Promoting Sexual Health for Young People in Kenya

Family Health Options Kenya Sexuality Counselling Approach

Jerusha Ouma and Anke van der Kwaak

Funded by WHO and implemented by the Royal Tropical Institute (KIT),
The Population Council Nairobi Office, in collaboration with Family Health Options Kenya.

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Acronyms

ABC	Abstinence, be faithful to uninfected partner, and condom use
AIDS	Acquired Immune Deficiency Syndrome
ARH&D	Adolescent reproductive health and development
ART	Antiretroviral therapy
ARV	Antiretroviral (drug)
CBS	Central Bureau of Statistics
DTC	Diagnostic testing and counselling
FGC	Female genital cutting
FHOK	Family Health Options Kenya
HIV	Human Immunodeficiency Virus
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute)
MCH	Maternal and child health
MoH	Ministry of Health
MVA	Maternal virginal abortion
NACADA	National Agency for the Campaign Against Drug Abuse
NASCOP	National AIDS and STI Control Program
NCPD	National Coordinating Agency for Population and Development
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PLWHA	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
PYE	Peer youth educator
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
VCT	Voluntary counselling and testing
WHO	World Health Organization

Executive summary

A study of Family Health Options Kenya (FHOK), one of the organizations providing promising sexuality counselling services, was carried out between December 2006 and March 2007 at its Nairobi and Kisumu youth centres. The general objective of the study was to define the content of sexuality counselling and assess factors influencing the quality of counselling that contributes to improved sexual health. Specifically, the study sought to:

- contextualize counselling services within a broader service delivery environment,
- document the content of the counselling related to sexuality issues,
- assess the quality of the counselling related to sexuality issues,
- assess the way the health system and environmental factors influence the counselling content and quality, and
- assess, as far as possible, the contribution of the counselling intervention to the success of the broader SRH programme.

Both quantitative and qualitative methods were used for data collection and analysis. Desk review of literature on sexuality was carried out to help contextualize the counselling intervention within the broader environment and to understand the assessment results. Data were collected from key informants, focus group discussions, observation of sexuality-related counselling, and exit and in-depth interviews.

FHOK is a non-profit, non-political and non-governmental organization committed to the pursuit of family well-being through responsible parenthood. The organization has spearheaded advocacy for providing reproductive health services to youth and has gone a long way to establish youth-friendly sexual and reproductive health services, including youth-friendly voluntary counselling and testing (VCT) services. Of the five youth centres run by the organization, only the two based in Kisumu and Nairobi were chosen for this study. Adolescent sexual and reproductive health services offered at the centres include:

- contraception and the treatment of minor ailments;
- VCT services;
- information and education on adolescent sexuality;
- life planning skills education;
- education and entertainment through video, TV and radio programmes;
- referral services;
- recreational and entertaining indoor games;
- counselling services; and
- training in peer counselling.

In contextualizing counselling services within a broader service delivery environment, a number of socio-cultural and religious factors come into play. In Kenya, sexuality issues are seen and understood as largely private activities, subject to varying degrees of social, cultural, religious, moral and legal norms. These norms exert influence on clients' behaviours and their access to and

acceptability of sexuality counselling. A lot of conservatism is still portrayed from the religious sector. Sexuality issues, for instance, are defined within the parameters of sexual relationships. Chastity is highly valued, especially for the youth, despite the largely sexualized media. Sexual cultures and gender norms vary between different ethnic groups in Kenya, and abuse, violence, and coercion are viewed in different ways. Counsellors asserted that they had a role to play in averting harmful sexual practices, such as sexual violence, female genital cutting, abortion, early and forced marriage and substance abuse, through counselling and raising awareness within communities. Persistent stigma attached to HIV/AIDS and sexuality issues limits disclosure of clients' sero-status and openness

Results from the study indicate that the content of sexuality counselling is as broad as the definition of sexuality. Information given during a counselling session depended on the issues or topics raised by the clients. Such topics included broad areas such as dating, love, relationships, marriage, self-esteem, assertiveness, decision-making, pleasure, sex, achieving sexual and reproductive health goals, HIV/AIDS, fertility and prevention of pregnancy, unwanted pregnancy, sexual identity, gender relations and sexual violence. The reasons why people seek counselling were described by respondents as psycho-social in nature, and counselling itself is a process of preparing individuals to accept their situation and live positively with it.

Observations results indicate that most counselling sessions (over 90%) were rated by the research team as good in content, both in Kisumu and Nairobi. Areas covered with adequacy (over 80% rating) for both sites included discussions on safe sex methods, number of sexual partners, information on the HIV testing process, meaning of HIV results, and assessment of capacity to cope with HIV results. It was observed that informed consent was sought by all the counsellors at the beginning of each session and only consenting clients were tested for HIV. There were also adequate discussions on personal risk reduction, adoption of the ABC approach, positive living, disclosure of HIV results, availability of immediate adequate support, and immediate plans. Follow-up plans were also discussed and referrals made to the majority of the clients. Clients generally mentioned during exit interviews that they were satisfied with the counselling services they received from the facilities both in Kisumu and Nairobi. However, there were a few areas which were observed to be poorly covered by the counselors and these included discussions on sexual identity, sexual pleasure, and gender based violence.

Privacy, confidentiality and provider characteristics were some of the key factors that contributed to quality counselling services at FHOK. Observation results indicate that privacy was rated as good in 85% of the counselling sessions observed. Privacy here referred to the location where the counselling session was taking place. Researchers were supposed to assess if the counselling room was secluded and could not be overheard. Key informants reported that in the context of HIV/AIDS, usually privacy is protected by observing confidentiality in carrying out HIV testing, disclosing results and keeping records. In about 96.7% of the counselling sessions observed, counsellors assured clients of confidentiality. All the counsellors explained the meaning of keeping confidentiality to the clients.

Generally, the provider–client relationship was observed to be good during the counselling sessions. All the clients were greeted in a culturally appropriate way, while face–to-face interaction was good for nearly all the sessions. In over 90% of the sessions observed, counsellors assured clients of what they would do to help them overcome their situations. All the counsellors were observed to use warm and kind tones and to be quite respectful to clients. The counsellors were also observed to be quite supportive (96.7%) and non-judgemental (98.3%) to the clients. They all used clear and understandable language that made communication with clients quite easy. Non-verbal communication by counsellors was also rated as good for the majority (over 90%) of the observed sessions. Other areas where the counsellors were rated as good included effectively listening to clients, commending clients for the courage to attend, appropriate balance of closed and open-ended questions to explore clients' situations, directing discussions properly, allowing clients to absorb information and respond, appropriate probing, and providing factual information based on clients' needs.

Even though they received assistance from volunteer youth peer counsellors, counsellors performance were challenged by heavy loads. They could not efficiently handle the large number of clients. The facilities also lacked adequate space for the many youth intervention activities at the centers. Limited number of providers led to long waiting time among clients.

The outcomes of sexuality counselling were assessed through perspectives of clients, providers within and without FHOK. What emerged is that counselling promotes positive living for PLWHA. Counselling was reported to impact positively on people's lives and was attributed to behaviour change in terms of increase in self-esteem, contraceptive use and demand for STI treatment, and decrease in risky sexual behaviour, among others. There was also reported increased use of health services by all groups in need of sexuality counselling. The outcomes were reinforced by counselling outreach activities of youth peer groups and other support groups facilitated by FHOK. There is need to conduct further studies to determine the extent of impact of counselling on clients.

FHOK has played a leading role in provision of an integrated SRH services to young people in Kenya. Innovative implementation strategies such as youth peer counselling and education and youth-friendly services has enabled it to reach out to many people with sexuality counselling. The youth centers are managed by young people themselves and they have put a lot of emphasis on training of youth peer counsellors. The leadership has ensured that the youth's opinions are considered with seriousness and they influence important decision making at the organization.

The infrastructure and logistics for operations within the organization, even though observed by the research team as not quite adequate at FHOK, can contribute to the quality of sexuality counselling if improved. Monitoring and evaluation of the services, including quality assurance mechanisms, enabled the organization to improve on the quality of their services. Furthermore, the services were found to be quite responsive to most clients' needs in terms of accessibility and acceptability. The organization has built a close-knit network of collaborators, through which it refers clients to access other services not available at the youth centres.

However, the organization is not without challenges. In the past couple of years, FHOK has experienced a reduction in funding for its activities. This was mainly due to its decision to support post-abortion care services for its clients, which was contrary to its donor's expectation. As a result, they have had to reduce the number of peer counselors and depend on referral for a number of services. Even though funding affected quality services offered, FHOK is still recognized in the country as a leader in sexuality counselling. It has showed success and created impact in the broader area of sexual and reproductive health in Kenya.

In order to improve on quality of sexuality counselling at FHOK, the study recommends the following:

- Strengthen and promote couples counselling as a strategy to ensure active participation of men in sexual health.
- Continue to facilitate community empowerment to handle sexuality-related issues.
- Build capacity for income generation, especially for young people and women.
- Employ more personnel to reduce workload for current staff.
- There is a need for continuous training of staff to enable them cope with emerging trends in sexuality counselling.
- All providers at the youth centers should have some counselling skills.
- There is need to improve working conditions for the counsellors by putting in place better support mechanisms to prevent stress and burnout.
- Build client confidence by facilitating continuity of counselling process through one counsellor.
- Consider clients' preferences for counsellors, such as age and sex.
- Continue community outreach with information on sex and sexuality issues.
- Expand services to rural populations.
- Address retrogressive cultural beliefs and practices that hinder sexual health in the community.
- Reach out to religious leaders to give realistic options that will encourage sexual health for young people.
- Improve communication between parents and young people.
- Expand the youth centre facilities to accommodate all the youth intervention activities.
- Strengthen and expand fundraising mechanisms to sustain the youth interventions.
- Improve on staff motivation, for example, through better remuneration.

1

Introduction and background information

Introduction

This chapter gives a detailed background of the study. It highlights how the need to develop evidence-based guidelines on how to better address sexuality within sexual and reproductive health (SRH) programmes was conceived. It notes that documentation has been lacking for most programmes that have been providing sexuality counselling, and this study is meant to fill this gap. A brief background to the study, which is covering four programmes, is also presented, including study justification.

Background

In 2002, the World Health Organization (WHO) convened a strategic committee to define priorities for a new area of work on sexual health. For this meeting, a review was commissioned from the Royal Tropical Institute (KIT) on the status of the evidence on the integration of sexual health interventions into SRH and HIV/AIDS programmes. This review was subsequently further developed and will be published by WHO and KIT in 2008. During the strategic committee meeting, the need to develop evidence-based guidelines on how to better address sexuality within SRH programmes, particularly in counselling sessions, was highlighted. The literature shows the importance of sexuality counselling or counselling that included discussion and information on human sexuality among other health topics. Despite the existence of many programmes that purported to include such issues, few programmes have been documented. It was found that in many of the intervention areas prioritized by the strategic committee, the situation was the same. There was too little evidence to form a basis for service delivery guidelines with respect to the integration of sexual health services. As a result, the new area of work set out to build the evidence base for programming in sexuality and sexual health by documenting promising programmes that successfully included the key sexual health interventions.

With the support of the Ford Foundation a project was developed to conduct a systematic review of the evidence on key sexual health interventions (initially it was planned to conduct a similar process for the topics of screening for sexual violence, integration of prevention and treatment of sexually transmitted infections (STIs), and sexuality counselling). These reviews would allow the team to select programmes to further assess the degree to which they were successful in implementing the key intervention. It was agreed that the assessments would be done as an operations research that investigates both health systems factors – which made inclusion of the intervention possible and successful – and the perceptions of clients and providers on the interventions. It was agreed that between four and six programmes that appeared promising would be selected, i.e. the programmes were considered successful as determined by a programme evaluation (versus an evaluation of specific interventions), and they offered the sexual health intervention in question. The programmes, if they agreed, would then be assessed using a rapid assessment methodology. Based on this methodology, promising programmes with the key intervention would be written up and published in a compendium of case studies. In this way, programme examples could begin to be available for the future development of guidance documents. Unfortunately, given limited

resources, WHO's Reproductive Health and Research department decided to move forward with only the sexuality counselling and sexual violence interventions in the 2006–2007 biennium.

A study of Family Health Options Kenya (FHOK), one of the organizations providing promising sexuality counselling services in Kenya, was carried out between December 2006 and March 2007. The general objective of the study was to define the content of sexuality counselling and assess factors influencing the quality of counselling that contributes to improved sexual health. Specifically, the study sought to:

- contextualize counselling services within a broader service delivery environment;
- document the content of the counselling related to sexuality issues;
- assess the quality of the counselling related to sexuality issues;
- assess the way the health system and environmental factors influence the counselling content and quality; and
- assess, as far as possible, the contribution of the counselling intervention to the success of the broader SRH programme.

Both quantitative and qualitative methods were used for data collection and analysis. Desk review of literature on sexuality was undertaken to help contextualize the counselling intervention within the broader environment and to understand the assessment results. Data were collected from key informants, focus group discussions, observation of sexuality-related counselling, and exit and in-depth interviews.

Justification for the project

Expanding reproductive health services to better address sexuality and sexual health issues continues to be challenging in many countries. There is still very little evidence for the most effective duration, content and follow-up of training of various cadres of health staff in counselling on sexuality and on how to sustain good-quality counselling alongside SRH services. As a result, despite the best intentions to expand reproductive health services to the broader SRH concept as prescribed in the International Conference on Population and Development (ICPD) Platform for Action, many programmes continue to struggle with the content of the 'S' in SRH. In the era of HIV/AIDS, the importance of better understanding sexuality to improve sexual health becomes increasingly critical, and reproductive health remains one of the best entry points.

WHO recognizes the need to develop an evidence base on the best approaches for offering counselling services that can help SRH and HIV clients address some of their most significant sexual health problems and concerns. Given the lack of evidence as to what works in a variety of settings and even within existing reproductive health services, WHO has embarked on this operations research initiative that aims to document good practice examples in SRH and HIV/AIDS counselling programming; synthesize lessons learnt to be shared for broader dissemination; and to provide guidance to countries on how to better provide counselling services on sexuality-related issues, within the context of existing programmes.

The study

WHO and KIT, in collaboration with Population Council researchers, conducted descriptive studies of four programmes that are currently providing counselling that specifically addresses sexuality-related issues within the context of their programmes. The operations research describes the content of the counselling intervention offered and how it has been integrated into the broader SRH or HIV/AIDS programme. The study also documents the environmental, human resource and managerial context in which the counselling is provided. The descriptive study of the counselling intervention in the four sites has only been conducted on programmes that have been previously assessed to be broadly successful – the SRH or HIV programme has been evaluated either externally (most desirable) or internally by donor or partner. Between October 2006 and April 2007, a variety of methodologies were used to assess and then describe the counselling interventions using a case study approach. The results of the research will contribute toward the generation of an evidence base for the development of guidelines for providing good-quality sexuality-related counselling in the provision of SRH and HIV services. The documentation of these promising practices also contributes to the knowledge base as to what is required for scaling up counselling services on issues related to a healthy sexual life.

New features

This assessment makes an important contribution to the delivery of SRH and HIV services. There has been little research into the content and quality of sexuality-related counselling practices in SRH/HIV programmes and the health system requirements for scaling up good-quality counselling in primary health care. To document and assess the content of the counselling related to sexuality, the study presents a draft definition based on the results of the systematic literature review against which we have compared and analysed the extent to which the counselling offered in the study sites confirms, rejects or adds to the current understanding as presented in the draft definition.

Other expected outcomes that are novel include the documentation of the conditions that are required to integrate and sustain sexuality counselling interventions to later develop intervention studies that can be further tested in countries. Given the difficulty in capturing both process and outcomes of counselling interventions, the study also contributes to the knowledge base on how to study counselling interventions and the potential contribution they make to the outcome of broader health programmes.

Techniques and skills

This study utilized a case study approach to the assessment of promising sexuality counselling interventions. To assess the content of the counselling, and the health system conditions necessary for its effective provision, a conceptual framework has been elaborated as a point of reference and includes a draft definition of what sexuality counselling is. The draft definition has been used to

assess both quality and content of the interventions under study. Methods used in the assessment are as follows:

- Counselling sessions were observed directly.
- In addition, exit interviews were conducted to assess the quality of counselling from various perspectives.
- Interviews with providers and managers were used to assess factors promoting and hindering the quality of counselling from a provider's perspective.
- Focus group discussions with users and non-users, referral centres, and providers gave insight into community perceptions of sexuality counselling and counselling needs.
- Health system and environmental factors were investigated through interviews with policy-makers, managers and via the desk review.

The instruments for the study were standardized to some extent, to ensure triangulation and comparability, where possible, of the findings across countries with the provision for cultural and language-specific adaptations that does not unduly influence compatibility. The study methods used form a well-established approach to the study of counselling and health system conditions.

The research instruments have been developed and finalized with the local research partners to ensure their generic acceptability in all research settings. The protocol and instruments were adapted to meet locally specific programme context and specifications. The researchers worked with programme managers to select and adapt the research instruments that best captured the evidence of effectiveness and replicability of the counselling intervention. For example, direct services were evaluated with direct observational methods and exit interviews. All instruments, once adapted, were translated, pre-tested and then finalized before use in the field. Local ethical approval was sought before the pre-testing of instruments.

The Kenyan team comprised the local investigator, who was selected on the basis of her expertise in conducting SRH research, and four research assistants (two anthropologists and two sociologists), all with a counselling background and substantial experience in conducting SRH research.

2

Methodology

Introduction

This chapter gives a description of study objectives and methodologies that were used for data collection, management, quality assurance and data analysis. Secondary data were gathered through desk review of various research reports and other relevant documents. Primary data were collected through key informant interviews, and a total of 11 interviews were conducted with priority stakeholders in the country and various programme managers, both from within and outside FHOK. Other methods of primary data collection used for the study were focus group discussions, observation of sexuality-related counselling, and exit and in-depth interviews. Criteria for sample selection are also stated, detailing the sample size and sample selection criteria. Limitations of the study are also discussed.

Objectives of the study

General objective

To define the content of sexuality counselling and assess factors influencing the quality of counselling that contributes to improved sexual health.

Specific objectives

1. To contextualize counselling services within a broader service delivery environment
2. To document the content of the counselling related to sexuality issues
3. To assess the quality of the counselling related to sexuality issues
4. To assess the way the health system and environmental factors influence the counselling content and quality
5. To assess, as far possible, the contribution of the counselling intervention to the success of the broader SRH programme.

