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Self-perceived Challenges of Lay Counselors Implementing Voluntary Counseling and Testing in Mopani District, Limpopo Province and South Africa

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ABSTRACT The demand for counselling and testing for Human Immune Virus (HIV) services is increasing in South Africa. The purpose of the paper was to identify the challenges faced by lay counsellors in implementing VCT in the health facilities of Mopani District Limpopo Province, South Africa. Qualitative research design was used to collect the data. The population consisted of 60 lay counsellors in the Greater-Tzaneen, Greater Letaba and Ba-Phalaborwa municipalities. Data was collected through semi-structured interview guide for focus group discussions. Data was analysed qualitatively through the open coding. The results revealed that lay counsellors experienced challenges when implementing the VCT programme, clients denying their HIV positive status and lack of counselling skills. Counselling aspects such as explaining the counselling process, the issue of pre-testing and post-testing, the importance of consent forms and how tests are conducted, are important processes that counsellors should effectively use for successful counselling sessions.

INTRODUCTION

In 2006 an estimated 39.5 million people were thought to be living with Human Immune Virus (HIV) worldwide and the number of people newly-infected was estimated at 4.3 million. More than 2 million new HIV infections occur globally and Sub-Saharan Africa accounts for more than 70 percent of the new infections (Leblanc and Andes 2015). An estimated 2.8 million new infections has occurred in sub-Saharan Africa, Eastern Europe and Central Asia and approximately 2.9 million people have died of HIV and Acquired Immune Deficiency Syndrome (AIDS) related diseases. It was further estimated that 3.1 million people had died as a result of the disease. In 2012, a United Nations Programme on HIV /AIDS (UNAIDS) report estimated that there were 35 million people living with HIV globally.

As documented in the UNAIDS (2011), South Africa has the largest number of HIV-infected people in the world. In 2011, the number of people living with HIV was 5,600,000. Adults aged 15-49 had a prevalence of 17.30 percent; adults aged 15 and above, living with HIV numbered 5,100,000 and women aged 15 and above, living with HIV numbered 2,900,000; whereas children aged 0-14 years, living with HIV numbered 460,000. It was also pointed out that deaths due to AIDS were 270,000 and orphans due to AIDS among those aged 0-17 years numbered 2100,000 (Department of Health 2012). It is likely that these children will be deprived of the proper care and supervision they need at critical periods of their lives. It has also been found that women and children are affected more than men.

Churchyard et al. (2006) stressed that HIV / AIDS has a devastating impact on South Africa. The influence is also felt in the health sector, where 15 percent of the health workers in the public and private sectors are HIV positive. There are many reasons why South Africa is so badly affected by AIDS. These include poverty, instability and ineffective government action prior to 1994, as well as government delay in providing Anti Retro Viral (ARV) to HIV positive people.

Lay counsellors assist people to understand the mode of infection and methods of preventing HIV through education, counselling and testing. According to Ismail and Ali (2009) lack of training and particularly on-going technical support of lay counsellors working in Preventing Mother-to-child Transmission (PMTCT) programme could lead to burnout and a decline in the quality of counselling services.

According to Dworkin and Pincu (2011), when clients find that they are HIV positive, they are likely to experience shock for a few weeks. Clients are often confused about the nature of

the infection, the mode of transmission and testing, and this makes them deny their HIV positive status. When clients deny their HIV status, it poses a serious challenge to the lay counsellors, who provide support services for clients who are HIV positive and assist people to know their HIV status.

If the challenges faced by lay counsellors are not addressed, clients who are HIV positive will not benefit from Voluntary Counselling and Testing (VCT). In addition, it will be hard to promote and sustain changes in risk behaviour in order to reduce HIV infection other preventative such as PMTCT, prevention of Sexually Transmission Infections (STIs) and referrals to Home based care. Ledikwe et al. (2013) are of the view that there are factors that are likely to affect lay counsellors' ability to perform their duties effectively. Insufficient resources often hinder the smooth delivery of services to clients.

The World Health Organizations (WHO) has encouraged governments to train members of the community as lay counsellors to increase the provision of VCT programmes in communities. Using members of the community is a way of improving VCT, making it available to communities be accessible and acceptable to many people. Lay counsellors play a very important role in increased VCT in many countries, including South Africa and Mopani in particular.

