Reflections on the training of counsellors in motivational interviewing for programmes for the prevention of mother to child transmission of HIV in sub-Saharan Africa

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Abstract

Introduction: Within the Southern African prevention of mother to child transmission (PMTCT) programmes, counsellors talk with pregnant mothers about a number of interrelated decisions and behaviour changes. Current counselling has been characterised as ineffective in eliciting behaviour change and as adopting a predominantly informational and directive approach. Motivational interviewing (MI) was chosen as a more appropriate approach to guide mothers in these difficult decisions, as it is designed for conversations about behaviour change. MI has not previously been attempted in this context. This paper reflects on how MI can be incorporated successfully into PMTCT counselling and what lessons can be learnt regarding how to conduct training with counsellors.

Methods: Thirty-eight lay and nurse counsellors at four sites in Southern Africa were trained in MI. After the initial training, they participated in a five-month inquiry group at each site, where an action researcher (AR) facilitated ongoing learning of new counselling skills and reflection. Transcripts of recorded counselling sessions were then analysed using the motivational interviewing treatment integrity (MITI) code to assess their skills in MI. The MITI analysis was discussed with the action researchers and a consensus was reached on how to improve training.

Results: Overall, the counsellors showed a global rating score of four out of seven, a reflection-to-question ratio of 0, a 43% open question score, an 18% complex reflection score and a 58% MI-adherent score. There were significant differences between the sites and between nurses and lay counsellors ($p < 0.05$). The action researchers suggested that the following factors were important in enabling learning and change: assessment of the baseline level of skills and readiness to change, reflection on real consultations, differences between the ARs and counsellors, a focus on the overall spirit of MI versus technical skills, the approach to information giving, managerial support and an appreciative versus a critical facilitation style.

Conclusion: Nurse counsellors in Namibia and Swaziland demonstrated beginning proficiency in MI, while lay counsellors in South Africa did not. From the dialogue with the action researchers, nine recommendations were made to guide the development of future training programmes.

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Introduction

In South Africa, one in three pregnant women is HIV positive and regional prevalence rates range from 16% of the adult population in Mozambique to 33% in Botswana.[1] One of the Millennium Development Goals is to halt and start reversing the global AIDS pandemic by 2015. In pursuit of this goal, pregnant mothers are enrolled in the prevention of mother to child transmission (PMTCT) programme. Without intervention, up to 36% of infants will be born HIV positive and breast-feeding is the most likely mode of transmission.[2] Within PMTCT programmes in South Africa, Namibia and Swaziland, counsellors talk with mothers about a number of interrelated decisions, such as whether to be tested for HIV and to take antiretroviral medication, how to disclose the results to family members, how to negotiate safer sex and how to feed their newborn infant. Both lay people and nurses are employed as counsellors.

Current counselling in the PMTCT programme has been characterised as ineffective in eliciting behaviour change and as adopting an informational or directive approach.[3,4,5] An informational approach involves the delivery of predetermined packages of information with a belief that educating the client will lead to the desired decisions and behaviour change. A directive approach assumes that the counsellors will use their authority to tell the clients what they should do and what would be best for them. Unfortunately, there is little relationship between acquiring information and behaviour change,[6] and a prescriptive style is likely to elicit passivity, overt resistance or superficial agreement from the client.[7]

Motivational interviewing (MI) is theoretically a more useful approach to helping mothers with these difficult decisions, as it is designed for conversations about behaviour change.[8] MI adopts a different way of being with the client, which is based on collaboration, evocation and respect for autonomy.[6] There have been a number of studies, mostly from developed countries, on the use of MI in an HIV context that support its potential to improve health risk behaviours and adherence to antiretroviral therapy[9,10] However, no studies were found using MI specifically in the context of the PMTCT programme.

This article presents part of the Infant Feeding Research Project (IFRP) [11], which aims to develop and assess a new PMTCT counselling format with associated training for counsellors and trainers. The IFRP is committed to the development of a more effective approach to PMTCT counselling that incorporates both MI and woman-centredness.[11]

The Medical Research Council has described the steps for developing such complex health interventions, namely exploring the relevant theory, modelling the new approach, and subsequently evaluating it in an exploratory trial.[12] This article reflects on only one aspect of the modelling step, namely how successful the PMTCT counsellors were in integrating MI skills into actual counselling sessions and what lessons can be learnt regarding how to conduct training.

