this manual, although acknowledging STIs and sexual activity as a factor in the transmission of HIV, also addresses other possible modes of transmission. This allows an understanding that other factors may increase an individuals' level of risk, thus discouraging labelling of presenting individuals as having engaged in risky sexual activity. However, on the other hand, Training Manual 5 seems to

focus on sexual behaviour as the sole risk factor in contracting HIV. In failing to provide equal weighting to other modes of transmission, counsellors may unconsciously label clients as acquiring HIV through sexual contact. In this way, counsellors may imply and project onto clients, their negative beliefs of sex and sexuality, including those mentioned above, enhancing the stigma experienced by clients.

If the patient seems alright, continue discussing safer sex practices, the risk of re-infection when continuing with unsafe sex and the need for a healthy lifestyle.

- Training Manual 5

On the other hand, Training Manual 7 raises the concern that counsellors must be aware of the beliefs surrounding sex and sexuality. An individuals' knowledge and thus social representations are generated through and rooted within an individuals' culture (Moscovici, 2001). It is therefore vital to take into consideration and understand an individuals' culture which fundamentally influence the generated social representations. Training Manual 7 acknowledges HIV as primarily transmitted through sexual activity, relating the represented immoral sexual act and the use of contraception to socio-cultural beliefs, a vital component in the VCT context. Behaviour change, the primary objective of VCT, occurs in combination with contextual factors, which largely influence an individual's viewpoint and assessment of his/her risk (Swanepoel, 2010). Therefore, acknowledgement of these contextual factors is fundamental in permitting greater change for those presenting for VCT. However, despite acknowledgement, the manual does not adequately portray what these beliefs may entail. Therefore, the trainee might be left without a fuller understanding of influencing factors. In this way, when confronted with these beliefs, a counsellor may be ill equipped for dealing with the client's beliefs towards encouraging behaviour change. Training Manual 4 acknowledges the influence of these beliefs and attitudes, and the impact they may have on behaviour and behaviour-change, highlighting the psychological impact of VCT (as discussed later in the chapter). The manual further highlights the detail required when implementing the knowledge taught, acknowledging the importance of counsellors being specific in the knowledge provided to presenting individuals. Nevertheless, this manual fails to address how counsellors can assess the client's readiness to participate in the discussion.

Because HIV is mainly transmitted sexually, cultural and personal attitudes towards sex and sexuality are extremely important. The counsellor should realize, too, that some people may hesitate - for cultural, religious or moral reasons - to consider the use of condoms, or any form of contraception. - Training Manual 7

Note the need to consider the test result in reference to most recent risk exposure. This result does not tell us about the exposure that occurred (specify) most recently e.g. 2 weeks ago or last night. You want to consider another test in... and/or encourage your partner to come and be tested. - Training Manual 6

It is important to remember here that risk reduction issues should be addressed to the extent that the client is emotionally prepared to participate in this discussion. - Training Manual 4

There is a tendency for counselors to develop broad and sweeping behaviour change plans: always wear condoms, abstain from sex, or remain monogamous. It is important for the trainer to be clear that the emphasis should be on incremental behaviour change and specific risk reduction plans. - Training Manual 4

The social representation of HIV as an STI impacts on the way counsellors may speak about HIV to clients presenting for VCT. Through this representation, counsellors are more inclined towards dealing with clients as being infected through sexual activity, and STIs, in turn focusing on the bio-medical aspect of HIV transmission, thus placing blame on the individual presenting for VCT. These discriminatory implications may be exacerbated when counsellors are unaware of the impact this may have on the client. This social representation reflects a purely bio-medical representation of HIV, where the primary cause of infection is sexual intercourse. This fails to address the social determinants of HIV transmission such as “poverty, peer pressure and gender norms” among others (Campbell, Foulis, Maimane, & Sibiya, 2005, p.474). This has implications for those infected through modes of transmission that are socially-based, such as poverty, a major concern in the South African context. In this way, individuals presenting for VCT may not receive the assistance in dealing with the social factors that may have led to

transmission. On the other hand, Training Manual 1 mentions STIs as a primary mode of transmission. However, social determinants are acknowledged as an important factor in the South African context in both manuals. In this way, HIV is represented as a social entity. This is particularly important as it permits counsellors increased awareness of surrounding factors and provides a real-world value and context to the content taught. Further, it enables the undoing of some of the negativity of the social representation of HIV transmission as a purely bio-medical entity. This is reiterated by Campbell and Mzaidume (2002, p.231), who state that these “frameworks are needed to treat HIV transmission and prevention as social issues”.

