

Experiences of lay counsellors who provide VCT for PMTCT of HIV and AIDS in the Capricorn district, Limpopo Province

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Human Immune Deficiency Virus (HIV) and Acquired Immune-Deficiency Syndrome (AIDS) still carry a stigma in the community. Many people do not know their status and they are still reluctant to be tested including pregnant women despite the fact that Voluntary Counselling and Testing (VCT) is offered for free in South Africa. In South Africa VCT for HIV and AIDS is offered by lay counsellors in public hospitals and clinics. The study conducted by Mate, Bennet, Mphatswe, Barker and Rollins (2009:5483) outlined that in South Africa the prevention of mother-to-child transmission (PMTCT) of HIV guidelines have raised hope that the national goal of reducing perinatal HIV transmission rates to less than 5% can be attained. A qualitative, exploratory, descriptive and contextual study was conducted in 15 public clinics of the Polokwane Municipality in the Capricorn District, Limpopo Province. The purpose of the study was to determine the experiences of the lay counsellors who provide VCT for the PMTCT of HIV and AIDS in the Capricorn District, Limpopo Province. Data were collected through one-to-one interviews using a semi-structured guide (De Vos et al, 2006:296). The findings of the study reflected the following: the content of training and counselling skills received by lay counsellors were satisfactory, there was lack of counsellor support and in-service education. A program for in-service education and support for all lay counsellors who have had VCT training should be conceptualised and implemented.

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Introduction and Background

The sub-Saharan Africa remains the most heavily affected region with HIV and AIDS infections worldwide. Sub-Saharan Africa accounted for 67% of all HIV and AIDS infections and 71% of all new infections in 2008 globally (UNAIDS & WHO, 2009:22). South Africa, has the highest number of HIV infected individuals, with about 5.3 to 5.5 million who represent a quarter of the burden of HIV infection in sub-Saharan Africa (Rehle, Hallet, Shisana, Pillay-van Wyk, Zuma, Carrara & Jooste, 2010:1 & Abdool Karim, Churchyard, Abdool Karim, Lawn 2009: 921).

Although the HIV test is free of charge in the public health centres of South Africa, only one person in five have tested for HIV and the majority of people are still reluctant to be tested. Many people are ignorant of their HIV status. A survey conducted in 2005 by the US Agency for International Development (USAID) in 12 high-burden countries with HIV/AIDS found that only 12% of men and 10% of women in the general population have both been tested for HIV and received their results (Bassett, Giddy, Wang, Losina, Freedberg & Walensky, 2008: 864). Approximately 40% of pregnant women in Africa are infected with HIV and without the antiretroviral intervention, between 21% -43% will transmit the infection to their babies during pregnancy, labour and delivery (Holmes, Preko, Bolds, Baidoo & Jolly, 2008:8). Mother-to-child transmission (MTCT) is the second most important route of HIV transmission in sub-Saharan Africa (Piot, Bartos, Ghys, Walker, Schwatlander, 2001: 68).

Before a client is tested for HIV, it is essential that s/he should be provided with pre-test counselling. If a client consents to testing, post-test counselling should be provided before the results are disclosed because those who test positive for HIV are bound to react with shock when they receive the results. Discovery of one's HIV-positive status is always a traumatic emotional experience (Granish & Mermin, 1999:91; Van Dyk, 2001:216; & Green & McGreaner, 1996:67). There is no cure for AIDS to date and this disease still carries a stigma in the community. There are very few people who have

the courage to publicly disclose their HIV status (Van Dyk, 2001:270). It is, therefore, necessary to provide counselling before and after a client is tested, and this can be a success provided the counsellors are provided with continued professional support towards the counselling duties that they perform. Although young women aged 15-24 years in South Africa continue to face the highest risk of HIV infection in the world, UNAIDS in Harrison, Newell, Imrie & Hoddinott, (2010:1471), the prevalence rate of HIV and AIDS among these women has declined between 2002-2005 and 2005-2008 (Rehle, Hallet, Shisana, Pillay-van Wyk, Zuma, Carrara & Jooste, 2010: 4).