Table I: Description of action researchers and counsellors

	Stellenbosch, South Africa	Eshowe, South Africa	Mbabane, Swaziland	Oshakati, Namibia	Total
	34-year-old Indian female with tertiary education and English as first language. Five-day training in MI.	43-year-old white male, general practitioner, with English as first language. Training in MI as part of an MMed programme.	41-year-old black female with nursing background and Swati as first language. Five-day training in MI.	50-year-old black female with nursing background and Oshiwambo as first language. Five-day training in MI.	
Action researcher					
Counsellors					
Age					
20–29 years	4	2	1	0	**7**
30–39 years	4	4	3	2	**13**
40–49 years	6	0	4	3	**13**
50–59 years	1	0	0	2	**3**
> 60 years	0	2	0	0	**2**
Sex					
Male	3	1	0	0	**4**
Female	12	7	8	7	**34**
Race					
Black	8	8	8	7	**31**
White	3	0	0	0	**3**
Coloured	4	0	0	0	**4**
Education					
Lay person with less than matric	1	0	0	0	**1**
Lay person with matric (high school)	5	6	0	0	**11**
Lay person with higher than matric	6	0	0	0	**6**
Nurse/other health professional	3	2	8	7	**20**
First language					
English	1	0	0	0	**1**
Afrikaans	6	0	0	0	**6**
Xhosa	8	0	0	0	**8**
Oshiwambo	0	0	0	7	**7**
Swati	0	0	8	0	**8**
Zulu	0	8	0	0	**8**
Total number of counsellors	**15**	**8**	**8**	**7**	**38**

Methods

Action research was chosen as the most appropriate method for developing and refining a model of PMTCT counselling that incorporated motivational interviewing. After initial training, counsellors would be able to use the new approach in PMTCT settings and simultaneously reflect on their experiences and adapt the model to their context and tasks.

Nurse and lay PMTCT counsellors from four sites in Southern Africa (see Table I) participated in the study. An action researcher was appointed at each site to train the counsellors, as well as to facilitate and document the action-reflection process. None of the counsellors had previously been exposed to motivational interviewing. Ethical approval for the study was obtained from the University of Cape Town in South Africa.

The study aimed to train 38 PMTCT counsellors in an approach that was aligned with the key principles of MI (see Box 1). The specific tasks and skills of MI behaviour change counselling are described in detail elsewhere.[7,8,13]

Box 1: Key principles of motivational interviewing

Collaborative
A partnership that recognises and respects the woman's expertise in and perspectives on her own 'reality' and what will work for her. It also recognises the counsellor's expertise in highlighting important topics, guiding an informed decision and sharing appropriate information. The counsellor avoids forcing her own perspective on the mother through adopting an 'expert stance' that may be unrealistic or unfeasible for this particular person.

Evocative
The counsellor should genuinely hold a vision that change is possible and that the mother is able to take decisions to achieve her goal of 'saving her baby' and to promote her own future. The mother's own dreams, goals and values should be explored, as any discrepancy between these and her current behaviour may evoke her motivation to change. The counsellor therefore evokes or 'draws out' of the mother her own motivation to change and avoids arguing with her or confronting her with the counsellor's rationale for why she must change.

Respectful of autonomy
The counsellor knows that responsibility for change is always in the hands of the mother and respects the mother's right to make the best informed decisions for her own life and situation. The counsellor may guide the mother in the decision-making process by providing structure and building self-awareness, but avoids persuading or even coercing the mother into solutions that the counsellor believes are 'right'.

The action researchers were trained by experts from the Motivational Interviewing International Network of Trainers. The counsellors were initially trained during three-day workshops that offered a theoretical understanding of MI, demonstrations and the simulation of skills within role-play situations. Initial training was performed by the action researchers and a recognised expert from the United States.

The counsellors at each site then participated in an ongoing inquiry group,[14] facilitated by the action researcher. Action researchers were encouraged to adopt an appreciative rather than overly critical facilitation style,[15] to listen and be open to different perspectives, and to foster a sense of curiosity and experimentation and collaborative ownership of the process among all members of the group. The groups met monthly over a period of five months, reflecting on the counsellor's experience of using MI and consolidating their learning through the use of further simulation and feedback. The four action researchers also met regularly and reflected critically with the principal investigators of the IFRP.