While certain biological factors such as untreated sexually transmitted diseases accelerate transmission, the main reasons for the rapid increase in infections in South Africa and worldwide appear to be social – including poverty and lack of employment, migrant labour and profound gender-based inequalities. - Training Manual 1

Socio-economic factors:

- ☐ *Poverty*
- ☐ *Unemployment*
- ☐ *Literacy levels*
- ☐ *Lack of information on HIV*
- ☐ *Gender inequalities*
- ☐ *Migration - Training Manual 7*

Theme 2: HIV socially represented as a deserved consequence for injecting drug users

Injecting drug users (IDUs) are a major concern in the fight against the pandemic. According to UNAIDS (2011a, p.48) “preventing HIV transmission through injecting drug use is one of the key challenges to reducing the burden of HIV”. However, the very nature of drug-use embodies negative connotations. Drug use, a social concern, is viewed as socially, politically and morally

deviant and sinful (Huggins, 2010). Therefore, HIV is socially represented as a deserved consequence for IDUs.

The second largest mode of transmission in many countries includes transmission through the sharing of needles and exposure to infected blood (Donoghoe, 2003, Hamers & Downs, 2003 as cited in Goodwin et al., 2004b). In the first quote provided below, HIV transmission is said to be transmitted through direct blood contact. Infection through drug use has been historically represented as an antisocial activity that is unnatural, unhygienic and irresponsible (Lawless et al., 1996, p.1371). However, in this context, drug-use, a predominantly negative, self-inflicted behaviour, is followed by blood transfusions and accidents, concerns that primarily do not hold individuals accountable for their infection. In this way, the training manual balances the negative social representation of HIV as a deserved consequence for IDUs with infection through blood that cannot primarily hold the infected individual accountable.

*Direct blood contact, including injection drug needles, blood transfusions, accidents in health care settings or certain blood products - **Training Manual 5***

On the other hand, Training Manual 6 and Training Manual 7 also acknowledges drug-use as a mode of transmission. However, the manual associates, once again, drug-use with sexual activity, leading to possible infection. In this context, sexual contact and drug-use are represented as the sole modes of transmission to counsellors. This may lead to counsellors assuming promiscuity or drug-use when clients test positive despite contradictory evidence (Lawless et al., 1996). In this way, HIV may be viewed as a deserved consequence for engaging in deviant behaviour. This may have, as mentioned above, detrimental consequences to clients who are positive due to factors requiring more in depth counselling, such as accidental transmission through blood transfusion.

*Alcohol and drug use are believed to increase sexual risk taking. It alters judgment, remove inhibitions and engender high risk sexual behaviours
- **Training Manual 6***

Alcohol and drug abuse is linked to higher risk for HIV transmission because it increases the likelihood of multiple partnerships and decreases the likelihood of condom use.

-Training Manual 7

Shared equipment for using drugs can carry HIV and hepatitis, and drug use is linked with unsafe sexual activity. - Training Manual 6

In socially representing HIV as a deserved consequence for IDUs, the training manuals, once again, fail to address the contextual concerns surrounding infection. According to the Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries (2007, p.48), IDUs may engage in a “culture of sharing”, where sharing ones needle portrays unity among the group, particularly so with ones close relationships. This is implied in Training Manual 2, as seen below; however, the manual fails to explicitly state the link between the sharing of needles and the unity among group members when doing so. Therefore, sharing of needles portray an issue of trust, where if unwilling to contribute to the relationship, an individual is seen as mistrusting. However, when taking into consideration the contextual factors, IDUs may be portrayed as complicated and problematic to treat. This lessens the counsellor’s willingness to attend to the client providing them with adequate care and support. This hinders the service provided and in turn impacts the fight against the pandemic. Therefore, despite contextual factors proving to be a hindrance to quality care, without these factors, counsellors are unable to make informed decisions and provide adequate care for clients. As a result, it is of fundamental importance that counsellors are made aware of the impact of drug-use on presenting clients, and the various contextual factors which could be utilised to inform counsellors on how to deal with IDUs adequately.