Mother-to-child transmission (MTCT) is the second most important route of HIV transmission in sub-Saharan Africa (Holmes, Preko, Bolds, Baidoo & Jolly, 2008:1). A high percentage of infants are at high risk of being infected with HIV and AIDS. In sub-Saharan Africa over 90% of the 1.1 million children below 15 years of age were infected with the HIV in 2002 (Piot, Bartos, Ghys, Walker & Schwatlander, 2001:968). In South Africa, 69 000 infants (5.9%) were infected with HIV at birth and 20 000 (1.8%) were infected through breastfeeding in 2002 (Colvin, Chopra, Doherty, Jackson, Levin, Willumsen, Goga & Moodly, 2007:466). In response to the increased number of MTCT of HIV and AIDS, the National Department of Health in South Africa initiated an intervention program to prevent mother-to-child transmission (PMTCT) of HIV and AIDS in two pilot sites in each of the country's nine provinces in 2001 (Department of Health, 2001:10 & Colvin, Chopra, Doherty, Jackson, Levin, Willumsen, Goga & Moodly:2007, 466). Subsequently the programme has been initiated in all the public hospitals and clinics. This intervention project caters for all pregnant women who present at public hospitals and clinics for antenatal care. When pregnant women report for antenatal care at public clinics or hospitals, they are offered VCT for PMTCT of HIV and AIDS by trained lay counsellors. These lay counsellors are trained by non-governmental organisations in VCT for PMTCT of HIV and AIDS to work with professional nurses at the public hospitals and clinics. The lay counsellors provide counselling to clients and those who agree to be tested

are then tested by professional nurses (Department of Health, 2001:10). Lay counsellors are employees of non-governmental organisations, while professional nurses are employees of the Department of Health at provincial level (Verbal communication with VCT for HIV and AIDS Capricorn District Coordinator). It is therefore, essential that the counselling offered by the lay counsellors be regularly evaluated in order to check its effectiveness.

Studies evaluating VCT for HIV and AIDS have concentrated on attempting to prove that VCT reduces the incidence of HIV infection, its role in changing risky sexual behaviour, whether counselled people come back for the results and the rate of attendance (Allen, Serufilira & Bogaerts, 1998:3338).

This study aims to explore and describe the experiences of lay counsellors in their counselling work, assess the content of the training received by lay counsellors and explore how counsellors view and cope with their counselling work. The quality of counselling provided by the counsellors determines the outcome. Poor quality counselling, for instance, could result in misunderstanding and even resistance to behaviour change. It appears that poor counselling is not uncommon.

Problem statement

In spite of the conscientious efforts by the Department of Health, Welfare and Social Development (Limpopo Province) to make health care facilities and services accessible to the majority of people, even in the under-resourced areas, the high rate of MTCT of HIV is still a major public health concern in the province. Lay counsellors play an important role in motivating clients to test, comply with taking nevirapine and bringing children for testing after delivery. This study focused on the experiences of lay counsellors with regard to VCT for PMTCT of HIV and AIDS which they provide to pregnant women. It was motivated by the intention of the researcher to explore the reasons for the alarming increase in the rate of MTCT of HIV in the province. There was a need to explore and describe the content and quality of training received by the lay counsellors and their experiences in the counselling work.

Research questions

The following research questions were formulated to delineate the focus and to explore the problem in detail:

- What are the experiences of lay counsellors who provide VCT for PMTCT of HIV and AIDS in the public clinics of the Polokwane Municipality in the Capricorn District, Limpopo Province?
- Do lay counsellors receive continuous support throughout their career after receiving VCT for PMTCT of HIV and AIDS training?

Objectives

The objectives of the study were to:

- Explore and describe the experiences of the lay counsellors who provide voluntary counselling for PMTCT of HIV and AIDS in the public clinics of the Polokwane Municipality in the Capricorn District, Limpopo Province;
- Explore the continuous support provided to lay counsellors after receiving VCT for PMTCT of HIV and AIDS training.

