

**MENTORSHIP:
THE PERSPECTIVES OF HIV/AIDS COUNSELLORS AND MENTORS**

VICKI MARGARET NOTT

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DECLARATION

This thesis, unless specifically indicated to the contrary, is my own original work.

A handwritten signature in cursive script, reading "V. Nott", is positioned above a horizontal dashed line.

Vicki Margaret Nott

THESIS SUPERVISOR'S APPROVAL OF THIS THESIS FOR SUBMISSION

As the candidate's supervisor I have/have not approved this thesis/dissertation for submission.

H. van Rooyen

Date: -----

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ABSTRACT

The devastating impact and spread of HIV/AIDS is well recognized throughout the world. HIV/AIDS counselling is one element of Voluntary Testing and Counselling (VCT), a process designed to encourage testing, provide support, care and prevention knowledge. Quality assurance, ongoing training and counsellor support are vital components for VCT to succeed. The implementation of mentorship for HIV/AIDS counsellors is recommended as an appropriate way of addressing current counselling concerns and providing professional and psychosocial support structures to produce benefits for the quality of VCT in the long term. This study aimed at contributing to the limited field of research on the topic of mentorship by conducting an in-depth examination of mentorship in general and in an HIV/AIDS context specifically. A qualitative, interpretative method, using both in-depth interviews and focus groups, was used to address three specific research questions relating to mentorship views of HIV/AIDS counsellors' and mentors' in KwaZulu Natal. A grounded theory analytic technique revealed that mentorship provides multiple functions such as guidance and support to counsellors, ongoing training and monitoring counsellor performance, which inevitably contributes to more motivated counsellors and improved quality of work. This study hopes to give greater insight into mentorship, specifically from the perspective of VCT counsellors and mentors, to those key role players and policy makers that are involved in the development of mentorship programmes for HIV/AIDS counsellors.

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CHAPTER 1 – INTRODUCTION

1.1 Background to This Study

The Human Immunodeficiency Virus (HIV) was first detected in 1978 (Family Health International, 2004). The virus has steadily become a universal phenomenon that has swept through the world, devastating and having life-changing effects on millions of people. The pandemic is changing family- and community-support structures and giving rise to new roles and responsibilities (HelpAge International, 2003). It is of particular concern that two-thirds of the people infected with the HIV/AIDS are in Sub-Saharan Africa. Of even greater concern is the fact that South Africa has the highest prevalence of HIV/AIDS in the world (Family Health International, 2004). The Department of Health's 2003 National survey shows the prevalence rate of HIV/AIDS among antenatal attendees to be 26, 5 % on a national scale and 36, 5 % in KwaZulu Natal (Department of Health, 2003). Kürschner (2001) links the rapid spread of HIV/AIDS in Sub Saharan Africa indirectly to the poverty in this region. People who have limited access to resources and information about HIV/AIDS and who, by virtue of poverty, have low immune systems are the most vulnerable.

Public health strategists are confronted, globally and nationally, with the challenge of containing and preventing the spread of HIV/AIDS. Counselling has been acknowledged internationally as being an effective prevention, care and treatment strategy (WHO, 2004). South Africa has followed the global trend of introducing voluntary counselling and testing (VCT) and Prevention from Mother to Child Transmission (PMTCT) as national strategies against the HIV/AIDS pandemic (Simelela, 2002). HIV/AIDS counselling takes place in a variety of settings in South Africa. National and Provincial Departments of Health are the main HIV/AIDS VCT service providers, but many non-government organisations (NGOs) also provide both pre- and post-test counselling and ongoing-support counselling for HIV/AIDS-positive patients (WHO, 2003).

VCT combines the HIV/AIDS test with confidential pre- and post-HIV/AIDS counselling and focuses on encouraging people, through the medium of counselling, to volunteer for testing (CDC, 2004; Simelela, 2002). Early HIV/AIDS detection contributes to preventing the spread of the disease and provides support and care for

the sick and dying (CDC, 2004; Richter, Durrheim, Griesel, Solomon, & van Rooyen, 1999; WHO, 2004). VCT aims to educate and motivate people to change their behaviours to avoid spreading the HIV/AIDS virus. VCT aims, further, to provide the necessary care and support for those with HIV/AIDS (Kanabus & Frediksson Bass, 2004). VCT is the beginning of the continuum of counselling and care, which commences with the asymptomatic stage, continues through the symptomatic stage and ends with preparing the patient for death (Kanabus & Frediksson Bass, 2004; Richter, et al, 1999). HIV/AIDS counsellors, therefore, deal with a multitude of problems associated with living with HIV/AIDS.

The importance of voluntary counselling and testing (VCT) as a preventive method has been well illustrated in HIV/AIDS research (Kanabus & Frediksson Bass, 2004; Richter, et.al, 1999; UNAIDS, 2002; WHO, 2004). However, successful VCT depends on the achievement of certain standards of service. UNAIDS (1997) raises concerns, expressed also by key HIV/AIDS stakeholders, about the effectiveness of counselling. Good counselling requires a careful selection of appropriate trainee counsellors who receive relevant and comprehensive primary and ongoing training (UNAIDS, 1997). Counsellors at VCT units in many parts of Africa and South Africa are local lay counsellors with no previous professional counselling training or experience. There is some apprehension about the length and level of training, which is not usually followed up with supervision (UNAIDS, 1997). The National AIDS Coordinating Committee of South Africa (NACOSA) in 1995 developed a set of minimum standards for counsellor training in an attempt to address the problems of high counsellor drop out because of burnout and the lack of support and back-up supervision and services (Engelbrecht, Tallis, Van Rooyen, Vanmili, Wood, 1995). The need for mentoring and supervision is substantiated by the World Health Organisation's (WHO) (2003) recommendation for counsellor supervision, support, and regular evaluation of counselling services as key components in ensuring quality services.

Of further concern is the fact that HIV/AIDS counselling is steeped in difficult and complex physical, psychosocial and spiritual problems, which the counsellors have to deal with on an ongoing basis (Kanabus & Frediksson Bass, n.d.). Many counsellors have excessive workloads and feel that they cannot deal with the high levels of stress

and burnout, which seems to be synonymous with HIV/AIDS counselling (UNAIDS, 1997). VCT evaluation studies both acknowledge and emphasise the need for support and on-going training for counsellors as crucial for the prevention of burnout and the maintenance of VCT services standards (UNAIDS, 1997; Richter, et al, 1999; WHO, 2003). In UNAIDS case studies (2002) it has been found that, “according to programme managers, mentorship and on-the-job training are critical components for ensuring quality assurance and, at the same time, providing support to the service providers (p.68). The implementation of mentorship for HIV/AIDS counsellors is recommended as an appropriate way of addressing current counselling concerns and providing support structures that have an impact on the quality of HIV/AIDS counselling services (van Rooyen, 2002; Richter, et al., 1996)

1.2 Motivation for this Research

The motivation behind this research is to examine mentorship and the mentorship process in the HIV/AIDS counselling context, firstly by examining the existing literature on mentorship in general, as used in a variety of contexts; secondly by looking at literature on mentorship specifically in the HIV/AIDS sector and, lastly, by exploring the views of those involved in the VCT process. A specific aim is to gain greater clarification on whether mentorship is viewed by counsellors and mentors as an effective means of providing the necessary professional and psychosocial support to produce benefits for the quality of VCT in the long term. A further aim is to incorporate the understanding of mentorship in the HIV/AIDS context into generic descriptions of mentorship.

In addressing these aims, the researcher considered that there appears to be a need for mentorship research that uses a methodology other than quantitative. In 1983, Merriam conducted an intensive literature search on mentorship research in a nursing context (Gray & Smith, 2000). She found that most research was based on poorly designed survey-collection methods. Definitions of mentorship appeared to be derived from the subjective perspective of the researcher and not from the perspective of the people involved in the mentorship process (Gray & Smith, 2000). It appears, therefore, that the establishment of an agreed-upon definition of mentorship, based on the subjective views of mentors and mentees has been problematic. Perplexity in the defining of mentorship in the HIV/AIDS sector is also evident (Engelbrecht, et al.,

1995; Kwitshana, 1998; Richter, et al., 1999). Although mentorship programmes for VCT counsellors are being introduced in South Africa, it appears that a clear definition and understanding of the concept of mentorship in the specific context of HIV/AIDS counselling is lacking. This confusion results in counsellors not utilising available mentorship facilities (Kwitshana, 1998). In addition, literature in this field of research in South Africa seems to be limited; this indicates that not much research has been done on mentoring in South Africa. More specifically, research on how the counsellors and mentors themselves view mentorship has been lacking. An aim of this study to try to achieve some consensus on the interpretation of mentorship as perceived by those involved in the HIV/AIDS sector.

The concept of adopting mentorship programmes in the HIV/AIDS arena has emerged over the last few years, alongside the development of lay counsellors' programmes (Richter, Durrheim, Griesel, Solomon & van Rooyen, 1999). Mentorship in this context is aimed at providing emotional and technical support, ongoing learning and the development of counselling skills, all of which are essential ingredients for improving the quality of service output (van Rooyen, van Rooyen and Kwitshana, 1999). The introduction of mentorship programmes is viewed as useful for managing, supporting and guiding existing counsellors in the HIV/ AIDS sector (Richter et. al, 1999). A motivational factor behind the implementation of mentorship in 1996, in South Africa, emphasised that many trained counsellors were leaving after training as a result of insufficient follow-up support (Smart, 1996).

HIV/AIDS mentorship programmes are aimed at providing a multidimensional support strategy to address counsellor burnout, to promote the quality of HIV /AIDS counselling and to contribute to the development of the counsellors (UNAIDS, 2002; Richter, et.al., 1999). This strategy includes two main components: supervision and mentorship. Typically, supervision deals both with the technical aspects of counselling and with time management and other managerial aspects. Mentoring refers, rather, to dealing with the personal problems that impact on counsellors' work. The inclusion of supervision in the definition of mentorship seems to add to the conceptual confusion that exists in the HIV/AIDS field (Engelbrecht,et al., 1995). There is a clear need in the VCT sector for the assessment of counsellors' skills, which is usually the function of a supervisor. However, counsellors regard a

supervisor as a powerful person to whom they are accountable, and they prefer the term mentor for the person providing them with guidance and support (Department of Health, 1999; Engelbrecht, et al., 1995). As already stated, one of the objects of this study is to explore the differences between supervisors and mentors, as perceived by the participants of this study. The purpose of the exploration is to establish if a supervisory component might be included in mentorship and if the supervisory and mentorship roles need to be performed by separate people. Transforming traditional mentoring structures to cope with VCT service needs, means a shift from the current informal structure of guidance and support to a more formal structure that includes additional managerial responsibilities, such as monitoring and assessment of counsellors. This shift may bring with it a change in the nature of mentoring and provide further uncertainty in defining the concept of mentorship (Woodrow, 1994).

Implementing mentorship programmes in the VCT field seems either to be slow in taking off or not to be getting off the ground at all (Richter, et. al, 1999). Previous failures to establish mentorship suggest that key stakeholders in the HIV/AIDS-service industry require clearer guidelines. Past attempts at defining mentorship have been based on the perceptions of people involved in mentorship-policy formation and not on the perceptions of active counsellors and mentors. Defining mentoring according to the ways, in which the various stakeholders in the VCT context perceive it, might be more meaningful and thus increase the likelihood of sustaining future mentorship programmes. Through this study, this researcher aims to contribute towards a broader knowledge of mentorship by providing results that reflect better clarity on the nature, role and function of mentorship.

1.3 Research Aims

The need for this study has, largely, arisen from recognition of the limited amount of formal research and literature on mentorship for HIV/AIDS counsellors available in South Africa. Most of the literature on this topic formed part of policy reports intended for the development of intervention programmes for HIV/AIDS mentorship (Engelbrecht, Tallis, Van Rooyen, Vanmili, Wood, 1995; Kwitshana, 1998; Richter, et al, 1999; van Rooyen, 2002; van Rooyen, van Rooyen & Kwitshana, 1999; Adendorff, 1995).

This research project is aimed, essentially, at exploring and gaining an understanding of how mentorship is constructed among counsellors and mentors. As counsellors and mentors are key stakeholders in the provision of HIV/AIDS services, this study will depend on participants who directly benefit or might benefit from mentorship to deliver an understanding of mentorship. To achieve greater insight into the research topic, a qualitative, interpretative method will be used. The research design will include an inductive approach, as the objective of this study is to establish a better understanding of mentorship, on the basis of the participants' experience.

Do lay counsellors, nurse counsellors or professional counsellors have similar views on mentorship? And are they in agreement with the views held by mentors? Or are there differences between what counsellors expect a mentor to be and what the mentors are providing? How do these views affect the provision of mentorship services from the perspective of the user and of the provider?

The aim of this research is therefore to establish:

1. How HIV/AIDS counsellors and mentors understand the concept of mentorship
2. How the perceptions of HIV/AIDS mentors compare with those of HIV/AIDS counsellors
3. How the understanding of mentorship revealed by the study compares with generic conceptualisations of mentorship

1.4 Overview of this study

Chapter two presents a review of the literature on mentorship in general, with particular focus on how mentorship is defined in various settings. Chapter three is concerned with mentorship in a South African HIV/AIDS-counselling context. The definition of mentorship in this context is examined with particular reference to the inclusion of a supervisory component, which seems applicable in an HIV/AIDS counselling setting. Chapter four outlines the methodology used. Chapter five describes the analysis and the results of the findings. The results and their relationship to the literature are discussed in chapter six, and chapter seven contains a

brief description both of the implementation of this research and recommendations for further research.

CHAPTER 2 - REVIEW OF THE LITERATURE ON MENTORSHIP

2.1 A Historic Overview of Mentorship

It is from Greek mythology in Homer's *Odyssey* that the term "mentor" originated to refer to a unique relationship between a more experienced person guiding, teaching and supporting one less experienced. Mentor was the name of the tutor and protector appointed by Odysseus to nurture, develop and teach his son, Telemachus, in preparation for becoming a wise king (Carruthers, 1993; Russell & Adams, 1997; Awaya, McEwan, Heyler, Linsky, Lum & Wakukawa, 2003). Homer's concept of mentoring is paternalistic: the developmental process of an adult guiding a child.

Relationships built on principles of guidance and wisdom have existed throughout history. Many historical writings, particularly in religious contexts, testify to the need for spiritual guides such as Gurus and Hasidic masters. These leaders not only provided spiritual guidance but leadership and supervision for all areas of their disciples' lives (English & Bowman, 2001).

Contemporary mentoring is filled with political and social connotations, which have produced confusion in the definition of mentoring (Garvey & Alred, 2003). However, the significance of the relationship between Mentor¹ and Telemachus was so distinctive that it has stood the test of time as a useful analogy for understanding a mutual relationship based on the imparting of greater experience and wisdom from one to another. Awaya et.al, (2003), outline the characteristics of Mentor's function in Telemachus's path to self-development. Mentor assisted Telemachus by providing guidance and advice to resolve his problems. He provided moral support and encouragement, yet stood back at the appropriate moments to allow space for Telemachus to prove himself. "Mentor's role was therefore, to be a father figure, a teacher, a role model, an approachable counsellor and advisor" (Carruthers, 1993, p. 12).

Mentoring was a common method of teaching young people during the Renaissance period. Many famous artists learnt their trade through the instructions of a mentor

¹ The goddess Athena adopted the human form of Mentor as a means of developing Telemachus's leadership potential.

(Lewis, 1996). Some famous mentorship relationships recorded in history are those of “Socrates and Plato, Freud and Jung, Lorenz de Medici and Michelangelo, Hayden and Beethoven, Boas and Mead” (Merriam, 1983, p. 162)

A typical illustration of mentoring in South African history can be found in the age-old training system for *Sangomas* otherwise known as traditional healers, manifested in the Zulu culture. Novice *Sangomas* usually live with their trainer for an extended period, during which they receive a comprehensive apprenticeship in the development of their healing talents. Khoisan healer training requires that a novice healer find a mentor who can educate him/her in the art of transcendence. This mentor serves the function of directing and supporting the novice through the intense physical and psychological barriers associated with going into a trance state (Rudnick, 2000)

In the late 19th century a movement called *friendly visiting* developed in the USA as a means of trying to alleviate the intense class tensions created by social unrest. The volunteers, who were middle-class women, were recruited to visit the poor. The aim was to develop special relationships with a poor family; through these relationships, the middle-class person could guide and educate the younger family members in assuming more appropriate behaviours and ambitions. This form of mentoring was distorted by underlying motives and unrealistic intentions and, ultimately proved to be unsuccessful (Freedman, 1995 as cited in Philip, 2003). The first sanctioned mentoring programme was introduced in the early 20th century as an alternative to sending juvenile delinquents to reformatories. The programme known as *Big Brother/Big Sister*, founded in 1921, inaugurated a set of ground rules outlining the specifics of a mentoring relationship. This interest group is still the largest known mentoring programme in the world today (Miller, 2002).

The second half of the twentieth century saw the revival of mentorship in a variety of sectors (Colley, 2001). The structure of mentorship differs according to the context in which it is found (Garvey & Alfred, 2003). Numerous mentorship programmes are found universally in modern educational, social, medical and occupational settings (Bennetts, 2003; Colley, 2001; Garvey & Alfred, 2003; Woodrow, 1994). The nature of the mentoring relationship in most contexts is that of a learning process, with knowledge being transferred from a person knowledgeable in a particular domain to

one seeking that knowledge. “ Such a relationship can make a significant contribution to professional, academic and personal development and learning as the mentee integrates prior and current experience through supportive and challenging dialogue”(Garvey & Alred, 2003, p.4).

Mentoring has, through time, evolved naturally in many contexts, from the apprentice-type interrelationship of the medieval craftsmen, to the multidimensional transference of knowledge, skills and experience to others, as we know it today (Lewis, 1996).

The following section, will attempt to illustrate the suitability and value of mentoring as a *modus operandi* for supporting, guiding and supervising individuals or groups from a variety of contexts. Each context in which mentorship has developed over time has contributed a unique element to the overall concept of mentorship as it is practised today. A broad comparison of the roles mentors have traditionally played will reveal the distinctive characteristics of mentorship in the HIV/AIDS counselling sector.

2.2 Diverse contexts of mentorship

2.2.1 Mentorship in the Nursing Profession

Mentorship was adopted into nursing terminology in the 1980s and 1990s to describe the process whereby a senior nurse took on the responsibility of assisting student nurses throughout the practical component of their training (Gray & Smith, 2000; Chow & Suen, 2001). Student nurses usually experience a transitional phase between the completion of their theoretical training and becoming professional nurses. They may have more than one mentor during their practical training, depending on the permanency of their placements (Woodrow, 1994). Mentorship in this context can be seen as serving a formal, structured, preparatory function in the attempt to achieve professionalism. The role of a student nurse mentor includes a strong supervisory component, in that mentors have the responsibility of assessing student performance in addition to their other functions of student support, role modelling and student counselling (Chow & Suen, 2001).

Clinical supervision, which, in this context, is viewed as an equivalent of mentoring, was introduced into the nursing context in the 1990s for two reasons. Firstly, this form of supervision, adapted from a social and psychotherapy background, was seen as a way of improving the public observation of the standards of nursing services. Secondly, clinical supervision serves as a process of supporting individual nurses and encouraging them to develop their knowledge and competency so as to enable them to engage in self assessment and reflection to the extent of taking responsibility for the quality of their nursing services (Cottrell & Smith, 2000). There is, however, some cynicism about a conclusive definition of clinical supervision in this context. Controversy revolves around the hierarchical connotations attached to the term, supervision. Nurses often view supervision as a disguised management tactic. To many nurses supervision means being observed by a managerial authority in a critical way (Cottrell & Smith, 2000).

2.2.2 Youth mentoring

Youth mentoring, or more specifically the mentoring of socially excluded youth, appears to be an area of mentorship that is included and well established in the governmental policies of numerous countries as a formalised programme aimed at re-engaging vulnerable youth into society. The focus of mentoring in this context is on transformation of the attitudes, values and behaviour of the youth. The underlying purpose of this mentoring process is to inspire those youth who have delinquent tendencies to develop themselves and their careers for future participation as fully functioning individuals in a broader social-economic environment (Colley, 2003). The nature of the youth-mentoring relationship can be described as “a close human bond developed through a dyadic relationship between mentor and mentee that is often represented as quasi-parental” (Ford, 1999, in Colley, 2003a, p. 79).

2.2.3 Mentorship within Business Organisations

The changing nature of market economies has put pressure on organisations to provide better products and services to consumers. These demands increase stress levels and employee anxieties about performance. Organisations in developing countries are forced to empower their disadvantaged employees. In addition, organisational decision-making processes have undergone restructuring, resulting in

distribution of power to all levels of the organisation. Mentoring seems to offer the potential to actively aid organisations in coping with new world demands and at the same time provide a psychosocial and career-developmental function in a flexible, people-centred manner (Eby, 1997; Lewis, 1996; Russell & Adams, 1997).

Traditional mentorship relationships in an organisational situation are usually between a senior member (mentor) and junior member (mentee). The mentor provides sponsorship, exposure, coaching, protection and challenges for the mentee. At a psychosocial level the mentor not only acts as a role model but also provides acceptance, counselling and friendship to the mentee (Eby, 1997) However, the nature of mentoring is changing in accordance with the introduction of new organisational strategies. The late 1970s saw, particularly in first-world countries, the drive to develop women and racially victimised employees in the corporate sector (Freedman, 1995 as cited in Philip, 2003). Specific mentorship programmes are being designed to cater for a range of necessarily diverse advancement strategies for alternative groups in an organisation. Such requirements may be gender-or race-specific or aimed particularly at unemployed people and people with disabilities (Russell and Adams, 1997).

2.2.4 Mentoring in Academic Settings

An academic environment lends itself to the concept of mentorship. A central theme in mentoring is the exchange of knowledge from a wiser person to a learner. The mentor role in an academic setting accentuates the supervisory and learning facilitation function that the mentor provides (Merriam, 1983). The orientation of mentoring in most tertiary academic settings is twofold, namely social and career. The first aim is to assist the student in areas such as social support and the development of professional relationships. The second – multidimensional – aim is career development, which requires the mentor to be an effective teacher, assisting the mentee with attaining funding, accommodation, publishing and connection with professional associations (St. Clair, 1994). Garvey and Alred (2003) aptly show that teaching is not solely a process of transferring skills and theoretical knowledge to students or pupils but that it is also a holistic developmental procedure that includes

aspects such as care and concern about students' immediate and future emotional and career needs and aspirations.

Mentorship in an academic setting can be seen as a partnership between teacher and pupil. The skill and effectiveness of the mentor is confirmed in the nurturing of this relationship. In addition, it is through the outcome of the relationship that the value of the education can be determined.

2.2.5 Summary

This brief summary of mentorship in a number of prominent contexts shows how each independent context has informed the formation of a general concept of mentorship. Mentorship in the nursing context is a structured process aimed at skills development, learning and improving the quality of nursing services. It has a strong supervisory element, based on the principles of clinical supervision and professional assessment. The nursing context has, therefore, added a supervisory component to the general idea of mentoring. The influence of nurse supervision is particularly noticeable in the conceptual development of mentorship in the HIV/AIDS sector. Professional nurses play a key role in both VCT services and the provision of supervision to counsellors. Here the supervision of HIV/AIDS counsellors is one of the main functions of a mentor.

The focus in youth mentoring lies in the transformation of values and attitudes in developing the mentee at a personal growth level. Mentorship in this context usually occurs during a difficult period of the mentee's life. Youth mentoring emphasises the parental or nurturing role of the mentor. Mentorship in an organisational context has contributed to mentoring aspects such as promotion of professional development and quality assurance. Lastly, academic mentorship emphasises the holistic nature of mentorship, which includes psychosocial and career development.

It will become evident in the next chapter of this literature review how each of these aspects of mentorship collectively contributes to the role of mentorship in HIV/AIDS counselling.

2.3 An overview of Mentorship in South Africa

Since the transformation of South Africa in 1994, mentorship has, in many areas of business, become important as a “development tool” for the redistribution of knowledge, power and skills from the previously advantaged to previously disadvantaged members of the socio-economic sectors of the country Cook, & Adonisi, 1994). As it is still a relatively new approach in South Africa, much debate and investigation surrounds the question of institutionalizing the mentor concept in a variety of sectors. The motivation underlying mentorship in several South African organizations, notably in the corporate sector, is based on the accelerated training of previously disadvantaged individuals. This alternative purpose behind mentorship has triggered a change in the way the association between mentor and mentored develops. The mentoring relationship in this context is no longer based on features such as the sincerity and compassion associated with the previous paternalistic attitudes of managers, but it is viewed as a relationship that is predetermined to achieve the best learning outcome in the shortest possible time (Cook, & Adonisi, 1994).

2.4 Definitions of Mentorship

As we can see from the following definitions of mentorship taken from the literature, the concept of mentorship is complex. Definitions of the role and function of mentoring are inconsistent and vague. (Woodrow, 1994).

Some definitions of mentoring found in the literature are:

- The Concise Oxford Dictionary (1987): “an experienced and trusted advisor” (p.472).
- Mike Pegg (1999, cited in Neufeld, 2003): “Wise and trusted advisors who are sage-like and street-wise. They are persons willing to meet with others and pass on their wisdom and experience. They are good listeners, and don’t usually give advice directly; rather they help others to think through options” (p.3).
- Sklinsky (2001): “Mentorship is a holistic process that facilitates personal and professional development of an individual” (p.1). Bennetts (1994) cited in Bennetts (2003): “person who achieves a one-to-one developmental

relationship with a learner, and one whom the learner identifies as having enabled personal growth to take place” (p.64)

- Carrad (2002, cited in Miller, 2002): “A one-to-one, non-judgemental relationship in which an individual mentor voluntarily gives time to support and encourage another. This relationship is typically developed at a time of transition in the mentee’s life and lasts for a significant and sustained period of time” (p.34).

