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University of the Witwatersrand, Johannesburg

School of Human and Community Development

Department of Social Work

TITLE: HIV AND AIDS: KNOWLEDGE, ATTITUDES AND PRACTICES OF COUNSELLORS AT NGOs IN EMFULENI MUNICIPALITY

A research report submitted to the Faculty of Human and Community Development, University of Witwatersrand in partial fulfilment of the requirements for the degree of Masters of Arts in the field of Social Development

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January 2018

DECLARATION

I, Daniel Mutasa, declare that this research is my own report. It has been submitted in partial fulfilment for Masters of Arts in Social Development at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other university.

Signature: _____

Date: _____/_____/_____

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I give honour and glory to God the Almighty who blessed me and made this study possible.

LIST OF ACRONYMS:

AIDS - Acquired Immune Deficiency Syndrome

CDC – Centre for Disease Control and Prevention

CICT – Client Initiated Counselling and Testing

D.o.H – Department of Health

ELM – Emfuleni Local Municipality

HCT – Human Immunodeficiency Virus Counselling and Testing

HTS – HIV Testing Services

HIV – Human Immunodeficiency Virus

IBM - International Business Machines Corporations

NGO – Non-Governmental Organisations

PICT – Provider Initiated Counselling and Testing

PLWHA – People living with HIV and AIDS

SPSS - Statistical Package for Social Scientists

TB - Tuberculosis

VCT – Voluntary Counselling and Testing

WHO – World Health Organisation

UNAIDS – Joint United Nations Programme on HIV and AIDS

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CHAPTER ONE: INTRODUCTION

1.1. STATEMENT OF THE PROBLEM RATIONAL OF THE STUDY

HIV and AIDS pandemic have continued to infect and affect millions of people across the globe (WHO, 2015). It is very important to have competent HIV and AIDS counsellors to assist in dealing with the physical, psychological and economic effects of the disease. HIV counselling and testing play a critical role in prevention, care, treatment and psycho-social support for those infected and affected by HIV and AIDS (Gatta & Thupayagale - Tshweneagae, 2012). Having relevant knowledge of HIV and AIDS, positive attitude towards PLWHA and necessary counselling practices can enhance a counsellor ‘s ability to help clients who seek HIV and AIDS counselling and testing services.

Most counsellors conducting HIV and AIDS counselling and testing services in South Africa are lay counsellors (Schneider & Lehmann, 2010). Therefore, it is important to find if counsellors in NGOs conducting HIV and AIDS counselling and testing have necessary knowledge about HIV and AIDS and investigate their attitudes towards PLWHA. An assessment of counsellor’s counselling practice is required. Schneider et al (2010) argue that poor counselling practices could affect the quality of counselling and result in misunderstanding and resistance to behaviour change. This is the first study to investigate knowledge, attitudes and practices of HIV and AIDS counsellors working for NGOs within Emfuleni Local Municipality.

1.2 PRIMARY AIM AND OBJECTIVES OF THE STUDY

AIM:

The main purpose of the study was to investigate the knowledge, attitudes and practices of HIV counsellors working for Non-Governmental Organizations (NGOs) within Emfuleni Local Municipality.

OBJECTIVES:

Objectives of this study were:

I. To determine counsellor ‘s knowledge of HIV and AIDS.
II. To determine counsellors’ attitudes towards PLWHA
III. To determine counselling practices of HIV counsellors

1.3 RESEARCH QUESTIONS

The following general research questions were posed with regard to HIV and AIDS counsellors practising in NGOs within Emfuleni Municipality:

1. What levels of knowledge about HIV and AIDS do counsellors have?
2. What are the counsellors’ attitudes towards PLWA?
3. How are counselling practices of counsellors in NGOs?

1.4 DEFINITIONS OF KEY CONCEPTS

Attitude: A predisposition or a tendency to respond positively or negatively towards a certain idea, object, person, or situation. Attitude influences an individual's choice of action, and responses to challenges, incentives, and rewards

Client: Any individual/s who visits a facility seeking services for counselling and or testing and support for HIV and AIDS related conditions

Confidentiality: The HIV counselling and testing service provider is required to keep secure and not discuss any information revealed by a client or the outcome of an HIV test without the knowledge and consent of a client

Health care professional: is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic way to people, families or communities

HIV counselling: An intervention that gives the client an opportunity to be educated and supported in order to explore his or her HIV risk; to learn about his or her HIV status and manage the consequences; to learn about HIV prevention and HIV and AIDS treatment, care and support services; and to learn how to modify behaviour to reduce the risk of HIV infection.

HIV counsellor: a trained individual who has successfully completed an HIV counselling course prescribed in the National Minimum Standards for Counselling and Training

HIV-positive: – presence of (antibodies against) HIV

HIV status: presence or absence of HIV

HIV test: blood test for antibodies against HIV

Informed consent: A process by which a client voluntarily confirms his or her willingness to provide a written or verbal consent to be tested for HIV or to provide information about his or her HIV status to a health care provider, health care worker, or researcher

Lay counsellor: Lay counsellors are volunteers in the non-governmental sector, they fulfil a role in relieving the burden of psychologists, counsellors, and health care professionals

Non -governmental organization (NGO): A civil society organization usually registered as not for profit, they are active in humanitarian, educational, health care, public policy, social, human rights, environmental, and other areas to effect changes according to their objectives

Post - test counselling: A dialogue between a health care provider/ worker and a client with the aim of informing the client of his or her HIV test results and assisting him or her to understand the implication of the results. This process assists the client to reduce the risk of infection and to facilitate access to appropriate services.

Pre -counselling: A dialogue between a health -care provider/ worker and a client with the aim of assisting the client to assess his or her own risk from HIV and to make an informed decision about whether or not to take an HIV test

Stigma: Stigma refers to attitudes and beliefs that lead people to reject, avoid, or fear those they perceive as being different

Knowledge: facts, information, and skills acquired through experience or education; the theoretical or practical understanding of a subject

Window period: the period between HIV infection and the detection of HIV -1/2 antibodies using serological assays, this signals the end of the seroconversion period

1.4 LAY OUT OF THE STUDY

The chapters are presented of the research report are presented as follows:

Chapter 1 will set the scene of the study and introduce the topic to the reader. It consists of the statement of the problem, aims and objectives of the study.

Chapter 2 will present the theoretical framework and literature review of the study. The chapter focuses on theoretical frameworks regarding HIV counselling, literature review on counsellors' knowledge and attitudes towards PLWHA and practices.

Chapter 3 will consist of the research methodology used in the study.

Chapter 4 will present the empirical results obtained in this study

Chapter 5 Discussion of results will take place

Chapter 6 is the final chapter of the study. It will present recommendations and conclusions that can be made, based on the results and discussions made in the study.

CHAPTER TWO

2. LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focuses on a theoretical approach used for HIV and AIDS counselling, and an overview of the available literature on HIV and AIDS in general. Review of studies related to knowledge of HIV and AIDS, attitudes towards PLWHA and practices will be undertaken. In South Africa, HIV counselling typically occur in clinical settings and non- medical sites. HIV counselling and testing is performed in diverse range of settings such as counselling and testing centres that are free-standing or integrated into hospitals, sexual health centres, churches, outpatient clinics, blood donation centres, drug treatment centres, family planning clinics, prisons, community health centres, and a diverse range of health outreach or community-based programmes (D.o.H,2016, UNICEF,2009). HIV counselling is conducted by nurses, doctors, social workers, other health care providers, professional counsellors, outreach workers (CHW) and volunteers (lay health workers) at NGOs with little more than a few days of formal training in HIV prevention counselling. (D.o.H, 2016, Schneider et al, 2010). Keeping this in mind the studies discussed in this section focus on the knowledge, attitude and practice of those primarily responsible for HIV counselling and testing in clinical and non-medical sites.

2.2 HIV AND AIDS OVERVIEW

AIDS is an acronym for Acquired Immune Deficiency Syndrome. Human Immuno-Deficiency Virus (HIV) was discovered to be the cause of AIDS in 1983, (Evian, 2006). According to van Dyke (2008), AIDS is not a specific illness, but a collection of many different conditions that manifest in the body because of the weakening of the body's immune system by HIV. UNAIDS (2017) and WHO (2015) advocate for HIV counselling as a key component of prevention strategies, complementing and supporting information, education, and communication strategies to combat HIV and AIDS.

In 2016, 25.7 million adults and children in Sub-Saharan Africa were reported to be living with HIV (UNAIDS, 2017). It is possible that the figures of people living with HIV could be above the estimated numbers as many people neither know their statuses nor seek counselling and testing services (WHO, 2015). Many African countries have vigorously campaigned for their citizens to know their HIV statuses. Clients can get early treatment and plan for their future. Many HIV and AIDS-related deaths which can be prevented and minimised by early intervention, occur due to ignorance and non-utilisation of available mitigation services.

Statistics indicate that in 2016, 741 000 adults and children in Sub-Saharan Africa died due to AIDS (UNAIDS,2017). An estimated 51% of people aged 15-49 years living with HIV in Sub-Saharan Africa know their HIV status. According to UNAIDS (2017), the number of people living with HIV who know their status doubled between 2003-2008 and 2009-2014, which is evidence that counselling and testing efforts have a visible effect on increasing knowledge of HIV status. However, despite increases in HIV and AIDS testing rates, more than half of the estimated 35 million PLWHA do not know their status (WHO, 2015).

Based on UNAIDS (2017) statistics, there has been a steady decline in new HIV infections in South Africa. In 2005, the figure was at 500 000, which further declined to 270 000 by 2016. There has been an increase of people living with HIV from 5.1 million in 2005 to 7.1 million in 2016. This is attributed to anti-retroviral uptake, which leads to longevity.

The number of people living with HIV who know their HIV statuses is reported at 6.1 million (WHO,2015). UNAIDS (2017) reports that 3.9 million people were on antiretroviral therapy as of 2016. On the contrary, it is worrying to note that only 45.8% of young people (15-24) are reported to have knowledge of HIV prevention (UNAIDS, 2017).

The South African government have put effort in scaling up HTS and strengthen its quality at all health facilities and non- health sites. According to D.o.H (2016), the proportion of people who have had an HIV test and are aware of their status has increased from 50 percent in 2008 to 66,5 percent in 2014. Furthermore, 92,3 percent of South Africans are aware of HTS services and 66,2 percent had actually utilised them in the past year (D.o.H, 2016). Over 4000 public health facilities are reported to be offering provider -initiated counselling and testing (PICT) and client -initiated counselling and testing (D.o.H, 2016). HTS services are available in medical, non-medical sites and in private sector as part of D.o.H efforts to fight the pandemic.