At the end of the five months, 24 of the 38 counsellors also submitted audio-tapes of at least one counselling session. All the submitted tapes were translated from Zulu, Xhosa, Oshiwambo, Afrikaans or Swati into English. The translation was organised and checked by the action researchers. The transcriptions were subsequently analysed by the first author, who had been trained in the use of the motivational interviewing treatment integrity (MITI) code. The MITI is a validated tool for assessing competence in MI.[16] The purpose of this was to give the inquiry groups some more objective measurement of how successfully MI had been incorporated into the counselling sessions. The action researchers, together with the principal investigators, reflected on the results of the MITI, as well as on their collective learning from the five-month inquiry groups, to reach a final consensus.

In MITI, an utterance is defined as a "complete thought" and therefore a sentence may be coded for more than one utterance. Each utterance can be coded once, according to whether it is MI adherent/non-adherent, an open/closed question, a simple/complex reflective listening statement, or just sharing information. The number of times a code occurs in a given transcript can be counted and the totals can be

Table II: Definitions and interpretations of MITI scores

Behaviour count or summary score thresholds	Beginning proficiency	Competency
Global Therapist Ratings: The global rating assesses the overall spirit of MI in the session by paying attention to the degree of collaboration, evocation and respect for autonomy and rating this from 1 (low) to 7 (high). In addition, a global rating from 1 to 7 is also given for the degree of empathy, which is defined as the extent to which the counsellor attempts to understand the client's perspective. The average of these two ratings is then taken.	5	6
Reflection to Question Ratio (R: Q): The ratio of the number of reflective statements to the number of questions.	1	2
Per cent Open Questions (%OC): The percentage of all questions (open or closed) that are open.	50%	70%
Per cent Complex Reflections (%CR): Percentage of all reflective listening statements (simple or complex) that are complex. Simple reflections typically convey understanding or facilitate client/therapist exchanges. These reflections add little or no meaning (or emphasis) to what the clients have said. Complex reflections typically add substantial meaning or emphasis to what the client has said.	40%	50%
Per cent MI-Adherent (% MIA): MI-adherent utterances are those that ask permission to discuss a specific behaviour, affirm the client's self-efficacy or offer appropriate support for the client's efforts to engage with the topic. MI non-adherent utterances are those that prescribe solutions in the form of advice, confront the client in a blaming or judgemental way or direct the client as to what they 'must do'. This gives the percentage of all MI-adherent and non-adherent statements that were adherent.	90%	100%

Table III: Results of MITI analysis

Criteria	All sites	Eshowe, South Africa	Oshakati, Namibia	Stellenbosch, South Africa	Mbabane, Swaziland	Lay counsellors	Nurse counsellors
Total number of counsellors	38	8	7	15	8	18	20
Number of counsellors coded	24	5	4	8	7	11	13
Number of coded utterances	1614	208	192	561	653	655	918
Global rating –empathy[a,b]	4.3	3.3	5.8	2.8	5.8	2.8	5.4
Global rating – spirit[a,b]	4.3	3.8	5.8	2.8	5.7	2.9	5.4
Reflection to question ratio[a,b]	0	0	1	0	1	0	0
Per cent open questions[b]	43	37	58	35	48	32	50
Per cent complex reflections[a,b]	18	17	18	11	27	12	22
Per cent MI-adherent[a,b]	58	57	96	19	85	22	86
Per cent giving information[b]	31	46	27	35	20	38	25

[a] = $p < 0.05$ for comparison between sites [b] = $p < 0.05$ for comparison between lay and nurse counsellors.

used to calculate a number of summary scores, which are interpreted in terms of either beginning proficiency or competence in MI (see Table II). Global ratings of empathy and the spirit of MI are also made using a seven-point Likert scale.

As the information giving was thought to be an over-emphasised characteristic of existing PMTCT counselling, an additional summary score was created that calculated the percentage of all utterances that gave information. Although not part of the usual MITI, this would give an indication of the amount of time spent giving information.

Results

The MITI results are summarised in Table III and the reflections of the action researchers are presented below as a series of themes. None of the groups achieved proficiency in the use of complex reflections. The counsellors in Namibia achieved beginning proficiency in all the other MITI criteria, and the counsellors in Swaziland followed a similar pattern, although they were just below the thresholds required for the use of open questions and MI-adherent behaviour counts. The nurse counsellors as a group also achieved borderline proficiency, with sub-threshold scores for the reflection-to-question ratio and MI-adherent behaviour counts. The counsellors in Stellenbosch and Eshowe and the lay counsellors did not achieve beginning proficiency in any of the criteria.