2.4.1 Difficulties in Defining Mentorship

The above definitions tend to create a stereotypical mental image of mentoring as the unique developmental relationship between an old, wise grey-head male with a talented adolescent male. This relationship is usually formed by chance and is characterised by its informality. It usually starts off superficially and develops into a receptive, complex, deep and often indescribable, unspoken bond. This bond dissolves, as naturally as it started, leaving the mentor with the satisfaction of achievement and the mentee with knowledge, skills and intellectual and personal development. Memories of this unique relationship are dear for life.

An examination of the earlier mentorship literature confirms this conjured image to a degree, describing the mentor as an older, more expert and more powerful than the mentee and serving the purpose of providing emotional and psychological support to the mentee (Eby, 1997; Levinson 1985; McAuley, 2003). However, as Colley (2001) argues, defining contemporary mentorship in such an idealistic manner is a far cry from reality and no more than a myth. A traditional construction of mentoring produces the expectation of a special, quasi-parental figure nurturing a privileged person in an effort to achieve his or her potential. This is an unrealistic interpretation of the modern-day mentor who is appointed and financially compensated to achieve a particular predetermined outcome depending on the context.

The concept of Mentorship has a different undertone in the South African context. Mentorship programmes have as their chief goal developing people, possibly with less emphasis on the psychosocial nurturing functions found in more informal traditional mentoring relationships. Hence, because of the formal nature of the programme, mentors and mentees often experience frustration at not being able to develop a close

relationship with each other (Cook & Adonisi, 1994). Mentor and mentee commitment to human development, clear role definitions and effective mentor matching can help ensure programme success. The ‘learning’ process that occurs in mentorship programmes in a business context in South Africa is fundamentally different from that of traditional programmes and, therefore, calls for a redefinition of the concept of mentorship in a South African context (Cook & Adonisi, 1994)

It seems obvious from the literature that no universal definition of mentorship exists, and that the definitional route is paved with complexity. A definition of mentorship is contextually bound. The intended purpose of the relationship determines the definition of the term (Brookes & Sikes, 1997). Garvey and Alfred (2003) say, “due to differing perspectives mentoring is sometimes misunderstood, and certainly the term ‘mentor’ is used to describe a diversity of ways in which one person may be influenced by another” (p.4). Bennetts (2003) warns about the dangers of using the term mentor to mean whatever the author wants it to mean, without making an attempt to define the concept appropriately. There appears, however, to be a definite trend in the literature towards the elimination of the traditional mentorship definition in the quest to define the concept of current mentorship in a more relevant way (Awaya, 2003; Colley, 2001; Gold, Devins & Johnson, 2003; Gibb, 2003; Stokes, 2003)

Although many researchers have spent time investigating various elements of mentoring – such as mentorship roles, the nature of the mentorship relationship, the matching of mentor with mentee, the benefits and disadvantages of mentoring - no consensual definition exists of the typical mentor, that would be applicable in any context. Gold, Devins and Johnson (2003) suggest that the reason for this lies in the nature of the mentoring relationship, in that each relationship is different and determined by a variety of factors.

2.5 Characteristics of the Mentorship Relationship

As is evident from the literature, the conceptualisation of mentorship is vague. It is, therefore, necessary to examine the various features of mentorship in order to contribute to the understanding of mentorship. Examining these various elements of mentorship allows us better insight into how contemporary mentoring differs from

traditional mentoring relationships (Awaya, et.al, 2003). This section will examine the nature of the individual elements inherent in a mentorship relationship. Each aspect of the relationship contributes to the whole of the mentoring structure.

2.5.1 Informal and Formal Mentorship Structures

Mentoring is structured on a continuum, ranging from a spontaneous unstructured relationship at one end of the scale to a systematic and formally structured mentoring approach at the other end. Most mentoring relationships in a South African organisational context lean to the formally structured end of the continuum. The reason for this is that most mentoring situations are pre-planned with goal-specific outputs as desired end results (Cook & Adonisi, 1994)

As already implied, traditional or informal mentorship relationships always occurred naturally and mostly by chance. The informal mentoring relationship is built on mutual respect and trust. The mentor is not trained in the skill of mentoring and never expects compensation for his/her efforts (Bennetts, 2003). In contrast, the formal mentor is trained, generally paid and follows a formal mentoring framework or model as a guideline. Both informal and formal mentorship are aimed at benefiting the mentee. However, these benefits are achieved in different ways. The secret to the success of these formal-type relationships lies in determining the needs of the mentee; guaranteeing confidentiality; developing appropriate mentor models to suit the context of the mentoring and evaluating mentor programmes (Bennetts, 2003).

McAuley (2003) distinguishes between two distinct approaches that fall at opposite ends of the continuum, namely, the systematic approach and the process approach. The systematic approach is characterised by firmly established boundaries and clear roles and functions, whereas the process approach, at the informal end of the continuum, relies on roles, functions and boundaries emerging as the mentoring relationship develops. Mentoring in an environment, such as HIV/AIDS counselling, could be viewed as a balance between the two opposing approaches. In this context, it relies on amicable relationships forming between mentor and mentee, and yet it incorporates a system of 'checks and measures' that can stabilise and enhance the development process. Thus, mentoring in the above context is a process of

professional development, which is based on predetermined, yet flexible and adjustable goals at the informal end of the continuum and on an accountability mechanism, which implies a reflection of the opposite, more structured end of the continuum.

In the South African HIV/AIDS situation, structured, formal mentoring programmes adhering to the application of the minimum supervision standards for mentoring to fit into the broader, structured HIV /AIDS counselling process, are designed to fulfil specific functions with the objective of assuring quality service in the HIV/AIDS sector (Engelbrecht, Tallis, van Rooyen, Vanmili & Wood, 1995).

2.5.2 Features of a Mentorship Relationship

A distinct feature of mentorship associated with not only informal/formal mentorship but with the generic nature of the mentoring is that of a continuum. The degree of structure of the mentorship relationship lies on a horizontal continuum, whereas the control of power between mentor and mentee lies on a vertical continuum. This continuum ranges from a hierarchical traditional mentorship relationship, where the mentor is all-powerful and the mentee powerless, to a more contemporary peer-mentor relationship and empowerment of the mentee (Colley, 2001).

The relationship between the mentor and mentee is largely determined by the nature of the organisational context in which both the mentor and mentee are employed, and it is based on specific outcomes that the organisation wishes to achieve. This reality could affect the mentoring relationship, with the mentee regarding the mentor with a scepticism based on the view that organisational interests outweigh those of the mentee (McAuley, 2003).

A universal feature of a mentoring relationship is based on principles of learning. A psychoanalytic approach offered by McAuley (2003) equates mentoring with transference and counter transference. Transference is a higher level of transmission and is not only knowledge based but includes aspects such as underlying emotions and feelings that evolve as the mentorship relationship develops. The mentor has the potential to transfer his/her positive or negative affections to the mentee.

Transference can be seen as a resource that equips the mentee in the process of self-development.

Positive and negative transference can be beneficial as well as dysfunctional. The positive dysfunctional element emerges when the mentee is over dependent on the mentor and the negative when the mentee develops an aversion to and becomes aggressive towards the mentor. The mentoring relationship, particularly a structured mentorship relationship, should, therefore, firstly, be based on caution when matching mentor and mentee and, secondly, constantly be evaluated to prevent or detect any dysfunctions (McAuley 2003).

Bennetts (2003) states that a noticeable feature of traditional mentorship is the “mutual respect underpinning these relationships, together with a deep sense of loyalty and affection and for many ... a metaphysical /spiritual aspect to the alliance” (p. 64). She argues that these relationship qualities are lacking in many contemporary formal mentorship relationships and warns that these important qualities should constantly be reviewed and incorporated into the structuring of mentorship programmes.

2.5.3 The Role of the Mentor

The role of the mentor is characterised as multifunctional and flexible. Mentors should be able to adjust their role to suit the needs of the mentor relationship at any point. As mentioned previously, the mentor provides dual, integrated functions: of career development (career advice and feedback) and psychosocial welfare (emotional support, promoting self esteem). (Burke & Mckeen, 1997; Stokes, 2003). Lewis (1996) identifies five core functions of mentoring in the broader context. These roles are: teaching, sponsoring, encouraging, counselling, and befriending.

The mentor’s behaviour should reflect the values of the organisation and provide a role model to encourage the same values in the mentee (Stone, 1999). The mentor performs a dual role in an organisation by advocating and seeking development opportunities for the mentee and, at the same time, in being a role model and through the exchange of knowledge, transmitting the organisational culture and requirements to the mentee (Lewis, 1996).

2.5.3.1 The Counselling Role

Many researchers in different applications of mentoring argue that there is a definite link or association between the role allocation of a mentor and that of a counsellor. A number of mentoring functions hold true for the role of a counsellor. Eby (1997) draws our attention to the emotional support a mentor provides to the mentee. Talbot (2000, cited in Stokes 2003) describes the role of a mentor as a “counsellor helping the mentee through inevitable difficult patches” (p.128). Both disciplines function essentially on a psychosocial level, which focuses on the emotional well being of the mentee or HIV/AIDS client respectively. The execution of this function demands skills such as listening skills, which reflect a clear understanding and sensitivity to the perspective of the other person.

Although similarities exist between the role of a counsellor and that of a mentor, it is important to identify the differences between the two roles. A fundamental distinction between the two is that counselling is primarily a professional activity, driven by theoretical approaches and professional ethical codes whereas mentoring hinges on “person-centred and emotional alignment between mentor and mentee” (Stokes, 2003, p.23).

The counselling function of a mentor and how this function differs from those of a professional counselling psychologist is clearly stated in the following extract taken from Lewis (1996):

A counsellor is someone who acts in the best interest of an individual. They have a high degree of empathy and communication skills. Here, we don't mean a counsellor necessary in the therapeutic sense of the term. We use it in a much higher sense to include friend, adviser, guide, guardian, and so on. (p. 31)

TABLE 1: Different mentor roles identified from the literature

Sounding board	The mentor should be able to listen attentively to the mentees' ideas and problems
Counsellor	An empathetic listener who uses reflection and questioning skills to help the mentee analyse his/her own problems.
Listener	Someone who simply listens
Critical friend	Willing and able to speak the truth openly and reflect on problems that others are afraid, embarrassed or reluctant to expose.
Net worker	Provides access to useful networks
Role Model	Serves as a role model through displaying professionalism, organisation, care and self-confidence.

Adapted from: (Gray & Smith, 2000; Stokes, 2003, p. 29; Stone, 1999)

2.6 Mentoring and Theory

Theories that adhere to the philosophical notion of Holism tend to best describe mentoring. Colley (2003) quotes the *Concise Oxford Dictionary's* definition of holism as "a theory 'that certain wholes are greater than the sum of their parts'" (p. 81). The underlying meaning Colley refers to in this definition is that a holistic theory is concerned with the development and treatment of individuals in their totality (Colley, 2003). The purpose of mentoring, as describe thus far, is guidance, support and development of individuals in both their psychosocial environments and their career or organisational environments (Bennetts, 2003; Garvey and Alfred, 2003; Gray and Smith, 2000; Sklinsky 2001). Two theories that follow principles of holism are Engagement Mentoring and Total Quality Management (TQM). Engagement mentoring is a theory specifically directed at mentoring excluded youth and aims at "treating the whole person of the mentee as an organic entity, understanding its parts in relation to each other" (Colley, 2003, p.84). The mentoring in Engagement mentoring focuses on changing the attitudes of the youth in preparation for a career

that serves the interest of the mentee, the interest of the organisation in which the mentee works and the interest of the organisation's clients (Colley, 2003). TQM theories focus on maintaining quality of the individuals and services within an organisation and transferring this quality to the consumers of the organisation. TQM is considered, as a continuous way of life, a thinking based on everlasting improvement. Quality is maintained through a process of ongoing employee and organisational development (Hansen, 1998). Mentorship programmes are established in organisations to provide ongoing development of mentees, with an underlying aim of improving the quality of consumer goods or services (Colley, 2003; Richter et al., 1999).

2.6.1 Mentorship Models

Models provide an overall framework of a particular phenomenon. A model of mentorship informs us about what the basic elements or characteristics of mentorship are and how they can be applied in reality. Therefore, models are a vital part of any mentorship programme design and implementation, serving the purpose of providing guidelines or steps from which mentors can structure their mentoring sessions (Brooks & Sikes, 1997; Lewis, 1996; Silverman, 2000). Mentoring models are not rigid, but can be compiled by selecting a variety of approaches from various models, which are adapted to best suit the mentoring context (Brookes and Sikes, 1997). In the case of this thesis, it is important to examine some mentorship models to determine if the models would be conducive to mentorship of HIV/AIDS counsellors.

2.6.2 The Four Base Model of the Mentoring Process

The four-base model of mentorship outlined by Lewis (1996) is an example of a generic mentoring model that can easily be adapted to suit a variety of contexts. This model defines structured or formal mentorship as a wheel with four bases, the organisation base; the context base; the development base and the interpersonal base. All four bases are interrelated and incorporate all the mentoring facets such as roles, skills, qualities and processes to ensure a useful model.

The organisational base consists of two interrelated areas of concern, namely, the organisation wherein the mentorship programme exists and the knowledge and

experience of the individual mentors. The mentorship relationship is affected by the culture of the organisation and by the mentor's knowledge, position and influence in the organisation; "if the mentor is to gain broad commitment to the objectives of the relationship and create or enable opportunities for the learner then standing and access within the organisation are vital"(Lewis, 1996, p. 28).

The context base refers to the purpose and the definite functions that the mentor will fulfil within the organisation, as well as the objectives of the mentorship programme.

The developmental base is usually an important component of any mentorship programme, even if mentee development is not the primary objective of the mentorship relationship. Mentors should be sensitive to ways of facilitating development in mentees. "At a minimum, mentors need a developmental orientation and some personal experience of developmental situations."(Lewis, 1996, p.29)

The interpersonal base reflects the nature and quality of the one-to-one relationship between the mentor and mentee. The values and aspirations of both the mentor and the mentee must be taken into consideration and communicated.

2.7 Summary

This chapter, which reviews the literature on mentorship in general commenced with a brief historic overview of the historical development of mentorship. The objective of chapter three is to review mentorship specifically in an HIV/AIDS counselling context by showing how mentorship in this context has been informed by a broader everyday concept.

CHAPTER 3 – MENTORSHIP IN A SOUTH AFRICAN HIV/AIDS COUNSELLING CONTEXT

3.1 Introduction

The previous chapter examined literature on mentorship in general. An attempt will be made in this chapter to define the concept of mentorship in an HIV/AIDS context. Particular reference will be made to the amalgamation of a supervisory component with a mentorship component to form an adapted mentorship category appropriate for the HIV/AIDS context. Although HIV/AIDS counselling mentorship has been informed by mentorship as practiced in a variety of other environments, the nursing context has had a particularly strong influence on the development of mentorship for VCT.

3.2 Background to HIV/AIDS Counselling in South Africa

The National AIDS Coordinating Committee of South Africa (NACOSA) was launched in 1992 for implementing the National AIDS strategy in the struggle against the spread of HIV/AIDS in South Africa. Counselling formed an integral part of NACOSA's plan. The aim of NACOSA was to provide and train HIV/AIDS counsellors to provide a much-needed counselling service in the HIV/AIDS sector in South Africa (Engelbrecht, et al., 1995; van Rooyen, van Rooyen, & Kwitshana, 1999; Richter, et al., 1999).

The goals of Voluntary Counselling and Testing (VCT) include primary and secondary prevention of spreading the HIV/AIDS virus, pre- and post-test counselling, psychosocial care and support, and resources to lessen the impact of the pandemic (Solomon, van Rooyen, Griesel, Gray, Stein & Nott, 2003). VCT is considered to be the beginning of the HIV/AIDS support continuum. The scope of VCT care and support for HIV/AIDS-affected individuals ranges from pre-test counselling to illness- and death- and- bereavement counselling (Richter, et al., 1999).

Since the introduction of HIV/AIDS counseling, supervision, counsellor support and ongoing training have been considered as important for maintaining counsellors' wellbeing and for quality services (Engelbrecht, et al., 1995; van Rooyen, van Rooyen & Kwitshana et al., 1999).

3.3 Defining Mentorship in the HIV/AIDS Counselling Context

While Colley (2001), is of the opinion that the literature on mentoring is increasing at an incredibly fast pace, very little has been documented on mentoring in the HIV/AIDS sector. Uncertainty about clear definitions of mentorship for HIV/AIDS counsellors continues to delay the institutionalising of mentorship in this field. As outlined by the National Counselling Coordinator in the mentorship programme progress report, a lack of standardization of approaches to and definitions of mentorship has created confusion for the programme (Kwitshana, 1998). A research study by Yacoob, Pillay and Nair (1998), found variations in the perceptions of mentors themselves of the concept of mentorship.

The lack of theoretical research in this discipline and the specific function of mentoring prevent the acceptance of clear-cut pre-existing definitions of mentoring in a VCT context. Mentoring of HIV/AIDS Counsellors is influenced by two distinct terms or concepts: namely, mentoring and supervision. Although, these terms may seem common to all counselling circumstances, they take on a different meaning in the context of the development of HIV/AIDS counselling in South Africa. "In the international literature, therefore, some of what is termed 'mentoring' in South Africa will be subsumed under the umbrella term 'supervision' (Ackhurst, 2003, p. 1). Considering the above, it seems imperative that the terms, mentoring and supervision need to be elucidated before incorporating them into any explanation of mentorship specific to this context.

3.3.1 Defining Supervision in Mentorship

The role of supervision of HIV/AIDS counsellors is different from conventional counsellor supervision in that it combines the notions of line management, technical skills development and accountability with the traditional supervisory role of counsellor support. (van Rooyen, 1999). The ultimate aim in including a supervisory component in defining mentorship in this context is to ensure that ongoing training and counsellors' technical development is monitored and controlled in an attempt to enhance the quality of HIV/AIDS counselling (Engelbrecht, et al., 1995; Van Rooyen, 2002).

HIV/AIDS counselling originates from a nursing context, and this has had a strong influence on the managerial processes in the HIV/AIDS context. As mentioned in the previous chapter, defining supervision in a nursing context is steeped with stumbling blocks. Nurses view being supervised as being observed by a superior manager who controls, assesses and inspects their work (Cottrell & Smith, 2000). The term supervisor seems to entail a judgemental and power-laden concept that many find contradictory of what is considered an appropriate definition for mentoring. Yet, as far back as 1951, Rogers agreed that there was an ethical responsibility towards the client to ensure quality supervision. In some professions, evaluation is emphasised as a means of ensuring quality (Woodrow, 1994). The literature on nurse supervision, often attribute these negative connotations as a misconception, and it is argued that the intended aim of clinical supervision in nursing is to support and guide nurses in their achievement towards higher levels of service quality (Cottrell & Smith, 2000). Traditionally, the term clinical supervision refers to a set of principles and concepts, which are used to oversee and guide the learning process of a particular profession. The focus is not on administrative functions but rather on the transference of technical knowledge as a way of improving services to others (Eye, 2001; Garman, no date; McMahon, 2003).

Lewis (1996) warns against the dangers of a mentor being a line manager because conflict on management matters might arise between the mentor and the mentee. Hierarchical difficulties may have an impact on the mentorship relationship. Ackhurst (2000) in her work on peer supervision of trainee psychologists outlines the “fine line” between supervision that provides a necessary, accountable structure and supervision that could cause evaluation concerns for individual trainees. She suggests that a supervisory role should be balanced by a flexible, open², two-way evaluation process as well as by a supportive traditional mentor-type function.

A research study by Zanting, Verloop and Vermunt (2001) on mentoring beliefs found that many of the mentors interviewed felt responsible for evaluating their students’ lessons and then making recommendations to them. Therefore, it appears as if a supervisor-adviser component or general assessment with feedback may be

² The supervisor and the trainee predetermine clear evaluation objectives.

suitable in attempting to define mentoring in particular circumstances where skills and techniques are being transferred. Student expectations included a focus on learning the practical elements of teaching from their mentors as well as a confirmation that they required. Critical feedback from their mentor on their work was essential for improving the quality of their performance. The results of a study conducted by Fagenson-Eland, Marks and Amendola (1997) indicates that both mentors and mentees reported that those mentees with supervisory mentors reported receiving more advice on mentoring functions such as career development and counselling than mentees whose mentors were not in a supervisory position.

Senior in-house counsellors often play a supportive role in an HIV/AIDS site. However, off-site professional counsellors are often brought in to provide psychological support. Even though, these mentors do, to a degree, monitor the quality of VCT counselling services, they do not have a supervisory relationship with the counsellors. Baez (2001) says that, in a VCT environment, the same person often performs the role of supervisor and mentor. It seems that the incorporation of supervision, a necessary part of VCT mentoring, has been met with resistance from many service providers and policy developers (Engelbrecht, et al., 1995; Kwitsana, 1998; van Rooyen, 1999). Support given to HIV/AIDS counsellors was originally termed supervision and was based on support structures similar to supervision for psychology intern supervision and student nurses. Although this support was available to most counsellors, they did not always make use of it. Possible reasons are that counsellors did not fully understand the nature and benefits of supervision or were afraid of the evaluation and assessment side of supervision (van Rooyen, 1997). The term supervision has authoritarian connotations, and is often viewed as a hierarchical rather than the preferred bottom-up support network. AIDS counsellors and workers prefer the term mentor to that of supervisor (Engelbrecht et al. 1995). In the HIV/AIDS field, a supervisor may be described as a line manager i.e. the person one is directly accountable to for the time and resources spent. “It appears that if the same person performs mentor and supervisor roles it could cause unnecessary tension that may affect the relationship between the mentor and the mentee” (van Rooyen, 1999, p. 29).

3.3.2 Defining the Mentorship Component

The mentoring component in the HIV /AIDS counselling environment deals with emotional support, personal problems and personal development. The position of a mentor is less powerful than that of a supervisor and does not include an evaluative or managerial function (Ackhurst, 2003). Although, the concept of mentorship in this context has a strong supervisory element, fundamental mentorship goals such as professional and personal development are essential to mentorship in the HIV/AIDS context (Carruthers, 1993). Mentorship is, therefore, viewed as an “expansion of the supervisory role, to include functions beyond performing of training and accountability tasks” (Taibbi, 1983, p. 238).

Mentorship ‘purists’ such as Miller (2002) and Whittaker & Cartwright (2000) would consider this attempt at defining mentorship as ‘pseudo-mentoring’ as it fails to comply with what they classify as the “minimum criteria for a mentor relationship” (p. 46). The criteria they set out consider a prime-mentoring goal to be aimed at individual or personal development, with very little emphasis on knowledge or skills development. This is contrary to mentorship in a VCT context, which usually occurs in a group setting and has a core supervisory component.

Two main role categories that outline the definition of mentorship are psychological and career functions. Career functions support career improvement, and the psychosocial function fosters the mentee’s sense of self. It is the supervisory component that supports career functions while the psychological aspects pertain more to the mentorship aspect. However, it is through a process of amalgamating the two above-mentioned aspects that the mentee receives the greatest benefits (Choa, 1997; Russell and Adams, 1997).

3.3.3 A Tailored Definition to Suit the VCT Context

One may question the usage of a term that has to be adapted to suit the context. However, key HIV/AIDS stakeholders have assumed the term ‘mentor’ as a term with fewer authoritarian associations than ‘supervisor’. Mentors are seen as able to play a supportive and evaluative role in relating to HIV/AIDS counsellors in South Africa. (Engelbrecht, et.al, 1995; van Rooyen, 1999). The main objective of implementing

mentorship for HIV/AIDS counsellors is to provide managerial, support and guidance structures to sustain and improve counsellor well-being and the quality of counselling services in the VCT sector (Richter, et al., 1999).

The HIV/AIDS counselling profession is steeped with depressing events such as having to tell people they are they are HIV positive or helping people to come to terms with death. Mentoring provides a strong counselling element in providing debriefing and support structure functions (van Rooyen, et.al., 2003). In addition, counsellors deal with a series of ongoing problems, which causes counsellors to experience high levels of stress. Stress in the HIV/AIDS sector is largely caused by problems in the work environment. Mentors, who are sensitive to the stressors, and at the same time, have a sound understanding and knowledge of the HIV/AIDS work situation can greatly help relieve the stresses (Kwitshana, 1998).

Cottrell & Smith (2000) advise that in the nursing profession, as in the HIV/AIDS counselling sector, caution is exercised against supervisors or mentors playing a therapeutic role. The mentor is chiefly responsible for providing the emotional support that relates to work efficiency: it is not the mentor's task to apply in-depth psychoanalytic therapy.

A supervisory or advisory role to VCT counsellors forms an integral part of a "holistic" mentorship process. Therefore, it appears that supervision is not only a function of overseeing or assessing counsellor outputs but that it serves a comprehensive purpose, which includes a range of regulatory as well as supportive duties. Other roles emerge from the supervisory role. Supervision is, therefore, a mentoring process that includes managerial control measures and supports the professional and personal development of HIV/AIDS counsellors in an attempt to improve the quality of VCT services (van Rooyen, Solomon, Nott, Brouard, Saloner, Blom, van der Watt, 2003).

van Rooyen (1999) states:

In the case of an individual being both a supervisor and mentor to a counsellor, it is the responsibility of the mentor to find a balance between management and support roles that they carry. The mentor also has to come to terms with the responsibilities he/she has for taking care of the mental health of the counsellor as well as being accountable to the counsellor and the organisation. (p.30)

Thus, we may assume that a reasonable definition for mentoring in an HIV/AIDS context should embrace a much wider approach than traditional definitions of mentoring. Mentoring functions should contain both a distinct supervisory and a psychological supportive aspect. The mentorship relationship with counsellors is more extensive than that with supervisors in that it addresses both the supervisory aim of assisting counsellors to help them provide quality services and, very importantly, focuses on trying to inspire a sense of self within counsellors through a process of self development (Taibbi, 1983). Mentoring in this context should be seen as a necessary, comprehensive effort by a nominated person, with the specific purpose of assisting counsellors in developing a sense of self- independence and accountability for the benefit of the organisation they work for and for the people they serve. (Garman, no date)

3.4 The Development of Mentorship in the HIV/AIDS Sector

Key stakeholders in the HIV/AIDS sector have acknowledged the importance of counsellor supervision and mentoring since the early nineties. Mentorship was seen as crucial for the sustainability of HIV/AIDS counselling programmes in South Africa (Baez & Mwitshana, 2001; Engelbrecht, et al., 1995; Richter, et al., 1999; van Rooyen, van Rooyen & Kwitshana, 1999). It was found that due to a lack of resources many of the counsellors were experiencing stress in their work environments, and not receiving the necessary support. This led to a high dropout rate of trained counsellors. The aim of mentorship was to provide supervision and support to all trained HIV/AIDS counsellors as a means of ensuring a continual upgrading of skills and preventing stress and burnout (Kwitshana, 1998).