2.3 THEORETICAL APPROACH

Literature has supported that a diagnosis of AIDS has a profound effect on the psycho-social circumstances of the individual (Joe, 2015). HIV and AIDS counselling has developed as a response to these psycho-social problems (CDC, 2015, WHO,2015). Kanekar (2011) expressed that clinical interventions in HIV and AIDS counselling have developed from unexpected and different counselling approaches Various approaches such as cognitive,

psychodynamic, systemic and humanistic (van Dyk,2008) are utilized by counsellors in providing education, prevention and treatment of HIV and AIDS and no approach is better in comparison to each other. The person centered approach of Carl Rogers (1951, 1954,1959, 1980) is utilized for HIV counseling and testing in South Africa (Reeves, 2014, Evangeli, Longley & Swartz, 2011, Rohleder & Swartz, 2005). Due to its wide practice in South Africa, the person centered approach will be discussed.

2.3.1 PERSON CENTERED APPROACH:

The person-centered approach, also called the client-centered therapy (Witty, 2007), was developed by Carl Rogers during the 1940s and marked a move away from the widespread use of psychoanalytical techniques which had previously dominated the therapeutic landscape (Seligman,2006). According to McLeod (2015), the main difference between humanistic counsellors and other therapists is that they refer to those in therapy as 'clients', not 'patients' due to the fact that they see the therapist and client as equal partners rather than as an expert treating a patient. Rogers (1959) called his therapeutic approach client centred or person-centred therapy because of the focus on the person ‘s subjective view of the world (McLeod,2015). Furthermore, Corey (2009) asserts that the Rogerian client-centred approach puts emphasis on the “person” coming to form an appropriate understanding of the world and themselves. The person centered approach views people as capable and autonomous, with the ability to resolve their difficulties, realize their potential, and change their lives in positive ways (Seligman, 2006). Carl Rogers’s person centered approach aimed at promoting the client’s self-esteem, authenticity and actualisation in their life, and help them to use their strengths (Seligman, 2006).

The person-centred approach initially focused on the client being in charge of the therapy leading to the client developing a greater understanding of self, self-exploration, and

improved self-concepts (Corey, 2009). The focus then shifted to the client's frame of reference and the core conditions required for successful therapy such as ensuring the therapist demonstrates empathic understanding in a non-judgemental way (McLeod, 2009, Seligman, 2006). Currently, the person-centred approach focuses on the client being able to develop a greater understanding of self in an environment which allows the client to resolve his or her own problems without direct intervention by the therapist (Corey,2009). The therapist should keep a questioning stance which is open to change as well as demonstrating courage to face the unknown (McLeod,2009). Rogers emphasized the attitudes and personal characteristics of the therapist and the quality of the client-therapist relationship as being the determinants for a successful therapeutic process (Corey, 2009).

What is unique about the person-centred approach are techniques used as they are different from those used in other therapies. The techniques used in person-centred therapy are employed by the therapist to create an environment that facilitates the process of self-awareness (Corey, 2009). The primary technique of person-centered approach is to actively listen and reflect the client's statements in a nondirective, non-judgmental manner, thereby providing a safe environment for the client's self-exploration (Sheon, 2006). Person-centered approach pivots on the development of a counsellor-client relationship based on unconditional positive regard. (Corey, 2009, Seligman, 2006). Unconditional positive regard denotes to the therapist accepting, respecting and caring about clients (Seligman, 2006). One can advance the view that this technique addresses the aspect of "attitudes" towards PLWHA. When applying person centered approach, a counsellor need to be accepting, respecting and caring to the person who seeks HIV and AIDS counselling and testing services and those who test HIV-positive. It can be further argued that the person centered

approach has relevance to HIV counselling and testing as it advocates for non-judgemental attitudes which is critical when working with PLWHA.

As with all psychological theories and approaches to therapy, the work of Rogers has attracted criticism and its strengths and weaknesses will be discussed. Some of person - centered approach ‘s strengths are that it is viewed as up to date, optimistic and relevant to a multicultural perspective (Seligman, 2006, van Dyk,2008). Taking into cognisant that HIV and AIDS have global implications, one can suggest that person -centered approach is appropriate for HIV counselling as it cuts across cultural lines. Research have substantiated the importance of client – therapist relationship (Corey, 2009, McLeod, 2009). It is advanced that through person - centered approach, clients have a positive experience of therapy when the focus is on them and their problems and clients feel that they can express themselves more fully when they are being listened to and not judged by counsellors (Seligman,2006). Person- centered approach is envisaged to empower clients as they have responsibilities to make decisions (Seligman,2006).

Criticism has been raised against the person-centred approach. Corey (2009) advanced the view that the approach may lead therapists to just be supportive of clients without challenging them. Seligman (2006) explicitly pointed that listening and caring may not be enough. In this context, one can critically reflect if person-centred approach is realistic when used for counselling clients who seek HIV counselling and testing. A counsellor may need to challenge a client especially if a client has wrong information and notions about prevention and treatment of HIV and AIDS.

Seligman (2006) maintains that person -centred approach fails to prepare clients for the real world due to the unconditional positive regard of the therapist. One of the most common criticisms of Rogers' person-centred angle on therapy surrounds the three core conditions

that his particular approach advocate as being crucial to this form of treatment, namely unconditional positive regard, empathy and congruence (McLeod,2009, Seligman,2006). It is argued that these three tenets are basic environmental conditions that should be provided by all good therapists when conducting counselling, regardless of whether they choose to adopt a person-centred approach. In addition, McLeod (2009) views that when these requirements are met a counsellor can then progress to a stage where their expertise in a particular field will help the client solve their problems. However, advocates of person-centred approach can counter this argument by indicating that consistency in maintaining the core conditions cannot be easily mastered.

Corey (2009) interrogated whether a helper ‘s lack of knowledge and expertise on the problem faced by a client could hinder getting a successful outcome. Empathetic, congruent and non-judgemental attitude of the therapist might not adequate on their own when counselling a client. Knowledge of HIV and AIDS will be required for successful intervention to take place. In further related criticism of the person-centred approach concentration on provision of the three conditions, doubts have been cast on the ability of a therapist to provide non-judgmental, unconditional positive regard to a certain form of client, such as a serial murderer or violent child rapist (Corey,2009, Seligman, 2006). Similarly, use of the person-centred approach when dealing with a client suffering from serious mental illness or a person who has faced serious psycho-social challenges such as HIV -positive diagnosis may not be entirely applicable. The researcher, witnessed a client who committed suicide after diagnosed HIV-positive and the applicability of the person-centred approach in such circumstances might become questionable. It is one ‘s view that the counsellor may need to be in control of the situation in some circumstances and lead the process in order to protect the client when he/she is mentally and psychologically affected.

To sum up, the person-centered approach is a non-directive, optimistic therapy that focuses on the client's ability to make changes in his or her life and that clients strive for self-actualisation. Person centered therapy has been used for HIV and AIDS counselling and it has relevance in HIV counselling as it is applicable to people from different cultures and diverse backgrounds. Its value of non – judgemental attitude appeals to HIV counselling as people who test HIV positive are vulnerable and needs support and guidance at such a crucial moment of their life.

2.4 NATIONAL HIV TESTING SERVICES: POLICY (2016)

In 2016, the South African government unveils HIV testing services policy. The policy is premised on the global initiative to accelerate universal access to HIV prevention, treatment, care and support services for people living with HIV and AIDS (D.o.H, 2016). HIV testing services is regarded as the entry point for the continuum of care for HIV and AIDS (D.o.H, 2016). The main goal of the HIV testing services policy is to identify people living with HIV timeously through the provision of quality testing services for all and linking them to appropriate prevention, care treatment and support services (D.o.H, 2016). The Department of Health (2016) is of the view that counselling and testing has improved and progressively become more available and acceptable to the people.

Since, 2016 the HIV counselling and testing (HCT) is now referred to as HIV testing services (HTS) as to embrace the full range of services that should be provided together with HIV testing. These services as outlined in the policy are:

- Counselling (pre-test information and post-test counselling)
- Linkage to appropriate HIV prevention, treatment and care services and other clinical and support services

- Coordination with laboratory services to support quality assurance and the delivery of correct results

(Source: HIV testing services: Policy, 2016 – D.o.H)

HIV testing services policy offers guidelines which must be adhered to by clinical and non-clinical service providers such as NGOs when rendering HIV testing services. Guiding principles of the policy are that HIV testing for diagnosis must always be voluntary, consent must be informed through pre-test information and testing must be linked to prevention, treatment, care and support services as to maximise individual and public health benefits (D.o.H, 2016). As part of practices of HIV and AIDS counselling an emphasis on client consent, confidentiality and privacy has been strongly enshrined in the policy. The importance of counsellors having proper knowledge of HIV and AIDS is articulated in the policy when it directs that healthcare workers and health auxiliary workers are to inform people about the risks of HIV (D.o.H, 2016). Without proper knowledge of HIV and AIDS, one can argue that it can be difficult to inform people about the risks of HIV.

One of the ethical considerations advanced in the HIV testing services policy is challenging discrimination against people with HIV as it undermines human dignity and hinders response to HIV and AIDS (D.o.H, 2016). Various studies (Delobelle et al, 2009, Okpala et al, 2017 & Vorasane et al, 2017) have researched on attitudes of various health professionals towards PLWHA. Discrimination against people with HIV has been reported on various quarters. The HIV testing service policy envisage that the HTS programme can help in reducing discrimination by creating knowledge and competence about HIV in communities (D.o.H, 2016). The HIV testing services policy emphasizes on improving practices of healthcare personnel on HTS as it is critical to the provision of high quality HIV testing services.

2.5 SERVICE DELIVERY APPROACHES: HTS

HIV testing services in South Africa are provided at health facilities and community-based settings. Provider Initiated counselling and testing (PICT) refers to counselling and testing that is routinely offered in a health facility (D.o.H, 2016). It includes providing pre-test information and obtaining consent and clients have the ability to decline testing as it is voluntary. Healthcare providers recommend HTS to all patients in a health facility, regardless of whether they show signs or symptoms of HIV. Community -based HTS includes a number of approaches such as mobile outreach campaigns, events workplace testing, home based testing and testing in educational settings and places of worship (D.o.H, 2016). Community based approach is aimed at targeting various client groups such as youth, men and women. Priority populations identified for HIV testing services in South Africa are: infants, children, adolescents, young women, pregnant women, couples, partners, men, survivors of sexual assault, prisoners, migrant and migrating populations and those abusing alcohol and other drugs (D.o.H,2016).

