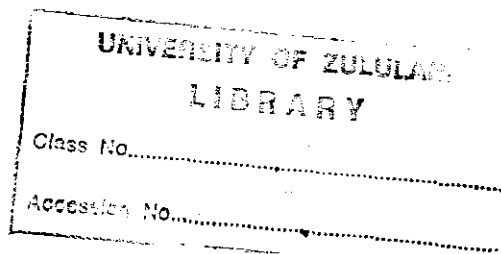


**AN APPRECIATIVE INQUIRY OF THE
VOLUNTARY COUNSELLING AND
TESTING (VCT) PROGRAM OF THE
UNIVERSITY OF ZULULAND**



NONHLANHLA MKHIZE

2008

**AN APPRECIATIVE INQUIRY OF THE VOLUNTARY COUNSELLING
AND TESTING (VCT) PROGRAM OF THE UNIVESRITY OF ZULULAND**

by

NONHLANHLA MKHIZE

A dissertation submitted to the
Faculty of Arts in partial fulfillment
of the requirements for the degree
of Masters in Clinical Psychology at
the University of Zululand.

Supervisor: Dr J.D. Thwala

January 2008

(i)

DECLARATION

This serves to declare that this dissertation is my own original work both in concept, compilation and execution.

All sources and references quoted have been duly acknowledged in the references section.


NONHLANHLA MKHIZE

18 FEBRUARY 2008
DATE

(ii)

ABSTRACT

Since the surfacing of HIV and AIDS epidemic in South Africa, various programs were implemented in order to educate and prevent the spread of this devastating disease. The Department of Health in South Africa therefore implemented the Voluntary Counseling Testing (VCT) programs across the country in workplaces, tertiary institutions, clinics as well as in hospitals.

However in spite of these attempts current studies indicate that the spread of HIV and AIDS is escalated particularly amongst the people between the ages of eighteen and thirty. With so many available VCT sites and centers that provide information about the disease and an opportunity to test for one's sero-status, one would expect not hear such an increase in new HIV/AIDS infections!

In view of the above a qualitative study was therefore undertaken to find out from the twenty five students who took part in this study. The aim of the research study is to find from the students who utilize the VCT program services at the University of Zululand their experiences about the program, what they appreciate about it and what can be done in order to ensure an efficient service which is in line with the South African HIV/AIDS Strategic Plan 2000 – 2005.

(iii)

DEDICATION

This is dedicated in love, humility and much gratitude to my father Clifford Z. Mkhize and my uncle Jerry B. Jiyane.

ACKNOWLEDGEMENTS

A project of this magnitude can never be achieved in isolation. I would therefore like to extend my gratitude to all those who helped in helping achieve this. Firstly I would like to praise the Lord Almighty for the type of people He has blessed me with in my family, especially my sister Thobile who has been my inspiration and pillar throughout this long, difficult and sometimes tedious journey.

To Dr, J.D. Thwala, my supervisor, for his patience, wisdom and his guidance throughout even when I did not deserve either.

1. *Finally if God had not planned for this it would not have come this far. There were times when I wanted to quit because of the hardships in this long and tedious journey, but Him being gracious and loving I have come this far.*

TABLE OF CONTENTS**CHAPTER ONE**

1.1	INTRODUCTION	1
1.2	MOTIVATION FOR THE STUDY	2
1.3	VALUES OF THE STUDY	4
1.4	OBJECTIVES OF THE STUDY	5
1.5	HYPOTHESES	5
	1.5.1 The age of the respondents does not influence the attitudes towards the CVT programme	5
	1.5.2 DATA GATHERING	6
	1.5.3 SAMPLE	6
	1.5.4 METHODOLOGY	6
1.6	Resume'	7

CHAPTER TWO**LITERATURE REVIEW**

		8
2.1	INTRODUCTION	8
2.2	HIV / AIDS IN CONTEXT	8
2.3	DEFINITION	8
2.4	HISTORY OF HIV/AIDS	9
2.5	PROCESS OF TRANSMISSION	10
2.6	STAGES OF DEVELOPMENT	11
	2.6.1 PRIMARY HIV INFESTION PHASE (ACUTE PHASE)	11
	2.6.2 ASYMPTOMATIC LATENT PHASE (CARRIER PHASE)	12
	2.6.3 MINOR SYMOTOMATIC PHASE (EARLY SYMPTOMS PHASE)	13
	2.6.4 MAJOR SYMPTOMATIC PHASE (OPPORTUNISTIC DISEASES PHASE)	13
	2.6.5 AIDS DEFINING CONDITION (SEVERE SYMPTOMATIC PHASE)	14
2.7	MODES OF TANSMISSION	14
	2.7.1 Infections through intimate sexual contact	15
	2.7.2 Infection through contaminated blood	16
	2.7.3 Mother to child transmission	17
2.8	Myths and fears about infection	17
2.9	Contributing factors	18
2.10	HIV TESTING AS A DIAGNOSTIC TOOL	19
2.11	Management of HIV Infection	19
2.12	Risk factors in SOUTH AFRICA	21
	2.12.1 BIOLOGICAL FACTORS	22
	2.12.2 SOCIAL FACTORS	23
	2.12.3 POLITICAL FACTORS	25

2.12.4	MEDIA INTERVENTION	26
2.12.5	SOCIO-ECONOMIC BARRIERS	27
2.12.6	CONFLICT AND VIOLENCE	28
2.12.7	CULTURAL PRACTICES	29
2.13	High risk groups	29
2.14	PSYCHOLOGICAL FACTORS	30
2.14.1	BLAME AND PREJUDICE	30
2.14.2	SOCIAL BEHAVIOUR AND CONDOM USE	31
2.14.3	RESPONSES TO ILLNESS	32
2.15	THE IMPACT OF HIV/AIDS ON EDUCATION	33
2.16	VOLUNTARY COUNSELLING AND TESTING	34
2.17	RESUME'	35

CHAPTER THREE RESEARCH METHODOLOGY

3.1	INTRODUCTION	36
3.2	RESEARCH METHODOLOGY	36
3.3	SAMPLING	38
3.4	DATA GATHERING	38
3.4.1	RESEARCH INSTRUMENTS	40
3.4.2	ADMINISTRATION OF THE QUESTIONNAIRE	40
3.4.3	ETHICAL CONSIDERATION	41
3.5	ANALYSING ODF DATA	42
3.6	RESUME'	43

CHAPTER FOUR RESULTS AND DISCUSSIONS

4.1	INTRODUCTION	45
4.2	CHARACTERISTICS OF THE SAMPLE	45
4.3	FINDINGS AND DISCUSSIONS	47
4.3.1	THEMES ELICITED FROM THE RESPONDENTS	48
4.3.2	DISCUSSION OF THE FINDINGS	50
4.3.2.1	EMERGING THEMES	50
4.3.2.2	EXPERIENCES OF THE PARTICIPANTS	55
4.3.2.3	PARTICIPANTS SUGGESTIONS FOR IMPROVEMENTS	56
4.3.2.4	NEGATIVE EXPERIENCES FROM THE RESPONDENTS	56
4.4	RESUME'	57

CHAPTER FIVE
RECOMMENDATIONS, LIMITATIONS AND AVENUES FOR FURTHER
RESEARCH 58

5.1 INTRODUCTION 58
5.2 RECOMMENDATIONS 58
5.3 LIMITATIONS OF THE STUDY 60
5.4 AVENUES FOR FUTURE RESEARCH 61
5.5 CONCLUSION 62

REFERENCES 63

APPENDIX A 69
APPENDIX B 70

CHAPTER ONE

1.1 INTRODUCTION

Approximately one-third of HIV-infected individuals do not know their HIV status. It is therefore imperative that effort should be made to find out the reasons why people do not get tested; and why the many who are tested fail to return for the results and counselling. There are obviously many possible reasons why people tend not to respond as they would be expected. One of the reasons could be that most VCT programs put their behaviour change emphasis on condoms (NIMH, 2000).

The role of HIV testing and its implications for prevention and clinical care are changing rapidly. New technologies for HIV testing provide high sensitivity, specificity and results within ten minutes. Early detection creates the possibility of access to early antiretroviral therapy and its potential treatment benefits. In addition, testing has shifted from blood banks and anonymous testing sites to mainstream health care settings (Bor, Miller & Goldman, 1992: 62; Grimwood, Crewe & Bettenridge, 2000: 284-287).

1.2 MOTIVATION FOR THE STUDY

Studies (Solomon, Van Rooyen, Griesel, Gray, Stein & Nott, 2004:9) indicate that knowledge of one's HIV status plays a pivotal role in modifying behaviour either to remain uninfected or to prevent infecting current or future partners. To this end, Voluntary Counselling and Testing (VCT) is recognized among international organizations as a successful, cost-effective and pivotal intervention for HIV/AIDS prevention and care. One consistent finding across the literature is that VCT is more effective as a secondary than primary prevention in African settings, mirroring the international literature in this regard.