The VCT programme includes a process in which an individual undergoes counselling to enable him or her to make an informed choice about being tested for HIV. This decision must be entirely that of the individual (Department of Health 2012). In this study, VCT is regarded as a programme that is implemented by Non-Government Organisations (NGOs). The NGOs recruit and train members of the community on how to conduct HIV counselling and pay them a stipend for the work done. In Limpopo Province these health workers are called lay counsellors.

Problem Statement

Limpopo Province consists of five districts namely, Capricorn, Mopani, Waterberg Vhembe and Sekhukhune. Each district is further divided into sub–districts and municipalities. Limpopo has shown an increase in HIV infections from 21.4 percent in 2009 to 22.1 percent in 2011. In the Mopani District the prevalence was 24.9 percent in 2010 and increased to 25.1 percent in 2011(Department of Health 2012). To contribute towards the achievement of Millennium Development Goal number 6, which mitigates the combat of HIV/AIDS and other diseases. Also, counsellors implementing the Community Responsiveness Programmes (CRP) in Mopani were expected to counsel between 8-10 clients per day. However, it was observed that the counsellors did not reach the targeted figure. It was estimated that CRP lay counsellors would see at least 120 clients per month and a total of 1440 people or clients per year. According to the statistics captured by 24 lay counsellors at CRP, they only managed to counsel 19,800 clients, instead of 34560 clients in 2009. The challenges for reaching the target could be variables such as a shortage of lay counsellors, lack of support from health professionals; inadequate space and lay counsellors' incompetence, as noticed by researchers who conducted the study while monitoring the VCT services in the Mopani District. In this paper the researcher explored the challenges faced by lay counsellors implementing VCT in Mopani District.

METHODOLOGY

Research Design

A qualitative and descriptive research design was used to identify the challenges of the lay counsellors, in implementing VCT in health facilities in Mopani District.

Population and Sample

The population comprised of all lay counsellors who were implementing VCT in the health facilities of Mopani District. The paper was conducted in four hospitals, four health centres and 20 clinics, where CRP lay counsellors were placed to render VCT services. Non-probability sampling was used. Thus elements were chosen from the population by purposively selecting lay counsellors and health facilities. All the lay counsellors who were in the purposively selected facilities constituted a convenience sample for interview and observation when conducting counselling sessions. Purposive sampling takes advantage of a group of subjects who fall within a population of interest and who are accessible to the researcher and is based on the researcher's

knowledge of the phenomena of the study (Brink 1996).

Data Collection

Data were collected using an unstructured interview for Focus Group Discussions (FGD) and individual interviews. Data collected from focus groups and from individual interviews were analysed qualitatively through the open coding method (Tesch 1990 cited in Cresswell 2009).

Three FGD comprising of six to ten participants were conducted and six participants comprised individual interviews. The local language, Xitsonga, was used during data collection. Data were translated into English by a language expert before data analysis. The following question was asked to the participants: "what are your challenges in implementing VCT?" This question was followed by probes such as "what are the challenges that you face with you clients, with the environment or counselling rooms, and with the health professionals?" Probing as a communication strategy was used as a clarity-seeking method. Permission to use a tape recorder was obtained from all the participants prior to capturing the data. Trustworthiness was ensured through the use of the criteria as outlined in de Vos et al. (2006) namely, credibility, transferability, confirm ability and dependability. Credibility was ensured through prolonged engagement, wherein the researcher had more than one contact with the group participants. Referential adequacy of using a tape recorder to record the interviews provided a suitable authentic record (De Vos et al. 2006; Babbie and Mouton 2007). On completion of data analysis One FGD comprising of five participants was interviewed for results verification. This was to validate and confirm the results. Ethical clearance was obtained from the University of Venda Research Ethics Committee, and the Research Ethics Committee of the Limpopo Department of Health and Social Development.

Data Analysis

The narrative data from interviews were analysed qualitatively through the open-coding method described in Cresswell (2009). The methods included the following steps: reading through all the transcripts to get a sense of the whole; after the researcher had completed the task for all the interviews, a list of similar topics was made, and data were grouped according the main themes and sub-themes (Brink 2006). Literature control was conducted after data analysis and that was aimed at forming the foundation to support the findings of this study during discussion of results (Cresswell 2009).