Research questions

1. What are the provider characteristics in relation to the promising/effective counselling services that positively address sexuality within the counselling session?
2. What are the key content elements of the interventions that are described as promising?
3. What contribution does the counselling have on behavioural, individual and health outcomes?
4. What contribution does the counselling intervention have on the broader SRH or HIV programme outcomes?
5. What are the commonalities of the interventions that are effective across countries?
6. What lessons can be learnt for scaling up future interventions?

Research instruments

Desk review

One important part of the study is the desk review, which includes an analysis and synthesis of local research reports, existing health management information systems and demographic and

health survey reports, evaluation of counselling service reports, policy reports at both national and district level, training materials, and health service statistics (ratio of clients per providers, HIR, partner involvement notification, teaching aids). This information allowed the research team to contextualize the counselling intervention within the broader programme. In addition, information on the cultural and religious context was gathered and summarized from the reports to further assist in contextualizing and understanding the assessment results.

Priority stakeholders and key informants

The assessment process began by notifying stakeholders about the study. At the beginning of the assessment, key informant interviews were conducted with priority stakeholders, including staff from FHOK who helped to identify key informants. Purposeful sampling following the stakeholder analysis was used to identify the relevant key informants.

The following key informants were interviewed:

- One Chief Gender and Social Development Officer from the Ministry of Gender and Sexual Development
- One Policy Advocacy Officer from the National Council for Population and Development
- One Programme Director from FHOK
- One Youth Projects Manager from FHOK
- One Field Coordinator from Women Fighting HIV/AIDS in Kenya
- One Field Coordinator from the Kisumu Initiative for Positive Empowerment
- One Assistant Project Leader from Kisumu Urban Apostolate Programme
- One Assistant Project Director from FHOK
- One Assistant Reproductive Health Officer from the Ministry of Health
- One Field Supervisor from the Ministry of Health
- Two Youth Centre Coordinators from FHOK.

Organizational diagram and standard questionnaire

The mapping of the institutional setting was carried out with the managers of the project under study. The aim was to visualize the institutional setting of the project and its possibilities for scaling up the projects. A standard structured questionnaire was used for interviewing the management and staff of each selected project. This assisted the study team in its effort to track commonalities and differences in the intervention under study.

Focus group discussions

Focus group discussions were conducted for each site included in the project under study. The participants were defined as having shared characteristics and were questioned in terms of their understanding and opinions concerning the counselling practices they received with respect to sexuality. The discussions were conducted with the primary target populations of the given services. Four focus group discussions were conducted with clients – two with post-HIV-test club members and two with teenage mothers – and two with counsellors – one in Nairobi and another in Kisumu. Each one involved between six and eight people and lasted approximately one hour.

Observation of sexuality-related counselling, and exit and in-depth interviews

Direct observations and exit and in-depth interviews were conducted to assess the quality and appropriateness of the content of the counselling session from the perspective of respondents, clients, counsellors and, eventually, trainers. The observational study and exit interviews conducted depended on the nature, use and type of services for which the sexuality counselling interventions were being conducted. A total of 60 clients were both observed and done for exit interviews. Only clients who agreed to be observed were interviewed at the exit. In-depth interviews were conducted with seven counsellors, nine clients and four trainers. In all cases, clients provided informed consent for the observation study to take place, and if they chose not to be observed, they were assured that they would not lose their service benefits in any way. This was spelt out in the informed consent form. Observations were carried out over a period of time to catch different types of clients and different provider workloads.

Informed consent

Only clients who consented to participate in the study were included. Interviews were recorded only for those who granted consent. Illiterate clients were asked to provide verbal consent after being read the consent form. A few clients refused to be observed, especially those who came for HIV diagnostic testing. On average each observatio session took 50 minutes to one hour.

Criteria for subject selection

Study groups and sample size

With the assistance of youth project managers from FHOK, two sites were selected for this study. The Nairobi site was selected for being the pioneer project and longest-serving youth centre. The Kisumu site was selected for being located in an enriched socio-cultural background. Generally, there were no distinguishing features between the two sites. After a purposeful sampling following the stakeholder analysis, 10 relevant key informants were identified.

Clients were recruited purposefully to ensure that a wide range of client types of the various services (voluntary counseling and testing (VCT), family planning, adolescent SRH, etc.) participated in the exit interviews. The interviews very much depended on the willingness of the clients to participate. The inclusion criteria for men and women were that they had to be of reproductive age (15–65 years) and had attended a counselling session at least once (excluding children below the age of 15).

Snowball sampling was used for the six focus group discussions with the clients. They were representative of the client base of the organization and the services provided.

Recruitment

Observation of counselling services and exit interviews

Users of counselling services were recruited by health personnel who were professionally involved with the clients. Health personnel asked users if they were willing to talk with a researcher about

their participation in the assessment before they entered the counselling services. During this brief discussion the researcher asked the provider and the client if they were willing to have their counselling session observed and/or if they were willing to participate in an exit interview. The client was offered the choice of a direct observation, an audio tape recording of the session, to participate only in the exit interview or not to participate at all. Informed consent was sought before the counselling session began. In cases where the client did not consent, the observer was called out of the counselling session before the clients entered. When the client consented, the counselling proceeded as usual with the addition of an observer present. Following the counselling sessions, exit interviews were conducted with the clients who consented, to get their feedback about the session.

Focus group discussions
Recruitment for focus group discussions took place with the assistance of community leaders, health personnel from the programme and other key informants familiar with the programme. Key informants were asked to consent to the study at community level and then were requested to identify 10 to 12 participants for the focus groups. Focus group discussions were held with men, women and adolescents from the community who were familiar with the programme (having either used the services or felt able to comment on the services).

Quality assurance

The quality of the data collected by the rapid appraisal was assured through providing confidentiality. All researchers signed a contract for keeping confidentiality, each informant was asked to sign an informed consent form, and the anonymity of all informants was assured. A coding system for all research sites within the country was put in place. The different instruments wedre tested in each location before use. The researchers involved in this study are all well trained, experienced researchers who have conducted similar studies on sensitive issues related to SRH or HIV.

The project is coordinated by KIT on behalf of WHO. KIT is responsible for the day-to-day management of the study. The coordinator works in close collaboration with WHO and an adviser for the Africa research sites, Dr Harriet Birungi of the Population Council in Kenya. In each selected project a research team consisted of a principal researcher from KIT, the WHO adviser and the local principal adviser.

Validity of the data was assured by triangulation. Data were triangulated by interviewing different stakeholders, key informants and client groups. The same questions were asked to the different study groups, as well as in individual and group discussions. The results from interviews, observations and desk review have been compared and contrasted in a systematic way. Results from the questionnaires were validated using the same process.

Data management

Central to our data management were:

1. Development of packages of research tools, including checklists to monitor and evaluate the research process in collaboration with country investigators
2. Coding for observations and interviews
3. Using the Statistical Package for Social Sciences (SPSS, a statistical software programme), a computerized data analysis framework was put in place before the research process started and discussed and disseminated in workshops prior to the assessment

Confidentiality of records, tapes and transcripts was assured through numeric coding. For all research instruments informed consent forms were designed. They were translated, checked and cross-checked and adjusted to the local circumstances of each assessment.

Data analysis

Analysis of the quality of counselling interventions was assessed against a quality assessment framework for counselling interventions. This framework was developed based on the results of the literature review of successful counselling interventions that addressed sexuality, sexuality manuals and in-country researchers. The quality of the counselling interventions was further assessed (triangulated) through the information gathered and analysed from the semi-structured interviews, observations and focus group discussions The open-ended questions were coded, organized into relevant categories based on the conceptual framework and the topic guides. Outcomes from the focus group discussions were coded according to the questions included in the topic guide and categorized. A matrix was developed to triangulate results.

The standard questionnaires were entered into computers for analysis using SPSS. The outcomes were reviewed as observation tables and compared among the different research sites. A uniform coding systems was used in all selected research sites. The comparison of results and final analysis of findings were conducted by the country research team. Results were shared with programme directors at the conclusion of the assessment process.

Limitations of the study

Some clients who came for HIV diagnostic counselling and testing did not agree to undergo observation by the research team. We were informed by the counsellors that these clients were already suspicious about their HIV status, so they were extremely anxious to know the test results. Only clients who accepted to be observed were included. The data collection period had to be extended by three weeks in order to get other clients who came for other aspects of sexuality counseling other than HIV/AIDS counseling. Most clients visiting the centres came for HIV counselling. The uptake of counseling in other sexuality areas has been low in the two centres, owing to the fact that counselling is a new phenomenon in Kenya, particularly couples counselling.

In Kisumu the STI clients were asking for free medical treatment before they left, as most research organizations have been offering this type of direct benefits. This made the Kisumu research team lose a substantial number of clients from the observation and exit interviews. The issue was reported to the center coordinator and the need to provide free STI drugs was emphasized to them.

Ethical considerations

Ethical clearance was obtained from the FHOK research and ethics committee, Ethical Committee of the National Council for Science and Technology and WHO research ethics committee. The protocol and instruments were reviewed by FHOK to ensure that the research was ethical and contextually appropriate. All the instruments and tools were pretested before commencing the study. Counselling sessions were audio taped with the consent of the clients and counselors. The program managers at the headquarters gave the research team permission to carry out the research at the center level and also assisted with selection of appropriate centers for the study. At the youth center, permission was first sought from the center coordinators and they gave clearance for interviews with counselors and clients. Individual consent was obtained from all the respondents. All the consents were documented and respondents remained with a copy which also contained the researcher's phone number. Clients consented voluntarily without influence from the service providers. Research assistants sought consent from clients before they entered the counseling rooms. All consent forms for clients were translated into the local language. The contents of the forms were read out to clients to ensure comprehension. It was emphasized that participation was voluntary and that their decision would have no negative consequences concerning access to services, benefits or their work.

3

Contextualization of sexuality counselling

Introduction

This chapter describes the contextual factors that affect quality of sexuality counselling, both at national and local levels. Factors influencing norms and beliefs around sexuality in Kenya are well discussed, with socio-cultural factors and religion featuring strongly. Gender-based violence, rape, female genital cutting, abortion, substance abuse and early marriage are discussed as harmful sexual practices that can be averted or managed through sexuality counselling. It gives a brief description of FHOK and the SRH services it offers. Background information is also given for the two study sites, where the respondents' profile, including age, sex, marital status, religion and place of residence, are presented.

Sexuality issues in Kenya

According to the latest Kenya Demographic and Health Survey (KDHS), 34% of the Kenyan population (33 million) are young people aged 10–24, while those between the ages of 10 and 19 make up 25% (Central Bureau of Statistics (CBS), 2004). Seven out 10 women and eight out of 10 men have had sex by the age of 20, with a median age at first sexual intercourse of 17 years (CBS, 2004). Often the youth experience a gradual movement towards heterosexual relationships which can lead to sexual activity. Among women age 25-49, the median age at first marriage is 19.7 years (CBS, 2004). Percentage of women ages 15-49 using contraceptives is 32, total fertility rate stands at 4.9% while infant mortality rate is at 115 per 1000 live births, (CBS, 2004).

According to the 2007 Kenya AIDS indicator Survey (KAIS) national HIV prevalence is estimated to be 7.1% among Kenyan adults ages 15-64. HIV prevalence among adults ages 15-49 is 7.4%. Women (8.4%) were more likely to be infected than men (5.4%), and young women ages 15-24 were four times more likely to be infected (5.6%) than young men of the same age group (1.4%). The same KAIS reports that among men aged 15-64, 85% are circumcised. It further reports that most sexually active Kenyans were unaware of their partners' status, especially in causal relationships. Overall, 6% of married or cohabiting couples in Kenya are discordant for HIV. The KAIS study also found condom use to be generally low, even among men or women with multiple partners, (KAIS, 2008).

Culture fundamentally affects sexuality and fertility by creating values, norms and expectations about sexual relationships, roles and behaviour. In most traditional cultural set-ups in Kenya, both pre-marital sex and pregnancy were frowned at and even punished. Despite religiosity featuring as an important determinant of indiscriminate sex in Kenya, traditional cultures have been eroded and the concept of abstinence not fully adopted, further compromising sexual behaviour (Brockman, 2001). Furthermore, a significant number of unmarried youth are becoming sexually active at an early age, prompted by the mass media presentation of sex as exciting and risk-free.

In Kenya, studies on adolescent sexual behaviour show that young people's premarital sexual encounters are generally unplanned, infrequent and sporadic, a pattern that pre-disposes the youth

to unwanted pregnancy and STIs (Centre for the Study of Adolescence (CSA)/UNICEF, 2003; Muganda, R (Ed.), 2001). Youth face multiple barriers to accessing SRH information and services. Sometimes services may not exist at all, or where they do exist the services are not affordable or are opposed by adults (CSA/UNICEF, 2003). Youth get their information from traditional and modern sources. Male youth, according to this study, usually get less training on sexuality orientation compared to their female counterparts. Females reported having elder sisters, aunties and grandmothers giving them information on their body growth and development, relationships, pregnancies and female roles. Many males report learning about sex through pornographic movies, through observation of adults, particularly parents, and from peers that engage in such sexual activities.

> *"Some of the things I have learnt on sexuality are from my peers, friends and here at the youth centre. Most of the issues on sexuality I learnt in school, in fact most of them like pregnancy, abortion, sex, relationship, love. When I identified the centre I also learnt more. It was taught in school especially in biology where we were taught body changes."* (HIV-positive female, Nairobi)

> *"When one of my aunts became pregnant out of wedlock, my mum sat us down and discouraged us from engaging in any sexual relationships with men. We have also learnt about sexuality from the books, teachers and radio programs. In secondary school we had a club where we used to share information on sexuality. Today most youth from towns learn about sexuality from the internet and the media. I learnt about sexuality issues mostly from my friends and from here at the youth centre. You also learn from personal experiences of dating and engaging in relationships."* (Teenage mother, Kisumu)

Surprisingly, at a certain age boys were expected to be sexually active and could have as many girlfriends as possible. This was particularly by parents of the young males. On the contrary, girls were expected to maintain their virginity until marriage, but at a certain age – particularly above age 24 – women are expected to show proof of their fertility before being married off:

> *"My aunt's husband asked me when I visited them if I am really fertile because to him at the age of 25 one should have a baby to show her fertility."* (Teenage mother, Kisumu)

The study indicates that sexual coercion of women is not uncommon in Kenya. It is more likely to happen when the woman is younger than her sexual partner. According to the majority of key informants, women learn and experience sex much earlier than their male counterpart, mainly through observation, playing among children and through coercion by older men.

Factors influencing norms and beliefs around sexuality in Kenya

In Kenya, issues of sexuality are not dealt with openly, despite the increasingly sexualized mass media. It was reported in the study that sexuality is still shrouded in silence and secrecy and often elicits feelings of shame and embarrassment rather than joy. For decades sexuality, just like death, has been wrapped in silence. Yet, many studies in Kenya, including the Kenya Demographic and Health Survey, have shown that sexual activity starts during adolescence. Much of this activity at this early age is risky and is characterized by unwanted pregnancy, dropping out of school, unsafe abortions, STIs, HIV/AIDS and reduced employment opportunities, especially for young girls (CBS, 2004).

Despite the social changes that have occurred in the lives of Kenyans, it was reported that religious institutions continue to celebrate an era of chastity and sexual conservatism. In a world that is characterized by technological advancement and increased connectivity, people are confronted with sexuality issues on a daily basis, through television, radio, music, newspapers, magazines and advertisements, making it impossible to escape. The most affected group are the youth because they have very little information to enable them to make informed decisions.

> *"When one of my aunts became pregnant out of wedlock, my mum sat us down and discouraged us from engaging in any sexual relationships with men. We have also learnt about sexuality from the books, teachers and radio programs. In secondary school we had a club where we used to share information on sexuality. Today most youth from towns learn about sexuality from the internet and the media. I learnt about sexuality issues mostly from my friends and from here at the youth centre. You also learn from personal experiences of dating and engaging in relationships."* (Teenage mother, Kisumu)

Adolescent sexuality exists side by side with a prohibitive silence to the extent that some parents offer contraceptives and even arrange abortions for their daughters but deny these in public.

> *"My mother took me for an abortion but warned me never to let anybody know it, not even my father. She later brought for me contraceptives to use so that I could not get pregnant again while in school."* (Female respondent, Nairobi)

Very few parents, unlike the youth, are willing to talk about sensitive and sometimes socially censured behaviours, especially in the rural areas. Issues of sexuality are shrouded in taboos and myths. For example, boys are told that abstaining from sex will result in serious backache caused by accumulation of sperm in the backbone. In certain ethnic groups in Kenya where fat women are regarded as beautiful, girls are made to believe that frequent sex will broaden their hips, lighten their skin colour and make them fatter.

"Peer pressure, like I used to wear short trousers and my friends discouraged me from that saying that I would not get a girl friend when I show off my ugly legs, so I had to wear long trousers. Socialization and cultural setting also plays a role, so that you don't have a way out but behave in the expected and right way according to your educational level. If you are illiterate then there are information that you cannot comprehend from the media or in books. Teenagers are more naive than other people who are mature. Teenagers are also more active sexually because of the energy that they have. If I am brought up in a family where no one cares about what I do I will end up being irresponsible and a failure." (Male respondent, Kisumu).

Sexuality is always a part of the kinship system, controlled within it, and subject to its purposes. Love is recognized and accepted as part of personal relationships. One may choose a marriage partner because of personal attraction, even though arranged marriages continue. Traditionally, in polygamous marriages, junior wives were often chosen by the first wife to meet work needs. Sex instruction does not often come from parents. In the presence of their children, they are expected to avoid any words, acts or gestures of a sexual nature. The rules of shame might allow openness about sexual matters with a grandparent. Among the Luo, a grandmother could be the confidant of her grandchildren on their sexual experiences. Nevertheless, sex is mostly meant for procreation in marriage (Brockman, 2001).

"Mostly grandparents used to guide us on issues to do with menstruation, changes in the body, how you are growing up and how to behave around with boys. When one was ready for marriage older women used to counsel on how to take care of the husband to be, how to cook and wash clothes and how to talk to the husband."

"Mostly grandparents counsel us particularly when faced with problems like STIs and unplanned pregnancies, but you can't open up much because the information might end up in your parent's hands."

Formal education was also reported to influence norms and beliefs around sexuality. While in school, young people are taught about physical growth of the body, puberty, adolescence, STIs, and family education, including, sex and other sexuality-related issues. The information people get from the school system enables them to make informed decisions about sexuality issues. Education is known to raise age at first marriage, due to the longer time spent completing schooling, thereby reducing the likelihood of early marriage.