Although mentorship programmes have been initiated in the past³, many have fallen apart. Most of the programmes were terminated due to lack of funds, counsellor resistance, role confusion, and transport problems (Richter et al., 1999; Yacoob et al., 1998). Mentorship is not being prioritised, despite many key stakeholders regarding mentorship as vital for the efficient running of VCT services (Richter et al., 1999). There is an evident lack of structure, resources and commitment from higher HIV/AIDS managerial structures regarding the strength and sustainability of mentorship programmes on a National basis (van Rooyen, et al., 2003).

The continued need for mentoring of HIV/AIDS counsellors is being recognised and has resulted in some individual VCT units in some provinces drawing up mentorship programmes (van Rooyen, et al., 2003). NGOs in particular have set up programmes for VCT counsellors, which usually make use of external professionals to provide psychological support to their counsellors. In most cases, mentors monitor the quality of counselling, and provide on-job training and support to counsellors (UNAIDS, 2002). The National Department of Health has recently reviewed the importance of providing mentorship to HIV/AIDS counsellors and have appointed professionals to develop a sustainable national mentorship programme that will provide HIV/AIDS counsellors with the necessary technical and emotional support (van Rooyen, 2002)

3.5 The Importance of implementing mentorship for VCT counsellors

As seen thus far, mentorship appears to have evolved as a tool to equip people to cope with the challenges facing the world and it would seem that mentorship could serve a definite purpose in confronting the demanding challenges that are associated with HIV/AIDS counselling. Research on mentorship for HIV/AIDS counsellors in South Africa has revealed that mentorship is considered to be the cornerstone in the emotional support structure of counsellors (van Rooyen, et al., 2003). Support is a key element in the prevention of counsellor burnout, which is currently being experienced among HIV/AIDS counsellors (van Rooyen, et al., 2003).

VCT plays an integral part in the struggle against HIV/AIDS in South Africa. However, unless certain key areas, namely; enhancing the quality of counselling;

³ Mentorship was piloted in Kwa-Zulu Natal in 1996 and then expanded to the other provinces.

counsellor support, training and development; and counsellor monitoring and evaluation are implemented and maintained, the current effectiveness of VCT services will be lost (Solomon, van Rooyen, Griesel, Gray, Stein & Nott, 2003). Bor, Scher & Salt (1992) believe that comprehensive evaluation and descriptions of the HIV/AIDS counselling practice, training and supervision of counsellors is lacking. HIV/AIDS is a relatively new problem and often counsellors have limited experience, or under developed skills in HIV/AIDS counselling. Management often does not have the 'know how' and time to deal with the emotional strains that counsellors experience. In the VCT context, emotional and technical support may be seen as a mechanism for improving the quality of counselling services (van Rooyen, et al., 2003) Mentorship can help counsellors recognize the weak areas in their counselling and at the same time provide an opportunity for the counsellors' own growth and development.

3.6 Problems Experienced by HIV/AIDS Counsellors

Management of the HIV/AIDS counselling sector is not always effective. Counsellor selection is not always done adequately (UNAIDS, 1997). People who do not have the appropriate qualities or motivation to be counsellors are sometimes sent for training (UNAIDS 1997). Training courses are limited, often consisting of a five-to - 10 day workshop, which is not always long enough to be able produce quality counsellors. Resources such as policies, funding, salaries and a counselling venue are inadequate and contribute to high levels of stress that counsellors have to deal with. Incompetent organisational structures, which do not adhere to fundamental ethical principles such as confidentiality, pre- and post-test counselling and tolerance of and empathy with HIV/AIDS patients by all the staff in an HIV/AIDS unit can overwhelm counsellors, and can lead to burnout (UNAIDS, 1997).

HIV/AIDS counselling is a demanding and stressful occupation. Counsellors may become emotionally attached to their clients and then have to deal with the numerous hardships that HIV/AIDS patients are confronted with (Bor, Scher & Salt, 1992). "Burnout is a state of emotional exhaustion that results when the counsellor has reached his or her limit to deal with HIV and the emotional stress it causes." (UNAIDS, 1997, p.5). Counsellor burnout may result in a counsellor feeling desperate and particularly frustrated with inadequate resources and their inability to help their clients, and this may cause them to express their frustrations out on their colleagues

and clients (UNAIDS, 1997). Research on burnout indicates that burnout contributes to degeneration in physical health, depression, unproductive work behaviours, and problems relating to social, interpersonal relations (Cherniss, 1992, p.1). Counsellors' support, in terms of emotional support, listening, being helpful and reliable has proved to contribute directly to decreased levels of burnout and increased volunteer counsellors' job satisfaction (Miller, 1992). The mentor's role description includes all the above-mentioned support functions and thus can be regarded as a vital element in the reduction of HIV/AIDS counsellor stress.

An investigation of the mentorship literature by Spouse (2000) showed that mentorship support contributed significantly to student nurses' adjustment to clinical settings, and to their general nursing activities and learning abilities.

Although counsellors work among other professionals in the VCT sector, they may be the only counsellors in the unit, with no backup team to discuss and develop new ideas or debrief about difficult cases (Bor, Scher & Salt, 1992). The mentor can by reflecting about counselling concerns, with the counsellor assist the counsellor in developing solutions to problems that the counsellor may be experiencing in a counselling session.

3.7 The Role of Mentoring in HIV/AIDS counselling

The mentor has a multitude of functions within a VCT organisation.

A situational analysis of mentoring of HIV/AIDS counsellors in South Africa found that mentors provided an emotionally supportive role and played a part in the personal development of counsellors by providing education, training and the necessary resources to improve their professional skills and services (van Rooyen, et al., 2003). Personal development includes aspects such as improved self-esteem and confidence, career motivation and positive behavioural change (Miller, 2002). Richter, et.al. (1999) report that the role of the mentor in the 1996 VCT Mentorship programme was to "sustain counsellor capacity; help to improve counsellor skills and competency; provide feedback to trainers regarding the continuing education needs of counsellors and to successfully link clients to community resources."(p.19). Mentors, because of their skills and knowledge should be able to coach and provide resources for their mentees to solve problems and achieve higher counselling outputs (Lewis, 1996).

The table below, derived from a study of mentorship of VCT counsellors in South Africa, indicates the roles performed specifically by the mentors of HIV/AIDS counsellors. The results of a situational analysis (van Rooyen, et al., 2003) on mentoring of HIV/AIDS counsellors in South Africa produced twenty-eight mentor roles/functions. Roles mentioned in the analysis may be placed in four broad categories, as indicated below. Table 2 lists four broad categories of mentor roles.

TABLE 2: Roles performed by mentors of HIV/AIDS counsellors in South Africa

Supervision	Through a supervisory role the mentor provides an array of services and performs various functions
Guidance	Guidance is provided by way of suggestions and advice on how to deal with various types of counselling cases
Support structure	Providing emotional and technical support
Developmental tool	The mentor helps shape and change counsellor attitudes and values

The four components collectively play a part in the overall benefits of mentoring HIV/AIDS counsellors and are discussed in more detail below.

- *Supervision*

Through a supervisory role the mentor provides a range of services and performs various functions. A supervisory or advisory role to VCT counsellors forms part of a “holistic” mentorship process. Therefore, it appears that supervision is not merely a function of overseeing or monitoring counsellor outputs but serves a comprehensive purpose, including a range of regulatory and supportive duties. Other roles emerge from the supervisory role. Supervision is therefore, a mentoring process that includes managerial

control measures and supports professional and personal development of HIV/AIDS counsellors in an attempt to enhance the quality of VCT services.

- *Guidance*

Most VCT units currently with or without mentors regard mentors as providing guidance and support to lay counsellors. This function helps prevent the emotional turmoil many counsellors experience. Guidance is provided in terms of sharing of ideas, making suggestions and giving advice in case management. The mentor assists and directs the counsellors in job-related aspects of their professional and personal life. Regular meetings achieve this either with individual counsellors or during group mentoring sessions.

- *Support structure*

An HIV/AIDS mentor is somebody with skills and knowledge in HIV/AIDS counselling. The role of the mentor is to transfer these skills and knowledge to the counsellors. Support is necessary in terms of providing relevant social, psychological or emotional information as a way of empowering counsellors to function more effectively. Debriefing and a strong support structure are considered an essential part of the VCT programme.

- *Development tool*

Mentors play an important role in the ongoing professional and personal development of HIV/AIDS counsellors. The mentor's promotion of personal development not only improves the quality of counselling but also "grows" counsellors to their full capacity. A prime goal of mentoring is the personal development of the mentee. This development feature of mentorship is aimed at developing mentees to the extent that they are capable of dealing with difficult issues on their own. Professional development can only be achieved through the incorporation of ongoing training opportunities and updated counselling techniques into the mentorship programme.

3.8 The Use of Models in the HIV/AIDS Counselling Context

Mentorship models in the HIV/AIDS counselling sector have been largely informed by mentorship on a general level. Most aspects of models specifically designed for mentorship of HIV/AIDS counsellors are borrowed from other mentorship models that belong to other contexts. Models of mentorship vary, but in general tend to include personal and professional support, counsellor training and quality assurance functions (Cottrell & Smith, 2000).

The structure of the mentoring session has a large influence on the type of model to be used in the mentoring programme. Mentoring can be done in variety of ways: individual, group or telephonic. The mode of mentoring depends largely on the intended outcome. Individual and telephonic mentoring is generally aimed at assisting counsellors with individual, personal problems (Lewis, 1996). Group mentoring, on the other hand focuses on issues common to the group (Lewis, 1996). Thus group mentoring tends to be a more appropriate model for improving the quality of service delivery because problems that are general to the counselling sector are addressed in a group situation, which is less time consuming than individual mentoring.

The sessions may be facilitated either by an expert or by counselling peers. The mentoring process may also differ depending on the counsellors' needs identified by the mentor (Blom, 2003).

In an HIV/AIDS setting the mentoring session may take on:

- A counsellor focused structure where the mentees is in need of emotional support.
- A mentor focused structure – The mentor dominates the session and provides a distinctive teaching and supportive function
- Client case management, where the mentor will focus on the needs of the client in a particular counselling situation. Case management sessions have a dual function of teaching counsellors counselling skills (Blom, 2003).

Facilitated peer group mentorship is used to a large extent in South Africa. This is possibly due to the shortage of mentors. The most preferred type of mentorship is that of face-to-face, individual mentoring with a mentor accessible whenever needed, either telephonically or on site (van Rooyen et al., 2003)

3.9 Summary

It appears from the available literature on mentorship in an HIV/AIDS counsellor context that we may, therefore, define mentorship as consisting of two parts: a supervisory and a mentorship element. The supervisory element is distinct from the accepted concept of supervision, which includes strong specific elements of line management and organisational management. Mentorship in this context provides a multitude of functions that, together, contribute to the personal and professional development of HIV/AIDS counsellors, reducing stress and burnout, while simultaneously aiming to increase and maintain quality-counselling services.

CHAPTER 4 – AIMS AND METHODOLOGY

4.1 Aims of this study

The goal of this applied research study was to investigate the process of mentorship that has recently been introduced into the HIV/AIDS sector in South Africa and, in particular, in KwaZulu Natal. Thus, an exploratory study was considered as an appropriate choice to make preliminary investigation into a relatively unknown area of research (Durrheim, 1999; Babbie, 1992).

The overall aim of this research was to gain insight into the nature of mentorship from the perspective of those involved in HIV/AIDS counselling services. The researcher proposed to accomplish this aim, by using a flexible, inductive research approach. The outcomes of this study may provide useful information for HIV/AIDS stakeholders and policy developers in the implementation of future mentorship programmes.

This study was guided by the following research questions:

1. How do HIV/AIDS counsellors and mentors construct the concept of mentorship?
2. How do the perceptions of HIV/AIDS mentors compare with those of HIV/AIDS counsellors?
3. How does the understanding of mentorship revealed by the study compare with generic conceptualisations of mentorship?

4.2 Research Design

This study used a qualitative research design. According to Silverman (2001) “Qualitative research is the analysis of words and images rather than numbers” (p.8). An advantage of qualitative methodology is that a hypothesis should emerge inductively from the data. This method differs from a qualitative hypothetical deductive approach where the hypothesis is formulated before commencing the study and then proved to be true or false. The strategy of developing inductive hypotheses tends to be an effective means of avoiding preconceived ideas that may influence the outcome of the study (Silverman, 2001). Silverman’s notion of avoiding

preconceived ideas is confirmed by Patton (1997), who claims that a qualitative method is considered to be a practiced method of preventing a research study from being controlled by predetermined or standardized categories. The qualitative process allows the complexity of defining concepts, in this case, mentorship, to surface through detailed and rich descriptions that each participant contributes. The qualitative design, therefore, allowed us to scrutinize the ways in which the participants create and give meaning to mentoring in the HIV/AIDS counselling domain.

As already emphasized, the intention of this study was to analyse mentors' and HIV/AIDS counsellors' experience. The researcher decided that an interpretive research paradigm was suitable for this undertaking. This type of research approach is widely used in qualitative research to understand the social reality that participants create for themselves in their use of ordinary language and expression (Terre Blanche and Kelly, 1999)

As Bradley and Schaefer (1998) argue:

Without human interpretive activity, there might not be anything true or false, likely or unlikely, limited or abundant, filling space or passing time. Things are not 'real' outside of our experience and interpretation of them. Humans are the measure of all things. (p.51).

Smith and Osborn (2003) outline interpretative research as being a "two-stage process or a double hermeneutic". The process involves, firstly, the participants in trying to make sense of their world and, secondly, the researcher trying to make sense of how the participants are trying to make sense of their world (p.51). The skill of interpretative research lies in being able to listen, question and interpret what the participants are saying in a way that will allow the researcher to appreciate the situation from an ontological as well as an epistemological point of view (Terre Blanche and Kelly, 1999). Ontology, as conceived by researcher following this approach, is concerned with the reality of subjective experiences, while an epistemological perspective refers to our gaining knowledge about others' experiences and meanings by interacting and listening to them within a specific

context (Terre Blanche and Kelly, 1999). This study planned to contribute to theoretical knowledge in the field of mentorship for HIV/AIDS counsellors based on the experiences of those concerned with this particular field of study.

Thematic analysis was used to examine and interpret the collected data. This analytic technique endeavors to find patterns of experiences that emerge from analyzing transcribed conversations. The emergent patterns are divided into categories and sub categories, which are linked by related patterns or themes. This allows for themes that emerge from the text to tell a complete story constructed from a collection of common experiences (Aronson, 1994).

An important element in data analysis, recommended by Silverman (2000), is that of using a constant comparative method, which entails comparing sections of the data and data groups with each other. The constant comparative method of qualitative analysis is a key analytic tool used in the grounded theory approach. “The purpose of the constant comparative method is to generate theory more systematically” than by merely coding and analyzing the coded data (Glaser & Strauss, 1967). It was, therefore, decided to incorporate the constant comparison method into the analysis. Using the constant comparative method enabled the researcher to build an explanation of how the counsellors and mentors constructed the concept of mentoring. The researcher is required, during the process of developing analytic abstractions, constantly to formulate questions and possible answers about the data as well as to look for the similarities and differences between the participants’ experiences of mentorship (Strauss, 1987). Conclusions, supported by existing literature, were structured into an argument, the outcome of which contributed to the formation of sound theoretical contributions to the topic (Aronson, 1994)

A multimethod interview approach for data collection was used as it was considered to be a more flexible approach for gathering data from both the mentors and the HIV/AIDS counsellors (Spouse, 2000). Potter (1999) suggests that interpretive programme evaluation should use a variety of data-collection approaches. It was decided, therefore, as this study is concerned with establishing the perspective of various stakeholders involved in mentorship programmes that more than one method

of data collection was needed to achieve more comprehensive and richer data. The two techniques used were face-to-face interviews and focus-group interviews.

Banister, Burman, Parker, Taylor, & Tindall (1994) warn about “whose purpose the conversation” or interview is trying to capture (p. 51). It is precisely for this reason that interviews with the mentors were incorporated into this study. It was believed that obtaining the mentors’ perspective on how they constructed or defined themselves would prevent the bias there would be if the assumptions were based only on the counsellors’ perspective, a bias that would cause a misrepresentation of the theoretical concept of mentorship.

Focus-group interviews are extensively used in health and particularly in HIV/AIDS research as a flexible means of collecting data through an informal discussion approach, focused on a particular topic or set of issues (Marks, Murray, Evans, Willig, 2000). The reason for using focus-group interviews in this research lies in the following advantages of this data-collection tool:

- Focus groups generate interaction between participants in a non-threatening environment, which encourages a higher level of responses.
- Participants are pressured to respond accurately, as their responses can be verified by the other participants.
- Focus-group interviews are time- and cost-effective as more than one participant is interviewed at the same time (Sloan, 1998; Kelly, 1999; Wilkinson, 2003).

As not many HIV/AIDS counsellor mentors had been appointed in KwaZulu Natal at the time of the data collection, the coordination of a focus-group interview with mentors was not feasible. It was decided rather to conduct face-to-face interviews with the mentors. Although individual interviews are more time consuming and complex than a focus-group interview, individual interviews provide a useful research tool for the natural exploration of experiences on a range of levels from general to complex and in-depth explanations, which are not always possible in a focus group (Banister et al., 1994; Terre Blance & Kelly, 1999). In addition, the interviews

provided useful information from a mentor's perspective, in that they allowed for the comparison of the similarities and differences between the mentor's understanding of mentorship and that of the counsellors. The choice of a multimethod data collection approach was further motivated by Potter's (1999) guideline that an interpretive research design often incorporates a variety of different perspectives as a way of gaining understanding of a number of stakeholders involved in a specific programme.

4.2.1 Deviant Case

A deviant case was selected for analysis as a way of testing the theory that emerged from the results of this study. Silverman (2000) suggests that using participants other than the research subject leads to greater knowledge of the research subject. The deviant group in this study was selected from a general health clinic in an organisational context. This was different from the other focus group in two ways. Firstly, the participants mainly performed general routine medical functions similar to those of a general practitioner. These participants were involved in doing HIV/AIDS counselling in addition to their other duties, whereas the participants from the other focus group were only involved in counselling in a Department of Health (DOH) VCT unit. Secondly, the participants from the deviant group, unlike the rest of the participants in the study, were not receiving any mentoring.

Reasons for including this deviant group were: firstly, to determine whether the counsellors felt the need to be mentored, and secondly, whether the experience and opinions of mentoring in this group differed from that of the counsellors and mentors who were involved in mentorship. The importance of including a deviant group helps the researcher gain insight into the research by examining situations that do not fit into the regular pattern of investigation (Babbie, 1992; Silverman, 2000).

Silverman (2000) suggests that the constant comparative method, and, specifically, comparing the participants' explanations with the explanations of a deviant group is one way of thinking critically about data analysis and improving the validity of a study. The use of a deviant case would, in addition, establish whether the mentors' perception of mentoring met the expectations of the counsellors not receiving mentorship.

4.2.2 Pilot Study

The researcher decided to conduct a pilot study. The pilot study used a focus-group approach. Ten HIV/AIDS lay counsellors who work for a Non-Government Organisation (NGO) participated in the pilot study. These participants represented the broader population for whom the results of the pilot study would be used (Pillay, 1999). The participants were all Black, of mixed gender and varied in age from approximately 20 to 45.

The pilot study using individuals from the target population was included in the research design as a functional means of testing the clarity, structure and relevancy of the focus-group schedule (Rosnow & Rosenthal, 1996). Other factors, such as potential language difficulties and group dynamics, which may have had a possible effect on the focus-group process, came to light during the pilot study. The researcher took note of the factors that could possibly impact on the quality of data collection in the other focus groups. Kanjee (1999) suggests that pilot studies are valuable for identifying potential problems with the projected research, and they enable the researcher to revise the design and data-collection instruments before starting the research.

The data collected from the pilot study was not included in the analysis but was regarded as a guideline for the overall study. A major limitation of the pilot study was that the quality of the tape recording was extremely poor, causing sections of the data for this focus-group interview to be distorted and inaudible. The researcher, nevertheless, gained valuable knowledge from conducting the pilot focus-group study, which helped inform the other focus group discussions.

4.3 Sampling and Delimitation of the Study

The study was conducted throughout the province of KwaZulu Natal. Two focus groups with counsellors and one interview with a mentor were done in Pietermaritzburg, one interview in Uvongo, one interview in Port Shepstone and one focus group in Escourt.

The participants in the study were all adult females. All were Black, except for the deviant group, which was made up of two White females and one Indian female. The participants in the deviant group were the only participants that were nurse counsellors. The other participants were either lay counsellors or professional mentors. The ages of the participants were estimated as ranging from 22 to about 50. All the participants were selected from the HIV/AIDS sector and were involved with counselling or mentorship. The total sample size was 11, excluding the counsellors from the focus group interview who were used for the pilot study.

The diagram below depicts the two sectors from which this study's sample was drawn. The coloured areas represent participants in this study, the green area the pilot group who were selected from a NGO, the yellow diagrams represent HIV/AIDS counselling service available from sectors other than the Provincial Department of Health (PDOH) from which participants were selected, pink areas represent the participants selected from the PDOH's VCT structure. Finally, the diagram depicting the participants from the PDOH is in the form of an organogram in order to indicate the participants' representation in the broader VCT structure.

A purposive sampling strategy was employed in the selection of the participants for this study. Purposive or non-probability samples are based on values of convenience and accessibility (Silverman, 2001; van Vuuren and Maree, 1999). The specific parameters of this study were HIV/AIDS counselling and mentorship. Purposive sampling of "information-rich cases" allows one to select participants according to the parameters of the population being studied and to make generalizations from the study cases to the larger population of VCT institutions in South Africa (Patton, 1997; Silverman, 2001, p. 104).

The sample size was compromised by difficulties in gaining access to participants attached to the Department of Health (DOH), thus constraining the boundaries of the study. It could be argued that a small sample, such as the one in this study was not representative of the population and therefore limits the generalisability of the study. Proponents of qualitative research, however, view generalisability of findings to be context dependent, and they emphasise that behaviour is best understood within a specific social or organisational context (Patton, 1997). It was felt that the research

4.4 Procedure

4.4.1 Collecting the Data

4.4.1.1 Entering the sites

Obtaining permission to interview HIV/AIDS counsellors in certain PDOH VCT sites proved to be difficult on two counts. Firstly, attempts to make contact with the coordinators and VCT managers in certain districts proved futile, and secondly, not many DOH or NGO VCT sites have mentors for their counsellors yet. However, using a type of “snowball⁵ technique”, potential participants were identified by communicating with various key stakeholders in the HIV/AIDS field ((Babbie, 1992, p. 292). Influential VCT coordinators from two districts in KwaZulu Natal assisted with gaining of the required permission to interview counsellors and mentors in their areas. Gaining entry to participants from NGOs proved less challenging.

4.4.1.2 Interviews

Three participants were approached to participate in the face-to-face interviews. The purpose of these interviews was to substantiate the focus-group data and to compare counsellors’ experience of mentoring with that of mentors. The reason for comparing perspectives was that one of the research aims was to establish whether any differences existed between the two perspectives. Two of the participants were currently employed by the DOH. One was employed as a VCT counsellor coordinator and the other as a Mentor coordinator. The third interviewee worked for a NGO as their counsellor-training coordinator. The training coordinator and the counsellor coordinator had both previously been employed as mentors to HIV/AIDS counsellors and the mentor coordinator was the acting district mentor until permanent mentors were appointed.

Semi-structured interviews were conducted. They were structured to the extent that the focus of the interviews was developed beforehand in the form of an interview

⁵ A nonprobability sampling method where each person interviewed may suggest additional people for interviewing. (Babbie, 1992).

schedule as an outline for the interviewer to follow. A semi-structured interview method tends to produce richer data than a structured interview (Smith and Osborn, 2003). However, the interview was flexible in that the interviewer was not dictated to solely by the schedule and was free to probe and pursue relevant matters based on the interviewees' responses. All interviews took place at the mentors' place of work and lasted about 60 minutes. The interviews were audiotaped for analysis after permission for this had been granted.

4.4.1.2.1 Interview Schedule

The interview schedule was divided into three sections.

- Section one aimed at establishing the participants' basic knowledge of mentorship in their organisation.
- Section two dealt with the understanding of mentorship and its value and function. The differences between a supervisor and a mentor were dealt with in detail.
- Section three focused on the qualities and skills of a mentor.

Open-ended questions were developed, based on a comprehensive review of the literature on mentoring. Possible prompts or probes were included in the schedule, as a means of extracting more specific information for questions that the researcher anticipated might prove difficult to answer. Probing boosted the flexibility of the schedule, which permits the researcher to clarify or expand on certain matters. This allowed for greater in-depth exploration of the participants' experience (Smith and Osborn, 2003).