Client-initiated counselling and testing known as voluntary counselling and testing (VCT) is whereby HTS is provided within healthcare facilities for clients who specifically seek counselling services (D.o.H, 2016). Clients may voluntarily seek to know their HIV status individually, as a couple or as a family. Most NGOs offers HIV counselling and testing services through Mobile and outreach HTS. These are services provided through vans and tents within the community to increase access to hard to reach populations (WHO,2015). Normally client-initiated counselling and testing services is provided by lay -counsellors who are employed by NGOs.

2.6 HIV COUNSELLING

Diverse interpretations arise when defining HIV counselling. Dhadwal et al (2009) defines counselling as a confidential dialogue between a client and a counsellor aimed at enabling the client to cope with stress and make personal decisions related to HIV and AIDS. On the other hand, van Dyk (2008) defines counselling as a facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self-knowledge, emotional acceptance, emotional growth, and personal resources.

The counsellor's role is envisioned to support or assist clients to assess their problems and the options or choices they have for dealing with these problems (Corey,2009). In this study the term "counsellor" will be used to refer to any health care workers, community based workers, lay counsellors and any service provider engaged in counselling clients who voluntarily, or through service provider initiative (PICT), seek counselling and testing for HIV on a full time or part time basis.

Sheon (2006) gave a distinction between HIV counselling from counselling in other environments. HIV counselling is given to people who have not specifically requested it. It comes as a package if you request an HIV test (WHO,2015). The "counseling" relationship in HTS is not requested by the client but imposed unilaterally by state laws regulating the provision of HIV testing (D.o.H,2016, UNAIDS,2017). Counseling is thus a condition for receiving the test. The second identified distinctive feature of HIV counselling is the medical environment whereby blood sample taking is involved as part of an HIV test. In this context, the counsellor is aware that the client might lack medical knowledge about the character and implications of HIV testing. Therefore, request for informed consent is paramount as medical and legal environments distinguish HIV counselling from other forms of counselling

(CDC, 2015, WHO,2015, van Dyk, 2008). In South Africa, HIV testing services guiding principles is centred on consent and confidentiality (D.o.H,2016) which are distinctive features identified by WHO (2015). It is imperative that HIV counsellors have necessary knowledge and practice as to understand the implications of HIV counselling and testing.

2.7 AIMS OF HIV TEST COUNSELLING

There are various aims for HIV counselling and testing globally. According to UNAIDS ,2017, WHO, 2015, UNICEF, 2009 and van Dyke ,2008, the following aims are identified as reasons for HIV test counselling:

1. To identify and clarify people's concerns and share knowledge about HIV and AIDS and assess client risks.
2. To check people's understanding of how HIV is transmitted, how transmission can be prevented and the meaning of anti-body test and assess their concerns of either a positive or negative result
3. To help people make more informed decisions by weighing up the benefits and disadvantages for them of having the test.
4. To provide clients with information about personal, medical, social, psychological and legal implications of being diagnosed either HIV positive or negative.
5. To provide psychological support to people infected and affected by HIV in improving their emotional, psychological, social and spiritual well-being

2.8 HIV AND AIDS COUNSELLOR ROLE/S

Counsellors have a critical role to play in addressing the challenges of HIV and AIDS pandemic and understanding about HIV transmission and behavioural change. Four roles for HIV counsellors identified by Rollins (2007) are:

- **Prevention:**

Counsellors can dispel myths about how the disease is spread and present accurate information and discuss the need to practice safe sex and client behaviour change

- **Working with those who are infected:**

Counsellors can motivate people to pursue their life goals, cope living with HIV and AIDS. Furthermore, counsellors can educate people on taking ARVS, and compliance. Counsellors can be a support system involved in assisting the client when he/she struggles with fear and trauma challenges in the future.

- **Working with those left behind:**

According to Rollins (2007) counsellors can work with spouses, family members, friends and co-workers of HIV and AIDS patients. Counsellors can be involved in facilitating and identity systems of care and support to those affected by HIV and AIDS. Client ‘s social, personal and career challenges can be addressed through counselling.

- **Training:**

Counsellors need training and basic understanding of people ‘s feelings in order to attend to clients when they test for HIV and AIDS. HIV counselling involves contact with various client groups.

2.9 LAY COUNSELLORS AND HIV PROGRAMMES

In South Africa and estimated 65000 HIV and TB care – related lay workers were reported to be working in public health sector, executing caregiving, support and advocacy roles (Schneider & Lehman, 2010). The emerging of lay health workers has been driven by shortages of health workers. According to Schneider et al (2010), community-based organizations and NGOs have formed care and support networks which makes use of lay personnel. Activities such as HIV counselling within the health system have become a function of lay health workers (lay counsellors) who are increasingly leading in provision of HIV counselling services (WHO, 2015). Based on various researches, WHO made policy changes and recommends HIV testing provision by lay providers (also known as lay counsellors) in July 2015 (WHO, 2015). WHO is of the view that expanding HIV testing services to trained lay providers working in the community may help to increase access to HIV testing services and their acceptability to people from key populations (WHO, 2015).

It is important to understand HIV counselling services in South African context, as lay counsellors are at the forefront on HIV testing services. State supported NGOs who employ lay counsellors are main drivers in HIV counselling services (D.o.H,2016).

2.10 KNOWLEDGE AND ATTITUDES TOWARDS PLWHA

A review of recent and previous studies on knowledge of HIV and AIDS and attitudes towards people living with HIV and AIDS (PLWHA) within health care system will be conducted. Basically, HTS differs from other counseling relationships in two aspects. People involved in HIV counselling and testing must have sufficient knowledge of HIV and AIDS and positive attitudes towards PLWHA (Turhan, Senol, Baykul, Saba & Yalcin, 2010) in order to enhance access and utilization of HTS. Increasing counsellor ‘s knowledge of HIV

and AIDS is required for effective HIV and AIDS counselling (Patel et al, 2013). Having necessary knowledge of HIV and AIDS helps counsellors to inform and educate people about the benefits of testing, the meaning of an HIV positive and an HIV-negative diagnosis, prevention options, privacy, confidentiality and right to refuse testing (D.o.H, 2016, WHO, 2015). People who test HIV positive after seeking counselling and testing services at public and private institutions faces a multitude of challenges. Testing for HIV can be a life changing experience and clients need psychosocial support (CDC,2015). One of the challenges they face is negative attitudes from health professionals and service providers (Delobelle et al,2009).

It is important to understand counsellors 's knowledge and attitudes towards PLWHA because having adequate knowledge of HIV and AIDS, level of education has been found to affect the attitudes of counsellors and the effectiveness of counselling provided to PLWHA (Patel et al, 2013). The attitude of the counsellor towards the person with HIV and AIDS is crucial to effective treatment of the disease and affects client 's desire to seek counselling and testing services (Johnson,2015). It is important for counsellors to be aware of their attitudes and how these can affect their work when counselling PLWHA.

A negative relationship between knowledge of HIV and AIDS and attitudes towards HIV and AIDS was reported in a study by Khorvash, Mohamardirizi, Ataiee, Khayamin and Bouroumandfar (2014). The study was cross – sectional and a questionnaire was completed by 303 participants. It was found that 57% of the participants had insufficient knowledge of HIV and AIDS, 98% had negative attitudes and 86% had a moderate tendency to care for HIV and AIDS patients. The level of participants knowledge of HIV and AIDS had a relationship with their attitudes towards HIV and AIDS. Nurses who had limited knowledge of HIV and AIDS had more negative attitudes towards PLWHA. Training of nurses was

recommended in order change knowledge nurses and midwives knowledge and attitudes and tendencies towards care provision for HIV and AIDS patients. Increasing knowledge of HIV and AIDS can play a role in reducing negative attitudes towards PLWA.

A study by Vorasane et al (2017) investigated the relationship between level of knowledge of HIV and AIDS and attitudes towards PLWHA. A structured questionnaire was completed by 558 healthcare workers (49,7% doctors and 50,3% nurses) from various hospitals in Vientiane, Lao. Across different health professionals who participated in the study, lower levels of HIV and AIDS knowledge were found to be associated with higher levels of negative attitudes towards PLWA. These findings are consistent and in line with findings in a study by Khorvash et al (2015) which indicated a relationship between knowledge of HIV and AIDS and attitudes towards PLWHA. Negative attitudes towards PLWHA negatively impacts on opportunities for prevention, education and treatment of HIV and AIDS. Increasing health care professionals level of education can play a significant role in reducing negative attitudes towards PLWHA.

It is important to establish whether a significant relationship exists between level of education and knowledge of HIV and AIDS as it might contribute to negative attitudes towards PLWHA. Famoroti, Fernandes and Chima (2013) investigated the impact of knowledge of HIV and AIDS and attitudes towards PLWHA by health care workers when providing care to patients. Tests of statistical significance showed a relationship between level of education and knowledge of HIV and AIDS, occupation and knowledge of HIV and AIDS and gender and knowledge of HIV and AIDS. A self- administered questionnaire was completed by 334 health care workers. Famoroti et al (2013) study was cross sectional and utilized quantitative methods. The results showed that health care workers had above average knowledge about HIV and AIDS. Males showed more comfort and empathy when

dealing with PLWHA. Famoroti et al (2013) recommended for provision of psychological and counselling support to HCWs and to further educate health care workers on HIV and AIDS to reduce the impact of stigmatization and discrimination against PLWHA.

A study by Adebajo, Bamgbala, Oyediran and Muriel (2003) further confirms existence of a relationship between level of formal education attained by a health care provider and their attitudes towards PLWHA. The study was conducted to examine the knowledge, beliefs and attitudes of health care providers from government owned health facilities. Results indicated that respondents level of knowledge was influenced by level of formal education attained, length of practice, gender and attendance to review courses on HIV and AIDS. Results showed that most of the participants (96,3%) had moderate to good knowledge of HIV and AIDS. Attitude towards PLWA was poor as 55,9% of health workers felt PLWA are responsible for their illness and 35,4% felt PLWA deserve the punishment for their sexual misbehaviours. Increasing health workers level of knowledge about HIV and AIDS was recommended as it can improve the quality of care and services rendered to PLWHA by health workers. Level of education has been reported to affect level of knowledge about HIV and AIDS.

Lack of knowledge about HIV and AIDS is widely believed to be responsible for negative attitudes towards PLWA. Zarei, Joulaei, Darabi and Fararouei (2015) assessed attitudes among health care providers toward PLWHA and found that the relationship between attitudes of health care providers and their knowledge of transmission, and willingness to provide services to patients was significant. The study was a cross sectional survey and a structured questionnaire was used to collect data. Negative attitudes on provision of services to certain client groups were reported. The results indicated that 39,6% and 46,2% of respondents preferred not to provide services to prostitutes and homosexual patients.