The efficacy study in Tanzania, Kenya and Trinidad was a randomized clinical trial that assessed whether VCT, given to individuals or couples, was effective in reducing risk behaviour associated with sexual transmission of HIV. Prior to the abovementioned study, several literature reviews, based primarily on observational studies indicated that VCT was especially effective in reducing risk behaviour among those diagnosed with HIV. The study found that there was a 35% reduction among men and a 39% reduction on women, in the proportion reporting unprotected intercourse with non-primary partners (Abdool Karim & Abdool Karim, 2005:155). Similar studies conducted in Uganda showed that those who undergo VCT showed no difference in sexual behaviour after one year when compared to those who had not been tested regardless of their sero-status

In direct contrast however, a study done in Kampala, Uganda showed that those who had been tested regardless of their sero-status reported safer sexual behaviour as compared to those who had not been tested (Solomon, et. al 2001:9).

Testing without counselling is however of limited benefit in terms of care, support, and prevention and may even favour undesired behaviours. Some pilot studies have successfully coupled VCT with screening for other diseases, such as tuberculosis. These initiatives exemplify the importance of carefully integrating VCT activities into the existing health systems according to local well-identified priorities. (Van de Perre, 2002: 86).

Research has indicated that one subgroup of the population, namely young people are particularly vulnerable in terms of contracting HIV/AIDS. Sub-Saharan Africa is the hardest hit of the world's HIV infected young people residing in this region. Between 70% and 80% of new infections occur among people aged 15 to 24 years. The majority of these individuals are in schools, colleges and universities, and the prediction is that AIDS will have a devastating effect on student population (Diedericks, 2003: 1). Of the over 60 million people who have been infected with HIV in the past 20 years, about half became infected between the ages of 15 and 24. Today, nearly 12 million young people are living with HIV/AIDS. Young women are several times more likely than young men to be

infected with HIV. In nearly 20 African countries 5% or more of women ages 15 to 24 are infected. Such statistics underscore the urgent need to address HIV/AIDS among youth (Ngcobo & Quinlan, 2005:2)

In light of the above the University of Zululand, in KwaZulu-Natal took on the initiative of having a Voluntary Counselling and Testing program in its main campus in May 2003. The VCT program was integrated into the existing medical clinic of the university. Students as well as staff members voluntarily test for their status.

1.3 VALUE OF THE STUDY

It is hoped that the study shall help the University of Zululand to:

- appreciate the strengths of the program
- check whether the information disseminated in the counselling and testing process is sufficient to encourage behaviour change
- determine the skills as well as the knowledge the counsellors have about the virus.

Overall, the study aims to highlighting the strengths; and address the weaknesses of the VCT program.

1.4 OBJECTIVES OF THE STUDY

- To investigate if knowing one's sero-status promotes safer sexual behaviour
- To investigate whether knowledge disseminated by the counsellors is sufficient to influence sexual behaviours.

1.5 HYPOTHESES

The following hypotheses have been made for the study:

- The respondents will hold positive attitudes and / or experiences about VCT programmes at the University of Zululand.
- The gender of the respondents does not influence his / her attitudes towards the VCT programme

1.5.1 The age of the respondents does not influence the attitudes towards the VCT programme.

An in-depth study of the literature discussing HIV / AIDS VCT programmes, as well as an appreciative inquiry has been undertaken to discover the nature and depth of the research already performed by other researchers in this field.

1.5.2 DATA GATHERING

Data was gathered by the counsellor employed at the Clinic. This was done to protect the identity of those being tested and served to uphold confidentiality.

1.5.3 SAMPLE

The sampling base for the study consists of at least twenty-five (25) participants who are currently enrolled as students at the University of Zululand. These students contacted the medical clinic at the University of Zululand to be counselled and to have their HIV status tested.

1.5.4 METHODOLOGY

The study utilises a method of an appreciative inquiry to collect its data. An appreciative inquiry is a phenomenological method for examining the life of an organization. It is a framework that has been successfully used in large complex systems and that reflects the aims of the group - to explore the innovations and

developments that are taking place across the system, in ways that would not become problem-focused and prevent ability to move beyond this (Reed, Pearson, Douglas, Swinburne & Wilding, 2001: 38). The sample is made up of students who are testing for their sero-status in the university's medical clinic.

1.6 Resume'

This chapter dealt with the introductory part and how the study was carried out. The next chapter will concentrate on the relevant literature review and its implications to present the study.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is going to look at HIV/AIDS in context, factors that render South Africa vulnerable to HIV / AIDS and will conclude by looking at the impact this disease has on education in this country.

2.3 HIV/ AIDS IN CONTEXT

This section includes the history, epidemiology, stages of development of HIV/AIDS and diagnosis. It also includes a discussion of the modes of transmission of the virus and the current management of the disease.

2.3 DEFINITION

In defining AIDS, Stine (2005:11 and 2005:29) said its a syndrome of opportunistic diseases, infections and certain cancers resulting from a compromised immune system, the damage to the immune system having been caused by HIV. This virus is not inherited, but acquired and when HIV enters the body, it attacks the immune system directly. As the immune system weakens, a point is reached where few antibodies survive and where the condition is

diagnosed as AIDS. From this point onward, opportunistic infections can invade the body with little resistance ultimately resulting to death

2.4 HISTORY OF HIV/AIDS

Between late 1979 and early 1981 doctors in the United States of America (USA) observed clusters of diseases that had previously been extremely rare. These included a rare form of pneumonia and skin cancer (Kaposi's sarcoma) which had mostly been identified in young homosexual men with a suppressed immune system. Similar clusters of diseases were soon identified in other parts of the world including Africa. In Central Africa, a new disease causing severe weight loss and diarrhoea called 'slim disease' was identified. In South Africa the first cases of the disease were recorded in 1982 (UNAIDS 2001).

Black (2005:530-531) claims that the virus that caused the abovementioned clusters of diseases was identified in 1983 by French scientist Luc Montaigner and confirmed by an American scientist Robert Gallo. In 1986 the virus was given the name: "The Human Immunodeficiency Virus (HIV)" (Stine, 2005:30-50). HIV- 1 is found in Central, East and Southern Africa, North and South America, Europe and the rest of the world. The HIV- 2 is virtually confined in West Africa and some Caribbean countries but is now slowly diffusing into other parts of the world. HIV-1 NA D HIV- 2 are transmitted in the same way, but HIV-

2 is much difficult to detect and may also take longer to affect its carrier. The HIV strains are further classified into subtypes which bear the letters of the alphabet. These subtypes have emerged as the virus mutates. The major HIV type in South Africa is HIV-1 subtype C. The initial epidemic in South Africa was due to an HIV-1 subtype B virus which mutated and has been overtaken by subtype C (UNAIDS, 2001).

2.5 PROCESS OF INFECTION

The National Institute of Allergy and Infectious Diseases (2004) wrote that in order to cause infection the virus has to enter the body and attach itself to a host cell, HIV attacks the lymphocytes cells also known as T- helper cells (white blood cells) in the human immune system which usually repel/attack by invading organisms. The HIV virus attaches itself to the CD4 receptors of the T- helper cells. Once attached, the virus replicates itself and destroys the cell's functioning. HIV is a retrovirus that is it does the "reverse" of what the viruses normally do. The normal transcription of genetic information of HIV is contained in RNA (Ribonucleic acid) rather than DNA (Deoxyribonucleic acid) as is the case in other viruses. HIV has its own enzyme that transforms RNA to DNA in order to produce more viruses. When HIV attacks the cell, its RNA invades the cell and the viral RNA transforms into DNA which fuses with the cell's own DNA, providing a major obstacle to the eradication of the virus from infected individuals. HIV then causes

the cell to produce new viral RNA and not proteins. When the viral RNA multiplies it breaks away from the infected cells which then usually die. HIV also infects other cells such as tissue cells in mucous membranes (for example, the mucous membranes found in the genital tract and the anal tract) and certain brain cells (Barnett & Whiteside, 2006: 32).

As the HI virus multiplies it produces several abnormalities in the immune system, the most notable being the reduction of T- helper cells (Diedericks, 2003: 7). HIV thus progressively suppresses and finally destroys the immune system. When a person is immune deficient, his/ her body finds it difficult to defend itself against many infections and some cancers. The body then becomes the target of opportunistic diseases which increase in frequency, severity and duration until the person dies from full blown AIDS (UNAIDS, 2001).

2.6 STAGES OF DEVELOPMENT

It takes approximately eight to ten years after HIV infection for AIDS to manifest itself. The infection can theoretically be divided into five stages as discussed below.

2.6.1 PRIMARY HIV INFECTION PHASE (ACUTE PHASE)

The acute phase can start as early as one week after infection and can last from six to twelve weeks during which time antibodies are not detectable and a blood

test during this time will show a negative result. This period is often referred to as the window period, a dangerous time during which a person can unwittingly infect others (Soul City Antiretroviral Treatment, 2005:7)). However once antibodies are detected the blood test result is positive and seroconversion is said to have taken place. Some 30% to 60% of infected people at this stage may suffer seroconversion illness which includes flu-like symptoms characterized by muscular pain, mild fever, weight loss and fatigue.

2.6.2 ASYMPTOMATIC LATENT PHASE (CARRIER PHASE)

The person with HIV in this phase is in a prolonged period without obvious visible symptoms. The asymptomatic phase is also referred to as the latent phase, but laboratory studies indicate the continuous progression of the disease in infected individuals. The asymptomatic phase lasts for up to three weeks during which up to 90% of people will develop non-specific symptoms common to many viral infections. The most common symptom is generalized swollen glands. This phase is associated with a CD4 cell count of 500 to 800 $cell/mm^3$. A normal CD4 cell count in healthy individuals is approximately 800 to 1200 $cell/mm^3$ (Soul City, Antiretroviral treatment, 2005:6).