Do not share unsterilized needles, cutting instruments or sharp instruments with others. - Training Manual 2

HIV, socially represented as a deserved consequence for IDUs, may have implications on how counsellors treat clients. Clients, who present for VCT as IDUs, particularly when infected, may inherently embody the negative connotations of the virus, in addition to those of being an IDU.

Individuals who inject drugs gradually embody the negative representations of deviancy and contamination and one who is unable to control their behaviour. Further, IDUs are often associated with increased risk-behaviour, thus, largely enhancing their risk of infection with HIV (Committee on the Prevention of HIV Infection among Injecting Drug Users in High-Risk Countries, 2007). Training Manual 7 explicitly states that coloured and white males are more likely to use high levels of alcohol and drugs. Despite based on research, this is particularly detrimental as an infected client, particularly those clients who are a white or coloured male, may be viewed as responsible for their infection. In this way, the HIV infected individual may be stigmatised and discriminated against, being seen as less deserving of treatment and assistance. Moreover, the HIV body, viewed as out of control and disorderly, is then viewed as chaotic and problematic (Huggins, 2006). In this way, infected clients are seen as less-deserving of already scarce resources. Further, counsellors may view these individuals as unworthy of their assistance, thus, impacting the quality of care provided. Therefore, it is vital for counsellors to be made aware of contextual concerns, which enable enhanced levels of understanding for the client and their coinciding challenges of possible addiction.

Coloured and white males are most likely to have high levels of alcohol and drug abuse. The sharing of needles to inject drugs is extremely high risk for the transmission of HIV. 4.7% of South Africans have injected drugs in their lifetime but only 0.1% of South Africans have ever shared needles to inject drugs. - Training Manual 7

Theme 3: HIV socially represented as an infection

HIV as socially represented as an infection, supports the notion of HIV as a viral disease, reinforcing the bio-medical approach to VCT. HIV/AIDS is persistently anchored as an infection fitting this to pre-existing notions of this anchor.

Social representations provide a common understanding of concepts and assist in communication among individuals within society (Moscovici, 1984 as cited in Howard-Payne, 2010). However, when placing value on predominant negative representations, this may severely hinder the current efforts underway in fighting the pandemic, including the VCT service. Training Manual

1 refers to AIDS, erroneously, as the disease and infection itself. Diseases, primarily corresponding to the bio-medical context, are primarily represented as a medical concern and subsequently viewed with stronger negative connotations (Larsen, 2009). The associations to disease are often linked to the “socially undesirable” which becomes characteristic of the infected individual thus portraying more negative representations in comparison to the social representations of infection or illness, which is represented as treatable (Goffman, 1963 as cited in Deacon, Uys, & Mohlahlane, 2009). In this way, the shift of terms from disease to infection, may aid in assisting to lessen those negative connotations. However, despite this shift of terms, infections, of any kind, are nevertheless represented as bio-medical, primarily treated by medical professionals who provide treatments that help clients in fighting further infection. Through socially representing infections as a bio-medical entity, this may result in the infected individuals support structure to perceive that they are less responsible or less able to help the infected individual. However, support from family and friends, play a vital role in helping the infected individual to physically and psychologically cope with the virus (Kruger et al., 2009; Van Rooyen, 2008). Through the challenges experienced with the treatment of HIV/AIDS, and the nonexistence of a cure, the use of the term ‘infection’ has gradually acquired negative social representations and thus similar implications to that of ‘disease’. This is seen in the quotes below, portraying STIs as an infection implying a medical association with negative connotations. The use of the word infections anchors HIV as a sickness that seemingly implies that this virus is primarily a medical concern and needs to be treated as such.

Sexually transmitted infections (STIs) are infections that are transmitted through body contact during sexual contact, including vaginal, anal and oral sex. -

Training Manual 7

STIs are caused by viruses, bacteria and parasites - Training Manual 7

The explanations provided by the manuals, despite providing counsellors with a comprehensive introduction to the virus, once again, emphasise a bio-medical approach. This is seen in words such as ‘white blood cells’ and ‘infections’, as seen in the quotes below. This may become problematic when training lay counsellors with limited knowledge on the bio-medical aspects of

the virus. Due to the aims of the current research, the researcher is unable to confidently assert that counsellors are receiving adequate explanations of the above mentioned bio-medically inclined words. Further, as seen in the quote provided below, Training Manual 5 refers to HIV as “destroying the body’s ability to fight infection” thus, signifying HIV as larger than a more common infection, suggesting plague imagery where an individual’s body is an agent of war, with the white blood cells attempting to fight the battle against the virus (as discussed later in the chapter).

