THE CHALLENGES OF MANAGING HIV/AIDS COUNSELLORS IN A RURAL DISTRICT IN THE EASTERN CAPE, SOUTH AFRICA

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requirements for the degree of

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by

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CONTENTS

THE CHALLENGES OF MANAGING HIV/AIDS COUNSELLORS IN A RURAL DISTRICT IN THE EASTERN CAPE, SOUTH AFRICA

ABSTRACT:

The pandemic of HIV/AIDS has challenged several aspects of contemporary social life. HIV/AIDS counselling has developed as a social response to provide support for those infected with the disease. Due to the nature and complexity of the disease, HIV/AIDS counsellors encounter a diversity and intensity of emotions when counselling. A support system that includes effective management and supervision may assist in resolving emotions and reactions that HIV/AIDS counsellors may experience as a result of working with HIV/AIDS clients.

This study examines the difficulties that both managers and the HIV/AIDS counsellors at a rural district hospital in the Eastern Cape and its surrounding clinics are faced with, in providing the HIV/AIDS counsellors with the support they need.

Engeström's (1987) model of activity theory was used as a conceptual framework guiding both the analysis and interpretation of the data. This model facilitates the identification of tensions and contradictions thereby opening a space for change and transformation within an activity system. Multiple sources of data collection were used that included focus groups with managers and HIV/AIDS counsellors, interviews with senior hospital staff and an official from the Department of Health, Eastern Cape, and a tour of the rural district hospital.

The findings suggest that HIV/AIDS counsellors do not feel supported by their managers. Managers in turn are of the opinion that they do not offer the support the HIV/AIDS counsellors' need. The lack of support is attributed to geographic

distances between hospitals and the clinics they serve, lack of available transport and the multiplicity of roles of both managers and the HIV/AIDS counsellors. Recommendations include the introduction of self-supervision, peer group supervision for HIV/AIDS counsellors.

KEY WORDS: Management, HIV/AIDS Counselling, Self-supervision, Peer Group Supervision.

BIOGRAPHY: Barbara Gerber completed her internship as a counselling psychologist at the end of 2001 and has recently taken up the position of general manager at St. Bernard's Hospice in East London. Her interests lie in bringing aspects of management and community psychology together so as to provide effective supervision to health care workers.

1. INTRODUCTION:

South Africa has one of the fastest growing levels of HIV/AIDS infection in the world. According to surveys conducted by the South African Department of Health of women attending antenatal clinics, the levels of HIV infection in the country increased from 0.7% in 1990 to 22.8% in 1998 (Stannard 2001). The estimated number of adults and children living with HIV/AIDS in South Africa in 2000 was 4 700 000, which is approximately 1in 9 South Africans (Department of Health, 2001).

The Eastern Cape is the second largest province in South Africa yet it is the poorest. Of the 6,3 million living in the Eastern Cape, 63% live in rural areas and of those, 56,3% are unemployed (S A. Population Census, 1996). In 1999 the level of HIV/AIDS infection in the Eastern Cape was estimated at 18.0 % of the population. This figure increased to 20,2 % in 2000. (Department of Health, 2001). Staff within the health sector of the Eastern Cape are faced with many challenges some of which are the vast distances between the rural district

hospitals and clinics; the poor condition of the roads and the shortage of resources such as transport, equipment and staff

1.1 HIV/AIDS counselling

"Aids has challenged several aspects of contemporary social life and conventional approaches to health care (Irinoye, 1999, p. 181). Being diagnosed with HIVAIDS has profound emotional, social and behavioural consequences. (Seeley & Wagner, 1991). One social response to the pandemic that has developed, as a form of support, is HIV/AIDS counselling. Clients need to be helped not only to deal with the difficulties that result from the social perception and stigma that surrounds the disease, but also with the acceptance of impending death (Irinoye, 1999). HIV/AIDS counselling is not only aimed at helping and protecting clients but it is also meant to, by informing clients of their role in preventing infection, to protect members of the client's family and the wider community (Irinoye, 1999).

HIV/AIDS counselling carried out by health care professional in South Africa has to date mainly involved pre-and post- test counselling of individuals within a hospital or clinic setting. As a result HIV/AIDS counselling has been seen as an educational process in which the client is offered guidance, advice and information on biomedical needs and conditions of the person (Balmer, 1992). A shift in focus, to accommodate the different areas of need, as explained in the previous paragraph places additional demands on the HIV/AIDS counsellor as HIV/AIDS counselling is only one task amongst a full range of nursing services that the counsellors are expected to provide at their sites of practice.

1.2 Confidentiality and HIV/AIDS counselling

Confidentiality, which is an accepted cornerstone of the client-counsellor relationship, is a controversial issue in the whole area of HIV/AIDS. Very often those individuals perceived by the wider community to be infected together with their families are socially ostracized and personally rejected (Herek, 1999).

As most of HIV/AIDS counselling is conducted within hospital and clinic settings, the professional discourse of confidentiality is upheld (Rankin & Gilbert, 2000). Staff, family and clients become obsessed by 'secrecy' (Uys, 2000). HIV/AIDS counsellors are placed in a double bind situation where part of their job is to make people aware of the disease on the one hand and yet on the other they need respect a clients wish to keep her/his diagnosis confidential.

Maintaining the confidentiality of a person's HIV status, whilst respecting an individual's rights, has broader implications. Not only is the silence and stigma of HIV/AIDS reinforced when confidentiality is maintained but the quality of the support that HIV/AIDS counselors require may be affected as sharing experiences of counseling HIV/AIDS clients with managers may be viewed as breaking a client's confidentiality (Bor & Scher, 1992). The concept of shared confidentiality which is described by Seidel (1996, p. 418) as the "sharing of sensitive information within a given community of people" may not be considered an option.

HIV/AIDS counselling should encourage clients to share their HIV/AIDS status with others in order to obtain support thereby reducing isolation, rejection and stigma (Seidel, 1996).

1.3 Management of HIV/AIDS counsellors

An abundance of literature is available on HIV/AIDS counselling (Balmer, 1992; Irinoye, 1999; Evian, 2000; Fawcett, 2001) whilst very little literature documents the management of HIV/AIDS counsellors in the South African context.

HIV/AIDS counselling, as with other direct human service programme, needs to be effectively managed in order to bring about sustainable results. In addition to the planning, leading, organising, controlling and evaluating of these programmes, it is the responsibility of managers to develop, support and enhance the skills and motivation of the service providers reporting to them.

(Lewis, Lewis & Souflee, 1991). Mental health care workers, which would include HIV/AIDS counsellors, require training and support from experienced and skilled support staff. (Freeman & Pillay 1997, Petersen et al 1997). It has been found that that without enough support counsellors may absorb more disturbance and distress from clients than they are able to process and release. This may leave counsellors overburdened (Hawkins & Shohet, 1989).

Careful selection and appraisal processes are also important aspects of managing human service programmes. Human service providers need access to fair performance management, training and the support and assistance that effective managers can give. Ongoing evaluation of the service providers is required so as to identify areas of further development and training as community and client needs may change rapidly. Through the vehicle of the 'management relationship' the manager provides support, encouragement, helps builds skills and oversees the service providers' or in this case, the HIV/AIDS counsellors.

1.4 The study

This paper reports on a study conducted at a rural hospital and its surrounding clinics in the Eastern Cape and argues that, due to a variety of constraining factors, managers are unable to provide HIV/AIDS counselors with the support that they require. The aim of this paper is to explore the challenges and constraints experienced by managers of HIV/AIDS counselors and to make recommendations which would assist managers in ensuring that HIV/AIDS counsellors receive the support that they need.

2. MANAGEMENT STRUCTURE WITHIN THE DEPARTMENT OF HEALTH

In an interview with an official from the Department of Health, Eastern Cape it was established that the hospitals and clinics are hierarchical organisations. Rules regarding the qualifications a member of staff needs, how and when an individual may be promoted, the level of authority and power each position in the hierarchy carries together with a well defined reporting structure are an integral

part of the system. An associated problem with the power and authority each position holds is the focusing of management on satisfying those above them in the hierarchy at the expense of spending time on coaching and supporting staff lower down in the hierarchy. This may lead to staff feeling frustrated, overworked and unsupported.

These above-mentioned characteristics can be best described by the bureaucratic system of management which, was influenced by the work of German social historian Max Weber (1864-1920). A bureaucratic organisation is pyramid shaped hierarchy with an increase in authority at each higher level in the hierarchy. Rigid rules and 'red tape' results in slow decision making and leaves little space for individual creativity and freedom for employees. Managers can be protective of their own authority often resulting in the impersonal supervision of staff with minimal coaching and support being provided by managers (Smit & Cronje, 1992 & Hellriegal, Jackson & Slocum 1999).

The bureaucratic system of management, which has been described by Burns & Stalker (1961 & 1994) as 'mechanistic', is more suited to stable environments. Due to the rapid social change, as is currently experienced in South Africa, and the complexity of managing the needs of staff in rural settings, a more appropriate model may be the contingency approach to management (Smit & Cronje, 1992 & Hellreigel, Jackson & Slocum, 1999).

Central to contingency theory is that management practices should be consistent with the requirements of the external environment and the capabilities of staff (Smit & Cronje, 1992 & Hellriegel, Jackson & Slocum, 1999). The resulting organisational structure is more organic in form than the bureaucratic system of management, thereby opening up space for flexibility and creativity, although managers need to be contextually sensitive (Burns & Stalker, 1961 & 1994, Boje, 1999).

3. SUPERVISION OF HIV/AIDS COUNSELLORS

Within a management context the words 'management' and 'supervision' are at times used interchangeably. However, within a counselling context there is a fundamental difference between the two. Within the context of a bureaucratic organisation, such as the Department of Health, the management and supervision of staff refers mainly to ensuring that staff get the job done whereas supervision in a counselling context refers to a professional, consultative, supportive aid for counsellors. Supervision is therefore a process whereby clients are helped indirectly by managers or a supervisor supporting the counsellor. It is a common complaint among counsellors in general that they do not receive good supervision, as their managers have neither the time nor the ability to supervise them (Hawkins & Shohet 1989). Although the main focus during supervision is on the client it is important that time is allocated to addressing the counsellor's own feelings and reactions that are evoked by working with clients (Feltham & Dryden 1994).

According to Hawkins & Shohet (1989), supervision has three different aspects namely educational, supportive and managerial.

Firstly the educational aspect relates to the development of the understanding and skills of supervisees and is achieved by providing " a regular space for supervisees to reflect upon the *content* and *process* of their work" and by providing "both content and process feedback" to supervisees (Hawkins & Shohet, 1989, p.43).

Secondly the supportive aspect of supervision acknowledges that counselling clients may result in counsellors becoming emotionally affected by clients' distress and pain. Not attending to these emotions may lead to stress or what is commonly known as 'burnout' Supervision allows for supervisees to be "validated

and supported both as a person and as a worker" and to " ... explore and express personal distress..." (Hawkins & Shohet, 1989, p.43).