2.6.3 MINOR SYMPTOMATIC PHASE (EARLY SYMPTOMS PHASE)

In this phase minor and early symptoms of HIV infection are visible. It is a period during which the body develops antibodies to ward off HIV. Even though HIV ultimately wins the battle, the body's immune system is able to keep the virus in check for a number of years. Opportunistic diseases may continually and intermittently present themselves because the body takes a while to detect foreign substances before it develops antibodies to fight them. Some of the symptoms are persistent weight loss, diarrhoea, a persistent cough, mild to moderate swelling of lymph nodes, occasional fever, neurological changes and fatigue. This stage is associated with a CD4 count of 350 to 500 cell/mm^3 (Soul City, Antiretroviral treatment, 2005:7).

2.6.4 MAJOR SYMPTOMATIC PHASE (OPPORTUNISTIC DISEASES PHASE)

In the major symptomatic phase major symptoms and opportunistic diseases appear as the immune system deteriorates. The symptoms of the previous stage become persistent and other symptoms such as recurrent herpes infections, shingles, bacterial skin infections and significant weight loss and abdominal discomfort occur. This stage takes up to about 80% of the time from infection to

death. It is associated with a CD4 cell count of 150 to 350 $cell/mm^3$ (Diedericks, 2003:9).

2.6.5 AIDS DEFINING CONDITION (SEVERE SYMPTOMATIC PHASE)

In this phase there is severe immunodeficiency resulting in the development of secondary opportunistic infections and tumours which represent the major cause of death in AIDS patients. The opportunistic infections may vary from one geographical location to another, depending on the prevalence of certain pathogens (parasites, fungi, bacteria and viruses) to which the immunocompromised individual may be exposed. Kaposi's sarcoma (a rare skin cancer), tuberculosis, pneumonia, meningitis and neurological abnormalities are some of the major diseases associated with AIDS. The severe symptomatic phase is associated with a CD4 cell count below 200 $cell/mm^3$ (Diedericks, 2003: 10).

2.7 MODES OF TRANSMISSION

According to Stine (2005: 199), HIV is not a strong virus. Every disease has a reproduction number (R_o) which refers to the number of other people each infected person would normally infect. The R_o of HIV is about 5. Compared to the R_o of malaria, which is 100 resulting in it spreading so explosively; HIV is

therefore not easy to transmit. In order for a person to be infected, the virus has to pass in sufficient quantities from one person's bloodstream to that of another, either directly or via bodily secretions.

2.7.1 Infections through intimate sexual contact

The virus is primarily transmitted through unprotected vaginal or anal intercourse. Research indicates that 75% of infections globally involve heterosexual intercourse and 25% involve sexual relations between men (Tladi, 2006; UNAIDS, 2001). The virus is found in high quantities in sexual fluids such as semen and vaginal fluids of persons infected with HIV. Unsafe sexual practices allow the virus to enter via the body fluids of the infected person into the bloodstream of the uninfected person. In order to gain entry into the human body, HIV must connect to the CD4 receptors. Many of the cells in the linings of the genital and anal tract have such receptors. The linings are very delicate and can be easily torn as a result of the friction during sexual intercourse, thus exposing the person to HIV infection. The presence of other sexually transmitted diseases such as syphilis, chancroid, gonorrhoea and others will greatly increase the chances of infection, because these diseases generate/create openings via mucous membrane inside the mouth. (Stine, 2005: 199-200).

2.7.2 Infection through contaminated blood

When HIV infected blood enters the bloodstream either through bodily contact (involving bleeding wounds, a blood transfusion or blood-contaminated syringes, razors blades and other sharp instruments) an infection can occur. The risk of transmission through blood is now minimal, because of advanced screening methods in most countries. The window period still creates problems for blood transfusion services but all blood donors are screened before acceptance.

Infection can result from blood-contaminated needles, syringes and other sharp objects. The sharing of contaminated needles and syringes by intravenous drug users causes a high risk of infection. HIV infection can also occur via shared tattoo needles and contaminated hospital instruments, particularly where hygiene and safety are substandard. The utilization and sharing of sharp instruments during rituals such as circumcision and scarification also pose possible dangers of infection. Recent results highlighted / identified a high prevalence of HIV in South African children of two years and older; highlighting the possibility of spreading HIV through unsterile needles . Contact sports such as boxing and rugby have been progressively mentioned as possible modes of HIV transmission and require attention from the sporting world.

2.7.3 Mother to child transmission (MTCT)

A mother who is infected with HIV can pass the virus on to her baby during pregnancy and at childbirth or through breastfeeding. More than 60% of MTCT occur during labour and delivery. Infection to the foetus mostly occurs if the mother becomes infected just after pregnancy, or if she is in the last phase of AIDS infection. About 30% of MTCT occurs through breastfeeding. Vitamin A deficiencies, breast disease, cracked nipples on the mother, and thrush and gastroenteritis in the infant can increase the chances of MTCT. Breast milk can also contain the HI virus, but will only enter the baby's bloodstream if the gastrointestinal lining has been injured or disturbed

2.8 Myths and fears about infection

There are many myths about HIV infection. Some people believe that AIDS can be prevented or cured by having sex with fat women, a virgin, a girl younger than 12, or a very young boy. Research indicates that these myths are unfounded and has since found the virus in body fluids such as saliva, urine and sweat. The quantities of HIV have however been too low for successful transmission, and there is no evidence to date that HIV is spread through casual contact between individuals. Additionally HIV cannot be transmitted via coughing, sneezing and light kissing, simple skin contact like handshaking, hugging and touching, or through food, water, shared utensils, toilets or insect bites (Diedericks, 2003: 13 and Irwin, Millen & Fallows, 2003:66 - 67).

2.9 Contributing factors

The “cofactor theory” refers to many factors that increase the possibility of an HIV – positive individual actually developing AIDS. Factors listed by the Aids Training and Information Counselling Centre of 2001 include:

- Excessive smoking
- Stress
- Previous and concurrent illness
- Poor nutrition
- Drug or alcohol abuse, and
- Pregnancy.

In such cases the immune system becomes suppressed which could contribute to the accelerated development of AIDS in an HIV positive individual. Studies in Uganda have confirmed that HIV infected individuals are more prone to malaria than non-infected individuals. Malaria causes a seven-fold increase in the HIV viral load of people with HIV-infection. One of the most common opportunistic diseases related to HIV such as tuberculosis, can also shorten the time it takes for HIV to become full-blown AIDS (Deidericks, 2003:14).

2.10 HIV TESTING AS A DIAGNOSTIC TOOL

The diagnosis for infection is based on laboratory testing of blood samples. There are currently two broad classes of tests. HIV antibody tools which react to the antibodies that have formed in reaction to the virus and a second group of tests which detect the actual virus in the blood. (The best known antibody tests in South Africa are the ELISA and the Western Blot tests. Antibodies can usually be detected four to six weeks after infection (HIV positive). The ELISA test is the most popular and it is commonly used as it is cost-effective and reliable. The tests are able to identify very low levels of antibodies and it is possible that a test may indicate a false positive. For this reason, a second test is usually done to confirm results (Diedericks, 2003:8).The HIV screening tests may however indicate negative results of a period of two, or in rare cases, up to six months after infection. This is called the window period (Soul City Antiretroviral Treatment, 2005:6).

2.11 Management of HIV Infection

Till to date, very little has been done in the development of an HIV vaccine. Researchers all over the world are currently working towards a vaccine which is hoped will be ready by 2007. Major advances have resulted in some antiretroviral drugs that can manage HIV and slow down its progression to AIDS, causing a

decline in the HIV/AIDS death rate in developing countries. The medication has however proven expensive, has side effects and offers no cure. Antiretroviral drugs are used to act against HIV and may delay the onset of non-specific systems common to viral infections and opportunistic infections (UNAIDS, 2002).

The three major forms of management of the disease are divided into 3 stages

- The first stage occurs when the CD4 cell counts are high in the individual. The emphasis here is on "positive living". The infected person must concentrate on staying healthy, eating the correct food and focusing on a positive mind.
- The second stage of management is when the CD4 cell count begins to decline. Prophylactic treatment to prevent TB and other common diseases is begun.
- The third stage involves the use of antiretroviral drugs to combat HIV directly. This can begin immediately when the CD4 cell count drops below 350 cell/mm^3 .

Currently there are 3 main categories of antiretroviral drugs:-

- Nucleoside reverse transcriptase inhibitors (NRTI's) of which Zidovudine (AZT) and Lamivudine (3TC) are best known;
- Non-nucleoside reverse transcriptase inhibitors (NNRTI's) of which Nevirapine (NVP) is best known
- Antiretroviral therapy used for the treatment of HIV/AIDS involves taking three or more different antiretroviral medicines on a daily basis. This is known as triple-drug therapy, most commonly known as High Active Antiretroviral Therapy (HAART). The most widely used combination to date is Zidovudine (AZT), Lamivudine (3TC) and Indinavir (Crixivan) (Foundation of Professional Development, 2001).although HIV cannot be cured through

HAART; it is becoming a manageable chronic disease similar to diabetes or high blood pressure. People taking HAART must be carefully monitored however because if the medication is not taken correctly, the virus can become resistant to it. The medication is also very expensive and requires sophisticated monitoring and support due to various side effects, such as nausea, vomiting, liver toxicity, kidney stones, diarrhoea and many more.