Based on findings in this study, it seems that increasing health care workers knowledge of HIV and AIDS can be a good strategy in tackling negative attitudes towards PLWHA.

A study to evaluate the awareness and attitudes of healthcare workers (HCWs) by Al-Salihy and Enad (2017) took place at Baquba Hospital. It was found that health care workers generally had good knowledge about HIV and AIDS. The similarity of studies by Zarei et al (2015) and Al-Salihy (2017) is that both used cross-sectional survey and questionnaires for data collection. The researchers in both studies emphasized the importance of increasing knowledge of HIV and AIDS among health care workers as to reduce attitudes towards PLWHA.

Gledovic, Rakocevic, Mugosa and Grgurevic (2015) assessed HIV related knowledge, attitudes and practice of health care workers (HCWs) in Montenegro. A total of 422 HCWs participated in the study and a self-administered questionnaire was used for data collection. An insufficient level of knowledge on HIV transmission was generally observed. More than half (55,7%) of participants had knowledge of HIV and AIDS. A need for continuous education for HCWs to increase their level of HIV and AIDS knowledge was recommended as it was envisaged to have potential in influencing change of HCWs attitudes towards HIV patients.

A research by Bektas and Kulakac (2007), carried an assessment of knowledge and attitudes towards HIV and AIDS of nursing students in Turkey. A total of 227 people participated in the study. A mixed method - qualitative and quantitative methods were used in this research. The results indicated that most of the participants had a moderate level of HIV and AIDS knowledge. The nursing students' negative attitudes towards PLWHA were driven by fear of becoming infected and pity. The findings underlined the need to increase

nurse's knowledge on all aspects of HIV and AIDS. The recurring assessment of these studies is the linkage between HIV and AIDS knowledge and attitudes towards PLWHA.

Discrimination and lack of care for PLWHA due to negative attitudes from health care workers and other service providers who provide HTS negatively affect the fight to reduce spread of HIV. IN a study of health care workers at Enugu in Nigeria, Okpala et al (2017) found significant relationship between the age (P<0,005), marital status (P<0,05), profession standing of respondents (P<0,05) and the respondents level of knowledge about HIV and AIDS. Most (94,6%) respondents have positive attitude towards PLWHA. On the other hand, there was no significant relationship between the respondents' marital status, religion and their attitudes towards PLWHA. This study corresponds with Gledovic et al (2015) for the need for training on HIV and AIDS to improve the knowledge and positive attitude towards PLWHA. Training of health care workers on HIV and AIDS is linked to their knowledge and attitudes towards PLWHA.

Ben-Ari (2008) explores Israeli professionals knowledge about and attitudes towards AIDS. The results of this study indicated that the knowledge scores of participants were higher than their attitude scores. There was a relationship between attitude scores and gender as women scored higher than men. However, nurses scores were significant lower on the attitude scale as compared to other professionals. The study sample of 370 professionals consisted social workers, nurses, therapists, psychologists and teachers. This study confirms that negative attitudes towards PLWA exists among professionals and training of these professionals by increasing their knowledge of HIV and AIDS can affect their attitudes as reported in Dhadwal (2009) study.

2.11 COUNSELLING PRACTICES

Practices as defined in Stevenson and Waite (2011) are a method, procedure, process or rule used in a particular profession or field which creates set of expected standards. On the other hand, best practices involve a method or technique that has been generally accepted over others because it has become a standard way of doing things (Stevenson et al, 2011). In HIV counselling, counsellors are expected to provide pre and post counselling, ensure privacy and confidentiality, get client consent, assess lifestyle and risk behaviours, explain the window period, discuss implications of negative and positive results with clients (D.o.H, 2016, W.H.O,2015, UNICEF,2009). These practices enhance the counsellors 's capacity to deal with challenges faced in the counselling process. Clients accessing HIV and AIDS counselling services need to understand the context of HIV and AIDS with regard to prevention, treatment and care. HIV counsellors are required to keep abreast with new trends in HIV and AIDS prevention as well as improving their counselling skills to address various needs of clients. Maintaining set standards and processes in HIV counselling is very important.

There seems to be a significant relationship between knowledge of HIV and AIDS, attitudes towards PLWA and practices of health care professionals. Patel et al (2013) found that participants who scored high on counselling knowledge of HIV and AIDS and counselling practices scored high on positive attitudes towards PLWHA. This finding supports increasing knowledge of HIV and AIDS to those engaged with HIV and AIDS in order to influence practices and attitudes towards PLWHA.

HIV counselling practices involves assessing risk behaviours of clients during the counselling process. Assessing client 's risk behaviours might positively affect a client 's behaviour and impact on HIV prevention. In a study by Peltzer, Tabane, Matseke, and

Simbayi (2010) a significant increase in HIV and AIDS knowledge, behavioural intentions, and risk reduction efficacy among participants was reported. Lay counsellors included risk assessment as part of their intervention during counselling sessions with clients. A total of 488 participants were involved in this exploratory study. Peltzer et al (2010) recommended risk reduction assessment as part of HIV and AIDS counselling as significant reduction in sexual partners, unprotected sex, alcohol and drug use was reported in their study. Therefore, behaviour risk assessment is critical part of HIV counselling practices as it can lead to behaviour change.

Good counselling practices affect prevention and treatment of HIV and AIDS. Ramalepe, Khoza and Maputle (2014) reported challenges in HIV counselling practices. In a quantitative with a sample of 33 lay counsellors, it was reported that 42% of participants assessed the risks and knowledge of clients on HIV transmission. Only 61% of the participants managed to discuss in detail the implications of positive results with clients. The researchers recommended in-service training and formal supervision of those involved in HIV counselling in order to enhance their knowledge of HIV and AIDS and improve HIV counselling practices. Risk assessment during counselling has been found to have positive effects on behaviour change in a study by Peltzer et al (2010).

Levi – Minzi and Sarrat (2014) recommended instilling good counselling practices and increasing knowledge of HIV and AIDS to lower negative attitudes toward PLWHA as their study showed a significant relationship between knowledge of HIV and AIDS and practices of those involved in counselling. Counselling practices and education have impact on attitudes towards PLWHA as factual and extensive knowledge of HIV and AIDS reduces negative attitudes towards PLWHA.

Privacy and confidentiality are critical components in HIV counselling. in rendering effective and efficient HIV testing services. Ngangue et al (2017) reported challenges of privacy and confidentiality in counselling. These findings are consistent with a study carried in South Africa by Mwisongo et al (2015) as they reported lay counsellors having challenges related to privacy and confidentiality. Lack of privacy and confidentiality can discourage clients from seeking HIV counselling and testing services. The importance of privacy and confidentiality was confirmed in a study by Akhiwu (2012) as willingness to utilize voluntary counselling and testing services was found to be significantly associated with level of confidentiality at testing centres.

A study of HIV and AIDS knowledge, attitudes and practices among healthcare workers by Delobelle et al (2009) have shown some gaps in knowledge, and some attitudes towards PLWHA and practices. Delobelle et al (2009) conducted an exploratory study on knowledge, attitude and practices of nurses in Limpopo, South Africa. Knowledge of HIV and AIDS was associated with professional rank, frequency of care and training (P<0,01). Nurses had highly positive attitudes towards PLWHA and there was statistical significant correlation between attitudes towards PLWHA and HIV and AIDS knowledge (P<0,01) and training (P<0,05). Practices investigated were universal precautions adherence such as wearing of gloves and disposing of needles when attending to patients. The majority of respondents (92,8%) indicated that they wore gloves when taking blood samples. This is a universally requirement and applies to those testing for HIV and AIDS. Training of nurses on HIV and AIDS was highly recommended to improve their practices.

Practices in HIV counselling are influenced by training of counsellors. Dhadwal et al (2009) conducted training of HIV counsellors and massive changes in counsellor's knowledge was evident as there was statistical significance difference between pre and post test scores.

Counsellor ‘s knowledge and attitudes and practices significantly increased after training of participants in the study. In a similar study by Msisuka, Nozaki, Kakimoto, Seko and Ulaya (2012) it was found that participants had moderate knowledge of HIV and AIDS before training. Before training, the participants scored 60% on knowledge of post counselling, 48% on counselling of children and 58% on knowledge of post exposure prophylaxis. The participants knowledge significantly increased after training which underscores the importance of training to enhance good practices of those involved with HTS.

A significant relationship between knowledge, attitudes and practices of professionals and service providers involved in HTS was reported in a research by Heunis, Wouters, Kigozi, Janse van Rensburg-Bonthuyuzen and Jacobs (2013). The aim of the exploratory research was to assess TB and HIV-related practice, knowledge and attitudes of CHWs. In the study, interviews were conducted with 206 CHWs at 28 clinics in the Free State province. The results indicated that more than half of respondents (54.9%) had not received basic training in HIV counselling and testing which affects their practices. Significant associations ($0.01 < p < 0.05$) between the types of CHWs and their sub-district location, and their TB and HIV-related training, knowledge and attitudes were observed. The researchers recommended and suggests that CHW TB and HIV training, knowledge and attitudes need to be improved if integrated TB and HIV services are to be implemented successfully. Training has consistently highlighter as important in improving health workers knowledge of HIV and AIDS, attitudes towards PLWHA and practices of those involved with HIV and AIDS programs.

2.12 SUMMARY

The literature review focused on person - centered approach to counselling, background and information about HIV and AIDS and previous studies regarding knowledge of HIV and AIDS, attitudes towards PLWHA and practices. The literature seems to largely suggests existing of significant relationships between knowledge of HIV and AIDS and attitudes towards PLWHA and practices. In some studies, findings showed lack of significant relationships between demographic variables with knowledge of HIV and AIDS, attitudes towards PLWHA and practices.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter focuses on the research design and methodology that was employed in this study. Included in this chapter are descriptions of the population and sample studied, procedures used for data collection, instrument, data analysis, reliability and limitations of the study.

3.2 RESEARCH DESIGN AND STRATEGY

There are various research designs and they fall into two distinct paradigms, namely quantitative and qualitative research. Babbie & Mouton (2001) defines a research design as a plan or blueprint of how a person intends to conduct a research. However, de Vos, Strydom, Fouche and Delport (2005) categorically state that definitions of research design are ambiguous and have various meanings.