The environment in which young people live profoundly influences their behaviors. There is need to strengthen protective factors in society that help youth make healthy choices. In particular, close relationships with parents and other adults, school attendance and supportive community norms are associated with positive youth behaviors. Conversely, young people who experience family instability, practice other risk behaviors, and have negative peer role models are more likely

to engage in early and unsafe sex. Poverty, including the impact of AIDS on family income, forces many young people out of the protective environments of home and school, increasing their risk of exploitation and unsafe sexual behavior. Street youth, displaced and orphaned youth are at particular risk. Young people may also fail to recognize their own personal risk because of a lack of knowledge and understanding of HIV.

Female ignorance of sexuality is associated with the feminine norms of virginity and the notion of "saving oneself" for one man. This double standard of female purity and early male sexual initiation limits women and girls from accessing accurate information and services and from talking openly about their bodies, sex and reproduction - so that they do not know what they need to know to protect themselves from HIV/AIDS. Furthermore, the way girls and boys are brought up is linked in gender-specific ways to their emotional and sexual needs. Girls, taught to be dutiful and submissive, and that to be real women they must be attractive to men, are susceptible to having early sex to be accepted, to be protected, for love; boys feel obligated to "seek and conquer" by exerting pressure on girls. Counsellors have a critical role in undoing all these misconceptions.

Harmful sexual practices

Key informants reported that sexual cultures and gender norms vary across various ethnic groups in Kenya, and abuse, violence and coercion are viewed in different ways. In some cultures, married women are obliged to have sex with their husbands, whether they like it or not, rape in marriage is not recognized, and sometimes men have a right to beat their wives if they have stepped out of line. It was reported that counsellors have a role to play in changing culture and promoting human rights and laws through counselling and linking up with health promotion activities.

Sexual violence

There is an epidemic of cases of sexual abuse, sexual assault and violence of all types against women and men in Kenya, according to key informants. These include rape, which in many cases is associated with incest. Focus group discussions with teenage mothers show that young mothers live in constant fear of fathers turning against their daughters. In their neighborhood most youth indicate that sexual violation is on the increase. Although both boys and girls can be victims, girls are up to three times more likely to be sexually abused than boys.

> *"Increasing rates of fathers defiling their daughters particularly daughters born out of wedlock worries mothers seriously because you don't know when it is likely to strike. Some men argue that because this is a child born with another man, she has competing interest with her mother too."*

> *"I mostly fear sexual violence and any other forms of violence between couples. This hurts most people and is very common nowadays. With rape one can end up with internal injuries or bleeding. Diseases like HIV/AIDS syphilis, gonorrhea and other sexually transmitted infections which you can get by having unprotected sex. I mostly fear sexual immorality especially in this era that we have strange diseases that are difficult to treat like HIV. I fear things like homosexuality/ lesbianism where we have people of same sex marrying is very shameful in the society and I always fear for my children when I think of this."* (Female respondent, Nairobi)

It emerged that it is difficult for women to leave abusive relationships for many reasons. These include economic dependency, nowhere else to go, fear of losing the children, breaking up the family, and losing the status of a wife. Counsellors can discuss facts about abuse in relationships with survivors, families and communities to help challenge their own misconceptions about themselves and their situation. Unfortunately, there is a culture of silence surrounding gender based violence, which makes collection of data challenging.

Female genital cutting

The results of the Kenya Demographic Health Survey of 2003 indicate that 32% of women are circumcised, down from 38% in 1998. Despite evidence that the practice is declining, it is still common in Kenya. Over 60% of communities in 49 districts still circumcise their girls, and in some regions up to 90% of women still undergo the practice (CBS, 2004; NCPD, 2003). one in four women aged 20–24 and one in five aged 15–19 have been circumcised (CBS, 2004; NCPD, 2003). The counsellors in the Nairobi youth centre mentioned that a few times they get female clients, mostly of Somali origin, coming to seek counselling on how they can regain their sexual pleasure. They mostly reported having felt pain during sexual intercourse. The counsellors reported having referred such clients to larger hospital facilities for further medical check-up.

Substance abuse

Drug and substance abuse remain one of the major problems confronting youth in Kenya today (National Agency for the Campaign Against Drug Abuse (NACADA), 2004). Studies indicate that many in and out of school adolescents, street children and other groups of adolescents use and abuse drugs (NACADA, 2004; CBS, 2004). One of the focus group discussion participants at Kisumu youth centre had this to say:

"I got addicted to taking drugs while in secondary school. I was influenced by my peers. One year later after I had completed secondary school, I met a friend of mine whom we used to take drugs with at school. I was shocked to learn that he had stopped taking drugs. He offered to take me to the counsellor who helped him to stop the habit. This female counsellor changed my life. She was such a pleasant person to talk with. I felt like she really understood what my problem was. But I can tell you drug abuse is a big problem with the youth. Many of my former friends still need help. I have managed to convince some to come for counselling and in fact we are now members of the post-test club here at this youth centre." (Male focus group discussion participant, Kisumu)

Early and forced marriage

Although the age at first marriage is rising, early marriage is still prevalent in certain parts of Kenya (CBS, 2004). It is manifested in forced marriage of girls as young as 12 years to older men, as well as unions between young people. Studies indicate that adolescent boys marry later than their female counterparts (CSA/UNICEF, 2003; CBS, 2004). Early marriage in Kenya is a consequence of many factors, including early pregnancy, lack of alternative opportunities for girls, and parents' desire for bride wealth (CBS, 2004; CSA/UNICEF, 2003; government of Kenya, 2001). Some of the participants in the focus group discussion comprising teenage mothers in Kisumu youth centre confirmed that they had been victims of early marriage. They narrated how they had been lured by men and even relatives to enter into marriages that they were not prepared for. They soon divorced their partners when they realized the marriages were not working. According to the 2003 KDHS report, 16% of currently married women live in polygynous unions (having one or more co-wives). Women with no or low education and those who are poor are more likely to live in polygynous marriages.

Abortion

A 2002 survey of abortion-related complications at 56 district- and provincial-level facilities in the public sector in Kenya estimates that over 20 000 cases of abortion complications are admitted annually to district health facilities alone (Ipas and Ministry of Health (MoH), 2003). The same survey also indicates that 40% of those who died of abortion complications at public health facilities were adolescents. Unsafe abortion, therefore, remains high, with recent estimates of over 300 000 cases reported annually, which translates to a rate of 800 abortions per day (Ipas and MoH, 2003). Four out of every 10 women who die of unsafe abortion complications are below the age of 20. Adolescents are also more likely to experience pregnancy-related complications. From the focus group discussion with teenage mothers it emerged that many teenage girls were worried about unwanted pregnancies. Many times they opted to do an abortion through very crude methods that they were taught by their friends. Such clients are usually referred to FHOK medical centres or to other available service providers for post-abortion care.

"We try our best to give the youth information on the dangers of abortion. We promote contraceptive use amongst the youth to avoid unwanted pregnancies in the first place. But in cases where they have already done the abortion, we counsel them on how to cope with their experience and how to avoid it so that it does not recur." (Counsellor, Nairobi)

Adolescent Reproductive Health and Development Policy Plan of Action, 2005-2015

Kenya Ministry of Health and Ministry of Planning and National Development (August 2005)

Owing to the high fertility and declining mortality experiences in the past, Kenya is characterized by a youthful population with over 40 per cent being younger than 15 years. This implies that over half of Kenya's population, about 33 million in 2004 is aged below 24 years, with a large proportion being adolescents. Consequently, Kenya faces the formidable challenge of providing its adolescents with opportunities for a safe, healthy, and economically productive future. In line with the ICPD recommendations, Kenya has put in place an Adolescent Reproductive Health and Development (ARH&D) Policy to enhance the implementation and coordination of programmes that address the reproductive health and development needs of young people in the country. The principles spelt out in the ARH&D Policy provided a conceptual guide to the development of this Plan of Action, which further distinguishes four strategic areas: advocacy; health awareness and behaviour change communication; access to and utilization of sustainable youth friendly services; and management. This Plan of Action also provides an estimation of the total resources required to achieve the goal and objectives outlined in the Adolescent Reproductive Health and Development Policy.

Sexual offences act

The sexual offences bill was signed into law in the year 2006. The law provides tougher penalties for rape and other sex-related crimes. It criminalizes deliberate transmission of HIV/Aids and provides rape victims with free medical care and counselling in public institutions. It also broadens the range of sex crimes to include gang rape, sexual harassment, child trafficking, sex tourism, rape, incest and wrongful accusation. Convicted rapists now attracts a minimum sentence of ten years while a maximum penalty will be life imprisonment. Penalty for deliberate transmission of HIV/Aids will be a prison term of at least 15 years.

Urban health

A study conducted by African Population and Health Research Center which compared the impact of socioeconomic deprivation on risky sexual outcomes in rural and urban Kenya showed that although poverty is significantly associated with the examined sexual outcomes in all settings, the urban poor are significantly more likely than their rural counterparts to have an early sexual debut and a greater incidence of multiple sexual partnerships (F. N. A. Dodooet al, 2007). The same study reports that the disadvantage of the urban poor is accentuated for married women; those in Nairobi's slums are at least three times as likely to have multiple sexual partners as their rural counterparts.

Study site

Family Health Options Kenya (FHOK)

FHOK is a non-profit, non-political and non-governmental organization committed to the pursuit of family well-being through responsible parenthood. FHOK, then known as Family Planning Association of Kenya (FPAK), was registered in Kenya in 1962 and affiliated to International Planned Parenthood Federation (IPPF) the same year. FHOK is a grassroots organization with a network of policy and programme volunteers. Its policymaking body comprises of elected officials from among the policy volunteers drawn from its various branches throughout the country.

FHOK has its headquarters in Nairobi and regional offices in all provinces except the North Eastern Province. Throughout Kenya, the association operates several reproductive health medical centres. It has a large, well-established network of community health volunteer workers and a network of peer educators. According to the Kenya Demographic and Health Survey (2003), FHOK's health facilities provided modern contraceptives to 3.3% of modern method users. It, therefore, supplements government efforts in the provision of family planning and other reproductive health services. The organization has spearheaded advocacy for provision of reproductive health services to youth and has gone a long way to establish youth-friendly SRH services including youth-friendly VCT services. FHOK's clinics are used as training facilities by MoH and other organizations, due to the high quality of service delivery. The organization also runs curative services, maternal and child health, laboratory services, pharmacy services, VCT and, most recently, services aimed at prevention of mother–to-child transmission (PMTCT) of HIV. Additionally, there are units at its headquarters that support its programmes, such as research and evaluation, information, education and communication (IEC) and management information systems.

Organization of services

SRH services

FHOK provides integrated SRH services through its eight clinics (known as family care medical centres) and community-based sites. It has increased its range of services from vertical family planning to integrated SRH, offering services such as:

- maternal and child health;
- maternity services;
- emergency contraception;
- unwanted teenage pregnancy counselling;
- syndromic management of STIs;
- education on adolescent sexuality;
- pap smear tests;
- laboratory investigations;
- pharmacy;

- VCT for HIV/AIDS;
- outpatient treatment; and
- referral services.

In the provision of these services, the rights and choices of the clients are paramount.

Youth programme

FHOK has been at the forefront of SRH programming for young people in Kenya. Its adolescent/youth programme started in 1977 as a family life education project providing SRH information to young people in schools. The project later expanded to accommodate out-of-school youth and service provision through model youth centres. The primary interest of the project is to increase awareness among all adolescents and young people on their sexual and reproductive health and rights and to empower them to make informed choices and decisions regarding their SRH and act on them. The programme has expanded from two to five youth centres located in Nairobi, Mombasa, Nakuru, Eldoret and Kisumu. The youth centres are run and managed by the young people themselves who are trained PYEs, and they provide an environment where both girls and boys can discuss their issues, share experiences, learn life planning skills, access reproductive health services and reciprocate by reaching out to their peers with information through organized peer education and community outreach activities. By doing so, they hope to contribute immensely to the vision of young people living healthy lives.

The objectives of the youth programme, as outlined in the current strategic plan, are to:

- respond to the reproductive health needs of the youth by developing and adopting appropriate and youth-friendly IEC materials and strategies;
- develop an innovative model for youth-friendly adolescent SRH service delivery targeted at the youth;
- influence public opinion and convince policymakers of the need to formulate and adopt youth policies and programmes to promote access to reproductive health information and services;
- advocate for gender equity and equality, and the eradication of harmful practices; and improve the social and economic status of young women.

FHOK implementation strategy

Peer youth education (PYE)

Peer Youth Educators (PYEs) serve as youth resources in schools, youth clubs and other community centres. The PYEs are well trained in sexuality counselling. To strengthen the youth programme, FHOK has greatly invested in building the capacities of young people themselves to design, plan, implement and manage the youth project. The counsellors from the youth centres acknowledged that without the volunteer PYEs, they would not cope with the huge number of clients seeking sexuality counselling.

Youth-friendly services
FHOK has taken the lead in the provision of youth-friendly SRH information and services. The youth centres are designed to attract young people, meet their reproductive health needs and ensure that services are accessible and acceptable to a wide range of young people. The Kisumu youth centre had an ample waiting area well equipped with a television and videos on life skills for young people, and this was a source of attraction for many youth.

Vocational training (Binti Africa)
The project partners with disadvantaged adolescent girls, especially adolescent mothers and orphans, in addressing their vulnerability to SRH-related risks. Vocational skills in hairdressing, tailoring, basic computing, and catering are integrated into life planning skills to not only address their SRH concerns but also to attain self-reliance.

Peer education activities are conducted through lectures, group discussions, video shows, individual talks, theatre performances, training of PYEs, formation of PYEs clubs and health information centres in both secondary and primary schools, and recreational activities. PYEs are involved in the development of IEC materials including booklets, pamphlets, brochures and newsletters, which assists them to disseminate SRH information to their peers.

Library services
The libraries provide a quiet environment for young people to study and are stocked with a wide variety of resource materials on SRH-related issues and general reading, including audio and video tapes.

Young people are a key resource to economic development and often shoulder the greatest burden of care; therefore, the FHOK youth programme endeavours to recognize their strengths and to build on their potential in finding solutions to their SRH needs.

Human resource development

People working for the youth centre

FHOK has well-trained volunteer peer educators. Whenever there is an employment opportunity, the volunteers are usually given the first priority, depending on their length of experience, capability and required professional qualifications. All VCT counsellors must be NASCOP (National AIDS and STI Control Program – the body which is also charged with the responsibility of setting standards for VCT training, training VCT counselors and vetting institutions that train VCT counselors) approved trainees with at least a certificate level of qualification in counseling and with some experience in counselling, either from its volunteer programme or from a recognized organization.

Youth centre coordinators

According to the operations guidelines, the role of 'youth centre coordinator' means a person in full-time employment of FHOK and whose terms of service include managing a youth centre and

all youth-related activities, including outreaches, managed by the centre. S/he shall be a person of good repute and of high integrity (done by doing background check of previous employment history and by relying on referees' recommendation) and shall at all times maintain confidentiality in matters concerning clients. S/he shall maintain a good interpersonal relationship with the public in general and with the youth in particular. The coordinator has several well-defined roles, including supervising volunteer youth educators, overseeing implementation of youth centre activities, services, maintaining a youth resource centre, determining cases that require referral services, recruiting and training volunteer peer educators, collaborating with other youth-serving organizations, monitoring and evaluation, and preparing and submitting project reports to the headquarters. Academically, the person shall hold degree or diploma certificate in social sciences or medical field such as nursing.

Volunteer youth promoters (VYPs)

The VYPs are recruited from the target group aged 10–19 years drawn from schools and institutional youth groups within the youth centre's catchment area. Their overall responsibility is to help other young people live a responsible life in preparation for a responsible parenthood. The operations guidelines have a well-defined procedure for the recruitment of the VYPs. Their role includes assisting peers to resolve personal problems affecting them, providing accurate information on adolescent SRH, distributing relevant IEC materials, and referring young people for services at FHOK and other youth-serving organizations. A code of conduct aims to enhance the effective management of the youth centre and also to create a conducive working environment for the PYEs.

Volunteer youth counsellors

In the youth centres' operational guidelines, it is stated that a volunteer youth counsellor shall be a person who has been trained by FHOK or another recognized youth-serving organization for the purpose of youth counselling on a voluntary basis. Duties of a volunteer youth counsellor include receiving referral cases from authorized people, conducting counselling sessions, including VCT (for those already trained in VCT), and keeping appropriate records, and assisting full-time counsellors whenever required to.

Friends of the youth centre

Friends of the youth centre are either former peer youth educators who have left the youth centre activities voluntarily, due to other commitments, or adults who, because of their age, are not allowed to be a PYE but who continue to work in their own communities in educating both adolescents and parents on reproductive health issues.

Staff salaries, benefits and incentives

Employee salary records and payment procedure

Detailed records of the staff are maintained for all employees of the association and their earnings. Salaries are only paid against evidence of work performance, and where staff absent themselves

from duty without written permission, remuneration due for the period of absence is deducted from their pay. Salaries and allowances are paid by cheque monthly in arrears and credited direct into the bank account of the employee concerned after the deduction at source of all sums due. However, the counsellors working at the youth centres reported dissatisfaction with the amount of salary paid to them. They said it was not commensurate with the daily workload. Some NGOs pay better salaries.

Gratuity and pension

Contributions towards the end-of-contract gratuity are banked monthly into a special gratuity account. The amount due at the end of the contract will only be paid after the contract has expired. Similarly, arrangements are made to ensure funds for provision of pension benefits are set aside and invested in an approved pension scheme. Levels for salaries and all allowances are established in the agreed letter of contract/agreement for each employee. Amendments to salaries and allowances, other than annual increments, and promotions are done only after discussion by the management committee and appropriate written authority by the Executive Director.

Medical expenses

A member of staff may claim reimbursement of expenditure incurred as a result of medical treatment received from the designated hospitals by submitting her/his claim on the prescribed form. Medical expenses in respect of either in-patient or out-patient treatment for an officer and her/his family will be refunded up to a maximum amount per annum.

Client–provider ratios and workloads

The counsellors reported being overworked due to a shortage of personnel. They usually work for eight hours a day. During the 12 months preceding the study, 2016 new visits and 1056 repeat visits were made at the Nairobi youth centre, while the Kisumu centre recorded 3028 new visits and 1012 repeat visits. In terms of personnel, the Kisumu centre had one clinical officer, three nurses, four counsellors, six volunteer counsellors, two laboratory technicians and two administrators. At the Nairobi centre there was one manager, one nurse, two counsellors, two volunteer counsellors and one laboratory technician. There were a total of 48 YPEs who assisted with community outreach activities for the youth in Nairobi and 30 in Kisumu. YPEs are not allowed to provide VCT services unless trained in VCT counselling.

Training of staff

Training of professional counselors

FHOK does not directly train professional counselors. However, they do hire staffs with university degree preferably in social sciences or diploma in nursing, and counseling. All counselors must be trained in VCT from a recognized institution which is also approved by NASCOP. In addition to these qualifications, they give preference to those who have gone through their youth peer counseling training and have acquired some counseling experience.