4.4.1.3 Focus Group Interviews

Two focus groups were conducted. The size of the groups varied between three and seven participants. The researcher facilitated both focus group interviews. One of the focus groups was co-facilitated by the VCT district coordinator. Another focus group was conducted at the organisational clinic where the participants worked. The counsellors in this group were not receiving mentoring. The other focus group met at

a district VCT office. The participants from this group received mentoring and came from various clinics to their head offices for the focus group interview. The researcher tried to provide an atmosphere in which the participants felt comfortable. All the participants were encouraged to share their views and experiences (Sloan, 1998). All the interviews were administered in English and lasted for approximately an hour. The implications of language limitations are explained in chapter seven.

4.4.1.3.1 Focus Group Schedule

The interview schedule for the focus-group interviews was the same as the interview schedule used for the interviews. The focus groups consisted of participants who were HIV/AIDS counsellors. However, the individuality of each participant had to be considered. The interview schedule for the focus group had to be flexible enough to allow participants to express their individual experiences and opinions. Focus group facilitation often requires the facilitator to develop statements by interpreting and summarising the discussion content as it emerges throughout the focus group discussion (Kelly, 1999). The schedule was only a flexible guide, as, during the interview, additional questions and probes arose spontaneously from the conversation arising from the discussion. The researcher observed differences and similarities of opinion throughout the group discussion. Notes were made of these similarities and differences, which were analysed with the data. Note taking during data collection helped during the analyses (Kelly, 1999). The interview schedule used for both the interviews and the focus group is in Appendix A.

4.5 Data Analysis

The discussions in the focus groups and interviews were transcribed *verbatim*. Although the researcher included important utterances, pauses and overlaps in the transcription, standard transcription conventions⁶ were not strictly adhered to. The researcher considered the transcription methods adequate, as thematic analysis, as opposed to conversation or discourse analysis, would be used to analyse the data. For confidentiality, the transcripts were stored in a safe place for future reference. The transcription of one of the focus groups is included in Appendix B.

⁶ Silverman, 2000 describes a set of transcription conventions

4.5.1 Reliability

“Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions” (Silverman, 2001, p.188). Certain practices, as described below, were adhered to as a way of achieving the consistency, essential for reliability. The focus-group interviews were carefully recorded and transcribed in detail in an attempt to enhance reliability. The completed transcripts were read and re-read while listening to the recording, as a way of checking the accuracy of the transcripts. Errors were corrected where necessary (Silverman, 2001). In one of the focus groups two tape recorders were used. This proved to be a useful technique. Any inaudible sections on one tape-recording were retrieved from the other. Rereading the transcripts served an additional purpose of becoming familiar with the content of each tape, and this contributed to a crucial part of the thematic analysis process (Terre Blanche and Kelly, 1999).

4.5.2 Validity

An important feature of any research is that the method should be reliable and the findings valid. To ensure validity, this study used two of Silverman’s (2001) suggested measures of validity for qualitative research: the constant comparative method and deviant case analysis. The constant comparative method requires that cases be compared to test the provisional hypothesis. This method requires that the researcher move constantly between the different sections of the data until all the data have been compared. As Silverman (2001) advises, this study included deviant case data in the analysis in order to supplement the constant comparative method. The deviant groups were not receiving mentoring and, therefore, held no preconceived ideas on mentoring. This group’s thoughts on mentoring provided additional information to the study which, when analysed, revealed some differences from the views of those participants already involved with mentorship. Based on Smith’s and Osborn’s (2003) recommendation on checking the validity⁷ of a research report, all the data, notes, interview schedules, audiotapes, transcripts, analytic coding and category lists, draft reports and the final report have been retained and are available, if

⁷ The validity of a study can be determined by doing an independent audit of the documents developed throughout the study

the findings of this study need to be clarified. This information will be stored for the required period of five years and will thereafter be destroyed.

4.5.3 Analysis

Thematic analysis in combination with the constant comparative component of grounded theory was used to analyse the data yielded by both the focus groups and the interviews. Aronson (1994) states, “Thematic analysis focuses on identifiable themes and patterns of living or behaviour.” (p. 1). The initial analysis procedure involved the researcher’s coding the data in detail, line for line, (as recommended by Strauss, 1987), into categories that were formed as the analysis advanced. Similar themes that naturally emerged from the content were grouped together into classified coded categories (Aronson, 1994; Smith 2003; Strauss, 1987; Terre Blanche and Kelly, 1999). Coding the data serves a multipurpose function. Firstly, coding directs the production of theoretical questions. Secondly, coding dissects the data into workable units, which allow the researcher to move from merely describing the phenomenon to a higher level of interpretation and theorizing. Lastly, coding is an essential activity in the discovering of core patterns or themes, which, when integrated into the analysis, produce distinct ideas and theories (Strauss, 1987).

The philosophy behind grounded theory is that the theory which becomes apparent from the data can be considered as the theory best suited to the planned research as opposed to the verification of *a priori* assumptions made before the data has been analysed (Glaser & Strauss, 1967). The theory is, in other words, systematically “grounded” in the explanations and understandings of the participants of the study. The focus of the analysis is on organizing the ideas that develop during analysis into a coherent hypothesis (Strauss, 1987).

The grounded-theory method of analysis resembles the thematic analysis approach in that the basic coding steps of the analyses are similar. The differences between the two approaches is, firstly, grounded theory generates theory as the analysis progresses, and, secondly, constantly compares data sets for the similarities and differences in themes or categories that emerge from the analysis.

The cut-and-sort technique of thematic content analysis has proven to be a quick and cost-effective method of analysis (Terre Blanche & Kelly, 1999). However, the researcher decided to analyse the data by using the NVivo software package. The advantages of using a computer software package to analyse qualitative data is that it reduces time and effort. In addition, NVivo helps organise the data into categories and sub categories by allowing the researcher to develop a coding structure consisting of various headings derived from common themes that emerge from the text (Silverman, 2000). Silverman (2000) warns of the limitations of adhering strictly to a coding scheme. Uncategorised data functions in a similar way to a deviant case. The researcher should, therefore, be constantly aware of potential new categories that could affect the results of the study. Another limitation of computer analysis is that the computer only produces a framework of categories. Meanings and theory that emerge from the data need to be developed through a thought process that cannot be substituted for by a computer (Silverman, 2000). A versatile feature of NVivo is that it allows the researcher to make memos throughout the analysis. Memos have the function of supporting the analysis and quality (validity) of the research.

Nvivo uses three types of headings, called nodes (QSR international 2002):

- Free nodes, that are an unstructured collection of ideas, are developed at random as an initial analysis. These nodes are used to build emerging themes as the analysis continues
- Tree nodes that are organized into categories moving from the general to the more specific.
- Case nodes, which group the tree nodes into refined, decisive and conclusive themes.

Appendix C contains a list of all tree nodes developed during the analysis.

The data analysis steps were as follows:

Step 1: The interview and focus-group transcripts were read and re read so that the researcher could become familiar with and develop a “theoretical sensitivity” towards the contents (Borgatti, n.d, p.2).

Step 2: Coding of the data was initiated by the researcher reading the transcriptions line for line. Central themes and sub themes, which occurred naturally in the material, were identified during the initial reading of the transcriptions. These themes were highlighted and coded as units of analysis. Notes on ideas relevant to the analysis were made on the transcripts.

Step 3: The transcribed interviews and focus-group data were transferred onto the NVivo software programme. The researcher's notes on the dynamics, verbal utterances and non-verbal behaviour noted during data collection were entered as memos on the NVivo programme. Ideas that emerged during the initial coding were also included as memos.

Step 4. A list of free node-coding categories was generated, based on the initial codes that developed from the line-by-line coding. The NVivo documents and memos were coded again using the free nodes as a guideline, as well as developing additional codes as the coding progressed.

Step 5: Once the data had been coded the free nodes were reviewed and a more comprehensive list of tree nodes established by combining codes with similar themes into the same tree node.

Step 6: The data was then coded across and between data sets into main categories with sub categories based on thematic patterns developing from the data. Coding was done by marking sections in the data as relevant to a particular theme or to one or more themes. The aim of the coding process is to dissect the total body of data into significant pieces that could later be clustered together in useable theories (Terre Blanche & Kelly, 1999). Theory starts developing during the coding process. Links start appearing among categories and a certain amount of overlap occur between data sets.

Step 7: Themes were elaborated at a more abstract level as part of the theoretical development. Similar themes were clustered together into conceptual categories (Smith & Osbourne, 2003). Theoretical connections were sought by comparing the codes (themes) within the same interviews and focus group and then between the

respective interviews (mentors), focus group (counsellors) and the deviant case for similarities and differences (Smith & Osbourne, 2003).

4.6 Ethical Considerations

Letters were sent to the stakeholders requesting permission to interview Provincial Department of Health HIV/AIDS mentors and counsellors (Appendix D). The ethical principles of psychologists and the code of conduct stipulate that psychologists obtain institutional approval for conducting research from the relevant organizational authorities prior to commencing the research (American Psychological Association, 2003). Organizational consent to conduct research was obtained at a first level. This was achieved by contacting VCT district coordinators telephonically to approve and coordinate the interviews and focus groups in their respective districts. The sister in charge at the clinic attached to a specific organisation granted permission for a focus group interview to be done.

The participants in the study were verbally briefed on the background and purpose of the study. They were informed that participation was completely voluntary and that they could withdraw at any time. Interview and focus-group participants were assured of strict confidentiality regarding personal information received. Permission was given to audiotape the interviews. Names were not to be disclosed during the transcription of the interviews and focus groups to ensure the confidentiality of the participants. They were also assured that the tape recordings would be securely stored after being transcribed. All the participants gave verbal consent for their participation in the study.

The stressful nature of HIV/AIDS counselling was a focal point of the interviews and focus groups and could, therefore, have evoked stressful memories and emotions for the counsellors and mentors. However, all the participants were allowed a period of debriefing after the interviews and focus groups to discuss any situations that made them feel uncomfortable during their participation.

The participants were also informed of the value of participating in this research, as the information collected might benefit the implementation of future mentorship programmes in the HIV/AIDS sector.

4.7 Summary

This chapter has outlined the methodology used in this study. The researcher was constantly aware of the importance of research-design problems associated with qualitative and, in particular, interpretive research that could detract from the validity and reliability of this study. Critics refer to interpretive research as “the vicious circularity of understanding – a process of projecting one’s own beliefs ... on the world and then rediscovering them as findings” (Kelly, 1999, p.424). Constant critical reflection on the researcher’s assumptions, role and influence on the research process was practised throughout this study as a way of avoiding any possible subjective researcher manipulation. A reflection on the study can be found in chapter seven.

CHAPTER 5 - RESULTS

5.1 Introduction

This study is concerned with the perceptions and experiences of HIV/AIDS counsellors and mentors have about of mentorship. The results of the analyses of individual interviews and focus group discussions reflect participants' understanding of mentorship. Themes that emerge in the results are supported by concepts in the literature. An interpretation of these themes deepens our understanding of the participants' stories and ultimately contributes to the formation of the theory of HIV/AIDS mentorship. These interpretations are discussed in chapter 6.

5.2 Orientation to the Focus Groups

Both the participants interviewed individually and the focus group participants appeared convinced of the urgent need for mentorship in the HIV/AIDS sector. The participants in one of the focus groups appeared nervous at the start of the discussion, but they gradually relaxed and, at the end of the discussion, said that they felt that the participation had been a worthwhile exercise, helping them to reflect and become more aware of the meaning of mentorship. In some interviews the discussion continued after all the items in the interview schedule had been dealt with. This, in itself, may be an indication of the extent to which counsellors and mentors in the HIV/AIDS sector value mentorship. The section on the differences between supervisors and mentors generated much discussion and "brainstorming". It was interesting to observe the development of the discussion and the changes in participants' perceptions. These changes will be outlined and discussed in the results that follow.

Five broad themes, each with subthemes emerged from the analysis. Appendix E contains a comprehensive list of codes and subcodes. The major codes included:

1. Benefits of mentoring
2. Structure of mentoring programmes
3. The roles and functions of a mentor
4. Differences between a supervisor and a mentor
5. Criteria for selection of mentors

Extracts from the interviews and the focus groups will be used to illustrate the concepts that emerged from the discussion. The following notations will be used to indicate from which interview or focus group the extracts came:

- ❖ FG 1/ 2 will be used to indicate from which focus group the extract was taken
- ❖ FG 1 is the deviant group without mentorship
- ❖ FG 2 is the group of counsellors with an existing mentorship programme
- ❖ INT 1/ 2/ 3 denotes the different interviews done with mentors
- ❖ () a number in brackets will indicate which individual in the group made the statement.
- ❖ Comments by the interviewer are indicated in italics
- ❖ Part of an extract that has been omitted to shorten it and can be identified by the use of ellipsis points (...)

It should be borne in mind that English is not the first language of most of the participants. The extracts have been used as transcribed, that is, word for word from the tape recordings. They are not, therefore, always grammatically correct.

5.3 Benefits of Mentorship for VCT

The benefits of mentoring for both the VCT sector and for the counsellors emerged in response to statements and questions about various stressors that VCT were experiencing. These statements, although prompted by broad questions on counselling in the interview schedule, were made spontaneously as the interview and focus-group discussions progressed. The focus on the stress of HIV/AIDS counselling was evident throughout the interviews and the focus group discussions. The reason for this may be that this study concentrated on perceptions of mentorship, a role generally associated with the provision of support and guidance during a difficult or vulnerable period of a person's life. From this we may assume that counsellors may find many aspects of their work debilitating and perceive a mentor as someone who can help them to cope with their work. An additional reason might be that the counsellors were given the opportunity to debrief and speak about their counselling experiences. A focus group discussion is very similar to a group mentoring session and has similar beneficial outcomes.

FG1 (2): I would enjoy having a mentor because I think, every time I tell someone they are HIV positive a little part of me dies as well. ... It is miserable, miserable conditions. You put out this picture that you are not trying to be deceitful or lying, but we are trying to give them hope, but in my heart of hearts, there is no hope, because you see what a miserable death they are dying.

The response was positive when the discussion specifically focused on the mentoring benefits participants have experienced. Interviewee 3 noted that counsellor attitudes had changed since the introduction of mentoring. Counselling was previously and is still currently seen as a job with no specific career path. Members of various communities, for humanitarian reasons, volunteered as lay counsellors. The introduction of mentorship might be one aspect that may led to greater legitimacy of counselling in the future.

INT 3: Mentoring has changed the way in maybe how they look at counselling. They were just doing it for the sake of doing it.

The need for mentoring emerged as a strong sub-category in the analysis of the data. The appropriateness of providing mentoring for counsellors is reflected and understood as a benefit of mentoring for both the counsellor and HIV/AIDS counselling services. Although Focus Groups 1 and 2 and all the interviewees (Interviews 1, 2 and 3) mentioned the difficult and stressful nature of VCT counselling, the deviant group, Focus Group 1, in particular, seemed very frustrated and despondent about their ability as counsellors actually to make a difference and to help their HIV/AIDS clients. This is illustrated by the extract that follows:

FG 1 (1): The bigger thing that I battle with personally is, I just can't understand the mentality. You know when someone is already positive, that they thereafter come in pregnant. I just think what was all the talking and counselling about ...you just think, are we banging our heads against a wall, because they are not doing any of it.

These sentiments, as well as the need for mentorship for this group, are confirmed by the interview with the mentor coordinator. Counsellors in the VCT district where she was the coordinator, before mentorship was introduced, were struggling with the

multiple problems of counselling positive HIV/AIDS clients. HIV/AIDS counselling includes providing a variety of support structures that go beyond the normal definition of counselling. Thus HIV/AIDS counselling is not only pre- and post-test counselling, but serves especially as a survival and backup mechanism for people living with HIV/AIDS. As will become evident from the results that follow, a mentor provides the necessary assistance, such as case management, problem solving, HIV/AIDS networking and providing resources that equip counsellors to deal with the uniqueness of each individual counselling case.

INT 2: This was not happening before the mentorship programme. They were just focussing on HIV/AIDS counselling.

There was agreement among the counsellors in Focus Group 2 on how stress and, especially, not coping with a counselling session can affect other sessions. One of the counsellors believed that, thanks to mentorship, she was able to deal with these problems and continue her counselling with a clear mind. The mentors who were interviewed perceived mentoring in a similar way, that is, as providing an opportunity for counsellors to debrief and in this way provide a more valuable counselling service

Is there a lot of counsellor burnout?

INT 1: If they have a mentor it is minimal ... you talk, you share, you know, you share the load because counselling is a very heavy load.

The above response referring to the advantages of mentoring in reducing counsellor burnout contrasts with the statement of despair of a counsellor from Focus Group (1) who receives no mentoring.

FG 1(3): You just want to run away from everything. You just want to be in a safe place. You don't feel safe. And you want to be objective. You don't want to be emotional.

Interviewee 3 was also concerned about the impact of stress on the counsellors in general and felt that much of the stress counsellors were experiencing arose from

mismanagement of cases, a lack of resources and a lack of emotional and professional support.

Both focus groups and one of the interviewees said that they had experienced incidents where stressed counsellors often display their frustrations in negative behaviour towards their colleagues. However, it appears that mentorship is an effective method of reducing staff conflict. In a VCT site mentorship provides counsellors with the benefit of gaining a better understanding of their fellow counsellors and developing healthy working relationships with them. Counsellors realise, through group mentoring, that colleagues are experiencing problems similar to theirs and that, through a process of discussion, counsellors can provide mutual assistance to one another. Thus, mentoring is the facilitation of a group counselling process as well as a peer learning process. Not only do counsellors gain a better understanding of their fellow counsellors but also at the same time learn from each other.

Do you have counsellors being critical of each other?

INT 3: Before they used to have that, that they are criticising each other but due to the introduction of mentorship, we told them it is not about maybe looking at who is not doing right, who is not doing the best but we are here to help each other so that at the end of the day we will all be providing quality counselling.

The counsellors and the mentors claimed that stressful working conditions, if left unresolved, tend to impact on family life. The benefits of a mentor for counsellors, means being able to debrief to someone who can understand the situation and can, in particular, understand the stressful aspects of counselling HIV positive or AIDS clients.

FG 1 (2) I need a release valve and I do go home and I blast. And I don't think my family are enjoying me at the moment. I know they are not. So if I had a mentor, they would hear it and my family might enjoy me more.

Mentoring as expressed by Interviewer 1, in the next extract, is not only concerned with relieving stress, but rather with developing the counsellor in a holistic manner.

Many factors are involved in being a good and effective counsellor. Mentors, thus, benefit counsellors in that they are concerned about both their professional welfare and their psychosocial welfare.

INT 1: When I mentor you don't only focus on the delivery of the actual service that a person is paid for but you also have to look at the person as a person first. ...Look at the people that are under you as a mentor holistically. Attend to all the aspects of the needs; physical, mental, social, academic because it helps them a lot, you know it shows that you are interested in them as people.

All of the participants perceived the distinctive value of mentoring as providing a contribution to effective, high-quality counselling in that counsellors are given emotional and professional guidance and support. Counsellors are better equipped and in a better emotional state to be able to help their clients deal with the hardships of living with HIV/AIDS. A summary of the further extracts can be found in Appendix F.

FG 2 (3): To me mentorship is a way of really trying to help a person to be able to assist a person to understand her situation, it also means that I can be able to be given help and that it will assist me in my work most of the time and it does help I can say so.

INT 3: At the end of the day we must be in a position to render quality HIV/AIDS counselling to our clients and to link them with resources to network for them in order for them at the end of the day to get what they were in our offices for.

It appears from this study that improved counselling skills and increased counsellor coping mechanisms, as by products of the mentorship process, should inevitably result in improved quality of the counselling services for the VCT sector.

5.4 The Structure of Mentorship Programmes

The analysis of the data produced a number of subcategories on participants' beliefs about the way a mentoring programme should be structured in their units and mentoring districts. The categories referred to matters such as who should be

mentored; the format for delivering mentoring; the frequency of mentoring; issues that should be discussed by mentor and mentee; and the ideal relationship between mentor and mentee.

Mentorship in KwaZulu Natal is still a new concept and only the participants in Focus Group 2 were receiving mentorship on a regular basis. Interviewee 1 and Interviewee 2 spoke of their experience of being mentors in their previous work situations. Interviewee 1 provides unofficial mentoring for new counsellors in her unit.

INT 1: We train our counsellors, we give them a full ten days theory part of the training. During the training we do have role-plays, you know, just to check on their counselling skills. There... after there is a compulsory three-day practical that they have to come back here for, where we often do mentoring.

Mentorship has just started in Interviewee 3's district. This participant had attended a Department of Health mentor-training course and was performing a mentor role in the district in which she worked, although she is the mentor coordinator and mentors had not been appointed at the time of the interview. The participants in Focus Group 1 had never received any mentoring and found it difficult to comment on the structuring of mentorship. They did, however, once prompted, and as the discussion progressed, express their views on some of the structural issues.

Interviewee 3 contributed many ideas on the structure of a mentorship programme, as she was at the time involved with the implementation of mentorship in the area. The aim of a mentorship programme as conceptualised in this district was to be able to visit the various units regularly to establish and help counsellors with the emotional and professional problems that they might be experiencing. By identifying problems in the group, the mentor is also able to ascertain if any individual problems exist among the counsellors. The mentor can then attend to these problems on an individual basis.

INT 3: We try to visit each and every site so that we get different challenges, problems and in fact then as well, we also know that we are in a position to identify maybe

problems, individual problems, if I may put it that way and which areas are they and which areas need to be considered and need comforting to that particular counsellor.

The VCT and PMTCT counsellors and nurses and the supervisor of the site usually attend the mentorship sessions. Sessions commence with identifying and dealing with common problems, where after second-level, in-service training on a specific applicable topic, other than pre- and post-test counselling, is presented and discussed in an attempt to broaden the counselling skills.

INT 3: I conduct a session whereby all the counsellors will be there of the site and together with the sister who is supervising in terms of VCT and PMTCT so that they would know exactly what it is expected of them ...Rather than just HIV/AIDS. That is the matter of concern because they only have counselling skills, pre-test skills and post-test skills and ongoing. So that is what we are saying in mentorship we are trying To integrate the two together, so that really our services will be improved and clients will be helped in all the spheres of their problems.

The structure of a mentorship session for Focus Group 2 tends to take on a similar format. The group receives an agenda beforehand. The counsellors outline their learning objectives for the day at the start of the session. Sessions include discussion of problems being experienced, new interventions and counselling suggestions. Role-plays are often incorporated into the sessions as a way of developing individual counselling skills.

Participants' reactions were mixed when they were initially asked who should receive mentoring. Focus Group 2, after some reflection and discussion, said that they believed that if the nurses administering the HIV/AIDS tests were included in counsellor mentorship they might gain a better understanding of the concept of counselling. They also believed that the nurses sometimes displayed and wished to discuss their emotions after testing a seropositive client

FG 2 (1): They can be mentored because they must understand the situation. They are working with a situation where there may be problems with the client.

(2) My supervisor, she confirms for me and knows the results. Somehow that has an impact on her, because after the client has left she comes back to me and we talk about it. Somewhere, somehow she got hit and for that she has to get rid of whatever the stress or whatever she underwent.

Both focus groups believed that mentorship should be available both in group sessions and individually. The mentors gave reasons for this opinion. Focus Group 2 currently only receives group mentoring. Speaker (4) in Focus Group 2 said that, as she was a very shy person, she often felt intimidated in a group situation. She usually refrains from contributing to the group discussion until she is encouraged to do so by the mentor. This only increases her shyness. She did, however, agree with the others that by participating in group mentoring, counsellors like her can become aware of common counselling problems and learn from each other's contribution to the discussion. The counsellors receiving mentoring (Focus Group 2) thought that the ideal mentoring situation would be to have a mentor employed in the unit, conducting regular group-mentoring sessions, but also available on a one-to-one basis, depending on counsellors' needs.

FG 2: (3) We would prefer regular mentoring, group and individual. Sometimes we would need a person who we can talk to after a counselling session that day. So it would be much better if your clinic could have a mentor and individual mentorship. Then in-group one, because you have that session and you talk and you come with a specific counsellor with a challenge ... you will be able to learn something there, solutions that will help each and every one of us. So that session will be very, very good.

Interviewee 1 spoke about group mentoring being a process of sharing counsellor skills and knowledge. Each counsellor, in participating in group mentoring, contributes in a unique way to the development of fellow counsellors.

INT 1: You share the knowledge and you share the skills and through that process obviously you learn a lot of things, because as much as you will be trained ... but each and every person has got something unique to bring to the mentoring session.

All the participants believed that individual mentoring was an essential part of mentorship. The counsellors said that they would be able to discuss personal problems in these sessions, which they saw as having a beneficial effect on their work. Interviewee 3 pointed out that many of the counsellors themselves are HIV positive and need a support outlet to deal with their own HIV/AIDS problems. There was agreement among the participants in Focus Group 1 that mentorship should be made available to counsellors either in a group, one to one, telephonically or even by email. Interviewee 3 expressed the concern that individual, face-to-face mentoring could be difficult to achieve as future mentors would each be mentoring between 10 and 15 counsellors.

INT 3: ...But the problem is as well is that they will be mentoring about 10 to 15 counsellors per counsellor mentor. So definitely there will be some limitations.

Most participants judged that group mentoring should be available at least twice monthly for new counsellors and, once they were more experienced, once a month. All the participants, however, believed it to be essential that mentoring take place on a regular basis for both inexperienced and experienced counsellors. They perceived mentorship as a safeguard against counsellor “burnout”

Should counselling be forever or should there be a point when the counsellor can go without mentoring?

INT 1: It depends on the environment. What type of counselling are they giving? Is it a stressful type of counselling or what? Uhm, you know, because if you say at one stage you leave them just like that, what if they have burnout?

INT 2: Each counsellor should be seen on a weekly basis. Yes, one and one and also perhaps once a month as a group would help.