Single therapy is mostly avoided as it can cause fairly swift mutation of the virus into drug-resistant strains. Single drugs however are administered prophylactically to stop MTCT (Soul City Antiretroviral Treatment 2005:14).)

2.12 Risk factors in South Africa

According to Kelly, Parker & Lewis (2001) most research tends to downplay the influence that historical, societal and cultural constructs have on behaviour. In order to understand the dynamics of the epidemic it is important to look at the unique factors that render South Africa vulnerable to the disease. This section will discuss these factors in depth and conclude on the projected impact of the country.

In order to understand these risk factors a bio-psychosocial approach is used. This model looks at the individuals as a combination of these systems namely biological social and psychological structures such as communities and the environment aimed to describe the South African dynamics that play a role in the HIV/AIDS epidemic (Diedericks, 2003: 22).

2.12.1 BIOLOGICAL FACTORS

The fact that the most common mode of transmission of HIV is sexual intercourse, might motivate people to think that the level and type of sexual activity in South Africa is different from that of the rest of the world. However, the sexuality activity survey done in 1998 indicated that South Africans are no or less sexually active than their foreign counterparts. What is more evident is that South Africans have more STDs than their foreign counterparts many of which go untreated. As mentioned before STDs are highly correlated with HIV infection. Sexual practices such as "dry sex" (where men believe that a dry vagina is a sign of faithfulness and women therefore utilise special herbs to or even sticks to dry the vagina before sex) are often found in South Africa. This practice can cause lacerations to the vaginal walls which could be conducive to the spread of HIV. UNAIDS indicated that uncircumcised men may have a higher risk of infection due to the fact that body fluids may be trapped under the foreskin. A study on sub-Saharan African men found that HIV prevalence was below 8% in men who had been circumcised men

In South Africa it is estimated that 2.2 million women have HIV/AIDS. There is increasing evidence that women have a higher vulnerability to HIV infection than men, one reason being physiology (Diedericks, 2003: 23). Since women are the recipients of semen they are exposed to the body fluids for a longer time.

Women may also be vulnerable when menstruating and when using contraceptives such as intra-uterus devices since these may cause infections and lacerations to the mucous membrane of the uterus. This allows easy entrance of the HIV into the blood stream. Women are also less likely to detect lacerations, possible infections or STDs in themselves since in women because of physiology, symptoms are less apparent. Women are also exposed to hospital treatment, medical instruments such as syringes and blood transfusions due to their reproductive ability. The above procedures have been connected to HIV infection in some cases.

2.12.2 SOCIAL FACTORS

Under the apartheid system the greater part of the South African population was allowed only temporary residence in urban areas and that only for as long as they were employed. They therefore had to migrate between their places of origins, namely homelands or neighbouring independent countries and their places of work. This led to impoverished homelands and the development of crowded temporary living areas close to work. These arrangements led to many men leaving their wives and families in the homelands and some entering into urban relationships and / or making use of the services of commercial sex workers. Many wives also entered into extramarital relationships for

companionship and for economic survival. In addition, health services were inadequate which often meant that sexually transmitted diseases were untreated. Although apartheid ceased to exist after 1994, migrant work is still a way of life for many South Africans.

It is sufficed to say that the pattern of some people being away from their families for long periods of time may have created (and may still be upholding) an ideal situation for the spread of HIV (Diedericks, 2003:24).

Another factor that may have exacerbated the spread of HIV is the fact that for many years not all South Africans had equal access to resources, education and medical care. Little or no information reached impoverished communities; many people were living in extremely crowded and unhealthy conditions with no access to even the basic services. Van Niekerk, (2001: 143-162), stated that 75% of the poor live in the rural areas which are void of resources including educational opportunities. The fact that 41% of adult South Africans are illiterate excludes a great number of people from written information on HIV.AIDS and its prevention.

2.12.3 POLITICAL FACTORS

The international community considers leadership to be crucial in curbing the spread of HIV. Leadership is considered to include both commitment and action. The United Nations General Assembly states that leadership by governments in combating HIV/AIDS is essential and that governmental efforts should be complemented by active participation by the civil society, business community and the private sector. In South Africa, the government launched the National AIDS Council (NAC) in February 2000 to participate in the management of the epidemic. This council is made up of representation from government, business, civil society and the medical sector. Further to this, mixed specialist technical task teams were established to advise the NAC on specific policy issues (Crepaz & Marks, 2002; UNAIDS, 2002).

Some leaders of the country appeared to be less committed to the problem of HIV/AIDS. During 2001 the President of South Africa Mr Thabo Mbeki questioned the relationship between HIV and AIDS, voicing his scepticism regarding the safety and success of antiretroviral drugs. This unfortunate incident caused not only widespread media reaction but also-and research surveys support this great confusion among members of the public. In attempt to diffuse the potentially harmful situation, the former President of South Africa, Mr Nelson Mandela entered into the arena acknowledging that AIDS has killed more people than any

war and added that government should look into more effective ways of managing the situation. This was supported by lobbying and advocacy by the Treatment Action Campaign (TAC (Diedericks, 2003: 25). Public perceptions regarding to the extent to which South African leaders are considered to be politically committed to combating the epidemic were reviewed during an HSRC survey (2002). The results indicated that the majority of South Africans believe that the leaders of this country are committed and do recognise the importance of HIV/AIDS. However there are not as many who believe that government allocates sufficient resources to dealing with the epidemic.

2.12.4 MEDIA INTERVENTIONS

According to Diedericks, 2003: 25 media have focused on communicating the message of HIV/AIDS to the people of South Africa. The apparent gaps in people's knowledge and their persistent misconceptions reveal that the media has not been effective as it could have been. Generally campaigns have placed a strong emphasis on sexual risk and the young with less emphasis on sexual behaviour such as abstinence. Very little attention has been given to other aspects of HIV such as care, stigma reduction or social mobilisation. The media has rarely targeted groups such as truck drivers, commercial sex workers, health workers, faith-based community organisations or community leaders.

2.12.5 SOCIO-ECONOMIC BARRIERS

According to the framework developed by Whiteside and Barnett, countries with low levels of social cohesion and relatively high levels of income face the most rapidly growing HIV epidemics and relatively high levels of infection. This theory offers one explanation for HIV/AIDS growing at such a fast pace in South Africa. On the one hand, the segregation of different groups of South Africans stimulated low levels of social cohesion on the other, the relatively high income of the government of the day helped put in place a good infrastructure for travelling. The entire-reaction of these two factors encouraged people to travel in search for employment opportunities thus creating opportunities for the HI virus to spread.

The current situation in our country works in favour of AIDS for other reasons. The high rate of unemployment lead to poverty and deprivation-circumstances in which people typically have less access to health services and sex education, which makes them more vulnerable to HIV (Diedericks, 2003:26). Also poverty causes malnutrition which reduces the body's immune system and makes it easier for HIV to enter the person's bloodstream. In addition research has indicated that increases sexual activity, increased commercial sex work and a

higher incidence of unplanned pregnancies are all found in depressed socio-economic conditions (Diedericks, 2003: 26). A limited access to recreational facilities has been known to lower the age of the onset of sexual activity. A study done by Lovelife in 2002 found that people with lower incomes are more prone to contracting HIV and that the HIV infection rate ranges from 21% among people living in private houses to 36% among those living in informal settlements. In simple terms, HIV/AIDS is not a priority in situations where basic survival is daily battle.

2.12.6 CONFLICT AND VIOLENCE

South Africa has a long history of political conflict and violence. Armed forces were involved in neighbouring countries such as Angola and Namibia from the early 1970's to the 1990's. The literature emphasizes that conflict and wars create an environment conducive to HIV infections, and points out that military forces and refugees add inordinately to the HIV-positive statistics. Crime and violence are the main sources of conflict in South Africa today. Rape is associated with a higher infection rate because the victim is more likely to suffer damage to genital tract as a result of being forcefully violated. As a consequent rape exacerbate the spread of HIV (Diedericks, 2003:27).

2.12.7 CULTURAL PRACTICES

Certain cultural practices may aggravate the spread of HIV/AIDS in South Africa. The ritual of circumcision for young men which marks their passage into adulthood is an act where a number of young men are circumcised upon the same occasion. Chances are that when sharp objects are used for all these men the mixing of blood is inevitable. Many young men have contracted HIV during the ritual (Diedericks, 2003; Le Marcis, & Ebrahim, 2005).

Other cultural rituals involve scarification and incisions as a treatment for illness and cutting a joint off a finger to signify the sacrifice of an art of the body to the ancestors as a protective measure. These procedures too could perpetuate HIV transmission.

2.13 High risk groups

It is scientific fact that anyone can contract HIV/AIDS irrespective of race, age, gender or class. Statistics indicate however that certain groups are more affected than others and therefore can be identified as high-risk groups. Women and low-income groups appear to be two such high-risk groups. Other groups such as homosexuals, intravenous drug users, and haemophiliacs, babies born from mothers who are HIV-positive, commercial sex workers, truck drivers, prisoners,

street children, sexual abuse survivors, promiscuous heterosexual individuals and young people can all be classified as high-risk groups. University students are also regarded as a high-risk group for HIV/AIDS (Diedericks, 2003; World Bank 2000).

Several factors impact on the high risk groups as discussed in the section below.