The counselors reported that they would like to have more refresher trainings in order to equip them with new information and skills in the field of sexuality counseling.

Training of peer youth counsellors

As the major strategy through which SRH services are rolled out to adolescents in the communities, peer counselling has been given a lot of emphasis in terms of training. The training takes a total of four weeks using a well developed training curriculum. As mentioned earlier, FHOK recruits most of its counselors from their already trained volunteer peer counselors. The counselors mentioned that the information they acquired from the peer counseling sessions were very useful to them. It helped them to be in a position to handle various sexuality issues better. From the trainings they also got to know how to handle young people better. Clients also mentioned during FGDs that they were generally happy with most of the counselors and that they appeared to have adequate skills in handling their problems or concerns.

Below is an overview of what each training area entails for peer youth counselling:

a) Introduction to peer counselling

In this introductory part of the curriculum, trainees are expected to understand the meaning of peer counselling. The basic premise behind peer counselling is that people are capable of solving most problems of daily living if they are given the chance. The role of the peer counsellor is not to solve another person's problems, but rather to assist the person in finding her/his own solutions. The peer counsellor helps the person to discover solutions to her/his problems by listening, sharing experiences, exploring options, identifying possible resources and giving support.

b) Development of self-awareness

Self-awareness is important for any kind of training. Through a series of self-reflective exercises the trainees assess and reassess their motives, desires and capabilities for becoming a peer youth counsellor. This session enables trainees to evaluate not only their genuine commitment to the training they are about to undertake but also their strengths and weaknesses in relation to counseling.

c) Counselling theories

Counselling theories offer practical grounding in the principles of counselling. They offer significant information regarding major ways of looking at human problems and providing assistance. Theories explain why things happen the way they do in life, and they guide our interpretation of social phenomena.

d) Introduction to counselling skills

In this area of the curriculum, peer counsellors are introduced to skills such as active listening, attending, verbal following and invitation to talk among others. All the professional counsellors must learn how to utilize these skills for effective counselling.

e) Overview of the counselling process

After getting a grip of the counselling skills, trainees are taken through the stages of a complete and effective counselling process. This process is also known as the "helping process". It is referred to as a process because it has a beginning, a middle and an end. Basically, a counselling process should have three phases:

- Phase 1: exploration assessment and planning
- Phase 2: implementation and goal attainment
- Phase 3: termination and evaluation.

f) Applying peer counselling to special topics in adolescent SRH

The training components include the following but are not limited to: counselling on sexuality, safe sex and STIs, STIs and HIV/AIDS, use of condoms, counselling clients for STI testing, HIV testing, counselling after the HIV antibody test and counselling for sexually abused clients. They get to know facts around these topics and how to relay the information to the clients.

Training methods

Trainers reported that they used a combination of various training methods which includes the following:

- The *lecture method*; involves the delivery of verbal information from the source to the receiver without much interaction. This is a traditional and popular method of relaying information.
- The *use of visuals*; visuals refer to the use of items that stimulate the sense of sight. They can be projected (overhead transparencies and slides) or not (pictures, slides and postures). They enhance critical thinking and analysis.
- *Experiential methods*; they include case study and role play. Case study is a real-life situation presented to illustrate certain facts, analyze problems and their consequences, examine relationships among variables, open room for debate, and lead to a logical conclusion. Role play uses short, illustrative dramatic scenes exploring a specific element.
- *Heuristic methods* are also used to train counsellors, with group work used to involve participants who are organized in small groups to discuss and prepare presentations based on their discussion.
- Other non-classified methods used for training include brainstorming, which is a free-flowing exchange of ideas on a given topic.

Trainers also reported that while conducting participatory training, the use of games and exercises is vital. These include such items as introductions/icebreakers, energizers and warm-ups. Games and exercises help to speed up and enhance the amount and quality of interaction in the group. They also do constant monitoring and evaluation of progress throughout the training period. This enables the trainer to assess the successes and failures of the process. Results would give an indication as to what the trainer should do for maximum achievement. However, the counselors mentioned that the period allocated for this training is short; the organization needs to increase the training period to allow for more practice. All in all they were happy with the training approaches.

Infrastructure and logistics

Following interviews with youth centre coordinators in both Kisumu and Nairobi and observations made by the research team, it was evident that the facilities did not have adequate space for all the youth activities that had been planned. Different youth groups, including post-test clubs, teenage mothers' groups and theatre groups, had to meet at the facilities at different times during a week due to limited space. All the same, it was observed that there was no interference in the rooms where counselling sessions were being conducted. Cleanliness was given a high priority in the two youth centres. The centres had waiting areas with seats and TV/ video to entertain and inform clients on STIs, and general information on sexuality, there were spaces where group sessions and health talks take place, place for drama activities and post test club meetings. There were also sections for vocational training, health club, library and counseling rooms, laboratory, clients' observation / resting room, pharmacy and administrative room. It was reported that reduction in funding also led to reduction in supplies and equipment over time.

Client flows/layout

The research team observed that during first visit to the youth centre, clients were issued with an intake form. The registration staff ensured that the client filled in the form satisfactorily, giving all relevant background information. They were then led into the counseling room to see the counselor. Any client who was found to need further services after the first visit was issued with a visit card to be produced on any subsequent visit. The attending provider in each case, and after consulting the client agreed on her/his availability, indicated the next appointment date. The card also indicated the date, time and the provider who last attended to her/him. This procedure was used in every subsequent visit so that the record became an effective monitoring instrument for the client's visits. Clients' records were filed and kept at the centre.

Quality assurance

The centers have also been carrying out regular activities to improve quality of care, which included Quality Client-Oriented Provider Efficiency (COPE) assessments, quality assurance for VCT and adherence to infection prevention measures. The centre coordinators usually provide progress reports on a monthly basis. The reports are reviewed by management staff and feedback given for future improvement. The process is rigorous and ensures that where possible their interventions are informed by passed lessons learnt.

To monitor the quality of their services, FHOK conducts client exit interviews in all its clinics. After clients have been served, they are interviewed by the clinic in charge on specific aspects of the care. This is normally conducted on a monthly basis through a random selection of new acceptors and revisits. Clients are asked questions on interpersonal relations, choice of method, informing and counselling or continuity of method use, and facilitative supervisions are also conducted to determine the degree of competence of the providers.

Funding

Prioritization of the counselling intervention within the organization's budget

Based on FHOKs commitment to provide high-quality services and champion the sexual and reproductive health and rights of young people, more projects continue being implemented under the youth programme. This programme area ranks second in terms of the amount of financial resources allocated to it. In accordance with its vision and mission, from 2005 FHOK has continued to expand the scope of the youth programme by including a youth-oriented programme entitled Young Men as Equal Partners. Funds were also allocated in 2006 for the integration of PMTCT-Plus into safe motherhood, increasing access to VCT and adolescent SRH information and services and incorporating models of care for integrating HIV/AIDS prevention and care into reproductive health services.

Continuity of funding for the services/interventions

There has been a continued decline in donor funding to NGOs over the years, and FHOK has not been an exception. To respond to this major challenge, it has embarked on a sustainability initiative with the basic principal of doing more with less. Other aspects of sustainability include the ability to make the right decisions and manage resources effectively while providing high-quality services in the most efficient manner. To achieve the this, FHOK developed four key strategies: cost recovery, business plans, integration of services, and marketing of services.

Business plans

The overall goal is to increase income and decrease expenditure to achieve a high cost recovery rate. For effective resource utilization in providing integrated reproductive health services in the family care medical centres, a business approach has been adopted where the cost of provision per service is calculated to determine the most competitive price for that service. In addition, the service providers have been equipped with skills for marketing and financial management.

Integration of services

With increasing demand for services, FHOK has increased its range of services from vertical family planning to integrated SRH, such as maternal and child health, pap smear tests, laboratory investigations, pharmacy, VCT for HIV/AIDS, outpatient treatment, and referral. Two of its eight family care medical centres offer maternity services to increase the local income and meet the clients demand.

Marketing services

In an effort to increase the client volume, significant efforts have been undertaken which include publicity of the family care medical centres and aggressive marketing to attract corporate clients. In addition, high-quality services are provided to retain the clients, as satisfied clients usually refer most of the new clients.

Support or subsidies received

Major financial support to FHOK has been from IPPF, which supported core activities with projects like Integrated Medical Centres and Community-Based Reproductive Health Services**,** Integrating PMTCT-Plus into Safe Motherhood, and Increasing Access to VCT and Adolescent SRH Information and Services._FHOK has received support from the Government of Kenya and specifically from the Ministry of Health and the Ministry of Planning and National Development through the National Coordinating Agency for Population and Development. This has been in the provision of VCT kits, contraceptives and other material support received from the Ministry of Health.

United Nations Population Fund (UNFPA) has been supporting Increasing Access to VCT and Adolescent SRH Information and Services, a project in Mombasa and Nairobi youth centres. UNFPA, through Family Health International, supports the IMPACT project with an objective of increasing promotion and strengthening of safer sexual behaviour and effective STI treatment health-seeking behaviour among male workers in three agro-based factories in western Kenya and communities within their vicinity. Engender Health supports the Behaviour Change Communication Project – Working with Youth through Drama. The Japan Trust Fund supports Expansion of STI and VCT Services projects also in western Kenya. Others donors are the UK Department for International Development (DFID), The World Bank through the government of Kenya and GTZ of Germany, among others.

Leadership and reputation

Youth centres

In the youth centre operational guidelines, a youth centre is defined as any premises, including all the facilities therein, that is established by FHOK for the purpose of disseminating SRH information and services to the youth. The centre is managed by a youth centre coordinator employed by FHOK. The guidelines states that the youth centre shall have a large visible identification board at its gate bearing the legend 'Youth Guidance and Counselling Centre', together with other identifying words, numbers and signs.

The youth centre committees

For the purpose of proper management of the youth centre, the coordinator established committees, each with its specific terms of reference. Each committee has its fundamental purpose as giving service to the youth. It works closely with the youth and keep abreast of youth trends and changing needs. Thus, all the committees are youth driven and have the youth as the centre of focus in all their activities. The youth centres have the following committees:

- advisory – consists of the youth or youthful professionals who are willing to offer expert assistance to the youth centre;
- gender – to improve and increase girls' participation in the youth centre activities, recommend gender-responsive materials to be used in the youth centre, recommend gender-responsive activities and ensure achievement of equal male and female participation in youth centre activities;

- publicity – to make the youth centre known to the general public, especially youth, using all avenues of information provision with an emphasis on gender issues;
- library – enhancing and improving the SRH knowledge of young people and the community through IEC materials and enhancing provision of youth-friendly information for use by young people; and
- Administrative – to develop and sustain managerial and operational structures for the smooth running of the centre. The committee also supervises and promotes all the activities that are performed on behalf of and by employees and volunteers of FHOK

How clients learnt about the youth centers

Only two of FHOK's five youth centres, at Kisumu and Nairobi, were selected for this study. Qualitative data indicate that the major services offered at the two centres include counselling on VCT, STIs, marriage, relationships, drugs, and family planning. Quantitative data from exit interviews show that clients (see Table 3.1) mostly learnt about the services offered at the youth centres through peers or spouses, sign boards and friends. When asked about how they chose to visit the particular youth centre, respondents reported that it was because the facility was easily accessible to them (33.8%), they were influenced by their peers (21.5%), the fact that the centres offered youth-friendly services (16.9%) and that the facilities offered services of good quality (15.4%), among others.

Table 3.1: How clients learnt about the services at the youth centres (n=60)(Nairobi and Kisumu data combined)

How client learnt about the services	N	Responses	Cases
VCT mobilization at my institution	5	7.2	8.6
Youth Health center	4	5.8	6.9
Radio	2	2.9	3.4
News paper	3	4.3	5.2
Promotional brochure	6	8.7	10.3
Peer/spouse/sibling	21	30.4	36.2
Family	2	2.9	3.4
Through a friend	8	11.6	13.8
Notice board/sign board	18	26.1	31.0
Total responses	**69**	**100.0**	**119.0**

Source: Exit interview
*Multiple responses allowed

Table 3.2 How did you (client) choose to come here (n=60, Nairobi and Kisumu data combined)

How did you chose to come here	Count	Responses	Cases
Was referred from another health centre	5	7.7	8.6
Was recommended by peers, spouses	14	21.5	24.1
The services are youth friendly	11	16.9	19.0
Has qualified staff/quality service	10	15.4	17.2
This is the only place which has the ser	3	4.6	5.2
Place is easily accessible	22	33.8	37.9
Total responses	**65**	**100.0**	**112.1**

Source: Exit interview
*Multiple responses allowed

a) Kisumu

Kisumu is the third largest city in Kenya, with a population estimated at 500 000 (UN HABITAT, 2005). It is the regional capital and an administrative, commercial, religious and industrial centre for the Lake Victoria basin. Kisumu is still one of the poorest cities in Kenya, and food insecurity, growing urban poverty and the high prevalence of HIV/AIDS are key concerns. It is estimated that about 60% of Kisumu's population live in slums and 15% have HIV/AIDS (UN HABITAT, 2005). Nyanza Province, in which Kisumu is located, has the highest prevalence of HIV/AIDS in Kenya. In spite of the high level of awareness, behaviour change is desperately lagging behind, which can be traced to the retrogressive cultural practices among other factors (Institute of Policy Analysis and Research, 2004).

b) Nairobi

Kenya's capital city, Nairobi, is an international, regional and local hub of commerce, transport, regional cooperation and economic development. There are great disparities in health care between informal settlements and the middle- and high-income areas, and the health problems are also different. Services offered at both Kisumu and Nairobi youth centres include reproductive health services, including contraception, and the treatment of minor ailments, VCT services, information and education on adolescent sexuality, life planning skills education, education and entertainment through video, TV and radio programmes, referral services, recreational and entertaining indoor games, counselling services, vocation training in various skills, and training in peer counselling.

Profile of respondents

Nearly half (46.7%) of the respondents in the exit interviews at both sites were aged 20–24 years, with majority (2/3) being males. Nearly all the clients (95%) were urban residents, while 65% of them were single and only 26.7% married. In terms of religion, majority (68.3%) of them were Protestants. A good percentage (40%) of the clients reported to be living with their friends, while only 16.7% were living with their parents at the time of the interview. This could be explained by the fact that there are many young people migrating from rural areas into urban centers to seek employment. When they have no relatives to assist them, they end up living with friends as they seek employment.

Table 3.3: Socio-demographic profile of respondents (n=30 per site)

	Kisumu %	Nairobi %	Total (%)
Sex of the respondents			
Male	80.0	73.0	77
Female	20.0	27.0	23
Age of the respondents			
15–19	16.7	13.3	15.0
20–24	46.6	46.7	46.7
25–29	16.7	23.3	20.0
30–34	16.7	10.0	13.3
>35	3.3	6.7	5.0
Respondent's marital status			
Single	60.0	70.0	65.0
Married	23.3	30.0	26.7
Separated/divorced	13.3	-	6.7
Widowed	3.3	-	1.7
Client's religion			
Catholic	16.7	30.0	23.3
Protestant	73.3	63.3	68.3
Islam	–	6.7	3.3
No religion	10.0	–	5.0
Who client lives with currently			
Parent	10.0	23.3	16.7
Brother	3.3	6.7	5.0
Sister	13.3	3.3	8.3
Cousin	10.0	30.0	5.0
Spouse/partner	6.7	3.3	21.6
Friend	50.0	30.0	40.0
Others	3.3	3.3	3.3
Respondent's usual place of residence			
Urban	93.3	96.7	95.0
Rural	6.7	3.3	5.0

Source: Exit interview

4

Content of sexuality counselling

Introduction

This chapter discusses the content of sexuality counselling. It explores the reasons why people seek sexuality counselling and the actual issues that clients discuss with counsellors during counselling sessions. It also highlights the changes that have occurred in sexuality counselling needs over time and other emerging issues that key informants and counsellors felt should be included in the current training curriculum.

Why people seek counselling

Table 4.1: Reasons for visiting the facility today (n=60 Kisumu and Nairobi data combined)

Reason for visiting today	Count	Responses	Cases
Client wanted information on sexual relationship	22	17.5	36.7
Client came for marriage counseling	30	23.8	50.0
Client wanted to know his/her HIV status	50	39.7	83.3
Client came for an issue arising from a previous visit	6	4.8	10.0
Client came because of illness	8	6.3	13.3
Client wanted information on FP	5	4.0	8.3
Client came for STD services	5	4.0	8.3
Total responses	126	100.0	210.0

Source: Exit interview
Multiple responses allowed

When asked to state reasons for visiting the youth facility on the day of the interview, (table 4.1 above), HIV counseling and testing was the most mentioned reason (39.7%). Other reasons for visiting the facilities included seeking information on sexual relationship, marriage, STI services, family planning and others came for a follow up of issues arising from a previous visit.

From the observations, it emerged that topics covered during counselling sessions were various, depending on the nature of the problem presented by the client. There was also a general consensus among counsellors during FGD sessions that people usually seek counselling in an effort to access information on a number of topics including:

- various reproductive health issues, such as abortion, fertility, pregnancy and sex;
- their HIV status and information on living positively with the virus;
- rape and gender-based violence;
- body growth and development;
- contraceptives/family planning use;
- love;
- sexual pleasure;
- dysfunctional sexual organs;
- safer sexual practices/risk reduction;
- dating and courtship;
- STI treatment;
- condom use;

- lack of employment; and
- means of gaining economic empowerment.

All these issues contribute to psycho-social disturbance for clients, which then prompts them to seek counselling. According to the counsellors, HIV related issues currently dominate counseling sessions. Positive HIV test results are often a source of depression for many clients. Usually some people contemplate committing suicide because to them living with the virus is equivalent to death. They worry about what neighbours will say, how their family members will react and what will happen to their children when they are dead. Children also get traumatized after the death of their parents, so they need counselling to accept and cope with their situation. It was further reported that growing up can cause psychological disturbance to adolescents due to bodily changes. Counselling usually help them understand themselves as they grow to become adults. Others seek counselling for help with making informed decisions, identifying referral facilities, accessing treatment, drug adherence, how to cope with the death of a parent or relative, education, choosing a career, for relationship problems, friendship, self-esteem, marital problems, powerlessness, lack of money, legal support, gender violence, substance/drug abuse, homelessness and general stressing conditions. Usually it is the clients who raise the topics for counselling.

Data from the focus group discussions with counselors indicated that clients may also seek counselling when they are concerned with addressing and resolving specific problems, making decisions, copying with stress and crisis, improving relationships and harmonizing feelings of conflict.