Differences in terms of the baseline level of skill

At the beginning, the lay counsellors had fewer basic communication skills and relevant medical knowledge than the nurses. More time was necessary within the initial training to focus on the basic communication skills, which form the foundation for MI – for example, how to organise the room or how to formulate an open question. Starting from a lower baseline, the lay counsellors may have improved significantly, but not to the point at which they achieved proficiency in MI according to the MITI:

"The ongoing training and action reflection process focused on a lot of really basic information as I was addressing [lay] counsellor needs, for example, they required more PMTCT information, they didn't know how to sit with client…" (Stellenbosch site)

"I was not at all surprised at the fact that my counsellors did not score too well using MITI. I feel that what we have accomplished in getting them to even be slightly adherent is something. If you will recall during the first training workshop it was clear that they were acting as health educators and there was little if any counselling happening. The fact that we are getting reflections and open questions taking place is great and I am sure that the counsellors feel better and more confident in their work as this is what they have verbalised. So even though a global rating of 3 is poor, it is in my mind up from where it may have been before." (Eshowe site)

Differences in terms of readiness to change

The counsellors differed in their own readiness to change, as for some MI initially was perceived as just another set of external guidelines that might not be applicable to the PMTCT programme. Several lay counsellors saw their work as just a stepping stone to a better paid job and were therefore not motivated to improve their counselling. Some initially participated more for the sake of the action researcher than for themselves. Those who did change substantially began with the realisation that their counselling was not having the effect they wanted and they therefore were interested in exploring MI. For some, their readiness to change increased as they gained insight into their performance and aligned themselves personally with the intention of being a better counsellor.

"The following I think has contributed towards our successful story; willingness to be associated with the project from all my counsellors. Readiness to change and to learn the new skills for the benefit of the clients – all counsellors." (Oshakati site)

"If I were to conduct this process again, I would have asked the ones who were not interested to leave as their negativity took a lot of time and energy to address." (Stellenbosch site)

"On the overall I think commitment was high among the Swazi and Oshakati counsellors. This could have been because they had seen non-compliance and were looking for ways to address it and also an interest in professional development. This was expressed in the initial workshops. I also think nurses were at an advantage in terms of ease of learning the concepts compared to lay counsellors." (Swaziland site)

"At first I was frustrated when they were doing this for the sake of doing it, then they were doing it for me (which was frustrating) but later they were doing it for themselves, for excellence in their work and for outcome. This is what I was seeking." (Swaziland site)

"I also sat in some counselling sessions and saw the 'coldness', 'distance' and perhaps 'indignation' between the counsellor and client. Once they started doing it for themselves and the group (counsellors) they became willing to learn and to reflect on their learning. Another

circumstance is that they know their information is not valued even though important so they were dissatisfied with not getting results and so their interest was kindled." (Swaziland site)

Importance of reflecting on actual consultations
Ideas expressed and skills exhibited in the workshop setting might not be translated into actual counselling sessions. Sites that were more successful spent more time reflecting on the recordings of actual counselling sessions and did this consistently over time.

"With the exception of the first inquiry group meeting, during all the meetings we spent more time reviewing the transcribed audio-taped sessions. I found this approach to be more appropriate and a useful tool towards learning the skills. It was from these transcribed versions that as a group we were able to follow each individual's progress and to comment on the positive growth and to identify where improvement is needed." (Oshakati site)

"Important factor was that I never actually was able to obtain real interviews and then review it with whole group, due to a variety of reasons. Some who had taped did not want their interviews to be made public to the group, others always professed not to have had any clients that week, etc. I should have insisted on this in order for all to see the level of MI applicability throughout. I think this lack of consistent review of taped interview correlates strongly to lack of MI adherence." (Stellenbosch site)

Differences in the action researchers
As action researchers in Swaziland and Namibia shared the same nursing background as their counsellors and spoke the same first language, this could have contributed to the better performance of MI in these settings. The sites which elicited more change appeared to engage more deeply in the inquiry process, with a sense of co-ownership by the group. These groups may have had more equality between the action researcher and group members and more alignment of purpose. For example, the members may have seen themselves more as part of a collaborative reflective and learning process and less as part of a training course or have felt less pressure from the action researcher to change or perform in a particular way. The action researchers needed to learn to trust the action research process and not try to force change. The action researcher also needed to build a strong personal relationship with each member of the group and to stay in regular contact between meetings.

"Reflecting on the differences and commonalities between action researchers – neither shared [Eshowe and Stellenbosch] the work experience of their groups. Also neither engaged in the appreciative inquiry process (if their reflections are anything to go by) in the same depth. Both appeared to me to have maintained something of a parental role as facilitators of their groups, thus perhaps not building self-efficacy to the same degree." (IFRP researcher)

"I have learnt that shifting from lecture/students culture to co-learner/researcher in the project has made my facilitation process easier. We were all travelling along same journey with my counsellors, a journey of sharing, learning and reflecting." (Oshakati site)

"I had prepared myself mentally to make a difference in their lives. To realise this I was very, very close to them. What I mean here is that besides visiting them (formally at the site), most of the time I used my cell phone calling them just to find out how they were progressing. Prior to all inquiry meeting I would also call them individually to check as to whether the date and time still suit them. I think this has drawn us as a group together and a bond of togetherness was created through this approach." (Oshakati site)

Nurse versus lay counsellors
The sites that scored better contained mostly nurses rather than lay counsellors. The lay counsellors may have been less committed to their "profession" and less motivated to commit to "continuing professional development". In some instances, increasing their alignment with purpose and self-goals led to their taking new jobs.

"In conclusion some of my [lay] counsellors were just not interested in learning or practicing MI. Their own lack of motivation became my primary focus. Thus I suggest that I was more of a practitioner than a trainer. I used a variety of methods…to increase their motivation, leading to five counsellors getting new jobs." (Stellenbosch site)

Overall spirit of MI versus specific individual skills
The global ratings of competence appeared higher than the ratings for some of the specific skills. In particular, the counsellors struggled to move beyond open questions to complex reflections. Simple reflections were often formulated as questions and not as statements. The groups that achieved higher global scores also appeared to spend more time reiterating and redefining the core principles in their inquiry groups.

"Only two of my counsellors could reflect with amazing ease from the third month of the process … There was one who was using questions all the way but this had a reflection effect on the clients. After I had noticed that, I asked her to role play in one inquiry meeting and the others noticed it too. The rest I felt, even when we started, for some reasons seem to have started too far off. Question and answer sessions seemed to continue once they were in counselling. I think they benefited because this was the first time somebody looked into their [counselling] sessions and in an appreciative inquiry mode." (Swaziland site)

"In terms of the difference between the global scores and the locals [MITI behaviour counts] I am interested to notice that Swaziland and Oshakati score very high on global and medium on MI adherent. I am not really surprised as it was my impression of transcripts that I have read from Oshakati, that despite sometimes being MI non-adherent in wording the intention of counsellors was very congruent with the spirit of MI and that the effect of counsellor communication was in-line with this. To me this points towards a limitation in the application of the MITI to our context…On the whole I am not that surprised by the results. My previous impression of the sites was that there was an in-depth understanding of the spirit of MI in Swaziland and Oshakati and less so on the other two sites." (IFRP researcher)

"I am glad we reached competency level. This was quite something because the counsellors struggled with collaboration early in the process because it was obvious that without it good efforts are lost. Evocation was good but respect for autonomy I didn't think it would appear because they struggled with 'giving their power away'. However we did spend time on it in our inquiry group because it was consistently raised in questions and concerns. Questions like 'What's the use of having expertise if it's not valued?' The role plays and redefining the concepts again and again helped." (Swaziland site)

Information giving and MI
Those counsellors who scored higher in the MITI gave less information. This may be a reflection of their shift from being health

educators to counsellors – moving from educating their clients with the right packages of information to guiding their client's decision making by offering information when it was needed.

"I notice a low uptake of the skill of complex reflection, but a fair uptake of [simple] reflection and open questioning in Swaziland and Oshakati. Interested to notice less information giving on these sites, which surprised me as I associated nurses with giving information." (IFRP researcher)

Differences in organisational support and structure

The more successful sites reported that they received support from the management of the health service. Where necessary, the action researcher had to negotiate directly with management to create an environment conducive to change.

"The relationship between me and the hospital management was wonderful and this has also contributed towards the success of the project…Negotiate on their behalf with the employers (on anything affecting a particular training)." (Oshakati site)

Concern was also expressed at the potential incongruence between the task-oriented nature of the health system (i.e. how many clients were educated on a particular topic) and the process-oriented nature of counselling in an MI style.

Appreciative versus critical stance

The action researcher's ability to hold an appreciative rather than critical stance was useful in terms of acknowledging the counsellors' achievements and successes, being respectful, tolerant and patient, and holding the belief that the counsellors were able to learn new skills. A problem-focused and overly critical stance was avoided, as it could reinforce the low status and often negative feedback that nurses and counsellors receive in the health system.