Methodology

A qualitative research method was used in this study in order for the researchers to explore and describe the experiences of the lay counsellors who provide voluntary counselling for the PMTCT of HIV and AIDS to pregnant women at the public clinics in the Polokwane Municipality of Capricorn District, Limpopo Province. Straus and Corbin (1990:15) report that qualitative research is concerned with the understanding of human beings and the nature of their interactions with other humans and with the surroundings resulting in new discoveries, insights and meanings.

Research design

In this study a qualitative, descriptive, exploratory and contextual design was used.

Descriptive design

A qualitative descriptive design was used to obtain complete and accurate information about the lived experiences

of the lay counsellors with regard to the phenomenon under study (Denzin & Lincoln, 2000:489). This design also enabled the counsellors to describe the in-service education and support which they receive after being trained in providing VCT for PMTCT of HIV and AIDS. Descriptive research provides an accurate portrayal or account of the characteristics of a particular individual, situation or group (Mouton & Marais, 1991:43). Furthermore the data that materialises from a qualitative study is descriptive because the researchers were interested in processing the meaning of and understanding data as described by the participants.

Exploratory design

The exploratory design was used in this study to gain insight in and an understanding of the phenomenon of voluntary counselling for PMTCT of HIV and AIDS that lay counsellors provide to pregnant women. The aim of the exploratory research is to establish the facts, to gather new data, to determine whether there are new patterns in the data and to gain new insights into the phenomena (Mouton, 1996:103; De Vos et al, 1998:24) and to explore the type of VCT for the PMTCT of HIV and AIDS training received by lay counsellors. Furthermore, the exploratory design assisted the researchers to ask probing questions based on the interview guide questions set prior the interview sessions to explore the experiences of the lay counsellors with regard to the in-service education and continuous support provided to lay counsellors after receiving VCT for PMTCT of HIV and AIDS.

Contextual research design

The researchers aimed at understanding the phenomenon which was studied as described by the participants in their lived world (Brink, 2006:113; Babbie & Mouton, 2001:272).

Population

A population is a complete set of persons or objects that possess some common characteristics that are of interest to the researcher (Brink, 1996:113). The population consisted of all the public clinics and all the lay counsellors working in the same clinics in the Polokwane Municipality of the Capricorn District, Limpopo Province.

Sampling

The Capricorn District has five municipalities namely Blouberg, Lepelle-Nkumpi, Aganang, Molemole and Polokwane. The Polokwane Municipality which has the most clinics (30) was chosen. As these clinics were many, there was a need to further delimit the population and so a random sample of fifteen (15) clinics was selected.

All the 15 clinics had one lay counsellor except for two clinics which had two. Where there were two counsellors a random sampling technique was used to select one. Fifteen lay counsellors were interviewed using semi-structured one-to-one interview guide until data saturation was reached.

All the lay counsellors had undergone the experience of being trained to become counsellors, have been counselling clients, have received in-service training and continuous support in their counselling work.

Data collection method

Semi-structured one-to-one interviews were conducted to explore and describe the experiences of the lay counsellors with regard to VCT for PMTCT of HIV and AIDS which they provide to pregnant women at public clinics (Babbie & Mouton, 2001:274 & De Vos et al, 2006:292). The central question that was posed to each participant in the same manner was:

"Can you describe the VCT for PMTCT of HIV and AIDS that you provide to the pregnant women?"

Probing followed after each participant responded to the central question until data saturation was reached (De Vos et al, 2006:290). Field notes were written on the pad to note verbal and non-verbal cues of the participants. A voice tape recorder was also used to capture all the individual interviews conducted.