Topics of discussion that arise in mentor sessions are varied. The participants agreed that case management was one of the main problems mentors dealt with in group mentoring sessions. Other problems revolved around the counsellors’ working environment (INT 1, INT 2, INT 3, FG 2 (2)). One of the participants thought that weekly individual mentoring for counsellors was necessary. The participants receiving individual mentoring and the mentors providing mentorship spoke about

various problems counsellors discussed with their mentor individually. These problems varied – emotional strain, lack of confidence, feeling intimidated while counselling better-educated clients, client-relationship problems, poor organisational skills and work conflicts. They were mostly problems linked to work matters. At a personal level the counsellors often discussed their own HIV/AIDS status, financial concerns, and domestic problems. Interviewee 2 said that the counsellors often saw her as a bridge between non-counselling staff members in the department and themselves, especially at times when relationships were strained.

What are some of the issues that a counsellor would discuss with a mentor?

INT 2: For instance what's happening is that the department will place counsellors in a government hospital or clinic. It does happen that sometimes the relationship between the two isn't working so well. I think the counsellors need to mention that ...to the mentor so that she can actually be the bridge between the two ... find ways of keeping a good relationship between the clinic staff and the lay counsellors in the clinic.

Interviewee 3 said that she sometimes had to approach counsellors about inappropriate behaviours that might impact negatively on the HIV/AIDS counselling sector. She believed that counsellors should set an example as role models by adopting a lifestyle that suggested adherence to HIV/AIDS prevention methods.

INT 3: Because at the same time we must maintain the status of the organisation that the counsellor is working in ... so the clients will lose hope so that at the end of the day we are promoting that we must be faithful, each and every time you must use a condom and you must be living examples of that.

It appears from the analysis that the relationship between a counsellor and a mentor should be friendly, warm and informal, yet be based on mutual respect and be maintained within professional boundaries.

INT 1: The way of conducting yourself, as much as you will be friendly, but they still respect and be loyal to you. ... They are friendly, open but obviously they know their limits.

FG 2 (3): It can be formal, but not tie type of formal

Participants felt that too formal a relationship would restrict counsellor confidence and hamper the mentees' faith in and trust of the mentor. It seems that counsellors experience a formal relationship as supervisory and judgemental.

FG 2 (2) Ja, you can't be too formal, because if you are formal that will restrict you somehow. You can't be yourself totally. You are restricted; you are worried that he is going to quote me. He is trying to find some mistake.

5.4 The Role and Function of a Mentor

Although, the function of the mentor emerged from the analysis of the data as constituting a separate theme, it tended to be very difficult to isolate the role and function. The boundaries between these and some of the other concepts that developed from the data sometimes became blurred, and some degree of overlap is evident in the results.

The following is a description of the sub categories that developed from the analysis

TABLE 3: Sub Categories referring to the Mentor Role and Function

SUB CATEGORIES	DESCRIPTION
Emotional Support	Debriefing; personal issues
Counsellor Advocacy	Conflict resolution; moderator;
Professional Guidance	Case management; Counsellor development; training needs; facilitator
Social support	Social events; group outings

When asked about what function mentors perform, all the participants referred firstly to the emotional aspects of mentoring. The counsellors as well as the mentors themselves believed that if mentors are aware of the emotional needs of counsellors, the tremendous stress that VCT counsellors are experiencing can to some extent be reduced; this would help prevent counsellor 'burnout' and improve counselling services. Emotional support includes support both with work stress and with stress

related to personal problems that the counsellor may be subjected to. A mentor spoke of mentors as attending to the people who work under them holistically.

INT 1: You are a counsellor yourself, a social worker, you know, you have got lots of roles to play, you are a leader you give direction.

INT 3: Because we know that once you are emotionally disturbed or whatever the case may be you can run proper counselling sessions.

FG 2 (2): I can just be myself and say, "I'm the one with the problem." ...I get another person to help me.

Focus Group 2 spoke at length about how they saw a mentor as providing an opportunity for counsellors to be able to communicate their personal feelings. This group only receives group mentorship, but perceived the role of a mentor as being more than case management and as including personal emotional guidance and support.

FG 2 (2): But I feel that we should concentrate more on the self. She should talk about me as a person, you know, my holistic thing as a person, like socially, spiritually, physically ... then that person will produce good work.

In addition, the counsellors in this group spoke about the debriefing function that mentors offer. After counselling sessions, counsellors often feel emotionally drained and detached, a state they judge as affecting their functioning negatively. The participants complained of not being able to sleep at night and feeling consumed by their clients' problems. The debriefing function that a mentor performs allows counsellors to communicate their problems, to find solutions and to achieve closure. Focus Group 1, the group not receiving mentorship, perceived the emotional support role of mentors in a similar way.

FG 2 (4): Sometimes it does help a lot because sometimes you find you have a problem and you don't know how to handle it and if you talk about it then you get help with your problem.

The concept of professional guidance and development surfaced in the analysis as an essential mentoring role or function. Interviewee 3 mentioned that before the implementation of mentorship in her district, counsellors received no professional guidance in counselling skills and case management. As the results have revealed, HIV/AIDS counselling is not confined to pre- and post-test counselling but includes social and psychological problems common to persons diagnosed with HIV/AIDS. The mentor's role is, therefore, to provide the necessary technical support and training for developing counselling skills. The mentor's role in identifying training needs and providing the necessary training cannot be under estimated.

INT 3: Yes, it is to conduct in-service training, maybe on those common issues like training gaps and that the need in training and to form support groups within their site.

Training is usually done during the group mentoring session. The mentor is required to facilitate group sessions and case presentations. Mentors' responsibilities include sourcing information and possibly applicable training courses or workshops as a way of expanding counsellor knowledge and improving counselling skills. Focus Group 2 confirmed that they received regular information updates, which helped them in their counselling. All the mentors emphasised the importance of improving general counselling skills.

Most participants perceived the fundamental function of mentoring to be that of counsellor development. The mentor's role is not only to develop a counsellor in counselling skills. Development can include any aspects that will contribute to the counsellor's personal development. Counsellor development leads to qualities such as improved self-confidence and work motivation, which should, inevitably, lead to better counselling. The following extract exemplifies a mentor's perception of what her role is towards her counsellors.

INT 1: Be a developer as well, you know develop people, you need to be a person that wants other people getting better

Interviewee 2 commented that counsellors are sometimes inappropriately selected. The result is that there are counsellors who are unable to cope with their work. Also, lay counsellors receive minimal initial training. Mentors should have the intuition to identify this problem and take on the responsibility of assisting and developing these counsellors. She spoke of being able to give direction with difficult counselling cases (INT 2). Counsellors can be guided through a problem-solving process whereby the mentor explores various options with the counsellor, instead of merely offering the counsellor a solution. A participant in Focus Group one claimed sometimes to feel that she was in a counselling “rut”. She believed that a mentor could assist her with new counselling strategies. Focus Group 2 also claimed that counsellor assessment was a vital part of mentors’ function.

INT 2: Someone that is going to be able to see someone that needs that kind of help, rather than finish the person. Kill the bridge instead of straightening it up.

Other ideas on the role of the mentor that came to light from the data analysis was that, firstly, a mentor operates as a counsellor representative in a VCT unit and secondly, that the mentor’s role should include the giving of social support.

Both focus groups spoke of how they believed a mentor should act as a spokesperson for the counsellors. Interviewee 2 expressed the opinion that the mentor could assist with communication and attitude problems in the VCT site. This role would include conflict management, with the mentor acting as a mediator between counsellors and other staff members and intervening at a higher level about work-related issues.

FG 1 (2): We need more power, you know, I am looking at this mentor as somebody that can help.

The counsellors accepted the supervisory role of a mentor as monitoring counsellor behaviour. One of the mentors interviewed included the reporting of inappropriate counsellor behaviours to the site supervisor as definitely being part of her job description.

INT 3: If an incident like that kept happening ... as a mentor I would have to go to the supervisor?

FG 2 (4): They have to tell us, like talk about behaviour of the counsellor that they expect. That she will remind us. (3) We have talk about that thing, that's how to behave because we must be professionals.

It appears from the analysis that the social support role of a mentor could include recreational activities in which the both the counsellors and mentors could participate as a group. It was suggested that social activities could be included at the end of a group-mentoring session. One of the mentors spoke of providing alternative therapy such as Echo therapy for her counsellors as a form of social support in recreational group activities away from the work situation.

5.6 Criteria for Mentor Selection

The analysis produced many similarities in the participants' views on the qualities and skills a capable and efficient mentor should have. Seventeen subcategories of personal or professional qualities emerged.

Participants had mixed feelings about the qualifications a mentor should have. By a qualified person the participants meant someone with a tertiary degree in either psychology or sociology. All the participants in Focus Group one, some in Focus Group 2 and interviewee 3, believed that a mentor should have some professional counselling qualification. The underlying motivation for this opinion was that tertiary education contributed to personal development and knowledge, which were seen as important qualities for mentorship. The table below lists essential skills and qualities considered necessary for a mentor.

Should a mentor be a professional person? What qualifications should they have?

INT 3: I wouldn't say it must really be a professional person, but that is also fine.

There is nothing wrong with that. But as well it can be somebody that has got all the skills.

However, according to all the participants interviewed in this study, a mentor could not function efficiently without having a background that included counselling,

especially counselling in the HIV/AIDS domain. Experience and comprehensive HIV/AIDS knowledge were, therefore, regarded as the most necessary skills required for effective mentoring. Without previous experience in the field the mentor would not be in a position to gain sufficient understanding of what counsellors experience in a counselling session.

TABLE 4: Perceived skills and qualities of a mentor

PERSONAL QUALITIES	Age Assertiveness Good communication and listening skills Confidence Interpersonal Skills Leadership qualities Positive attitude Nonjudgemental attitude Flexible nature
PROFESSIONAL QUALITIES	Counselling experience and skills Facilitation skills Formal education HIV/AIDS knowledge Life skills Passion for mentoring Previous mentoring experience

FG2 (5): To me I think counselling experience is more important to a mentor. So that she would be more understanding towards our type of session, what we are talking about she can relate to.

For Interviewee 2 formal education and good counselling skills would benefit mentorship but a qualification and even previous experience were pointless without constant personal upgrading and development. Mentor qualities include applying continuous learning, specifically in the areas and skills that counsellors need.

Interviewee 1 held the view that a formal qualification was not at all necessary and that an academic qualification often caused the mentors' approach to be at too high a level for the counsellors.

INT 1: No, it could be anyone who is good at mentoring. It doesn't take an academic to be, because some academics become too academic for the counsellor to understand. I have got a degree but I don't want to believe that I was a mentor because I had a degree. It's my personality. It is the belief in people, you know.

Participants' opinions about the number of years of experience mentors should have varied from one year to five years. They generally believed that experience need not necessary be stipulated in years but that counselling intuition and maturity be the determining factors.

The conclusion was that a professional qualification was desirable but not an essential requirement for mentoring and that mentor selection could include HIV/AIDS counselling experience as an alternative qualification

One of the counsellors spoke of the importance of personal qualities. There was agreement throughout the interviews and in the focus group that the possession of certain personality qualities was imperative for mentorship.

FG 2 (3): So if you are born a person with these qualities, you can make a better mentor than a person that went and studied psychology for the sake of getting that degree.

Focus Group two's counsellors and one of the mentors mentioned good facilitation skills as requisite for mentorship. Group mentoring facilitation should focus on the development of relationships amongst counsellors, yet, at the same time, provide constructive skills training at a general level to accommodate the levels in terms of knowledge and experience of the counsellors. This Focus Group pointed out that their mentor facilitated group mentoring by directing the group discussion, asking specific questions and offering counselling suggestions.

It was interesting to observe that the counsellors in Focus Group two perceived age as a central factor for mentorship. Much discussion revolved around the supposed ideal age for a mentor was. The younger counsellors felt that an older person should assume the role of a supervisor. They considered age to be linked with a judgemental personality. The majority saw a mentor as someone from the same generation as themselves. However, after reflecting on the question of age some counsellors felt that an older person with the “right” personality, attitude and qualification could be a good mentor.

FG 2 (2): We say the age thing because old people they look and check and “these people of today, they have attitude.” And that type I really don’t want to mentor me. I want somebody who is from the same era.

The counsellors interviewed in Focus Group one saw a mentor as a person with life experience and believed that more mature people had better-developed life skills.

It appears from the analysis that a positive attitude is central to mentorship qualities. All the participants interviewed talked about attitude as a vital feature of good mentorship. A positive attitude was seen as: being approachable, open minded, flexible and having good human relations skills. Mentors with a positive attitude reduce counsellors’ sense of being threatened and subordinate to the mentor. The counsellors in Focus Group two confirmed the above qualities and emphasised that a mentor should be viewed as non-threatening, warm, confident and assertive.

INT 1: I would focus more on the mentor attitude, because if you have got the right attitude it goes a long way. If you have got an open door policy, you can get through to anyone.

Being non-judgemental was seen as a very positive quality. Both Focus Groups and a mentor emphasised the importance of a mentor’s adopting a non-judgemental attitude towards mentees. A judgemental or hypercritical attitude tended throughout the interviews to be associated with a supervisory role and will, therefore, be included in the category referring to the differences between a supervisor and mentor.

It appears from the analysis that a combination of many factors and qualities is considered to be prerequisite in the selection of mentors.

5.7 Differentiating Between Supervisor and Mentor

Questions and discussion exploring the participants' understanding of supervision and mentoring raised much discussion in the interviews and Focus Groups. All the participants in this study strongly asserted that the roles of supervisors and mentors should be distinct. The mentors interviewed tended to be clearer in their descriptions of the differences: the counsellors, although adamant that there were distinct differences, could not precisely pinpoint the main differences.

The general feeling was that counsellors were not able to confide in a supervisor in the same way as they could in a mentor. They agreed that they would never disclose personal information to supervisors for fear that they use it against them at some point.

FG 2 (4): Yes I prefer them to be different because like if I look at my situation, my supervisor there are some things that I am unable to tell her, but I would be able to tell my mentor.

It appears that traditional associations with supervision are still apparent in the HIV/AIDS sector. Interviewee one, described a supervisor as perceived by the counsellors as somebody with an oppressive nature constantly seeking out counsellor error. Her experience of mentoring included aspects of line management and supervision. She believed that her success as a mentor was a result of her having the right personality qualities and attitude. The difference between the two concepts in her opinion was a result of the word supervision, which in itself immediately implies a superior being.

INT 1: I was managing them and I was mentoring them ... for some of us once you are called a supervisor you are super. Already you are on a level where the other people are not. I have always said rather use a mentor than a supervisor because of the traditional connotations of the very term supervisor.

The participants in Focus Group two, in particular, entered into an in-depth discussion about the feelings and experiences attached to the concepts of supervisor and mentorship and the effect of these feelings on their understanding and mentorship. Supervision clearly holds negative connotations for many of the counsellors and is understood to have a totally different function to that of mentoring. The counsellors do not necessarily dislike their supervisors, but the supervisor - counsellor relationship tends to be built on more structured, rigid and formal principles. The position of the supervisor is considered to be hierarchical and thus power based, with the supervisor as the superior and the counsellor the subordinate. Interview one implied that a supervisor's role was essentially task orientated while a mentor's focus was essentially on emotional well-being. From the analysis, it appears that the justification for the distinction between the supervisor's role and the mentor's role in contributing to counsellors' performance output is that the mentor directs and guides the counsellor in work-related issues, whereas a supervisor's role is one of criticism. Focus Group one saw supervisors as applying predetermined policies and mentors discussing and making suggestions about work performance.

It should be added that, as the discussion with Focus Group two progressed, some of the counsellors' attitudes about their supervisors and supervisors in general changed. Initially, the conversation focused on the autocratic and authoritarian characteristics associated with supervision. There was a clear shift of focus, however, once the counsellors had reflected on their relationships with their supervisors. Their unfavourable attitudes changed to one of greater acceptance and trust; sometimes there even appeared to be strong bonds of communication between them and their supervisors. This may be illustrated in two extracts from a counsellor's response in an interview. In the first extract the counsellor implies that a supervisor's duties should be restricted to monitoring counsellors' work and in the second extract she sees her supervisor as serving a mentoring role.

FG 2 (2): With supervision I find that it monitoring work. To be corrected but it is more on a formal basis ... you don't have to be as warm as a mentor. A mentor has to be calm ... non-threatening ... she must not abuse her power and authority. Whereas that can appear in supervision.

FG 2 (2): For me right now my supervisor does more than my mentor. We get on very, very well. We are able to sit for about an hour and talk about a case and talk about me. She is both my supervisor and my mentor.

A reason why supervisors tend not to do mentoring is that those in the VCT sector are usually selected from a nursing background and lack the counselling skills they would need to be of assistance to counsellors. The counsellors agreed it was for this reason and because of supervisors' inadequate understanding of counselling that they were not able to assess their counselling ability.

FG 2 (4): Some of them do not understand the basis of counselling the person too much. But in counselling sessions you have to understand the person's problem and her emotions. They just give pills to the client.

The counsellors, when asked about being assessed by their mentor, responded that they valued and understood the importance of being evaluated and that they initially felt vulnerable and nervous about the mentor judging them unfairly. However, they found that they could relate more openly to their client in the presence of a mentor as opposed to that of a supervisor. It appears, therefore, that being assessed for one's counselling skills is often intimidating, but that it is less so if the element of power, associated with supervisors is removed from the situation.

FG 2 (3): Not somebody who is seen as power or authority. Because your mentor if she is there when you are counselling somebody, I think it would help she could tell you when maybe I have done something wrong.

FG 1 (3): For my personal need I would rather have a mentor. I think by guiding you she is indirectly assessing your needs.

In addition, it appeared from Interviewees two and three, that they believed a mentor to be in a better position to ascertain whether poor counselling skills are related to incompetence or emotional problems or a lack of coping skills. Interviewee three spoke of how a mentor would seek the reason why a counsellor is not performing well and be likely to assume a supportive role that would help the counsellor deal with the problem.

INT 3: And the mentor can even understand like if my child dies. I know that that particular somebody cannot do counselling. What is happening at the moment is that sisters in charge they are expecting them to work. So the mentor can understand all that but maybe the supervisor will not understand that.

Interviewee one said that counsellors were usually very positive in their assessments. Constructive feedback was an important part of evaluation and the counsellors saw this as an opportunity to discover their strengths and weaknesses and thereby to improve their counselling skills.

A mentor who was interviewed believed that, ideally, the roles of mentor and supervisor should be separate, but that this was not always possible. Because of staff shortages, supervisors have occasionally to act as mentors, and as the average mentoring district was too large for the mentor always to be available to all the lay counsellors.

INT 2: They should be two separate people, but realistically it doesn't work like that. Sometimes the sister who is there is site supervisor and might need to practice mentorship to a counsellor at that particular time.

It appears from the analysis that supervisors and mentors fill different needs in the VCT sector. However, a supervisor with the right skills and qualities could adopt the role of a mentor and at the same time function at a supervisory level in the VCT unit.

5.8 Summary

This chapter has presented the results of the analyses of the qualitative data yielded in this study. Interview extracts were used to illustrate the perceptions and experiences of mentors and those of VCT counsellors. A discussion of these results follows in Chapter six.

CHAPTER 6 - DISCUSSION OF FINDINGS

The results of the qualitative data analysis suggest that participants in this study define mentorship in terms of its role or the purpose it serves in their psychosocial and occupational worlds. In reflecting on the results of this study, the researcher aims to expand on the counsellor and mentors' understanding of mentorship by linking the results to appropriate theories mentioned earlier, in an attempt to develop a deeper understanding of mentorship. Theories that lend themselves to mentorship and that have had an influence on the elaboration of hypotheses developed from the themes that emerged from this particular study are: Total Quality Management theory, Holistic Mentoring Models and Social Learning Theories (Baron & Byrne, 1994; Holley, 2003; French & Bell, 1999)

On the basis of the results of this study, this discussion will commence with a general description of mentorship in Kwazulu Natal, South Africa. This will be followed by a discussion of how the participants perceive mentorship in their environments. The discussion will include a comparison between the perceptions of mentors and those of counsellors. Lastly, this chapter will consider whether the characteristics of mentorship in the HIV/AIDS sector are universal to mentorship.

6.1 An Overview of Mentorship in the HIV/AIDS Sector in South Africa

Very little on mentorship programmes for counsellors in the VCT sector has been contributed to the literature in South Africa. However, most VCT effectiveness studies and VCT situational analyses view the implementation of mentorship programmes for VCT counsellors as a necessity (Baez & Mwine, 2001; Miller, 1992; van Rooyen, et al., 2003; UNAIDS, 1997; van Rooyen, 2002). "According to programme managers, mentorship and on-the-job training are critical components for ensuring quality assurance and at the same time, providing support to the service providers" (UNAIDS, 2002, p. 68). Although mentorship programmes have been started in some Provincial Health clinics in South Africa, many have, for various reasons, not been sustained (van Rooyen, et al., 2003; Richter, et al., 1999) The Minimum Standards for Counselling and Training (van Rooyen, van Rooyen & Kwitshana, 1999) specify the implementation of mentorship and supervision as essential for the sustainability of quality counselling.

The writer's journey towards understanding counsellor and mentor perspectives on mentorship started by reviewing the current mentorship programmes, in which some participants were involved in. The objective was to ascertain if the participants' understanding of mentorship reflect the reality of their experiences.

Mentorship is a relatively new approach in Provincial HIV/AIDS counselling sites and has been in implementation in NGOs for longer. The Social work, Psychology and nursing professions usually provide some form of supervision for their staff. Supervision for mental health professionals developed for two reasons: firstly, to prevent possibly inferior levels of psychotherapy, which could aggravate psychological problems, and, secondly as an opportunity for personal growth for the therapist (Bor, Scher & Salt, 1992). Although, it can be argued that substantial differences exist between professional psychology counselling and lay counselling in a HIV/AIDS context, they have a common element of having to deal with emotionally difficult circumstances (van Rooyen, 1997). The results of this study provide evidence that counsellors and mentors involved in HIV/AIDS counselling consider the implementation and sustainability of mentorship programmes to be beneficial to the HIV/AIDS counsellors and to their organizations as a whole.

The intention behind mentorship programmes in KwaZulu Natal is to regularly provide counsellors with the training, support and guidance that they need. Mentorship takes place mostly in groups, but, if personal problems are identified, the mentor will deal with them on an individual basis. Group mentoring includes case management, general discussion of the counsellors' work environment, and role-plays. Transference of skills occurs through group discussion. The participants in this study regarded group mentoring as a satisfactory method of learning as they share the goal of acquiring better counselling skills. This method is compatible with theories of social learning, which assume the acquisition of attitudes, knowledge and experience to be formed by direct social interaction or observation of others' behaviour (Baron & Byrne, 1994). Learning occurs by counsellors' reflecting on past counselling experiences, reinforcing the counselling skills, facilitated by the mentor, and by interacting with each other on a common concern, namely, HIV/AIDS counselling.

Some participants said that they felt self-conscious and did not contribute to the discussion. A function of mentoring that emerged from the data was that of promoting counsellors' self esteem or self-belief. Bandura's (1997) theory of self-efficacy defines a sense of individual accomplishment as based on the belief a person has in his or her capability of performing a task and on the belief that a specific behaviour will yield a certain outcome. The mentor can, thus, through positive facilitation increase self-confidence in counsellors, a greater self-confidence that will inevitably contribute to counsellors becoming more interactive in the group situation.

Face-to-face or individual mentoring did not occur as often as group mentoring. The reasons for this were that mentorship programmes need to be expanded to achieve this. The ratio of counsellors per mentor is high. The implementation of mentorship programmes and, specifically, individual mentoring on a national scale requires huge financial inputs, which place additional budgetary strains on the Department of Health. Individual mentoring was viewed as being more beneficial for preventing counsellor burnout than group mentoring. The advantages of individual mentorship, which included supportive counselling on matters external to work situations was deemed essential to any mentorship programme, from both the counsellors' and mentors' viewpoint. The participants' opinion on the aim of individual mentoring is similar to that outlined by Whittaker & Cartwright (2000), who see mentorship as a structural process where the counsellor is given space and time to talk through various personal or work-related problems.

The relationship between the counsellor and the mentor appears always to be informal, yet based on reciprocal respect with counsellors and mentors aware of their professional boundaries.

6.2 Mentor and VCT Counsellors' Understanding of Mentorship

It appears, from the analysis of the data collected in this study, that the participants perceive mentorship as providing a positive and much-needed function. The participants did not once mention negative experiences of mentorship. The general impression throughout this study was that the participants were enthusiastic about the value of and encouraged by mentorship becoming a realisation in a stressful and depressing VCT world.

Holistic nature

The analysis revealed mentorship as fundamentally twofold in nature. Mentorship is seen, firstly, as a counsellor-support structure, which aims at promoting the holistic personal development of counsellors and secondly, as contributing positively to the expansion of comprehensive, quality VCT counseling. The two roles are interrelated.

“Holism has been fundamental to the ethos of guidance and counselling since the impact of Carl Roger’s client-centred work in the 1960s” (Colley, 2003, p.79). As emphasized in many studies on mentoring and career guidance, mentorship requires a holistic approach. A holistic approach, in this context, implies that counsellors are treated as a totally integrated system, focuses on the social, work and personal aspects that affect each individual counsellor (Foster, 1999 cited in Colley, 2003).

It seems, therefore, that mentorship, which was designed as an intervention to support counsellors in VCT counselling contexts embraces more than work- related matters, and should be viewed as supporting and guiding the counsellor in his or her totality. It appears difficult in the HIV/AIDS world to separate work-related from personal matters that are external to the work situation. A disruption in one area – of work or of the person - will affect the other area. The counsellors and mentors spoke of the effect a difficult counselling session has on their personal lives and of how inappropriate behaviours outside of work could impact on the effectiveness of their counselling. It is evident from the results that a mentor is seen as a bridge between work and the counsellors’ lives outside of work. The role that the mentor plays in terms of counsellor development, debriefing, support and professional guidance contributes to counsellors being able to achieve balance and stability both in their work and in their personal lives. The mentoring that counsellors receive on personal matters is, of course, necessarily limited, as the focus in individual mentoring is on those short-term personal problems that impact on the work situation and on suggesting solutions to those problems. The mentors in this study said that they were not trained as professional psychologists and would refer counsellors with complex personal problems not directly related to their work to qualified psychotherapists.