For this study, a quantitative approach was utilized, using a non-experimental field survey design to examine variables of interests. A questionnaire was used as a data collection tool. This design involved a field study whereby the research is carried out in the actual environment in which a phenomenon is observed originally (Welman, Kruger & Mitchell, 2011). There was no manipulation of the existing environment with participants in the research process. The intention of the design is to show the greatest similarity to real life. Participants who are already HIV counsellors at NGOs within Emfuleni Local Municipality were randomly selected to participate in the study.

3.3 POPULATION

A population is the study object and consists individuals, groups, organizations, human products and events or the conditions to which they are exposed (Welman et al, 2011). In elaboration, Welman et al (2011) p52 says, “a population encompasses the total collection of all units of analysis about which the research wishes to make specific conclusions”. The target population for this study was consisting all counsellors involved in HIV counselling and testing at Non-Governmental Organisations operating within Emfuleni Local Municipality, located in Gauteng Province, South Africa. A database from the Department of Health and information from Emfuleni Department of Health and Social Development was used to identify relevant NGOs.

3.4 STUDY SAMPLE AND SAMPLING PROCEDURE

A sample is a subset of measurements drawn from a population in which the researcher is interested (Heppner, Wampold & Kivlighan,2008). Convenience sampling was used to have a sample of HIV counsellors from the population (all HIV counsellors at NGOs in ELM). A sample of hundred and one (101) HIV counsellors participated in the study. An invitation to participate in the study was requested in form of a written memo to various NGOs involved in HTS.

3.5 PILOTING THE STUDY

Out of the identified NGOs involved in HTS within Emfuleni Municipality, one HIV counselling site was selected for piloting the study. A questionnaire for the pilot study was distributed. The purpose of the pilot study was to orientate the researcher to the study site and the data collection tool. The pilot study was not included in the main study. Heppner et al (2008) emphasised that a pilot study is an integral part of the research process. Piloting assists

researchers to avoid any possible obstacles that might arise in the study. Necessary adjustments were made based on the pilot study.

3.6 RESEARCH INSTRUMENT

A self- administered questionnaire was utilised as a research instrument. According to de Vos et al (2005), the basic objective of a questionnaire is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue. The instrument was designed to collect demographic information of respondents, and elicit responses on knowledge of HIV and AIDS, attitudes towards PLWA, and practices of counsellors.

3.7 DATA COLLECTION

Data collection began after the researcher got permission from Witwatersrand University Ethics committee and relevant NGOs to conduct the study. Data was collected through a self-administered questionnaire whereby the respondents were handed a questionnaire to complete. The researcher collected the questionnaire upon completion by the respondents.

3.8 DATA ANALYSIS

Analysis is defined as categorising, ordering, manipulating and summarising of data to obtain answers to research questions (Heppner et al,2008). The answers are found through interpretation of the data and the results (Welman et al,2011). Quantitative data can be analysed manually or by using a computer-aided package. The responses of the counsellors in this study were measured using an ordinal scale, whereby a rating scale of responses from 1 to 5 (representing responses ranging from strongly disagree to strongly agree) was used. In this research, data was analysed utilising the International Business Machines Corporations (IBM) Statistical Package for Social Scientists (SPSS, Version 20). In this

study three composite variables regarding knowledge about HIV and AIDS, attitudes towards PLWHA, and counselling practices were constructed from all questions in the questionnaire.

After data collection, the data was prepared for data entry and encoded. A spreadsheet was used for data entry purposes before analysis. SPSS was used to generate frequencies, percentages and cross tabulation utilising the Pearson Chi -square to test the significance of relationships between knowledge of HIV and AIDS, attitudes towards PLWHA, practices of counsellors and the demographic variables of the respondents. Tabular and graphic displays were utilised to summarise data. Measures of variation were part of data analysis. Measures of variation are indicators of dispersion around the mean, variance and standard deviation (de Vos et al, 2005). Descriptive statistics, such as frequencies, means, median and standard deviations were utilised to summarise the data.

3.9 RELIABILITY AND VALIDITY OF THE STUDY

The reliability of a measurement procedure is the stability or consistency of the measurement (Heppner et al,2008). Validity is the extent to which the research findings accurately represent what is really happening in the situation (Welman et al, 2011). Using more than one measure of the same construct in the questionnaire assisted in addressing construct validity. Rating and social desirability scales in the questionnaire were intended to identify individuals who provide invalid responses (Welman et al, 2011). Cronbach's coefficient alpha was used to determine the reliability of the measuring instrument. Cronbach's coefficient alpha is a measure of the internal consistency of a measurement/test (Welman et al, 2011). Cronbach's coefficient alpha ranges from 0 to 1 with a value of 0.7

and above considered as a very good value of reliability. In this study, the Cronbach coefficient alpha was 0.7, which is acceptable in terms of value of reliability.

3.10 LIMITATIONS OF THE STUDY

It is imperative to be cautious when interpreting these results due to various study limitations. The study sample was not representative of all HIV counsellors in Gauteng Province or in South Africa. This limits the ability to generalize the results and apply the findings to all NGOs conducting HIV counselling and testing in Gauteng Province and in South Africa. The study sample consisted of NGOs funded by Department of Health and does not include private facilities, such as private hospitals and clinics, which makes it impossible to perform a comparative analysis.

Due to the fact that the findings of this study are based on counsellors' views and perceptions, possible bias cannot be ruled out. The other limitations emanate from the size of the survey, as the sample size was small.

3.11 ETHICAL CONSIDERATIONS

In this study the researcher made efforts to adhere to all the principles of ethical research. The following ethics were upheld when conducting the research: informed consent, confidentiality and anonymity, and protection of participants from harm. Permission to conduct research was obtained various from the relevant Non-Governmental Organisations (NGOs) and authorities in Emfuleni Municipality. The researcher ensured this by implementing or following the ethical code of conduct when carrying out the research from the selected sites.

The participants from the sites were informed about consent as to seek their agreement for participation in the study. It was clearly stated that the participation was voluntary and should

the participants want to withdraw from the study at any time, they were free to do so. Permission was requested from the participants to participate in the study on a voluntary basis. The researcher ensured that the identity of the participants was kept confidential. When conducting the research, it was ensured that participants were not exposed to psychological and physical harm by following and implementing the research code of ethics. An ethics clearance certificate was obtained from the University Research Ethics Committee.

3.12 SUMMARY

The chapter gave an outline of how the research was conducted. The research design and strategies were discussed. The methodologies used for data collection and analysis were outlined. The research instrument used for this study was a self-administered questionnaire. The limitations and ethical considerations faced in this study were also discussed. Chapter Four will focus on the results and discuss the findings of the study.

CHAPTER FOUR

4. RESULTS

4.1 INTRODUCTION

This chapter focuses on empirical analysis and results gathered from the study. The data analysis was carried out using IBM SPSS Statistics version 23. All statistical tests were done at 5% level of significance. The findings from the study will be presented in sequence, according to the sections in the questionnaire. The following will be covered:

- socio-demographic data,
- knowledge of HIV and AIDS,
- attitudes towards PLWHA,
- Practices

4.2 DEMOGRAPHIC INFORMATION

Respondents provided demographic information for this study, which was used to describe the sample. The demographic information included gender, ethnicity, age, marital status, years of experience and level of education. The socio-demographic characteristics of respondents are presented in Table 1. A total of 101 respondents were included in the study: most of the respondents 85 (84,2%) were females and few were 16 (15,8%) males. The majority of respondents 100(99%) in this sample were blacks. Moreover, 39(38,6%) respondents were between 31-40 age group and very few 2(2%) were aged above 61 years. Over half of the respondents 53(52,5%) had matric qualification. Certificate was next 25(24,8%), followed by 15(14,9%) below matric qualification. Most of the respondents

were single 54 (53,5%) whilst 35(34,7%) were married. More than half of the respondents 51(50,5%) had 1-5 years of HIV counselling experience whilst 27 (26,7%) had 6-10 years of counselling experience.

Table 1: Frequencies distribution of Demographic Variables (N=101)

Variable	Category	N	n	%
Gender	Female	101	85	84,2
	Male	101	16	15,8
Ethnicity	Black	101	100	99
	Coloured	101	1	1
Age Group	20-30	101	31	30,7
	31-40	101	39	38,6
	41-50	101	21	20,8
	51-60	101	8	7,9
	61+	101	2	2
Marital status	Married	101	35	34,7
	Single	101	54	53,5
	Divorced	101	6	5,9
	Widow	101	3	0
	Living with partner	101	3	3
Level of Education	Below Matric	101	15	14,9
	Matric	101	53	52,5
	Certificate	101	25	24,8
	Diploma	101	6	5,9
Years of employment	<1	101	7	6,9
	1-5	101	51	50,5
	6-10	101	27	26,7
	11+	101	16	15,8

4.3 KNOWLEDGE OF HIV AND AIDS

An analysis on the association of composite variable of knowledge of HIV and AIDS with selected demographic factors was completed. Descriptive analysis showed that the majority of respondents 86(84,8%) in the study had adequate knowledge of HIV and AIDS. While 15(15,2%) lacked knowledge of HIV and AIDS. On the knowledge scale the mean score was 4,2805; *s*= 0,80 reflecting good knowledge of HIV and AIDS.