> *"The person must have had a burning issue and needed information and comfort. When a girl/boy disappoints you, you go for counselling to relieve yourself off the problem. When you are addicted to sex, you would consult, and a girl who is being pressurized to have sex by the boyfriend while she feels she is not ready may also go for counselling. Disappointments from friends and family members may prompt one to seek counseling."* (female counsellor, Nairobi).

Counselling was described by counselors as a process that has a beginning, middle and end. The process generally includes:

- exploring risk factors and risk reduction plans;
- identification of support centres;
- referral to care and support services available;
- coming up with a memory book for the dependants who will be left behind;
- how to adhere to antiretrovirals (ARVs);
- behaviour change plans;
- client disclosure;
- partner involvement; and
- options available for making informed choices.

Counselors reported that they had the role of bringing clients to the level where they felt confident about their sexuality and sexual desires. Clients on their side indicated that after they presented their problems, counsellors took the lead in raising key sexuality issues during the counselling sessions.

Observations results (in table 4.2 below) indicate that most counselling sessions (over 90%) were rated by the research team as good in content, both in Kisumu and Nairobi. However, there were a few areas which were observed to be poorly covered by the counselors (table 4.2) and these included sexual identity, which was not discussed with up to 93.8% of clients observed in Nairobi and 80% of clients observed in Kisumu; sexual pleasure which was not mentioned at all during counseling sessions in Nairobi while in Kisumu it was not mentioned for 73.3% clients observed and gender based violence not mentioned for 96.7% of clients observed in Nairobi and 76.7% of clients observed in Kisumu. 63.3% of clients observed in Nairobi were not asked about number of sexual partners they had, compared to Kisumu where the coverage was rated as good for 96.7 clients. Sexual pain was also not discussed at all with clients in Nairobi as compared to 73.3% of clients not discussed with in Kisumu. Generally, sexuality issues were better addressed in Kisumu than in Nairobi. Areas covered with adequacy (over 80% rating) for both sites included safe sex methods, information on the HIV testing process, meaning of HIV results, and assessment of capacity to cope with HIV results. It was observed that informed consent was sought by all the counsellors at the beginning of each session and only consenting clients were tested for HIV. There were also adequate discussions on personal risk reduction, adoption of the ABC approach, positive living, disclosure of HIV results, availability of immediate adequate support, and immediate plans. Follow-up plans were also discussed and referrals made to the majority of the clients (see details in table 4.2 below). Clients generally mentioned during exit interviews that they were satisfied with the counseling services they received from the facilities both in Kisumu and Nairobi.

"I am happy with the way I was counseled, the counselor addressed all the issues that were disturbing my mind and I think they are doing a good job, people out there should know that they can be helped here anytime they are depressed with some problems," a male client, Kisumu.

Table 4.2: Ratings on content coverage during sexuality counseling, (n=60), (data combined for both Nairobi and Kisumu sites)

Content	N/A %	Not covered %	Poor %	Fair %	Good %
Asked client if used protective methods	0	7.5	0	0	92.5
Asked client number of partners	0	33.3	16.65	0	50
Information concerning HIV testing process	4.35	0	0	1.65	95
Information concerning window period	1.65	0	28.35	0	70
Discussion of meaning of HIV results	1.65	0	0	5	93.3
Capacity to cope with HIV-positive results assessed	3.35	1.65	0	6.65	88.3
Discussion of partner involvement	1.65	16.65	1.65	13.35	66.7
Informed consent given	0	1.65	0	0	98.35
Discussion of personal risk reduction	0	1.65	1.65	0	96.7
Adoption of ABC approach discussed	0	0	0	20	80
Follow-up arrangement discussed	0	0	0	0	100
Discussion on positive living	1.65	13.3	1.65	3.35	80
Discussion on disclosure of HIV results	0	5	1.65	3.35	90
Discussion on personal risk reduction	0	1.65	0	0	98.35
Discussion on sexuality and sex safe methods	0	5	1.65	18.35	75
Discussion on gender-based violence	0	86.7	5	5	3.3
Discussion of sexual pleasure	0	86.65	3.35	5	5
Discussion of sexual pain	0	86.65	5	3.35	5
Discussion of sexual identity	0	86.65	3.35	3.35	6.7
Checked availability of immediate adequate support	0	6.65	3.35	1.65	88.35
Immediate plans, intentions and actions reviewed	0	1.65	0	3.35	95
Follow-ups discussed and referrals made	0	5	0	8.3	90

Source: Observation data

Even though no client came for post abortion care during the study, counselors reported that such clients were usually counselled on how to handle the post-abortion trauma, usage of contraceptives to avoid recurring unwanted pregnancies, and relationships, among other issues. For post-rape counseling they explained that trauma counselling was provided for the victim and family, HIV/AIDS counselling was done in the context of trauma, and HIV post-exposure prophylaxis (PEP) adherence counseling was also done. The clients were referred (both inside and outside the facilities) for the management of injuries, pregnancy prevention and HIV prevention using PEP.

While counselling clients on condom use, counsellors reported that they had to demystify moral and cultural justifications used in the past to blacklist condoms; for example, that condoms are not safe because they have small holes or pores, that they reduce sexual pleasure, that they are meant for sex workers, and many others. The information given to the youth was that when used correctly, condoms are so far the best method for STI and pregnancy prevention among sexually active youth. Counsellors noted that since condoms were shared between sexual partners, it was crucial to provide basic guidelines on negotiation techniques for safe sex for men and women. This kind of information was passed on to the youth through a multifaceted approach using youth post-test clubs, youth peer clubs and community outreach activities. Demonstrations were given on correct condom use, and people were given sessions to share their experiences and testify how

condoms had transformed their sexual behaviour by keeping them safe from STIs and unwanted pregnancies.

For STI and HIV/AIDS counselling, observations by the research team revealed that counsellors usually begun by doing a risk assessment for the client, in which they shared knowledge about how STIs and HIV are transmitted, and then explored the possibility of transmission in the client's life. They helped clients to reflect on their (and their partners') past and present sexual and drug-using behaviour and whether this might have put them at risk of STI or HIV infection. Counsellors explained that they were trained not to make any assumptions about clients. The client may have had partners of the same sex or opposite sex now or in the past. Meanwhile, the counsellor provided information on the level of risk of different sexual activities and discussed in detail each of their concerns. When the counsellor had talked about all the issues, s/he summarized the main points and asked how the client felt about their likely risk. The counsellor shared with the client her/his own assessment of a likely risk. The counsellor then moved on to make a risk reduction plan with the client or talked about the HIV test if appropriate.

Counsellors also reported that during PMTCT counselling sessions, they helped clients to understand what actions they could take to prevent the transmission of HIV to their children. They assisted clients to decide on whether to conceive or not. Those who decided to have a baby were advised on how to minimize the risk of HIV infection during conception and pregnancy or through breast-feeding. They were advised on when to take ARVs, and issues of adherence were stressed. Key informants added that PMTCT uptake was improving with time. With increased awareness, more mothers were going for HIV testing early and were increasingly getting enrolled for the PMTCT services. Mothers were motivated by the fact that they could still fulfill their reproductive rights, despite their HIV-positive status.

Abstinence from sexual activities was reported as a very important component of sexuality counselling, especially for young people who felt unready to have sex, people with unfaithful partners, or people not able to have sex due to separation or illness. Those who were sexually active and could not abstain were encouraged to consistently use condoms, to go for VCT to know their HIV status and to engage in stable relationships. This was reported to be a process that could not be achieved in one day. The youth peer clubs both in Kisumu and Nairobi were better placed to reinforce such behaviour change for young people.

Even though gender based violence was observed to be poorly covered by counselors, the very counselors reported during indepth interviews that in abusive relationships, they had a role to help clients talk about the abuse. They were trained on how to look out for symptoms of abuse and screen clients (especially women) for physical or sexual abuse, provide initial counselling and refer them to available services. They support clients to ask the law to intervene, build the client's support network to put pressure on the abuser to change, and initiate community work aimed at changing sexual and gender norms. Through peer educators' out -reach activities the communities were usually taught to avoid retrogressive cultural practices and norms. There was a difference

in what counselors reported during in-depth interviews and actual observation on counseling pertaining to gender based violence. Our conclusion here was that the counselors may not be living up to their imagined or reported roles.

Content of issues discussed during first visits

Clients reported during FGD sessions and exit interviews that during first visits, emphasis was put on reasons for seeking counselling, HIV information and testing, window period, positive living, issues of good intimate relationships, proper and affordable nutrition, safer sex methods, avoidance of stress to help keep the CD4 level constant, and counselling in general. Other issues discussed include disclosure of HIV status to trusted partners and relatives, discussion of client's worries and concerns, and developing memory books. Clients also received information on family planning and life skills.

Issues discussed in the follow-up sessions

Depending on the nature of the counselling services sought by clients, issues discussed during follow-up sessions varied but centred on revisiting previous issues, condom use, issues of disclosure and partner involvement, and overcoming emotional stress and fears.

> "*We still talked about rape and how I can overcome the emotional stress that this caused me. We also talked of how I could overcome my fears, whether I should go on with the relationship or stop it.*" (Teenage mother, Kisumu)

Clients who test positive during the first visits also reported discussing access to antiretroviral therapy (ART), adherence and possible complications of using ARVs, opportunistic infections, referrals and the drugs' cost.

> "*In my second visit we discussed my fears, referrals, drug adherence, nutrition and possible complications of using ARVs.*" (Single woman on a return visit in Nairobi)

Issues of psycho-social support featured strongly in the follow-up visits and discussions with clients. Clients were encouraged to join post-test clubs at the centre and other support groups for people living with HIV and AIDS (PLWHA). Family involvement was also emphasized during such visits. Clients who had resumed good health through ART wanted to get information on family planning, condom use and PMTCT. Referrals to home-based care providers are also made. Discussions are also held on how to generally overcome stigma in the community. Clients are encouraged to go public about their HIV status as a way of reducing stigma.

According to the counsellors, issues to be discussed during follow-up visits may include recapping on all the sexual activities discussed earlier with the client and their level of risk. Counsellors give clients information on other sexual activities that they might enjoy, as appropriate, and

explore with them the good and the bad points of each choice in terms of level of HIV (and pregnancy) prevention, enhancing relationships, intimacy and pleasure, partner's preference, other consequences, practicality and feelings. They help clients to think about the potential results of each choice and make their own decisions. For example, women may need careful thought and preparation to speak to their partners about condom use.

Issues raised by clients during counselling sessions

During counselling sessions many issues arise from clients. These include how best to make decisions on family and sexual problems, how to get treatment and the possible side effects of drugs, partner involvement and how counsellors can assist in solving issues that might emerge. Counselors reported during FGD that sexuality issues usually raised by the clients showed gender differentials, with females showing more concern with pregnancies and males showing concerns with how best they satisfy their sexual partners. HIV-positive clients expressed concern over their nutritional needs while taking ARV drugs. Some of them asked if they could be assisted to access more food while on these drugs, to enable them to maintain good nutritional status and to avoid weight loss. They also worried about care and support for their children after they die. Female clients reported difficulty in disclosing their HIV status to their spouses. They mostly feared violence, as one client expressed:

> *"My husband will be very disgusted with me. For now I do not have the courage to face him. He will say that I am the one who brought the disease in the family. I know he will beat me; he may even send me back to my mother."* (Female client in Nairobi)

It was reported by key informants that generally it was difficult for women to tell men about STI or HIV infection because of gender inequality, and men often do not wish to inform their partners. Counsellors explained that they usually helped such situations by exploring the best way for clients to tell their partners about the infection for them to get treatment. They explored how the partner might react to the news and what the client could do to minimize risk of rejection, conflict or abuse.

> *"Understanding the risks of infertility and damage to babies can motivate people to seek STI treatment promptly and to inform their partners. Understanding the increased risk of HIV and its impact on both clients and families can motivate a change of behavior", MOH official, Kisumu.*

Information on sex and sexuality issues: counsellors' views of case scenarios discussed during FGDs

a) Young man living positively on ARVs who desires to have a relationship, eventually marry and have children

Information that would be provided by counselors to the client:

1. Encourage the client to disclose his sero-status to the other partner.
2. Prepare the client psychologically to avoid effects of stigmatization, because many people he will approach may turn him away.
3. Referral can be given once the client gets a partner so that they can be advised further on his case.
4. Explain the risks of having unprotected sex, and the possibilities of contracting other strains of HIV and development of resistance for a partner who is not on ARVs.
5. Provide information on other technologies such as test tube babies, including screening and cleaning of sperm.
6. Prepare the client to work with his self-esteem, ego and personality.

b) Discordant couple where the woman is HIV-positive and is under pressure by in-laws to have another child

The following information would be provided by counselors to the client:

1. Encourage her to disclose her status to the partner and relatives who exert pressure on the couple concerning childbirth and their marriage relationship.
2. Assist her to deal with the internal pressure first, accept her condition and live with it.
3. Let her know of the risks that may come with having the baby.
4. Let her weigh the benefits and risks, because if she discloses her status, the family may chase her away.
5. Advise her to seek professional help before they have any babies, and explain the need to use condoms.
6. Refer the couple to a support group for discordant couples so that they can disclose and share their fears with people in similar situations.
7. Counsel the couples not to give in to pressure from his people and be counselled on how to make wise decisions and concentrate more on her husband and not the relatives.

The responses to the two scenarios show that counselors seek a balance between supporting clients wishes and psychological risks of disclosure and the information that help a client to make decisions. Counselors indicated they would be supportive in disclosing the HIV status to the client's relatives and this would help in reducing the associated stigma.

Who should counselling be for?

Key informants agreed that counselling is a service that may be needed by anybody, depending on the prevailing circumstances. An orphaned child needs to be counselled on how to cope

with her/his parents' death. Adolescents and youth need counselling on how to cope with body growth and development and general sexuality issues and relationships as they grow up. Parents are frequently confronted with challenges of scarce resources for household consumption and parenting, including guidance to adolescent children. FGD participants expressed concern with parents who are negative about sexuality education efforts; sexuality counselling should target them more. Some young women also voiced their concern over rising numbers of fathers raping their daughters in some communities in Kenya. They reported that the biggest challenge was that such people were usually protected by their other family members and the cases were hardly reported to the law enforcing agencies. It also emerged that parents needed to be empowered with sexuality information so that they can offer supportive environment for sexuality counseling.

Teachers need counselling on child support issues, given that they interact and assist children with varied challenges including poor performance in school work, rape cases, child labour, and economic hardships at home. Couples often face relationship problems ranging from infertility, unsatisfactory sex, extramarital affairs, dysfunctional sexual organs, pregnancy complications and STIs, among others. Drug abusers were equally reported as a special category of people that needs counselling to enable them to recover from the problem. The addicts usually suffer from impaired judgement and as a result become vulnerable. For street children and street families to be effectively rehabilitated, a lot of counselling and guidance needs to be done. Other vulnerable groups that need counseling include sex workers, discordant couples, homosexuals, rape victims, victims of gender violence, people working in the transport industry (for instance, long-distance truck drivers), hotel industry workers, bar attendants, and other marginalized groups in society, such as disabled people. Finally, religious leaders were mentioned as a special category that needs counselling because of their negative attitude towards sexuality issues. In Kenya today, the religious fraternity is well known for promoting abstinence among young people without giving room for other options available.

> *"This counselling should target all ages, parents' adolescents and children. From age 5 onwards people grow up with several source of information particularly messages on sexuality issues. This empowerment should also target opinion leaders, community leaders and religious leaders. These messages should target specific audience, age group and should be offered to primary schools, secondary schools and other institutions."* (Key informant Kisumu)

> *"School-going children from age 13 and above, couples both in relationships and marriage, youth in general, teachers in school, parents, HIV-positive persons/PLWHAs and discordant couples really need proper counselling."* (Key informant Nairobi)

From the information above, it became clear that people confuse counseling and training or education to gain knowledge on how to handle various sexuality issues. Teachers, religious leaders, commercial sex workers and long distance track drivers among others would suite the category of people that needs to be sensitized on sexuality issues in order to make the counseling environment more supportive.

Changes in counselling needs of clients

Key informants generally agreed that counselling needs of clients are dynamic and that they change with time, depending on the prevailing circumstances. Previously, the major areas where counselling was sought included rape, STIs, drug abuse, family planning, HIV testing, sexual activities and living positively with the HIV virus. With improved access to ART, clients, especially males, are seeking information on how to improve on sexual pleasure and consistent use of condoms (more so for discordant couples). With improved treatment and quality of life, many HIV-positive women and couples are considering having children, while others want to avoid having children; clients want to be advised on ART adherence, good nutrition, sero-discordance, and sexual satisfactions.

With the uptake of ARVs, many clients are now seeking information on nutrition. They would like to know the kind of foods that go well with the drugs. What follows next in the discussions is usually how to improve food security in the clients' households. Specifically, clients would like to be economically empowered to improve the quality of their lives even when they are living with the virus. The need for economic empowerment was also expressed by teenage mothers. They asserted that without economic empowerment, it would be difficult for some of them to abandon risky behaviour such as commercial sex work.

Sexuality issues to be included in the training curriculum: Counselors / key informants perspective

Counsellors showed the need for the integration of sexuality issues into the training curriculum, and most areas noted for inclusion into the curriculum include:

- Sexual empowerment, livelihood skills and economic empowerment for PLWHA;
- Life skills training, relationships communication, and creation of awareness and behaviour change advocacy within communities;
- Human growth and development;
- Ways of addressing clients' needs, referrals and follow-up plans, including issues of support groups like post-test clubs;
- Concerns of the youth, such as assertiveness to empower the opposite sexes on how to take responsibilities for their own sexualities, and how to make informed choices;
- Concerns of the youth, such as assertiveness to empower the opposite sexes on how to take responsibilities for their own sexualities, and how to make informed choices;
- Sources of information on HIV/AIDS, such as positive living;
- Sexual rights of discordant couples;

- Parenting skills, family counselling for all family members, and communication in family relationships;
- Exploring care options, understanding patients' concerns, and helping patients to make an informed choice;
- Referral for legal support for clients
- Nutritional counselling;
- Sexuality counselling for children;
- Fostering positive attitude for sex and sexuality for communities;
- Handling discordant couples;
- Sexuality counselling for the whole family;
- Community participation in HIV prevention, care and support.
- Counseling on sexual orientation

Emphasis was made on the need for frequent refresher trainings for counselors because of the dynamic nature of the sexuality issues arising from clients. On the same note, training curricula should also be revised periodically to suite or address the prevailing sexuality issues. In addition, they reported that there is need to develop a standard counselling guideline that captures all the various components of sexuality.