Data analysis

Data that had been collected from the semi-structured one-to-one interviews using a voice tape recorder was listened to and transcribed verbatim. The aim of data analysis was to produce a detailed and systematic recording of issues that were addressed during unstructured one-to-one in-depth interviews (Burnard & Morrison, 1994:462). The categories and sub-categories

were systematically identified as based on Tesch's method of qualitative analysis (De Vos et al, 1998: 343).

Trustworthiness

The researchers adopted various strategies to ensure trustworthiness of data as suggested by Lincoln and Guba (1985:290) and Krefting (1991:214) models concentration on the following criteria: credibility, dependability, confirmability and transferability.

Credibility

Credibility was ensured through prolonged engagement in the study field with the participants so as to capture the realities of the study. Follow-up interviews sessions were conducted to verify that participants still responded in the same way as compared to the first interview session. Triangulation of data collection methods were insured by capturing field notes and usage of voice recorder in all unstructured interview sessions (Babbie & Mouton, 2001:276). The research proposal, the field notes and the tape recordings of all the interview proceedings were given to an independent coder to analyse and allocate categories and sub-categories independently. The researchers and the independent coder met and reached an agreement on the categories and sub-categories identified independently from the collected data (Babbie & Mouton, 2001:277).

Dependability

Dependability was ensured by thick description of the research method used in the study to enhance the possibility of repeating the study by another researcher. The concept of dependability refers to the consistency of research findings in a qualitative study (Babbie & Mouton, 2001:277; & Holloway & Wheeler, 2002:254).

Confirmability

Confirmability was ensured by sending the copies of the verbatim transcripts, field notes and protocol to an independent coder for analysis. The findings of this research are the product of an inquiry and not the researcher's bias (De Vos et al, 1998:351; Babbie & Mouton, 2001: 278). Written field notes and the use of a voice recorder supported the semi-structured one-to-one interviews during which data have

been collected from the participants themselves (De Vos et al, 2006: 346).

Transferability

Transferability refers to the extent to which the findings of the study can be applied in other contexts or with other respondents (Babbie & Mouton, 2001:277). Purposive sampling was used to select the lay counsellors and the research method and the design were fully described.

Ethical considerations

Ethical standards, as outlined by DENOSA position statements (1998:2.3.2), were used in this study. All participants signed an informed consent form before they could participate in the study. The purpose of the study was explained to each participant before commencing with the unstructured interview sessions. The researcher obtained permission to conduct the study from the University of Limpopo Ethics Committee, Limpopo Province Department of Health and Social Development and the supervisors of the clinics. The participants were requested to read and sign the consent form if they agree to participate in the study and interviews were conducted in a private room away from distractions.

The participants were made aware that they were not forced to answer any questions if they felt the questions violated their privacy and they can withdraw from participating without penalty. The participants were informed that field notes would be written and that a tape recorder would be used during interviews to capture the proceedings of the interview sessions. The clinics and the participants were allocated numbers and their real names were not used to ensure confidentiality and anonymity in the entire research project.

Results and discussions

The following categories and sub-categories emerged during data analysis using Tech's open coding method of data analysis as described in De Vos et al (1998: 343). A narrative account of the categories and sub-categories, supported by direct quotes from participants are presented below. The direct quotes from participants are presented in italic writing and represent the experiences of the participants.

Category 1 : Training Benefits

Counsellors who offer VCT for PMTCT of HIV and AIDS should first undergo a 10-day training course on VCT and shortly thereafter a 5-day course on VCT for PMTCT of HIV and AIDS. On analyzing the data on training benefits, 5 sub-categories emerged:

Sub-category 1.1: Myths Reversed

The study results revealed that lay counsellors, after they have attended the VCT for PMTCT training course they acquire factual knowledge which help in clearing the myths that they do have with regard to HIV and AIDS. A lay counsellor confirmed by indicating that *"Training helped me learn that if someone is HIV-positive it doesn't mean that the person was promiscuous."* Human Immune-Deficiency Virus and Acquired Immune-Deficiency Syndrome is not only transmitted through sexual intercourse, but it can be transmitted by health care workers if they use contaminated needles and syringes when administering injections to patients. Coming into contact with contaminated blood through an open wound is another mode of HIV and AIDS transmission (Evian, 2003:15; Van Dyk, 2001:25; White, Ben, Kedhar, Orroth, Biraro, Baggaley, Whitworth, Korenromp, Ghani, Boily & Hayes, 2007:9798; & Ward, 1999:35).