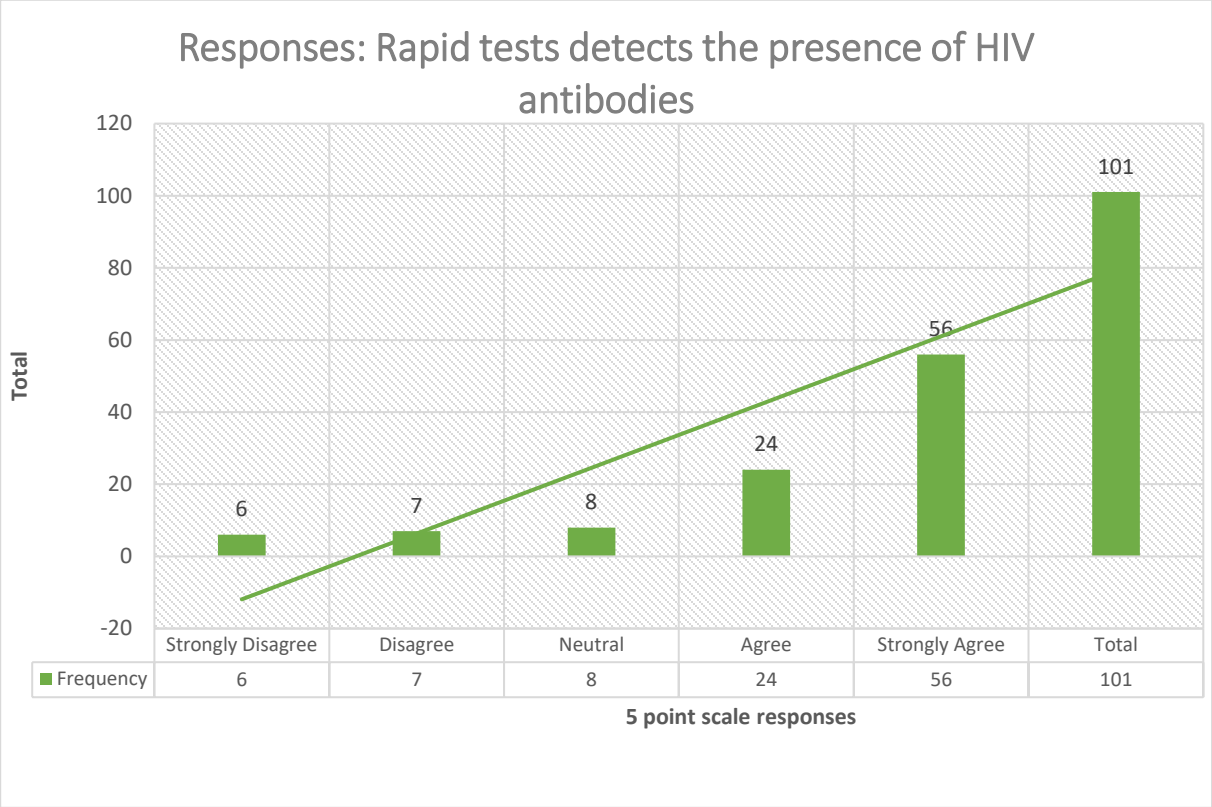
Tests of difference between distributions, t-tests and analysis of variance were completed to measure any statistical significant difference between the means and distribution of sample. There was no significance difference (P=0,958) on scores for knowledge of HIV and AIDS between males and females. The ANOVA results indicated that age (F=1,339, P=0,261), marital status (F=0,419, P = 0,794), race (F=0,004, P= 0,948), years of experience (F= 0,573, P =0,634) and qualifications (F = 0,888, P = 0,474) had no significance association with HIV and AIDS knowledge. Table 2 below showed the relationship of knowledge with demographic factors.

Descriptive analysis was completed on HIV and AIDS knowledge to find the distribution of knowledge. The majority of the study group 98 (97%) knew that HIV and AIDS can be transmitted by sexual intercourse without using a condom whilst very few respondents 3 (3%) disagreed with the statement. A high proportion of respondents 80 (79,2%) correctly indicated that the rapid tests detects the presence of HIV antibodies, while 13 (12,8%) disagreed with the statement and 8 (7,9%) were neutral. A high number of respondents 79(78,2%) correctly indicated that a window period takes 3 months. On the other hand, 17 (16,9%) gave incorrect respond about the window period. Figure 1 below shows responses to knowledge statement that says that the rapid tests detects the presence of HIV antibodies.

Table 2. Relationship of knowledge with demographic factors, N = 101

Variable	Category	X_2 (P Value)
Gender	Female	
	Male	(F=0,004, P= 0,948)
Ethnicity	Black	
	White	
	Coloured	
	Indian	(F=0,004, P= 0,948)
Age Group	20-30	
	31-40	
	41-50	
	51-60	
	61+	(F=1,339, P=0,261)
Marital status	Married	
	Single	
	Divorced	
	Widow	
	Living with partner	(F=0,419, P = 0,794)
Level of Education	Below Matric	
	Matric	
	Certificate	
	Diploma	(F = 0,888, P = 0,474)
Years of employment	<1	
	1-5	
	6-10	
	11+	(F= 0,573, P =0,634)

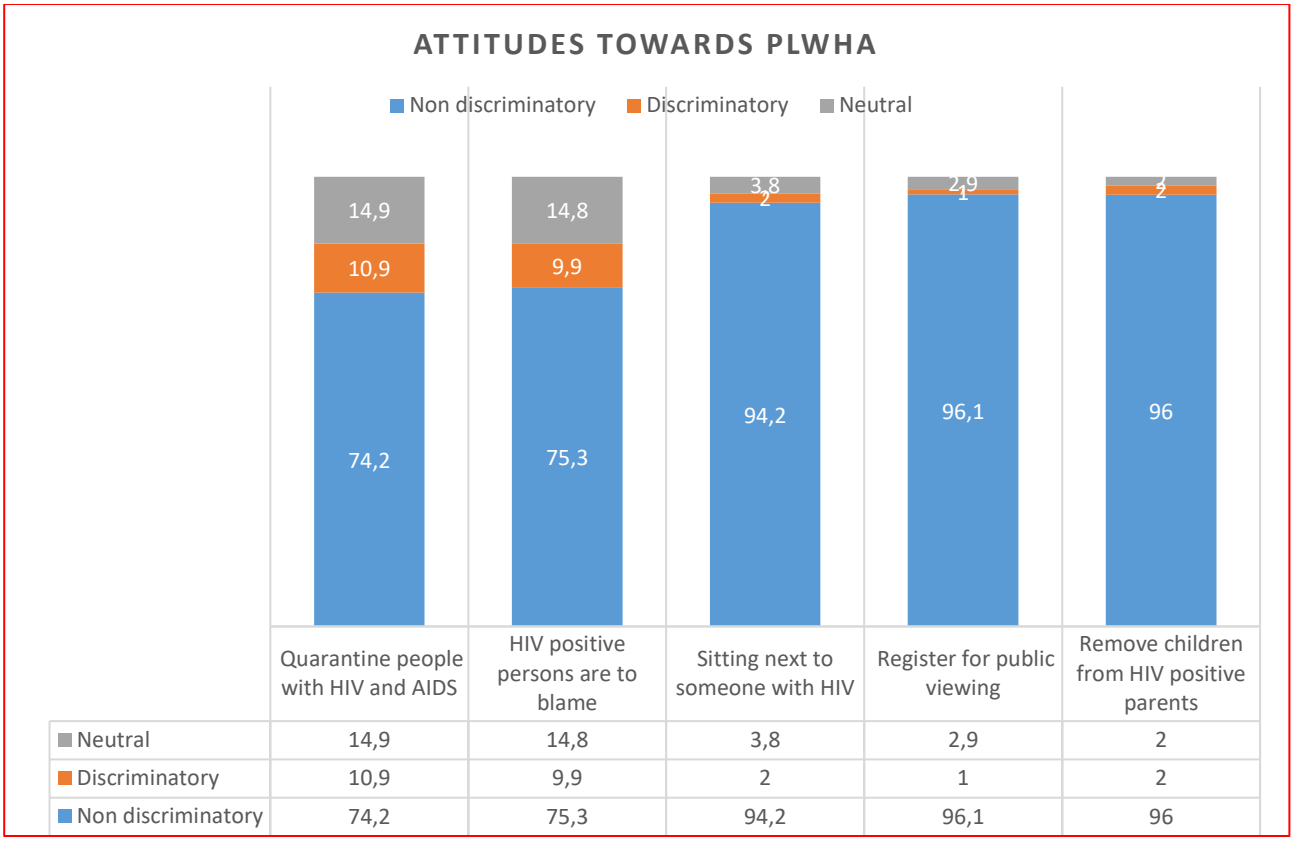
Figure 1: The rapid tests detects the presence of HIV antibodies



4.4 ATTITUDES TOWARDS PLWHA

An analysis on association of attitudes towards PLWHA with demographic factors was finalized. A high number of respondents 88 (87,16%) had positive attitudes towards PLWHA. The attitude mean was 1,5188 and standard deviation was 0,62940. The t-tests (P=0,576) showed no observed difference in the mean score for males and females on attitude towards PLWHA. The study also assessed association of attitude towards PLWHA variable with the following demographic factors: age, marital status, race, years of experience and qualifications. ANOVA results showed that there was no significance influence between attitude towards PLWHA and age (F =0,479, P=0,751), marital status (F= 0,397, P=0,810), race (F=0,684, P= 0,410), years of experience (F=0,292, P = 0,831) and qualifications (F=0,839, P=0,504). Figure 2 shows the distribution of responses to attitudes questions.

Figure 2. Percentages of responses to the variables assessing attitudes towards PLWHA



	Quarantine people with HIV and AIDS	HIV positive persons are to blame	Sitting next to someone with HIV	Register for public viewing	Remove children from HIV positive parents
Neutral	14,9	14,8	3,8	2,9	2
Discriminatory	10,9	9,9	2	1	2
Non discriminatory	74,2	75,3	94,2	96,1	96

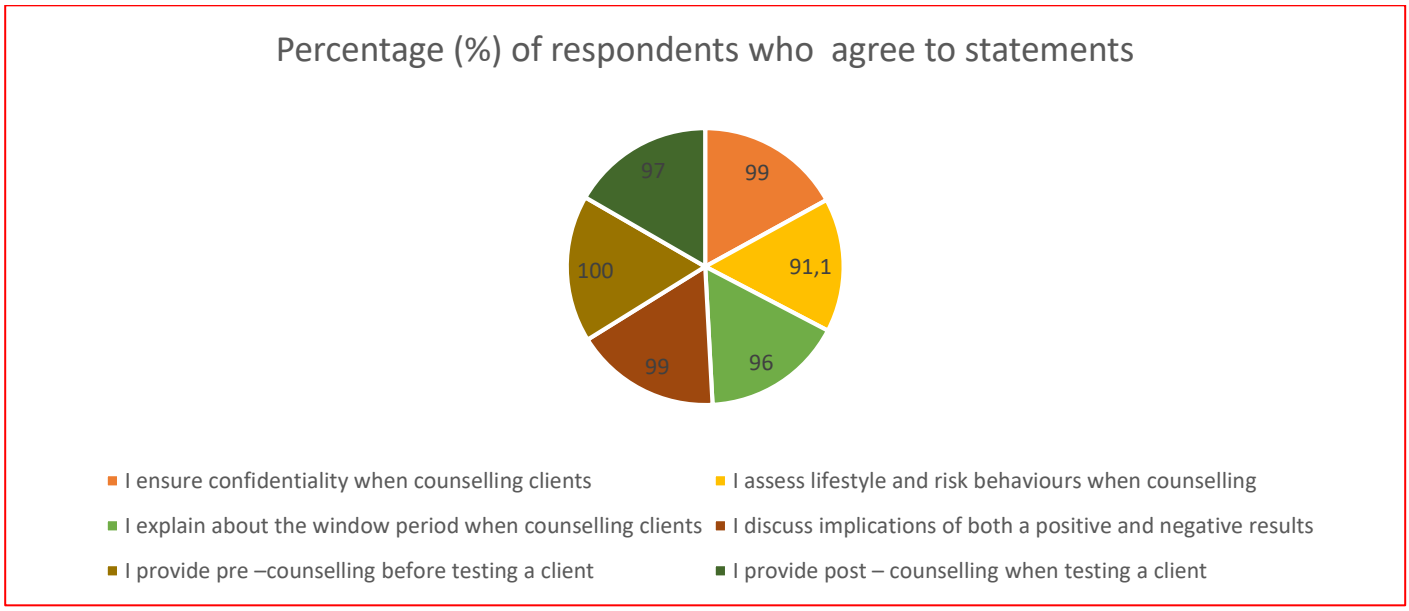
An analysis of distribution of attitudes towards PLWHA yielded various results. On responses to statements of attitudes towards PLWHA, most respondents 75 (74,2%) indicated that it was wrong to quarantine PLWHA. Fewer respondents 11 (10,9%) think it is fine to quarantine PLWHA. Over three quarters of respondents 76 (75,3%) did not place blame on PLWHA. While only 10 (9,9%) respondents blame PLWHA for their situation. The majority of respondents 95(94,1%) had no problem of sitting next to someone who is HIV-positive whilst 2(2%) indicated that they will not sit next to someone with HIV and AIDS. However, 4 (4%) respondents were neutral to the statement. According to the respondents 97(96,1 %) it will not be proper to have a public register for those who have HIV and AIDS. On the contrary 3 (3%) are of the view that it is proper to have a public register for those who have HIV and AIDS.