One of the mentor's functions, the development of client-centered counselling skills, is strongly acknowledged by the counsellors. The support mentors give the counselling team or an individual counsellor is considered equally significant. The counsellors are usually members of the community in which they work and are also often affected by HIV/AIDS in their own lives or in those of their families and the community (Matanhire & Hammond, 2003). Those involved in the HIV/AIDS system see a mentor as a buffer against work or other elements that may influence counsellors' work.

The theory of Total Quality Management (TQM) has recently – and universally – infiltrated numerous organizations (French & Bell, 1999). This new approach is one of many new emerging theories associated with a shift from traditional hierarchical organisational management to a people-management approach. The assumptions of TQM, which focus on “continuous quality management” (p. 228) corresponds with the mentors' function of maintaining and improving the quality of VCT counselling services and improving the quality of the working life of the employees in the organization. The emphasis is on providing a quality service to clients by promoting healthy relationships in the organisation, on an ongoing evaluation of organisational outputs, and especially on the importance of continuous coaching and learning. The value of supervision based on TQM models is recognized in the literature on nursing supervision and is being introduced into nursing supervision to protect and enhance nursing services (Cottrell & Smith, n.d.). Many significant role players involved in HIV/AIDS counselling research advocate for the inclusion of quality-assurance mechanisms in existing HIV/AIDS counselling programmes as a way of improving and maintaining the ethical and technical standards of counselling. Quality testing and counselling is achievable by adhering to predetermined criteria, which focus on long-term quality care for clients in the HIV/AIDS sector (Australian Government, 2001; FHI, 2004; WHO, 2003; WHO, 2004).

Sensitivity to the developmental needs of counsellors provides mentors with design possibilities for appropriate professional training models (Taibbi, 1983). Professional development in training models is pointless without the consideration of holistic counsellor development, which, as appears from the analysis, forms part of a mentor's professional profile.

Support

It was generally accepted among the counsellors in this study and strongly emphasised by the mentors that VCT counselling is a demanding and stressful job. According to Miller (1992) there is a definite lack and an urgent need for “models of effective staff support” for HIV staff (p. 429). Counsellors deal with numerous external pressures such as being stigmatised and being exposed to the socioeconomic problems associated with working with HIV/AIDS patients.

Stress is definable according to three theoretical models (Marks, Murray, Evans & Willig, 2000). The stimulus model sees stress as “when you are under a lot of pressure”. According to the response model, stress is defined as the “physical and psychological feeling of being stressed out”. Finally, according to the interactional model, stress is experienced “when you can’t cope” and when “you lack the resources to cope” (pp 99 – 100). A mentor is perceived, according to the results of this study, as a buffer and as providing the necessary skills to strengthen counsellors’ coping mechanisms.


“Burnout is a state of emotional exhaustion that results when the counsellor reaches his or her limit to deal with HIV and the emotional stress it causes.” Uncontrolled emotions are expressed through anger, which is often directed at colleagues or even at clients (UNAIDS, 1997). Stress is real, and is not manifested as an event, but is a process that develops over time (Anderson, 2001). Emotions experienced by HIV/AIDS workers are described as a “sense of failure, fear, inadequacy, over identification, resentment and even hostility (Miller, 1992, p. 431). All the participants in this study believed that mentorship should be included as part of the VCT process as a way of alleviating continuous stress. The counsellors and the mentors perceived one of the most important functions a mentor performs as being to provide emotional support to counsellors. From this, we can conclude that the availability of mentorship for HIV/AIDS counsellors probably reduces the stress and burnout common in the HIV/AIDS sector. This was particularly obvious in the outcome of the analysis of the data received from the Focus Group without a mentorship programme. It appears that work stress has an impact on the family life of some of the counsellors. Research shows that family and in particular intimate family

members may not provide the kind of support needed for dealing with stressful situations. Good results have been achieved by providing effective support networks for stressed people (Sue, Sue & Sue, 1991).

HIV/AIDS counsellors tend to experience frustrations caused by the lack of understanding of other medical staff members, supervisors in particular, about the nature and importance of counselling (Kwitshana, 1998). The results show that counsellors expect a mentor to be able to serve as a link between themselves and clinic staff members, and thereby to develop better relations between the counselling and other staff members in the unit. The mentor, therefore, plays the role of a mediator between the HIV/AIDS counsellors and the broader VCT system.

Quality Counselling

As the results revealed, mentors believed that effective counsellor selection was not always practised and that the level of counselling skills was often inadequate (UNAIDS, 1997). The minimum standards and an accreditation process were initiated in March 1998, in an attempt to improve the level of counselling service delivery. Results from a HIV/AIDS evaluation study undertaken by Richter, et al. (1999) showed that HIV/AIDS counselling service provision was hampered by problems such as “poor selection of counsellor trainees, lack of follow-up training and a formal system for accrediting counsellors.” (p. 24). The incorporation of mentorship and supervision in the VCT counselling industry was viewed as one of the strategies to assist with assuring quality counselling (Richter et al., 1999). The initial training of HIV/AIDS counsellors is limited and usually extends over no more than 10 days (Baez & Mwitte, 2001). Generally lay counsellors come from the community in which they are working and do not have any counselling background. Moreover, HIV/AIDS counselling is not yet recognised as a profession, and the counsellors are not well paid (Gikundi, 2002; UNAIDS, 1997). These limitations contribute to motivational problems and poor quality of counselling. Formalising mentorship by introducing structured mentorship programmes can be seen as an instrument of systematic support to help lay counsellors deal with counselling problems and stress management. Counsellors are able to rely on a formal structure to deal with their situation instead of having to depend on family and the community for support. This not only increases



counsellor motivation, but heightens the effectiveness of the counselling team (Mantanhire & Hammond, 2003). The mentor assists in shaping and changing counsellor attitudes and values and therefore not only develops their professional skills and knowledge but also cultivates a relationship between themselves and the mentee through the use of a range of interpersonal skills (van Rooyen, et al., 2003). A study done by UNAIDS (2002) found that counsellors perceived being able to be debriefed and interact with a mentor contributed to good service delivery.

Poor quality of counselling will reduce the effectiveness of HIV/AIDS counselling interventions, and ongoing supervision, mentoring, evaluation and improvement of skills is recommended as a way to improve and maintain quality counselling in the HIV/AIDS sector (Chopra, Jackson, Asworth & Doherty, 2004). Mentorship programmes are designed to provide ongoing training, evaluation and counsellor assessment and to attend to the developmental needs of the counsellors in an effort to maintain the quality of VCT services (van Rooyen, 2002). The results indicate that the counsellors recognise the need to be regularly assessed. The mentor, rather than a supervisor, is perceived as the suitable person to do monitoring and evaluation of counselling skills. The Department of Health in Kenya has embarked on a quality health-care campaign and considers the implementation of evaluation programmes other than that of traditional hierarchical supervision as important in contributing to aspirations of building and providing quality health care to people in affected by HIV/AIDS (Gikundi, 2002).

HIV/AIDS counselling developed around the HIV testing procedure, which, due to the extraordinary needs stemming from the pandemic, is under-developed and under-resourced. HIV/AIDS units seem “focused on counselling for testing and less active in the broader psychological spheres of education, prevention and ongoing support counselling (Richter, et al., 1999, p. 148). A common misconception of HIV/AIDS counselling is that it amounts only to pre- and post-test counselling. While pre- and post-test counselling is fundamental in preparing and supporting the client through the VCT process (UNAIDS, 1997), ongoing VCT counselling entails being resourced to assist clients living with this debilitating virus in a variety of ways. Ideally, “counselling should occur along a continuum of care”, which starts before testing and continues through to death and bereavement (Richter, et al., 1999, p. 23). Thus

HIV/AIDS counselling is not only pre- and post-test counselling, but serves also as a survival and backup support mechanism for people living with HIV/AIDS. VCT is considered as a vital link between HIV/AIDS prevention and support (Richter, et al., 1999). In order for counsellors to be constructively involved in providing support they need to have the necessary knowledge and skills. As became evident from the results that follow, a mentor provides the necessary assistance, such as in case management and problem solving. The view that developed from the results of this study is that a mentor through a process of ongoing professional and psychosocial development is able to equip counsellors to deal with the numerous counselling problems they are faced with.

It appears from the results of this study that improved counselling skills and increased counsellor coping mechanisms could contribute to an improved quality of counselling for the VCT sector.

6.2.1 Understanding the Distinctions between a Supervisor and a Mentor

The pattern that emerged from the data analysis tended to reflect some confusion among the counsellors about differentiating between a supervisor and a mentor. The confusion seemed apparent in the choice of the word. As seen in the results, the word, “supervisor” held negative connotations for counsellors, whereas their attitude to “mentor” was positive. There seemed to be some evidence of mentor role conflict emanating from an attempt by the mentor trying to balance the needs of the mentee with those of the organization. Although mentors are chiefly responsible for the well-being of the counsellors, they also have a duty to meeting their organizational responsibilities. These tensions are not exclusive to the HIV/AIDS sector but tend to be generic to mentorship as a whole and have been well described in the mentorship literature (Rosmarin, 1988).

The psychological and social counselling profession views clinical supervision as imperative for maintaining quality counselling. Achieving quality counselling standards differs in a VCT context from those of other professional counselling contexts in that the mentor rather than the supervisor takes on this responsibility. This perception differs from the definitions of the mentor and supervisor in the Minimum

Standards for Counselling and Training document (1999). Supervision is viewed as being responsible for case management and the transference of technical counselling skills. The mentor is considered responsible solely for counsellors' emotional and developmental well-being. This document recommends the roles of mentor and supervisor should be performed by different people (van Rooyen, 1999). Whittaker & Cartwright (2000) argue that it is often difficult to separate the two roles as mentor and a supervisor have 'different priorities to different circumstances' (p. 72). However, if the same person has to perform both roles they should be clear about what role they are performing at what point. The participants in this study seemed to take it for granted that the mentor was responsible for technical education, assessment, and counsellor support. The supervisor was associated purely with the managerial side of HIV/AIDS counselling.

VCT supervision, mostly in medical settings, in Kenya perceives the role of the mentor in the same way as the participants in this study. Supervision is viewed as providing an opportunity where counsellors can reflect on their work and learn through their reflection process. Supervision of counsellors includes aspects such as support, learning, evaluation and monitoring professional matters (Gikundi, 2002). The participants in this study said that they would prefer the mentor to perform evaluative duties. It can be argued that having a mentor perform evaluation and assessment of the counsellors' work moves beyond the supportive function characteristic of mentorship and has the potential for tension between the mentor and the mentee. Open communication and building trust in the counsellor-mentor relationship is crucial to prevent the conflicts that might arise because of the counsellor's been fearful of the mentor's evaluating his/her work (Akhurst, 2000). The results of the present study indicate that counsellors experience their relationship with their mentor as built on honesty and trust and that they accept the evaluative component of the mentorship's role. Mentorship, in a VCT context in South Africa, therefore is perceived as a substitute for what is known in the counselling and medical profession as clinical supervision.

In line with Taibbi's (1983) view, mentorship requires an expansion of the supervisory learning relationship in that it should include personal development and overall counsellor well-being. The purpose of mentorship, therefore, is counsellor

development is just as important as professional development and, equally, the provision of a quality services.

VCT supervisors are usually senior nurses who are appointed on the basis of their medical knowledge and abilities. As mentioned in the results, VCT supervisors are expected to perform mentoring roles, as the availability of mentors is limited. Supervision in these contexts should be open to creating an environment that would develop and sustain a mentorship-type relationship. This is achievable by adding emotional and training support to their usual function of managing counsellor outputs in the training of supervisors. This accomplishment will not only benefit counsellors but also provide supervisors with the opportunity for their own development (Taibbi, 1983).

We may, thus, conclude that the term *mentorship* is the term that mentors and counsellors in KwaZulu Natal who participated in this study prefer for describing the system of intervention that is intended to provide counsellors with psychosocial support, professional guidance, monitoring and evaluation. In addition, *mentorship* includes some aspects of traditional clinical supervision.

6.2.2 Mentor Qualities

Many NGOs and Department of Health mentors appoint external experienced mentors, who are professional social workers and psychologists to debrief, teach and advise counsellors (UNAIDS, 2002). The results of this study showed that all the participants believed that mentors should be permanent appointees in the organization. Having a mentor as part of the VCT unit would, they considered, yield a twofold benefit. Firstly, the mentor would be available when needed. Secondly, good mentor-mentee relationships are more likely when counsellors and mentors work together in the same environment.

Previous counselling experience is perceived as an essential selection criterion for appointment as a mentor. As outlined in the tender proposal for the establishment of a mentorship programme for HIV/AIDS counsellors promoting experienced counsellors

to mentorships provides counsellors with career development opportunities, which, in turn, motivates them and renews their energy levels (van Rooyen, 2002).

It appears both from the results and from the available literature on mentoring that a mentor should have a positive attitude, give quality time to others, listen and be free from bias (Whittaker & Cartwright, 2000). “Mentors should be able to be approachable, confident in their own ability and good communicators” (Gray & Smith, 2000, p. 1547). A mentorship quality that featured strongly in the results was high self-esteem and confidence. Evidence in the literature suggests that self-confidence is the “single best predictor of success” (Baron & Byrne, 1994, p. 253). If self-confidence is a strong indicator for success, we may assume that the more self-confidence a mentor has, the better the chance of a mentorship relationship and programme being sustained.

The mentors, in this study, perceived their desire to mentor counsellors in the HIV/AIDS sector as stemming from a passion for counselling and a genuine empathy with the nature of counselling in this sector. It is evident that the mentors believe that the implementation of mentorship will play a significant role in counsellor development, and that this will, without doubt, improve the quality of counselling services. According to Allen, Poteet and Burroughs (1997), ‘other-focused’ (p.83) reasons for mentoring are based on the desire to transfer information or knowledge to others and in doing so to “build a competent workforce” (p.83). Results such as these lead to the presumption that most mentors are likely have altruistic personalities, which might be described as an innate disposition to help others (Baron & Byrne, 1994). This is in line with other studies of perceptions of mentorship. Students and nurses often describe a good mentor as a person with a genuine desire to help people (Gray & Smith, 2000).

6.3 Similarities and Differences between Mentors’ and Counsellors’ Perceptions

The results of the thematic analysis revealed that while there was some disagreement, there was mostly agreement. It is obvious from the results that mentors and counsellors have similar perceptions and expectations of mentors and mentorship. All the participants tended, unambiguously, to hold the same ideas on the nature of mentorship, the role of the mentor, and the mentorship relationship. This can be

confirmed by the thematic patterns that emerged both in the interviews with the mentors and in the focus groups with the counsellors.

An area of concern that the mentors focussed on, but was never mentioned by the counsellors is that of HIV/AIDS counselling training. The mentors all believed that, in the first place, VCT counsellors do not receive adequate training in their short training period for the rate at which HIV/AIDS is spreading. There is, in the second place, a big gap between theoretical counselling knowledge and the implementation of practical counselling skills. These concerns are confirmed in a study by Baez and Mwitte (2001), which found that health-care workers and lay counsellors in an HIV/AIDS context were “taught basic counselling and coping skills but their training never empowered them to effectively put their knowledge into practice” (p.4). Recommendations of Baez and Mwitte’s (2001) study were that mentorship should be increased and outcome evaluations done to monitor counsellor skills. All the counsellors acknowledged the importance of assessment as a vital element in monitoring the quality of counselling services.

Ongoing training, during group mentoring sessions, was viewed by the counsellors as a way of reflecting and finding solutions for cases they were finding difficult. The provision of referrals networks and updated information on VCT counselling was seen as part of an ongoing mentorship programme and not as a supplement to their initial training.

It can be assumed, then, from the results of this study, that mentors perceived themselves and their roles in the same way as the counsellors perceive them. Both individual and group mentorship, which includes both personal counselling and work-related counselling, was apparently essential to any mentorship programme. This was the view of both counsellors and mentors.

A point raised by the counsellors but not by the mentors was the age of the mentor. The younger counsellors believed that the ideal mentor should be slightly older than themselves, but not more than 10 years older. This is close to the age gap of 8 to 15 years as generally recommended in other studies (Rosmarin, 1988). Levinson et al. (1985) warns against too big a generation gap generating a parent-child relationship

and too small a gap threatening the professional respect, which characterises a healthy mentorship relationship.

The mentors viewed regular, long-term counselling training as essential. The same sense of urgency about their training was not evident in the counsellors' Focus Group, which, instead, found a need for individual mentoring urgent; counsellors tended to view case management discussed in a group situation as adequate for their training needs.

6.4 Comparing Mentorship in the HIV/AIDS Context to other Contexts

Definitions of mentorship suggested by the participants were consistent throughout all the interviews and the Focus Group Discussions. Indeed, participants from the group who did not receive mentorship tended to view mentorship in the same way as the participants who were familiar with mentorship.

There was general agreement that a mentor can be defined as one who provides support, guidance, and psychosocial and career development. This agreement was also evident in the results of this study. However, comparisons between different contexts of mentoring and different models of mentoring are complicated by the fact that mentoring is different for different settings "Mentoring is not based on a single generic model, but is a collection of strategies used flexibly and sensitively in response to changing needs" (Brookes & Sikes, 1997, p. 35).

Mentorship seems synonymous with counsellor support and personal development. This view is supported by Woodrow's (1994) study of the perceptions of mentors in the nursing sphere, which describes the shift in nursing from a task-orientated approach to a holistic nurse-development approach, as facilitated by the mentor. The holistic approach adopted by the engagement-mentoring model, designed specially for intervention with socially isolated youth (Holley, 2003) fits well into a HIV/AIDS counselling context.

Dilemmas similar to those in a VCT context associated with separating the role of the supervisor and the mentor, specifically on assessment, tend to be evident in a nursing context. As VCT services originated from a nursing context, where the first

counsellors were nurses trained in testing and counselling, it can be assumed that the supervisor/mentor predicament is a result of traditional nursing assessments being based on a hierarchical, judgemental approach as opposed to the advisory and guiding approach synonymous with mentorship. There is a similar problem with the emergent model of mentoring often used in educational settings. “The mentor is required to act not only as support and confidante, but also as assessor and examiner.” (Bennetts, 2003, p.72). It seems unlikely that a trusting relationship can be built when the mentee is aware that the mentor is responsible for assessing his/her work (Bennetts 2003). In an HIV/AIDS context mentorship tends to be based on a balance of power. Counsellors feel less threatened in such an environment and more ready to accept being assessed than in the traditional hierarchical evaluation and assessment environment. It appears, therefore, that the term mentorship is “conceptualised and used synonymously with supervision” in most contexts (Spouse, 2000, p.513). In this study the participants clearly differentiate between the duties of a mentor and a supervisor. They did not see supervision as an activity intended to foster professional support and development as it was seen in many of the other contexts, but rather as a “control device” designed to ensure work outputs.

The concept of mentoring based on counsellors’ and mentors’ understandings and experiences that emerged from this study thus seem very similar to the modern definition of mentorship applied in other contexts. The mentor is seen here and, generally, elsewhere as a facilitator of learning, a role model for appropriate organizational behaviour and as someone to provide support and guidance during difficult times (Chow & Suen, 2001). It seems from the literature that a new approach to mentoring is developing, which as in the context of HIV/AIDS counselling includes both individual and group mentoring settings. It can thus be concluded that mentorship in the HIV/AIDS sector is consistent with what is now a universally accepted definition of mentorship.

CHAPTER 7 REFLECTIONS ON THIS STUDY

This chapter reflects on both the strengths and limitations of this study and considers its implications. This reflection, a summary of the study, contains, firstly, a subjective account of the reasons for undertaking the research, and, secondly, the research method used.

7.1 Strengths of this study

Research on mentorship in the HIV/AIDS field and specifically on the perspectives of counsellors and mentors on mentorship has, universally, been very limited, but it has been especially so in South Africa. The HIV/AIDS pandemic is a phenomenon with personally and nationally far-reaching social, economic and psychological consequences. According to the literature on HIV/AIDS monitoring and evaluation the most effective method, to date, of combating the spread of the virus is by encouraging people to be tested, providing ongoing information on effective prevention methods and advocating against the stigmatisation of HIV/AIDS (Kanabus & Frediksson Bass, 2004; Richter, et.al., 1999; UNAIDS, 2002; WHO, 2004).

Counselling is considered to be an effective component of VCT for providing all the above features. A trained medical professional administers the HIV/AIDS test, and the counsellor through post-, pre-test and ongoing counselling provides crucial psychological support to the client for the duration of the illness. This means that counsellors need to be equipped to deal with the variety of challenges that HIV/AIDS patients have to cope with. Initial lay-counsellor training appears to be restricted to basic counselling, which is inadequate for dealing with the numerous aspects of HIV/AIDS that confront counsellors.

A common element highlighted throughout this research study was the psychosocial stress that HIV/AIDS counsellors suffer. It was further evident from the literature and from the findings of this study that ongoing, comprehensive counsellor training and psychosocial support is essential. The importance of implementing a mentorship programme for HIV/AIDS on a national scale has been acknowledged. This project, therefore, has focused on a subject of vital importance. When research is undertaken, both participants and key stakeholders are led to serious reflection on the topic. This researcher noted the enthusiasm of the participants about being enabled to contribute

towards a better understanding of mentorship, and the resultant greater motivation that they showed. This study aimed at contributing to the limited field of research on this topic by conducting an in-depth examination of mentorship in general and in an HIV/AIDS context specifically. This was achieved, firstly, by examining the literature on the subject and by analysing the collected data on the perceptions of the active HIV/AIDS mentors and counsellors. Previous definitions of mentoring had relied on the perspectives of key stakeholders involved in designing and implementing mentorship programmes. Perspectives of counsellors and mentors are different from that of policy makers. A possible strength of this study derived from its establishing the differences between programme planners', HIV/AIDS counsellors', and mentors' constructs of mentorship. This study offers a perspective of mentorship derived from the counsellors and mentors involved in HIV/AIDS counselling in an attempt to give greater insight into mentorship to those who develop mentorship programmes for HIV/AIDS counsellors.

Affording the participants the opportunity to discuss, clarify and reflect on the concept of mentorship may be regarded as, in itself, a strength. In their debriefing, the counsellors claimed that they had found deliberation on this concept of great value. Engaging in discussion about mentorship had provided them with a better understanding of various aspects of mentoring.

One particular subject that generated discussion was that of distinguishing between the mentor's role and the supervisor's. A great deal of scepticisms towards supervisors was evident at the beginning of the discussions with the counsellors. However, participants in this study became conscious through a process of logical thinking that supervision and mentorship had common elements and that the differences between the two might be attributed to the personal qualities of the people delivering the supervision or mentorship service.

The method of enquiry selected for this research is a direct strength. Although statistical analysis is useful for some kinds of investigation, it fails to provide an in-depth understanding of certain human experiences. A qualitative approach was used in this study, to concentrate on the subjective experiences verbally expressed by the participants. Using semi-structured interviews as a qualitative technique encourages participants to reflect on and to describe their subjective experience. This cannot be

achieved by a questionnaire or structured technique. The purpose of this research was to explore the underlying perceptions HIV/AIDS counsellors and mentors. The selected interpretative and grounded theory techniques provided a structured analytic process. In addition, grounded theory methods offer the opportunity to constantly interact directly with data. The tools selected to improve the validity of data, namely, the constant comparative method and the inclusion of a deviant case add to the strengths of this study. Constant comparison ensures that the data is analysed to a point of saturation and the inclusion of a deviant case protects against any preconceived ideas the researcher might have about the data. The understanding of mentorship that developed left the researcher feeling stimulated and enthusiastic about having undertaken this piece of research.

7.2 Limitations of this study

The researcher made every attempt to conduct this research as scientifically as possible. However, the researcher does acknowledge that the study has certain limitations.

Recruiting participants for this study was a serious limitation. Obtaining permission from the Department of Health in particular districts proved to be very difficult. Although permission was not denied, the appropriate authorities failed to respond to written requests to allow their employees to participate in this study. One area of concern, associated with the difficulty in recruiting participants, and which generally relates to the use of a qualitative methodology, is that of generalising the results of this study to the broader population. Although, all the participants in this study were involved with HIV/AIDS, we cannot presume that all HIV/AIDS counsellors and mentors have the same perceptions and experiences of mentorship. However, this was an exploratory study aimed at developing preliminary notions based on perceptions in the field. The researcher thus believes that the sample used for this study was adequate for its intended purpose.

Most of the participants were Zulu speaking and the focus groups and interviews were all done in English. Although the study was not at all compromised by this fact, the researcher did sometimes have to explain the meanings of the questions in detail.

Language problems also came to the fore during transcription. Poor pronunciation and incorrect grammar made transcribing difficult.

7.3 Implications of the Findings

A valuable aspect of this study is that the results presented in this study may have positive implications both for the improvement of existing mentorship programmes and for the development of new mentorship policies. The results provide a deeper insight into how counsellors and mentors view mentorship. Incorporating the views of those involved in VCT mentorship might contribute to mentorship programmes being more meaningful for those concerned.

Defining the concept of mentorship across a range of contexts appears to be problematic. Literature on HIV/AIDS mentorship in South Africa exposes the difficulty of establishing a standard definition of mentorship in the HIV/AIDS field. The results of this research project have the potential to open up discussion, which, in itself has repercussions for explaining and describing mentorship in this particular field. The findings of this study, based, as they are, on the perceptions of those receiving and giving mentorship, may, therefore, contribute to clarifying and understanding mentorship in the HIV/AIDS context in South Africa.