Conclusion

HIV related issues dominated counseling sessions at FHOK. Counselors were quite conversant with the HIV counseling procedure as they were observed to adequately take clients through exploring risk factors and risk reduction plans; identification of support centers; referral to care and support services available; how to adhere to antiretrovirals (ARVs); behaviour change plans; client disclosure; discussed partner involvement; and other options available for making informed choices. However, the content of sexual orientation, sexual pleasure, and gender based violence were not adequately covered by the counselors. Some counselors mentioned during in-depth interviews that they needed more training on such topics to improve their competence. Following the dynamic nature of sexuality issues, there is need to regularly revise the training curriculum in order to respond to the emerging needs of both clients and counselors.

5

Quality of sexuality counselling

Introduction

The factors that contribute to quality sexuality counselling are explored in this chapter. Privacy was assessed by observing whether the counselling sessions could be overheard, while confidentiality was assessed in carrying out HIV testing, disclosing results and keeping records. The provider–client relationship has been explored in detail as a major contributor to quality counselling. Appropriate usage of verbal and non-verbal communication is also very important for quality counselling. Referrals and linkages with other service providers also contribute to the quality of services to clients, since they enable clients not to miss out on services that they require.

Privacy and confidentiality

Table 5.1 below shows that privacy was rated as good in 85% of the counselling sessions observed. Privacy here referred to the location where the counselling session was taking place. Researchers were supposed to assess if the counselling room was secluded and could not be overheard. Level of interruption was rated as good if there was no interruption at all during the counseling session, it was rated as fair if the session was interrupted a few times and poor if there were several interruptions during a session. Key informants indicated that in the context of HIV/AIDS, usually privacy is protected by observing confidentiality in carrying out HIV testing, disclosing results and keeping records. In about 96.7% of the counselling sessions, counsellors assured clients of confidentiality. The counsellors explained the meaning of keeping confidentiality to the clients.

Table 5.1: Observed privacy and confidentiality ratings, n=60 (Kisumu and Nairobi data combined)

Quality	Poor %	Fair %	Good %
Privacy	0	15	85
Sitting arrangement	0	0	100
Face-to-face interaction	0	1.7	98.3
Level of interruption	26.7	18.3	55
Counsellor assured clients of confidentiality	0	3.3	96.7

Source: observation data

Key informants explained that confidentiality is when personal information about clients is not revealed without clients' permission. The research team observed that the clients' records were well kept in locked cabinets at the youth centres. It emerged during focus group discussions sessions with clients that lack of privacy can actually bar clients from accessing counselling services. One of the focus group discussion participants narrated her experience thus:

> *"I one time took my sister to a public hospital for STI treatment and while on the queue a nurse came calling, 'Where is that girl who had gonorrhea' then everyone wanted to see who it was. My sister was so embarrassed that she swore never to return to that facility."*

One of the long-serving counsellors at FHOK explained that clients respect counsellors more and open up with their situations when they know that they maintain confidentiality. From her experience, confidentiality helps clients admit during counseling sessions that they have been involved in high-risk behaviour such as drug abuse and multiple sexual partners. Data from focus group discussions revealed that young people do not want their sexuality issues shared with their parents. When adolescents learn that their concerns are shared with their parents they immediately stop using such services. Generally, young people are greatly disturbed and affected by a feeling of suspicion that their sensitive and intimate health concerns are being shared with others. For young people under the age of 18, counselors reported that they encouraged them to inform their parents or guardians about their test results. However, if the counsellor determined that it was in the best interest of the young person for his/her parent to know the results, the counsellor assisted the young person in every way possible to disclose this information. Those who refused to disclose at all to anybody were however, not forced to disclose. Confidentiality and privacy, therefore, are key to successful implementation of sexuality services to young people.

In couples counselling, it was reported that procedures should provide a safe and trusting environment where the couple can feel free to express their feelings. Confidentiality encouraged clients to disclose their HIV status to each other. However, it was not common for couples to seek counseling together at the two study sites. Only two groups were observed during the study period. Peer counselors were reported to be already doing some advocacy at the community level in order to sensitize people on the importance of couple counseling.

Key informants reported that confidentiality should also be observed between counsellor and supervisor, so that counsellors may discuss their caseload freely during supervision sessions. The identity of the client should still be protected, and it should not be possible for the supervisor to identify the client.

Provider–client relationship

The key informants from both study sites agreed that a good counsellor is one who provides services following the guidelines provided by the ethics and principles of counselling. However, they noted that counselling may sometimes become ineffective because the counsellor fails to internalize these guidelines clearly. Generally, the provider–client relationship was observed to be good during the counselling sessions. All the clients were greeted in a culturally appropriate way, while face–to-face interaction was good for nearly all the sessions. In over 90% of the sessions observed, counsellors assured clients of what they would do to help them overcome their situations. All the counsellors were observed to use warm and kind tones and to be quite respectful to clients. The counsellors were also observed to be quite supportive (96.7%) and non-judgemental (98.3%) to the clients. They all used clear and understandable language that made communication with clients quite easy, (table 5.2 below).

Non-verbal communication by counsellors was also rated as good for the majority (over 90%) of the observed sessions. These included keeping appropriate eye contact with the client, counsellor nodding when necessary and using both hands, appropriate facial expressions and other encouragers. The providers found out what the client knew about the problem (95%) and were able to build very well on it (83%). For HIV/AIDS counselling, the counsellors were observed to be well equipped with up-to-date knowledge on the disease. Other areas where the counsellors were rated as good included effectively listening to clients, commending clients for the courage to attend, appropriate balance of closed and open-ended questions to explore clients' situations, directing discussions properly, allowing clients to absorb information and respond, appropriate probing, and providing factual information based on clients' needs. They were all able to give a good summary of the main issues discussed during the sessions, details can be found in the table below.

Table 5.2: Provider – client interaction ratings, n=60 (both Kisumu and Nairobi data combined)

Quality	Not covered %	Poor %	Fair %	Good %
Clients greeted in a culturally appropriate way	0	0	0	100
Counsellors introduced himself/herself before the counselling sessions	0	0	3..3	96.7
Counsellor relaxed	0	0	11.7	88.3
Counsellors assured clients of what they would do to help them overcome their situations	0	0	10	90
Counsellor encouraged clients to speak	1.7	0	10	88.3
Clients helped to express their emotions	0	0	11.7	88.33
Counsellor listened to clients effectively	0	0	6.7	93.3
Use of kind and warm tones and counsellor respectful	0	0	0	100
Counsellor supportive to client	0	0	3.3	96.7
Counsellor non-judgemental	0	0	1.7	98.3
The counsellors praised clients for the courage to come	0	0	6.7	93.3
The counsellors kept eye contact appropriately	0	0	6.7	93.3
Used non-verbal communication appropriately	0	0	1.7	98.3
Counsellor used appropriate balance of closed and open ended questions	0	0	11.7	88.3
Counsellor used clear and understandable language	0	0	0	100
Counsellor found out about what the client knew about the problem	0	0	5	95
Counsellor built on what client knew	0	0	16.7	83.3
Counsellor allowed client to absorb information and respond	0	0	8.3	91.7

Source: observation data

Most respondents reported that they were satisfied with the way they were handled by the counsellors:

> *"She responded well to all the worries and concerns that I had, I got more information about my problem, and the time was adequate. I like the way she was patient with me; I am happy."* (Client, Nairobi)

Referrals

Of the clients in the study, 81.7% were either referred or asked to come back for a service at the FHOK youth centre. They were also informed on where to get the referral services. Clients were referred for services such as DTC, VCT, STI counselling and treatment, post-abortion care, and counselling on PMTCT, family planning, sexual relationships, marriage, sexual pleasure, sexual identity, gender relations, sexual violence, unwanted pregnancy, fertility, X-ray examinations, ARVs, and post-test club membership and support. In the youth centre operational guidelines, it is clearly stated that any client who, by the nature of her/his needs, the centre coordinator or the attending counsellor considers needs referral to other agencies shall accordingly be referred. The youth centre coordinator shall use a referral form indicating the client's background and case summary. The referral agent shall then return the card to the referring youth centre coordinator for follow-up.

To make a good referral, it was reported by key informants that the counsellor must ask her/his clients which places they prefer, what their experience has been of different places, any barriers to following through with the referral, and what would make it easier for them to know. Counsellors need to explain in detail what clients can get from the referral and, if it helps, give them a note to take to the provider. Counsellors should give their clients a written list of facilities and their contacts. Lastly, they should do a follow-up to their clients to find out whether they were satisfied with the service and what help was provided.

In an interview with one of the youth centre coordinators, he clearly stated that with reduction in donor funding in the recent past, FHOK's major strength for the youth project has remained referral. The organization has formed very strong collaborative networks and linkages with various government ministries and community-based and non-governmental organizations (NGOs) to address their clients' different needs. Some of the organizations that FHOK collaborates with for referrals include the following:

Table 5.3: FHOK Collaborators

Organization	Area of collaboration
• Impact Research and Development Association (Tuungane Project)	• Community education • Provision of VCT and general counselling • Capacity building • Theatre/drama activities • Care and support/provision of ARVs
• The Ministry of Health	• Procurement of STI drugs and other contraceptives • Capacity building • IEC • Referrals • Supervision of counsellors • Training manuals • Health-related policies and guidelines
• Ministry of Home Affairs, Children's Department • Ministry of Culture and Social Services • Ministry of Education	• Community education • Advocacy • Community education
• KAPC (Kenya Association of Professional Counsellors)	• Community education through the 'Straight Talk' project • Capacity building/training
• CDC/KEMRI	• VCT • ARVs • Care and support • Referrals • Research
• SWAK (Society for Women and AIDS in Kenya) • KIPE (Kisumu Initiative for Positive Empowerment) • KUAP (Kisumu Urban Apostolate Programme) Pandipieri • WOFAK (Women Fighting AIDS in Kenya) • ITM – Belgium (Institute of Tropical Medicine) • Kenya Red Cross Society • STIPA (Support for Tropical Initiative in Poverty Alleviation) • NCAPD (National Coordinating Agency for Population Development) • GTZ – Kenya • TEMAK (Teenage Mothers Association of Kenya) • MERLIN	• Care and support • Counselling • Referrals • Community education • IEC • Capacity building • Group therapies • Exchange programmes • Implementation of commercial sex workers project • Puppetry theatre • Provision of ARVs

Clients' preference for counsellors

Exit interview results indicate that many clients in Nairobi have no preference of counsellors, while most clients in Kisumu would prefer a counsellor of a different sex, that is, males preferred to be counseled by females and vice versa. Teenage mothers (Kisumu) in their focus group discussions agreed that they preferred counsellors of the opposite sex and in a similar age group, as they would not be free to share their private issues with counsellors of their parents' age.

"Some counselling sessions are too short to make one open up. Some counsellors here are just trained on VCT but very few are trained on substance abuse and career guidelines. I have no preference as long as my counseling needs are addressed."

"The counsellors here offer high-quality counselling and have positive attitude towards us because they too are youth."

"We prefer being counselled by opposite sexes because people understand and relate well with opposite sex."
"The young counsellors are the majority here but whether volunteers or employed they are good to us." (Focus group discussion participants in Kisumu)

Those who had no preference mentioned that as long as they got quality counseling services that addressed well their concerns, they did not really care about the age or sex of the counselor.

Table 5.4: Clients' preference for counsellors

Preferences for counsellors	Frequency
A counsellor of different sex	13
A counsellor of same sex	10
A younger counselor	10
An older counselor	9
No preference	18
Total	60

Source: Exit interview (n=60)

According to counsellors, most married (heterosexual) people prefer to be counselled by older, married counsellors, especially for couples counselling. They tend to believe that such counsellors are likely to have had practical experience with marital issues. Some female clients prefer older women because they tend to understand adolescents' problems. Perhaps they could have had children with similar problems. Clients' other desired characteristics for counsellors include counsellors who are respectful, can keep confidentiality and are generally positive about youth. Eighteen respondents said they had no preference for a counsellor as long as they showed capacity to handle their counselling needs.

"The age of the service providers also matters a lot, especially when one is seeking counselling on things that have to do with sex. If the counsellor is as old as my mum, they might judge me or tell me that I'm too young to engage in sex." (Teenage client, Kisumu)

Aspects of counselling liked by clients

Table 5.5: Services liked by clients

What client liked most	Count	Responses	Cases
Liked Short/no waiting time before being attended to	14	12.1	23.3
Liked Privacy/confidentiality	21	18.1	35.0
Liked Sufficient time allowed/not rushed	9	7.8	15.0
Client able to discuss his/her worries	13	11.2	21.7
Friendly/non-judgemental counsellor	26	22.4	43.3
Liked Useful/sufficient information given	33	28.4	55.0
Total responses	116	100.0	193.3

Source: Exit interview (n=60 both sites combined)
Multiple responses allowed

Most clients showed appreciation in certain areas where the counsellors had done better. These included good-quality services offered by the organization, such as VCT, STI treatment, referral, free counselling, high level of confidentiality, and integration of the services to avoid cases of stigmatization. They also liked the fact that they had sufficient time to discuss their worries and that counselors were non judgmental.

> *"The way I'm free with the counsellor, the privacy in that nobody hears what you are talking about and the fact that I have never heard anybody talk about the things I discussed with the counsellor. She knows how to keep secrets."*
>
> *"These counsellors have good follow-up systems, they know how to handle clients, and there is no stigmatization in this facility."*

> *"This facility has a good referral system and has high level of confidentiality, the place is centrally placed to many and their integrated services avoid stigmatization. Because they offer many other services, nobody will know if I came for VCT or STI treatment or family planning services."*

Aspects disliked by clients

The issue that was mentioned to be requiring great improvement was waiting time for clients (as shown in Table 5.6 below). Clients stated that when they are not able to exhaustively discuss their worries, they tend to dislike the services offered and many times relocate to other facilities that offer better services. Usually clients do not want to be judged for what they are. Clients also mentioned that they did not like being referred to other service providers. Other clients from exit interviews had nothing to dislike about the services offered at the two facilities.

Table 5.6: What clients disliked most about services offered at facilities

What client disliked most about services received	Count	Responses	Cases
Disliked long waiting time	8	8.7	13.8
Disliked limited space	3	3.3	5.2
Not able to discuss his/her worries/concerns	2	2.2	3.4
Disliked unfriendly/judgemental counselor	2	2.2	3.4
No dislike	24	26.1	41.4
Painful prick when withdrawing blood for test	2	2.2	3.4
Disliked long counseling session	1	1.1	1.7
Dislike too many referrals	50	54.3	86.2
Total responses	92	100.0	158.6

Source: Exit interview (n=60)
Multiple responses allowed

Counsellors' dislikes

Most counsellors are not happy with how the organization has not been keen to implement strategies to motivate them, especially those working as volunteers. The swelling number of clients in the facilities means that more counsellors ought to be employed, but no effort has been made to do so. Some counsellors also showed dislike of clients who fail to open up during discussions.

> *"I have no dislike, but it depends on whether I'm competent with a problem that a client has come with, when I cannot handle it I refer."*
>
> *"I dislike when clients fail to open up, burn-outs and lack of motivation to do the service and lack of training opportunities in other related problems."*

Suggestions for change

Most clients reported that more service providers should be employed to offer quick services without making them wait for long (more than one hour) before they are served. This would also see a range of services offered in the facilities. Even though it was not expensive, the cost of treating STIs was a concern to some clients who could not afford it due lack of source of income. Some clients also mentioned that they would like to be attended to by the same counselor each time they visit the facility. Others suggested that counseling sessions should be made more demonstrative, that the services should be offered for 24 hours and others suggested that couple counseling should be encouraged at the centers.

Table 5.7: How to attract more clients

Recommendation	Count	Responses	Cases
Keeping the environment clean	1	1.4	1.9
Having more service providers	25	34.2	47.2
Make counseling more demonstrative	5	6.8	9.4
Expand facility/counseling rooms	11	15.1	20.8
Offer 24 hour counseling services	8	10.9	15.1
Offer IEC materials	9	12.3	17.0
Encourage couple counseling	4	5.5	7.5
Free STI treatment	8	11.0	15.1
Provide modern FP methods	2	2.7	3.8
Total responses	73	100.0	137.7

Source: Exit interview (n=60)

Counsellors also mentioned that there is need for FHOK to employ more staff to match the increasing number of clients accessing the services. The staff should be trained in the new areas emerging in counselling to enable them to address all the needs of clients. The counsellors, and more particularly the volunteers, should be motivated with better pay to show appreciation for their work. More rooms should be allocated for counselling to help reduce waiting times for the clients who want to access VCT services.

Conclusion

Privacy, confidentiality and provider-client relationship are key to quality counseling services at FHOK. Clients open up more to discuss their issues when they know that they will be kept private and confidential. While some clients have no preference for counselors, others have preference for sex and age. Since the provider preferences vary, it may be advisable for FHOK to employ a variety of counsellors and let clients choose from the available ones There is also need to employ more providers at the two facilities in order to efficiently serve clients. The providers also showed a desire for more training and motivational opportunities.

6

Outcomes of sexuality counselling

Introduction

This chapter looks at the various outcomes of sexuality counselling from the perspectives of clients, providers, program staff at FHOK and key informants outside FHOK. It discusses outcomes of counselling in terms of behaviour change such as clients' high self esteem; reduction in risky behaviour; uptake of specific services, such as condoms and other contraceptives, demand for STI/HIV testing; and ARVs. However, it is important to note the difficulty of attributing behavioural outcomes to the counselling interventions alone. The reported behaviour change might have been as a result of support group activities which created an enabling environment for positive living for clients. It could also be a result of improvement in the larger national health system. Moreover, there are many other non-governmental organizations carrying out sexual and reproductive health interventions in the country.

The analysis was guided by the following conceptual framework. The health systems environment and the quality of counselling have been discussed in the previous chapters.