RESULTS AND DISCUSSION

The results of the three focus group discussions, and individual interviews were analysed simultaneously because the same central question was used for all groups and the results showed similar responses. Themes and sub-themes emerged from this analysis as are summarised in the Table 1.

Table 1: Categories and sub-categories of the findings

Themes	*Sub- themes*
Lay Counsellors' Perceived Challenges Regarding the Implementation of the VCT Programme	Challenges with regard to clients' behaviour
	Challenges related to the environment/counselling rooms
	Challenges with regard to Health Professionals
	Challenges with regard to stipends

Challenges with Regard to Clients' Behaviour

The participants mentioned that there were some challenges with regard to the behaviour of clients who came for VCT, as well as pregnant and breast-feeding mothers who came for PMTCT; clients on ARV or who needed to receive treatment, and difficult couples. The participants further mentioned that some of the VCT clients dispute their HIV results when these are presented to them. Participants felt that this is due to anger, guilt, depression, anxiety or fear of being discriminated against by their family members and the community. The study also showed that women do not accept their HIV positive status because they are afraid of being discriminated against or because their husbands will divorce them. However, a few participants mentioned during the individual interviews that they had met clients who disputed their HIV status. During a focus group discussion one partici-

pant mentioned that clients deny their status because they do not believe they could be infected and they are afraid of being shunned by friends and family. Another area of concern was that some clients were defaulting on treatment. However, only five per cent of the participants had come across a client who defaulted on treatment. During the focus group discussions, a few participants mentioned that they had challenges with some couples. A few participants mentioned during individual interviews that they had challenges with some couples. During the individual interviews one female participant said the following: *"I met a couple which was on ARV, and both partners had not disclosed the status to one another. One day the man wanted to accompany the woman to the clinic, but the woman refused. However, the man followed her and found her at the ARV clinic. The woman did not want the man to hear what the counsellor was saying; so she asked the man to buy her some food. While he was away the lay counsellor stressed to the woman the importance of disclosing her status. The man was also on ARV but they both did not disclose this to one another."*

Another participant said *"Clients don't come to collect their CD4 cell blood count. They only come when they are very sick. When asked why they do not come, the client will say they did not have money for transport or they went home to Mozambique and did not have the money to come back. When the clients are very sick it is difficult to educate them about HIV and AIDS."*

Another participant said *"There is too much denial in our area and a lot of polygamy. If a woman is married to a man who has other wives, and tests positive, she will not tell anyone in the family for fear that they will say she is the one who came with the disease."*

Another participant said *"Clients in denial move from one clinic to another, testing for HIV and disputing their HIV-positive status. In so doing, they deny themselves early treatment."*

Mqimeti et al. (2011) revealed similar findings; namely, that the reason why clients were not using VCT or coming back for CD4 was due to fear of a positive HIV test, discrimination and stigmatization. Leblanc and Andes (2015) also revealed that HIV is steeped in gendered cultural and social norms. They found that culturally gender bias might be attributable to HIV prevention efforts almost solely geared toward women and that men were identified as indicators of risks for transmission (Leblanc and Andes 2015; Sankoh et al. 2015). Almost 50 percent of the respondents mentioned fear of a positive result as the main reason for not coming back. Most of the participants reported denial and fear for ruining their families' reputation as the main reason for not coming for follow-ups.

Regarding denial, van Dyk (2001) found that most HIV and AIDS people go through a phase of denial when given HIV positive results. He added that denial is an important and protective defence mechanism because it temporarily reduces emotional stress. Van Dyk (2001) believes clients should be allowed to cling to their denial if they are not ready to accept their diagnosis because denial gives them a breathing space in which to rest and gather strength. Karamouzian et al. (2015) found that women in Iran also maintained their secret for the sake of their families' reputations. Some individuals reported having trouble talking about the disease to their lovers and children (Karamouzian et al. 2015; Sankoh et al. 2015). The counsellor should however confront denial if it causes destructive behaviour such as refusing medical care or if the client continues to indulge in unrestrained high risk behaviour.

Dworkin and Pincu (2011) indicate that when clients found that they were HIV positive or that they had been diagnosed with AIDS, they were likely to temporarily experience shock, anger, depression, fear and anxiety, resentment towards HIV-negative persons, and to engage in bargaining. HIV-infected people need information; they are often confused about the nature of the infection, the mode of transmission and testing. The clients are often shocked and in a state of disbelief, which makes them dispute the HIV results. The researchers further indicate that counsellors should understand some of the difficulties that the clients have and should assist them to internalise a positive self-concept and shed the stigma that is associated with the illness.