7.4 Further Research

The concept of mentorship for VCT is new to South Africa and, thus, invites numerous potential research studies.

A recommended area for further research is that of representation. In order to satisfy the need to generalise results to a broader population, it is recommended that this study be expanded, by using a larger sample, selected nationally.

Additional areas of research required in this field are associated, firstly, with the motivation and personality traits of mentors. What motivates people to become mentors? Secondly, an in-depth exploration and development of mentoring models is required. These can contribute significantly to the success of mentorship in the

HIV/AIDS counselling field and mentorship policy that will assist VCT service providers.

7.4 Conclusion

This study has aimed at a comprehensive examination of mentorship in general, and of mentorship specifically in the context of HIV/AIDS counsellors in Kwazulu-Natal, South Africa.

The literature review began with a chapter giving a historical account of mentorship, which highlighted the changing nature of mentorship. The original paternalistic kind of mentoring has now been replaced with a more structured, purposeful and goal-directed mentorship. This change has caused confusion about establishing a universal definition for mentoring. The difficulty of defining mentorship in general was discussed in chapter two. The importance of acknowledging the context in which the mentorship is taking place became evident from the literature review.

Various contexts in which mentorship has been established for some time were described. Aspects of mentorship especially in the nursing context have significantly influenced the HIV/AIDS mentoring sector. Mentoring models were also outlined in this chapter.

Chapter three provided a description of the literature associated more specifically with HIV/AIDS mentorship in South Africa. Literature on HIV/AIDS mentorship is very limited. These limitations impact has intensified the difficulty of clearly defining mentorship in this context. A distinction was made between two aspects of mentorship, namely, supervision and mentorship. Mention was made to how the concept of supervision in, for example, the nursing context, has influenced HIV/AIDS mentorship. The negative image of supervisors has lead to the term mentor being used to describe the person responsible for monitoring service outputs and providing essential psychosocial support for counsellors. Defining mentorship in a VCT context can best be explained by showing a combination of the features of supervision and mentorship. The benefits of mentoring subjects undergoing VCT were outlined in this chapter, as were the associated problems. The chapter concluded with a discussion of various models of mentoring for HIV/AIDS counsellors.

The aims and methodology selected for this study were clearly explained in chapter four. A qualitative approach that used an interview- and focus-group interview method for data collection was considered to be the most appropriate method for exploring the participants' experience. The data was analysed by using a grounded theory technique of codes and categories to develop theory.

Chapter five described the results of the study, which were discussed more comprehensively in chapter six. An attempt was made in this chapter to integrate and substantiate the findings of the study by referring to the existing literature on the subject. The discussion revolved around the participants' understanding of mentorship, highlighting its holistic nature. A holistic approach to mentorship suggested support and guidance in both the personal and work contexts of individual counsellors.

A major finding of this study was that mentorship, which includes support and training for counsellors, contributes to the improvement and sustainability of quality counselling. Counselling is improved by providing a mentor who cares for the well being both of the counsellor and for the HIV/AIDS counselling services. The mentors' role in guiding counsellors in ways of reducing work-related stress; on-going training; and counsellor assessment inevitably contribute to more motivated counsellors to improve the quality of their work.

The qualities needed for mentorship have been outlined. Identifying the criteria for mentorship was important in that it helped distinguish between mentorship and supervision. The difference between supervision and mentoring formed a significant part of the study, and thus of the discussion. Supervision, because of its association with authoritarianism in nursing, has a negative image in the HIV/AIDS counselling sector. Counsellors are not opposed to supervisors' assessing their work or providing basic mentoring functions, but they do not want these functions to be performed by a person who lacks counselling experience and the quality of caring, considered as essential in selecting mentors. We may, therefore, conclude that mentorship and supervision may well provide similar functions, and yet there appear to be distinct differences in the qualities of the persons performing these functions.

The study found that mentors and counsellors had very much the same perceptions of all the aspects of mentorship that emerged from the results. Similar findings were discussed regarding a comparison between HIV/AIDS mentorship and mentorship in other fields mentorship

As a result of this study, a theoretical base for mentoring was constructed to take account of how counsellors and mentors in a HIV/AIDS setting experience mentorship. Obtaining these views might contribute more significantly to sustainable mentorship programmes than relying on the views of programme developers who are removed from a counselling and mentoring context.

It is evident from this study that both HIV/AIDS counsellors and mentors of counsellors perceive mentorship as an essential part of the VCT sector. We may further conclude that the provision of mentorship for counsellor is one element that may lead to better counselling services. Improved counselling services should result in more knowledge about prevention, the overcoming of stigma and enhanced psychosocial support in combating the HIV/AIDS pandemic.

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APPENDICES

APPENDIX A - FOCUS GROUP GUIDE

Name of Site: NGO _____
Public Health _____
Private Clinic _____

Type of counsellors in the group
Lay counsellor
Professional Counsellor
Nurse counsellor

Total amount of participants in the group _____

Region: Urban
Rural

SECTION 1

GENERAL

The aim of this section is to establish what the participants' basic knowledge and experiences are, regarding issue about mentorship

1. Do you have a mentorship programme in working in your unit? If yes, please could you explain what your views are on the programme?

IF NO, can we talk a bit about what you would like to have in terms of some sort of guidance system?

IF YES, Can you describe in detail what elements make your units mentorship programme work or not work?

PROBES TO BE USED IN THIS SECTION:

1. How mentoring benefits this organisation and the counsellors in this organisation?
2. Who do you think should be mentored and why do you think so?

SECTION 2

MENTORING AND SUPERVISION

This section aims to find out how counsellors understand and value mentorship. In addition, this section focuses on what the functions of a mentor are and whether the same individual can perform mentoring and supervisory functions?

1. What do you understand by the term mentorship and what value does it have for you?
2. What kind of activities should a mentor provide?

PROBES:

1. What are your feelings about what the role of a mentor should be?
 2. How often should a counsellor be mentored
 3. What would some of the issues be that counsellors would discuss with mentors?
-
3. Is mentoring the same as supervision? What do you think the differences are between a mentor and a supervisor?

PROBE:

1. What would you prefer or what would your needs be, a mentor or a supervisor?
 2. How do counsellors feel about mentors assessing their work performance?
-
4. How do you feel about the same person being a mentor and a supervisor?

PROBE:

1. What do you think some of the problems or difficulties would be?

SECTION 3

QUALITIES AND SKILLS OF AN IDEAL MENTOR

1. What do you think the qualities and skills of a good mentor should be?

PROBE:

1. What do you think the criteria should be to select a mentor?
2. Who should be mentors?

PROBE:

1. Professional psychologist / social workers or non-professional people
 2. What would the advantages and disadvantages be of using a professional or non-professional person?
 3. What would you prefer and why?
-
3. What kind of relationship should exist between a mentor and a counsellor?

PROBE:

1. What are your opinions on individual vs. group mentoring?

APPENDIX B -TRANSCRIPTION OF A FOCUS GROUP

FOCUS GROUP INTERVIEW DONE AT A VCT CENTRE ON THE 28TH APRIL 2004 WITH A GROUP OF HIV/AIDS COUNSELLORS FROM VARIOUS DEPARTMENT OF HEALTH CLINICS IN KWAZULU NATAL.

GROUP SIZE: 3 COUNSELLORS

1 VCT DISTRICT COORDINATOR

1 COUNSELLOR WHOM JOINED THE GROUP AT THE LATTER STAGE

VENUE: VCT CLINIC AT THE ESCOURT PROVINCIAL HOSPITAL

DURATION: 1 HOUR 20 MINUTES

GENERAL OBSERVATIONS:

The focus group session was tape-recorded using two Dictaphones. This method work well when transcribing as it meant that listening to the other tape could identify unclear words. The result was that the already transcribed sections were constantly being checked for exactness, thereby ensuring validity of the data.

The VCT coordinator in the this particular district organized three counsellors from different VCT sites in the district. One counsellor who was busy with a counselling session that was being assessed by her supervisor joined the group at a latter stage of the interview.

The VCT coordinator requested a copy of the interview schedule. I was concerned that the presents of the coordinator would impact on the counsellors' respond to the interview. However, there seemed to be a good relationship between the counsellors and the coordinator. Her presents turned out to be very valuable as she acted as a competent co- facilitator, asking useful and valuable questions, which gave depth to the interview.

She also requested a copy of the transcribed interview. Permission to do this was requested by me to the counsellors. All the counsellors agreed to this.

I was asked to brief the group on the background and purpose of the interview. The counsellors appeared a bit unsure of what was expected from them. The briefing was followed by a quick chitchat on VCT issues, which served as a useful 'ice breaker'.

The interview only started once all the counsellors agreed they were ready to.

I explained the format of the interview to the group before commencing.

The focus group, like most focus groups started off slowly, but as it progress the counsellors became more relaxed and conversed more.

At the end of the focus group everyone discussed how they felt doing the interview. All the counsellors felt it was a wonderful opportunity to reflect on their mentoring sessions and how they would like the sessions to be.

Do you all have mentors in your units? Are you all being mentored?

Speaker 1: We have got one mentor at this present moment, who is the district mentor but we are working on getting site mentors, but for now we have got only one who is a district mentor.

How does mentoring benefit your organization and the counsellors in the organization?

Speaker 3: Mentorship does benefit me a lot. It encourages me to do more work in my site where I am stationed and it helps me to grow and like understanding others who have some issues that are difficult and I can relieve some of those issues and work out solutions towards these issues we have. Like challenges we face. One counsellor may have a different challenge and another counsellor another challenge and if we talk in that mentorship workshop then maybe we are able to help each other. So it does benefit us.

Speaker 4: Sometimes it does help a lot because sometimes you find that you have a problem and you don't know how to handle it and if you talk about it then you get help with your problem. When you talk about it with others and you feel, sometimes you feel comfortable to know "ah" that the other people have the same problem it is not my problem maybe, sometimes I think I am not doing my work well so when if the other person has the same problem it is easier. You feel free doing your work and get solutions.

Speaker 2: Ja, it is more or less the same thing for me. It helps me a lot because for one it shows me that I am not the only one going through that crisis. When we are in a mentorship session we express more or less that we have similar problems so it really does help me to understand that there are other people who also go through it and we can together to try and find a solution. It also helps me because there I don't have to be a counsellor, you know. I don't have to sit and guide that person. I can just be myself and say 'I am the one with the problem.' I don't have to listen to somebody else who has a problem and I don't have to take charges and try to help that person. I get another person to help me. I can just sit and be myself.

In a VCT site with counsellors and nurses and other people involved, whom do you think should be mentored?

Speaker 2: I am not sure I understand or not, the question.

Do you think the other people involved and that work at the unit should also be mentored or just the counsellor?

Speaker 3: You mean like sister, health workers, nurses?

Speaker 1: Okay, let me give you the background for this thing. In each clinic there are counsellors that are doing VCT and then there are nurses who are doing comprehensive services, but when it comes to testing the counsellors they do the screening and then the nurses they only come for confirming that. But most of the nurses don't do counselling per say for HIV. We have got counsellors. There are very few instances when there are nurse counsellors doing the counselling.

The nurses obviously know what the results are of the test. Do any of you feel that they should also get mentoring?

Speaker 3: The nurses who are counsellors or the nurses doing the testing?

Anybody in the unit

Speaker 1: How do you feel about those people do you think they need to be mentored as well because they test and they see the result? How do you feel about that situation? Do you think they need mentoring like you are being mentored or do you think it is okay if they come for just that minute and then disappear? How do you feel?

Speaker 3: They can be mentored because they must understand the situation. They are working with a situation (1). ...where there may be problem with the client.

Speaker 2: I also think so because sometimes my nurse, my nurse (ha!) my supervisor she confirms for me and knowing the results, Somehow that has an impact on her, because after the client has left she comes back to me and we talk about it. Somewhere, somehow she got hit and for that she has to get rid of what ever, the stress of whatever that she underwent.

Speaker 4: I also agree with her that they should somehow because, it is like when we do our ... they do also come to a shock somehow. So by leaving them out, they don't understand. Some of them they don't understand the basis of counselling the person to much. They only know when the person comes to them and says "I am sick' with this and this" and then they give them something and check them and that is all. But in counselling session you have to understand the persons problem and her problem and emotions. So if they come and just pills. They just give pills to the client. Sometimes they may not understand really. So they have to be mentored to understand more about the problem we have got. Then they need to empathize with them, the need to empathize with the client. Ja

Yes, and I suppose it would create a better understanding between you as a counsellor and the nurse?

Speaker 4: Yes, yes. Just that they can get a better understanding of what the environment that we are working in.

What do you understand by the term mentorship and how do you value your mentor?

What does the word mentor say for you?

Speaker 3: To me mentorship it is a way of really trying to help a person to be able to assist a person to understand her situation, it also means that I can be able to be given help and that it will assist me in my work most of the time and it does help me, I can say so.

Speaker 4: It relieves the stress that that you don't have to carry that burden of the working environment weight.

Speaker 2: For me it's helping me. It's supporting me. It's directing and guiding me. So that I can be efficient and effective doing my work.

What kind of activities should a mentor provide?

Should provide or do?

Or in your case what are the activities that your mentor provides. In this unit you have a mentor, what they do provide or maybe they are not providing what you think they should. What there things that you feel the mentor is not providing?

Speaker 2: Me specifically we talk a lot about my counselling session and how I feel. I tell them "Oh, I felt bad because of this and this and that. And we normally focus on that on how I am feeling and that is very good. "How I am feeling, I am stressed, I am tired and everything. But I feel that we should concentrate more on the self. Not only me okay but also somehow you feel comforted in people and that is fine. But that is where it ends or we talk about difficult cases, difficult cases we talk about them somehow throughout, that is where it ends. But I feel that I need more. She should talk me as a person, who know, my holistic thing as a person, like socially, spiritually, physically because I feel that if a person is emotionally, physically what ever you need say like satisfied then that person will produce like good work, because that is how I feel.

Speaker 3: Ja, Me too. It should provide that you can come maybe first. You can come to a case where you maybe feel the client needed you. The case of the client did touch you and then maybe when you come to the mentorship you mention just mentioning how it happened, how it happened, but they don't ask how did you feel how did it make you feel that thing. Sometimes you have clients that tomorrow you say 'uhm that patient I still remember her if only I could help like this and this' and you couldn't help. If the could maybe, the mentorship can try and help each and every person like not in the book like the do but each and every person. Say last month, which a case that you found out more and more you get in touch with it as such, then you she can ask, "What touched you? What made you feel like that? Why do you feel like that?" And then maybe afterwards I can be helping her in that way. Sometimes you do feel like that case, if I can find someone that I can talk to and it would help me and tell her how it made me feel, maybe it would be better for me.

You say that you would like to talk more about specific cases that you have to deal with?

Speaker 3: Ja, because when you have had a person in a session for HIV you can't talk to anyone about. But sometimes you feel like if perhaps I could tell someone even

if we don't mention the name, we will keep it confidential. Just to, to they know that if there is something that happened. But you can't find that person each and everyday. Because sometimes you feel that you can't even sleep because of someone's problems. I know it is not suppose to be like that but that happens. If I am battling with a person, how can I help that patient? That's when you need someone to talk to. Last time when we had a mentor session, with our mentor I said to her that I had a problem. I am angry with something, because I didn't do something correct. I wake up each and every night maybe at midnight and said "Why didn't I do that, why didn't I do that?" I will always be angry at me that I didn't do it correctly, because maybe I didn't find someone that will say, "no you didn't do it correctly, because of this of this. It is not that you are not good. You are, you are good except that you were mistake, you made a mistake, at that point in time. You are not the only one that makes this mistake."

Speaker 2: I agree with her, I feel we should have them more often. Because you have difficulties like that everyday and you can't wait for really one a month. What happened at the beginning of the month and say it's like month end. I think we should have them more often and by the time, like, I am being honest now, that drains you in your other counselling sessions, you are not as acceptive because you are still worried or stressed about that thing. Let the thing come and then let the mentorship push it away and then you are fresh and up and going for you next counselling session.

So you would prefer to have somebody at a regular basis that you can approach whenever you needed them?

Group: Ja

What other activities do you think the mentor should be providing? How do you fill about technical skills, furthering education, workshops etc?

Speaker 2: Ja we get those. Whenever there is an update on something that the counsellors must know, then they call us we learn about SDIs we learn about newest testing kits and we learn about something else. So that is not a problem

Speaker 3: With education, we get a bit, so, ja, that one is more often like she says. We do get some of those sessions where we get educated about other, other infections, so that it would be able to benefit each and every client. They help us in our session, counselling session. Even though I can say I do want to have, maybe more like TB aid education so that we can help patients that have TB, because some of them come to us and ask questions, and somehow you don't know how to help that patient that has got TB, but if you could have more, maybe mentorship within those sessions like TB you would be able to help that person with TB and HIV. Then you will be able to link those two things together. But other issues, like SDIs, we are able to help even a youngster a teenager who comes to the clinic, like "okay we have been given a assignment at school and we want pamphlets about SDI." So, if you know about that you start with telling her first "this and this and that" and then give pamphlet. Like yesterday, some children came asking for TB pamphlets. I had some pamphlets but I didn't have those for TB specifically, but I tried to explain to them how you get TB,

how you help someone that gets sick. If I could have had more information about TB I could have given them more, and handed out the pamphlets as well.

Speaker 1: I am identifying the links now. The link with mentoring and training. Because seemingly these are the training needs that are actually coming out clearly, that if perhaps in a mentoring session at the end of the session, training needs should be identified and be channeled to the right training compartment. Ja, because seemingly within this district we have got a trainer

So, the mentor would not do the training, you would use your trainer?

Speaker 1: Ja, the role of the mentor is to identify the training needs she can address on the job, but if it means in-service or a workshop, she needs take those training needs to the trainer so that the trainer can actually take them forward or develop a person depending on their need.

Perhaps I should have asked this question earlier. How do you mentorship sessions work?

Speaker 2: Nothing much, ha! ha! We get down and we write our objectives for the day, like what to expect to learn by the end of each session. We read them aloud so that they all hear and then we just, we already have an agenda on what we will be talking about on that specific day and ja, then we just talking. Talk the whole day on problems, or no problems, new interventions or whatever. Then at the end of the day, we go back to our objectives and see if they were met.

Speaker 4: And try get problems and suggestions if we can. And then we try sometimes to make a still like were a counselling session. (Group: role play) whereby you see how you are coping with your counselling skills and everything, so that you will be able to help wherever you are doing work. So mentorship somehow helps us to do that.

So where does the mentor fit in? Do they facilitate the session or they give you definite guidelines?

Group: Uhm, the do

Speaker 1: Meaning, meaning

Speaker 2: No she sometimes acts as a facilitator, depending. She asks us. It is almost like a counselling session. She asks us questions, she expects answers from us. Like somewhere, somehow where she sees the needs we are offline or something, she corrects. "This is the way it is suppose to be done".

What are some of the issues that you talk to her about?

Speaker 2: Sometimes she will ask us do we have problems maybe in our site where we are working besides counselling sessions, just problems. Do we have maybe concerns maybe regarding the place we are working in, the room we are working in the staff do we have any problems regarding them. She also asks like "do you have

problems” and then maybe she will come back in the second mentorship session she maybe give you feedback about your problem she had coped with and a solution for that problem you had before.

Are you all in the same mentor group?

Group: Ja, yes, everybody

Other issues you can think of?

Speaker 2: No, I mean she just asks us difficult cases we have.

How do you feel about discussing personal issues with your mentor?

(Talk within the group)

Speaker 4: They have to tell us, like talk about the behaviour of the counsellor that they expect. That she will remind us.

Speaker 3: Ja, They have to talk about that thing. Each mentorship, we have to talk about that thing, that’s how to behave because we must be professionals.

Speaker 2: Yes, there is the thing that they need to focus more on me, the counsellor the individual because I also have my own problems. Ja I need to talk to somebody about it. Whereas she just asks me work related. I would rather talk about my personal problems. Like sometimes if you wake up on the wrong side of the bed you have to take it to the counselling room, you know.

Do you think a mentor and a supervisor have the same type of roles? What are the differences between a mentor and a supervisor?

Speaker 2: But, with supervision I find that it is monitoring work. To be corrected but it is more on a formal basis. You don’t have to be friends or you don’t have to, you don’t have, I don’t know how to put it, but you don’t have to be as warm as a mentor. A mentor has to be calm. He or she has to be non-threatening. I have to be able to relax around her. She mustn’t use abuse her power and authority “that I am a mentor”. Whereas that can appear in ... supervision, Ja, Ja

Speaker 4: Ja, that is correct. The same thing as she says. A supervisor can maybe mentor you in how you do your work, each and every day. And maybe try to correct you if she knows how to correct you. Because, sometimes, at the moment our supervisors, most of them don’t know more about us, about the problem more. So, we try to maybe tell them that somehow this is this and this is this. Then if they have understand what you have tried to tell them then in the later stage if they see that you are not doing, what you said it was suppose to be like, they can say that is not what you are suppose to be do. Then mentor maybe you can tell her then somehow in a session, counselling session you can say that ‘I have done good, I am sure that I have done good things in the session’ Then you go to the mentor and you try to explain to her in this situation you did this and this and this. And then she will tell you “no you were not suppose to say it like that, maybe if you could take another angle and do it

like that and that, it will be better. And you understand “Oh, Ja, I thought I was right, but I wasn’t right. The mentor can guide you somehow, in the situation.

Speaker 2: She is more of a friend

Speaker 3: Ja, then the supervisor

Speaker 1: And the supervisor?

(Lots of laughter)

Speaker 2: Iyha, Iyha, no

What does the supervisor do? What is her role?

Speaker 3: In my site my supervisor, her role is to see that our work is done. I do my work as I am suppose to. I call a sister to confirm I don’t have to do it myself, there has to be a sister. The supervisor may see if I have done something wrong. So she is there to see that I am there to do it correctly

Speaker 4: Sometimes they tell you something that you know better then her because You are in the working area you are used to that thing. She thinks that you must do it this way but it is not like that, you know this is not like that. And she doesn’t sometimes she doesn’t expect to tell her or discuss it with her; “you know how it is if you do this, this way”. Because she is the supervisor so she know better than you.

Speaker 3: But I confess differently. In my situation my supervisor is so nice, we can talk, we can talk. I can say, “No, maybe its better doing it like that” Then she says, “oh ja, it is better.” Then we do it like that. If her idea is better than mine, then we can do it like that. And then she also there, the supervisor is there that if you are not feeling well, like the person who appointed you, like your boss not your supervisor, she is not there to see that you are feeling well. If you are not feeling well, she can see “that my colleague is not feeling well today, I am her supervisor, I can call her in, Do you think you will be able to work today?” “Yes I think so” She will talk to me, like that even if it is not like sitting down an hour long. Five minutes will be enough for her to talk to me, just to talk to me. So with my supervisor it is much easier.

Speaker 2: Ja, my supervisor is also nice, we get along very, very well. She informs me of everything, like meetings. She orders my things, my kit and all that. No she is very nice.

Speaker 3: And if you don’t know, like in a situation of like giving medicine, we are not supposed to give people medicine. The sisters do that and then she will call you, “you see, and this and this.” and then maybe she’ll inform you the weight of children, I didn’t know if a child is four months how much child must weigh, I didn’t know everything, but she came and told me “this and this” just to educate me so that I will know more about things. Like the older people, “ if they weigh this much you can just send them to me so that I can see them and give them this and this”. Now, I know okay this one weighs this so I can shift her this side. So the relationship between me and my supervisor is more helping to me.

Speaker 4: Ja, she has to understand the problem because we have to solve the problem.

Speaker 2: Ja, because our job is identifying the problem and working on it. So, she says that her supervisor does that. What I quite like of my supervisor, you know the ICIN book, I know off by heart. So it is easy for me. So if I have a client or a child who has got this symptom, symptoms, I ask her questions, and then if I see that the child is really sick I can then like, relocate the problem.

You seem to have a good relationship with your supervisor, but what is it that difference between your supervisor and your mentor?

Speaker 3: Okay to me I can say that, even though I say the supervisor sometimes ask me what I am doing in my work, but she doesn't take that much. She just asks that for me when I am feeling tired. But the mentor may have the time possibly an hour to ask how it was, how I feel. If I say, maybe she will ask in relations to work, which she directs towards me but she will have more time than the supervisor, asking me just how I am feeling.

Speaker 4: The mentor must be able to come to adjust herself to my level. Like she said she "become just like a friend". Although she is my mentor. Just like a friend, so that it can be easy for me to talk to her. She must be able to adjust herself.

Speaker 2: For me right now my supervisor does more than my mentor. You know, as I said, we get on very, very well. We are able to sit for about an hour and talk about a case and talk about me and talk about. She cares; she's going... she is both my supervisor and my mentor. So, by the time I go to my mentoring sessions I have already had a little bit of my mentoring at the clinic, for me personally.

She is maybe more available at this stage.

Let's just summarise briefly. Do you think a mentor and a supervisor can be the same person or would you prefer it to be two different people?

Group: different, different,

Speaker 4: Yes, me, I prefer them to be different. I think it would be better if they are different because like if I look at the situation now, my supervisor there are some things that I am unable to tell her, but I would be able to tell my mentor. I think it is better to be different.

Speaker 1: She is saying that she cannot tell this one and she can tell. Is it because of the distance or the availability of the supervisor, or something, what is it? Why would you say I cannot tell this one but I can tell, and you are actually saying the relationship is very good? What is it?

(Laughter)

Speaker 3: I don't know, but I don't feel just like that. There is nothing I see, I can't tell you. But the mentor, because sometimes I can see, I can remember the way she

asks questions, sometimes gets hooked, maybe tricked and you tell her personal things that you said. Sometimes I don't want to tell personal things to somebody I am just like that. But somehow she gets to ask me questions that will lead me to tell her personal things. But the supervisor, even if she asks me I won't tell her.