Human Immunodeficiency virus [HIV] attacks white blood cells, destroys the body's ability to fight infections and causes AIDS - Training Manual 5

The HIV virus causes AIDS. The virus attacks and destroys important immune cells in the body. - Training Manual 1

The above socially represents HIV as an infection and thus, as a purely medical concern. However, this fails to address the complexity of representing the HIV infected person as anything other than sick. This is particularly challenging with chronic incurable infections such as HIV where the medical condition becomes closely linked to the identity of the individual (Larsen, 2009). In this way, counsellors are more likely to refer to the medical condition as opposed to the person. This permits an opportunity for medical professionals to detach and de-personalise their clients, to protect themselves from becoming too emotionally attached to their clients. Although understandable, HIV as a chronic illness requires further engagement with the client (Thorne & Robinson, 1988 as cited in Larsen, 2009). Taking into consideration the work that is completed by VCT counsellors in the process, it is not affordable for counsellors to become emotionally unattached given their role.

When HIV is socially represented as an infection and anchored in sickness, inferences are made in relation to the contamination and pollution of those infected (Schoeneman et al., 2010). Through HIV being viewed as primarily a medical concern anchored in sickness, previous literature has indicated the “constant connection between sickness and sin, the impure, the undeserving and the guilty” (Gillman, 1988, Gillman, 1988 as cited in Lawless et al., 1996,

p.1376). According to Schoeneman et al. (2010) people diagnosed as being HIV positive are frequently considered infectious and contagious. However, when viewing clients as contagious, this places blame on the infected individual and encourages discrimination. VCT counsellors, viewing clients as contagious, has implications for the non-verbal behaviour expressed in counselling. This includes touching clients, sharing a bathroom and hugging them among other behaviours. These behaviours portray warmth, support and acceptance for those infected. However, if seen as contaminated, counsellors may increasingly stigmatise the client. This may also, once again, limit the support and engagement in the treatment process received from family and friends further stigmatising the client hindering behaviour change.

HIV, as socially represented as a disease and infection perpetuates blame and discrimination of those infected, failing to address the psychological impact that this may have on the presenting individual. Media representations, often largely influencing the dominant representations within society, may impact on at risk individuals not wanting to present for VCT due to the potential stigmatisation. In combination, through social representations of HIV as an infection and disease, there may be major implications in individuals not presenting due to possible discrimination received from counsellors. Therefore, through educating society on HIV/AIDS on how HIV is transmitted, aiming towards modifying negative social representations by taking into considering social and psychological factors, may contribute to lessening the stigma associated to HIV and in turn VCT. It is consequently essential for a collaborative approach, between VCT organisations and organisations that influence dominant representations such as the media, in reducing the current crisis.

Theme 4: HIV socially represented as a plague

HIV, socially represented as a plague, once again, infers a bio-medical emphasis on HIV (Briggs, 2010). Through socially representing HIV as a plague, a sense of panic, fear and calamity is augmented. Through this fear, an increased sense of vulnerability is experienced and increased reliance on the medical field towards finding a solution to assist in clarifying the pandemic and lessening the panic experienced.

Social representations have been generated over years gradually becoming a “taken for granted or ontological reality” (Markova, 1996 as cited in Howarth et al., 2004, p.235) thus, signifying an overpowering influence (Moscovici, 1984, as cited in Howarth et al., 2004). Objectification, the second mechanism in generating social representations, represents abstract concepts as concrete elements, experienced through an individual’s senses (Hoijer, 2011; Moscovici, 2000). Therefore, through portraying certain images of infected individuals, HIV is socially represented as a plague. However, individuals are viewed as active agents and not passive recipients frequently collaborating and challenging dominant representations (Joffe, 1998, p.29 as cited in Howarth et al., 2004, p.237). However, the mass media play a fundamental role in contributing and sustaining dominant representations. In the mass media, HIV has historically been represented as a plague and closely associated to plague imagery (Joffe, 1995). This involves representing those infected as sick, weak and skeletal.