Sub-category 1.2: Learning Curve

When someone attends a training course, there are new important things that are learned and learning new things is always challenging. The learning experienced by the participants were expressed in the following statements by counsellors in clinic one and two respectively: *"The importance of antenatal care visits to pregnant women."* *"Learning about ARVs, nevirapine and counselling skills was challenging."*

Sub-category 1.3: Respect

One of the qualities of an effective counsellor is to respect the counselees. Clients who are counselled should be respected and be addressed by their names (Du Toit, Grobler & Schenck, 1998:77; Van Dyk, 2001: 211 & Hamilton & Dinat, 2006:37). From the statement made by the counsellor in clinic three, it is evident that the facilitators taught the counsellors to be respectful. Lay counsellors in clinic one and

Table 1: Categories and Sub-categories

CATEGORIES	SUB-CATEGORIES
1: TRAINING BENEFITS	1.1: Myths Reversed 1.2: Learning Curve 1.3: Respect 1.4: Practical Skills 1.5: Theoretical Knowledge
2: THERAPEUTIC ATTITUDE DEVELOPMENT	2.1: Therapeutic Skills Development
3: CONTENT OF TRAINING	3.1: Acceptance and Living with HIV 3.2: Dietary Counselling 3.3: Prevention of Further Infection 3.4: Communicating Professionally with Clients 3.5: Adherence to Counselling and Treatment
4: PERCEIVED TRAINING SHORTCOMINGS	4.1: Insufficient Information and Clarification on Some Aspects 4.2: Lack of Information by Some Facilitators 4.3: Time Limitation
5: ADDITIONAL TRAINING NEEDS	5.1: Anti-Retroviral Therapy and Performing the Rapid HIV Test 5.2: Couple Counselling 5.3: Starting Support Groups
6: BENEFITS OF COUNSELLOR SUPPORT GROUP	6.1: Stress Reduction 6.2: Opportunity for Debriefing and Supervision 6.3: Evaluation of Own Counselling Work
7: LAY COUNSELLORS' EVALUATION OF THEIR COUNSELLING WORK	7.1: Esteemed, Appreciated and Alluding to Burnout 7.2: Expression of Job Satisfaction 7.3: Experiencing Stress 8.3: Expression of Altruism
8: RATINGS OF THE LAY COUNSELLORS BY CLIENTS AND NURSES	8.1: Feeling esteemed and appreciated 8.2: Ability to Establish Trust 8.3: Respect and Value 8.4: Negative Attitudes Displayed Towards Trained Lay Counsellors

two indicated that : *“They taught us to respect clients and even other counsellors.”*

Sub-category 1.4: Practical Skills

Counselling is a very practical skill and should ideally be taught using demonstrations and simulations of different practical situations. Lay counsellor in clinic one: *“Facilitators were good at demonstrations and they simulated all situations of counselling and this helped me to understand better.”*

Sub-category 1.5: Theoretical Knowledge

The facilitators did not only display

practical skills, they were also knowledgeable in theoretical issues regarding VCT for PMTCT of HIV and AIDS as expressed by a respondent in clinic 13 in the following statement: *“The trainers were experts and had enough and recent knowledge about HIV and AIDS to impart.”*

Category 2 : Therapeutic attitude development

The attitudes of the counsellors have to be observed because it has an impact for counselling to be successful. Counsellors are human beings, but once they decide on becoming counsellors their attitudes towards the

counselees need to be therapeutic because clients who are counselled are usually hurt or they have to deal with a hurting situation.

Sub-category 2.1: Therapeutic Skills Development

The therapeutic skills such as self-awareness, empathy, being supportive to the clients and positive living, which emerged from the counselling training received by the lay counsellors, concur with those discussed by Hamilton and Dinat (2006:38). Lay counsellors in clinic nine, seven, six, ten and 11 respectively: *“We learned to discover ourselves before becoming counsel-*

lors.” (Self-awareness). “The facilitator treated us well in order for us to learn to treat clients well.” (Exemplary). “We were taught to empathise with the clients.” (Empathy). “We learned and changed our attitude towards HIV-positive people and to regard HIV and AIDS to be like any other disease.” (Positive living).

Category 3 : Content of training

When counsellors were asked to describe the content of the counselling information which they have received, the following sub-categories emerged: acceptance and living with HIV, dietary counselling, prevention of further infection, communicating professionally with clients, motivating clients to adhere to counselling and treatment disclosure of HIV status, ongoing counselling, imparting knowledge and nevirapine administration.

The content of the training received by counsellors was captured in the sub-categories presented here as follows:

Sub-category 3.1: Acceptance and Living with HIV

This principle was well understood by the lay counsellors as subsequently stated by lay counsellors in clinic 13 and one respectively: “We learned to accept that HIV-positive persons are still human beings. We also learned how to counsel HIV-positive people to live positively with the virus.”

Sub-category 3.2: Dietary Counselling

Breastfeeding remains an important route of acquisition of HIV infection in infants. An estimated 630 000-820 000 infants were newly infected with HIV and 280 000- 360 000 were infected through breastfeeding in 2001(Coovadia, Rollins, Bland, Little, Coutoudis, Bennish & Newell, 2007: 1110; Coutoudis, Pillay, Kuhn, Spooner, Tsai & Coovadia, 2001: 381). To prevent MTCT of HIV through breast feeding HIV-positive mothers should be counselled on feeding options (Liiff, Piwoz, Tavengwa, Zunguza, Marinda, Nathoo, Moulton, Ward, & Humphrey, 2005: 701). Lay counsellor in clinic four: “I have learnt how to counsel mothers about feeding methods to PMTCT of HIV to their babies.”

Sub-category 3.3: Prevention of Further Infection

To prevent re-infection condom use by

the couple is recommended. Information on re-infection should be included when counselling a couple who are both HIV-positive (John, Carey, Kiarie, Kabura & John-Steward 2008:408). Lay counsellor in clinic nine: “I learned how to counsel clients regarding the use of a condom when the couple are both HIV-positive.”

Sub-category 3.4: Communicating Professionally with Clients

Counselling is conversation between the counsellor and the client and the counsellor needs to acquire certain communication skills Egan, 1998 quoted by (Van Dyk, 2001:214) and (Hamilton & Dinat, 2006:38). Lay counsellor in clinic eight: “I have learnt counselling skills such as respect, empathy confidentiality, approach, being non-judgemental, listening, history taking, answering questions and not to decide for clients.”

Sub-category 3.5: Adherence to Counselling and Treatment

Lay counsellor in clinic 14: “I have learnt to inform clients to adhere to on-going counselling, taking of nevirapine, giving nevirapine to the newborn baby within 72 hours after delivery.” Administration of nevirapine forms part of the information which should be included when providing VCT for PMTCT of HIV and AIDS (Department of Health, 2001:14).

Category 4 : Perceived training shortcomings

VCT Training was done by facilitators. Shortcomings were identified under the following sub-categories: insufficient information and clarification on some aspects, lack of information by some facilitators time limitation, superficial information and the attitude of some facilitators.

Sub-category 4.1: Insufficient Information and Clarification on Some Aspects

The shortcomings are highlighted in the statements they made: Lay counsellor in clinic nine “The information we have on the Rapid Testing Kit is insufficient”. “We do not have sufficient information to explain why in some cases one partner may test negative whereas the other may test positive. During training we were not

given sufficient information on the different types with regard to HI Virus 1 and HI Virus 2 and ARV's. Which ARV's drugs can be taken during pregnancy and which ones may not.”