"Acknowledging all their efforts and commenting on their work most of the time boosted their morale…I have learnt to be more appreciative, tolerant and respectful of my counsellors' efforts and commitments towards the project vision…To future trainers; be there for the counsellors, recognise them as unique individuals who are capable to learn." (Oshakati site)

Discussion

This study has highlighted key lessons learnt by the IFRP on how to train PMTCT counsellors in motivational interviewing. The combination of initial workshops, followed by regular reflection on actual consultations as well as personal visits to the clinic by the action researcher appeared to be the most effective combination. The benefit of ongoing feedback and coaching in learning MI has been shown elsewhere, as well as the poor relationship between the clinician's self-reported skilfulness and what is observed in practice.[17]

The study has also suggested that it is possible to train PMTCT counsellors in MI and achieve "beginning proficiency" according to the MITI[16] code. The groups in Namibia and Swaziland performed significantly better than those in South Africa, and the action researchers suggested a number of reasons to explain this. If these lessons were formulated as recommendations to future trainers they could be summarised as in Table IV. The nurses performed significantly better than the lay counsellors and also gave significantly less information. "Beginning proficiency" implies that they achieved the lowest level of performance expected of a clinician; however, to test the effect of MI in a future clinical trial, 'competency' should be attained. The counsellors struggled particularly with the ability to formulate complex reflections.

Table IV: Key recommendations

1. Assess participant's baseline counselling skills prior to or at the beginning of training so that progress can be monitored and learning needs determined.
2. Counsellor's readiness to change should be assessed and explored at the beginning of training and periodically.
3. A combination of initial training workshops, ongoing action-reflection in small group meetings as well as individual mentoring in the clinic setting over a number of months is most likely to be successful.
4. After initial training, learning should be based as much as possible on audio or video tapes of actual counselling sessions, or on direct observation with feedback.
5. Facilitators should ideally be able to speak the same first language as the participants and understand their working environment.
6. A group process that is characterised by listening, inquiry, curiosity, reflection, experimentation, openness and collaboration in learning creates an environment for change that is also coherent with MI.
7. Training that focuses on achieving an understanding of and alignment with the spirit of MI may be more successful than training with a focus on specific techniques as a starting point.
8. The support of facility managers is important in enabling the implementation of new counselling styles.
9. Training should be appreciative of the counsellor's successes and build self-confidence. Training should avoid reinforcing the problems, deficiencies, and failures of the counsellors.

The threshold levels used in the MITI were originally developed in the United States and in relation to the performance of psychiatrists using MI as psychotherapy. Further research may be needed to determine what level of MI performance is required by counsellors within African PMTCT settings to elicit behaviour change.

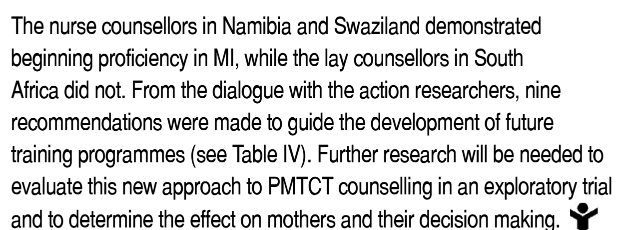
This study represents only a part of the IFRP's findings, which also conclude that, while MI is an important component of a new approach to PMTCT counselling, it may not be wholly sufficient in itself.[18] For example, the counsellor should have awareness of her own gender- and culturally-determined perspective on sex, women and gender roles, and how this may or may not align with her role as a counsellor in building self-efficacy and respecting autonomy in her client.[11,19]

Limitations of the study

Counsellors who did not submit tapes still participated in the inquiry groups and were observed by the action researchers. The main reasons for not submitting tapes were that they were not seeing clients during that month or lacked time or motivation. The counselling sessions were translated and it is possible that the original meaning and grammatical formulation were distorted. The MITI analysis was performed by only one person and inter-rater reliability was not performed. However, the MITI results were congruent with the action researchers' experience and feedback and formed a means of stimulating reflection and learning.

Conclusions

The nurse counsellors in Namibia and Swaziland demonstrated beginning proficiency in MI, while the lay counsellors in South Africa did not. From the dialogue with the action researchers, nine recommendations were made to guide the development of future training programmes (see Table IV). Further research will be needed to evaluate this new approach to PMTCT counselling in an exploratory trial and to determine the effect on mothers and their decision making.



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