2.14 PSYCHOLOGICAL FACTORS

2.14.1 BLAME AND PREJUDICE

Some people viewed AIDS as a problem of only certain cultural groups, e.g. Whites regarded AIDS as a disease affecting only Black people, while Black people believed it arose from White communities. The disease has been viewed as a disease affecting only certain high-risk groups such as homosexuals and commercial sex workers (Diedericks, 2003: 28). The important message to get across is that blame and prejudice results in people ignoring their own vulnerability, and discriminating against and marginalising people have acknowledged their HIV/AIDS status. Although the constitution of the country protects HIV positive people from being discriminated against, many individuals have experienced being shunned by their communities, physically abused and even killed (Van Niekerk, 2001:164). Such prejudice and discrimination has resulted in emotional trauma and fear on the part of infected individuals and

their families, and have prevented communities from being open about the disease, which is counterproductive to HIV programmes.

2.14.2 SOCIAL BEHAVIOUR AND CONDOM USE

The number and type of people with whom an individual has sex may differ from one environment to another. The circle of partners is usually small and the broader it becomes, the greater the possibility of spreading the disease. An individual who has simultaneous sexual relationships is more likely to be exposed to the disease than individuals who regularly change but remain faithful to one partner at a time (UNAIDS, 2002). The fact that some cultures encourage polygamy or having extramarital affairs may be a contributing factor in the spreading of the disease. *Abstaining from sex may help from spreading the disease or contracting the virus, but for how long?*

It has become clear from the promotion of condom use as a preventative method has been met with some form of resistance. Data from the Demographic and Health Survey of 1998 showed a correlation between an early onset of sexual activity and a low rate of condom use. The survey showed that approximately 35% of non-married women in the ages of 15 to 19 years had had at least one sexual partner in the last 12 months, and that only 16% of all women interviewed had used a condom in their last sexual encounter with their

non-spouse partner (Lovelife, 2002). A number of factors that have a negative impact on condom use have been indicated. Some feel that condom use is unnatural, compromises the pleasure of sexual intercourse and undermines the trust between partners. Others stigmatise condom use as being promiscuous, many are uncomfortable and embarrassed about buying condoms. Research has also found that Black youths do not like 'white' condoms. Additionally, condoms are seen as clinical, boring and unsexy. There is also a belief in some cultures that "blocking the flow of fluids involved in sexual intercourse blocks the exchange of the gift of self", and that such a blockage will prevent fertility and cause illness. Some avoid condoms because they believe that repeated contributions of semen are pivotal in forming or ripening the growing foetus.

2.14.3 RESPONSES TO ILLNESSES

Some cultural groups believe that mental illness as well as physical illness can be caused by disharmony between men and his ancestors, by a god or his spirits, witches and sorcerers, by natural causes, or by a breakdown in human relationships. Others accept that failure to carry out appropriate rituals prescribed for everyday life may cause them to fall ill since they neglected to purify themselves. This conviction that everything that happens to a person can be attributed to external, supernatural beings or powers is symptomatic of belief

that individuals cannot be held responsible or accountable for their own behaviours (Diedericks, 2002: 30).

2.15 THE IMPACT OF HIV/AIDS ON EDUCATION

The impact of HIV/AIDS on the educational sector has not gone unnoticed. According to the World Bank (2000) case studies assessing seven universities in 6 countries including South Africa, found that HIV/AIDS is seriously affecting universities. HIV/AIDS has an effect on how many students are available to tertiary institutions. Attrition rates due to death, illness, financial constraints, and the demand for home-based care (for infected family members and dependent children) will reduce enrolment rates. This will have an effect on the sustainability of universities and the decrease of intellectual commodity which will in turn have a negative effect on the economy, since only countries that improve their educational productivity and deliver on an adequate number of competent graduates to the labour market will improve their wealth-creating abilities thus the prosperity for all (Diedericks, 2003:35).

HIV/AIDS may also reduce the quality of education and could further widen the gender gap in education since female students are more adversely affected than males. Many students will have to take time off to nurse the sick, to seek medical care and attend funerals which may cause them to miss classes and even

terminate their studies. Teaching sickly, depressed, unmotivated and demoralised students will also impact on the instructional outcomes.

2.16 VOLUNTARY COUNSELLING AND TESTING

Rachier, Gikundi, Balmer, Robson, Hunt K and Cohen (2004:176) say that *Voluntary counselling and testing (VCT) has become a basic component in the provision of HIV/AIDS services, and the number of VCT sites in sub-Saharan Africa is increasing rapidly. VCT sites have also been established in tertiary institutions inline with the AIDS Strategic plan 2000-2005 as implemented by the Ministry of Health, as a means to curb the spread of HIV/AIDS in the youth.*

The VCT centres are particularly essential since according to the study by Unicef (2001) as cited by Ngcobo and Quinlan in 2005:2) the world's youngest people are threatened by HIV/AIDS. They further state that of the 40 million living with HIV/AIDS, more than a quarter is aged 15 to 24 years

When discussing the efficacy of VCT for achieving prevention goals, Solomon, et al (2001:4) two main preventative outcomes are usually addressed i.e.

- The efficacy of VCT in achieving primary prevention, i.e. facilitating behaviour change in those who test negative

- The efficacy of VCT in achieving secondary prevention, i.e. facilitating behaviour change in those who test positive.

One consistent finding across the literature is that VCT is more effective as a means of secondary than primary prevention in African settings, mirroring the international literature in this regard. This means that VCT is more effective at facilitating behaviour change in those who test positive than in those who test negative.

2.17 RESUME'

This chapter discussed in depth the relevant literature for this study from the Such HIV/AIDS in context, history of HIV/AIDS, process of infection, stages of development which includes the five stages, modes of transmission, myths and fears about infection contributing factors, HIV testing as a diagnostic tool, management of HIV, risk factors in South Africa, political factors, high risk groups, psychological factors and lastly the voluntary counselling and testing.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The focus of this study is to appreciate the Voluntary Counselling and Testing programme that is running at the University of Zululand's clinic. Chapter three aims to achieve this by discussing the various aspects of the research process. This includes the research design, the research instrument, sampling design, interpretation of data as well as the proposed method of data analysis. The reasoning behind the methodology will be outlined.

3.2 RESEARCH METHODOLOGY

The research methodology for this study is based on a qualitative approach. The main aim of the study is to conduct an appreciative inquiry (AI) of the Voluntary Counselling and Testing (VCT) programme that is currently running in the University of Zululand, main campus at KwaDlangezwa, KwaZulu Natal.

According to Cooperrider, Barrett & Strivastva (1995:157-200) an Appreciative inquiry examines that which is working in a programme and it is hoped that that the tool should reveal the positives of this programme. It is a way of thinking

and working with groups, organizations and communities that assume all human systems have at least some positive features, i.e. something is working well. By fostering reflection on the system's strengths and best practices and sharing stories of highpoints, organizations can shift perceptions of the situation from being problem-ridden to being resource rich.

Cooperrider et al further state that AI seeks, fundamentally, to build a constructive union between a whole people and the massive entirety of what people talk about as past and present capacities: achievements, assets, unexplored potentials, innovations, strengths, elevated thoughts, opportunities, benchmarks, high point moments, lived values, traditions, strategic competencies, stories, expressions of wisdom, insights into the deeper corporate spirit or soul- and visions of valued and possible futures. Taking all of these together as a gestalt, AI deliberately, in everything it does, seeks to work from accounts of this "positive change core"— and it assumes that every living system has many untapped and rich and inspiring accounts of the positive. Link the energy of this core directly to any change agenda and changes never thought possible are suddenly and democratically mobilized.

For the purpose of this study the researcher made use of an open-ended questionnaire which allows the participants to express their perceptions/

attitudes towards the Voluntary Counselling and Testing programme of the University of Zululand.

3.3 SAMPLING

For the purposes of the study the researcher used a non-probability method known as a convenient sampling. Terre Blanche, Durrheim & Painter, describe convenience sampling as selecting participants who are available (2006:50). The students of the University of Zululand who consult the clinic for voluntary and counselling as well as testing made up the sample.

In total of the sample is made up of twenty two participants split according to the following:

Gender of the participants:

Female	18
Male	4
Total	22

Table 1: Analysis of Gender Participation

Age distribution of the participants:

21 – 25	17
26 – 30	7
31 – 35	1
Total	25

Table 2: Age Distribution of Participants

Level of education of the participants:

1 st year students	4
2 nd year students	5
3 rd year students	13
4 th year students	1
Postgraduate students	2
Total	25

Table 3: Level of Education of Participants

3.4 DATA GATHERING

3.4.1 RESEARCH INSTRUMENTS

There are several instruments available to a qualitative researcher such as observation, survey/questionnaire, interviews, focus groups, and others when collecting data.

In this study the researcher chose to use a questionnaire with 3 open – ended questions “What has been your experience with the VCT programme in this institution?”, “What do you appreciate about the programme?” and “How can the programme be improved?” These type of questionnaires are suitable for this study of this nature since they allow respondents to communicate their experiences or opinions about a specific issue in their own words without any restrictions (Terre Blanche, Durrheim & Painter,2006: 486).

3.4.2 ADMINISTRATION OF THE QUESTIONNAIRE

The University of Zululand’s clinic which was selected for this research was approached with a written request to conduct research (See annexure A).