4.5 COUNSELLING PRACTICES

Analysis focused on association of practices with demographic factors. HIV Counselling practices responses 98(97%) indicates very good counselling practices by counsellors. The mean for practice was 4,6238 with standard deviation of 0,42469. T– tests (P=0,990) showed that gender had no significant influence on practice. An analysis of relationship between composite variable of practice and demographic factors was completed using ANOVA. The results showed that practice had no significant relationship with age (F=0,421, P=0,793), marital status (F =1,228, P=0,304), race (F=0,791, P=0,376) and years of experience (F=0,866, P=0,461). However, the results showed that there was significant relationship between practice and qualifications (F = 4,335, P= 0,003). Level of qualifications was categorized into five groups which are below matric, matric, certificate, diploma and degree. The ANOVA results indicates significance on comparison between below matric and matric (P=0,034) on practice as an independent variable. The significance was found on multiple comparison of qualifications: matric and diploma (P=0,017), matric and certificate (P=0,001), diploma and matric (P=0,017). On the other hand, there was no significance of relationship between degree and other qualifications with practice as an independent variable.

Figure 3 shows the percentage responses to questions on HIV counselling practice. Distribution of responses in counselling practices indicated that 100 (99%) respondents ensure confidentiality when counselling clients. On the other hand, 100 (99%) respondents specified that they discuss the implications of both positive and negative results with clients. All respondents 101 (100%) said they provide pre-counselling before testing a client. Most respondents 97 (96%) indicates that they explain the window period to clients. In addition, 92 (91,1%) of respondents indicated that they assess lifestyle and risk behaviours of clients.

Figure 3. Percentages of response to the variables assessing counselling practice



4.6 FACTOR ANALYSIS – PEARSON CORRELATION: KNOWLEDGE, ATTITUDE AND PRACTICE

Correlations were used to describe relationships between three variables: knowledge, attitudes and practices. The results showed no relationship between practices and attitudes towards PLWHA (*r*=-0,128), practices and knowledge (*r* =0,003). There was no relationship between attitudes towards PLWHA and practices (*r*=0,128), attitudes towards PLWHA and knowledge (*r*=0,042). The results indicated no significant relationship between knowledge and practices (*r*=0,003), knowledge and attitudes (*r*=0,042). There was no direct relationship between knowledge, attitudes and practices as the correlation coefficient close to zero indicates no relationship. Table 3 shows results on factor correlations between counselling practices, attitudes towards PLWHA and knowledge of HIV and AIDS.

Table 3: Factor Correlations: Practice, attitude and knowledge

			Practice	Attitude	Knowledge
Spearman's rho	FA_Practice	Correlation Coefficient	1,000	-0,152	.295**
		Sig. (2-tailed)		0,128	0,003
		N	101	101	101
	FA_Attitude	Correlation Coefficient	-0,152	1,000	-.203*
		Sig. (2-tailed)	0,128		0,042
		N	101	101	101
	FA_Knowledge	Correlation Coefficient	.295**	-.203*	1,000
		Sig. (2-tailed)	0,003	0,042	
		N	101	101	101

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

CHAPTER 5

5. DISCUSSION

5.1 INTRODUCTION

The purpose of this study was to investigate the knowledge of HIV and AIDS, attitudes towards PLWHA and counselling practices of counsellors at NGOs. Statistical analysis to measure the degree of association between demographic factors with knowledge of HIV and AIDS, attitudes towards PLWHA and statistical significance was completed.

5.2 DEMOGRAPHICS

The findings showed that the majority of people involved in HIV and AIDS counselling at NGOs in the study were females. The likely explanation might be high involvement of women in caring fields. A significant finding in the study was the race of respondents as most 100 (99%) were blacks. The probable reason can be that most NGOs in ELM are located in black townships.

5.3 KNOWLEDGE OF HIV AND AIDS

Respondents in the study had a high level of knowledge about HIV and AIDS. In the study 86(84,8%) respondents had knowledge of HIV and AIDS whilst 15(15,2%) lacked knowledge about HIV and AIDS. This finding is contrary to a study by Khorvash et al (2013) whereby 57% of respondents had insufficient knowledge of HIV and AIDS. Similar findings were also reported in a study by Gledovic et al (2015) whereby 55,7% of the respondents had knowledge of HIV and AIDS and insufficient knowledge of HIV transmission was reported. In another study of by Bektas (2007) the respondents knowledge of HIV and AIDS was moderate. The differences in proportion between this study and other findings might be explained on the basis of differences in classification of the levels of knowledge.

The findings showed no significance relationships between knowledge of HIV and AIDS with gender, age, race, education level, years of practice and marital status. Demographic factors did not determine whether a person will have poor or good knowledge about HIV and AIDS This finding contradicts findings of a study in South East, Nigeria by Okpala et al (2017) which found significant relationships between age, marital status and professional cadre of the respondents and their level of knowledge about HIV and AIDS.

There was no correlation between knowledge of HIV and AIDS, attitudes towards PLWHA and counselling practices. Having good knowledge of HIV and AIDS was not associated with a possibility of having either positive or negative attitudes towards PLWHA. This finding is in contrast to a study by Khorvash et al (2013) which reported a significant negative correlation between HIV and AIDS knowledge and attitudes towards PLWHA. In another study by Vorasane et al (2017) lower levels of HIV and AIDS were found to be associated with higher levels of negative attitudes towards PLWHA. A study in South Africa by Delobelle et al (2009) reported high level of attitudes towards PLWHA and a statistical significant correlation with HIV and AIDS knowledge and training. Zarei et al (2015) findings are similar to those of Khorvash et al (2013) and Delobelle et al (2009) as a relationship between negative attitudes towards PLWHA and knowledge of HIV and AIDS were found. The above findings are not consistent with the findings in this study. Despite the fact that the respondents in the study had high levels of positive attitudes 88 (87,16%) towards PLWHA, no statistical significant relationship was found between HIV and AIDS knowledge and attitudes towards PLWHA.

5.4 ATTITUDES TOWARDS PLWHA

The results showed that attitudes towards PLWHA were non – discriminatory. Most of the respondents 88 (87,16%) expressed positive attitudes towards PLWHA. The finding is consistent with a study by Okpala et al (2017) which reported that 94,6% of the respondents had positive attitude towards PLWHA. On the other hand, Khorvash et al (2013) reported conflicting findings on attitudes towards PLWHA as most respondents (98%) had negative attitudes towards PLWHA. Vorasane et al (2017) findings were consistent with Khorvash et al (2013) as nearly half (50%) of respondents had negative attitudes towards PLWHA. Findings by Gledovic et al (2012) showed high level of negative attitudes towards PLWHA which was consistent with findings by Vorasane et al (2017) and Khorvash et al (2013). The differences in these findings might be attributed to exposure and different levels of HIV and AIDS prevalence in various countries.

In the findings there was no significant relationship between attitudes towards PLWHA and years of experience as a counsellor. This is contrary to findings by Vorasane et al (2017) who reported a significant relationship between attitudes towards PLWHA and years of experience as those with more experience had better attitudes towards PLWHA. In Vorasane et al (2017) study, nurses and doctors who had exposure to PLWHA for a longer duration and had received training were less likely to report negative attitudes towards PLWHA. The likely explanation of this variance is due to the fact that there is higher HIV and AIDS prevalence in South Africa as compared to Lao and most respondents in this study have higher exposure to HIV and AIDS, hence high prevalence of positive attitudes towards PLWHA regardless of years of experience.

The findings in this study showed no significant relationship between attitudes towards PLWHA and demographic variable such as gender, race, marital status, educational level

and years of experience. Respondents attitudes towards PLWHA was not determined by their gender, race, marital status or educational level. This finding is similar to a finding by Okpala et al (2017) which found no significant relationships between attitudes towards PLWHA and marital status of respondents. A study by Delobelle et al (2009) also found no association of attitudes towards PLWHA with age, gender and educational qualifications. In the study it. Contrary to findings by Ben – Ari (2008) study in Israel which reported that women scored higher than men on attitude, this study found difference in scores by women and men on attitudes towards PLWHA.

Statements interrogating individual components of attitudes towards PLWHA showed that respondents were against segregation and discrimination of PLWHA. Most respondents 75 (74,2%) indicated that it was wrong to quarantine PLWHA. Most respondents 97(96,1%) indicated that it is not appropriate to have a register for those who have HIV and AIDS. Respondents did not show support for coercive policies against PLWHA. Having a register of PLWHA violates human rights and privacy of those infected and affected by HIV and AIDS. These responses indicate a high positive attitude towards PLWHA and understanding that PLWHA are part of society and should be treated like any other person.

Most of the respondents 76 (75,3%) disagreed with apportioning blame to those who have HIV and AIDS. Respondents indicated that PLWHA cannot be blamed for their condition or situation which indicates positive attitude towards PLWHA. This finding is quite consistent with findings by Delobelle et al (2009) when 63% of respondents disagreed with the statement “most people with HIV and AIDS have only themselves to blame”. However, there is a slight difference in terms of percentage in response to the question. Overall, respondents’ attitudes towards PLWHA was very good.