(Lots of laughter)

Speaker 2: I think maybe it should be different in one way in the sense that, if your supervisor becomes a mentor I think it has to somehow affect your work. Because with the mentor, you are able to tell her personal things. But now if your supervisor, if you tell your supervisor these personal things, it might affect your work. Because, okay fine it is professional, but not that professional, because now she knows something about you. Whereas, she should just stick to work.

Speaker 3: It is like, I see them, I am not saying that I am different then there age. My supervisor, ah, ah, a she is old, so I won't be able to tell her more, like personal things and that. Ja, they are older then me, like my mother, so some of the issues I won't be able to tell them, but the mentor she is not my mother, she is my sister. So I know my sister, I can tell her. I can say "you know there is something, like this and this and this" Even if won't be so personal, because I am not that person who likes tell each and everything that happens to my life. I would rather toAnd she might use that, like against me, thinking I am a bad. Like "you are not being affective because of this and this and that"

Speaker 4: She will like interpret it wrong if you make a mistake.

Speaker 1: Perhaps looking at the age, because something that came out around the age. Who would you prefer, would you prefer somebody that is closer to your age or somebody who is old or somebody who is young?

As a mentor or supervisor?

Speaker 1: As a mentor.

Speaker 3: Aai, not my age. It could be like thirty or something like that. But not my mother. She my supervisor is like my mother. I don't talk to them that much. I do talk. Sometimes they tell me things, "we have seen you somewhere" and then you say "Ah, how come". No "somebody said" and I am trying my best not to say ... (lots of laughter from group) you know it and everything. There are some things you don't want to tell her but a mentor you can tell anything.

Speaker 2: A mentor can be almost my age and a little bit older. Not old, but my peer is somebody I can talk to about anything. I am comfortable with her or him. So my age to plus/ minus ten years from my age. Plus ten years, about ten years from my age. But definitely no more, no more.

Group: All talking and laughing at one – inaudible

Speaker 3: But if she is too old sometimes they pretend as if the never went through that stage...

Speaker 2: They judge you

Speaker 3: Ja, they just judge you.

Speaker 4: But this you have got today. But she was once part of the youth of that day in her time.

Speaker 1: Perhaps I am hearing another question. If perhaps your mentor is not, and your supervisor or a mentor is not so judgmental would you accept that person irrespective of the age? If it is somebody that is open, somebody that is understanding, some one who doesn't judge, somebody that has got the right attitude and she is actually at your level. Would you say no still to that person or would you say "okay, because we can actually relate to this person, so the age in this context would not matter". How would you feel?

Speaker 2: If she had the right qualification. Because I mean I am friends with my mother's friends. They are very open. So they are more like my friends because of their personality. Of the qualities that they preserve. If she or he has those qualities then he or she can be my mentor. We say the age thing, because old people they look and check and "these young people of today. They have attitude." And that type I really don't want to mentor me. I want somebody who is from the same era. Who I can talk to.

Speaker 4: It happens it is my sometimes, it is attitude. I can have a bad attitude towards her. That happens, let's not put the blame on them. That sometimes it happens that I have a bad attitude towards someone. It just happens. Maybe we will think that she thinks she is clever. Sometimes she is not even doing that, but that is how we will feel about her. We will interpret her wrong.

Speaker 1: So perhaps I am hearing, qualities here.

That was the question I was going to ask. What are the qualities of a good mentor?

(Lots of laughter from the group)

What type of personality, qualities or skills should a mentor have?

Speaker 2: She must probably be board minded, open. She has to be friendly. Non-threatening. She must be confident. You don't want to be mentored by a person who is not sure of herself. Uhm, She must be intelligent, she must be focused. She must be a strong person and assertive, yet warm and down to earth.

Speaker 3: And ready to update anyone ...the person involved.

Speaker 4: She must be warm.

And counselling experience? How much counselling experience do you think a mentor needs?

Speaker 4: Ja, and that one counts.

Speaker 2: For me...

Speaker 3: For me it doesn't because if you are born a fashion designer, you are a fashion designer. You go through tech, just to get the certificates and to get the basics. But if you are born with something then it is innate and there is nothing you can do. So if you are born a good person with all these qualities. You can make a better mentor than a person that went and studied psychology for the sake of getting that degree. That's what I think.

Speaker 5: To me I think counselling experience is more important to a mentor. So that she would be more understanding towards our type of session, what we are talking about she can relate to. If she doesn't know more about counselling she can know about mentor and maybe if she is like, like what a motivational speaker, a motivational speaker can talk and motivate in your work. But if she doesn't know your situation she won't be able to relate more her motivational speech towards your counselling. So counselling experience can be able to help a mentor.

Speaker 4: And she must love people, love her work. Not just for doing it for money. Because she will do it wrong if she does it for money.

Speaker 1: So I am hearing, talking about talking about the experience, are you looking at a time frame perhaps, where we talk experience? How long do you think this one is experienced now to mentor others?

Speaker 2: I feel that if you have been a counsellor, even for six months you basically know what is going on in a counselling session. You don't need ten years to be a mentor. Because counselling is more or less the same process over and over. When with different, with each situation unique, but it is more or less the same thing. So, if you have been a counsellor, you know what goes on in the counselling room, you know your stresses, you know what strains you. You basically you know, and then from there you will be able to mentor somebody else. Like she said you already know, you more or less know what goes on there. As long as you've been there. I wouldn't say that I find that important, as long as you have experienced it.

Speaker 2: I won't be a mentor at this moment. I could wait maybe a year or maybe two years and I can be able to be a mentor.

If you, say the DOH of health said "okay choose mentors for KwaZulu Natal? What would your selection criteria be?

Speaker 4: To be counselling experience can count. Experience can count maybe a year and maybe like Lily said openness and flexibility that will also count as a criterion whereby you will want someone who will be a mentor for us, but counselling experience to me is most important. A year. And a good character.

(A fifth person joined the group)

How do you feel about a qualification, a formal qualification?

Speaker 2: I feel both. I feel yes and no. Because a person that has tertiary experience they have gained more knowledge, they know more than someone who only has a matric. Whereas, also I feel that is discrimination because a person can be a very mentor without it. So I feel both. I am not sure, how I am feeling.

Speaker 3: I say yes to a qualification. I prefer that does. Even though I won't say what qualification a mentor have, just ... but just She came one day in my clinic and I was having so many clients who are antenatal, so she asked "Has sister been" and I said "yes she has been". "She has been, oh okay if she has a spare be I could be able to help her" and I was like "uhm a mentor doing that, she can be able to help the sister, she knows every thing." Then I was like... so qualifications to me count even though I don't know what will be those qualifications she needs, because nursing maybe not a qualification that you may require to be a mentor. But qualification can help you to be a better mentor.

Speaker 2: You know there are qualifications that can focus on things needed for a mentor, like a person who has done psychology who's done like social science, who's done communication, but there are also qualifications that we know, that are like oil and water. A person who is like an engineer. (Lots of laughter and talking). The thing is if you gone through tertiary, you learn. It doesn't matter what course you are doing. You go in another person and when you get out you are totally another person. You have experienced things you can call it life orientation so you come out a different person.

You have just joined our group, would like to tell us how you feel about mentors?

Speaker 5: Now, I am just hear from their opinion that is the right and exactly what mentors should be, somebody who has experienced, that one, who my sister says. Somebody who has undergone any tertiary education. He has the information, what so ever. That particular person has been ... in the aspects of mentoring. I think that is the thing....

And other qualities that you think a mentor should have?

Ja, the life skills, what we are taught as counsellors. The skills, (cough) lifestyle and what somebody should be when he is in the institution.

Perhaps we should have included this question in the previous section. What should the relationship between the mentor and the counsellor be like? Should it be professional or more causal? How do you feel your relationship with your mentor should be?

Speaker 2: Ja, you can't be too formal, because if you are formal that will restrict you somehow. You can't be totally; you can't be yourself like totally. You are so restricted; you are worried that he is going to quote me. He is trying to find some mistake.

Speaker 3: It can be formal, but not the suit and tie type of formal.

Speaker 3: Semi formal. You can be able to get to get a sense of how you are able to say no. You can be laugh and even touch her, but when she want respect, then you have to respect her, yes.

Speaker 5: Ja, to be casual is not right. Because you can do it at any time, anyhow. It is like when something is casual then you do what you like. Your world is yours. No other person next to you is suppose to

Speaker 3: A relationship with a mentor is something like, when you meet in town. Okay, you just say "oh hello," and be happy to see each other and be happy to talk about something else. And when you see each other in the mentorship session, you can be formal there and talk to her nice and don't say like "Oh I know her" and talk to her like want to talk to her. Be polite and show your respect towards her.

We come to our last question. Just some ideas about individual mentoring sessions and group mentoring sessions, and what you would prefer.

Speaker 3: We would prefer regular mentoring, group and individual. Individual and group session of mentoring will be good, because sometimes we would need a person who we can talk to after a counselling session that day. So it would be much better if your clinic could have a mentor and individual mentorship. Then in-group one, because you have that session and you talk and you come with a specific counsellors will come with a challenge, you come with your challenge or if someone comes with a challenge, you will be able learn something there, solutions that will help each and every one of us. So that session will be very, very good.

Speaker 2: I agree with her, both group with individual. There may be somethings that I may want to talk about, but I am not comfortable in front of the whole group. And also with the individual, I have been preaching this; it focuses more on me than us. Whereas, with the group it is everyone, there is no specific. Ja, with the group it is nice also it is inspiring, it is motivates so many other ...and they talk of the problems, we solve them together. You come out being motivated and inspired and fresh and refreshed.

Speaker 4: Ja, sometimes with a group, if we are a big group then I end up not talking about my problems, because of the time. And sometimes there are people like Speaker 2, who just (click of the fingers twice). And I am shy and I want to talk but I am scared. So we can do both. Sometimes we need the individual mentorship and sometimes when a counsellor talks about her problem, I know I have the same problem. But sometimes, I feel panic. I can't even raise my voice and speaker 2 can raise her and then I end up keeping quite and then you are quite, you can't talk.

Speaker 2: That really does happen. That is something that happens. We should try to do something. Because there are others that are talking like myself and others that say "ooh she talks to much, she is so confident"
And they don't have confidence like me and they feel inferior and they are like quite all the time. To the extent that the mentor specifically asks, "you haven't spoken"
And I don't like that.

Speaker 5: Ja, we are different some of us are shy, some are not. I like this individual also the group. Because we are in a group, who gain some threads from others or you gain something, which is hers. Sometimes that one is the same as yours so when you share and when the mentor is answering those, then you are gaining from others.

Speaker 4; And sometimes a counsellor tells you about her problems and you “oh, I have never had that, this thing doesn’t happen”. And one day it happens to you and you know “oh, that was it” So the group is effective.

Do the mentors sit in on the counselling session? Does it help?

Speaker 4: That one is right, but it makes somebody to be “Yeesh!” (Indicates nervous). You tend to be tense and to be formal. You don’t be open like you are with your client. It makes you be formal and to ask her ..., I don’t know.

Speaker 3; I am worried. It makes you think, they way I am sitting, the way I am talking maybe she is judging me, the way I am talking. And sometimes the client can’t speak because they are afraid.

(Lawnmower cutting outside – difficult to hear)

Speaker 2: I think it depends on your relationship with your mentor. If your mentor is more your friend, you are comfortable talking to your client. You try to put the client at ease that the mentor is not a threat. She or he can be open with my mentor around. Whereas your mentor is more of a boss to you, then I say the wrong things, because you try and impress her now and you are not listening to yourself, you are just trying think of words better, that she will not be find a way that,... you are trying to correct yourself and you end up messing up and then in the problem will be sometimes if the client learns, she goes out and says “what, but she must not find out”

Speaker 3: Like I say I hate it I really, really hate it. I don’t feel comfortable.

Speaker 5: But I think sometimes we need those things.

Speaker 1: Whom would you prefer to sit in with you? Your mentor or your supervisor? Who would you be comfortable with in a counselling session?

Speaker 3: A mentor. Because a supervisor is not trained. She is not trained in the counselling skills or the programmes that you are.

Speaker 1: Even if she is trained in the counselling skills, and in the programme you are doing and she just wants to see whether you are actually doing well.

Speaker 3: Right, then a supervisor is okay. If she is friendly? But not by somebody who is seen as power or authority. Because your mentor if she is there when you counselling someone, I think it would help, she could tell you when maybe I have done something wrong “in your next session, this question, maybe ask the question like that and that”. So a mentor will be able to help you with the session.

Speaker 4: If she can wait and tell me at the end of the session, not just like if I am talking to speaker 2

Speaker 3: No not like that.

Speaker 2: A supervisor can also disarm herself, her power. You know, just take it off.

Speaker 5: A supervisor can also be a mentor.

Speaker 3: Ja, because she would be there and if you have a problem she would be able to help you. For at the moment if you have a problem, sometimes you have a problem, you can talk with her out. "As a counsellor, if I have this and this, how do I handle it?" Then she will help you. I think my supervisor does have some idea, if I ask her "I've I have problems" and then she will say, "Okay you can do this and this"

Speaker 5: But as speaker 1 has said, if a supervisor has all those counselling skills, maybe she can add as a mentor.

So you feel a supervisor and a mentor can be the same person?

Speaker 5: Ja, if she can do what a mentor... it is not easy. It is a hard one.

Speaker 1: But I actually say if the supervisor can be relaxed or distant as she was saying and she was having all the skills then she can actually do the mentoring because she is the one that is around most of the time.

Speaker 1: Perhaps do you have any other ideas of perhaps monitoring what is happening inside the counselling room? Any ideas that can be done or that can be useful?

Speaker 2: All of that, if you know there is somebody watching you, somebody (inaudible) for you, its that what I meant. If someone is playing a tape recorder, you know that you are having a bad day today, you know that the video camera is taping "oh, my god," You think

Speaker 5: This morning when I was working my supervisor was watching, so at the end of the session "I didn't hear you mentioning the next appointment, I didn't hear you asking did you disclose to the other members of the family, you didn't ask what about other family." So when somebody is evaluating you.....

Speaker 3: A supervisor can be a mentor at that moment when she knows. She has all those counselling skills. She can be a mentor for work situation. But I will still need my mentor to talk about my situation. I will still need that mentor, But in those days where she maybe help me with something in the work situation, she can be a mentor. Ja, but she is a supervisor and just a supervisor.

Speaker 2: But speaker one is asking us what do we think, Ways to monitor the counselling session. Because if I think, you know it is a natural thing that the body reacts to any threatening stimuli. So I really don't know.

Speaker 3: I don't have any ideas.

Speaker 2: I am trying to respond to your question. I am saying that a body reacts to a certain threatening thing, like when a person is watching you or listening and you react negatively most of the time.

Okay so you would you prefer to do the assessment the supervisor or the mentor?

Group: At the moment the mentor

Speaker 1: Perhaps the reason why I was trying to differentiate between both of them, because as they were saying they started the programmes and the supervisors didn't know about their programmes. But now we are having workshops for the supervisors, and in each session, there is a checklist for the supervisor to actually supervise the counselling, so that we have quality counselling. But I am hearing that it is okay with the supervisor if she is skilled to utilize those. Because they actually give feedback afterwards so that you can improve and then they give you the checklist so that you check yourself at the end of the session. Like she is saying that the supervisor was with her this morning. She made an appointment "that I will be coming to see you" and she is here to utilize the tool and they have been together. How did you feel?

Speaker 5: I feel I ... what I like at last when we had finished with the session and when the patient was out, she just sat down with me and she analyzed. "I didn't hear you asking the next appoint" And I thought, "oh I didn't know, notice that." Another thing she asked, "I hear you saying about the disclosure and she said she would disclose to the partner, but you didn't ask to other members of the family. You didn't ask about that, because it was important that other family know."

Speaker 1: So it was fine.

Speaker 5: So, if somebody is watching you. Wow, I tell you

Speaker 3: That was the first time, maybe the next time won't be so bad, maybe the third it should be better.

Speaker 4: Yes, if it is the same person

Speaker 3: Ja, I am not afraid of people assessing me, but maybe if it is first time, a formal thing, I might try and do it correctly and end up doing it wrong. But the second time I think it will be better.

Should we just summarise quickly with each person what a mentor means for you.

Speaker 2: A mentor for me is a person who will guide me, who will assist me when I need help, she will support me, and she will direct me to becoming an efficient and effective counsellor.

Speaker 4: Ja, it is the same for me. She is a person who helps me to release stress and to make my work effective.

Speaker 3: Ja, to me a mentor would be, she is the person who helps me a lot, like when I am stressed and she helps me to understand my work, like understand what to

do and what not to do, because she helps me. She is there again to help me understand my colleagues, because I am aside, because I am counsellor I am working only as a counsellor, and to understand the colleagues are there to help me. They are there to help me focus continually and to succeed. So she helps me to succeed in that way.

Speaker 5: She nurtures. That is the good thing of the mentor is just to help, to give just the guidance. I understanding that she doesn't dictate, but she just guides for the effectiveness of the counsellors

APPENDIX C - ALL TREE NODES

<p>1. <u>Structure of mentoring - models</u></p> <p>1.1 Ratio of mentor per counsellor 1.2 Structure of mentoring 1.3 Who should be mentored? 1.4 Individual or group mentoring 1.5 Problems 1.5.1 Size of mentoring district 1.5.2 Difficulties mentors face 1.5.3 Shortage of mentors 1.5.4 No mentoring 1.6 Solely mentorship 1.7 Frequency of mentoring 1.8 Full or part time mentoring 1.9 Internal- external mentoring 1.10 Relationship 1.10.1 Issues discussed 1.10.2 Type of relationship 1.11 Mentors for mentors</p>	<p>3. <u>Role of Mentor</u></p> <p>3.1 Conflict resolution 3.2 Counsellor development 3.3 Emotional support 3.3.1 Personal problems 3.3.2 Debriefing 3.4 Advocate for counsellors 3.5 Professional guidance 3.5.1 Case management 3.5.2 Identifying training needs 3.5.3 In-service training 3.6 Social support</p>
<p>2. <u>Benefits of mentoring</u></p> <p>2.1 Before and after intro of mentoring 2.2 Need for mentoring 2.2.1 Need to talk to a professional 2.2.2 Problems counsellors deal with 2.2.3 Problems counsellors have 2.2.4 Stress of counselling 2.2.5 Impact on home life 2.3 Value of mentoring 2.4 Quality counselling 2.4.1 Counsellors seen as unique 2.4.2 Holistic counsellor care</p>	<p>4. <u>Criteria for mentor selection</u></p> <p>4.1 Age of mentor 4.2 Assertive 4.3 Communication skills 4.4 Confident 4.5 Counselling skills/experience 4.6 Listening skills 4.7 Facilitation Skills 4.8 Formal/professional education 4.9 HIV/AIDS knowledge 4.10 Leadership skills 4.11 Lifeskills 4.12 Non judgemental 4.13 Passion 4.14 Personality 4.14.1 Attitude 4.14.2 Flexible nature 4.14.3 Previous mentoring experience</p>
<p>5. <u>Differences Mentor and Supervisor</u></p> <p>5.1 Supervisor being a mentor 5.1.1 Difference between Supervisor and Mentor 5.1.2 Nurse supervisors 5.1.3 Sister in charge 5.1.4 Role of the supervisor</p>	<p>5. <u>Differences Mentor and Supervisor</u></p> <p>5.2 Role of the supervisor 5.3 Counsellor assessment 5.3.1 Mentor sitting in on session 5.3.2 Performance assessment</p>

APPENDIX D - REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Vicki Nott
School of Psychology
Email: nottv@nu.ac.za or notts@mweb.co.za
Tel: 033-2605075/0827732736
Fax 033 -2605809

Attention Girlie Zondi
VCT COORDINATOR
HIV/AIDS & STD Health Department
PIETERMARITZBURG
3200

Dear Ms. Zondi

RESEARCH ON PERCEPTIONS AND EXPERIENCES OF MENTORSHIP OF HIV/AIDS COUNSELLORS

I am a Research Psychology masters student and doing my internship at the University of Natal Pietermaritzburg.

I am working for my internship with Ms. Heidi van Rooyen on the National Mentorship project as the project coordinator. A part of the project requires that we need to establish how HIV counsellors and mentors feel about mentorship. This information will also serve as the data for my thesis, which is concerned with the meaning of mentorship.

I need to conduct interviews with mentors of HIV/AIDS counsellors and with some of the counsellors. I would be grateful if you could extend the necessary permission for me to interview the said people.

The results of these interviews would be available, if required.

I look forward to hearing from you at your earliest convenience.

Yours truly

Vicki Nott

APPENDIX E - CODING THEMES

1. Benefits of mentoring

- 1.1 Urgent Need for mentoring**
- 1.2 Value of Mentoring**
- 1.3 Quality Counselling**
- 1.4 Holistic Counsellor Care**

2. Structure of Mentorship Programmes

- 2.1 Who should be mentored?**
- 2.2 Format for the delivery of mentorship**
- 2.3 Issues discussed during mentorship**
- 2.4 The relationship between mentor and mentee**

3. Role/Function of Mentor

- 3.1 Counsellor Development**
- 3.2 Emotional Support**
- 3.3 Professional Guidance and Development**
- 3.4 Social Support**

4. Differences between a supervisor and a mentor

- 4.1 Separation of roles**
- 4.2 Traditional connotations linked to supervision**
- 4.3 The Supervisory relationship**
- 4.4 Counsellor assessment**

5. Criteria For Mentor Selection

- 3.1 Personal criteria**
- 3.2 Professional criteria**
- 3.3 Qualifications**
- 3.4 Experience**

APPENDIX F - SUMMARY OF EXTRACTS

Extracts taken from counsellors Focus Groups in red

Extracts taken from mentor interviews in green

BENEFITS OF MENTORING

STRESS RELIEF

FG 2 (3) It relieves the stress that you don't have to carry that burden of the working environment weight.

FG 1 (2) I need a release valve

INT 3 What was stressing us most was the fact that we are unable to help our clients in dealing with their social problems but now that the mentor is here trying to integrate the two counselling and holistic approaches, it is an eye opener and we know exactly what to do now.

SUPPORT

FG 2 (3) For me it's helping me. It's supporting me. It's direction and guiding me. So that I can be efficient and effective doing my work.

INT 1 ... if you are not happy at work you are never happy.

IMPROVED WORKING RELATIONSHIPS

FG 2 (3) She is there again to help me understand my colleagues... they are there to help me focus continually and to succeed. She helps me to succeed in that way

THE STRUCTURE OF MENTORING

FG 2 (2) Talk the whole day on problems of no problems, new interventions or whatever. Then at the end of the day, we go back to our objectives and see if they were met.

FG 1 (2) Yes, it's difficult, because we haven't really every thought about it

INT 3 We try to visit each and every site so that we get different challenges, problems and in fact then as well, we also know that we are in a position to identify maybe problems, individual problems.

INT 1 Okay in terms of the structure it would depend again on how many people I would be mentoring so that I can plan accordingly.

TYPE OF MENTORING

FG 2 (3) There may be somethings that I may want to talk about, but I am not comfortable in front of the whole group ...with the group it is everyone, there is no specific ... it is nice it is inspiring, it motivates so many other. They talk about the problems and we solve them together. You come out motivated and inspired and fresh.

PROBLEMS DISCUSSED

INT 1: Uhm at times it will be space issues especially when they are not using their own premises ... it will be personal issues ... you find they are having conflicts amongst themselves.

FG 2 (2): Sometimes she will ask us do we have problems maybe in our site where we are counselling besides counselling sessions, just problems.

RELATIONSHIP

INT 3 It must be professional but not in a way that you will have to make sure that you are not approachable.

INT 2: Not a friend for sure. It can be as warm as possible, but there should always be that difference that you are her mentor you are not her friend.

FG 2 (5): Ja, to be casual is not right. Because you can do it at any time anyhow. It is like when something is casual then you do what you like.

THE ROLE OF THE MENTOR

EMOTIONAL SUPPORT

FG 2 (2) Yes, there is the thing that they need to focus more, on me, the counsellor, the individual because I also have my own problems.

PERSONAL DEVELOPMENT

INT 1: So believe in people and allow them to grow, it is very important.

PROFESSIONAL DEVELOPMENT

And be able to give some direction with some of the cases they may be having.

Ja, the role of the mentor is to identify the training needs she can address on the job.

MONITORING COUNSELLOR BEHAVIOUR

INT 3: I think as a mentor we have got a responsibility of reporting some of the cases as well to the site supervisor.

CRITERIA FOR MENTOR SELECTION

AGE OF MENTOR

FG 2 (3) Aai! Not my age. It could be like thirty or something. But not my mother. She my supervisor is like my mother.

EXPERIENCE

INT 2 you may be sitting in a profession for twenty years but you may not be doing the work they way you are suppose to do.

INT 1 Yes, counselling experience matters a lot if you are going to mentor counsellors.

FG 2 (5) But if she doesn't know your situation she won't be able to relate towards your counselling.

QUALIFICATION

INT 2 What matters more for me is the expertise or knowledge.

FG 2 (2) because a person that has tertiary experience they have gained more knowledge.

PERSONALITY

INT 2 Someone with a positive attitude about other people and someone who is warm and approachable

DIFFERENCES BETWEEN A SUPERVISOR AND A MENTOR

INT 1 Ja supervisor is traditional, you know the people that were, are always looking for the wrong.

INT 2 They should be two separate people. You will find that the sister in charge of the clinic is the supervisor.

FG 1 (1) I would see a supervisor set-up when you would have to follow that according to policy whereas a mentor, you discuss things together and you might not go along with the suggestion.

ASSESSMENT OF WORK

FG 1 (2) For my personal need I would rather have a mentor. I think by her guiding you she is indirectly assessing your needs but at the end of the day she is not going to say I get six out of ten. That I think is what a supervisor would do