Once permission was granted by the Manager of the clinic the VCT counsellors who are trained and were deployed by the Department of Health currently employed by the clinic, were asked by the researcher to collect data from the willing students who came to be counselled then tested

The respondents had to write their responses on the space provided beneath each question on the questionnaire (See Annexure B)

3.4.3 ETHICAL CONSIDERATIONS

In order to ensure the participants' rights to privacy and confidentiality were met, the following were taken into consideration:

- Participants were briefed by the counsellors about the nature and need for this research study.
- All participants gave their verbal consent agreeing to take part in the research project and were offered the opportunity of exiting from the study at any time should they so desire. (None of the respondents felt the desire to exercise this right).
- Research participants were guaranteed that their responses would be handled with confidentiality and sensitivity.
- To ensure that identities of the respondents were unknown, none of the participants are known to the researcher and none gave their names when responding to the questionnaires.

3.4 DATA GATHERING

3.4.1 RESEARCH INSTRUMENTS

There are several instruments available to a qualitative researcher such as observation, survey/questionnaire, interviews, focus groups, and others when collecting data.

In this study the researcher chose to use a questionnaire with 3 open – ended questions “What has been your experience with the VCT programme in this institution?”, “What do you appreciate about the programme?” and “How can the programme be improved?” These type of questionnaires are suitable for this study of this nature since they allow respondents to communicate their experiences or opinions about a specific issue in their own words without any restrictions (Terre Blanche, Durrheim & Painter,2006: 486).

3.4.2 ADMINISTRATION OF THE QUESTIONNAIRE

The University of Zululand’s clinic which was selected for this research was approached with a written request to conduct research (See annexure A).

Once permission was granted by the Manager of the clinic the VCT counsellors who are trained and were deployed by the Department of Health currently employed by the clinic, were asked by the researcher to collect data from the willing students who came to be counselled then tested

The respondents had to write their responses on the space provided beneath each question on the questionnaire (See Annexure B)

3.4.3 ETHICAL CONSIDERATIONS

In order to ensure the participants' rights to privacy and confidentiality were met, the following were taken into consideration:

- Participants were briefed by the counsellors about the nature and need for this research study.
- All participants gave their verbal consent agreeing to take part in the research project and were offered the opportunity of exiting from the study at any time should they so desire. (None of the respondents felt the desire to exercise this right).
- Research participants were guaranteed that their responses would be handled with confidentiality and sensitivity.
- To ensure that identities of the respondents were unknown, none of the participants are known to the researcher and none gave their names when responding to the questionnaires.

- Finally participants as well as the clinics were informed that a copy of the research document once completed would be made available for their perusal should they wish to view it.

3.5 ANALYSING OF DATA

In Vaile & Hallug (1989:46) three – step format for phenomenological investigation explain that in the second step the researcher should engage in a process of analyzing these descriptions so that the researcher comes to a grasp of the constituent or common elements that make the experience what it is With the open ended questionnaire collected from the respondents the researcher collected data from the answer sheets which were provided beneath each question. These responses were then typed into hard copy texts See annexure (B). This data was then analyzed using the following steps:

- The researcher read through the transcripts a number of times.
- Each transcript was analyzed individually. Key themes were elicited by breaking down the information received into natural meaning units and a summary or essential profile was written.
- A summary of each age group was written (common profile). Paying attention to recurring themes.
- Lastly a final summary of all responses received was drawn up (group or pattern profile).
- The identified themes were then explicated in detail to reveal respondents experiences of the VCT programme.

Creswell (1998:144) states that classifying means taking the text or qualitative information apart and looking for categories, themes or dimensions of information. As a popular form of analyzing, classifying involves identifying five or six general themes. These themes in turn he views as a "family" of themes with children, or subthemes and grandchildren represented by segment so of data.

Interpretation involves making sense of the data, the "lessons learned". As categories and patterns between them emerge in the data, the researcher must engage in the critical act of challenging a pattern that seems so apparent (de Vos, Strydom, Fouché & Delport (2002:344).

3.6 RESUME'

Appreciative inquiry is a way of thinking and working with organizations, groups and communities that assume that all human systems have at least some positive features, i.e. something is working well. Like any other qualitative research study, appreciative inquiry aims at enhancing understanding of the social world by helping to reveal the multifaceted nature of social reality.

The focus of the this research project is therefore to enhance understanding and place emphasis on the value of skilled Voluntary counselling and testing counsellors if we as South Africans aim to combat/ curb the spread of infections amongst our youth.

The third and final step in Vaillie & Hallug (1989: 46) suggested format is to “produce a research report that gives an accurate and articulate description of an experience.

This chapter paid attention to the research process that this study used. It included the sampling design as well as data collection and analysis.

CHAPTER FOUR: RESULTS AND DISCUSSIONS

4.1 INTRODUCTION

Research design and methodology were closely analyzed in chapter three, chapter four aims to discuss the data collected from the research study and examines the findings of the inquiry. This will help test the hypothesis formulated in chapter one.

4.2 CHARACTERISTICS OF THE SAMPLE

The respondents' particulars namely; age, gender, level of education and population group were included in the questionnaire. The respondents that took part in the study were students of the University of Zululand who came to the clinic to be counselled and tested in just one day. The sample comprise of students who are at their first year of study to those who are postgraduates. The respondents range between the ages of twenty one to thirty five years. Of note the sample is not representative of the "rainbow nation" of the South African community even though this university enrolls students from all ethnic groups in South Africa.

Out of the twenty five questionnaires that came back from the counsellors who collected data on behalf of the researcher, twenty two respondents gave their opinions and three questionnaires came back blank.

4.3 FINDINGS AND DISCUSSIONS

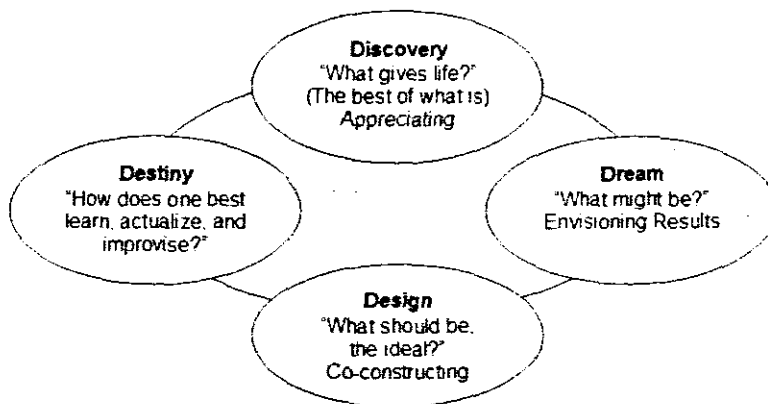


Figure 1: An appreciative inquiry 4-D cycle

The first question: "What has been your experience with the VCT programme in this institution?" requires respondents to discuss their involvement with the programme, feelings, observations and level of knowledge gained through consultation with the counsellors in the clinic (DISCOVERY).

The second question: "What do you appreciate about the programme?" gave respondents the opportunity to reflect on the positives of the programme; what they value, are grateful for or hold in high esteem (DREAM).

The third and last question: "How can the programme be improved?" asked respondents to give their opinions on what can be done to add or increase value

to the VCT programme. The final question emphasized positive, growth, creating a vision for a sustainable effective programme.

4.3.1 THEMES ELICITED FROM THE RESPONDENTS

NO	THEMES	ILLUSTRATION
a.	Kindness and caring	Most of the respondents repeatedly mentioned this theme. Kindness and caring are important catalysts when dealing with people who might be anxious especially when faced with situations that could potentially change their lives.
b.	Preparation	Again, most of the respondents felt that the VCT programme gets them prepared for being tested as well as to have the courage to withstand the the outcome of the results.
c.	Insight/ information	Almost all the participants in this research study felt that the VCT programme in this University campus provides them knowledge about HIV/AIDS which adds to knowledge they already possess and/or clarify some of the myths about this pandemic. One respondent expressed that more reading, updated material can be made available in the clinic as there is a tendency to loose some , if not all of the information while one is being tested or afterwards.
d.	Confidentiality	This was a prominent theme in almost all the respondents. Confidentiality is an important factor which forms part of all medial personnel by which they swear to uphold at all times unless they are given permission by the "patient", in this case the

		<p>testee to discuss their sero-status to a third party.</p> <p>The respondents expressed that most students do not test for their sero-status as they are afraid that a third party (namely, other students, lecturers, and other University personnel will eventually know of their status.</p>
e.	Evasiveness/guardedness	<p>This is also a theme that came up in the responses from the participants. <i>Evasiveness or guardedness is manifested in this study by the responses which only have the biographical data and by those who are non-committal to express their opinions about the VCT programme on this campus, but were the testees in the clinic during collection of data for this study. One participant wrote that he felt intimidated to be a part of this research study.</i></p>
f.	Skills	<p>Most of the research participants are of the opinion that the counsellors in this clinic possess the skills required to provide an efficient service.</p>
g.	Ongoing support	<p>Ongoing support for the students who whose results reflect a positive sero-status is another theme that participants felt it is needed in order to improve the programme.</p>
h.	Motivation	<p>The participants in this study felt that more students should be motivated know their sero-status through campaigns.</p>
I	Value of the programme	<p>Another theme that emerged from the participants of this study is the value of the programme. The respondents feel that the programme is valuable as it teaches the students about HIV/AIDS whilst providing the opportunity to know ones sero-status.</p>

4.3.2 DISCUSSION OF THE FINDINGS

This section of the study will closely examine the nine key themes in Table 4.3.1 that were identified; the experiences of the participants as well as their opinions of how to improve the VCT programme in the University of Zululand.