Sub-category 4.2: Lack of Information by Some Facilitators

According to the lay counsellors, some of the facilitators appeared to lack information on certain aspects as expressed by the respondents in the statements below. Lay counsellor in clinic seven: “Some facilitators could not explain how MTCT of HIV and AIDS occurs during birth.”

Sub-category 4.3: Time Limitation

According to the lay counsellors the training period of five days on VCT for PMTCT was rather too short as expressed in the statement: Lay counsellor in clinic two: “The time was too little to learn all that I need to know about VCT for PMTCT of HIV and AIDS.” Although the respondents felt that the counselling training period was limited, it does not differ with what is regarded as the norm for the duration which training of lay counsellors should take. Hamilton and Dinat (2006:36) maintain that counselling may be practiced by lay people who do not necessarily have a formal background of psychology and the duration of their training could last 5-10 days.

Category 5 : Additional training needs

The lay counsellors were asked to identify the areas in which they felt they needed more training. The following sub-categories emerged from their responses: anti-retroviral therapy, rapid test, couple counselling and support groups.

Sub-category 5.1: Anti-Retroviral Therapy and Performing the Rapid HIV Test

Lay counsellor in clinic 13: “I need more training about the ARV's and how to prick and perform the Rapid HIV Test because registered nurses are too busy and clients are made to wait long to be tested.”

Lay counsellors cannot be trained in the administration of ARV's and performing of the HIV test because they do not have the medical background and are not registered with any profes-

sional council. To perform the rapid HIV and AIDS test, a finger is pricked to obtain a drop of blood. According to the Government Gazette, 5 January 2007, in the case of a finger prick for the withdrawal of blood for testing, only persons registered in terms of the Health Professional Act (Act 56 of 1974) as medical practitioners or Nursing Act, 2005 (Act No. 33 of 2005) as nurses or any person who has been trained to perform such a procedure.

Sub-category 5.2: Couple Counselling

Lay counsellor in clinic 11: *"Some women come with their partners and I need training on couples counselling and I need proper skills to deal with that."*

Sub-category 5.3: Starting Support Groups

The need to establish support groups to meet the needs of persons living with HIV/AIDS in every community is significant hence the need by counsellors to be trained in establishing support groups. Lay counsellor in clinic 11: *"I need more training on how to start a support group."*

Category 6 : Benefits of counsellor support group

There was no counsellor support groups formed in all the VCT sites. The counsellors felt that they needed to have such support groups. The lay counsellors were asked to describe how the counsellor support groups would benefit them. The following sub-categories emerged.

Sub-category 6.1: Stress Reduction

Lay counsellors perceived that counsellor support group could benefit them by reducing stress.

Lay counsellor in clinic eight: *"In the group we can share problems we encountered at work, learn new ways of counselling clients, have a chance to ventilate our feelings and talk about salary problems especially unpaid salaries."*

Sub-category 6.2: Opportunity for Debriefing and Supervision

Lay counsellor in clinic 14: *"Here we can get courage to go on. This can be a good place for refreshing our minds. We can correct the wrong things we*

do when counselling."

Sub-category 6.3: Evaluation of Own Counselling Work

Lay counsellor in clinic 12: *"This is the opportunity to evaluate how one is progressing with PMTCT counselling."* From the information provided above, it is evident that follow-up training is very crucial for the lay counsellors if they are to perform their work efficiently. It is interesting to note that follow-up training is regarded by lay counsellors as a platform for dialogue and an opportunity for debriefing.

Category 7 : Lay counsellors' evaluation of their counselling work

Counsellors were asked to evaluate their counselling work to establish how they felt about it. They also had to indicate whether they experienced burnout. The following sub-categories emerged, and were supported by the statements uttered by the respondents:

Sub-category 7.1: Esteemed, Appreciated and Alluding to Burnout

Lay counsellors in Zambia were confident in their counselling skills and found their work to be rewarding (Sanjana, Torpey, Scharzwalder, Simumba, Kasonde, Nyirenda, Kapanda, Kakungu-Simpungwe, Kabaso & Thompson, 2009: 1481).