5.5 COUNSELLING PRACTICES

HIV Counselling practices responses 98(97%) indicates very good counselling practices by counsellors. Almost all respondents 100 (99%) indicated that they ensure confidentiality when counselling clients. The importance of confidentiality to clients is confirmed in a research by Akhiwu (2012) whereby 90% of respondents who had worries about confidentiality were not willing to utilize VCT. Therefore, since client's utilization of VCT services is linked to confidentiality, it is paramount for counsellors to ensure confidentiality when counselling clients.

Making a client understand the implications of a positive and negative result when testing for HIV and AIDS is part of HIV counselling practice (D.o.H,2016) Almost all respondents 100 (99%) specified that they discuss the implications of both positive and negative results with clients. In comparison, the findings in a study by Ramalepe et al (2014) in Mopani District in Limpopo, indicated that 61% of the participants discussed in detail the implications of positive results with clients. There is a disparity between this study and Ramalepe et al (2014) on "discussing implications of results with clients" as a high percentage indicated that they discuss implications of negative and positive results. This might possibly due to level of training and education of counsellors.

Assessing client 's risks during counselling process has been found to positively affect client's behaviour. In the study, 92 (91,1%) of respondents stated that they assess a client 's lifestyle and risk profile. This finding is in contrast to Ramalepe et al (2014) study, which reported that only 42% of the respondents assessed clients' risks. A high number of respondents indicate assessing clients risk profile and a study by Peltzer et al (2010) reported the positive effects of risk assessment during HIV counselling process.

Pre- counselling is an integral part of HIV counselling and testing practices. **I**n the study, all respondents 101 (100%) indicated that they provide pre – counselling which is positive and encouraging. Pre-counselling is intended for the counsellor to review the client ‘s risk of infection, assist the client in understanding why he/she needs a test and psychologically prepare the client for a potential HIV-positive result and obtained informed consent (UNICEF, 2009). Providing post counselling is vital in HTS. The majority of respondents 98 (97%) indicated that they provide post counselling to clients which is significant and very encouraging. In a study in Mombasa, Kenya (Delva et al,2006) reported challenges in provision of pre and post counselling as required in UN assessment tools. However, the differences in findings can be due to the fact that Delva et al (2006) study was based on practical observation. Respondents bias due to desirability factor is possible in studies.

CHAPTER 6

6. RECOMMENDATIONS AND CONCLUSION

6. 1 RECOMMENDATIONS:

This study had several limitations that should be taken into account when interpreting the results. Firstly, the study utilized a convenience sampling method to select participants, which can result in results not being generalizable to HIV counsellors in all NGOs as some NGOs might have been over or under- represented. Respondents bias when responding to questions on attitudes towards PLWHA is possible due to social desirability. A larger sample should be used to make recommendation for other organizations. To enable further understanding of the constructs, further research on HIV and AIDS counselling can be done in order to find challenges leading to improvement of knowledge of HIV and AIDS, attitudes and practices of those involved in HIV counselling.

6.2 CONCLUSION

The findings of this study showed that the majority of counsellors at NGOs within ELM have good knowledge of HIV and AIDS and high positive attitudes towards PLWHA. The responses suggest implementing of best practices in HIV counselling. There was no significant association between knowledge about HIV and AIDS, attitudes towards PLWHA and practices of counsellors. A significant relationship was found between qualifications and counselling practices.

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Title of the Study: HIV AND AIDS: KNOWLEDGE, ATTITUDES AND PRACTICE OF COUNSELLORS AT NGOs IN EMFULENI MUNICIPALITY

I hereby consent to participate in the research study. The purpose and procedures of the study have been explained to me.

I understand that:

- My participation in this study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose not to answer specific questions asked if I do not wish to do so
- There are no foreseeable benefits or particular risks associated with participation in this study
- My identity will be kept strictly confidential, and any information that may identify me will be removed from the interview transcript
- A copy of my completed questionnaire without any identifying information will be stored permanently in a locked cupboard and may be used for future research.
- I understand that my responses will be used in the write up of a Masters project and may also be presented in conferences, book chapters, journal articles or books.

Name of Participant: _____

Date: _____

Signature: _____

Good day,

REF: KNOWLEDGE OF HIV AND AIDS, ATTITUDES AND PRACTICE OF COUNSELLORS AT NGOs IN EMFULENI MUNICIPALITY

My name is Daniel Mutasa and I am a post graduate student registered for a Master's Degree in Social Development at University of Witwatersrand. As part of requirements for the degree, I am conducting research on Counselling and Testing in Emfuleni Local Municipality, focusing on counsellor's skills, knowledge and attitude towards people who are HIV positive. It is hoped that gathered information will assist in understanding the status quo of HIV counselling and testing in Emfuleni. The outcome of this study can inform both knowledge base and practice in HIV counselling.

As HIV counsellors in testing sites within Emfuleni, you are ideally positioned to contribute to my research. I hereby humbly request you to participate in this study. If you accept my invitation, participation will entirely be voluntary and you are free to withdraw at any stage without a penalty. There are no consequences or benefits in participating in this study. If you agree to participate, I will give you a questionnaire to fill in at time and place that is convenient for you. No one other than the researcher will have access to the questionnaires.

Should you be willing to participate, a questionnaire will be given to you for completion. All your responses and answers will be private and confidential. There will be no link between your identity and responses in the questionnaire. Your right not to answer any question in the questionnaire will be respected.

You can contact me telephonically on 0731981886 . or my supervisor If you have any concerns or complains regarding the study, you may contact my supervisor Dr. TS.Nkomo on 0117174481 , email : Thobeka.Nkomo@wits .ac.za.

Regards,

Daniel Mutasa

Appendix. C Questionnaire

Thank you for sparing your precious time to complete this questionnaire. The questionnaire will assist the researcher to study HIV Counselling and Testing (HTC) and gain an understanding of counselor's knowledge of HIV and AIDS, attitudes towards PLWHA and practice on HIV counselling. It will be appreciated if you complete the questions in honest. Please note that the information asked for is purely for academic purpose and will be treated as strictly confidential. Your names are not required.

BIOGRAPHICAL INFORMATION: Section A

The following information is needed to enable meaningful data analysis. We appreciate your help in providing this important information.
Mark the applicable block with a cross (X). Complete all questions.

Bio 1: Please state your age **(years)** :

Bio 2	**Gender:**	**1. Male**	**2. Female**			
Bio 3	**Race:**	**1. Black**	**2. White**	**3. Coloured**	**4. Indian**	**5. Other**

Bio 4	**Marital status**	**1.Married**	**2. Single**	**3.Divorced**	**4. Widow**	**5. Living with partner**

Bio 5	**Qualifications**	**1.Below Matric**	**2.Matric**	**3. Certificate**	**3.Diploma**	**4. Degree**	**5. Postgraduate**

Bio 6: How many years have you worked as an HIV counsellor **(years) .....Months:** ……..

Bio 7: How many clients do you see per day for counselling purpose: **Number:** ……..

SECTION B: HIV AND AIDS KNOWLEDGE

The following statements aim to tap your Knowledge of HIV and AIDS. Would you please indicate to what extent you agree with these statements by using the following 5-point scale, where **1= strongly disagree and 5= strongly agree**

1	2	3	4	5
Strongly disagree	**disagree**	**neutral**	**agree**	**Strongly agree**

	STATEMENT	**SCALE**				
1.	A window period takes 3 months	1	2	3	4	5
2.	The rapid test detects the presence of HIV antibodies	1	2	3	4	5
3.	HIV can be transmitted by sexual intercourse without a condom	1	2	3	4	5

SECTION C: ATTITUDE TOWARDS PEOPLE LIVING WITH HIV AND AIDS:

The following statements aim to research on attitude towards people living with HIV and AIDS. Would you please indicate to what extent you agree with these statements by using the following 5-point scale, where **1= strongly Disagree** and 5**= strongly agree**

1	2	3	4	5
Strongly disagree	**disagree**	**neutral**	**agree**	**Strongly agree**

	STATEMENT	**SCALE**				
1.	If possible, it is a good idea to quarantine people with HIV and AIDS	1	2	3	4	5
2.	Most people with HIV and AIDS have themselves to blame	1	2	3	4	5

3.	I would not like to sit next to someone with HIV and AIDS	1	2	3	4	5
4.	Names of HIV and AIDS patients should be kept in a register for public viewing	1	2	3	4	5
5.	Children should be removed from parents who have HIV and AIDS	1	2	3	4	5

SECTION D: PRACTICES

The following statements aim to check on your practices for HIV counselling and testing. Would you please indicate to what extent you agree with these statements by using the following 5-point scale, where **1= strongly Disagree** and **5= strongly agree**

1	2	3	4	5
Strongly disagree	**disagree**	**neutral**	**agree**	**Strongly agree**

	STATEMENT	**SCALE**				
1.	I ensure confidentiality when counselling clients	1	2	3	4	5
2.	I assess lifestyle and risk behaviours when counselling	1	2	3	4	5
3.	I explain about the window period when counselling clients	1	2	3	4	5
4.	I discuss implications of both a positive and negative results	1	2	3	4	5
5.	I provide pre –counselling before testing a client	1	2	3	4	5
6.	I provide post – counselling when testing a client	1	2	3	4	5

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

DEPARTMENTAL HUMAN RESEARCH ETHICS COMMITTEE (SOCIAL WORK) CLEARANCE CERTIFICATE

PROTOCOL NUMBER: SW1/17/09/01

PROJECT TITLE: Counselling and Testing (HTC) for HIV/AIDS in Emfuleni Municipality: Counsellors' skills, knowledge of and attitudes towards HIV/AIDS

RESEARCHER/S: Mutasa, Daniel (1397290)

SCHOOL/DEPARTMENT: SHCD Social Work

DATE CONSIDERED: 13 September 2017

DECISION OF THE COMMITTEE: Approved

EXPIRY DATE: 12 October 2019

DATE: 11 October 2017

CHAIRPERSON: Dr F. Masson

Cc: Supervisor: Dr T. Nkomo

DECLARATION OF RESEARCHER(S)

To be completed in **DUPLICATE** and **ONE COPY** returned to the Administrative Assistant, Room 8, Department of Social Work, Umthombo Building Basement.

I/We fully understand the conditions under which I am/we are authorised to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the committee. **For Masters and PhD an annual progress report is required.**

SIGNATURE

26/10/2017
DATE

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES