

**PHYSICIANS' TRANSMISSION PREVENTION ASSESSMENT
AND COUNSELLING PRACTICES
WITH THEIR HIV-POSITIVE PATIENTS**

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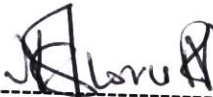
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DECLARATION

I declare that the dissertation hereby submitted to the University of the North, for the degree of masters in clinical psychology has not previously been submitted by me for a degree at this or any other university, that it is my own work in design and in execution; and that all material contained therein has been duly acknowledged.

Signed: -----

Date: 11-06-2002-----

DEDICATION

I sincerely dedicate this project to my fiancée Ms. Shiba Tholakele Annah. I am humbled to have a person of her caliber in my life; a devoted and supportive partner who supported me throughout, until the project was completed.

To my sister, Beatrice and brother-in-law, Steven Pule, who have been with me ever since I registered with the University of the North. To their four children Stuart, Xolly, Tshepiso, and Kedibone for being a source of inspiration.

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Jer. 29: 11

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ABSTRACT

This study sought to explore the medical doctors' transmission prevention assessment and counselling practices towards their HIV-positive patients. In addition, it sought solutions or answers to the question of whether HIV-positive patients are given sufficient prevention assessment and counselling by their medical practitioners or doctors. It is based on the hypothesis that medical doctors who work with HIV-positive patients can help to prevent transmission of HIV by assessing HIV-positive patients for risky sexual behaviours, and can, thereby, provide risk reduction counselling.

A sample of 15 medical doctors was purposefully selected from the population of medical doctors working in the following hospitals: Mankweng, Pietersburg, and Seshego, in the Central Region of the Northern Province. A semi-structured interview schedule was used as a tool for gathering data. Qualitative analysis procedures, including a coding template and conceptual clustered matrix, were used. In addition, patterns of themes that emerged from the data were studied inductively.

Medical doctors responded differently to the coded items, and three main themes emerged. These themes are: medical doctors' perceptions of their role in HIV prevention assessment and counselling; medical doctors' use of cues to revisit assessment and counselling patients about risk behaviours; and negotiating appearing judgmental about HIV-positive patients and their (patients') risk behaviours. As a result, three main styles of engagement emerged from the data: "consultant," "collaborator," and "consultant/collaborator." However, when a rational decision cut-off (coding analysis across eight coding categories) was used, the third style "collaborator" disappeared. Medical doctors in the study would not fit into the criterion of collaborators, and most of them fell within the consultant/collaborator style of engagement.

Consultants conducted prevention assessment and counselling during initial visits of their patients, and when their patients presented sexual transmitted infections. In addition, they

focus on what the patient present during consultation, i.e. biomedical aspects of the patient's care, and the view themselves as sources of information. Medical doctors with some components of collaborator style strive to form an effective collaboration with their patients. They focus on both biomedical and psychosocial needs of their patients. Medical doctors who fell within the consultant/collaborator style tend to focus on biomedical needs of their patients, view themselves as educators, and referred most of their patients to other health workers.

The findings suggests that the above three styles may influence behaviour change in patients differently, and may also offer insight into the role medical doctors' may play in prevention and counselling HIV-positive patients.

CHAPTER ONE

1. Introduction

In this section, the researcher shall define Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). There shall also be a brief discussion on the origin of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome, the prevalence of HIV/AIDS in South Africa, focusing on the Northern Province, and how HIV/AIDS is transmitted, particularly horizontal transmission. Furthermore, there shall be a discussion on the three main stages of HIV, namely: seropositive medically asymptomatic stage, seropositive and medically symptomatic stage, and Acquired Immune Deficiency Syndrome.

1.1. Definition of HIV/AIDS

According to Meyer and Pauker (1987) the AIDS epidemic frightens us all, but we should not allow our fear to cloud our judgment. Doka (1997) states that AIDS can be both a disease and a syndrome. Thus, the HIV virus directly infects the immune system, as well as cells, and by doing so increases the susceptibility of the body to opportunistic diseases and neoplasm. According to Alonso and Petertin (1999) acquired immune-deficiency syndrome (AIDS) is a progressive and potentially fatal suppression of the immune system. It occurs when HIV infects the T4 helper cells (Schmitt, Bigley, & Mckinnis 1988). The primary aetiology of AIDS is infection with type-1 human immunodeficiency virus (HIV-1). The hallmark of HIV-1 infection is the progressive depletion of CD4+ helper T cells, which are extensively, involved in co-ordinating the body's immune response. Moreover, HIV commonly invades the central nervous system and is casually linked to a variety of neurologic and neuro-pathological disorders (Kelly, Grant, Heaton, Marcotte, & the HNRC Group, 1996).

HIV (Human Immunodeficiency Virus) is the viral agent and a retrovirus, which attacks the immune system most notably the helper T-cells. The virus appears to be transmitted exclusively by the exchange of cell-containing bodily fluids, especially semen and blood. The period between contracting the virus and developing symptoms of AIDS is highly variable, with some individual developing symptoms of AIDS quite quickly and others free of symptoms for as long as 8 to 9 years or more (Ostrow, 1990). In general terms, once an individual has been infected with HIV he/she usually has a prolonged period with minimal or no physical symptoms.

Alcarno (1997) states that AIDS is diagnosed through the presence of an unusual opportunistic infection that results from the impairment of the immune system such as pneumocystis carinii pneumonia or an unusual neoplasm (cancer) such as Kaposi's Sarcoma or non-Hodgkin's lymphoma. In many cases of HIV infection, the virus grows very rapidly within the first few weeks of infection and spreads throughout the body. At this point the virus affects primarily two types of immune cells, particularly the helper T-cells and the macrophage. Early symptoms experienced at this stage are mild, with swollen glands and mild flu-like symptoms predominating. After three weeks to six weeks, the infection may abate, leading to a long asymptomatic period, during which viral growth is slow and controlled (Moore, Hidalgo, Sugland, & Chaisson, 1991).

Among other symptoms HIV usually invades the central nervous system (CNS) and it is causally linked to a variety of neurological disorders. According to Kelly *et al.* (1996) the direct invasion of the central nervous system by HIV, the numerous neoplastic and infectious central nervous system weakness, and neuro-psychiatric medications used to treat HIV-related disorders, have created a complex new area of study and treatment within neurology and neuro-psychiatry. According to Kaemingk and Kazzniak (1989) the most severe manifestation of HIV infection in the brain is HIV-1 associated dementia (HAD). This infrequent neurobehavioural disorder is characterised by moderate to severe cognitive and psychomotor slowing, impaired concentration and attention, memory disturbances, and often-motor incoordination and weakness (Lezak, 1995).

In addition, HIV infected persons develop a variety of opportunistic infections, tumours, and/or neurological illness. According to Grant and Martin (1994), a more common neurobehavioural complication of HIV-1 infection is termed 'mild neuro-cognitive disorder' or 'minor cognitive/motor disorder' (MCMD). This condition is diagnosed when a person exhibits deficits in at least two behavioural or ability domains. These domains are based on comprehensive, neuro-psychological testing (e.g., attention, learning, verbal skills, psychomotor abilities, or memory) and, when the level of impairment is significant enough to have a notable impact on day-to-day functioning (e.g., work performance, activities of daily living) (Grant & Atkinson, 1995). Therefore, prevention and early detection of HIV infection through testing and counselling is a major part of primary and secondary prevention efforts. Counselling is a facilitative process in which a counsellor or medical officer working within a framework of an enabling relationship uses some special skills to help people help themselves more effectively (Phillips & Coates, 1995).

1.2. The Origin of HIV/AIDS

Van Rensburg (2000) indicates that phylogenetic analysis based on the molecular structure of viruses suggests that there have been multiple transmissions of simian immune-deficiency viruses from African primates to human beings, giving the rise to both HIV-1 and HIV-2. However, doubt remains about when and how the AIDS epidemic began. Until the arrival of the human immune-deficiency virus (HIV), the great influenza pandemic of 1918, in which 20 million people died, was regarded as the greatest virus-borne calamity of the twentieth century. It is estimated that since the appearance of HIV in the 1980s, more than 50 million people have been infected.

Sub-Saharan Africa remains the worst affected region with 70% of all HIV/AIDS cases but only 8% of the world's population (AIDS Epidemic Update, 1999). There is an assumption that African primates infected with related pathogens called Simian Immunodeficiency in their natural hosts, give rise to a syndrome similar to AIDS in human when they infect Asian primates (Murphey-Corb, Martin, Rangan, Baskin, Gormus, Wolf, Andes, West, &

Montelaro, 1986). This makes possible the explanation for the appearance of the HIV/AIDS epidemic in the mid-to-late twentieth century to be hard or impossible to prove. However, evidence points to multiple trans-species transmission of SIV to human from both infected chimpanzees and sooty mangabeys to give rise to HIV-1 and HIV-2 respectively. The infection exploded into AIDS pandemic because of particular social, political, economic and behavioural changes which occurred in Africa during and after the colonisation period.

1.3. Prevalence of HIV/AIDS in Northern Province, South Africa

This study explored the physicians' transmission prevention assessment, and counselling practices towards their HIV-positive patients in different health care settings using semi-structured interview, particularly in the Central Region of the Northern Province, in South Africa. In this country, South Africa, the incidence of HIV/AIDS escalates at a very tremendous rate. According to the International Association of Physicians in AIDS Care (2000), South Africa continues to be the worst affected area in the world. By the early 1997, the Government of South Africa had estimated that 2.4 million South Africans were living with HIV. According to the Metropolitan Life LTD and the Actuarial Society of Southern Africa (1998) 3.2 million of South Africans are HIV infected, and almost 1 in 5 pregnant women is infected. According to Tom (2000), the 1999's rate stands at 22.4% in comparison to the 1998 rate of 22.8%.

It is presently estimated that about 4.2 million of South Africans are living with HIV/AIDS. It is also indicated that this epidemic can reduce South Africa's average life expectancy from 60 years to around 40 years by the year 2008. As a result of the escalating rate of HIV-infection in South Africa, the former Minister of Health Nkosazana Ndlamini-Zuma proposed that HIV/AIDS should be a notifiable disease in South Africa. One of the reasons is that some of the infected people do not want to inform members of their immediate family about their conditions and this worsens the spread of this epidemic (Metropolitan Life LTD & the Actuarial Society of Southern Africa, 1998).

In addition, HIV/AIDS is the major disease affecting the youth in South Africa. According to Statistics South Africa (2000) HIV prevalence-antenatal survey findings were estimated to be 17.04% in 1997 and increased to 22.8% in 1998. In 1997, the Northern Province alone had about 8.2% of infected pregnant women, and in 1998 the percentage increased to 11.5%. The implication is that each and every year the percentage of HIV/AIDS patients increases, and this poses a question whether or not the HIV-positive patients are given sufficient counselling so that they should not practice risk behaviours and thus spread this epidemic/disease.

It is clear that in South Africa the prevalence of HIV/AIDS is high; however, the increase rate is beginning to stabilise. Thus, 1999's rate stands at 22.4% in comparison to the 1998's rate of 22.8%. However, new HIV infections are continuing to increase among young and economically active persons. Surveys reveal that women in their twenties continue to have the highest HIV prevalence rates with a trend towards slightly lower HIV prevalence among teenage group. HIV prevalence also increased in some provinces with no significant changes in KwaZulu-Natal, the Northern Cape and Northern Province. However, KwaZulu-Natal remains the province with the highest prevalence rate, but there was no increase from 1998. The Western Cape remains the province with the lowest level of infection, but there was a 36.5% increase from 5.2% in 1998 to 7.1% in 1999 (Statistics South Africa, 2000).

For the purpose of this study focus shall be on HIV-positive patients because, as indicated earlier, they are mostly faced with difficulties. According to Beardsell and Coyle (1996) counseling HIV-positive persons is seen as inspiring in them behaviour change and protection for their future sexual partners. HIV-positive patients are uncertain about their future; they think that they are going to die soon.

It is for this reason that when physicians and medical officers assess and counsell them, they (medical doctors) should address the patients' fears about the future (Peräkylä & Bor, 1990). It is advisable that such a process be done as early as possible before the patients

develop some suicidal ideation (Bor & Miller, 1988). The goal of such interaction should include persuading patients to talk about their future and moving from an expression of troubles toward problem management.

1.4. Transmission of HIV/AIDS

According to Grant and Martin (1994) it remains unclear when HIV first began to infect people, but certainly by the late 1970s the HIV epidemic had begun, and the infection began to spread rapidly in the 1980s. The predominant modes of spread of HIV vary in different areas of the world, although there are proven routes of transmission. No instances of transmission were documented between people who lived in the same household but were neither sex nor injection-equipment-sharing partners. The sharing of toilet articles, cooking and eating utensils, towels, and other household items does not transmit the virus. There is no evidence that HIV is transmissible through food, inanimate objects, unbroken skin contact, insect or other animals, water, or saliva.

The major modes of acquisition of HIV-1 infection according to Lindegren, Caldwell, and Oxtoby (1995), are quite different for adults and children in the U.S., and elsewhere in the world. The institution of vigilant screening of the blood supply and treatment of factor VIII compounds, “vertical” transmission, namely, mother-child, has become the predominant mode of acquiring HIV-1 in the paediatric population. In adults, “horizontal” transmission, namely via sexual relations, use of contaminated needles or syringes, or via tainted blood products, remains the principal routes, although these modes are also becoming important in the adolescent population. Additionally, in some countries, because of the extensive use of needles and syringes coupled with a paucity of oral medications, the incidence of paediatric HIV-1 infection is much greater than in adults.

The central nervous system could potentially become infected during early stages of fetal development. Although there are also sub-populations of children who acquire HIV infection prenatal, during birth, or in uncommon occurrences, postnatal via breast milk

(child-mother transmission has also been rarely reported during breast-feeding) (World Health Organisation & International Council of Nurses, 1991). Infection of the brain at immature stages of development may account the earlier and more rapid clinical presentation of HIV-1-associated neurologic disease seen in young children as compared to the long latency often seen prior to the onset of neurologic disease in adults (Choi & Coates, 1994).

1.5. Stages of HIV Infection

There are three descriptive clinical stages of the HIV infection according to Nye and Parkin (1994), which are:

1.5.1. Seropositive and Medically Asymptomatic Stage

For the purpose of this study, the asymptomatic phase or stage shall be defined as the period after resolution of the primary infection until a diagnosis of AIDS is made. During this phase, the patient is clinically well from the viewpoint of HIV-induced diseases. The duration of this phase varies, and it is not clear if all HIV-infected individuals will progress to AIDS, but a total of 80%-90% will develop signs or symptoms within 10 years after seroconversion (Nye & Parkin, 1994). In most if not all patients, HIV is actively replicating at a very high level, at all stages of infection. At this stage there is a progressive immune-suppression, which is not clinically evident until a certain critical threshold is reached.

Under the current AIDS definition, this threshold is a CD4+ count under 200 cells per cubic millimeter or a CD4+ lymphocyte percentage of less than 14%. However, defects in immune function other than a quantitative depletion of CD+ lymphocytes may occur, and certain diseases may appear at CD+ counts greater than 200 cells per cubic meter for example, tuberculosis (TB), cancer of the lymphnodes (non-Hodgkin's lymphoma), Kaposi's sarcoma (KS), oral candidiasis, and occasionally, pneumocystis carinii (PCP).

Thus, according to Nye and Parkin (1994) many individuals who test positive for the presence of HIV antibodies exhibit no symptoms associated with AIDS; however, they may have psychiatric disturbances.

1.5.2. Seropositive and Medical Symptomatic Stage

Medical symptomatic stage is used to describe the illness of individuals who are seropositive and exhibit symptoms of AIDS, such as fever and weight loss, but who have no specific opportunistic infections or neoplasm (e.g. Kaposi's Sarcoma). According to Nye and Parkin (1994), fever, malaise, weight loss, fatigues, and night sweats are common in advanced disease. The symptoms are often attributed to HIV itself; another cause is usually found upon investigation.

1.5.3. Acquired Immune Deficiency Syndrome

According to Nye and Parkin (1994), AIDS is diagnosed when individuals who have contracted HIV have had at least one opportunistic infection, or a diagnosis of dementia, encephalopathy or neoplasm. The duration and course of the illness vary. Lezak (1995) points out that AIDS is defined by the presence of inactive disease state associated with immunological compromise, such as wasting disease with fever and diarrhea, or a condition of neurological deterioration, or an opportunistic infection or malignancy. As the HIV infection evolves into AIDS, the incidence and virulence of brain damage increases greatly, positive relationship between the status of the immune system, disease severity, and cognitive functioning has been currently documented.

According to Gansler and Klein (1992) cerebral changes usually show up on MRI scanning as brain atrophy and in multiple small diffuse or larger bilateral sub-cortical (mostly white matter, and also deep gray matter) lesions, and occasionally in a single focal lesion. From 75% to 90% of all patients with AIDS will have some central nervous system (CNS) involvement by the time they die due to opportunistic infections. Most deaths occur two to

three years after the onset of AIDS, particularly if the accompanying diseases are not treated, but some patients live five years or longer (Lezak, 1995).

According to Kelly *et al.* (1996) once an individual has been infected with HIV, he/she usually has a prolonged period with minimal or no physical symptoms (asymptomatic). HIV-infected persons develop a variety of opportunistic infections, tumours, or neurological illness. The Centers for Disease Control (CDC) (1992) defines three clinical levels of HIV infection: asymptomatic, minor symptoms, and AIDS-defining conditions (categories A, B, and C, respectively). These categories are each further divided into three strata based on CD4 lymphocyte counts (500, 200-499, and 200).

Table 1. CDC (1993) Classification System for HIV Infection

CD4+ cell Counts Categories	Clinical Categories		
	A-Asymptomatic lymphadenopathy	B-Symptomatic but not A or C condition	C-AID indicator conditions
>500/mm ³	A-1	B-1	C-1
200-499/mm ³	A-2	B-2	C-2
<200/mm ³	A-3	B-3	C-3

Bold entry means 1992 AIDS-indicator condition (A-3, B-3, C-1, C-2, and C3). Category A includes acute HIV infection, Asymptomatic infection, and progressive generalized lymphadenopathy. Category B includes conditions associated with HIV infection, but which were not included in the CDC's 1987 case surveillance definition of conditions associated with severe immunodeficiency. Examples of "less severe" conditions include oropharyngeal candidiasis (thrush), persistent vulvovaginal candidiasis, severe cervical dysplasia or carcinoma, oral hairy leukoplakia, and recurrent herpes zoster involving more than one dermatome. Category C conditions are those associated with severe immunodeficiency identified in the CDC's 1987 surveillance definitions for AIDS

Individuals who have CD4 counts less than 200 are defined as having AIDS. Persons with AIDS are defined according to their clinical condition (category C diseases), or by CD4 counts of 200 or less (namely, groups A3, B3, and C3), or both. Table 1 cited in the Centers for Disease Control (1992) summarises the 1993 CDC classification system. However, there are different systems used to classify the severity and progression of the

HIV infection. The other system is the Walter Reed (WR) staging system, which consists of seven stage systems based on T4 cells counts and clinical concomitants of HIV infection. However, this will not be discussed here. Although, both the WR and CDC scoring systems permit the conceptual classification of inter-individual and intra-individual progression of HIV-related illness, the CDC classification is the most widely used.

CHAPTER TWO

2. Literature Review

The 'literature review' section focuses on theoretical perspectives of living with HIV/AIDS, particularly the role and cognitive theories. In addition, human dimensions of HIV/AIDS shall be discussed, more particularly the confrontation of HIV-positive results and self-concept of HIV-positive patients, and counselling HIV-positive patients in health institutions. Furthermore, pools for clinical practice shall be discussed under the following sub-headings: sexual history, reducing risk of sexual transmission infections, deciding on risk-reduction plan, safer sex repertoire, relationships with partners, having children, coping with HIV/AIDS, and loss and grief. Effective secondary prevention and barriers to the effective secondary prevention shall also be discussed under the following sub-topics: sense of unfairness, condom use, practicing safer sex after test results, lack of information, feeling of rejection and discrimination, inability to talk with sexual partners, discussion about sex, illness symptoms, and religion and social behaviour.

In addition safer sex principles and practices, too, shall be discussed in this section. Interventions to reduce risk behaviours shall be discussed under the following sub-headings: knowledge of health risks and health promoting behaviours, perception of personal risk, perceived effectiveness of change and response efficacy. The section also includes faith in medical technology, sociodemographic variables, social network affiliation and peer norms, personality factors and cognitive cues, sexual impulse control, and alcohol or drug use. Furthermore, there shall be discussions on prevention strategies for HIV/AIDS. The last part of this section includes the statement of the problem, objectives for the study, hypothesis, rationale of the study, and significance of the study.

2.1. Theoretical Perspective

According to Fan, Canner, and Villarreal (1996) the field of social psychology concentrates on human behaviour in-groups. This field of psychology holds that many aspects of our behaviour are determined by the direct or indirect influence of the others. It is interesting that social psychologists have developed theories, which explain different aspects of people's behaviours. Despite this fact, there is no theory that explains all aspects of people's behaviours, although theories taking a similar approach have been useful in explaining different parts of individuals' behaviour. Those approaches can be grouped into three general theoretical perspectives, which are:

- ❖ Role theory,
- ❖ Learning theory, and
- ❖ Cognitive theory.

The role and cognitive theories are essential to the understanding of the human and societal dimensions of HIV and AIDS. Learning theory can be briefly described here as focusing on the relationship between stimuli (such as rewards and punishment) and responses (such as changes in personal behaviour). Despite the fact that this theoretical perspective illuminates some aspects of human and societal dimensions of AIDS, the theory is less relevant than are the other two theoretical perspectives.

2.1.1. Role Theory

The basic idea that underlies role theory is that the roles we have are significant determinants of the ways we interact with others and the ways others interact with us. Thus, role theory sees roles as the fibers of the social network that inter-links all of us (Fan *et al.*, 1996). From a social group perspective, roles link people, especially through expectations about and understanding of roles. These understandings and expectations are the main motivators and explanations for behaviours. In trying to simplify this theory,

allow the author to request that you think of just one of the roles that many readers may have; for example, the role of being a student. As a student the understanding is that I have certain obligations and responsibilities, such as writing papers and taking examinations. My supervisor also has obligations and roles related to my roles, such as: passing on information and ideas, reviewing my written work, and grading my examinations. These roles are very real and order the interaction of students and their professors.

To understand how real these expectations are, one can think of cases where some of the role expectations are not being met. Imagine an instance where the professor never gave lectures and never answers questions posed to him by students. In my role as a student, I will justifiably be upset when this occurs because that social interaction is not a balanced one; thus the professor will still assign grades. According to Fan *et al.* (1996), one way of resolving the issue would be that I (the student) drop the class and thus end the role interaction. If one is observant and analytical enough, she/he would note in this example that the upset that the student experiences does not relate to any thing “on the inside,” of either the student or the professor, such as personality issues; instead, it is the result of mismatched role explanations.

Role expectations, according to Fan *et al.* (1996), are also known as norms, which are socially defined standards of behaviour that guide individual actions. Thus, in the example given above about the student and her/his professor, the obligation and responsibilities (for example, taking tests) are norms, and it is not known what should properly occur between a student and a professor. People in these roles would not know how they are expected to behave. In the literature norms are seen as one of the factors that can affect people’s decisions to protect themselves from HIV/AIDS infection and its transmission to others.

2.1.2. Cognitive Theory

The cognitive perspective is different from the role theory because it (cognitive theory) focuses on the conceptions inside people’s minds, not factors (such as roles) in the outside

world. The basic idea behind cognitive theory is that mental conceptions (cognitions) give us a framework both for interpreting experiences and shaping our actions. Thus, cognitions are mental representations of knowledge or thoughts, not feelings or actions. Related individual cognitions are combined in our minds into cognitive structures, called schemas. Schemas serve as reference points for organizing past experiences or interpreting new experiences, or they serve as templates for activating new ideas. These mental representations undergo mental processing that eventually leads to action or inaction. In this paper, the researcher is most concerned with social cognitions, cognitions that focus on people in our lives and our interactions with them (Fan *et al.*, 1996).

In order for these theoretical perspectives to be simple for the reader, Fan *et al.* (1996) used an example to illustrate the perspective and utility of cognitive theory, with particular attention to social cognition. The names used in the example are hypothetical and the example goes thus: Vivian and her friend, Joy, see a poster describing a panel discussion by people with AIDS (PWAS) that is to occur later in the week. Assume that Vivian has taken a class on HIV/AIDS and has some experiences and knowledge of AIDS. Joy expects an occasional news report on television. When they see the poster about the PWAS panel, each of them will unconsciously draw on the schemas in her mind to envision what the PWAS panel might entail and, based on that, may decide whether to take action or not.

If the cognitive processes for Vivian are to be considered first, it would be clear that she studied HIV and AIDS, has seen videotapes in class about PWAS, and has met several people with AIDS. These experiences have resulted in cognitions, which will have been stored in her mind and united into schema about PWAS. Thus, when she sees the poster about the panel, the schema is activated (her schema about the panel). These schemas will make Vivian think of a small group of people who reflect the HIV situation, as she understands it in her community. However, Joy has a much different picture in her mind when she reads the poster. Fan *et al.* (1996) states that because she has had no direct knowledge about HIV/AIDS, and no experience with anyone who is HIV-positive, she does not have a well developed schema upon which Vivian can draw to interpret the poster.

Instead, Joy draws on (almost unconsciously and instantaneously, remember) schemas about a panel and about HIV/AIDS based on a few television camera shots. She pictures very sick people, some coughing, and some in wheelchairs, some very angry and belligerent. Obviously, Vivian has a clear idea about who and what the panel will involve and her cognitions have positive and neutral connotations. Joy's cognitions are vague and they have negative connotations. Thus, unless other positive cognitions are activated for Joy, it is unlikely for her to attend the panel (Fan *et al.*, 1996).

In this example, cognitions and schemas are brought into play in the interpretation of the new realities, and from the interpretation the likelihood of experiencing the event begins to vary. Joy would benefit more from attending the PWAS panel than Vivian since the experience will be very new and different for her. But, because of the way cognitive process works, Joy is unlikely to attend. Even if her friend, Vivian, tries to convince her to attend, the images in her mind are barriers to overcome. Social cognitions are unique in people have a tendency of changing that the objects on which they are based, and adding a new external reality with which our minds need to deal (Fan *et al.*, 1996). They also indicate that our cognition form a general balanced and ordered whole. Cognitive theory is essential when considering such human issues as self-esteem and self-concept for people with AIDS or those interacting with them. The cognitive perspective also helps to explain such societal issues as stereotyping those with HIV/AIDS and the difficult of changing people's attitude and options.

2.2. Human Dimensions of HIV/AIDS

It is indicated that those living most directly with HIV/AIDS are people infected with the virus. These individuals have significant challenges (psychologically, socially, and physically) in dealing with HIV. They are also seen as having significant opportunities of not opening to the rest of us. These challenges and opportunities have been explored using perspectives from both the role and cognitive theories above.

2.2.1. Confronting the News of Infection

Many HIV positive people first learn about their seropositive status after an HIV test. Others receive this news when they develop their first opportunistic infection and, in the course of working with their doctors to diagnose this physiological change, learn that they are HIV positive. In both cases it can be a significant challenge to deal with the new information concerning HIV infection. Thus, the news of HIV infection puts major pressure on the individual's self-concept. According to Fan *et al.* (1996) the self is probably one of the most developed schemas each of us has in our mind. Thus, our self is a social construct, developed and maintained in interaction with others.

2.2.2. Self-Concept

According to Fan *et al.* (1996) since the self-schema is regularly activated, it is one of the strongest schemas in most people's cognitive structures. Parts of the self-schema can vary, and minor adjustments are regularly made, but human beings have a constant and firm self-concept. One part of the self-schema that varies is our self-esteem, our positive or negative evaluation. Thus, a series of good experiences can boost our self-esteem. Consider a cognition situation a patient confronts when he/she learns that he/she is HIV-positive. This news is a direct and significant threat to his/her self-concept. It is understandable from the cognitive perspective that the patient's first reaction would be denial, because this new piece of information does not fit well into his/her self-concept.

Indeed to accommodate the reality of HIV-positive status, the patient will have to change many aspects of his/her self-concept, something that none of us does quickly or easily. In most instances, rather than the HIV counsellor who does not play a large role in the patient's life, there is none else who knows this information (Ostrow, 1990). The implication is that the patient may simply decide that the results are wrong and may, therefore, deny the new information to preserve his/her self-concept; in so doing, the patient may continue spreading the virus further. Good HIV/AIDS counsellors or medical

doctors dealing with HIV patients are prepared for that reaction and realize the tremendous pressure that exists in most of us to maintain our current self-concept. While, many people who learn that they are HIV-positive may go through a period of denial, most do not act out their anger, they are willing to talk to their closest, most important friends or medical doctors (Fan *et al.*, 1996).

2.3. Counselling an HIV-Positive Patient

Carballo and Miller (1989, p. 121) state: "HIV counselling is an on-going dialogue and relationship between patients and counsellors aiming at preventing HIV transmission and providing psychosocial support for those affected, directly and indirectly. In order to achieve these aims, counselling seeks to encourage and enhance self-determination, to boost self-confidence, improve family and community relationships and quality of life." They suggest that prevention counselling have five main steps, which are:

- (i) Determining whether the life style of an individual presents a risk of HIV infection.
- (ii) Working with HIV-positive patients so that they understand the risks.
- (iii) Helping to identify the meaning such behaviours may have for them (patients).
- (iv) Helping to identify and define the potential for behaviour change.
- (v) Working with individuals to achieve and sustain appropriate and chosen changes in behaviour.

Despite the length of this definition, Silverman, Peräkylä and Bor (1992) acknowledge that without research, we cannot know what counselling looks like in neither practice nor its overall efficacy in prevention and impact reduction. According to Wilson and Kaplan (2000) the care of patients with HIV has always involved conversations about sexual behaviours, substance abuse, disability, and death. However, both medical doctors and patients have difficulty discussing embarrassing, stigmatizing, or painful topics such as these (Curtis & Patrick, 1997). Becker and Joseph (1988) indicate that prevention of HIV transmission requires either abstinence from or modification of relevant behaviours.

According to Phanuphak, Muller, Sanangbin and Sittitrai (1994), professionals or specially trained health workers, consisting of nurses, psychologists, and hospital social workers give the counselling of HIV. They indicate that it should be provided on an individual basis, in a comfortable private room. Besides, a counselling session is intensive, regardless of whether it is a pre-test or post-test counselling. An average counselling session lasts between 20 and 30 minutes. Such counselling sessions focus on reducing psychological stress, assisting patients in developing options and decision-making and reinforcing loving and supportive relationships with family and friends.

Discussion about death, dying and resuscitation is best avoided during a period of hospitalization. According to Peräkylä and Bor (1990) working with patients coming for an HIV antibody test or having been diagnosed as HIV antibody positive requires medical officers and paramedical professionals to deal with the patients' fears of what may happen with them in future. They advise that it is important for physicians and/or counsellors to first find-out what the specific fears of the patient are, and then encourage him or her to speak further about them. Carballo and Miller (1989) observe that the principle of providing counselling on a regular and systematic basis to people with HIV and AIDS has been taken up by health planners and AIDS committees in a wide range of countries the world over. This has been done because AIDS has proliferated all over the world, particularly in Africa, and it is clear that national health systems will be unable to take care of even the physical needs of patients, let alone provide psychological or spiritual support (Green, 1994).

HIV counselling is increasingly being proposed as a key component of programs, for example, within national AIDS control and prevention plans, both complementing and supporting information, education, and communication strategies, and as a sine qua non of clinical management. It is now generally held that AIDS control and prevention cannot and should not be carried out in the absence of counselling. It is also indicated that individuals, their families, and loved ones can not and should not be expected to make major life changes without the support that comes from and through counselling. This requires an

improved interaction between patient and health care provider providing new opportunities for the empowerment of patients, the mobilisation of communication around issues of quality of life during illness, and the importance of psychosocial support in disease prevention. In addition, Phillip and Coates (1995) state that if HIV counselling and testing is provided in a social context it may have greater impact on risk behaviour.

According to Carballo and Miller (1989) the role of the health care sector has been to define the need for and then make available a mix of services that has included on the one hand, preplanned medical care, on the other hand, information and education designed as much to facilitate the acceptance and use of those services as to promote disease prevention and behaviour change. Thus, in the context of HIV infection and disease, individuals and groups are now being asked to assume a new degree on individual responsibility for health maintenance and prevention. If that endeavour is to be successful, information and education on HIV prevention and risk reduction will need to be complemented by a type and responsibility but, more importantly, allows individual to assess the feasibility of that behaviour and its implication for life-style and social relationships. The comprehensive nature of counselling activities designed to enhance individual empowerment; decision-making and behaviour change may need to become the basic framework around (Carballo *et al.*, 1989). The prevailing research on AIDS risk and reduction focuses on the degree to which individual actions comply with scientific guidelines for HIV prevention.

Thus, if counselling initiatives are to be effectively supported and exploited to their full potential, many of the challenges implicit in these emerging roles and functions will need to be addressed through new conceptual as well as training and service development approaches. Among the first is the need to better define and characterise counselling in a way that promotes it in a comprehensive fashion and gives it active support in as wide a range of setting as possible. Yet if counselling is to be successful in providing the motivation and the support for behaviour change and greater individual responsibility for HIV prevention, adherence to confidentiality may well need to be one of its cornerstones (Silverman, Perakyla & Bor, 1992). It is also suggested that in an area as complex as that

of HIV/AIDS counselling, there need to be continuation of monitoring and appraisal of the influences different contexts have on HIV infection and the psychosocial response to it.

Lastly, Winiarski (1997) recommends that effective HIV safer-sex counselling is best delivered in a trusting relationship, in which information about reducing the risk of transmission is offered thorough, sensitively, and with respect for the needs, problems and cultural context of the individuals or couples being counselled. Safer-sex counselling is best offered in the context of supporting people in dealing with HIV and with life in general, in a broad, whole-person perspective. It deals with both sexuality and loss. It requires that the counsellor is self-aware of values, beliefs, and feelings elicited by the work, especially about sexuality, illness, and death, and is willing to deal with those honestly and to get help when needed.

2.4. Pools for Clinical Practice

The following topics, according to Winiarski (1997), are typically covered during a risk-reduction session with an HIV-positive patient: (1) Sexual history, (2) Reducing risk of sexual transmission, (3) Deciding on risk-reduction plan, (4) Safer-sex repertoire, (5) Relationships with partners, (6) Having children, (7) Coping, and (8). Loss and grief. However, not all the topics are relevant for each person, and not all are covered each time. The physician or counsellor can make an attempt to assess, which of these are important for the patient and the situation, and focus on those topics first.

2.4.1. Sexual History

The meaning of sexuality in the person's life is explored, as well as sexual activity in the past year and before. Changes in sexual behaviour, interest, and attitudes are assessed. Beyond these basics it is also important to ask about how illness and disability affect sexuality and sexual self-image for the patient and the partner, keeping in mind that sexual development continues throughout the lifespan, not only in adolescence.

2.4.2. Reducing Risk of Sexual Transmission

Use and efficacy of condoms is reviewed. Condom breakage or other problems are assessed, and suggestions are discussed to address these. Choice of condom type/brands, other contraceptives is discussed. Information about other sexual transmitted diseases and protection, and treatment for these is presented.

2.4.3. Deciding on Risk-Reduction Plan

In this area, the health care provider covers various sexual practices and how to evaluate risks and protection against transmission. The discussion also includes the exploration of communication and negotiation with the sexual partner, and elicits issues and concerns or problems in talking about and practicing safer sex with that partner. The health care giver can suggest strategies to support behaviour change and to avoid "relapse" to unsafe sexual behaviour.

2.4.4. Safer-Sex Repertoire

Sexual practices other than preventative intercourse can be explored, evaluating risk in each case. The idea is to promote thinking about and experiencing sex and intimacy creatively. For those clients who no longer have sex, or who have it less often than they wish, discussion may be opened about any desire to restore sexual activity and to increase intimacy and sexual satisfaction while still protecting one's partner from transmission.

2.4.5. Relationships with Partners

This area includes a broader discussion about needs for intimacy and how to meet them. Single patients may want to talk about their concerns regarding dating, getting involved, and coping with loneliness, and patients with partners may have concerns about relationships.

2.4.6. Having Children

The desires to have children and the decisions that are facing couples are discussed. Risks of transmission to mother and offspring are presented. Options (including donor insemination, adoption, involvement with children of others, and methods to reduce risk in conceiving) and the pros and cons of each are explored for those who have put aside plans to have children, and support is offered for dealing with feelings about not having one's own children.

2.4.7. Coping

The partner's overall well-being, his/her ability to function emotionally and socially, and his/her ability to cope with HIV within his/her life circumstances are assessed.

2.4.8. Loss and Grief

The patient with HIV faces multiple losses in functioning, opportunities, dreams, and intentions, as well as physical health and anticipated lifespan, and the health care giver needs to become aware of and acknowledge these losses. Support should be given for grieving what is lost in relationships and sexuality, in particular, as an essential step before a person can move on to live fully within the limits imposed by HIV infection.

2.5. Effective Secondary Prevention

Secondary prevention with women with HIV or female partners of men with HIV involves intervening to reduce the risk of HIV transmission perinatally to offspring through pregnancy, accepting medical treatment and declining to breast-feed (Winiarski, 1997). Efforts at secondary prevention that are reported include several populations and approaches. In studying HIV positive women and childbearing decisions, partner related factors such as: whether a partner is sero-negative, whether a woman has a sense of power

in the relationship, and whether there are conflicts between the woman and her partner, are important for HIV positive women. These factors are important in determining women's approach to safer sex and childbearing decision.

HIV-positive persons having unprotected sex with partners at risk for HIV transmission often relate discomfort in discussing HIV with others. However, people who are HIV-positive and who have sex have a social and legal responsibility to disclose their infection to their partners, or else there is increased potential for transmissions and infecting others. In a study conducted by Winiarski (1997) HIV-infected women indicated that ethical responsibility and concern for partners' health led to the disclosure to partners and that a desire for support was the reason for disclosing to family and friends. At Huntington Hospital Hemophilia Center, a risk reduction clinical model was developed that would provide a separate risk-reduction sessions for patients during their annual comprehensive evaluations, in addition to social worker, nursing, and physician meetings, to which partners are invited as well.

Winiarski (1997) indicates that as part of the risk-reduction service, they offered free confidential or anonymous testing for partners, free condoms and safer sex literature, counselling for adolescents as a frank and routine part of their medical care, and separate counselling for partners or parents of adolescents as required. The risk-reduction sessions for children are designed to make it comfortable to address any questions and to promote communication later on safer sex. Parish in Winiarski (1997) adds that Huntington Hospital Hemophilia Center is also participating as a site for the adult Hemophilia Behavioural Intervention Evaluation Project, and the project involves developing and piloting an individualized intervention to reduce HIV transmission between men with HIV and hemophilia, and their female partners. The intervention makes use of a stage-based behavioural approach, developed from the Transtheoretical Model of behaviour change, in which behaviour change is conceptualized as a process through stages, each approached with different strategies.

The intervention developed in Huntington Hospital Hemophilia Center's project was designed to enhance communication skills and was offered to participants either individually or in group retreat settings. In addition, components of the stage-based communication skill approach may be valuable in secondary prevention with other populations. Several tenants emerged as important in HIV transmission prevention counselling for people who are HIV-infected and their sexual partners. Firstly, the belief that people with HIV, like anyone else, need and deserve closeness, care, and connectedness in their lives. It is normal to seek sexual expression and intimacy. Secondly, becoming sexually involved when an individual has HIV does, however, raise some unique issues. Those issues include disclosing HIV status to a partner, communicating feelings and concerns about having safe and healthy sex (Winiarski, 1997).

2.6. Barriers to Effective Secondary Prevention

According to Winiarski (1997) the barriers to effective secondary prevention of HIV transmission are many, but fall into categories arising from the HIV-infected persons, from the partners, from cultural/social system, and from the counsellor or agency. Those barriers are (1) Sense of unfairness and condom use, (2) Practicing safer-sex after test results, (3) Lack of information, (4) Rejection and discrimination, (5) Inability to talk with partners, (6) Discussion about sex, (7) Illness symptoms, and (8) Religion and social behaviour.

2.6.1. Sense of Unfairness and Condom Use

It have been found that for some, the problem is that they still wish to have children, and their goals for safety and pregnancy conflict; actually in the first years of safer-sex recommendations, the birth rate among people with hemophilia increased. These issues involve losses and resentments, an unresolved stand in the way of making healthy behavioural choices and changes. Condom use presents a further barrier, particularly the need to learn a new behaviour. Their negative feelings about condoms and their failure to keep them always available stands in the way of using them all the time.

2.6.2. Practicing Safer-Sex After Test Results

HIV-infected people say that they began to practice safer sex consistently only after receiving their test results. Thus, any barrier to testing-attitudes fears, stigma, or practical matters of cost, access, or confidentiality, has the potential to impede safer sex.

2.6.3. Lack of Information

A lack of accurate information, or misinformation, represents another barrier to secondary prevention. In addition, Harrison, Smit, and Myer (2000) suggest that information, education, and communication typically forms the starting point for HIV prevention activities.

2.6.4. Rejection and Discrimination

Many people make the decision to keep their HIV status secret because they fear rejection and discrimination. Not only does secrecy cut people off from receiving the support of others, it also impedes a self-acceptance that is a critical part of the process of behaviour change and the decision to protect a partner or oneself.

2.6.5. Inability to Talk with Partners

Sometimes, partners know little or nothing about the risk they face, and not being able to talk with a partner directly is a barrier for the counsellor. When the partner is not informed, he/she cannot share the responsibility for safer-sex. Sometimes, a partner knows of the HIV infection but takes the position that "if he or she goes, I might as well go, too," something of a Romeo and Juliet theme. Such situations suggest an overuse of denial. At the same time it is important to note that denial is often encouraged and reinforced among people dealing with chronic disease: such behaviour is often seen as brave or stoic.

2.6.6. Discussion about Sex

Sex is considered a highly private, sensitive area of most people's lives, and reactions to discussions of safer sex may range from being completely unwilling to discuss the subject with any health care provider to deny having unprotected sex.

2.6.7. Illness Symptoms

Illness symptoms can get in the way of secondary prevention. Thus, dementia, fatigue, disturbed thinking, reduced capacity to reason or problem-solving, and suspicion can manifest with HIV/AIDS, and each of these problems makes it difficult for the person to understand, decide, make changes, and trust. People with HIV infection and their partners experience behavioural and physical barriers to using condoms, discomfort, loss of sensation, outright dislike, loss of spontaneity, and allergic sensitivity to latex or lubricants.

2.6.8. Religion and Social Behaviour

Some messages about safer sex conflict with some religions, social behaviour in some groups, and values held by people of various political beliefs. The relative lack of power held by women in many relationship stands in the way of their asserting their right to refuse unsafe sex or to insist on condoms.

2.7. Safer Sex Principles

According to Potts, Crane, and Smith (1993) the most important safer sex principles are:

- Use barrier precautions for vaginal and rectal intercourse, but withdraw prior to climax and ejaculate outside the partner.

- The only absolutely safe sex is abstinence from any behaviour, which exposes another person to bodily fluids, as touching and “dry” kissing carry no risk of HIV transmission.

It is important to know and understand the most important principle, which is that sexual expressions and transmission of HIV in various populations differ substantially along trajectories of age, race, culture and gender. It should also be borne in mind that to be effective any educational programme about transmission of HIV/AIDS must be knowledgeable about different practices and sensitive to different personal expressions and values. It should also be realised that penile\rectal, and penile\vaginal transmission accounts for the largest number of sex-related HIV infections.

Potts *et al.* (1993) stress that in bivariate analyses of large cohort studies, despite sexual risk behaviours there were no other behaviours that achieved statistical significance as an independent mode of infection. However, in multivariate analyses, rectal contact and enema uses were found to correlate with a higher risk of infection, but no other behaviour achieved significance. Most sexual transmissions occur in persons who engage in receptive rectal or vaginal intercourse without barrier precautions. However, there is no situation in which a lack of barrier precautions for vaginal or rectal sex between partners at HIV-infection risk is defensible from a public health standpoint.

Despite the effective barrier, which latex condoms present, penile/rectal and penile\vaginal transmissions do occur, albeit more rarely, among those persons who practice rectal and vaginal intercourse using barrier precautions, most likely due to product failure. In these authors' belief demonstration and written demonstration of the correct use of latex condoms and lubricants must be made part of safer sex education. Clients must also be counselled that latex condoms are not complete protection and abstinence from rectal and vaginal intercourse will lower their risk of infection to near zero. Women must be educated in ways to decrease their risk of infection by anal as well as vaginal routes (Sherr, 1999).

Penile-rectal and penile-vaginal transmissions also occur more frequently in the setting of concurrent rectal or vaginal irritation, infection or disease. Genital ulcerative diseases (GUD) such as trichomonas, chlamydia, syphilis, gonorrhoea, herpes and condyloma are among the infections, which predict a substantially increase of transmission. It has also been found that localised irritation caused by chemical irritants may also increase the likelihood of infection should the barrier fail. Therefore persons should refrain from rectal or vaginal intercourse in the setting of concurrent rectal or vaginal irritation or disease. Thus, personal and social programs of STD/GUD detection, treatment and prevention will decrease HIV transmission (Ferrand & Snijder, 1997).

Potts *et al.* (1993) state that trauma is not a necessary component to transmission of HIV. However, if barrier precautions are not used for vaginal and rectal intercourse, even the most gentle and atraumatic event may result in HIV transmission. For the reason that preparatory rectal douching or enema increases the likelihood of infection should barrier precautions fail, it (rectal douching or enema use preparatory to rectal intercourse) should be discouraged. A higher rate of tampon use was noted among infected wives as compared with uninfected wives of HIV infected haemophiliacs, and was also found that its use result in dryness, desquamation and other cellular abnormalities, which may increase the likelihood of infection. It is therefore recommended that the generous use of water for all occasions of vaginal intercourse be used, and that alternative methods of absorption should be tried if tampon-related vaginal irritation or dryness occurs.

According to Maticka-Tyndale (1992) transmission by deep kissing is theoretically possible. A study conducted by Levy and Greenspan (1988) cited in Potts *et al.*, (1993) demonstrates that oral secretions contain HIV, however, oral secretions have been demonstrated to inactivate HIV in vitro. For these reasons, persons should refrain from kissing when either partner is experiencing oral bleeding or disease. Penile-oral transmission by fellatio is also theoretically possible, and the case for its occurrence is stronger than that for kissing since the amount of virus is markedly greater in ejaculation than in oral fluids. The following has also been found to be theoretically possible; vaginal-

oral transmission by cunnilingus, therefore persons who wish the greatest protection should use dental rubber dams or plastic wrap as barriers. They should also refrain from cunnilingus in the setting of vaginal or oral bleeding or disease and during menstruation.

People who wish the greatest protection should refrain from tribadism during menstruation or when vaginal infection or disease is present. Anal-oral transmission may occur during anilingus, since anal secretions and faecal matter may contain lymphocytes. Thus, persons should refrain from faecal/oral contact to avoid enteric infections. They should also use dental rubber dams or plastic wrap as barriers. Breast milk of infected women has been demonstrated to contain the human immunodeficiency virus; therefore partners should avoid ingestion of breast milk from an infected person (Potts *et al.*, 1993).

2.8. Safer Sex Practices

Among the most important safer sex practices is the use of condoms. Other guidelines for safer sex involve activities taking place outside the body. Among these practices is the massaging of various sensitive parts of the body; rubbing the bodies together and stroking the partner's genital organ so long as the penis does not come in contact with the vagina or rectum; masturbation, either of self or of the sexual partner, and kissing the various parts of the body. It should be noted, however, that deep or "French" kissing could involve a slight risk if mouth or gum sores are present and if large amounts of saliva are exchanged. The purpose of safer sex is to avoid contact with potentially infection fluids by either alternative sexual practices or by the proper use of a condom during intercourse. According to Taylor (1991) the effectiveness of safer sex practices is underscored by the results of a study by Fischl in 1988 (see Table 2).

Table 2. The relationship of sexual activity to development of HIV antibody among 58 spouses of HIV-positive individuals.

Sexual Activity	Tol. Number	HIV +	HIV-	%Converted
Abstinence	13	0	13	0%
Sexual contact with condoms	23	3	20	13%
Sexual contact without condoms	22	14	8	64%

Spouse did not display HIV antibodies at the beginning of the study. Source: Fischl et al. (1987) cited in Taylor (1991) "Heterosexual Transmission of Human Immunodeficiency Virus (HIV): Relationship of sexual Practices to seroconversion". Third International Conference on AIDS. Washington, D.C. p. 178.

2.9. Interventions to Reduce Risk Behaviours

According to Ostrow (1990) interventions to reduce risk behaviours can be explained explicitly through the health belief model, which focus on behaviours under an individual's control and presumes that people act in order to maximise net benefits of their actions. According to the health belief model, a number of factors operate to either promote or retard desired behaviour change, which are:

2.9.1. Knowledge of health risks and health-promoting behaviours

Knowledge of what constitutes risk is obviously an essential prerequisite to voluntary health-promoting behaviour change. Knowledge about AIDS has been seen to play a role in motivating initial behavioural change, particularly in persons who see themselves as being at relatively low risk and are initially less informed about the disease and the routes of HIV transmission. According to Ostrow (1990) knowledge alone, however, does not ensure long-term sexual behaviour change. Thus, education that aims solely to increase knowledge would appear to be limited in its ability to induce and maintain alterations in sexual behaviour.

2.9.2. Perception of personal risk

A perception of personal risk appears to be more important than objective knowledge in motivating behavioural change. It has been noted that individuals tend to underestimate their own vulnerability, operating under an “optimistic bias” regarding their health. Teenagers, for example, may have difficulty applying biological knowledge of sex and pregnancy to their behaviour, believing as they characteristically do that “it won’t happen to me” (Gordon & Klouda, 1994).

2.9.3. Perceived effectiveness of change and response efficacy

Individuals who are knowledgeable of behavioural risks and who feel they are personally at risk must also feel that they are capable of making recommended behavioural changes (response efficacy) and that those changes will actually make a difference for them (perceived effectiveness). The highest-risk individuals recognise behaviour change to be an effective means of risk reduction for others, but perceive it to be “too late” in their own cases. Just because of the potentially long period of time between infection and the development of disease and the lack of proof that life style changes will reduce chances of becoming ill, individuals at very high risk may not believe that behaviour alterations will actually make a difference for them (Ostrow, 1990).

2.9.4. Faith in medical technology

Overconfidence in technological solutions to the control of AIDS and HIV transmission may reflect incorrect knowledge or be a form of denial of individual risk. The belief that science will provide a cure in the near future was found to be directly correlated with a continuing large number of partners and the persistence of high-risk sexual practices (Ostrow, 1990). According to Swantz and Lic (1994) indigenous organisational forms have seldom been taken seriously or become part of the modern system because they are viewed

as being too traditional and thus, negative in light of the scientifically based medical profession.

In Tanzania, the health authorities have at times contacted traditional health practitioners and their practice has been used to challenge health information, but less often have they been involved in planning the cooperation between the traditional and modern health services. They have rather been incorporated in pre-planned measures, as is the case in fighting cholera or more recently AIDS. Green (1988) indicates that collaboration with traditional healers, by working through professional associations of healers, is proposed as an effective intervention strategy, and may not only change healing practices that may contribute to the spread of HIV/AIDS, but may also directly influence the public and even in condom distribution. By working through churches a potential barrier to providing educational and distributing condoms can be removed (Rees, Beksinska, Dickso-Tetteh, Ballard, & Htun, 2000).

2.9.5. Sociodemographic variables

This includes economic status, age, and access to health care. According to Rees *et al.* (2000) many women move from poor, rural areas to find employment and resort to sex work when no other employment is found. In addition, men from South Africa and the region move to the large industrial centers and mining areas in search of work. As a result a large population of men lives in hostels away from their homes and families and sex work developed around these single-sex hostels and mines is sustained primarily by the migrant labour system. In many African and Asian countries, sex workers have been identified as a core reservoir for sexual transmitted infections (STIs). Assuming that the same situation prevails in South Africa, health interventions amongst sex workers are therefore crucial to the successful containment of the HIV epidemic. Sex workers use both the public and private sectors for health care (Nzila, Laga & Thiam., 1991).

According to Green (1988) a good deal of female sexual behaviour in Africa can be viewed as economic survival and adoption of patterns of male dominance. Patterns of male dominance also make it possible for males to coerce women, including teenage girls, into sexual intercourse without much fear of having to account for their behaviour so long as the woman is currently unmarried. In addition, sexual practices must be understood in their cultural context in order to understand the transmission of AIDS, the necessary intervention points to interrupt transmission, and realistic strategies for intervention.

In the case of AIDS risk behaviours, geographic differences have been related to the degree of saturation of HIV and the likelihood of having a close friend or lover with AIDS. Such direct experience with the condition has been reported by some men to be motivational factors in behavioural change. Some researchers have found that increased age and years of homosexual activity are related to persistence of higher-risk activity. Some authors indicate that the lag in risk-reducing behaviour change might be partly explained by lack of access to health care and information by time, and energy devoted to coping with crises more immediate than long-range health outcomes (Gordon and Klouda, 1994).

2.9.6. Social network affiliation and peer norms

In most studies of teenage health behaviours, it was found that thoughts reported by teenagers responding to whether or not they would ride to a party with a drunk friend were four times more likely to be social in nature than specifically health related. Social reinforcement is especially important for behaviour changes that require co-operation and social interaction. Factors such as availability or desirability of partners, emotional needs for affection and contact, clarity of values, communication skills and future plans are likely to influence sexual or reproductive health decisions (Ostrow, 1990).

2.9.7. Personality factors and cognitive cues

Individuals of an oppositional character may view risk-reduction education as a struggle over control of their personal lives and may therefore be resistant to change. Those who characteristically respond to anxiety with avoidance behaviour as well as those with a strong sense of shame about sexual matters may fail to seek out frank and explicit information needed to institute changes (Gordon & Klouda, 1994).

2.9.8. Sexual impulse control

According to Ostrow (1990) reported level of ability to control sexual impulses was found to be related to reduction in the number of partners and the modification of anal intercourse. Many of those who reported persistence in high-risk sexual behaviour stated that the behaviours were too enjoyable for them to stop, even though they were aware of risks involved. When individuals are sexually compulsive or “addicted,” the immediate gratification or relief of tension resulting from a sexual encounter temporarily overshadows the potential negative consequences.

2.9.9. Alcohol or Drug use

According to Gibson (1998) behavioural research on AIDS which has considered substance abuse variables reveals a strong positive association between potential HIV-transmitting sexual behaviours and multiple measures of drugs abuse, including use of drugs during sex, number of drugs used, and frequency of combining drugs and sex. More than half of those refraining from alcohol or drug use during sex were likely to have been at no risk of infection over the previous 6 months, while those who used alcohol or another drug even rarely during sex were 2-3½ times to be at high risk. Those who increased levels of risky behaviour over six month period were more likely to have used drugs, to have used multiple drugs, and to have had a high proportion of sexual encounters involving drugs (Ostrow, 1990).

2.10. Prevention Strategy for HIV and AIDS

Harrison, Smith and Myer (2000) indicate that a number of prevention efforts in South Africa have been implemented by the national and provincial governments and various non-governmental organisations. These efforts include: information, education and communication programmes, condom distribution, peer education, and behavioural risk reduction strategies. More recently counselling and testing has been used to help person assess their risks, to encourage or reinforce behaviour change, and to refer infected persons to clinical care (Higgins, Galavotti, O'Reilly, Schnell, Moore, Rugg & Johnson, 1991). According to Winiarski (1997) if public health efforts for reducing the risk of transmission of HIV were to be concentrated where they would have the most potential for positive effects, it would make sense to start with those people who are currently in a position to directly effect transmission: the people with HIV themselves and their sexual partners.

Many HIV positive people continue to have sex, and those uninvolved may seek romantic relationships, although their attitudes about relationships and condoms may vary (Norman, Parish and Kennedy, 1995 cited in Winiarski, 1997). It is not known how often HIV-infected people put someone else at risk, although, studies reviewed by Winiarski (1997) indicate that up to 40% might have unprotected sex after notification of their positive HIV serostatus. It is also believed that primary prevention is emphasised in intervention planning and evaluation, focussing on self-interest as a motivator, and that even writings which deal with the health needs and medical treatment of people who are infected with HIV pay minimal or no attention to prevention of HIV transmission.

2.11. Statement of the Problem

The Northern Province is the most rural province in South Africa. Albert (1995) remarks that about 91% of the inhabitants of this province are scattered in the former Lebowa, Gazankulu, and Venda homelands where access to facilities is still inadequate. As indicated in the previous chapters, HIV prevalence is estimated to be 17.04% in 1997 and

increased to be 22.8% in 1998. In 1997, the Northern Province alone had about 8.2% of infected pregnant women, and in 1998 the percentage increased to 11.5% (Tom, 2000).

This study seeks to explore medical doctors' transmission prevention assessment and counselling practices towards HIV-positive patients, and answering the question whether HIV-positive patients are given sufficient transmission prevention assessment and counseling by their medical doctors. It is believed that if medical doctors do their work properly the rate of infection would be reduced or lowered. The fact of the matter is that patients perceive their medical doctors to be sources of knowledge and information.

2.12. Rationale of the Study

Despite public health efforts to reduce risky behaviours associated with HIV/AIDS, transmission or infections rates are still high (Gerbert, Love, Caspers, Linkin & Kurack, 1999). To date, prevention efforts have focused on reducing the unsafe sexual and needle-use behaviours of HIV-negative individuals, with less effort focused on reducing the risky behaviours of the HIV-positive individuals who engage in HIV-related risky behaviours for numerous complex reasons.

Recent qualitative studies by Gerbert, Johnson, Herzing and Love (1996); and Barlow and Durand (1997) report that some HIV-positive patients had had unsafe sex or had shared dirty needles since learning about their status. Gerbert, Brown, Volberding, Cooke, Caspers, Love, and Brownstone (1999) indicate that even physicians with substantial number of HIV patients may not be conducting adequate prevention counselling. These studies also indicate that there is no study that carefully explores the transmission preventative assessment and counselling practices of medical doctors towards their HIV-positive patients, this is the second study aimed at redressing such a gap.

2.13. Significance of the Study

The study is significant given the importance of obtaining information about the current medical doctors' counselling approach towards HIV-positive patients' high-risk behaviours. It also casts more light on using assessment information to counsell patients about how to reduce risky behaviours and thereby improve their health and reduce the risk of transmission.

2.14. Objectives for the Study

The objectives are:

- To determine prevention measures taken by medical doctors towards reducing the risky behaviours of their HIV-positive patients.
- To determine medical doctors' perception of their role in conducting counselling with HIV-positive patients.
- To evaluate the medical doctors message content and counselling HIV-positive patients about risk behaviours.

2.15. Hypothesis

According to Peltzer, Hira, Wadhawan and Kamanga (1989) if physicians and/or medical officers do their work properly, patients would be helped to behave in ways that may retard the progression of the disease and reduce transmission of the virus. Phillips and Coates (1995) support this when they indicate that patients who are helped through counselling will be able to help others to come to terms with their personal risk. Thus, doctors who work with HIV-positive patients may help reduce transmission by assessing and counselling those patients to reduce their unsafe or risky behaviours.

In the study conducted by Bor (1989) on AIDS counselling, the doctors' involvement in AIDS prevention and HIV test counselling increased after seminars were offered to a group of doctors in Canada. These doctors reported having greater confidence in talking about the antibody test with their patients, recommending testing for spouses and treating HIV-positive patients. In another study conducted in the United States of America, physicians did not routinely discuss AIDS prevention with their patients even though patients rated them (doctors) as the most credible source of information on AIDS prevention (Gerbert *et al.*, 1999). That clearly had implications for physicians or doctors' training, specifically training in counselling skills.

CHAPTER THREE

3. Methodology

The methodology incorporates issues and information concerning the subjects/participants of the research, the sampling procedure, and size sample. In addition, methods include procedure for collecting data and the methods of data analysis.

3.1. Participants

A total sample of 15 medical doctors from hospitals in the Central Region of the Northern Province, viz.: Mankweng 6 (40%), Petersburg 7 (46.6%), and Seshego 2 (13.3%) Hospitals completed the interview. The majority of the sample is from the former Lebowa homeland who speaks Northern Sotho as their first language. In addition, the sample comprised community medical doctors 9 (60%), medical officers 4 (26.6%), registrars 1 (6.6%), and specialists 1 (6.6) working in medical, outpatient, and gynaecology departments in the above mentioned hospitals.

Most of the sample was male (80%) and of Africans origin (80%). Their average age was 28 years with a range of 20 to 45 years. Most of the medical doctors had been practicing in their current settings for about 1 to 5 years, and they see approximately 1 to above 20 new cases of HIV per day. Table 3a, and Table 3b, summarise the biographical information of the participants.

3.2. Sampling Procedure and Sample Size

This is a qualitative study, which used purposeful sampling. Medical doctors thought to be capable of providing a full description of the research topic were intentionally selected through an expert informant's assistance. The initial plan of the researcher was to focus on doctors who are specifically involved in counselling or treatment of HIV-positive patients.

It has been found from an expert informant that in public hospitals each and every medical doctor comes into contact with at least three to four HIV-positive patients per day. There is no HIV/AIDS clinic working with HIV-positive patients in the province.

Table: 3.a. Biographical Information of Participants: Nationality, Gender and Age

GENDER		NUMBER	PERCENTAGE
1.	Male	12	80%
2.	Female	3	20%
NATIONALITY			
1.	African	12	80%
2.	Indian	2	13.3%
3.	White	1	6.6%
AGE GROUP			
1.	20 – 25	2	13.3%
2.	25 – 35	10	66.6%
3.	35 – 45	3	20%

3.3. Procedures

A combined interview guide approach with standardised open-ended questions was used. In some of the questions, participants responded by “Yes or No” and motivated their responses. The interview was used because it offered core questions, and also allowed the researcher to respond and explore relevant topics in greater depth (Patton, 1990). The interview schedule addressed the following topics:

- Biographical information or data of the participants
- Doctors’ practices regarding transmission prevention assessment
- Doctors’ practices regarding transmission prevention counselling
- Doctors’ perceptions of their role in conducting counselling
- Factors that cue assessment and counselling, and
- Content of counselling messages

Furthermore, participants were requested to sign a consent form before they were interviewed. Their concerns about the use of a tape recorder during the process of interview were addressed. They were also assured of confidentiality because only the relevant information was collected and used for the research purpose. The interviews took place in the doctor's quarters, lasted for approximately thirty minutes, and were audiotaped. The audiotapes were transcribed and thereafter scratched. The University of the North Ethics Committee, Senate Committee, and the Northern Province, Department of Health and Welfare (Research and Quality Improvement Section) approved the research protocol.

Table: 3.b. Number of years in practice, current setting, and ranks and number of patients

	Frequencies	Number	Percentage
1. Number of years in practice	1 – 10	14	93.3%
	10 - 15	1	6.6%
2. Number of years in Current Setting	1 – 5	15	100%
3. Rank	Medical Officer	4	26.6%
	Specialist	1	6.6%
	Community Doctors	9	60%
	Registrar	1	6.6%
4. Number of Patients per Day	1 – 10	6	40%
	10 – 20	8	53.3%
	20+	1	6.6%

3.4. Data Analysis

To analyse the data, qualitative analysis procedures developed by Miles and Huberman (1994) were used. A coding template created by Crabtree and Miller (1992) to identify general themes in the data was used, which allowed for a variety of materials to be consolidated and subsequently analysed.

In the second phase of analysis, a conceptual clustered matrix was created to display the data, and participants' responses were tabulated and compared.

In the final phase, patterns of themes that emerged from the data were studied inductively. Results were continuously directed at the knowledgeable informant who aided actively in the interpretation of the findings (Gerbert *et al.*, 1999).

Patterns of medical doctors' styles of engagement were divided into three categories, according to Gerbert *et al.* (1999), which are: 1) "Consultant style," 2 "Collaborator style," and 3) "Consultant/collaborator style," which shall be discussed later. To distinguish these medical doctors' patterns, a rational decision cut off (coding analysis) was used.

If a medical doctor had a majority (six or more) of 3s across the coding categories, he/she was placed above the first cut off. Thus, this medical doctor's response revealed a more engaged counselling style.

If a medical doctor had a majority (six or more) of 1s across the coding categories, then he/she was placed below the second rational decision cut-off. This medical doctor's responses revealed a briefer, less engaged, informational counselling style.

All other responses fell between these two extremes and signify that these medical doctors share qualities of both counselling styles.

The internal validity of the findings from the interview results was established by the constant comparative method, along with the continuous review by the knowledgeable informant, and an external rater who assisted in the development of dominant themes coded one quarter of the data.

A Spearman rank coefficient was used to estimate interrater reliability at .96. Where the raters disagreed, the average of raters' scores was used as an estimate of the medical doctor response. Confirmation of the reliability of the doctors' responses throughout the interview was achieved by comparing medical doctors' responses to select interview questions with responses in related areas throughout the interview.

CHAPTER FOUR

4. Results

This section includes coding template analysis of dominant themes, which shall be discussed under the following sub-headings: doctors' perceptions of their role; medical doctors' use of cues; and negotiating appearing judgmental about HIV-positive patients' risk behaviours. Medical doctors' perception of their role shall be discussed under the following sub-topics: transmission prevention assessment and transmission prevention counselling message.

Furthermore, the section includes medical doctors' responses and summary of medical doctors' style of transmission prevention assessment and counselling, which shall be discussed under collaborator, consultant, and consultant/collaborator styles.

4.1. Coding Template Analysis Dominant Themes

The scientific analysis of the coding template (Table 4a.) revealed three main themes: Doctor's perceptions of their role in HIV transmission prevention assessment and counselling; their (Medical Doctors') use of cues to revisit assessment; and negotiation of appearing judgmental.

4.1.1. Doctor's perceptions of their role

Medical doctors perceived their role in HIV transmission prevention assessment and counselling differently. Most medical doctors view counseling HIV-positive patients to reduce risky behaviours as part of their job, particularly, giving information about HIV/AIDS and risky behaviours due to the fact that "Patients are more likely to take advice and information given by medical doctors" (as one medical doctor worded it). They seemed to believe that it is patients' decision as to determine how the information would be used. It

is not surprising because only few of them who prioritise counselling patients about risky behaviours as compared to clinical conditions or medical needs of those patients. Those who prioritise transmission prevention assessment and counselling HIV-positive patients feel it a good opportunity to give advice and information to patients. There is a very interesting argument put forth by some medical doctors that if ever there are doctors who prioritise medical and psychosocial aspects of the patients' care, they are not providing effective services. They strongly argue: "Time is a luxury medical doctors do not have and cannot afford to waste." In addition, "counselling is also situational based because those (patients) who consult present among other things with mental confusion."

Some of them strongly argue that prioritisation of transmission prevention assessment and counselling is impossible. One doctor said, "However, counselling patients about risky behaviours is my second priority because HIV-positive patients need to be shown love and care when counselling and educating them about risky behaviours." There are few medical doctors who focus on both aspects of patients' care, medical needs and risky behaviours. The argument put forward is that time factor impede negatively on the provision of effective counselling. "In public hospital, a single doctor is expected to see many patients, and as a result transmission prevention assessment and counselling becomes impossible," (as one medical doctor indicated).

If ever there is a suspicion that an individual patient is engaging in risky behaviour, he/she is referred back to HIV/AIDS counsellors, social workers and psychologists. Other medical doctors view their colleagues to be better trained in providing counselling services to HIV-positive patients because "through counselling, HIV-positive patients are encouraged to disclose their HIV-status to their families and partners." To reach that level time and skills are required and medical doctors perceive the above mentioned professionals as possessing those qualities.

Table 4.a.: Coding Template Identifying General Themes

Coding Categories	Participants' Responses	Responses
Doctors' Role	Giving information and referring patients to other health workers due to lack of time and inadequate counselling skills.	36%
	Encouraging patients to change their risky behaviours to prevent the spread of the virus.	40%
	Doctors focus mostly on the patients' medical needs and the danger of contracting STDs.	60%
	Dangers of re-infection, and transmission of HIV to others during counselling and giving information.	26.6%
	Usually ask patients the following questions: "Do you use condoms each and every time you have sexual intercourse."	33.3%
Cues	Recent STDs and other infections trigger doctors to counsel or reassess HIV positive patients about risky behaviours.	66%
Neg. Judgmental	Doctors believe that each and every person can be HIV infected. We are either affected or infected by the virus.	60%
	It is also important to take HIV/AIDS just like other diseases with the potential for killing people. Treating HIV-positive patients like other patients with different conditions helps doctors to be neutral about HIV/AIDS.	46.6%
	It is the patient's decision whether to change their risky behaviours or to continue spreading the virus. Doctors only give advice to those patients.	40%

(a). Transmission Prevention Assessment

Some medical doctors find themselves in a dilemma about their role in HIV transmission prevention assessment and counselling. When they were asked: "During the initial visits of HIV-positive patients do you ask what kind of risky behaviours they may be doing," most were found to be asking their patients. However, they also reported: "Most of the patients do not admit that they are engaging in risk behaviours." Medical doctors usually ask the following questions: "Do you have a boy-/or girlfriend. How many sexual partners do you

have, and do you use condoms? Have you ever had STDs before and what kind of birth control do you use?"

The other percentage of doctors responded to the same question by saying: "Patients who consult or get admitted to a hospital are usually at the advance stage of HIV/AIDS and they are just dying. Others who get admitted due to HIV/AIDS related infections, such as tuberculosis and pneumonia, are treated and discharged. Following-up those particular patients is difficult if not impossible because when they come for check-up they are seen by a different doctor. I may not be sure if ever those doctors ask questions about risk behaviours patients may be doing." However, there is a strong feeling from those medical doctors that such questions fall within the jurisdiction of counsellors and medical doctors' focus should be on the patient's presenting problems and treating them.

Half of the participants partially revisit patients' risky behaviours. When medical doctors were asked: "If HIV-positive patients tell you they are engaging in risky behaviours in the first few visits, do you reassess it on an ongoing basis," most responded by saying "no" and others said "yes". In response to the question: "What do they do with those patients," they indicated that they ask them (patients) the following questions: "Do you use condoms, are you sticking to one sexual partner, and does your sexual partner know about your HIV-status. Is your family aware of your HIV status?" They only asked questions aimed at patients' sexual practices or behaviours but not getting into the ways of helping patients to use their resources towards reduction of risky behaviours.

Other medical doctors try to make patients aware of other infections related to HIV/AIDS. One medical doctor responded as follows: "I say to my patients, listen, can you see how risky you are, you are risking your life and others', ...this means that you are having unprotected sex." Basically, patients are given relevant information about HIV/AIDS, but are not really helped to understand the effects of having unprotected sex. In addition, patients are helped to understand: "It is no use to be angry at their partners, but trying to accept the condition because it is the best thing to do."

A fraction of doctors feel that there is no need for frequently repeating or reassessing one thing time and again, “patients should understand right from the first consultation and/or pre- and post-test counselling.” Medical doctors were asked: “Do you make risky behaviours part of a problem list?” It is interesting because most of them make risky behaviour part of their problem list, however, they do not prioritise it. They indicate that they do not make it part of the problem list only with HIV-positive patients, but all patients who have STDs. “I make those patients aware that they are risking their lives by practicing unsafe sex and spreading the virus,” (as one doctor worded it).

However, most of the patients are believed to benefit from post-test counselling and those who continue with their risk behaviours are frequently referred back to counsellors. Thus, most of the doctors are in between – view themselves as sources of information about risky behaviours, and responsible for actively helping the patients use the information to reduce risky behaviours. The conceptual clustered matrix (Table 4b) facilitated the refining of the coding template and also involved summarizing the responses of each research participants on the codes relevant to the emergent dominant themes from the initial analysis of the data.

(b). Transmission Prevention Counselling Message

There is a feeling among doctors that when counselling patients for HIV/AIDS transmission prevention focus should be on giving information about HIV and removing the myth around this disease. Most doctors give similar information to HIV-positive patients who consult in their rooms and those in the wards. One medical doctor indicated: “I ask my patients... do you know anything about HIV/AIDS, ... I start explaining to them HIV/AIDS and how it affects people.” “I also explain the meaning of HIV-positive results and their implications....” ...HIV/AIDS can not be cured, but we can only prevent or control opprtunitistic infections, and to be HIV-positive is not the end of the world....” In addition, patients are reassured that they are not the only people who are HIV-positive, “approximately 1500 people get infected per day in South Africa,” said a medical doctor.

Table 4b: Conceptually Clustered Matrix

Coding Categories	Participants' Responses
(1). MDR	“Drug treatment and counselling HIV-positive patients to reduce their risky behaviours are my responsibility. However, most of the patients are referred to HIV/AIDS counsellors...for further assessment and counselling. The best I do is giving information to patients about HIV/AIDS. However, my focus is more on the patient’s medical needs.”
(2). TPA	I usually ask patients: “Do you have sexual partners, and do you use condoms.” In addition, patients are given information and advices about HIV/AIDS support groups and available drugs. “Giving information time and again about HIV/AIDS and advice on how should patients live remains the most important thing amongst doctors.”
(3). C	“Most doctors reassess and counsell HIV-positive patients who present with recent sexual transmitted diseases. Thereafter, patients are referred... for further assessment and counselling.”
(4). TPA-R	“Patients are shown the danger of having unprotected sex and spreading the virus to other people. Giving them information about HIV/AIDS and what they should do to live positive with HIV. The focus of doctors is mostly on the patients’ medical needs. Thus, most doctors do not make risky behaviours part of their problem list because we do not do actual counselling.”
(5). T-TPCM	“Focus of counselling is on giving information to patients about HIV/AIDS. Encourage the use of condoms and protecting those whom they (patients) love and living around them. In addition, giving information about the dangers of contracting sexual transmitted diseases.”
(6). NJ	“There is no reason for being judgmental about HIV/AIDS patients. Each and every person can be HIV positive, it is therefore, important that HIV-positive patients be treated fairly. I try to be as neutral as possible when treating HIV-positive patients. Patients are not responsible for making decisions whether to spread the disease or not. Most of them are illiterate and do not understand risky behaviour. Medical doctors and other health workers are responsible for guiding and advising patients.”

Note A: *MDR = Medical Doctors' Role, TPA = Transmission Prevention Assessment, TPA-R = Transmission Prevention Assessment-Revised, C = Cues, T-TPCM = Type of Prevention Counselling Message, and NJ = Negotiation of Judgement.*

“...To be HIV-positive does not mean that you are dying now or tomorrow, many people are HIV-positive but they do not know because they never tested” (one medical doctor worded it). A particular doctor stated: “... you are HIV-positive and you should not put your life and others into risk. Make sure that you use condoms, ...if it happens that you bleed... no one should touch your blood barehanded.” However, some medical doctors feel that it is also the community’s responsibility to assist in the reduction of the spread and transmission of HIV/AIDS. Giving information about HIV/AIDS remains the most important thing for doctors. Medical doctors advise patients to bring along spouses for HIV testing and counselling. Those who did not inform their partners about their status are encouraged to do so, as a way of showing their responsibility as human beings. They are also advised to improve their health behaviour and diet. Basically, the content of counselling message is educating patients about living positive life with HIV and accepting the condition.

Other medical doctors strongly feel that counselling HIV-positive patients is not part of their duty; they all recommend that those patients should inform their spouses and partners about their HIV status. Furthermore, information is imparted on the danger of getting children and the importance of using condoms when they engage in sexual intercourse and consulting a doctor for any opportunistic infection. When medical doctors were asked: “Do you mention the danger of contracting STDs, re-infection or transmission of HIV to others in you counselling message?” Most of them focused only on the danger of contracting sexual transmitted diseases. They argue that if counselling is effective, it should address the danger of contracting STDs. Others believe it is important to address transmission of HIV to others by HIV-positive patients. These medical doctors strongly argue that contraction of sexual transmitted diseases and re-infection is less important in HIV-positive patients.

4.1.2. Doctors' Use of Cues

Almost all medical doctors conducted some form of transmission prevention assessment and counselling in the first consultation with HIV positive patients. They usually reassessed or counselled patients when they (patients) presented with a sexual transmitted disease (STD) (93.3%). The remainder of medical doctors reassessed patients if they presented with risky behaviours such as changing of sexual partners, HIV positive couple planning to have children, and those who lack information or knowledge about HIV/AIDS.

4.1.3. Appearing Judgmental about HIV-Positive Patients

“There is no reason for being judgmental about HIV/AIDS because each and every person can be HIV-positive through bad luck.” One medical doctor stated: “I take or treat HIV-positive patients like any other patient with a particular condition, not related to HIV/AIDS. I usually imagine myself in that particular person’s situation and other people discriminating against me.” Most of the medical doctors may be through experience and understanding that HIV/AIDS is just as other diseases, which can be contracted by any living being, are not judgmental at their patients. Thus, “... each and every body is either affected or infected because our relatives if not ourselves are HIV-positive therefore, there is no reason for being judgmental about it.”

Medical doctors perceive their responsibility to be that of providing care and treatment to patients in pains without being judgmental about their conditions. Some of them (medical doctors) feel there are those patients who make them feel they (patients) wanted to be infected because even if they try to help them, they remain the same. “As long as HIV-positive patients are responsible and taking advice there is no need for blaming them,” a particular medical doctor said. Some doctors feel it is their responsibility to protect not only HIV-positive patients, but also the society. “Patients are not trained in understanding of HIV/AIDS only health workers, particularly doctors. If they are not able to influence patients to change their risky behaviours, it is rather important to refer them to HIV/AIDS

counsellors.” Thus, “... medical doctors and patients should work together in helping them to change their behaviours. As part of the society, medical doctors should make sure that what patients decide on is not harmful to the society.”

However, some of the medical doctors perceive their role as limited in the consulting rooms, where they give information to the patients. They argue that the way patients live outside the consulting room is none of their responsibility: “Patients also have responsibility to protect those whom they love from acquiring HIV.” One medical doctor stated: “I give patients information about a particular condition, it is upon the patient to do as advised. If they do not want to change is their own problem.” Thus, after counselling patients about their risky behaviours, medical doctors feel it is the duty to be responsible. Furthermore, they indicate that it also depends on how the patient was behaving or living before, but the larger part of responsibility remains with the patient, thus “patients have responsibility to change their behaviours.”

4.2. Medical Doctors’ Responses

The patterns of medical doctors’ responses appeared to be divided into three significant styles of engagement in transmission prevention assessment and counselling; “consultant,” “collaborator” and “consultant/collaborator” as previously mentioned. To further describe these styles, eight coding categories that appeared to differentiate medical doctor styles of conducting transmission prevention assessment and counselling were selected. Consultants’ style (coded 3) reported that they conduct transmission prevention assessment and counselling during the initial visits of their patients or when the patient presents with sexual transmitted diseases. Thus, they primarily view themselves as sources of information about HIV/AIDS and available drugs.

4.3. Summary of Doctors Styles of Transmission Prevention Assessment

The transmission prevention assessment and counselling style for the participants are summarised into (1) Consultant, (2) Collaborator, and (3) Consultant/collaborator styles (Gerbert *et al.*, 1999).

4.3.1. The Consultant Style

Consultants focus primarily on the biomedical aspects of patients' care and view their role as sources of information about HIV/AIDS and available retro-viral drugs. They believe it is their responsibility to treat patients, but they do not do actual transmission prevention assessment and counselling. Patients are just referred to other professionals who are viewed as, "...mostly responsible for counselling patients to reduce their risky behaviours," without consultants having discussed with them. When medical doctors were asked: "Where does counselling about risky behaviours fall on your list of priorities compared to medical needs for HIV positive patients?" One medical doctor stated: "I prioritise the patients' medical needs while the other aspects, particularly counseling is left in the hands of counsellors and psychologists." They usually refer their patients because they feel that counselling patients about their risky behaviours is time-consuming, and as medical doctors time is one thing they do not have. About 20% of medical doctors met the criteria of consultant style, the most part of medical doctors are identified within consultant/collaborator style to be discussed below.

Furthermore, consultants do not make risky behaviours part of their problem list when treating HIV/AIDS patients. Thus, they only treat what the patient presents during consultation. In some instances they revisit risky behaviours only when they receive a medical cue, such as sexually transmitted disease. They believe "there is nothing to be done neither through medicine and counselling because those patients are just going to die." They basically do not have enough time to sit down with patients; the argument put forward is that, "there are many patients they see per day." Generally, consultants do not conduct

transmission prevention assessment and counselling in depth, but shortly during the initial visit and during history taking. Thus, they conducted transmission prevention assessment and counselling only during the initial visits and/or when a medical cue such as STD occurs and they viewed themselves primarily as a source of information.

Table 5a gives examples of medical doctors' responses coded on a 3-point rating scale for eight coding categories. A rating of 1-indicates a weighing of the quality of response toward "consultant." A rating of 3-indicates a weighing of the quality of response toward "collaborator," and a rating of 2-indicates an intermediate weighing. Column 1 includes the questions associated with each of the coding categories and columns 2 to 4 present examples of the consultant style, components of both styles, and of the collaborator style, respectively.

4.3.2. Collaborator Style

Medical doctors considered as using the 'collaborator style' focus not only on the biomedical but also on the psychosocial aspects of patients' care. Collaborators are both interested in "managing the disease at the technical level" and engaged in problem solving about risky behaviours. They strive to form an effective collaboration with the patient because they believe transmission prevention assessment and counselling is an important part of their job. "Depending on the level of trust the patient has on me. I ask: 'What do you understand about risky behaviour?'" However, those doctors who have the element of collaborator style in this study were unable to offer proper services because they do not feel absolutely responsible for counselling patients.

During initial visits, collaborators assess patient knowledge about risky behaviours and the level of behavioural risk. As indicated earlier, participants in this study may not meet all the criteria of being collaborators. They basically focus on medical needs of the patient's care; their concern is not solely on the psychosocial cues, which may be responsible for patients spreading the virus. However, in this study collaborators are only present in the

medical doctors' responses that were coded on a 3-point rating scale for eight coding categories. In the ratings across the eight coding categories for each medical doctor, the 'collaborator style' disappeared.

Collaborators will go beyond providing a neutral educational message by acknowledging the patient's difficulty of practicing safer sex and drug use, expressing empathy concerning the difficulty, affirming sexual desires, and offering strategies and specific tools to help patients reduce risky behaviours. They express concern about how patients' behaviours may be affecting patient health and transmission to others without blaming or shaming the patient. Despite the fact that they try to be unjudgmental, medical doctors are directive, telling the patients what to do. Counselling in their perspective may include referral, but only after they have engaged the patient in discussions about risky behaviours and have tried to influence them to change their behaviours. Results indicate that medical doctors in public hospitals shift their responsibility to HIV/AIDS counsellors, social workers, and psychologists.

4.3.3. The Consultant/Collaborator Style

Some medical doctors are neither of the two patterns or counselling styles, discussed above, and they fall within "consultant/collaborator" style (coded 2). Medical doctors with components of consultant/collaborator style tends to focus primarily on the biomedical aspects of patients' care and view themselves as educators, but they also believe that they have some responsibility for helping patients change risky behaviours. "...Counselling patients to reduce their risky behaviours is part of my responsibility, ...I do not prioritise it, as it is time consuming." These doctors assess risky behaviours "on an ongoing basis," using standardised assessment questions, asking patients about sexual partners they have and change of those partners. They also state to patients that their behaviours "changing partners and not using condoms" put their lives at risk of being re-infected and transmitting the virus to other people. They basically provide patients with advice and information about the available resources such as HIV/AIDS support groups.

Table 5.a.: Representative Quotes from Medical Doctors

Coding Categories	Consultant Style (Coded 1)	Consultant/Collaborator (coded)	Collaborator Style (Coded 3)
<p>MDR "Do you think counselling patients to reduce risky behaviours is part of your job? Where does counselling about risky behaviours fall on your list of priorities compared to medical needs for you HIV positive patients?"</p>	<p>"Patients who effectively post-test counselled usually change risky behaviours... counselling patients learn to reduce the number of sexual partners.... They learn that it is not a solution to deny their status... I prioritise risky behaviours for those who are still negative. HIV positive patients I tell them to use condoms. They are going to die soon, so there is little I can do as a doctor..."</p>	<p>"Is my responsibility, most people benefit from post-test counselling. I usually advice them to change their sexual behaviours... AIDS counsellors do the most part of counselling. I prioritise both aspects of patients' care. Patients need to be counselled... accept their condition and not to spread the virus.... I also give information about how should they care for themselves. Treat opportunistic diseases that patients present during consultation."</p>	<p>"Counselling encourages safer sexual behaviour as well as prevention of the spread of HIV/AIDS. It reduces the degree of patients' anger. Counselling patients... is the first on the list of priorities. The best we can do as doctors and health workers is help to reduce...transmission through counselling..."</p>
<p>TPA "During the initial visits with your HIV-positive patients, do you ask what kinds of risky sexual and needle use behaviours they may be doing? What question do you use? What kinds of things do you say?"</p>	<p>"I do not ask the kinds of risk behaviours they may be doing. Those who come to the hospital get treated and discharged. When they come again another medical doctor sees them and I am not sure if ever they border asking those questions. However, I give them information about HIV/AIDS."</p>	<p>"I usually ask... do you have a sexual partner, how many do you have, I also ask them, do you change girl- or boyfriends, and tell them... that may put you at risk of transmitting the disease or virus... Do you use condoms during sexual intercourse...? I advice them to consider bringing their partners for counselling and inform them about their (patients) HIV-status."</p>	<p>"Depending on the level of trust the patient has on me as a doctor. Level of interaction plays an important role.... It is difficult to say how do I assess and counsel patients, but give information, telling them that HIV/AIDS is not the only incurable disease... so be positive and let life continue. Even though you are HIV-positive there are still a lot of things you can do. You are not dying today or tomorrow, be strong and always use a condom..."</p>

<p>Cues "What would trigger you to counsel or reassess your HIV-positive patients about risky behaviours?"</p>	<p>"I reassess those patients who present with recent STDs."</p>	<p>"Those who have STDs and recurrent-infections I reassess and refer to HIV/AIDS counsellors."</p>	<p>"When an HIV-positive patient who has been counselled present STDs... I give them information about being HIV-positive and having a baby. Basically I encourage them not to have a baby."</p>
<p>TPA-R "If your HIV positive patients tell you they're engaging in risky behaviours in the first few visits, do you reassess it on an ongoing basis? Do you make risky behaviours part of a problem list? Is there ever a time that you would make risky behaviours part of a problem list?"</p>	<p>"I talk to patients once, there is no enough time in a public sector to counsel one patient time and again. The only thing I do is just to shortly ask them: " Are you now practicing safer sex."</p>	<p>"I reassess risky behaviour, but not always... I refer patients to a psychologist, as it will be an indication that they are not benefiting from me. I ask patients, how many sexual partners do you have, are you married, is your spouse also losing weight, and do you use condoms..."</p>	<p>"I usually do it as a routine. I make it a point that I keep on asking them about their behaviours. I try to find-out if ever they are reducing their sexual partners..."</p>
<p>T-PCM "Could you tell me, specifically, what you say to someone when counselling him or her? Do you mention the danger of contracting an STD, re-infection, and/or transmission to others in your message to practice safe sex?"</p>	<p>"...if you do not use condoms it means that you want to spread HIV/AIDS to other people... protect yourself and others from contracting other STDs and transmitting the virus to other people."</p>	<p>"I basically educate, educate, and educate all patients who have been diagnosed to be HIV-positive... giving information about living positive with HIV/AIDS... use condoms, ...mentioning the danger of contracting STDs..."</p>	<p>"I say to them live a positive life and enjoy life even if you are HIV-positive. I also say to them, to be HIV-positive does not mean that you are dying now or tomorrow, also mentioning the danger of contracting STDs..."</p>
<p>NJ "How do you negotiate appearing judgmental when you talk to your HIV</p>	<p>"HIV-positive patients should always think of the innocent people before</p>	<p>"Yeah, that is a difficult thing and it depends on the age of the patient. I usually feel sorry for</p>	<p>"I never judged any HIV-positive patients... try to be as neutral... develop positive attitude and hope</p>

<p>positive patient about risky behaviour and/or transmission?"</p>	<p>putting them at risk and infecting them with the virus..."</p>	<p>children because they do not know anything about HIV/AIDS."</p>	<p>about the future... HIV/AIDS is like any other contagious disease, I am willing to sit down with them and talk."</p>
<p>PDM "Some physicians think it's the patient's decision whether to engage in risky behaviours, what do you think about that?"</p>	<p>"I do agree with those doctors ...patients decide whether to engage in risky behaviours or to change... it is up ... to practice safer sex and reduce chances of re-infection and infecting others."</p>	<p>"I think it is both sides, the patients as well as doctors should work together in helping patients change their risky behaviour. But most important is that patients should take it upon themselves to go out of the doctor's consulting room and practice safer sex..."</p>	<p>"I disagree with those doctors. It is not the patient's decision whether to spread the virus or not, but a responsibility for all of us.... Patients are not informed about HIV/AIDS, so they need a medical doctor...."</p>
<p>TPCI "Do you think it is your responsibility to try to change you HIV positive patient's risky behaviours? If so, how do you go about trying to influence your patient's behaviour?"</p>	<p>"I tell my patients to have one partner, be faithful and use condoms..."</p>	<p>"I inform patients about... wrong and right... advice them with the hope..."</p>	

Note: *MDR = Medical Doctor's Role, TPA = Transmission Prevention Assessment, TPA-R = Transmission Prevention Assessment-Revised, T-TPCM = Type of Prevention Counselling Message, NJ = Negotiation of Judgement, PDM = Patient Decision-Making, TBCI = Transmission Prevention Counselling Influence.*

Doctors using the ‘consultant/collaborator style’ strongly believe that risky behaviours are not solely the patients’ decision but both doctors and patients. One doctor indicated: “Both patients and doctors should work together in helping patients change their risky behaviour.” They believe that patients usually get confused and depressed after the diagnosis of HIV/AIDS. Therefore, doctors should come in and help patients to come to terms with the diagnosis and help patients make healthy decisions. When they feel like patients are not benefiting from their services and for lack of time in public hospitals, they refer patients to other health workers, namely: social workers, psychologists, and HIV/AIDS counsellors. Table 5b displays the ratings across the eight coding categories for each medical doctor. The distribution of medical doctors’ styles ranged from collaborator to consultant. In general collaborator style (coded 3) report that they conduct transmission assessment and counselling on an on going basis

Table 5.b.: A rational decision cut off (Coding analysis across eight coding categories)

Coding Categories									
MD I	MDR	PTA	CUES	TPA-R	T-TPCM	NJ	TPCI	PDCI	TS
1.	3	3	1	2	1	3	2	2	17
2.	3	2	3	1	2	3	1	2	17
3.	2	1	1	2	3	2.5 ^a	2	2	15.5
4.	1	3	1	1	3	3	2	2	16
5.	2	1	1	1	3	3	3	1	15
6.	1	1	2	1	1	3	3	2	14
7.	1.5 ^a	1	1	2	2	3	2	2	14.5
8.	3	2	1	2	2	3	3	2	18
9.	2	2	1	3	1.5 ^a	3	1	1	14.5
10.	2	1	1	2	1	3	3	1	14
11.	1	3	2	1.5 ^a	3	3	2	2	17.5
12.	2	3	1	1	2	1	2	2	14
13.	1	1	1	1	1	3	2	1	11
14.	3	1	1	2	1	1	1	1	11
15.	1	3	1	1	1	1	1	1	10

Note A: MDI = Medical Doctor’s Identification, PR = Medical Doctor’s Role, TPA = Transmission Prevention Assessment, TPA-R = Transmission Prevention Assessment-

*Revised, T-TPCM = Type of Prevention Counselling Message, NJ = Negotiation of Judgement, PDM = Patient Decision-Making, TBCI = Transmission Prevention Counselling Influence, and TS = Total Score. **Note B:** If a medical doctor had a majority (six or more) of 1s across the coding categories, then were placed below the second rational decision cut-off. These medical doctors, responses revealed a briefer, less engaged, informational counselling style. All other responses fell above the consultants and signify that these medical doctors share qualities of consultant/collaborator counselling styles. **Note C:** ^aRater disagreement (average of 4 scores)*

Consultant/collaborators view themselves as responsible for giving information and for actively helping patients use that information to improve their health and reduce the risk of transmission they shared qualities of both counselling styles, their average total score (mean = 16) was far to the average total score for consultant medical doctors (mean = 11). These consultant/collaborator medical doctors tended to use referral to social workers, HIV/AIDS counsellors and psychologists to augment patient care.