Challenges Related to the Environment

Challenges related to counselling room was experienced by most of the lay counsellors. In some facilities the counselling rooms are small and hot, with no air conditioning, while in some facilities there are no specific rooms for counselling. Participants further indicated that they

often share the rooms with other professionals and this made counselling difficult as they had to wait for other health workers to finish what they were doing first. The focus group interviews showed that some of the participants experience challenges with the counselling rooms, which they said are small and hot. Thirty-five per cent of the participants reported during observational sessions that the rooms are very hot in summer with no air conditioning. Some participants were observed counselling in rooms not specifically designated for counselling. They added that counsellors sometimes have to use maternity and labour wards.

During observational sessions in health care facilities, health workers were observed going into the counselling room while the counselling sessions were in progress. She said: *You see what they do, they just open without even knocking; there is no privacy. I have written "DO NOT DISTURB" on the door but this does not mean anything to them. They come in, even when the counselling session is in progress. They just come and you see the fridge in which the placentas are stored before collection*. The participants also mentioned that there are no hand-washing basins in the counselling rooms.

Most participants did not mention during focus group discussions the hand washing basins. Some of the participants mentioned that they do not have hand washing basins in the rooms. Observation revealed that 45 percent of the participants did not have hand washing basins in the counselling rooms.

One participant said *"When there are many clients, I use the shower room which is very small. The chairs are very close to each other and it is uncomfortable."*

Another participant said *"This room that I am working in is used as a store room as well as a duty room. Many items for the clinic are stored in this room, and health workers come in any time to take whatever they want."*

Another participant said *"There are two lay counsellors but only one counselling room. We are wasting a lot of time waiting for the other person to finish counselling."*

Mqimeti et al. (2011) found that only 8.3 percent of the lay counsellors in Limpopo Province Health Services had a private counselling room. The results concur with those of the current study, which found that 35 percent of the lay counsellors did not have proper counselling rooms. The authors further indicated that scaling up of HIV programmes has multiple challenges, some of which needed long-term strategies to overcome the challenges, such as lack of proper monitoring and evaluation tools, scarce human resources; inadequate health care infrastructures and non-availability of suitable counselling and clinical care space. Leblanc and Andes (2015) also found that VCT was exclusively offered at the hospitals where privacy was compromised in Yendi District, Northern Ghana. The men's negative perceptions of the hospital included lack of confidence in the capacity of service providers to maintain confidentiality and good relations with the clinical staff (Leblanc and Andes 2015). Karamouzian et al. (2015) also revealed that clients felt inconvenienced and ashamed whenever they were obligated to let health care service providers know that they were HIV positive

Challenges with Regard to Health Professionals

Lay counsellors experienced challenges with some of the health professionals who delay coming to conduct HIV tests after pre-test counselling; who do not take them as part of the health team. During focus group discussions and individual discussions participants mentioned that they have challenges with health professionals. The majority of the participants in focus groups mentioned that they are not supported by health professionals. However, some participants mentioned during the individual interviews that they are supported by health professionals. One participant mentioned that the health professionals are very good and supported them. She said: *"I sometimes hear counsellors complaining about the health professionals, saying they are not good to them, but we are happy; the health workers are very good and they support us."*

One participant said *"Health workers don't regard us as part of them. We don't work as a team; we don't attend meetings with them; when we have personal problems we are afraid to tell them."*

Another participant said *"I am working fine with the health workers; they are willing to assist me; they understand that I am not working for the government and they assist me with statistics."*

Another participant said, "There is a shortage of health professionals; that is why they

delay in coming and conduct the tests. There are only two professional nurses; when one is attending a workshop the other will be doing all the work. I also expect her to assist me with counselling."

During observations many clients requested for assistance from the health professionals. Petersen et al. (2015) revealed similar studies that support and supervision of lay counsellors in routine care is generally poor. Where supervision and support is observed there also appears to be little distinction between supervision and debriefing. In many instances there was only one or two professional nurses. Regarding the shortage of staff, Ismail and Ali (2009) conducted a study in Addis Ababa to assess the quality of antenatal care for PMTCT. It found that the shortage of manpower in health care facilities resulted in counsellors not devoting sufficient time for counselling because of they are engaged in other mother and child health (MCH) activities in the health centre, such as managing deliveries and family planning.