Training Manual 1 and Training Manual 4 indicate to counsellors the influence of the media in particular, in representing HIV/AIDS through graphic images of disease and ill health. Further, these training manuals acknowledge imagery of those infected and healthy as limited in media representations. It is also recognised that these representations, as Training Manual 1 explicitly states, influence the attitudes and beliefs about an individual’s everyday behaviour. Such imagery proposed by the media has a negative impact on the fight against HIV. Through this acknowledgement of how HIV is socially represented, counsellors are further enabled to educate and dispel myths about infected individuals thus lessening the stigma that may be assumed onto others.

The initial projections of people; living with HIV/AIDS by the media were often images of people who are ill. It was a harsh reality that shocked the world. They were portrayed in bed, emaciated and downcast. In most cases where people were healthy, instead of their faces we saw their heads turned away - Training Manual

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Many people are only aware of those in their community who are ill with AIDS and are not aware of those who are HIV infected and living healthy and productive lives. - Training Manual 4

Often AIDS education and awareness programs appear to focus on the physical suffering, diseases and symptoms associated with the end stage of AIDS. - Training Manual 4

The growing influence of new ideas and attitudes often linked to the media, television, movies and advertisers, significantly shape social expectations and behaviour, especially in young people. - Training Manual 1

Human Immunodeficiency virus [HIV] attacks white blood cells, destroys the body's ability to fight infections and causes AIDS - Training Manual 5

Through this representation, individuals may identify and associate those infected to the dominant imagery. The lack of a cure for HIV, fuels this association to a plague. When representing HIV as a plague, this closely associates the virus to increased levels of hopelessness (van Servellen, Padilla, Brecht, & Knoll, 1993 as cited in Harris & Larsen, 2008). However, a prevailing sense of hopelessness and perceived inevitable doom has implications for the commitment of counsellors and medical professionals to caring for clients. This is evident in Training Manual 5 above, which represents and anchors HIV as a plague through describing the virus as 'attacking' and 'destroying'. In this way, HIV- infected individuals are seen as impaired and defeated. Through socially representing HIV as a plague, those infected may be treated with less value, as they are viewed as individuals who are inevitably doomed for death. In this way, counsellors and medical professionals may commit to caring for those individuals who they are able to make a significant medical improvement towards, and thus enhance their chance of living. However, this fundamentally fails to address the impact on clients who are infected. Increased levels of hope assist in maintaining a healthy lifestyle and in turn promotion of less risky behaviour (Harrison, 1993 as cited in Harris & Larsen, 2008). Further, with enhanced levels of hope, clients are able to experience enhanced welfare influencing their quality of life

(Chammas, 1999; Heinrich, 1999, 2003, Watts, 2001 as cited in Harris & Larsen, 2008).

Therefore, increased awareness of social and psychological factors may assist in lessening the stigma associated to HIV/AIDS and VCT and in turn improve the clients' well-being and quality of care provided and balance the negative social representation of HIV as a plague.

Training Manual 1 describes AIDS as an outbreak and viral disease, once again, representing HIV as a plague. Further, this manual personalises the message given to counsellors by stating that no individual is immune to the virus thus, exposing every person to the virus making them accountable for taking the necessary precautions to decrease their risk. In addition, Training Manual 4 similarly states the importance of counsellors taking precautionary measures to ensure their physical well-being. This makes counsellors aware that every person is vulnerable to infection influencing how they may take precautions in their daily work. This is particularly important for counsellors who have been working for a long time without becoming infected, leaving these counsellors to feel somewhat immune to the virus. Explicit messages such as these provided in the manual make counsellors aware of the challenges associated with the virus which often feed into the VCT procedure having major implications in combating the pandemic.

The 'AIDS epidemic' refers to the present outbreak of a previously unknown viral disease, where the rate of new infection is increasing rapidly. - Training Manual 1

Using infection control steps with all patients is important because a health worker (VCT counselor) cannot always know when a patient's body fluids are infectious; even if the patient is HIV negative they can have hepatitis B or C. - Training Manual 4