Terre Blanche et. al (2002:144) say this is the fourth step in qualitative research. Here the researcher will explore the above themes closely in order to capture the finer nuances of meanings. This process is known as elaboration.

4.3.2.1 EMERGING THEMES

The themes that emerged in this study which are tabled above are now going to be discussed further with reference to examples and links to them.

A. KINDNESS AND CARING

Kindness and caring proved to be the most important theme with many of the participants. They expressed that it helps those who test when the counsellors show this element as it makes them feel less anxious about the testing procedure. Kindness and caring lays opens to door to openness. Kindness and caring are useful characteristics to have in counsellors as these help make the

ones being tested gain trust in the testing procedure and process. These particular themes can be similar to empathy that psychologists and psychiatrists display towards their patients/clients.

B. PREPARATION

Kindness and caring lead to the second theme which is elicited that from the participants of this research known as preparation. The kind treatment leads the tested, *in this case the students to feel prepared to engage in the process of testing and engage fully in absorbing the information about HIV/AIDS which the counsellors disseminate to the students.* Preparation makes the students want to know more about the benefits of the VCT programme and to further clarify any myths they might have concerning the pandemic.

c. INSIGHT/ INFORMATION

Another theme that was highlighted by this study is that VCT programme is an eye-opener to those who are naïve about the pandemic. One respondent further stated that *although she has been hearing about how to prevent herself from contracting the virus, she has since been informed that there are other ways of contracting the virus besides sexual intercourse or sharing needles that are used by substance abusers.*

Although the programme seems to be capable of educating students about the virus to a certain extent, some of the respondents expressed that more information is needed in the form of booklets/ pamphlets that can be read by the tested after undergoing the test. This particular readable information will serve as a reference for the tested in case they forget to remember some of the factual information that was kindly disseminate by the counsellors during testing. These booklets should, according to a few respondents contain other information that the counsellor might not elaborate on during testing, such as the changes that occur to a person who is infected with the virus at various levels.

D. CONFIDENTIALITY

The assurance that the identity of those who come to be tested hence the results thereof are kept in confidence between the counsellor and the testee is another reason that most of the respondents of this study are encouraged to use the service. The participants expressed that knowing that they won't be identified as HIV positive by their fellow students and personnel of the University without having given permission for such information to be openly shared to third parties is comforting. This gives those who test positive a chance to come to terms with the results as well as gives them time to prepare psychologically.

There were however five of the respondents who expressed that confidentiality in this institution is not guaranteed as they have come to know of people who

used the service and whose sero-status was divulged without their consent to other students.

E. EVASIVENESS/GUARDEDNESS

As mentioned in the table above, two respondents who used the services of the clinic expressed that they have never been tested for their sero-status at the clinic. As a result of this these particular participants had no opinions for this study.

This raises concern for the researcher as baseline projections in Salomon and colleagues' study showed that without any behavioural change the HIV/AIDS prevalence rate would remain relatively stable, but the number of new infections would increase by 52.3 million by 2020 (Stine, 2005:5).

Although these respondents are not representative of the student population of this University one would wonder why students who are between the ages of twenty to twenty four years, who are on their third year level of study in their courses have never had even the curiosity to know their sero-status.

F. SKILLS

At least half of the respondents in this study are of the opinion that the counsellors were skilled enough to provide an efficient service. Although this

theme was raised by the participants none of them elaborated further on these themes

G. ONGOING SUPPORT

A third of the participants in this expressed the need for ongoing support in the form of group support as well as individual support for those who find that they have the HI virus. These respondents said this is a crucial thing as one might not know how to handle the results of testing HIV positive. Further they might not even comprehend the physiological changes that they might undergo as well as what is the next thing to do after having tested positive. By this the researcher means knowing how much or how far the virus has affected the person's body. One respondent among these further stated that some people might even be tempted to end their lives after learning that they are immuno-compromised because of the lack of ongoing support.

H. MOTIVATION

Although a few respondents expressed the need for this theme the researcher of this study feels it is an important aspect to consider when curbing the spread of HIV/AIDS infections among students, especially those who are at tertiary level. Some of the respondents added that vigorous campaigns need to be done regularly to encourage students to know their status.

I. VALUE OF THE PROGRAMME

Value of the programme is another theme that came up in the participants of this study. The respondents felt the VCT programme in this institution is valuable as it gives educates, creates awareness as well as provides an opportunity for students to test for their sero-status.

4.3.2.2 EXPERIENCES OF THE PARTICIPANTS

The majority of the participants' experiences in this appreciative study of the Voluntary Counselling and Testing (VCT) programme of the University of Zululand appeared to be positive. Most the respondents expressed that.

- "The counsellors are kind ,caring and understanding"
- "It really is an eye opener to naïve students"
- "It is informative"
- "The counsellors add to knowledge that one possesses by checking with the testee how much h/she knows about HIV/AIDS"
- "The counsellors are non-judgmental".
- "Confidentiality is guaranteed".
- "I gained knowledge of many other ways the HI virus is transmitted besides orally and sexual intercourse"

4.3.2.3 PARTICIPANTS' SUGGESTIONS FOR IMPROVEMENTS

Most participants expressed that even though the University of Zululand's VCT programme seems to be doing this best to create awareness as well as provide an environment for participants (students) to test for their sero-status, they maintain that there is room for improvements.

- "More counsellors need to be employed to avoid waiting for long periods"
- "Vigorous campaigning must be done to improve awareness"
- "Ongoing support for those who test HIV positive should be implemented"
- "Confidentiality should be improved to avoid stigmatization"
- "Additional reading material to be given to people coming in to take home for further reading as some of the information may be forgotten during the counselling/ testing process"
- "Ensuring proper record keeping in order to facilitate follow-ups for testees whose results are HIV positive"

4.3.2.4 NEGATIVE EXPERIENCES FROM THE RESPONDENTS

As mentioned in Table 4.1 in the theme evasiveness/ guardedness, one participant left the questionnaire blank and another expressed that he cannot express any opinion as he has not yet utilized the services of the programme.

4.4 RESUME'

This chapter discussed the main results and discussion of the responses obtained from the participants of the research study. The researcher started by discussing the characteristics of the sample, the various themes that were elicited by the respondents, namely positive experience and the negative ones.

CHAPTER FIVE

RECOMMENDATIONS, LIMITATIONS AND AVENUES FOR FURTHER RESEARCH

5.1 INTRODUCTION

Chapter four was a detailed discussion on the results of the research study. The main themes were identified and discussed. This chapter will focus on the issues around the VCT programme in the University of Zululand that still need to be addressed, recommendations, limitations and avenues for further research.

5.2 RECOMMENDATIONS

Cooperrider (1990:14) explains that virtually any pattern of organizational action is open to alteration and configuration. The right conditions need to exist in order to encourage this change. The guiding image of the future is to be found deep within the internal dialogue of the organization. A research study aims to create a dialogue at various levels about the VCT programme of the University of Zululand by creating a suitable environment for dialogue.

Despite some of the positive opinions and experiences expressed by the respondents about the University programme in this institution, there are certain concerns and issues which the researcher feels need to be addressed.

The following recommendations are derived from the information gathered from the respondents.

a) More rigorous attempts need to be made to encourage students to know their sero-status. This not only will curb the spread of HIV/AIDS infections among people, who are at tertiary institutions, but will be imparting knowledge about this pandemic as well as assist those who results indicate that they are HIV positive to live a healthy positive life. *The fact that some respondents seemed to be evasive or guarded when responding to the questionnaire might indicate that so any people are still naïve about this epidemic. This might be attributed to a lot of factors such as stigmatisation, fear, lack of knowledge and many more.*

b) Another important issue that some of the participants brought to the fore is confidentiality. Most medical personnel are ethical bound by their code of conduct not to divulge treatment issues to a third party unless permission is granted by the patient or client. Some professional will argue that confidentiality is not absolute, but that is a topic for another discussion. If the utilising the services of the program do not believe that everything that is being discussed during the counselling and testing session remains in confidence between the tester and the one being tested, it is therefore the opinion of the researcher that the purpose of the counselling and testing service is not being upheld.

- b) *Additional reading material should be provided to people who come for counselling and testing to remind them of the factual information disseminated during the session to help with the retention of information.*

5.3 LIMITATIONS OF THE STUDY

a) *For the purposes of data collection for this study, VCT counsellors were asked to collect data from the participants although this was a precaution to conceal the identity of the participants. This approach posed limitations as there was no identifying data to help follow up interviewing possible for this study. Some of the respondents were evasiveness or guardedness which could be interpreted in different ways.*

b) *Another second limitation for this study is that the sample is not representative of the University of Zululand's student population so therefore the results of this study cannot be generalised*

c) *for this study the VCT counsellors were the ones who collected the data for this study. This could have a contributing factor in the limited number of respondents that took part in this study. The study had aimed at sample much bigger than twenty five respondents, but this was not attainable. The questionnaires were given to the counsellors in February in order to allow for enough time for the research to conduct workshops randomly with students for them to elaborate on the opinions expressed in their responses.*

D) *Total commitment from the VCT counsellors to help in this study was a major limitation. As mentioned above, questionnaires were given to them in February but the researcher only*

received only data collected on the 6th of November from the students who came to the clinic to access the VCT program n one day between 08:00 to 13:00 hours.