Zacharia et al. (2005) found that HIV and TB place a major burden on existing health services in Malawi. This has caused a shortage of staff in public health facilities. A study conducted in Zimbabwe by Shetty et al. (2005) found that the use of paid or volunteer lay counsellors can augment the counselling capacity in public health facilities. Also, nurses are reluctant to take on the additional task of counselling. Pre- and post-counselling by lay counsellors is acceptable to clinic staff and clients.

Leshabari et al. (2007) studied the experiences and concerns of nurses working as infant feeding counsellors for HIV-exposed mothers in the Kilimanjaro region in northern Tanzania. Their study revealed an overwhelmingly high level of stress and frustration by counsellors as a result of the constantly increasing workload. There was pressure to compromise the quality of work for the sake of increased workload. The counsellors mentioned that they were stressed and frustrated. They experienced a feeling of hopelessness and felt that their work had little in common with their desire to heal which they considered the heart of the nursing profession. They said the new roles in which they are trained require a very different approach to patient interaction and that health-related decisions rest to a large extent with the patient.

According to Haines et al. (2007), many health personnel lack the background and orientation to provide supportive environment for programmes for community. In addition, health workers and health professionals usually perceive community health workers as lowly aids. In other words, when a hierarchical and paternalist relationship exists between health workers and health professionals, communication deteriorates because of distrust and lack of understanding, compounded by an increase in disrespect for lay counsellors. Malema et al. (2010) found that there were health professionals who were not so appreciative of the lay counsellors. Poor role definition and lack of clear pathways for advancement for lay counsellors was also an area of concern and supported in a number of studies (Petersen et al. 2015).

Challenges with Regard to the Stipends

Lay counsellors receive meagre stipends. Lay counsellors also experienced challenges with regard to stipends which were not regular, and they felt that, if they were hired by the government their stipends could improve in terms of regularity and amount. Lay counsellors mentioned that they are committed to their work even though is very stressful. The lay counsellors said they assist the health workers by relieving them of the pressure of having too much work. One of them responded as follows:

The stipend is too little compared to the type of work we do; the work is stressful. The stipend stresses us even more. We love our work, we are committed, we enjoy what we doing, we are helping people but we get too little.

Black et al. (2011) investigated how the irregularity of payment of lay counsellors affects HIV testing at an antenatal clinic in Johannesburg; the results revealed that during the months when the payment is interrupted lay counsellors counsel few clients only 53 percent tested in the months of non-payment, compared to 79 percent in the months following payment of stipend. Late payment of lay counsellors markedly reduced uptake of HIV testing which remains the key barrier to the performance of PMTCT, sexually-transmitted Infections (STI) and other referral services in South Africa. The authors further indicated that full recognition of the role that lay workers play together with the formal employment contract and labour protection

could significantly improve public health HIV service delivery.

Woolman et al. (2009) argue that failure to provide adequate remuneration and secure employment for the lay HIV counsellors may be one of the primary reasons that the National PMTCT coverage is only 33 percent. Sanjana et al. (2009) and Peltzer (2010) also express the view that payment for the lay counsellors is too little as compared to the work that they do.

CONCLUSION

Lack of support, acknowledgment, and teamwork on the part of health professionals might contribute to the lack of competence among lay counsellors in implementing VCT programmes. Employees who believe that they are being treated fairly in the workplace might realise the need to be more committed and striving for continuing professional development. Lay counsellors will learn and benefit more from health professionals who support them and work with them as team members. Lay counsellors felt isolated and not part of the teams in which they desired to be. Low remuneration in the form of irregularly paid stipends demoralised the lay counsellors and made them incompetent.

RECOMMENDATIONS

The payment of better stipends by the Department of Health and Social Services would boost their morale. In addition, recognition of the role of lay counsellors; provision of formal employment contract and labour protection, could significantly improve public health HIV services.

LIMITATION OF THE STUDY

The study was limited to lay counsellors who provided lay counselling programmes in the purposively sampled health care facilities in Mopani District of Limpopo Province. Therefore the findings may not be generalised to the entire province. One of the researchers was the trainer of lay counsellors involved in the study, in order to minimise bias, she was excluded from taking part in the focus and individual interviews.

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