HIV, socially represented as a plague has implications for those infected, as HIV is anchored in notions of being an evil perpetrator. Research conducted by Campbell et al. (2005) portrays the dominant representations of AIDS as a plague, as being evil, shameful and embarrassing. HIV socially represented as a plague implies that those who are infected by this evil perpetrator, is the enemy who partook in risky behaviour (Howard-Payne, 2010). In this way, infected individuals then embody this evil and the individual themselves become the evil perpetrator able to infect others (Burris & Rempel, 2008). Representations such as these may perpetuate a continuous

cycle of blame, stigma and discrimination of those infected, particularly when psychosocial factors such as poverty, are not taken into consideration. Moreover, HIV socially represented as a plague may evoke a fear of death, which may severely hinder presentation at VCT centres thus obstructing efforts to lessening the crisis. Therefore, HIV socially represented as a plague anchors HIV in death, hopelessness, fear, panic and inevitable doom. This has implications for HIV being viewed as the evil perpetrator enhancing the stigma and discrimination of those infected further implying that no individual is safe from the virus, resulting in further disregard for those infected. This enhances the fear experienced hindering the fight against HIV.

Theme 5: HIV socially represented as the ultimate prankster

The body, as a vehicle for which systems of health and illness are understood, is closely associated to the social and cultural discourses prevalent in society (Rozenburg, 2012). The media has played a fundamental role in representing these discourses as dominant thus enhancing the various social representations of HIV. This is particularly so with the HIV-infected body, which is often anchored in weakness and gruesome depictions of a degenerated body (Persson, 2004). In this way, the HIV-infected body is represented as portraying hostility and unattractiveness clearly distinguishing those infected from those who are not (Persson, 2004). However, with the development of medication and treatment in managing HIV (Anti-retrovirals), individuals are able to lessen the visible signs of the infected body. Therefore, in this way, HIV is socially represented as the ultimate prankster.

HIV, as socially represented as the ultimate prankster, focuses on the appearance of the infected individual (Schoeneman et al., 2010). The infected body as severely degenerating, weak and skeletal predominates social representations of the HIV infected body (Persson, 2004). This is acknowledged in Training Manual 5 through the use of the words ‘wasting syndrome’ as seen below. Through this, society begins to develop clear distinctions between the healthy and ill body. In this way, the degenerating HIV-infected body is viewed as powerless and out of control thus, “making the disease visible in this way” (Gilman, 1988 as cited in Persson, 2004, p.61). Society places a fundamental value on the shape of individual’s body emphasising the continuous desire to work towards what is perceived as the ‘perfect’ body (Lupton, 2012). This

entails individuals engaging in activities, such as weight loss and cosmetic surgery, to attain the 'perfect' body which is represented as thin, attractive and healthy (Lupton, 2012). However, paradoxically, the perceived 'perfect' slender body, with its associated positive connotations, may resemble an HIV-infected body.

In this stage, patients experience wasting syndrome, Pneumocystis Carinni pneumonia (PCP), toxoplasmosis of brain, Kaposi's sarcoma, lymphoma, extra-pulmonary TB, extra-pulmonary Cryptococcus and other diseases - Training Manual 5

Four of the seven training manuals, namely Training Manual 2, Training Manual 3, Training Manual 5 and Training Manual 7, provide information on OIs including dealing with certain symptoms and treatment of these OIs. These OIs are primarily physically based, including weight loss, painful swallowing, nausea and vomiting, rashes, diarrhoea and ulcers among others. Further, the manuals also discuss tuberculosis (TB), skin disease and sclerosis including others. It is, therefore, vital for counsellors to be provided with this information, although bio-medically based, as counsellors are then able to recognise the severity of the virus when clients present for VCT. With the progression of HIV, the infected body becomes increasingly visible through intensified bio-medical and psychological symptoms (Avert, 2013; Prince et al., 2007 as cited in Freeman et al., 2008; Nath et al., 2008). As symptoms intensify and become increasingly visible with the development of OIs, the HIV-infected body can be viewed as becoming increasingly contaminated. This is particularly so with the development of OIs which, over time, intensify and become more frequent as the individual's immune system is weakened (CDC, 2009). In this way, there is a gradual collapse of the HIV-infected body as it slowly degenerates. Therefore, through viewing the infected body as contaminated, this encourages counsellors to look for visible signs of the infected and contaminated body increasing the stigma experienced for those clients. However, this is particularly problematic, as counsellors; within a client-centred framework (as discussed later in the chapter) should be empathic and provide unconditional positive regard (McLeod, 2003). However, in describing OIs, Training Manual 5 refers to these OIs as illnesses representing uncleanliness and being unhealthy. This may enhance the discrimination experienced by those presenting for VCT.