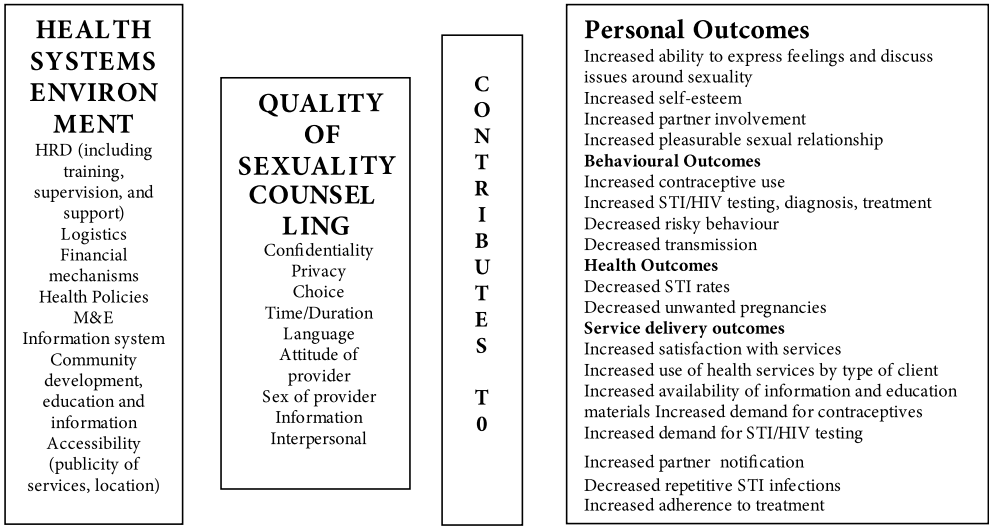


Figure 1: Conceptual Framework

Personal and behavioural outcomes

From the study it emerged that positive living with the HIV virus is a major counselling outcome for many PLWHA. Clients reported during FGD sessions how some of them were now enjoying psychological well being and even better health as a result of repeated counselling. Some clients also appreciated referral services from where they were further empowered on how to live positively with their situations. Key informants agreed that counselling reduces risky behaviour, fears and worries, restores self-esteem, and encourages responsible behaviour. Some of the clients that were referred to the facility post-test clubs have also joined the counsellors in reaching out to

others, either as peer educators in the centres or as volunteer counsellors in the facilities. Other clients indicated that counselling had enabled them to open up to disclose their HIV status to their partners with the help of counsellors and the support groups.

All focus group participants indicated that all their counselling experiences were very useful, particularly to clients that live positively. Teenage mothers reported positive change of attitude after counselling. Counsellors had been instrumental in addressing their worries and fears. This was attested by a young mother living positively:

> *"I almost took my life when I conceived a baby while in secondary school. That is also the time I realized I was HIV positive. When I was referred to this centre I got a friendly female counsellor who really understood my dilemma at that time. The lady changed my mind and even now she is still my counsellor and I respect her very much. Despite being HIV positive, I am not a worried person .I feel good about myself, the ARVs are working well for me, I feel healthy and life continues."* (Female client, Nairobi)

Clients also narrated how the counseling services received from FHOK had enabled them to overcome both personal stigma and stigma in their communities. Through FHOK counseling at the facilities, post test clubs and outreach activities, the communities generally became aware of the basic facts about HIV/AIDS and consequently became more supportive to those who are infected and affected by the virus. Tom, a youth living with HIV had this to say during FGD session with youth in Kisumu:

> *"When I was informed that I was HIV-positive, I wanted to commit suicide. Life made no sense to me. I thought about my parents and friends and I did not know how to disclose to them my status. I cried so much. I hated myself. When I came for counselling at this centre, I realized I was not the only one infected by the disease. I was told that I could live for a longer period if only I lived positively with the virus. Slowly, I began to change my attitude. I later joined the post test club in this Kisumu centre. I met other HIV-positive people who were more optimistic in life than I was. Together we shared our experiences and we supported one another even better. Personally, I have gone public about my status. When I talk about my life people do not believe me. One advantage about going public is that people lack anything to gossip about you because you have already said it all. Instead they sympathize with you. But eventually they learn to live together with you without sympathy. The level of acceptance in the community increases and people begin to talk freely about the disease. They see me do my work like any other person. I look healthy and others are beginning to doubt if am really positive. Others come to seek advice from me when they test positive for the virus."* (FGD participant, Kisumu)

Increase in self-esteem

In 2005, the organisation encouraged the scaling up of post-test clubs; this resulted in 12 meetings that brought together 56 support group members (30 females and 26 males). The club members also conducted five outreach activities, during which they encouraged young people to go for VCT services through personal testimonies and success stories. In addition, the clubs proved to be good referral points for the youth testing HIV-positive or negative. The active participation of volunteers has helped to break some of the barriers that existed for young people that fuel discrimination and stigma. One of the youth reported how she used to underrate her self-worth until she went through several counselling sessions and joined a post test club:

> *"I hated myself so much. My mother died when I was a young girl. I was brought up by my step mother who always made me feel that I was a burden in her household. She always made sure I had chores to perform while her own children were playing. She called me names. I thought I was the ugliest girl in the village. After completing secondary schooling, I became pregnant. Unfortunately, the father to the baby declined to support me. My world crumbled. Thanks to Kisumu youth centre. When I came here for the first time, I came to seek abortion service. But after going through several counselling sessions, I changed my mind. The counsellor informed me about the consequences of abortion and I decided to keep my baby. The counsellor was so supportive. Later on she advised me to join the post-test club where I met several single teenage mothers. Later on we formed our own support group. Today I feel much better about myself and I am more confident to face the challenges of life. I now have the courage to talk before others, I know all the consequences of unprotected sex and so I can negotiate for condom use with my partner."* (Female FGD participant, Kisumu)

Counsellors also noted that many clients report that counselling had helped them restore a good relationship with their partners. Some of those who had marital problems were able to put aside their differences and reunite in happiness after going through couple counseling. Couples were counselled on ways to improve communication between themselves and how to care for one another's needs. Program staff at FHOK also reported that due to counseling the number of people who disclosed their HIV status either to their spouses, family, or friends had increased. They also reported an increase in the number of clients sharing their HIV status publicly.

Increase in condom use

According to the organization's annual reports, the youth centres continue to promote the use of condoms among the sexually active youth. A total of 126 890 male condoms and 2019 female condoms were distributed through different project activities, including during counselling sessions in 2005. In 2006, the number increased, with a single peer educators and friends of the youth project distributing a total of 11 886 males and 4470 female condoms. The drama groups also distributed a total of 80 960 male condoms and 318 female condoms to sexually active young people in the same year. In-depth interviews with counsellors in both facilities also indicated that condom use had been on the increase, with young people opening up during condom demonstrations to

follow the steps of correct use. Counsellors attribute this increase to counselling activities within both facilities and the youthful counsellors volunteering to give out such information to others through peer education.

However, it emerged during focus group discussions with the youth that correct and consistent use of condoms still remains a challenge for many young people. Partners in a long-term relationship tend to trust one another, and the moment the issue of trust comes in, condom use is no longer applicable.

Increase in demand for contraceptives

Even though annual records of reproductive health services at FHOK indicate that there were fewer family planning clients in 2006 than in 2005, contraceptive uptake was reported to have generally improved compared to previous years. The clinics attracted 36 551 family planning visits in 2006 and 38 409 in 2005. The 31% decline in the number of clients was partly attributed to the stock-out of some contraceptives. The improved performance was attributed to the continuous efforts by service providers to increase awareness on the availability of the services to clients. Despite the shortcomings in contraceptive supplies in the country, counsellors interviewed reported that there has been an increased uptake of contraceptives, particularly after counselling clients on the appropriate methods for use for their circumstances. This has seen reduced cases of unwanted pregnancies being recorded among the youth clients.

Service delivery and health system outcomes

Increased use of health services by all groups in need of sexuality counselling

According to the FHOK annual report, the total number of youth accessing sexuality health services increased from 27 814 in 2005 to 78 316 in 2006. This was a positive achievement, because of these, 45 126 (58%) were new clients in 2006. A total of 167 770 youth were counselled during the period, with HIV accounting for the highest (27 985) number of cases, abstinence (26 647), STIs (23 026) and drugs (18 051), among others. The counsellors said there had been a steady increase in the number of clients in need of sexuality counselling; six of the seven counsellors noted that even clients with other concerns showed lots of interest in sexuality messages such as love, fertility, STI, contraceptives, among others, indicating the thirst for more sexuality information.

Increase in demand for ARV

From the organization's annual reports, more clients were served with ARVs in 2006 than in 2005 and this was linked to increased counselling services and referral. In 2005, only 73 clients were reported to be on ARVs, of which five were below the age of 13 years. Due to a lack of infrastructure, FHOK has not spread the service countrywide, thus limiting provision of ARVs to just the Nairobi West and Eldoret medical centres. The ARVs are sourced from the Kenyan Ministry of Health. Due to the high number of clients, the supplies are replenished on a monthly basis, because there is no limit to the number of clients that FHOK can recruit. In 2006, after the introduction of PMTCT services, 5891 antenatal clients were served, of which 857 (14%) were voluntarily tested and found

to be HIV-positive. However, the organization has plans to expand ART services in various parts of the country.

Increase in demand for STI/HIV testing

The number of youth in demand for STI/HIV testing has been increasing since 2004 as activities that target the youth in general have been scaled up. In 2005, the organization treated a total of 25,041 young people and referred 10,701, compared to 39 689 treated and 14 318 referred for VCT and STIs in 2006. This was also seen in the high number of clients seeking HIV testing services as recorded in the exit interviews and observation sessions. The counsellors agreed that most youth were opening up to seek relevant HIV information and medication for STI infections. The records indicate that there were repeated visits by the youth to the facility.

Improved capacity of the health delivery system

In 2006 twenty personnel from clinics and head office were trained in comprehensive HIV/AIDS care and leadership in project management. This training targeted different participants: doctors, clinical officers, nurses, pharmaceutical technologists, and laboratory technologists. In addition, staffs were trained in PMTCT and in ARV adherence counselling. Other training included 20 staff trained on pharmaco-vigilance, and 20 clinical staff updated on evolving HIV testing and quality control issues.

The Peer Youth Educators (PYEs) have continued to enjoy the organization's attention in terms of training opportunities. The trained volunteers continue to refer youth for VCT services, conduct VCT/IEC outreach activities with VCT counsellors and distribute condoms.

In 2006, a total of 30 people that included the youth project officers and PYEs attended various workshops and trainings organized by partner organizations and government ministries. These included the Department of Gender in the Ministry of Gender, Sports, Culture and Social Services, UNFPA, Ministry of Health, Liverpool, Population Council and Engender health.

To ensure the provision of high-quality PMTCT services, the Ministry of Health continued to support FHOK clinics by training services providers. In 2006, two members of staff were trained in DTC, two in safe motherhood and three in TB management. The Ministry of Health supplied the clinics with anti-TB drugs and TB test kits following the training.

Increased written resources on sexuality counselling

The organization's project staff and volunteers sourced youth-specific IEC materials on HIV/AIDS and adolescent SRH from partners, organizations and government ministries. A total of 4939 IEC materials were distributed, and 21 IEC events were also conducted by the project staff, PYEs and FOYs at various project sites. In 2006, senior staff worked with other team members to review the abstracts for the 2nd Africa Conference for Sexual Health and Rights. One other FHOK member of staff presented a scientific paper on SRH issues at the conference.

To continually refocus its services to its youth clients, FHOK has been able to refine its policies and approaches to meet the needs of the youth through contributions of some of its commissioned studies:

- A comparison of costs of providing separate STI and HIV services and providing integrated SRH/HIV facilities: this study was conducted in 2005 and has enabled FHOK to decide on the cost of service provision that is affordable to the youth.
- Fertility desires, sexual practices and contraceptive use by PLWHA: this study, carried out in 2006, has enabled the counsellors to serve PLWHA better due to their high demand for information on fertility and contraceptive efficacies. Initially, counselors had difficulty discussing fertility desires of PLWHA and this was identified through the study. The shortcoming was addressed through training.

Conclusion

Results show that counseling contributes to behavior change in terms of living positively with the HIV virus, high self esteem, reduction in risky behavior, improved negotiating skills, increased demand for contraceptives, increased condom use and increased use of ARVs. However, it is important to recognize the fact that it is not easy to absolutely attribute the reported behavior change to the counseling services at FHOK alone. There are many players in sexual and reproductive health interventions in the country, including the government. There is also need for further research to determine the extent of contraceptive use and condom use among PLWHA, and their desire for fertility.

7

Conditions for promising sexuality counselling

Introduction

This chapter documents conditions of promising sexuality counselling. It looks at how FHOK has increased its range of services from vertical family planning to integrated SRH. It explores how the organization's implementation strategy has contributed to its success in implementing adolescent SRH. Other conditions contributing to quality sexuality counselling include provider motivation, infrastructure, responsiveness of services to clients' needs, quality assurance, and referrals to increase accessibility of services.

Organization of services

FHOK provides integrated SRH services through the youth centers, clinics and community-based sites. It has increased its range of services from vertical family planning to integrated SRH, offering services such as: maternal and child health; maternity services; emergency contraception; unwanted teenage pregnancy counselling; syndromic management of STIs; education on adolescent sexuality; pap smear tests; laboratory investigations; pharmacy; VCT for HIV/AIDS; outpatient treatment; and referral services. Clients are usually referred to relevant centers or institutions for services which are not available at the youth facilities. In the provision of these services, the rights and choices of the clients are paramount.

The youth project has increased awareness among adolescents and young people on their sexual and reproductive health and rights and has empowered them to make informed choices and decisions regarding their SRH. The programme has expanded from two to five youth centres located in Nairobi, Mombasa, Nakuru, Eldoret and Kisumu. The youth centres are run and managed by the young people themselves who are trained PYEs, and they provide an environment where both girls and boys can discuss their issues, share experiences, learn life planning skills, access reproductive health services and reciprocate by reaching out to their peers with information through organized peer education and community outreach activities.

FHOK implementation strategy

FHOK uses multiple approaches to reach out and to provide SRH services to its clients. Such strategies include peer youth education (PYE), youth-friendly services, and vocational training. This has enabled them to reach out to many young people with sexuality counseling. Vocational training gives young people the opportunity to learn skills that they can use to earn a living thereby addressing their immediate economic needs. Young people are a key resource to economic development and often shoulder the greatest burden of care; therefore, the FHOK youth programme endeavours to recognize their strengths and to build on their potential in finding solutions to their SRH needs. To strengthen the youth programme, FHOK has greatly invested in building the capacities of young people themselves to design, plan, implement and manage the youth project. The counsellors from the youth centres acknowledged that without the volunteer PYEs, they would not cope with the huge number of clients seeking sexuality counselling. FHOK has taken the lead in the provision of youth-friendly SRH information and services. The youth centres are

designed to attract young people, meet their reproductive health needs and ensure that services are accessible and acceptable to a wide range of young people.

Human resource development

People working for the youth centre

FHOK has well-trained volunteer peer educators. Whenever there is an employment opportunity, the volunteers are usually given the first priority, depending on their length of experience, capability and required professional qualifications. All VCT counsellors must be NASCOP (National AIDS and STI Control Program – the body which is also charged with the responsibility of setting standards for VCT training, training VCT counselors and vetting institutions that train VCT counselors) approved trainees with at least a certificate level of qualification in counseling and with some experience in counselling, either from its volunteer programme or from a recognized organization.

Staff salaries, benefits and incentives

The counsellors working at the youth centres reported dissatisfaction with the amount of salary paid to them. They said it was not commensurate with the daily workload. Some NGOs in the country pay better salaries.

Client–provider ratios and workloads

The counsellors reported being overworked due to a shortage of personnel. They usually work for eight hours a day and each counselor attends to an average of 6 people per day. On a busy day, counselor handled more than six clients. In terms of personnel, the Kisumu centre had one clinical officer, three nurses, four counsellors, six volunteer counsellors, two laboratory technicians and two administrators. At the Nairobi centre there was one manager, one nurse, two counsellors, two volunteer counsellors and one laboratory technician. There were a total of 48 YPEs who assisted with community outreach activities for the youth in Nairobi and 30 in Kisumu. YPEs are not allowed to provide VCT services unless trained in VCT counselling.

Supervision and support systems for providers

Program reports reviewed by the research team shows regular quarterly support and supervision sessions conducted for all the integrated services and meetings held to sort out issues arising during the supervisory visits. There were work plans developed for each clinic indicating the time frame and people responsible for sorting out identified problems. Issues requiring head office attention were discussed with senior officers at the head office and solutions sought. Reports of supportive supervision were also written and feedback given to the specific clinics by the trained supervisors. The counsellors also had a special arrangement with the Ministry of Health counsellors to hold supervisory and support meetings once a month to prevent burnout. The supervision session was reported to be the forum at which counsellors reflect on their work with clients and learn from that reflection through their interaction with an experienced counsellor who is trained in counsellor supervision and takes on the role of supervisor. Supervision was said to be important in terms of helping counsellors with personal and professional growth and development by learning from the

experience of other counsellors. Since most counsellors encounter stressful situations with clients, supervision provides support for their emotional well-being. It is a requirement of the Kenyan national VCT guidelines that each counsellor accesses group supervision at least once a month. Trainers are also expected to attend monthly supervision to learn from each other and obtain support to deliver high-quality training.

Training of staff

Training of professional counselors

FHOK does not directly train professional counselors. However, they do hire staffs with university degree preferably in social sciences or diploma in nursing, and counseling. All counselors must be trained in VCT from a recognized institution which is also approved by NASCOP. In addition to these qualifications, they give preference to those who have gone through their youth peer counseling training and have acquired some counseling experience. The counselors reported that they would like to have more refresher trainings in order to equip them with new information and skills in the field of sexuality counseling.

Training of peer youth counsellors

As the major strategy through which SRH services are rolled out to adolescents in the communities, peer counselling has been given a lot of emphasis in terms of training. The training takes a total of four weeks using a well developed training curriculum. As mentioned earlier, FHOK recruits most of its counselors from their already trained volunteer peer counselors. The counselors mentioned that the information they acquired from the peer counseling sessions were very useful to them. It helped them to be in a position to handle various sexuality issues better. From the trainings they also got to know how to handle young people better. Clients also mentioned during FGDs that they were generally happy with most of the counselors and that they appeared to have adequate skills in handling their problems or concerns.

Infrastructure and logistics

Following interviews with youth centre coordinators in both Kisumu and Nairobi and observations made by the research team, it was evident that the facilities did not have adequate space for all the youth activities that had been planned. Different youth groups, including post-test clubs, teenage mothers' groups and theatre groups, had to meet at the facilities at different times during a week due to limited space. All the same, it was observed that there was no interference in the rooms where counselling sessions were being conducted. Cleanliness was given a high priority in the two youth centres. The centres had waiting areas with seats and TV/ video to entertain and inform clients on STIs, and general information on sexuality, there were spaces where group sessions and health talks take place, place for drama activities and post test club meetings. There were also sections for vocational training, health club, library and counseling rooms, laboratory, clients' observation / resting room, pharmacy and administrative room. It was reported that reduction in funding also led to reduction in supplies and equipment over time.

Client flows/layout

The research team observed that during first visit to the youth centre, clients were issued with an intake form. The registration staff ensured that the client filled in the form satisfactorily, giving all relevant background information. They were then led into the counseling room to see the counselor. Any client who was found to need further services after the first visit was issued with a visit card to be produced on any subsequent visit. The attending provider in each case, and after consulting the client agreed on her/his availability, indicated the next appointment date. The card also indicated the date, time and the provider who last attended to her/him. This procedure was used in every subsequent visit so that the record became an effective monitoring instrument for the client's visits. Clients' records were filed and kept at the centre.