CHAPTER FIVE

5. Discussion

The section in discussion incorporates the approach used by medical doctors during prevention assessment and counselling HIV-positive patients; reduction of risk behaviour in HIV-positive patients; and knowledge of risk behaviours and behaviour change. It also includes conclusion, limitations of the study, and recommendations.

5.1. Approach to HIV-positive Patients' Risk Behaviour

The study clearly shows that medical doctors perceive their role in HIV transmission prevention assessment and counselling differently. Most view transmission prevention assessment and counselling as part of their job, particularly, giving information about HIV/AIDS and risky behaviours. However, few of them prioritise prevention assessment and counselling patients about risky behaviours as compared to clinical or medical needs. Some medical doctors, who have some elements of 'collaborator style,' prioritise prevention assessment and counselling.

These medical doctors have feelings of responsibility, particularly for "giving information and helping patients use that information to improve their health, and reduce the risk of transmission." These findings correspond with those of Gerbert *et al.* (1999) who indicate that collaborators tend to engage patients in building a relationship inclusive of personal psychosocial aspects: "I try and involve myself in their life... to get a good social history." However, in this study those medical doctors (with some elements of 'collaborator style') are unable to offer proper and effective services because of time factor and that there are trained counsellors who work with HIV-positive patients in the hospitals.

Although, most medical doctors argue that those colleagues who prioritise medical and psychosocial aspects of patients' care, they are providing ineffective services. They

strongly argue that prioritisation of assessment and counselling is impossible in public health institutions. These findings suggest, for example, that most medical doctors do not play a more active, ongoing role in influencing patients to reduce risk behaviours. Indeed, they use more of 'consulting style' waiting for a medical cue before discussing risk behaviours patients may be doing. Therefore, their effectiveness may not be like that of research in other areas of prevention, which shows that prevention messages within the context of an established patient-physician relationship can increase patients' prevention behaviour (Fleming, Barry, Menwell, Johnson & London, 1997).

According to Gerbert *et al.* (1999) patients who are not contemplating changing their risky behaviours, may react negatively on a physician's attempt to engage them in personal discussions and teach them to reduce risk. This may go to an extent of affecting the physician-patient relationship and jeopardise the patients' health. In short, these findings suggest that medical doctors working with HIV-positive patients should engage them (patients) in building a working relationship and also addressing their personal psychosocial aspects. Peräkylä & Bor (1990) support the argument, they indicate that patients are may be less likely to cut off their relations with their support networks, including doctors or to develop psychiatric complications if they are involved in their treatment.

5.2. Reduction of Risk Behaviour in HIV-positive Patients

The findings of this study reveal that medical doctors conduct some form of transmission prevention assessment and counselling in the first consultation with their patients. They usually reassess or counsel patients who present with sexually transmitted disease. In addition, results reveal that patients admitted for HIV/AIDS related infections, get medical treatment and when they stabilised, they are discharged or referred to other health professionals. These medical doctors believe that their job is "to deal with the symptoms of HIV/AIDS" and only focus on helping patients maintains "as healthy lifestyle as they are able." In addition to responding to medical cues and patient questions, medical doctors with

some elements of collaborator style revisited transmission prevention assessment and counselling patients (Gerbert *et al.* 1999).

However, these are the least compared to consultants who just ask what patients do and tell them: “You are risking your life and others’.” It is a fact that medical doctors have the opportunity to help prevent transmission of HIV by assessing their patients for risky behaviours. In addition, by providing counselling to the patients about how to reduce these behaviours, most medical doctors view transmission prevention assessment and counselling as part of their job, particularly giving information about HIV/AIDS. However, there are few of those who try to understand patients’ feeling and perceptions about risk behaviours as compared to clinical or medical needs of those patients.

Findings suggest that some medical doctors have feelings of responsibility, particularly for giving information and helping patients use that information to improve their health and reduce the risk of transmission. These findings correspond with those of Gerbert *et al.* (1999) who indicate that collaborators tend to engage patients in building a relationship inclusive of personal psychosocial aspects. They strive to form an effective collaboration with patients and they believe that transmission prevention assessment and counselling is part of their job. Medical doctors feel compelled to give advice and information and are convinced that patients are likely to take advice and information given by their medical doctors. Unfortunately, these medical doctors in this study are unable to offer proper services because of time factor and number of patients.

Medical outcomes study physicians in busy, high volume practices regardless of type of practice organisation were rated as less participatory unlike those in lower volume practices. In addition, busy practices with shorter office visits have empirically linked with less effective patient behaviour during those visits. Thus, patients were shown to be less effective in information seeking during visits lasting less than 18 minutes (Kaplan, Greenfield, Gandek, Rogers & Ware, 1996). These findings suggest that in public health institutions effective participation of patients in their treatment and time factor and number

of patients a medical practitioner see per day hamper understanding of their diagnosis. In supporting these findings Silverman, Peräkylä and Bor (1992) state that these medical doctors simply announced their patients' diagnosis or limited themselves to an instruction to their patients. The implication is that patients are not given enough time to ask questions about their conditions, but to take instructions from the medical practitioner.

Kaplan, Greenfield, Gandek, Rogers and Ware (1995) support the argument, indicating that accumulating empirical studies show that patients of physicians who encouraged them to participate more effectively in treatment decisions have more favourable health outcomes, both physiological and functional status, than those whose patients do not. In addition, more time with the physician has been associated with more favourable ratings of the encounter by the patients. According to Silverman, Perakyla and Bor (1992) patients should be involved in their own treatment and medical doctors should encourage offer of changed behaviour. According to Carpenter, Fischl, Hammer, Hirsch, Jacobson, Ketzenstein, Montaner, Richman, Saag, Schooley, Thomson, Vella, Yeni, and Volberding (1998); and Deek, Smith, Holodniy and Kahn (1997) even with the effectiveness of new drug therapies, the reduction of risky behaviours remains the only proven way to prevent horizontal HIV transmission (drug therapy can prevent vertical transmission) and could also positively affect HIV-positive patients' health status.

5.3. Knowledge of Risk Behaviour and Behaviour Change

It is clear from the findings that medical doctors, who dwell much on giving information about HIV/AIDS and risky behaviours instead of assessing and counselling their HIV-positive patients, may not be effective in the process of helping patients and reduction of HIV transmission rate. In addition, Stall (1994) states that individuals with HIV did not change their risky sexual behaviours even though they had accurate information about risky behaviours. This finding is also supported by research conducted by Flowers, Booraem, Miller, Ireson, Copeland and Furtado (1991); and O'Connor and Saunders (1992), which shows that mere knowledge of health risk associated with behaviour, does not always lead

to behavioural change. In contrast, the study conducted by Weinhardt, Carey, Johnson and Bickham (1998) on “The effects of HIV counselling and testing on sexual risk behaviour” indicates that most HIV-positive participants and HIV-serodiscordant couples reduced their frequency of unprotected intercourse and increased their condom use, after receiving counselling and testing.

According to Ostrow (1990), knowledge of what constitutes risk is obviously an important prerequisite to voluntary health-promoting behaviour change. In addition, knowledge about HIV/AIDS has been seen to play a role in motivating initial behaviour change, particularly in persons who see themselves as being in a relatively low risk and less informed about the disease and the route of transmission. The implication is that medical doctors and those involved in health care of HIV-positive patients should change from being the source of information to transcending knowledge of risk behaviour and usage of that knowledge in enhancing healthy behaviour among patients. Moving from that perspective is perceived as a positive way of reducing the risk of transmission because education that aims solely to increase knowledge would appear to be limited in its ability to induce and maintain alterations in their (patients) risky behaviours. Generally, health workers can prevent transmission of HIV by assessing HIV-positive patients for risky sexual behaviours, and by providing risky reduction counselling.

The fact is that HIV-positive patients engage in HIV-related risky behaviours for numerous complex reasons, “confusion after diagnosis of HIV...” and “they do not know that what they are doing is risky” (as some medical doctors indicated), they are coerced by others and/or they may be psychologically disturbed. Helping these patients would be difficult to achieve in public hospitals because the vast majority of doctors who are in close contact with patients do not intensively assess and/or counsell those patients.

5.4. Conclusion

In conclusion, the findings of this study reveal that most medical doctors tend to focus primary on biomedical aspects of patients' care and also see themselves as source of information. However, they do believe that they have some responsibility for helping patients change risk behaviours, but they do not make risk behaviour part of their problem list. "Counselling patient... part of my responsibility... do not prioritise it, it is time wasting" (as one medical doctor worded it). In addition, findings suggest, for example, that some medical doctors believe risky behaviours are the patients' decision, but they do refer patients to other health professionals, particularly HIV/AIDS counsellors. Medical doctors themselves rarely get actively involved in giving patients risk reduction information and helping them (patients) use that information to reduce risky behaviours.

It is therefore; clear that some medical doctors may not be prepared to engage patients in psychosocial assessment (prevention assessment) and in ways of reducing their risky behaviours. The reason behind this attitude may not be known, but most of them may be overwhelmed and pressed by time factor and number of patients in public health institutions. Furthermore, from the results it is clear that health fraternity is faced with barriers for changing medical doctors' prevention and counselling practices or styles, especially within the scope of their medical training or education. Therefore, there is a need for scrutinising and asking questions whether it is necessary for medical doctors to provide transmission prevention assessment and counselling HIV-positive patients directly. It would appear effective to augment patient care by referring patients to other health care professionals, for example, psychologists.

5.5. Limitations of the Study

This study has several limitations; particularly that the majority of the participants were male community doctors. The other limitation is in relation to the generalization of the findings because it included only three health institutions, which were targeted in the

Central Region of the Northern Province. However, being only the second study to explore medical doctors' transmission prevention assessment and counselling, its findings may contribute in finding solutions to the prevention of horizontal HIV transmission. In addition, the study could not explore factors that contribute to medical doctors' prevention assessment and counselling styles due to time factor. It did not look into the effectiveness of one style in relation to the other in changing patients' behaviour.

5.6. Recommendations

Public health efforts for reducing transmission risk of HIV should concentrate where they would have the most potential effects, thus they should start with HIV-positive patients and with their sexual partners. It is not known how often HIV-infected people put someone else at risk. However, the fact that about 1500 people are infected per day means that HIV-positive people may be having unprotected sex after notification of their serostatus.

Medical doctors should regularly assess and counsel patients about transmission prevention, keeping in mind that there are deep psychological and social motivations why patients engage in risky behaviours, and teach patients the tricks on how to reduce risky behaviours. In addition, there is a need to counsel sexual partners of HIV-positive patients because partners themselves might not be co-operative, believing that it is their fate to take the risk and perhaps to die along with their mates.

The transmission prevention assessment and counselling skills of doctors in public health institutions should be enhanced through workshops and seminars conducted by experts on working with HIV-positive patients. There should be a risk-reduction clinic that would provide separate risk reduction sessions for HIV-positive patients. The clinic may also play a significant role in ushering in societal issues such as stereotyping those with HIV/AIDS, and difficult of changing people's attitudes towards HIV-positive patients. However, considering the way cognitive process works, HIV-positive people may not attend, the schemas in their minds are barriers to overcome.

The clinic should endeavour to improve interaction between patients and health care providers, particularly medical doctors. It should provide new opportunities for the empowerment of HIV-positive patients due to the quality time medical doctors should spend with their patients and enhance follow-ups. In addition, public health care delivery systems should implement protocols to augment patients' care, which shall ensure that all HIV-positive patients receive effective counselling to change their risky behaviours. More research is needed to further understand the role that medical doctors can play in prevention assessment and counselling HIV-positive patients to reduce risky behaviours. Furthermore, research should be done to determine medical doctors' characteristics that contribute to their prevention assessment and counselling styles. Research should explore the relationship between public health institutions versus private health institutions, and medical doctors' prevention assessment and counselling style. Lastly, to study which medical doctor's prevention assessment and counselling styles between 'consultant' and 'collaborator' styles, which effect greater behaviour change in patients than the other.

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Appendix A

University of the North Ethics Committee

Project Title: Physicians' Transmission Prevention Assessment and Counselling Practices with their HIV-positive Patients.

Project Leader: Ndlovu, R. V. (Mr.)

Consent Form

I, ----- hereby voluntarily consent to participate in the following project.

I realise that:

1. The study deals with - **Physicians' Transmission Prevention Assessment and Counselling Practices with their HIV-positive Patients.**
2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage;
3. The ethics Committee has approved that individuals may be approached to participate in the study.
4. The experimental protocol, i.e., the extent, aims and methods of the research, has been explained to me;
5. The protocol sets out the risks that can be reasonably expected as well as possible discomfort for persons participating in the research, an explanation of the anticipated advantages for myself or others that are reasonably expected from the research and alternative procedures that may be to my advantage;

6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation;
7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research;
8. Any questions that I may have regarding the research, or related matters, will be answered by the researcher;
9. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact a member of the research team;
10. Participation in this research is voluntary and I can withdraw my participation at any stage;
11. If any medical problem is identified at any stage during the research, or I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor;
12. I indemnify the University of the North and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

Signature of Researched Person

Signature of Witness

*Signature of Person that Informed
the Researched Person*

Signature of Parent/Guardian

Signed ----- this ----- day of -----200 1