Thirdly the managerial aspect of supervision assists in providing quality control, ensuring that the work of the supervisees is appropriate and ethical. This aspect allows the supervisees to "plan and utilise their *personal* and *professional* resources better" and to be "pro-active rather than re-active" (Hawkins & Shohet, 1989, p.43).

Supervision of counsellors may take the form of individual supervision, self-supervision, group supervision or peer supervision (Hawkins & Shohet, 1989; Feltham & Dryden, 1994; Gomersall, 1997 & Ackhurst, 2000). For the purposes of this study only self -supervision and peer group supervision will be discussed.

In self -supervision the aim, is to develop the ability with counsellors to reflect on their work with clients. This involves the counsellor reflecting both on the process of the work with the client together with becoming aware of personal feelings, thoughts, actions and body sensations whilst working with and following a session with a client (Hawkins and Shohet, 1989). This process can be further enhanced by the counsellors writing up their reflections and exploring the impact that their work has on their personal life and vice versa. Self-supervision requires both time and self-discipline. The advantages of self–supervision include not being dependant on a counsellor being in the same physical location as a supervisor and that it allows a counsellor to stand back from their work and to assess and make changes in the way they work or to seek supervision on specific areas of their work.

According to Gomersall, (1997) peer group supervision may be defined as "a group of people of similar status who are engaged in a similar line of work... who set aside regular committed time to examine the nature of their work..." (Gomersall, 1997, p. 108). Peer group supervision may take the form of a group,

a dyad or a triad and are neither hierarchical nor evaluative (Akhurst 2000). The absence of a supervisor in a peer group may however increase the risk of difficulties related to group dynamics as there "is no outside facilitator whose job is to watch the process" (Hawkins and Shohet, 1989, pp. 105-106).

However valuable sharing of knowledge, skills and experiences may take place between members of a peer group as well as providing the space to explore the personal impact counselling has on member (Gomersall 1997). In addition to these advantages, as peer group supervision is not dependant on a professional supervisor it "can be a relatively low-cost endeavour which is easy to organise" with savings on time, money and expertise (Gomersall, 1997, p. 118).

4. THE SEXUAL HEALTH COUNSELLING PROJECT (SHCP)

The managers and HIV/AIDS counsellors that participated in the study had all, during 1999, attended the training offered by the Sexual Health Counselling Project (SHCP).

The SHCP was developed in response to the need to train, manage and supervise HIV/AIDS counsellors in the Eastern Cape and was initiated by the Psychology Department, East London Campus of Rhodes University and funded by a grant awarded in 1998 by the Eastern Cape Department of Health. This paper arose out of the involvement of the researcher with the SHCP in the following ways:

- as a consultant to the SHCP on the development and training of the management component of the SHCP,
- in a research project for the partial fulfillment of her Honours degree in psychology entitled, "An analysis of the possible shifts in managers' understanding of the activities and attributes involved in the managing of counsellors" (Gerber 1999) and

- as a facilitator of follow-up workshops conducted with both managers and counsellors during the course of 2000 as a Masters Psychology student.

The purpose of the study was not to provide an evaluation of the SHCP, however the project provides a window through which the challenges of managing HIV/AIDS counsellors in a rural context in South Africa may be explored.

The SHCP was to trained nurses in the employ of the Department of Health or Non-Government Organisations (NGOs) offering HIV/AIDS related services, as counsellors, thereby being able to offer counselling services at clinics within the primary health care system. In so doing, the project hoped to contribute to the development of sustainable expertise in the Eastern CApe with regard to counselling and the management thereof (Gilbert, 1998). Participants were drawn from a limited number of districts in the Eastern Cape Province so as to provide a strong core of trained counsellors and managers. Two thirds of the participants lived and worked in the rural districts of the Eastern Cape. During the course of 1999 a total of 81 counsellors and 48 managers were trained and awarded certificates (Gilbert & Rankin 2000).

One of the overall aims of the project was to challenge and "change the standard practices that operate in the health sector where counsellors act as experts giving advice to the 'naïve' or 'ignorant' person about the medical, personal and interpersonal issues relating to the HIV/AIDS pandemic" (Gilbert & Rankin 2000, p. 1). To promote improved sexual health and sexual practices at a community level, the project aimed to introduce a more comprehensive counselling service than just pre- and post- counselling to those living with HIV/AIDS and their immediate families and friends.

In order to achieve this objective and to provide a "supportive institutional environment for counsellors", a two-tiered model of training was developed which included both managers and their HIV/AIDS counsellors. (Gilbert & Rankin 2000.

p.2). The intention was to have the managers manage the HIV/AIDS counsellors in a similar fashion to the three aspects of supervision as described by Hawkins & Shohet (1989), namely educational, supportive and managerial (see section 3). To this end managers were trained in the principles of counselling and community interventions in addition to the managerial functions of selection and managing performance. The selected HIV/AIDS counsellors were equipped to address relationship issues within the family and community with a focus on the problems of HIV/AIDS, sexually transmitted diseases (STDs) and sexual health. The role of the HIV/AIDS counsellor, as envisaged by the project, went beyond that of a counsellor, in that it moved the role of the HIV/AIDS counsellor to that of an agent to promote improved sexual health practices. The HIV/AIDS counsellor was therefore expected to become a social agent within the community (Gilbert 1998).

Subsequent to attending the training programme, support was provided by the Psychology Department for both managers and counsellors in the form of six follow-up visits to each site of practice during which individual supervision occurred. A series of workshops were held within each of the districts during the course of 2000.

5. PARTICIPANTS AND CONTEXT OF THE STUDY

The four managers and six HIV/AIDS counsellors who participated in the study were all in the employ of the Department of Health, Eastern Cape. All had attended the SHCP during the course of 1999. Of the four managers, two managers had two counsellors reporting to them, whilst two managers managed one counsellor each. The four managers and two counsellors were based at a rural district hospital in the Eastern Cape, whilst four counsellors worked in the surrounding clinics serviced by the hospital.

The hospital, which for ethical reasons is not named, is situated in one of the furthest rural districts of the Eastern Cape and is located in the outskirts of a local town. The access roads to the town and those within the town were in a poor condition. The general impression of the town was that it was impoverished. In contrast to the town, the hospital, which had been in operation for two years at the time of the research, appeared modern, well laid out, secure and clean. On a guided tour of the hospital with one of the managers the following was observed:

- the laboratory did not have equipment to test blood. As a result laboratory staff were sitting around with no work to do.
- Three of the five vehicles available for staff to use in carrying out their duties were out of order and had been for varying lengths of time, from one to three months. It was not known when they would be repaired.

It was evident from the available organisational chart and from discussions with the Superintendent and the Nursing Services Manager that an explicit hierarchy and reporting structure were in place in the hospital. A strong emphasis was placed on the right qualifications and number of years experience for each position. These characteristics are similar to those described by the bureaucratic branch of traditional management theory (see section 2). Due to a shortage of qualified staff, senior management were required, in addition to their managerial function, to perform nursing duties.

Senior management viewed counselling and HIV/AIDS counselling in particular as a priority. Challenges identified by senior management included the extent and number of social problems that counselors encountered, e.g. suicide, depression, marriage problems and that counseling is only one part of a counsellor's job. The Superintendent of the hospital felt that it would be more effective to have full-time counsellors to ensure continuity of the counselling service and for other nursing staff to have a basic understanding of counselling.

Senior management were not involved with the HIV/AIDS counsellors in any way but trusted their managers to provide the HIV/AIDS counsellors with the follow up and support that they needed.

6. CONCEPTUAL FRAMEWORK: ACTIVITY THEORY

A conceptual framework allows the researcher to decide what the important features in a study are, which relationships are likely to be important, what data is to be collected and how it will be analysed (Robson, 1993). The challenge was to find a tool that would provide insight into the management processes and relationships that operated between managers and HIV/AIDS counsellors, taking into account the context in which they worked. Since the goal of the study was to explore and understand the relationship between human action and mental functioning on the one hand and the cultural, institutional and historical situations in which this action and mental functioning occurred on the other hand, a socio-cultural perspective was adopted. As activity cannot be understood or analysed outside the context in which it occurs, the unit of analysis in socio-cultural research is contextually embedded activity (Wertsch, 1995).

Within the broader paradigm of socio-cultural research Engeström's (1987) model of activity theory was adopted as a conceptual framework to analyse and interpret the data of this study. The origins of activity theory may be traced back to the theory and research initiated during the 1920s and 1930s by Vygotsky, Leont'ev and Luria, the founders of the socio-historical school of Russian psychology (Engeström & Miettinen, 1999).

Activity theory aims to move beyond the individual and locate an understanding of human interaction in people's actions within their contexts. Activity theory proposes that that the unit of analysis in human inquiry is 'activity' (Engeström & Miettinen, 1999). The way in which people perceive and understand themselves, others and reality is dependant on the kind of 'activity' and the social relations

they engage in. Activity theory is therefore a socio-cultural and socio-historical lens through which human activity may be analysed, thereby providing a conceptual framework for understanding the interaction of individuals or groups in their socio-cultural-historical contexts by using contextually embedded activity as the unit of analysis (Jonassen & Rohrer-Murphy 1999).

Central to activity theory is the concept of 'mediated action', which is based on Vygotsky's (1978) work on early childhood development. According to Vygotsky (1978), two cultural forms of behaviour develop in early childhood, the use of tools and human speech (signs). Tools are of a material nature whereas signs are psychological or conceptual in nature. These tools and signs, which are culturally, defined, play an essential role in shaping human action and have either an empowering or constraining effect on the action. (Wertsch, del Rio & Alvarez, 1995). The use of cultural tools results therefore in the transformation or redefinition of human action (Wertsch, 1995). Individuals only have access to the world indirectly or mediatory through the use of cultural tools and signs. Human action is therefore characterised by 'mediated action' (Vygotsky, 1978). In other words, the relationship between an individual and an object is mediated by material and/or or psychological/conceptual tools.

Engeström (1987) introduced the concept of an activity system as a dynamic unit of analysis to study the elements of human activity. Engeström (1993, p. 67) states that "contexts are activity systems" that incorporate the idea that human activity occurs in a system constituted by the elements of that activity and carried out within a particular socio-cultural-historical context. In addition to Vygotsky's (1978) material and psychological/conceptual tools that mediate human action, Engeström (1987) introduces social tools into his model of activity theory. These social tools refer to the rules, community and division of labour of the human activity system.

The structure of the human activity system proposed by Engeström (1987) as illustrated in Figure 1, is constituted by the elements, namely, subject, object, tools, rules, community and division of labour.

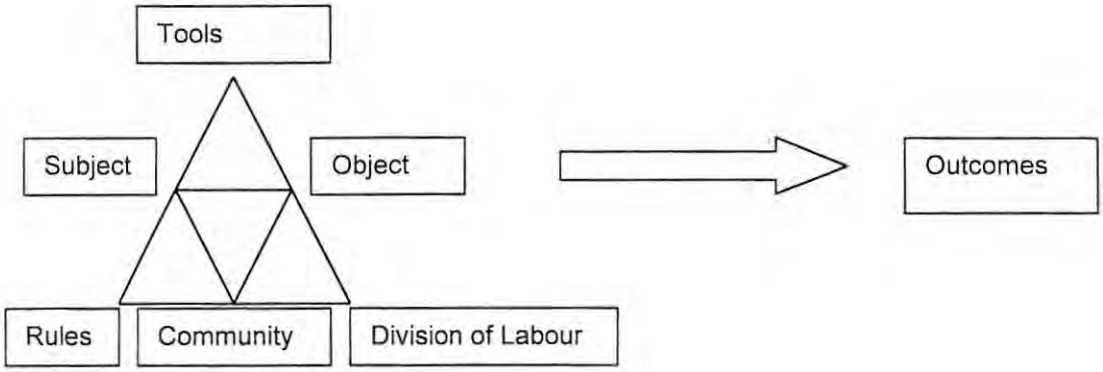

Figure 1: Visual representation of the human activity system (Engeström, 1987, p. 78)

The elements should not be viewed as discrete entities but rather as inter-related, continually interacting with and impacting on one another. An explanation of each element (Centre for Activity Theory and Development Work Research, 1998, Engeström 1987, & Jonassen 1999). together with an example from the study follows:

- The *subject* of an activity is the individual or group engaged in the activity and from whose perspective the activity is viewed when analysing the activity. For example, the subjects in this study are the managers and the HIV/AIDS counsellors.
- The *object* of the activity is the problem space at which the activity is directed, which can either be given or anticipated, e.g. an object for the managers was to provide effective management to the HIV/AIDS counsellors and for the HIV/AIDS counsellors the object was the effective HIV/AIDS counselling of clients and community interventions.
- The *tools* refer to the material and conceptual tools that mediate the relationship between the subject(s) and the object(s) in an activity system,

e.g. managers require transport *(material tool)* to visit the HIV/AIDS counsellors at the clinics and managers make use of previously acquired selection skills *(conceptual tool)* in selecting the appropriate HIV/AIDS counsellors.

- The *rules* relate to the implicit and explicit norms, values, regulations and conventions that constrain or enable the actions and interactions within the activity system, e.g. the level of confidentiality adhered to by the managers and HIV/AIDS counsellors with regard to counselling of clients.
- The *community* refers to the individuals or groups who share the same general object of the activity, e.g. hospital staff, clients and members of the community.
- *Division of labour* refers to both the horizontal division of tasks and vertical division of power and status between the subjects within an activity system, e.g. the tasks assigned to HIV/AIDS counsellors by their managers.
- The *outcomes* are the intended and unintended results produced by the activity, e.g. clients' feelings of satisfaction/dissatisfaction at the counselling service provided by the HIV/AIDS counsellors.

Tensions and contradictions may occur between and within the elements of the activity system. Firstly, "different subjects due to their different histories and positions in the division of labour, construct the object and other components of the activity in different, partially overlapping and partially conflicting ways. (Centre for Activity Theory and Development Work Research, 1998, p. 3). Secondly, activity systems do not exist in isolation or in a vacuum but are understood within their historical context, and they are continually interacting with and influencing and being influenced by other activity systems. (Engeström 1993). The external influences from one activity system may impinge on another, which in turn may be appropriated by the activity system, resulting in an imbalance within the particular activity system. These imbalances, tensions or contradictions occur within and between the various elements of the activity system. Individuals and groups constantly work through these contradictions, reconstructing and

renegotiating the elements of an activity system, e.g. as new subjects enter an activity system tasks are re-assigned and rules are re-interpreted. Activity systems therefore are neither static nor homogeneous, developing and transforming as solutions to the imbalances and contradictions are found (Centre for Activity Theory and Development Work Research 1998).

Engeström (1993) argues that it is in the identification of the tensions and contradictions within an activity system that a space for change is developed. These internal and external tensions and contradictions become the motive and force for change, development and transformation in activity systems (Engeström & Miettinen, 1999). As a result, Engeström (1993, p. 71) states that "an activity system is a virtual disturbance-an innovation-producing machine". One of the roles of the researcher is to help make the contradictions explicit so as to facilitate change.

Engeström's (1987) model enables data to be fractured and interpreted in such a way that a deeper understanding of contextually embedded activity may be obtained. The advantages of using activity theory in this particular study include that:

- the challenges facing both the managers and the HIV/AIDS counsellors within their context could be identified.
- the complexity of the identified challenges could be understood and therefore effective ways to address the challenges could be isolated, that could lead to transformation.
- the management processes and relationship between managers and HIV/AIDS counsellors could be described and understood in activity theory terms.

7. DATA GATHERING

Permission was granted by the Superintendent of the hospital for the author and a colleague to run two focus groups at the hospital during July 2000. One focus group was conducted with the managers and the second with the counsellors. Permission was obtained from all participants to audiotape each focus group, transcribe the audiotapes and use the information for research purposes.

The author and her colleague facilitated the focus groups. The main role of a facilitator of a focus group is to provide direction, using an interview guide for group discussion but not to suggest potential responses (Stewart & Shadasani, 1990). An interview guide informed by the research question was constructed prior to the running of the focus group.

The purpose of the focus groups conducted at the hospital was to obtain first-hand information from the managers and HIV/AIDS counsellors regarding the nature of the contradictions and incongruencies that operated in their relationships with each other.

The areas that were explored in the focus group with the managers included:

- Day-to-day performance management of counsellors;
- Problems that counsellors experience;
- Support provided to counsellors by managers:
- Community interventions with which counsellors are involved.

The areas explored during the focus group with the counsellors included:

- Counselling situations;
- Problems encountered during the counselling process;
- Support received from managers;
- Additional support required.

In addition to the focus groups, further information regarding the context and the relationship between the managers and the HIV/AIDS counsellors was obtained from interviews with an official of the Department of Health, Eastern Cape and the Superintendent, Nursing Services Manager and a Matron of the hospital. A comprehensive tour of the hospital and observation of a SHCP trained manager consulting with patients was also undertaken. The organisational chart, mission, vision and a patients' charter provided additional information about the hospital context.

A possible limitation of this research was that the data collected was in the form of a narrative of how the managers and counsellors each perceived their relationship as opposed to observation of the actual interaction between managers and counsellors.

8. DATA ANALYSIS

The two focus groups each represented an activity system of the managers and the HIV/AIDS counsellors respectively, which were analysed using Engeström's (1987) model of activity theory. The steps undertaken in the analysis for each focus group were as follows:

Step 1 Transcriptions of the audiotapes from each focus group were made. The text was presented in tabular form so as to allow for the identification of the elements and contradictions alongside the relevant text.

Step 2. A symbol or word was chosen as a code to represent each element of an activity system and thereafter a key of all the codes was compiled, e.g. DOL represented division of labour and Mctool represented a manager's conceptual tool (*For exam purposes see Appendix A: Key of Data Analysis Codes*).

Step 3: Each text was read and re-read four times for the identification of the elements of the activity system. Associated words/sentences in the text were used to describe the elements, which had been coded. Reading the text in this manner allowed the author to enter a hermeneutic-like process, with each successive reading resulting in the further identification, refinement and understanding of the elements.

Difficulty was experienced in the coding process when reference was made by the counsellors in their focus group to the fears and feelings they experienced when having to inform a client that s/he had tested positive with the HIV virus. Initially these emotions were coded as conceptual tools since they were interpreted as mediating the HIV/AIDS counsellors' actions and reactions to the clients. With subsequent readings of the texts a decision was taken to further code fears and feelings as emotions. It was felt that the explanation of a conceptual tool within Engeström's (1987) model of activity theory did not adequately address the human elements of emotion and compassion.

Step 4. Contradictions in the text were then noted within and between elements
The contradictions were numbered adjacent to the appropriate coded elements in the text. A brief explanation was provided of the nature of the contradiction. An excerpt from the managers' text is provided in Table 1 as means of illustration (*For exam purposes see Appendix B: An extract of Analysed Text – HIV/AIDS counsellors' focus group, pp. 21-22).*

Steps 3, & 4 were repeated and validated by an independent analyst.

Step 5: The contradictions were extracted from each text and grouped according to the elements involved in the contradiction (*For exam purposes see Appendices C & D, Manager contradictions and HIV/AIDS counsellor contradictions respectively).* Forty-four contradictions were identified in the

managers' focus group and forty in the counsellors' focus group. (*The analysed transcripts of the two focus groups are available from the researcher).*

Contradictions pertaining to similar issues were then linked. The extent to which contradictions arose with regard to each of these issues was noted. The findings of the manager's focus group were then compared to findings of the HIV/AIDS counsellor's focus group.

Transcript of Managers' focus group	Activity	Theory Elements	Contradictions & Comments
It is quite difficult to monitor X on a daily basis because she is far out in the location and when we go to the clinics we supervise a lot of things **How often do you get out to see your counsellors?**	Mrule 1	Managers to monitor HIV/AIDS counsellors' performance	Contradiction 23: Obj 1 & Mrule1.Distances between the hospital & clinics make monitoring of counsellors by managers difficult.
Maybe once or twice a month but it also depends on transport	Mdol 1 Mmtool 1	Managers see Counsellors in clinics 1-2 times per month Transport	Contradiction 24: Mdol 1 & Mmtool 1. Lack of transport limits number of times managers can see counsellors in the clinics

Key: Obj: 1 Object 1- Effective management of HIV/AIDS counsellors
Mrule 1 Rules pertaining to managers within Object 1
Mdol 1 Division of labour pertaining to managers within Object 1
Mmtool 1 Managers material tool pertaining to managers within Object 1

Table 1: Excerpt from managers' Focus group 26/6/2000, p. 11-12.

Step 6: Six questions, informed by the constitutive elements of an activity system, guided the interpretation of the contradictions that had emerged. The findings are presented and discussed in the next section in relation to these questions.

9. FINDINGS AND DISCUSSION

The findings will be discussed in answer to the 6 questions concerning the elements. However as elements do not exist in isolation some of the answers to the questions have been grouped together For this reason, contradictions that

involve the element *rules* pertaining to *division of labour* and *tools* will be included in the discussion on the latter. Similarly contradictions involving the element *community* will be discussed in the sections on division of labour.

9.1 Objects

Are managers and HIV/AIDS counsellors working towards the same object?

Having been through the SHCP training the managers identified their object as the effective management of HIV/AIDS counsellors. The HIV/AIDS counsellors identified their object as the effective HIV/AIDS counselling of clients and community interventions. These two objects, although different, are geared towards the same intended outcome, that of providing an effective HIV/AIDS related service to infected clients and the community.

During the focus group discussions, the managers stated that they appointed HIV/AIDS counsellors that they could trust and who had either previous counselling experience or an interest in counselling so that they (the managers) could rely on the counsellors to do the work with minimum supervision. The managers adopted this approach in an attempt to overcome the pressure of their multiplicity of roles, e.g. general management function and general nursing. This object was confirmed in the first reading of the managers' focus group text. This object, which was referred to as 'effective management within the Health System', conflicted with the responsibility that the managers had towards the counsellors and had the unintended outcome of the HIV/AIDS counsellors feeling unsupported by the managers (see 9.2.2 & 9.4.1).

The HIV/AIDS counsellors during their focus group expressed an understanding of the managers' diverse roles and whilst needing management and support, made allowances for the managers' inability to provide this support.

9.2 Tools

What constraints operate re material and conceptual tools?

In this section material tools, namely transport, and conceptual tools, namely emotions, will be discussed.

9.2.1 Material Tools: Transport The material tool that posed a major constraint in the management of HIV/AIDS counsellors was transport. Transport related contradictions are shown in Table 2).

Subjects	No.	Description of contradiction
HIV/AIDS Counsellor Contradictions	9	Due to transport problems often the results of the blood test are not back in time for the review date that has been given to the client. Counselling service is therefore seen as unreliable. Extra pressure for the Cs
	11	More pre-test counselling done than post-test counselling due to unreliability of transport bringing results back in time for review date with client
	13	Follow-ups to clients further complicated due to shortage of transport. Cs are forced to use mobile clinics and/or taxis when treatment needs to be administered to a client
	25	Lack of availability of transport prevents Cs from making the necessary visits to clients and their families
	30	Ms need to ensure that Cs get the required transport. This was possible when one of the Ms was in control of the transport. The M is no longer in charge and the M is no longer able to give the Cs the support with regards to obtaining transport.
	34	Lack of transport results in Ms only going out to clinics 1-2 a month which means no support for Cs
	37	Lack of transport for taking blood samples to Frere and Frontier Hospitals and for Cs to attend circumcision campaigns have resulted in the community losing trust in the Cs
	38	Procedures cannot be followed with clients because there is no transport and therefore clients will not want to come back for more procedures.
	39	Ms are aware of the transport problem but Cs think that they can do nothing about it
	40	Ms care about the transport problem that affects the Cs but it is ruled by other hospital members, Stores and the Transport Controller. Added to this is that the transport is always out of order
Manager Contradictions	9	Ms do not have the means to follow up with Cs
	10	Lack of transport, funds and distances are barriers to C performing their jobs. Follow ups not done as often as should be – Transport
	24	Lack of transport limits number of times Ms can see Cs in the clinics.

Table 2: Contradictions relating to transport

Transport in general is a problem within the Department of Health, Eastern Cape and not only at the hospital and clinics that formed part of this study. In an interview with an official from the Department it was ascertained that there is generally a lack of new vehicles and that repairs to existing vehicles are difficult to arrange as approval for their repair is a centralised and lengthy process. The official indicated that approximately 75% of the trips made with the vehicles are for administration related activities, such as attending meetings and training courses and not for providing services such as following up clients and visiting outlying clinics. Furthermore the transport officer who is in charge of allocating vehicles and organising their servicing and repairs is a member of the administration staff who generally has little understanding of the needs of the nursing staff

HIV/AIDS counsellors experience problems in the service they offer to the community due to lack of transport. Blood tests are often not back in time for the review date given to the client due to lack of transport and equipment (see HIV/AIDS counsellor contradictions 9, 11, 37). Follow up home visits and administration of treatment to clients and their families are compromised (see HIV/AIDS counsellor contradictions 13, 25, 38 & manager contradiction 10). HIV/AIDS counsellors involved in circumcision school interventions experience difficulties in attending circumcision campaigns. (see HIV/AIDS counsellor contradiction 37). As a result, members of the community have lost faith in the services provided by the HIV/AIDS counsellors as indicated in this quote from one of the HIV/AIDS counsellors, "I think the issue of transport is very much nerve wracking because we have lost trust from the community" (HIV/AIDS counsellor focus group 27/6/2000, p.24).

Part of a manager's function is to ensure that the staff they manage have the necessary resources which will enable them to effectively perform their jobs (Hellriegel, Jackson & Slocum 1999). Transport is crucial for the HIV/AIDS counsellors to successfully go about their jobs. Managers are aware of the

transport problems the HIV/AIDS counsellors are faced with, but they are unable to rectify the problem as the allocation of transport is with the stores controller and not under their control (see HIV/AIDS counsellor contradictions 30, 39 & 40). The stores controller would fall under the element of community in the activity system. This is supported by a comment made by an HIV/AIDS counsellor, "The managers know the problem... they do care but it's beyond their control because it's ruled by other hospital members" (HIV/AIDS counsellor focus group, 27/6/2000, p. 25).

The consequences of these transport related issues for the HIV/AIDS counsellors include that the counselling service offered to the community is seen as unreliable, trust in the counsellors is lost, and clients do not want to return for other procedures (see HIV/AIDS counsellor contradictions 13, 37, 38).

In addition to not been able to provide the HIV/AIDS counsellors with the transport to effectively carry out their jobs, managers are unable, due to lack of transport, to follow up regularly with the HIV/AIDS counsellors in the clinics. Managers try and resolve this contradiction by visiting the clinics at least once or twice a month (see manager contradictions 9, 24 & HIV/AIDS counsellor contradiction 34). What little support managers do offer however, is not seen by HIV/AIDS counsellors to be supportive. "In the clinics we have transport problems. Managers are unable to visit us. If they do, its once or twice a month so we have no support" (HIV/AIDS counsellor focus group 27/06/2000 p. 23).
As a way of trying to resolve this contradiction HIV/AIDS counsellors requested that meetings be arranged where they could share their experiences of counselling and the related problems with their managers and other HIV/AIDS counsellors. However due to the transport situation and the many different responsibilities that both managers and HIV/AIDS counsellors have (see 9.4.1) these meetings have never taken place.

9.2.2 Conceptual Tools: Emotions. Contradictions concerning HIV/AIDS counsellors' emotional feelings are reflected in Table 3.

Subjects	No.	Description of contradiction
HIV/AIDS Counsellor Contradictions	18	Cs have to tell clients when their results are positive but they are also faced with their own fears and how they will cope with the client's reaction
	19	Working with HIV/AIDS clients cause Cs to become fearful about their own and their partners' health
	20	Working with HIV/AIDS clients cause Cs to think & become fearful about whether they will be assaulted by the client
	29	Due to the nature of their work Cs experience difficult feelings prior to disclosing HIV status to clients and during the counselling session. They require support in the form of talking about the situation & feelings but Ms are not doing this.

Table 3: Contradictions relating to emotions

Emotional issues arise for the HIV/AIDS counsellors when having to disclose a client's positive HIV/AIDS status. Uncertainty as to how they will cope with the client's reactions and fear for their own physical safety (see HIV/AIDS counsellor contradictions 18, 20) are two of the areas the counsellors need to address. In addition to these fears, HIV/AIDS counsellors become anxious about their own and their partner's health when they become ill or start to cough more than usual (see HIV/AIDS counsellor contradiction 19). These findings confirm Irinoye's (1999) argument that due to the progressive nature and social perception of the disease, people with HIV/AIDS bring a wide range of intense emotional reactions to a counselling situation.

To overcome these contradictions the HIV/AIDS counsellors are of the opinion that the sharing of their experiences and feelings would be supportive.

> *"By support I mean, as counsellors as I said, when we actually do counselling, apart from how you feel before disclosing sad news to the client, you also have your own feelings about the situation. After the counselling session, when the client leaves, at least she has got a clear sense of direction as to what she is going to do next but your own feelings that were actually raised during the*

counselling sessions, you've got nobody to talk to. Just talking, not a session, someone you can talk to. That is the support I am referring to". (HIV/AIDS counsellors' focus group, 27/6/2000, p. 22).

These findings support the need to introduce supervision for the HIV/AIDS counsellors during which time is allocated to addressing the counsellor's own emotions and reactions that are evoked as a result of their work with a client (Feltham & Dryden, 1994).

It is interesting to note that it seems as if the managers have no awareness of the emotional needs of the HIV/AIDS counsellors. Other contradictions such as lack of transport (see 9.2.1) and the many different areas that they counsel in (see 9.4.2) were referred to by the managers during their focus group but no mention was made of the emotional support that the HIV/AIDS counsellors felt they needed.

This lack of awareness on the part of the managers may be attributed to the complaint that many counsellors have of their managers, that of neither having the time nor the ability to supervise them (Hawkins & Shohet, 1989). In order to be able to supervise counsellors, managers themselves need to be skilled counsellors. As the managers only received an overview of the counselling skills that the HIV/AIDS counsellors received they (the managers) would not be equipped to support the HIV/AIDS counsellors in this area. According to Hawkins & Shohet's (1989) description of supervision (see section 3) managers would not be in a position to fulfil the supportive aspect of supervision.

9.3 Rules

What rules operate and influence the relationship between the managers and the HIV/AIDS counsellors?

Clear rules govern the concept of confidentiality and the HIV/AIDS client for both

managers and HIV/AIDS counsellors. Contradictions relating to confidentiality and the stigma surrounding HIV/AIDS are presented in Table 4.

Subjects	No.	Description of contradiction
HIV/AIDS Counsellor Contradictions	14	Confidentiality around AIDS results in some of the family members not knowing the true diagnosis of the patient which puts C in a difficult position
Manager Contradictions	29	Part of Ms training on SHCP was to follow up & support Cs on all aspects of their jobs. Cs state that counselling is private and that Ms are not to sit in or know anything about the session
	31	Ms receive some reports but do not "care" much about them as they are seen to be private & counselling is between Cs and client. Concept of shared confidentiality?
	32	Between respecting clients' right to confidentiality and contributing to the stigma & silence surrounding HIV/AIDS

Table 4: Contradictions relating to confidentiality and the stigma surrounding HIV/AIDS

The managers' understanding of counselling is that it is 'private' and 'secret' activity, which needs to be kept between the counsellor and the client. One manager stated that "we are not watchdogs" (managers' focus group, 26/6/2000, p.13) This belief is reinforced by the HIV/AIDS counsellors, who do not allow the managers to sit in or know anything about the counselling or the client they are involved with (see manager contradiction 29). In addition the reports by the counsellors on their work are taken to be private and as a result managers are not very concerned with the reports (see manager contradiction, 31) as can be seen from this quote, "The counsellors say it's private. I am not supposed to sit in or know ....From her verbal reports, I think her counselling is good." (Managers' focus group, 26/6/2000, p. 13)

This stance, taken by both the managers and counsellors, which confuses privacy or secrecy and confidentiality places the counsellors in a powerful position and yet at the same time impacts negatively on the support managers could provide to the HIV/AIDS counsellors (Bor & Scher 1992). The HIV/AIDS counsellors are reinforcing the contradictions on the one hand by saying they

need support (see 9.2.2) and yet on the other withholding their experiences of counselling from the managers.

It is interesting to note that no mention was made by either the managers or the HIV/AIDS counsellors regarding the concept of shared confidentiality referred to by Siedel (1996) as the sharing of sensitive information with a select few. Confidentiality and the value of shared confidentiality was an integral part of SHCP training of the managers and HIV/AIDS counsellors and was further discussed during follow up visits to counsellors and managers at their sites of practice and at the workshops held within each district. Shared confidentiality would allow the HIV/AIDS counsellors to share their experiences of counselling with each other and their managers. This would be of benefit to the HIV/AIDS counsellors as they would be learning and gaining the support that they need (see 9.2.2) from each other.

Confidentiality was also referred to by the HIV/AIDS counsellors in relation to their clients and their families. Mention was made of the tension that exists between respecting clients' rights to confidentiality whilst further contributing to the stigma and silence surrounding HIV/AIDS (see managers'contradiction 32 & introduction). This puts the counsellor in a difficult position as very often family members of an HIV/AIDS positive person are unaware of the diagnosis due to the individual's fear of being personally rejected and socially ostracised (Herek, 1999). The role of the counsellor is to support and educate family members on how to care for a person with AIDS. The HIV/AIDS counsellor is unable to do so if the client does not want to disclose their status (see HIV/AIDS counsellor contradiction 14).

9.4 Division of Labour

In each activity system, how does the division of labour structure and create contradictions?

In this section the following areas will be discussed: - the multiple roles that both managers and HIV/AIDS counsellors have, the different areas in which the HIV/AIDS counsellors counsel, the management of HIV/AIDS counsellors and the collapse of boundaries between managers and the HIV/AIDS counsellors.

9.4.1 Multiplicity of roles: Managers and HIV/AIDS counsellors have many different roles and duties to perform. The contradictions that arise as a result of these varied commitments are laid out in Table 5.

Subjects	No.	Description of contradiction
HIV/AIDS Counsellor Contradictions	23	Cs are frustrated and experience many problems. Ms many different roles multicaps (SHCP metaphor) prevent an in-depth understanding of the Cs situation, problems & frustrations
	26	Ms have many commitments to attend to within specific timeframes which prevents them or limits the time they have available to sit with, listen to and go through reports with the Cs
	27	Due to Ms other commitments Ms not able to listen to & respond to Cs and not able to recall everything whilst conducting a follow-up
	31	Ms have many different duties that take away time available to spend with Cs
	32	Cs have many different roles (multicaps, metaphor ex SHCP) that take away time available to spend with Ms
	35	Ms are required to visit all the clinics and are therefore not able to provide the Cs with the necessary support.
Manager Contradictions	11	Ms having to perform many different roles which all compete for the Ms time.
	16	Ms need to have the time to provide support to Cs. Ms not able to due to time pressures and multiplicity of roles
	22	Ms are not having regular meetings with their Cs

Table 5: Contradictions relating to the multiplicity of roles of both managers & HIV/AIDS counsellors

Managers are both managers to the HIV/AIDS counsellors and other hospital and clinic staff and professional nurses. These different commitments are the source of much frustration to the HIV/AIDS counsellors. The time the managers have available for the HIV/ADS counsellors is therefore limited (see HIV/AIDS counsellor contradictions 26, 31, 32 & manager contradictions 11, 16). The lack of time prevents the managers from having an in-depth understanding of the HIV/AIDS counsellors' situation, leading to problems and frustrations (see HIV/AIDS counsellor contradictions 23, 26). As a result the HIV/AIDS counsellors feel that even when the managers are with them they do not really hear and

understand them and are unable at a later stage to recall what was discussed (see HIV/AIDS counsellor contradiction 27). This was verbalised by one of the HIV/AIDS counsellors "You sometimes wonder if she is really listening and responding the way you wanted her to and you find when doing a follow up, she cannot recall everything" (HIV/AIDS counsellors focus group 26/6/00, p.22).

This problem is further complicated by the many different roles that the HIV/AIDS counsellors have in addition to counselling which takes away from the time they have available to spend with the managers (see HIV/AIDS counsellors' contradiction 32)

As with the transport situation, the HIV/AIDS counsellors are aware of the demands placed on their managers (see 9.2.1) and are understanding of why the managers are not providing them with the support they need.

> *"Sometimes you find that there is almost no time for that, not because she wouldn't like to listen to you but because she has other commitments (HIV/AIDS Counsellors' focus group, 27/6/2000, p.21*

> *"whew, the multicaps (multiple roles) .... They are having a busy image but they can't help that, its because their involvement in their roles are so extensive" (HIV/AIDS counsellors focus group 26/6/00, p.10).*

The managers in turn are aware that due to their other commitments they do not have the time to provide the HIV/AIDS counsellors with the support they need. One of the managers said the following "There is not enough time to sit down and give support.....I feel we really need to make some time and sit with them" (Managers' focus group 26/6/00, p.10).

9.4.2 Counselling Areas: Counsellors were trained on the SHCP to counsel HIV/AIDS and sexual health related issues. Contradictions arose in this

area as the community have many other problem areas that require counselling. These contradictions are reflected in Table 6.

Subjects	No.	Description of contradiction
HIV/AIDS Counsellor Contradictions	1	Cs were trained on the SHCP to counsel in the Sexual Health Area & not over all areas that they are currently involved in.
	3	Cs are often not aware that they will be counselling until after or during history taking. Clients come in for one problem and it turns out that they need counselling
	4	Cs were trained on the SHCP to counsel in the Sexual Health Area & not over all areas that they are currently involved in.
	5	Cs were trained on the SHCP to counsel in the Sexual Health Area & not over all areas that they are currently involved in.
	15	In health education the C takes the role of an expert and tells people what to do. In counselling the C involves the person eliciting their thoughts, fears resources, ideas etc
	16	Cs are involved in 2 practices that require very different skills In health education the C takes the role of an expert and tells people what to do. In counselling the C involves the person eliciting their thoughts, fears resources, ideas etc
	42	Cs were trained to counsel in the area of sexual health & HIV/AIDS but are counselling across a broad range of areas
Manager Contradictions	5	Cs was trained to counsel around HIV/AIDS, whereas the community has many different problems, which require C to counsel in many varied areas.
	33	Cs were trained to counsel in Sexual health related issues

Table 6: Contradictions relating to the activity of counselling

In addition to counselling HIV/AIDS clients and their families, counsellors are involved in areas such as family counselling, rape, sexual abuse, chronic diseases, homosexuality, STDs, terminal illness, circumcision, finances, marriage counselling, pre-retirement counselling, social problems, bereavement, oncology and domestic violence (see managers' contradictions 5, 33 & HIV/AIDS counsellors' contradictions1, 4, 5, 42).

Although the training on the SHCP focused on HIV/AIDS, the counselling skills covered were generic and therefore transferable to different situations that require counselling. This would mean that the HIV/AIDS counsellors would be more than adequately equipped to cope with these different situations. However it must be remembered that HIV/AIDS counsellors have to deal with very intense and diverse emotional reactions in their clients (Irinoye, 1999). Additional

counselling therefore may add to their already heightened emotions resulting from dealing with HIV/AIDS clients (see 9.2.2) and feelings of being unsupported by their managers (see 9.4.1)

9.4.3 Management of HIV/AIDS counsellors: The managers were equipped by the training of the SHCP to select, manage, follow up and support the HIV/AIDS counsellors. The contradictions that arose in this area are presented in Table 7.

Subjects	No.	Description of contradiction
Manager Contradictions	6	Ms to meet with Cs on a regular basis but they are not.
	7	M should meet with C on a regular basis & not only when there are problems
	17	Ms to provide support to Cs but Cs decide if they need it.
	18	Ms are not having regular meeting with Cs
	19	Cs using different consent forms
	21	Ms are not having regular meetings with their Cs
	22	Ms too busy to manage day to day performance of Cs
	23	Distances between the hospital & clinics make monitoring of Cs by Ms difficult
	26	Ms prior knowledge that the C can handle everything, means that C won't need management if M is not around
	27	Can it be assumed that because a M has prior knowledge of a C and that no problems are reported by the C to the M that the C does not have any problems?
	30	Inconsistency in records given to Ms. Combination of written & verbal.

Table 7: Contradictions relating to management of HIV/AIDS counsellors

Lack of transport (see Material Tools: Transport), the geographic distance between the hospital and the outlying clinics (see managers' contradiction 23) and the multiple nature of the managers' jobs (see 9.4.1) severely restrict managers from effectively managing the HIV/AIDS counsellors.

One of the rules that was intended to guide managers in their management of the HIV/AIDS counsellors was that they were to meet with the HIV/AIDS counsellors on a regular basis. A contradiction arose around this area as regular meetings do

not occur (see managers' contradictions 6, 7, 18, 21). "Although we did meet at times, it wasn't regular" (Managers counsellor group, 26/6/2000, p. 11)

Managers made it clear in their focus group that they are far to busy (see 9.4.1) to manage the performance of their HIV/AIDS counsellors. This was further complicated by the distances between the hospital and the clinics (see managers' contradictions 22, 23).

> *" It is quite difficult to monitor on a daily basis because she is far out in the location but then when we go to the clinics, we supervise a lot of things (Managers' focus group, 26/6/2000, p. 11)*

The managers were proactive in trying to resolve this contradiction by ensuring that during the selection process, they selected HIV/AIDS counsellors that they had prior knowledge of and who were capable of working without much managerial support (See Contradictions Ms 26).

> *" When I did selection, knowing that I am busy I made sure I selected someone who can stand on their own…..is capable and can handle everything" (Managers' focus group, 26/6/2000, p. 12)*

Support was provided by managers when specifically requested by the HIV/AIDS counsellors (see manager contradiction 17). However the question needs to be asked that if no problems were reported to the managers can it be assumed that the HIV/AIDS counsellors do not have any problems?

A further area of concern that points to a lack of effective management is the inconsistency in the HIV/AIDS counsellors' record keeping. Different consent forms are being used (see manager contradiction 19) and whilst some HIV/AIDS counsellors submit written reports to their managers, others merely provide verbal reports and some, a combination of both written and verbal (see managers' contradiction 30). These inconsistencies may be indicative in the

breaking down of bureaucracy in which there are specified rules to be followed (Smit & Cronje, 1992 & Hellriegel, Jackson & Slocum, 1999).

9.4.4 Collapse of Boundaries: In addition to their job as managers, the managers become involved with the counselling of clients and in community interventions. These contradictions are reflected in Table 8.

Subjects	No.	Description of contradiction
Manager Contradictions	3	M to manage & provide support to C & not to do the counselling themselves.
	4	Ms to manage Cs & not to substitute for Cs when on leave
	20	Ms take over client & offer counselling
	34	Both Ms & Cs do the task of engaging with the Youth Group together. Collapse of boundaries between Ms & Cs
	41	Ms active in community projects. Boundaries between Ms & Cs collapsed.

Table 8: Contradictions relating to the collapse of boundaries between managers and HIV/AIDS counsellors.

The boundary between managers' and HIV/AIDS counsellors' responsibilities collapses in two areas. There are times when a manager will take over the counselling role from an HIV/AIDS counsellor. This occurs, for example, when an HIV/AIDS counsellor has a problem with following-up on a client, when the HIV/AIDS counsellor is on leave or when the HIV/AIDS counsellor is under pressure and has many patients (see manager contradictions 3, 4, 20).

Managers also play an active role in community projects by assisting HIV/AIDS counsellors or the community directly by attending meetings, planning, drawing up proposals, training and encouraging different groups to network (see manager contradictions 34, 41).

These actions of the managers are another way in which managers try and resolve the contradictions. Their actions may be seen to be supportive of the

HIV/AIDS counsellor, the clients, and the community, but may add to the already existing pressure that managers are under (see 9.4.1).

According to the training of the SHCP and the reporting structure of the Department of Health, the roles of management and HIV/AIDS counsellor are seen as separate. Seen in this way the boundaries between the managers and the HIV/AIDS counsellors are experienced as fixed. In working towards the outcome of providing effective services to HIV/AIDS clients, their families and the community, there has been a collapse of boundaries between managers and HIV/AIDS counsellors.

This collapse of boundaries is not compatible with the existing organisational structure within the Department of Health, that can be described according to Burns & Stalker (1961 & 1994) as mechanistic, and based on the bureaucratic theory of management with strict levels of authority within a hierarchical reporting structure (Smit & Cronje, 1992 & Hellriegel, Jackson & Slocum, 1999).

However, due to the nature of the HIV/AIDS pandemic, the lack of resources, e.g. transport and time, and the fact that managers have the skills and a compassion for helping others, the collapse of the boundaries may be viewed as constructive. The contingency theory of management in which the requirements of the external environment and the capabilities of the staff are taken into consideration would be a more appropriate approach in managing HIV/AIDS counsellors. Working in this way would assist managers and HIV/AIDS counsellors in addressing the needs of the community they are serving.

9.5 Outcomes

What are the Outcomes?

Several outcomes, namely, a change in management style, a request for additional counsellors and the need for a support system for HIV/AIDS counsellors were highlighted through the focus groups.

9.5.1 Change in Management Style: Although there has not been a change in management style when working with the HIV/AIDS counsellors, there has been a change in how managers work with other staff and the community. Contradictions relating to these changes are reflected in Table 9.

Subjects	No.	Description of contradiction
Manager Contradictions	38	Autocratic versus participatory management styles. This contradiction is situation dependant & therefore appropriate
	39	Ms are now expecting staff to come up with possible solutions to their problems. Staff specifically come to Ms because they do not know what to do
	40	Ms no longer just giving advice, they are sitting down together with staff and talking
	42	Community expected Ms to provide them with information but the Ms wanted to hear about their ideas in addition to sharing theirs.
	43	Previously Ms had the belief that they knew how things should be done. Staff also have/had this expectation. This has changed to Ms realising that sharing information & joint problem solving is more appropriate
	44	It would appear that the staff other than the counsellors have benefited more from this change in management style. Ms tend to leave Cs alone except if the Cs tell them of any specific problem

Table 9: Contradictions relating to change in management style

There is evidence from the reports of the managers that since the SHCP their style of managing has changed from being autocratic to being more participatory. Managers believed previously that they knew how things should be done which is in line with a bureaucratic way of thinking. Managers have realised that sharing information and joint problem solving is more appropriate and therefore are no longer giving advice but are sitting down with staff and discussing issues. Managers are now expecting staff to come up with possible solutions to their problems (see manager contradictions 38,39, 40, 43).

> "Although I am not saying I don't become autocratic at times. There are times when you feel things have to be done your way but at times we sit down and discuss things together. I think there is a shift....We know now what to do. It's difficult sometimes because people come to you with a problem, when you ask them for possible solutions to it they will tell you the reason they come to you it's

because they don't know what to do. They expect you to solve it" (Managers' focus group, 26/6/2000, pp 16 –17)

The managers attribute this change to the transformation of the health services and the various courses that they have attended, including the SHCP.
In addition to a change in management style with general staff, managers have also transferred these new skills beyond the hospital and clinic settings to working with the community. The bureaucratic system of management does not allow for creativity and individual thinking (Smit & Cronje, 1992 & Hellriegel, Jackson & Slocum, 1999).

The aim of the Management Support Course of the SHCP was that the managers would make use of these concepts when dealing with the counsellors. However it would appear that the staff other than the counsellors have benefited more from this change in management style, with the managers tending to leave the counsellors alone unless the counsellors tell them of any specific problem (see manager contradiction 44).

9.5.2 Need for more counsellors: Counsellors have recognised the need for more counsellors to meet the demand from the community.

" I think if many counsellors can be trained outside for example, pensioner teachers could be trained as counsellors, village health workers and some teachers in the neighbouring schools. ....People with standing. Some of them were education inspectors and are still energetic" (HIV/AIDS counsellor focus group, 27/6/2000, p. 26).

9.5.3 Support for HIV/AIDS counsellors:
The HIV/AIDS counsellors would like support from their managers and proposed three different kinds of meetings to address these needs:

- Each counsellor to meet with his/her individual manager
- Counsellors to meet with other counsellors
- All counsellors and managers to meet together.

Managers are in agreement that they need to make the time for monthly meetings with the counsellors. No mention however, was made by the managers of meeting individually with their counsellors or that the counsellors should get together on their own. Two constraints in making these meetings a reality are transport and time.

10. CONCLUSION AND RECOMMENDATIONS

The contradictions identified in the study have less to do with the managers and HIV/AIDS counsellors personally and more to do with the resources, system and the context. The challenges that the managers of HIV/AIDS counsellors experience may be attributed to:

- A lack of available transport, which has a negative impact on the services that HIV/AIDS counsellors offer to their clients and the community. In addition managers are unable to meet with HIV/AIDS counsellors on a regular basis to provide them with the support that they need.
- The complex nature of HIV/AIDS, which due to its very nature of progressive human suffering and impending death, arouses diverse emotional reactions in clients. HIV/AIDS counsellors may become emotionally affected by clients' distress and pain.
- The viewing of confidentiality as something secret and private, which prevents HIV/AIDS counsellors from sharing their experiences of counselling with managers and gaining the support they need.
- The many different roles managers have to perform, which reduces the time they have available to spend following up and supporting HIV/AIDS counsellors .

- The extent of the needs that the community has that require counselling which is vast may add to the counsellors already heightened emotions from dealing with HIV/AIDS clients.
- A collapse of boundaries between managers and HIV/AIDS counsellors wherein managers become involved in counselling and community interventions. This is challenging to the bureaucratic nature of the hospitals and clinics.

The managers being aware of some these challenges tried to resolve these contradictions by selecting competent HIV/AIDS counsellors they would not have to manage. Even though the HIV/AIDS counsellors have an understanding of the managers' situation and make allowances for them they main outcome of the study was that the HIV/AIDS counsellors do not feel supported by their managers and are of the opinion that they are in need of support.

Given the situation regarding transport, the geographic distance between the hospital and clinics and the demands placed on the managers time, the supervision of counsellors by managers within the current system is not sustainable. Ways in which affordable and appropriate ongoing professional and personal support can be provided to HIV/AIDS counselors is through peer-group supervision and self-supervision. Peer group supervision is a way of overcoming these issues whilst at the same time providing counsellors with the support they require. Self-supervision allows a counsellor to assess and make changes in the way they work or to seek supervision on specific areas of their work.

The application of Engeström's (1987) model of activity theory in this study has brought to the fore, the nature of some of the contradictions and tensions in managing HIV/AIDS counsellors in a rural district of the Eastern Cape. The activity of the focus groups provided the managers and HIV/AIDS counsellors with an opportunity to have conversations during which they gained knowledge about one another. This knowledge may empower them to change their actions, which may lead to the resolution of contradictions and to the transformation of

the activity systems. Using activity theory in this way the study itself can be said to be an intervention rather than an investigation.

REFERENCES

Akhurst, J.E. (2000). *Peer group supervision as an adjunct to individual supervision: An Investigation of Models of Learning.* Ph.D. thesis, Grahamstown, Rhodes University.

Balmer, D.H. (1992). The aims of HIV/AIDS counselling revisited. *Counselling Psychology Quarterly*, 5 (2), pp.204-213.

Boje, D. (1999). *Five centuries of mechanistic-organic debate.* Available from http://cbae.nmsu.edu/~dboje/betwee.html [Accessed 12 December 2001].

Bor, R. & Scher, I. (1992). Supervising professionals involved in the psychological care of people infected with HIV/AIDS. *Counselling Psychology Quarterly*, 5 (1), pp.95-110.

Burns, T. & Stalker, G. M. (1961). *The management of innovation.* London, Tavistock.

Burns, T. & Stalker, G. M. (1994). *The management of innovation.* Oxford, Oxford University Press.

Centre for Activity Theory and Development Work Research, (1998). *The activity system.* Available from http://www.helsinki.fi/~jengestr/activity/6b0.html [Accessed 6 October, 2000].

Department of Health (2001). *National HIV and Syphillis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa (2000).* Pretoria, Department of Health.

Engeström, Y. (1987). *Learning by expanding: an activity-theoretical approach to developmental research.* Helsinki: Orienta-Konsultit.

Engeström, Y. (1993). Developmental Studies of work as a testbench of activity theory: the case of primary health care medical practice. In: Chaklin, S. & Lave, J. eds. *Understanding practice: perspectives on activity and context* . Canada, Cambridge University Press, pp.64-103

Engeström, Y., & Miettinen, R. (1999). Introduction. In: Engeström, Y. Miettinen, R. & Punamaki, R. L.. eds. *Perspectives on activity theory.* Cambridge, Cambridge University Press, pp. 1-16.

Evian, C. (2000). Counselling. In: *Primary Aids Care.* Durban, Jacana Education.

Fawcett, C. (2001). HIV counselling: it's more than one-on-one. *AIDS Bulletin,* 10 (2) July, pp.22-26.

Feltham, C. & Dryden, W. (1994). *Developing counsellor supervision.* London, Sage.

Freeman, M. & Pillay, Y. (1997). Mental health policy – plans and funding. In: Foster, D. Freeman, M. & Pillay, Y. eds. *Mental health policy Issues for South Africa.* Cape,Town, MASA, pp.32-53.

Gerber, B. (1999). *An analysis of the possible shifts in managers' understanding of the activities and attributes involved in the managing of counsellors.* Unpublished Honours project. East London, Rhodes University.

Gilbert, A. (1998). *Proposal for the establishment of an HIV/AIDS and STD lay counselling project.* Unpublished Sexual Health Counselling Project documentation. East London, Rhodes University.

Gilbert, A. & Rankin, J. (2000). Changing the social practices of public health counsellors in the Eastern Cape: tensions uncertainties and achievements. In: *Proceedings of the XIIIth International AIDS Conference*. Bologna, Monduzzi Editore.

Gomersall, J. (1997). Peer group supervision. In: Shipton, G. ed. *Supervision of Psychotherapy and Counselling: Making a Place to Think.* Buckingham, Open University Press, pp.107-118.

Hawkins, P. & Shohet, R. (1989). *Supervision in the helping professions.* Buckingham, Open University Press.

Hellriegel, D., Jackson, S. E. & Slocum, J. W. Jr. (1999). *Management* (8th ed.) Cincinnati, South Western College Publishing.

Herek, G. M. (1999). AIDS and stigma. *American Behavioral Scientist* 42 (7), pp. 1106-1116.

Ironye, O. (1999). Counselling people affected by HIV and AIDS. In: Orubuloye, I. O., Caldwell, J. C. & Ntozi, J. P. M. eds. *The continuing HIV/AIDS epidemic in Africa: responses and coping strategies.* Canberra, Health Transition Centre, The Australian National University.

Jonassen, D. H., & Rohrer-Murphy, L. (1999). Activity Theory as a Framework for Designing Constructivist Learning Environments. *ETR&D,* 47(1), pp.61-79.

Lewis, J. A., Lewis, M. D. & Souflee, F. Jr. (1991). *Management of Human Service Programs.* Pacific Grove, Brooks/Cole Publishing Company.

Petersen, I., Parekh, A., Bhagwanjee,A., Gibson, K., Giles, C. & Swartz, L. (1997). Community mental health care: ensuring community participation. In: Foster, D. Freeman, M. & Pillay, Y. eds. *Mental Health Policy Issues for South Africa.* Cape Town, MASA.

Rankin, J. & Gilbert, A. (2000). "Umhlangabenzi mncedisi woluntu": challenging traditional notions of counselling. In: *Proceedings of the XIIIth International AIDS Conference*. Bologna, Monduzzi Editore.

Robson, C. (1993). *Real world research. A resource for social scientists and practioner-researchers.* Cambridge, Blackwell.

Seeley,J. & Wagner, U. (1991). The development of a community-based HIV/AIDS counselling service in a rural area in Uganda. *AIDS Care,* 3, pp.207-217.

Siedel, G. (1996). Confidentiality and HIV status in Kwazulu-Natal, South Africa: implications, resistances and challenges. *Health Policy and Planning,* 11 (4), pp.418-427.

Smit, P. J., de J Cronje, G. J (1992). *Management principles. A contemporary South African Edition.* Kenwyn, Juta & Co, Ltd.

South Africa Population Census (1996). *Eastern Cape.* Available from http://www.ststssa.gov.za/RelatedInverseSites/census96/HTML/press/Part009.html [Accessed 30 January 2002].

Stannard, L. (2001). *The HIV epidemic in South Africa.* Available from http:www.uct.ac.za/depts/mmi/jmoodie/anco.html [Accessed 9 October 2001].

Stewart, D. W. & Shamdasani, P. N. (1990). *Focus groups: theory and practice.* Newbury Park, Sage.

Uys, L. R. (2000). Confidentiality and HIV/AIDS in South Africa. *Nursing Ethics,* 7 (2) March, pp.158-166.

Vygotsky, L. (1978). *Mind in society: the development of higher psychological processes.* (M. Cole, V. John-Steiner, S. Scribner, & E. Souberman, Trans.) Cambridge, Harvard University Press.

Wertsch, J. V. (1995). The need for action in sociocultural research. In: Wertsch, J. V., del Rio, P. & Alvarez, A. eds. *Sociocultural studies of the mind.* Cambridge, Cambridge University Press. pp.56-73.

Wertsch, J. V., del Rio, P. & Alvarez, A. (1995).Sociocultural studies: history, action and mediation. In: Wertsch, J. V., del Rio, P. & Alvarez, A. eds. *Sociocultural studies of the mind.* Cambridge, Cambridge University Press. pp.1-34.

Appendix A: Key of Data Analysis Codes

Subjects:	Ms	Managers
	Cs	HIV/AIDS counsellors
Objects:	Obj 1	Effective management of HIV/AIDS counsellors
	Obj 2	Effective management within the Health System
	Obj 3	Effective HIV/AIDS counselling of clients and community interventions
Outcomes:	Out.	Intended and unintended results/outcomes
Tools:	ctool 2/3	Conceptual tool pertaining to either Object 2 or 3
	mtool 2/3	Material tool pertaining to either Goal 2 or 3
	Mctool 1	Managers'conceptual tool pertaining to managers in Obj 1
	Mmtool 1	Managers' material tool pertaining to managers in Obj 1
	Cctool 1	Counsellors' conceptual tool pertaining to counsellors in Obj 1
	Cmtool 1	Counsellors' material tool pertaining to counsellors in Obj 1
	ctool 1	Conceptual tool relating to both Ms and Cs in Obj 1
	mtool 1	Material tool relating to both Ms and Cs in Obj 1
Rules:	Rule 2/3	Rule relating to either Obj 2 or 3
	Mrule 1	Rule pertaining to managers in Obj 1
	Crule 1	Rule pertaining to counsellors in Obj 1
	Rule 1	Rule pertaining to both managers & counsellors in Obj 1
Community:	Com	The wider community that has an influence and/or a relationship with the subjects (managers & counsellors)
Division of Labour:	Dol 2/3	Division of labour pertaining to either Obj 2 or 3
	Mdol 1	Division of labour pertaining to managers in Obj 1
	Cdol 1	Division of labour pertaining to counsellors in Obj 1

Appendix B: An extract of Analysed Text – HIV/AIDS counsellors' Focus Group, pp. 21-22

TRANSCRIPT OF HIV/AIDS COUNSELLORS' FOCUS GROUP (meeting held on 27th June 2000)	ACTIVITY THEORY ELEMENTS		CONTRADICTIONS & COMMENTS
I want to speak to you now about the SHP trained managers, your counselling managers. What involvement do your managers have in your work? Whew	Cctool 1	Loaded exclamation	Contradiction 23: Obj 1 & Dol 2
C: the multicaps, because I don't want to totalise them. As a frustrated counsellor with the problems I have, I would say they are having a busy image but they can't help that, it's because their involvement in their roles are so extensive. At times even you feel you would like to take her to the situation so that she witnesses you can't.	Cctool 1 Cctool 1/ emotion Dol 2	Multicaps Frustration Ms are involved with many different roles	Cs are frustrated and experience many problems. Ms many different roles (multicaps SHCP metaphor) prevent an in-depth understanding of the Cs situation, problems & frustrations
What do you mean take her to the situation so that she can come and sit while you counsel, to watch you counsel?			
C: Sometimes the client needs to be nursed at home. There is a need for you to go there regularly. You go there not to counsel the patient but to visit the family so that she (manager?) sees and have a look at the situation (no one knows she is HIV positive) you are talking about and see how the family is treating the patient. This needs you to frequent there because when you frequent one place that is sometimes easily interpreted as loafing.	Dol 3 Mctool 1	Cs conduct house visits to see both patient and family Interpretation	Contradiction 24: Dol 3 & Mctool 1 Cs need to make frequent visits to certain patients & their families & is at times misinterpreted by Ms as they are not fully aware of the situation
C:There is also the transport problem. You cannot afford to dig into your pockets every time. We need the hospital transport, which is not always available. At times you even doubt if she has understood the report, the phone needs her, there's that, she's supposed to go there.	mtool 3 mtool 3 CcTool 1 Mctool 1 Mctool 1	Unavailability of transport Money Doubting Lack of Understanding Distractions	Contradiction 25: mtool 3 & Dol 3 Lack of availability of transport prevents Cs from making the necessary visits to clients and their families
C: one other problem I would say, with managers, hey, in fact exactly as she is saying. You know, sometimes when you are involved in counselling or engaged in a project, you need time to sit down and give report and get support in a way. Sometimes you find that there is almost no time for that not because she wouldn't like to listen to you but because she's got other commitments she has to attend to at a specified time. That is really a problem or even if you have time to finally sit, it can only be for ten minutes because she has to attend to something else.	Mrule 1 Mctool 1 Dol 2	Ms to support Cs by meeting with them and going through their reports Lack of listening Ms attend to many comittments within specific time frames	Contradiction 26: Mrule 1 & Dol 2 Ms have many commitments to attend to within specific timeframes which prevents them from or limits the time they have available to sit with, to listen to and go through reports with the Cs
This does not give you a chance to present the problem the way you would have loved to and you sometimes wonder if she is really	Mrule 1	Ms to listen to and respond to Cs issues	Contradiction 27: Mrule 1 & Dol 2 Due to Ms other commitments Ms not

listening and responding the way you wanted her to and you find that when doing a follow up, she cannot recall everything. It was once suggested that counselling needed to be broadened to include other categories of workers. I think that is important because for example the person who is controlling transport at the hospital is not a nurse, is a clerk. At some stage with the circumcision programme that we are doing, our constituency mainly is on the traditional functions. There are traditional functions when boys are going to be circumcised; it's where you find a broader audience. They think that we want to go to all these traditional functions because we want meat, it's as if we go there for enjoyment. They don't have insight in the whole process. **You were saying you would like more support. What do you mean by support?** **C:** By support I mean, as counsellors as I said, when we actually do counselling, apart from how you feel before disclosing sad news to the client, you also have your own feelings about the situation. After the counselling session, when the client leaves, at least she's got a clear sense of direction as to what she is going to do next but your own feelings that were actually raised during the counselling sessions, you've got nobody to talk to. Just talking not a session, someone you can talk to. That is the support I am referring to.	Mctool 1 & Out Dol 1 Cctool 1 Dol 3 Com Com ctool ctool 3/ emotion ctool 3/ emotion Mrule 1	Lack of listening Lack of responses Lack of recall Cs suggested that counselling be broadened to other categories of workers Thinking Cs attend traditional functions General staff Lack of insight Feelings before disclosing sad news to client Feelings left with after counselling Ms to support	able to listen to & respond to Cs and not able to recall everything whilst conducting a follow-up <u>Contradiction 28:</u> Dol 3 & Com (General staff) Part of the Male Cs job is to attend traditional functions around circumcision. Lack of insight of the whole circumcision process by general staff lead them to think that Cs are attending purely for their enjoyment <u>Contradiction 29:</u> Mrule 1 & ctool 3. Due to the nature of their work Cs experience difficult feelings prior to disclosing HIV status to clients, during and after the counselling session. They require support in the form of talking about the situation & feelings but Ms are not doing this.

Appendix C: Manager Contradictions

Also see Appendix 1: Key of Data Analysis Codes

Mmtool 1-Obj 1: 9, 24
Contradiction 9: Ms do not have the means to follow up with Cs.
Contradiction 24: Lack of transport limits number of times Ms can see Cs in the clinics.
Mctool 1-Obj 1: 26, 27
Contradiction 26: Ms prior knowledge that the C can handle everything, means that C won't need management if M is not around
Contradiction 27: Can it be assumed that because a M has prior knowledge of a C and that no problems are reported by the C to the M that the C does not have any problems ?
mTool 3 & Obj 3: 10
Contradiction 10: lack of transport, funds and distances are barriers to C performing their jobs
Follow ups not done as often as should be – Transport
Rule 2- mtool 3: 36, 37
Contradiction 36: Cs room used for counselling and managing. Shortage of space-3 counsellors share the space.
Contradiction 37: Unavailability of transport prevents Ms & Staff getting together to jointly solve problems
Rule 3-mtool 3: 14,
Contradiction 14: Cs need to counsel in private but 3 counsellors have to share 1 room in the hospital
Rule 3-Mctool 1: 15
Contradiction 15: M assumes C has privacy when away from hospital
Rule 1: 20
Contradiction 20: Ms take over client & offer counselling
Rule 2: 1, 38, 39, 40, 43
Contradiction 1: Being a CPN does not always mean one is a manager
Contradiction 38: Autocratic versus participatory management styles. This contradiction is situation dependent & therefore appropriate.
Contradiction 39: Ms are now expecting staff to come up with possible solutions to their problems. Staff specifically come to Ms because they do not know what to do
Contradiction 40: Ms no longer just giving advice, they are sitting down together with staff and talking
Contradiction 43: Previously Ms had the belief that they knew how things should be done. Staff also have/had this expectation. This has changed to Ms realising that sharing information & joint problem solving is more appropriate
Rule 3: 31
Contradiction 31: Ms receive some reports but do not "care" much about them as they are seen to be private & counselling is between Cs and client. Concept of shared confidentiality?
Mrule 1 - Obj 3: 6
Contradiction 6: Ms to meet with Cs on a regular basis but they are not.
Mrule 1 - Rule 2: 13
Contradiction 13: Ms ensure priority given to counselling but this requires other staff taking on tasks.
Mrule 1-Rule 3: 29
Contradiction 29: Part of Ms training on SHCP was to follow up & support Cs on all aspects of their jobs. Cs state that counselling is private and that Ms are not to sit in or know anything about the session
Mrule 1-Obj 1: 18, 21, 22, 23
Contradiction 18: Ms are not having regular meeting with Cs
Contradiction 21: Ms are not having regular meetings with their Cs
Contradiction 22: Ms too busy to manage day to day performance of Cs

Contradiction 23 Distances between the hospital & clinics make monitoring of Cs by Ms difficult
Rule 3-Cdol 1: 30
Contradiction 30: Inconsistency in records given to Ms. Combination of written & verbal.
Mrule 1- Mdol 1: 2, 3, 4, 8
Contradiction 2: C in OPD is both a C & a M
Contradiction 3: M to manage & provide support to C & not to do the counselling themselves.
Contradiction 4: Ms to manage Cs & not to substitute for Cs when on leave
Contradiction 8: Follow up is an important function of management
Mrule 1-Dol 2: 16, 25,
Contradiction 16: Ms need to have the time to provide support to Cs. Ms not able to due to time pressures and multiplicity of roles
Contradiction 25: Management not possible if Ms & Cs are not on overlapping shifts
Mrule 1-Cdol 1: 17
Contradiction 17: Ms to provide support to Cs but Cs decide if they need it.
Crule 1-Dol 3: 19
Contradiction 19: Cs using different consent forms
Com-Obj 3: 5, 35
Contradiction 5: Cs were trained to counsel only about HIV/AIDS, whereas the community has many different problems which require C to counsel in many varied areas.
Contradiction 35: Different people out there training. How do they interact with those trained on the SHCP?
Com-Dol 3: 28, 33
Contradiction 28: Clients not wanting to be tested seen as a problem by Cs
Contradiction 33: Cs were trained to counsel only in Sexual health related issues
Com-mdol 3: 42
Contradiction 42:
Community expected Ms to provide them with information but the Ms wanted to hear about their ideas in addition to sharing theirs.
Mdol 1 - Obj 1: 7
Contradiction 7: M should meet with C on a regular basis & not only when there are problems
Dol 1-Obj 1: 34, 41
Contradiction 34: Both Ms & Cs do the task of engaging with the Youth Group together. Collapse of boundaries between Ms & Cs
Contradiction 41: Ms active in community projects. Boundaries between Ms & Cs collapsed.
Dol 2 - Obj 1: 11
Contradiction 11: Ms having to perform many different roles which all compete for the Ms time.
Dol 3 Obj 3: 12, 32
Contradiction 12: Cs having to perform many different roles which all compete for the Cs time
Contradiction 32: Conflict between respecting clients right to confidentiality and contributing to the stigma & silence surrounding HIV/AIDS
Obj 1-Obj 2: 44
Contradiction 44: It would appear that the staff other than the counsellors have benefited more from this change in management style. Ms tend to leave Cs alone except if the Cs tell them of any specific problem

Appendix D: HIV/AIDS Counsellor Contradictions

Also see Appendix 1: Key of Data Analysis Codes

mtool 3-Obj 3: 8, 9, 10
Contradiction 8; Blood cannot be tested at the hospital due to lack of lab equipment.
Contradiction 9: Due to transport problems often the results of the blood test are not back in time for the review date that has been given to the client. Counselling service is therefore seen as unreliable. Extra pressure for the Cs
Contradiction 10: As for Contradiction 9 but the situation is worse at the clinics.
Mctool 1-Cctool 1: 39
Contradiction 39: Ms are aware of the transport problem but Cs think that they can do nothing about it
Rule 3-mtool 3: 12, 13
Contradiction 12: Cs are not able to carry out the required follow-ups with clients because of the geographical area and distance clients live from the hospital & clinics
Contradiction 13: Follow-ups to clients further complicated due to shortage of transport. Cs are forced to use mobile clinics and/or taxis when treatment needs to be administered to a client
Rule 3-ctool 3: 18
Contradiction 18: Cs have to tell clients when their results are positive but they are also faced with their own fears and how they will cope with the client's reaction
Mrule 1-ctool 3: 30
Contradiction 30: Ms need to ensure that Cs get the required transport. This was possible when one of the Ms was in control of the transport. The M is no longer in charge and the M is no longer able to give the Cs the support with regards to obtaining transport.
Mrule 1-Mmtool 1: 34
Contradiction 34: Lack of transport results in Ms only going out to clinics 1-2 a month which means no support for Cs
Rule 1: 36
Contradiction 36: Ms are required to discuss problems Cs experience with them but they are not.
Rule 3: 17
Contradiction 17: Cs have to be aware that their patients make use of two different forms of treatments, Western and Traditional
Rule 1-Rule 2: 35
Contradiction 35: Ms are required to visit all the clinics and are therefore not able to provide the Cs with the necessary support.
Rule 2-Obj 1: 31
Contradiction 31: Ms have many different duties that take away time available to spend with Cs
Rule 3-Obj 1: 32
Contradiction 32: Cs have many different roles (multicaps, metaphor ex SHCP) that take away time available to spend with Ms
Mrule 1-Dol 2: 26, 27
Contradiction 26: Ms have many commitments to attend to within specific timeframes which prevent them from or limits the time they have available to sit with, listen to and go through reports with the Cs
Contradiction 27: Due to Ms other commitments Ms not able to listen to & respond to Cs and not able to recall everything whilst conducting a follow-up
Rule 3-Dol 3: 33

Contradiction 33: Cs are required to counsel patients/clients but at times Cs are involved with other activities of their job which prevent them from counselling. This leads to dissatisfaction on the part of the client and some have left without being counselled

Com-mtool 3: 37, 38, 40

Contradiction 37: Lack of transport for taking blood samples to Frere and Frontier Hospitals and for Cs to attend circumcision campaigns have resulted in the community losing trust in the Cs

Contradiction 38: Procedures cannot be followed with clients because there is no transport and therefore clients will not want to come back for more procedures.

Contradiction 40: Ms care about the transport problem that effects the Cs but it is ruled by other hospital members, Stores and the Transport Controller. Added to this is that the transport is always out of order

Com-Dol 3: 2, 6, 14, 28

Contradiction 2: Objectives of SHCP with regard to community interventions about sexual health & conflicting church attitudes

Contradiction 6: Welfare Dept. not taking responsibility for counselling people around their disability grant applications. These people then come back to the hospital, increasing the load of the Cs

Contradiction 14: Confidentiality around AIDS results in some of the family members not knowing the true diagnosis of the patient which puts C in a difficult position

Contradiction 28: Part of the Male Cs job is to attend traditional functions of circumcision. Lack of insight of the whole circumcision process by general staff lead them to think that Cs are attending purely for their enjoyment

Dol 3: 3, 15, 16, 21, 22

Contradiction 3: Cs are often not aware that they will be counselling until after or during history taking. Clients come in for one problem and it turns out that they need counselling

Contradiction 15: In health education the C takes the role of an expert and tells people what to do. In counselling the C involves the person eliciting their thoughts, fears resources, ideas etc

Contradiction 16: Cs are involved in 2 practices that require very different skills

In health education the C takes the role of an expert and tells people what to do. In counselling the C involves the person eliciting their thoughts, fears resources, ideas etc

Contradiction 21: Working on different shifts often result in different Cs conducting pre and post – tests

Contradiction 22: Cs give dates to clients when results will be back but Cs are never sure when results will be back. Therefore often post-test is conducted by someone else due to shift system

Dol 2-Obj 2: 23

Contradiction 23: Cs are frustrated and experience many problems. Ms many different roles (multicaps SHCP metaphor) prevent an in-depth understanding of the Cs situation, problems & frustrations

Dol 3-Obj 3: 1, 4, 5, 7, 11, 42

Contradiction 1: Cs were trained on the SHCP to counsel in the Sexual Health Area & not over all areas that they are currently involved in.

Contradiction 4: Cs were trained on the SHCP to counsel in the Sexual Health Area & not over all areas that they are currently involved in.

Contradiction 5: Cs were trained on the SHCP to counsel in the Sexual Health Area & not over all areas that they are currently involved in.

Contradiction 7: One of the objectives of the SHCP was for counsellors to be respectful of clients. Referring to clients as "suspects" is not respectful practice

Contradiction 11: More pre-test counselling done than post-test counselling due to unreliability of transport bringing results back in time for review date with client

Contradiction 42: Cs were only trained to counsel in the area of sexual health & HIV/AIDS but are counselling across a broad range of areas

Dol 3-ctool 3 emotion: 19, 20

Contradiction 19: Working with HIV/AIDS clients cause Cs to become fearful around their own and their partners' health

Contradiction 20: Working with HIV/AIDS clients cause Cs to become fearful about whether they will be assaulted by the client

DoI 3-mtool 3: 25
Contradiction 25: Lack of availability of transport prevents Cs from making the necessary visits to clients and their families
Mrule 1 & ctool 3: 29
Contradiction 29: Due to the nature of their work Cs experience difficult feelings prior too disclosing HIV status to clients during and after the counselling session. They require support in the form of talking about the situation & feelings but Ms are not doing this.
DoI 3-Mctool 1: 24
Contradiction 24: Cs need to make frequent visits to certain patients & their families & is at times misinterpreted by Ms as they are not fully aware of the situation
CdoI 1-Cmtool 1: 41
Contradiction 41:The meetings that Cs are wanting were spoken about last year but due to lack of transport and the geographic spread of the clinics they haven't taken place
DoI 2-Mctool 1: 43
Contradiction 43: Ms are caring about the Cs but they are very busy. Cs would like more time with their Ms to support them with the feelings that are triggered in counselling. In addition they would like to have more regular meetings with other Cs and meetings with all the Cs and their Ms.