5.4 AVENUES FOR FURTHER RESEARCH

The following avenues for future research have been identified.

- a) More research in this area is necessary. A large scale research study would have a greater impact in effecting behaviour change. This would require a lot of funding, time and other resources that the researcher might need.

- b) Follow-up workshops could be idea to ascertain the level of awareness and knowledge attained by the people coming in to test for their sero- status from other VCT sites or centres from other tertiary institutions. This could help prove or not whether the VCT programs are a valuable tool to help prevent the spread of HIV and AIDS.

- c) A different study that would assess reasons why the students at tertiary institutions, who most societies consider to be the future generation are naïve to the impact this epidemic has on the economy of the country, skills availability or shortages, the population and other sphere of life.

- c) Lastly a study that investigates the correlation between the attitudes of our South African leaders as well as their behaviour towards HIV and AIDS and the escalating increase of the new infections would an interesting avenue.

5.5 CONCLUSION

This final chapter discussed the recommendations, limitations and possible avenues for future research studies. It opened vital opportunities for the VCT program in this University that could further enhance the program. As shown by the studies done in other parts of the African continent such as Botswana and Kenya that *Voluntary Counselling and Testing programs are the vital technique that can be employed successfully to the society to curb the spread of HIV and AIDS* it can be safely concluded that this study will benefit the University in future decision making with regards to HIV and AIDS issues.

Research is the first tool in creating a dialogue around VCT programs, the spread of HIV/AIDS and encouraging appreciation of the services open to us for our own survival.

REFERENCES

Abdool Karim, S.S. & Abdool Karim, Q. (2005). **HIV/AIDS in South Africa**. Cambridge University Press: Cape Town.

Barnett, T. & Whiteside, A. (2006) **AIDS in the twenty first century: Disease and globalisation**. Basingstoke: MacMillan.

Black, G.J. (2005). **Microbiology principles and explorations**. John Wiley & Sons: New York.

Bor, R., Miller, R. & Goldman, E. (1992). ***Theory and Practice of HIV Counselling: a systemic approach***. Cassell: London.

Cooperider, D.L., Barnett, F. & Strivasta, S. (1995). ***Social construction and Appreciative inquiry: A journey in organization theory***. U.K. Avebury Press: Aldershot

Cooperrider, D. L. (1990). **Positive Image Positive Action: the affirmative basis of organizing in Appreciative Management and Leadership, (Strivasta, et al (eds))**. Joseey Bass: San Fransisco.

Crepaz, N. & Marks, G. (2002). "***Towards an understanding of sexual risk behavior in people living with HIV: A review of social, psychological and medical findings.*** AIDS, 2002, 16,. AIDS organization of South Africa.

Creswell, J.W. (1998). **Qualitative inquiry and research design; Choosing among five traditions.** SAGE Publications: New Dehli.

Diedericks, A. (2003). ***University students HIV/AIDS Knowledge, Information, Sexual behaviour and Perceptions of Voluntary Counselling and Testing (VCT).*** University of Port Elizabeth: South Africa.

de Vos, A.S. , Strydom, H. , Fouché, C.B., Delport, C.S.L. (2002). **Research at Grass roots, for the social sciences and human professions (2nd ed).** Van Schaick: South Africa.

Grimwood, A., Crewe, M. & Bettenridge, D. 2000). ***HIV/AIDS Current issues.*** **South African Health Review.**

Irwin, A., Millen, J. & Fallows, D. (2003). **Myths and Facts, tools for fighting the AIDS pandemic.** South End Press: Cambridge.

Kelly, K. Parker, W. & Lewis, G. (2001). **Reconceptualising behavior change in the HIV/AIDS context.** In Stones (Ed) **Socio - political and psychological perspectives on South Africa.** Nova Science: London.

Le Marcis, F. & Ebrahim, V. (2005). People living with HIV and AIDS in everyday conditions of township life in South Africa: between structural constraints and individual tactics. ***Sahara Journal of Social Aspects in HIV/AIDS Research Alliance, 2(1), 217-235.***

Loveliflife, (2002). **HIV/AIDS in South Africa.** Retrieved from www.lovelife.org.za on December 20, 2006.

National Institute of Allergy and Infectious Diseases. (2004). "***How HIV Causes AIDS'*** National Insitutite of Health. U.S. Department of Health & Human Sciences.

National Institute of Mental Health. (2000). ***Early Detection of HIV: Implications for Prevention Research.*** Release date January 6, 2000.

Ngcobo, N. & Quinlan, T. (2005). ***The responses of South African Youth Organisations to the HIV/AIDS epidemic.*** University of KwaZulu Natal: Durban. Available from www.heard.org.za.

Rachier, C. O. Gikundi, E., Balmer, D.H., Robson, M., Hunt, K. F. & Cohen, N. (2004). "***The meaning and challenge of voluntary counselling and testing (VCT) for counsellors – report of Kenya Association for Sub-Saharan Africa***". Journal des Aspects Sociaux du VIH/SIDA, Vol 1 No 3, November 2004.

Reed, J., Pearson, P., Douglas B. , Swinburne, S. & Wilding, H. (2001). ***Going home from hospital – An appreciative inquiry study. Center for the care for older people***, University of Northumbria: Newcastle.

Solomon, V., Van Rooyen, H., Griesel, R., Gray, D., Stein, J. & Nott, V. (2004). ***A Critical Review of the Voluntary Counselling and Testing Literature in Africa***. Health Systems Trust: Durban.

Soul City Antiretroviral Treatment **A health workers guide** (2005). Jacana Media. South Africa.

Stine, G. J. (2005a). **An AIDS Update, An Annual Overview of Acquired Immune Deficiency Syndrome**. Pearson Education Inc. San Francisco.

Stine, G. J. (2005b). **2005 AIDS Update**. Pearson Education: San Francisco.

Terre Blanche, M. & Durrheim, K. (2002). **Research in Practice; Applied methods for the social sciences**. University Cape Town Press: Cape Town.

Terre Blanche, M. Durrheim, K. & Painter, D.(2006). Research in Practice; Applied methods for the social sciences. University of Cape Town Press: Cape Town.

Tladi, L.S. (2006). "*Poverty and HIV/AIDS in South Africa: an empirical contribution*". **Journal of Social Aspects of HIV.AIDS**, 3, 1, May 2006.

UNAIDS (2001). ***The impact of Voluntary counselling and testing: A global review of the benefits and challenges***. Geneva.

UNAIDS Joint United Nations Programme on HIV/AIDS. (2002). ***Report on the global HIV/AIDS epidemic***. Geneva.

Van de Perre, P. (2002). *HIV Voluntary counseling and testing in community health services*, **Lancet** Vol 356, Issue 9224.

Van Niekerk, A. A (2001). ***Moral and Social Complexities of AIDS in Africa***. Journal of Medicine and Philosophy, Volume 27, No. 2. University of Stellenbosch: South Africa.

Vaill, R. S. & Hall, S. (1989). *Existential – Phenomenological Perspectives in Psychology*. Plenum Press: U.S.A.

World Bank (2000). Exploring the implications of HIV/AIDS epidemic for educational planning in selected African countries: the demographic question.

World Bank: Washington (The Galiber Report).

**APPENDIX A: REQUEST TO CONDUCT RESEARCH AT THE UNIVERSITY OF
ZULULAND'S MEDICAL CLINIC**

BB 1517 MUDLI LANE
P.O UMLAZI
4031

29 August 2006

DR. VILAKAZI
UNIVERSITY OF ZULULAND CLINIC
KWADLANGEZWA

MADAM

PERMISSION TO CONDUCT RESEARCH

I hereby request permission to conduct research in your clinic for academic purposes.

I am currently enrolled for a Masters degree in Clinical Psychology with the University of Zululand. My dissertation is on the critical review of the voluntary counseling and testing (VCT) program within the institution.

The information received will be treated anonymously and confidentially.

Thanking you in advance for your cooperation.

Yours sincerely

**MISS N MKHIZE
(STUDENT PSYCHOLOGIST)
TEL: 0764289457**

**DR. J. THWALA
(SUPERVISING PSYCHOLOGIST)
TEL: 035-9026616**

APPENDIX B: RESEARCH QUESTIONNAIRE

AN APPRECIATIVE INQUIRY QUESTIONNAIRE OF THE VOLUNTARY COUNSELLING AND TESTING (VCT) PROGRAMME OF THE UNIVESRITY OF ZULULAND

The study aims at finding out the students experiences and improvements if any that will be suggested by you in order to help the University's Voluntary Counseling and Testing programme.

The questionnaire has two sections. Section A is for your biographical details, Section B contains the questionnaire. Underneath each question there is a space provided to express your opinion in this matter.

SECTION A: BIOGRAPHICAL INFORMATION

INSTRUCTION: Please indicate your response by making a cross (X) in the appropriate box or writing your response in the block provided.

1. Age:

2. Gender:

3. In what year of study are you?

1 ST	2 ND	3 RD	4 RD	Postgraduate
-----------------	-----------------	-----------------	-----------------	--------------

4. What degree are you currently studying?

5. Under which Faculty does your degree fall?

6. In which population group do you belong?

Black	White	Coloured	Asian	Other
-------	-------	----------	-------	-------