The lay counsellors were also interested in future training and continuing in what was considered a professional field, including obtaining advanced certificates and degrees. Lay counsellor in clinic nine: *"I feel very happy when my clients cooperate and come back for more counselling. I feel very good even though I have too much work. I feel I need to study psychology to become a psychologist because I fear that my job may end at any time because I am on a contract."*

Sub-category 7.2: Expression of Job Satisfaction

The lay counsellors enjoyed and found their work meaningful and important because they regarded it as helping fellow community members to cope with their HIV-positive status. Lay counsellor in clinic five: *"I feel happy because I am assisting the nation."*

Sub-category 7.3: Experiencing

Stress

Working with HIV/AIDS clients places a considerable amount of emotional strain on caregivers (Dageid, Sedumedi & Duckert, 2007).

Lay counsellor in clinic two: *"It stresses me when a large number of clients test HIV-positive."* The lay counsellors were also stressed by the fact that they were not permanently employed. *"I feel happy but I need to be permanently employed."*

Sub-category 7.4: Expression of Altruism

Lay counsellor in clinic 13: *"I care for HIV-positive clients because I have one at home."*

Category 8 : Ratings of the lay counsellors by clients and nurses

The counsellors were asked to describe how they think they were rated by their clients whom they counselled.

Sub-category 8.1: Feeling Esteemed and Appreciated

Lay counsellor in clinic ten: *"After counselling, many clients they phone me and express their appreciation. HIV-positive mothers are thankful because their babies are negative."*

Sub-category 8.2: Ability to Establish Trust

Lay counsellor in clinic ten: *"When I am on leave, clients will rather wait for me than go to another counsellor."* It is good for counsellors to feel valued by their clients because they have to provide a service to them. Feeling appreciated by their clients will keep the lay counsellors motivated and dedicated to their work. The researcher is, however, concerned that the client's opportunity to receive treatment is delayed because the preferred counsellor is not available. It becomes a public health concern that the client may miss an opportunity to get emergency help, thus reducing her chances of benefiting from the service.

To attain a comprehensive perspective on how they felt about their work, counsellors were also asked to describe how they think they were rated by the nurses they worked with. They had mixed feelings about how they thought they were rated by the nurses as stated in the sub-categories supported by their state-

ments.

Sub-category 8.3: Respect and Value
Lay counsellor in clinic one: *"They never disturb me when I am busy in a counselling session. They consult with me and involve me in all decisions. When I am day off they give me a full report of what happened in my absence."*

Sub-category 8.4: Negative Attitudes Displayed Towards Trained Lay Counsellors
Although the majority of nurses appreciated lay counsellors as members of the team, some nurses, however, were not so appreciative, as demonstrated in the statement below: Lay counsellor in clinic one and two: *"I feel good but I am stressed by the nurses who look down upon us. "Some nurses look down upon me".*

Conclusion and recommendations

The content of the training received by the lay counsellors appears to be comprehensive. They elaborated with ease about the content, the therapeutic skills and the counselling skills they have received. Although the lay counsellors mentioned what they perceived to be shortcomings in their training, it was observed that most of what were regarded as shortcomings were skills that were above their scope of practice because they were not trained medical professionals.

It is recommended that the registered nurses should explain to the lay counsellors about the scope of practice of the different health professionals and that to perform certain duties, accountability is required and one has to undergo education and training.

There were no counsellor support groups formed in the VCT sites and lay counsellors felt that they needed to have such groups. The support groups are seen as a platform where they could have a chance to ventilate their feelings, give each other support and assist one another and even talk about their unpaid salaries. It is recommended that counsellor support groups be formed in all the sites as counselling is a very stressful work especially when clients test HIV-positive.

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