Quality assurance

The centers have also been carrying out regular activities to improve quality of care, which included Quality Client-Oriented Provider Efficiency (COPE) assessments, quality assurance for VCT and adherence to infection prevention measures. The centre coordinators usually provide progress reports on a monthly basis. The reports are reviewed by management staff and feedback given for future improvement. The process is rigorous and ensures that where possible their interventions are informed by passed lessons learnt.

To monitor the quality of their services, FHOK conducts client exit interviews in all its clinics. After clients have been served, they are interviewed by the clinic in charge on specific aspects of the care. This is normally conducted on a monthly basis through a random selection of new acceptors and revisits. Clients are asked questions on interpersonal relations, choice of method, informing and counselling or continuity of method use, and facilitative supervisions are also conducted to determine the degree of competence of the providers.

Responsiveness of services to the client

Accessibility of services

The organization makes services available to all through its community-based services and has also integrated some to give clients best services under one roof. However, according to the 2006 review, community health volunteers' performance has been decreasing over the years due to lack of incentives such as honoraria, training, supervision and free medical care from FHOK clinics. The number of PYEs has also reduced due to lack of adequate funding to support them. This has left only two sites in operation with volunteers. Focus group discussion participants reported that, because the youth centres are located in a few urban areas, they are not easily accessible to the majority of the youth living in rural areas. Furthermore, there is fee of Ksh. 50.00 which all clients are expected to pay whenever they visit the centre for certain services, apart from VCT. The laboratory and pharmacy services within its clinics are also offered at a fee. The youth reported that this money was not affordable to some of them and so sometimes it barred them from seeking services from FHOK youth facilities. Clients also reported that sometimes the long waiting time for the services made them avoid the centres.

Acceptability of services

The youth centres are run and managed by the young people themselves who are trained PYEs, and they provide an environment where both girls and boys can discuss their issues, share experiences, learn life planning skills, access reproductive health services and reciprocate by reaching out to their peers with information through organized peer education and community outreach activities. By doing so, the centres hope to contribute immensely to the vision of young people living healthy lives. However, the perception that the organization predominantly provides family planning services has stopped many parents and the religious fraternity recommending the services for the youth. This prompted the organization to change its name from the Family Planning Association of Kenya to FHOK. The change of name has helped in changing people's perceptions and they are now widely accepted in the country.

The youth programme has built the following strengths in reaching the youth with SRH information and services: peer approach; a wide range of services and flexible operating hours; youthful, trained service providers; involvement of the youth at all levels; A high degree of confidentiality is observed;

young people are treated with dignity and respect; the use of an edutainment approach such as drama and dance; and a comfortable environment for service provision to youth. The sites also conduct forums that bring together parents, teachers and young people, where issues such as parent–youth communication, prevention of STIs and HIV infections, and drug and substance abuse are discussed. This has increased the acceptability of services offered by FHOK to people in the recent past.

Funding

Prioritization of the counselling intervention within the organization's budget

Based on FHOKs commitment to provide high-quality services and champion the sexual and reproductive health and rights of young people, more projects continue being implemented under the youth programme. This programme area ranks second in terms of the amount of financial resources allocated to it. In accordance with its vision and mission, from 2005 FHOK has continued to expand the scope of the youth programme by including a youth-oriented programme entitled Young Men as Equal Partners. Funds were also allocated in 2006 for the integration of PMTCT-Plus into safe motherhood, increasing access to VCT and adolescent SRH information and services and incorporating models of care for integrating HIV/AIDS prevention and care into reproductive health services.

Continuity of funding for the services/interventions

There has been a continued decline in donor funding to NGOs over the years, and FHOK has not been an exception. To respond to this major challenge, it has embarked on a sustainability initiative with the basic principal of doing more with less. Other aspects of sustainability include the ability to make the right decisions and manage resources effectively while providing high-quality

services in the most efficient manner. To achieve the this, FHOK developed four key strategies: cost recovery, business plans, integration of services, and marketing of services. These has enabled them to survive the reduction in donor funding.

Leadership and reputation

Youth centres

In the youth centre operational guidelines, a youth centre is defined as any premises, including all the facilities therein, that is established by FHOK for the purpose of disseminating SRH information and services to the youth. The centre is managed by a youth centre coordinator employed by FHOK. The guidelines states that the youth centre shall have a large visible identification board at its gate bearing the legend 'Youth Guidance and Counselling Centre', together with other identifying words, numbers and signs.

The youth centre committees

For the purpose of proper management of the youth centre, the coordinator established committees, each with its specific terms of reference. Each committee has its fundamental purpose as giving service to the youth. It works closely with the youth and keep abreast of youth trends and changing needs. Thus, all the committees are youth driven and have the youth as the centre of focus in all their activities.

Problems/challenges of sexuality counselling services at FHOK

Key informants acknowledged that sexuality counselling, being a new approach to adolescent SRH in Kenya, has faced a number of challenges. The health system framework lacks an effective model for implementation of sexual health counselling. For instance, the follow-up component was mentioned to be missing. Whereas VCT services are offered for free, the cost of some of the integrated services, such as maternity care, and the laboratory cost were said to be expensive for the majority of Kenyans. The system has also failed to adequately respond to the dynamics of counselling as new implications arise. These shortcomings have directly affected the quality of sexuality counselling services at FHOK.

Whereas FHOK has been a very stable organization providing SRH services, it has suffered financial setbacks in the last few years. One of its greatest challenges, as mentioned by one of the youth coordinators, is the limited number of personnel:

> *"We need more peer educators because our clients (the youth) are many as they form a third of the Kenyan population. Motivation of the young volunteers still remains a challenge. We need to build and retain our youth volunteers through better pay. FHOK can only offer Ksh. 2000 per volunteer per month. Our volunteers often move to other organizations making us to have less experienced volunteers most of the time. Limited funds and personnel have slowed down our outreach activities particularly, mobile clinics."*

A lack of adequate facilities and equipment has made the organization rely heavily on referral to meet clients' needs. During the focus group discussion sessions with the youth, they clearly stated that whenever they were in need of SRH services, they preferred to get it from a "one-stop clinic". Many of them reported having given up when they were referred to many providers in different locations to get services that otherwise would have been provided at the centre. For instance, clients who qualify for ARVs found it bothersome being referred to another health facility to access the drugs. One counsellor commented thus: "our referral system is not liked by many clients, particularly those who test HIV-positive".

The employees felt that their work would be enhanced if the information centre was expanded with more computers and current reading materials. This would also benefit the clients with adolescent SRH information. There is also need to strongly integrate recreational services in the larger youth intervention programme.

Distance to the youth facility was mention as a barrier to access for clients that came from far away. People from long distances or out of town cannot access services at FHOK, the organization has limited staff to serve many clients, clients at times wait for a long time to be served, there is a lack of advanced capacity in counselling and poor privacy because counselling rooms are limited, and some services are charged so some people cannot afford them.

Greatest external constrains

The greatest constraint which was mentioned by the management of FHOK is the reduction in donor funding in the last few years. For a very long period, the organization depended on funding from IPPF. IPPF had to reduce funding because it was greatly affected by the US government's change of policies on reproductive health. Consequently, FHOK has had to scale down most of its activities for youth interventions.

One thing that was evident from the interviews was that FHOK has been quite slow in responding to the reduction in donor funding. It found it difficult to beat the stiff competition for donor funding that was already set by other NGOs in the country. In addition, competition posed by international organizations such as PATH, FHI and CDC that are interested in direct implementation of SRH activities has made funding to the organization decrease because these are its former donors.

The cultural environment has also been a constraint to the organization. Even though people's perceptions and attitudes are changing, there has been difficulty in talking about sexuality issues, as culture dictates that sexuality and sexual matters are private. Cultural practices such as female genital cutting, early marriage, and the low status of women continue to make it difficult to offer sexuality counselling services because they are so ingrained in some communities. Unfortunately, institutions have failed to adopt intervention strategies that are responsive to these cultural challenges in their bid to offer counselling to the youth.

The situation has been aggravated by religion. Many religious groups in Kenya continue to perceive sexual issues as embarrassing and unholy. Some religious groups are still opposed to community sensitization on sexuality issues, especially sexuality education for the youth. This has been made worse by the perception from the community that FHOK only provides family planning services. The belief among some religious groups is that only immoral or promiscuous people seek contraceptive services to prevent pregnancies. These negative religious attitudes towards contraceptive use have been a hindrance to the organization's implementation plan. Conflicting sources of information about sexuality from the media, religion and peers have confused some youth about services offered at FHOK. Ignorance and gender power relations have affected women's access to services at the organization. The Kenyan law prohibiting induced abortion has also contributed as a hindrance to adolescent SRH services at FHOK. By providing post-abortion care, it has been misconstrued to promote abortion.

Conclusion

FHOK continues to play a major role in sexuality counseling in Kenya. The youth peer counseling strategy has enabled them to reach out to many young people with counseling services. However, the organization has been greatly affected by reduction in donor funding. They had to reduce the number of peer counselors and professional counselors and depend on referral for a number of services. This has increased the workload for the few counselors. The youth centers are not accessible to rural populations as they are only concentrated in urban centers. The little registration fee is prohibitive to unemployed youth and this hinders some of them from accessing the services.

8

Conclusion and recommendations

Conclusion

Privacy and confidentiality were essential for sexuality counseling at FHOK. Only staff who adhere to confidentiality requirements were maintained by the organization. The counseling rooms were kept private away from any form of interference and the clients records were safely locked up in file cabinets. Clients opened up and discussed their sexuality issues better when they were assured of privacy and confidentiality. However, health system limitations in resource-poor settings negatively affect the quality of the counselling, including the capacity to integrate sexuality issues. Due to a reduction in funding for the youth centres, FHOK has had to rely too heavily on referral of clients to other service providers, yet the youth reported being comfortable with "a one-stop shop" for their sexuality problems. Some clients feared that they would lose their privacy and confidentiality if they were referred from one provider to the other. Too many referrals may compromise on quality of services and client satisfaction.

The providers dealt most often with HIV/AIDS issues, which they were largely comfortable with. HIV/AIDs issues still dominate the counseling sessions at FHOK, perhaps due to the high prevalence rates (7.4%) of the virus in the country. The content of HIV/AIDS counselling was adequately covered during counseling sessions and included such areas as pre- and post-test counselling with informed consent, preventive behaviour education and the involvement of the sexual partner, emotional support to cope with the present and plan for the future, guidance on disclosure of one's sero- status to the significant other, reproductive health decision-making planning, drug adherence information, and ways to strengthen self-esteem and address denial and stigma. Support groups such as post test clubs at the youth centers were quite functional in terms of offering psychosocial and spiritual support to clients. However, from the interviews with the counsellors, it emerged that there was need to organize frequent refresher trainings for the counsellors to enable them to handle effectively the newly emerging issues of economic empowerment and SRH for PLWHA, homosexuality, and others.

Many PLWHA are now concerned about socio-economic support, which includes care and support for orphans and vulnerable children, support during the latter stages of the disease at home, and ways to replace lost income and diminish the subsequent family burden. The other concern to clients was lack of availability of strong legal referral or assistance to ensure that her/his rights are respected, to prevent property grabbing after death, and to reduce stigma, discrimination, abuse and violence. The youth center in Kisumu had better referral networks to cater for such needs of clients than the Nairobi one.

Clients often came for advice about sexual satisfaction and pleasure, which was not often addressed by counsellors, possibly because they did not know how to discuss it. Other topics not addressed well included gender violence and sexual identity.

Sexuality counselling at FHOK revolves around a diversity of issues such as relationships, marriage, self-esteem, assertiveness, STI treatment, ABC prevention approach, decision-making, achieving

SRH goals, HIV/AIDS, fertility and prevention of pregnancy and unwanted pregnancy. Different clients usually present different problems with these issues. The providers are therefore obliged to use their counselling skills to help clients cope with their different situations.

The attributes and characteristics of counsellors can have an effect on client satisfaction with the counselling provided. Organizations need to know their clients' provider preferences if they are to provide high-quality sexuality counselling. Counselors at FHOK were observed to be respectful enough and this enhanced clients' feeling of dignity and self-worth. The counselors were also non-judgmental, deliberate and relaxed and this enabled them to talk with counselees at their own pace. Emotional over-involvement can cause the counsellor to lose objectivity. The nature of introduction helps clients to feel relaxed and willing to accept counselling. Repeat visits by clients are appreciated with the same counsellor. Provider characteristics can be enhanced through proper training, closer supervision and support, in addition to availability of a conducive working environment.

There were suggestions that counselling on sexuality should be a key part of an integrated prevention package. Counselling is a gateway to prevention, treatment and care services. It should be steered from a disease-orientated towards a positive and respectful approach to sexuality and sexual relationships. VCT helps build awareness of HIV/AIDS, and reduces the stigma of the disease.

FHOK has a rich resource of well trained and experienced young peer counselors. This has enabled them to reach out to many young people with SRH services. The counselors are young graduates with degree or diploma in social sciences or nursing. They are carefully selected through interviews to meet laid down standards set by FHOK. All of them have gone through VCT training and youth peer counseling training conducted by FHOK. The training is meant to shape their attitude through self reflection and to build their skills in sexuality counseling. Their work efficiency and motivation is however affected by low remuneration which is not commensurate with the high workload at the facilities.

Reported effects of counseling included behavior change in terms of living positively with the HIV virus, high self esteem, reduction in risky behavior, improved negotiating skills, increased demand for contraceptives, increased condom use and increased use of ARVs. However, it is difficult to absolutely attribute the reported behavior change to the counseling services at FHOK alone. More research is therefore needed in this area.

The youth programme has built the following strengths in reaching the youth with SRH information and services: peer approach; a wide range of services and flexible operating hours; youthful, trained service providers; involvement of the youth at all levels; high degree of confidentiality observed; young people treated with dignity and respect; the use of an edutainment approach such as drama and dance; and a comfortable environment for service provision to youth. Together with other quality assurance mechanisms like efficiency assessments, the quality of sexuality counseling services for young people at FHOK is above average. Despite some challenges faced

by the organization, clients still reported that they were satisfied with the counseling services they received.

Recommendations

Lessons learnt from FHOK that can be applied to other counseling programs:

- To improve the utilization of sexuality counselling services by young people, efforts must be made to address factors that affect accessibility and quality of care, such as provider attitude, confidentiality, and hours of service. Service providers should adopt positive attitudes when dealing with adolescents and youth, and should ensure their easy access to the range of counselling services that they need.
- Counselling is likely to be more effective if it is part of a broader health promotion strategy, which includes health education and opportunities for dialogue between men and women, young and old in the community to create enabling and supportive environments.
- The relevant authorities and agencies should support training on sexuality and gender for all health providers: addressing attitudes, norms and values, biases, gender, sexual diversity, and violence, among other issues.
- There is need to support community interventions discussing norms, values, culture, and alternative rites and practices to effectively address sexuality problems.
- The government and other organizations should ensure that budgets are included for training/ support mechanisms for counsellors.
- The government should develop a standard curriculum for sexuality counseling training to be used by all institutions providing such trainings in the country.
- Linkages and collaborations between different SRH providers including the government are important for successful implementation of sexuality counseling.

To improve access, content and the quality of sexuality counselling, FHOK needs to consider the following:

- Strengthen and promote couples counselling as a strategy to ensure active participation of men in sexual health. Address men's dominant role in decision making concerning sex issues and assist them to appreciate women's sexuality. This will help reduce sexual violence mostly meted on women.
- Build capacity for income generation, especially for young people and women.
- Employ more personnel to reduce workload for current staff.
- There is a need for continuous training of staff to enable them to cope with emerging trends in sexuality counselling. Emphasis should be put on trainings on gender based violence, sexual pleasure, sexual pain and sexual orientation. These areas were noted as not well covered by counselors. If possible, FHOK should consider training their own professional counselors.
- All providers at the youth facilities should have some counselling skills so that they become more responsive to clients' counseling needs.
- There is a need to improve working conditions for the counsellors by putting in place better support mechanisms to prevent stress and burnout.

- Build client confidence by facilitating continuity of counselling process through one counsellor.
- Consider clients' preferences for counsellors, such as age and sex. For instance, consider allowing clients to schedule appointments with a particular counselor of their choice. This helps to build clients' confidence and motivation to change behavior.
- Expand services to rural populations and ensure costs of services are affordable to clients.
- Training of providers should be tailored to be responsive to the needs of HIV positive clients. They tend to have sensitive needs and providers needs to be aware of.
- Continue to facilitate community empowerment to handle sexuality-related issues. Continue community outreach with information on sex and sexuality issues.
- Educate communities against retrogressive cultural beliefs and practices that hinder sexual health in the community. These will go a long way to address gender-based violence, unequal gender power relations, low self-esteem in women and practices such as FGC and early marriage for girl children.
- Reach out to religious leaders to give realistic options that will encourage sexual health for young people.
- Improve communication between parents and young people.
- Expand the youth centre facilities to accommodate all the youth intervention activities.
- Continue to promote youth-friendly SRH services.
- Strengthen and expand fundraising mechanisms to sustain sexuality counseling and other youth interventions.
- There is need to improve on staff remuneration as they mentioned that their salaries were not commensurate with the work they did.
- Further research needs to be conducted to determine the extent and nature of influence of sexuality counseling on behavior change and other positive health outcomes.

References

Brockman, N (2001) Kenya, in Francoeur, RT (Ed.) *The International Encyclopedia of Sexuality, Volume I–IV 1997–2001.* New York, NY: The Continuum Publishing Company (http://www2.hu-berlin.de/sexology/IES/kenya.html, accessed 21 September 2006).

Central Bureau of Statistics (CBS), Ministry of Health (Kenya) and ORC Macro (2004) *Kenya Demographic and Health Survey 2003.* Calverton, MD: CBS, Ministry of Health and ORC Macro.

Centre for the Study of Adolescence (CSA) and National Council for Population and Development (NCPD) (2004). *Adolescent Health and Development in Kenya: What the Statistics Say, 3rd Edition.* Nairobi: CSA/NCPD.

CSA/UNICEF (2003) *The Situation of Young People in Kenya 2003.* Nairobi: CSA.

F. Nii-Amoo Dodoo, Eliya M. Zulu, Alex C. Ezeh (2007). Urban-rural differences in the socioeconomic deprivation-Sexual behavior link in Kenya. Social Science and Medicine 64 (2007) 1019-1031.

Government of Kenya (2001) *The children's Act, Cap 586, Laws of Kenya.* Nairobi: Government Printers.

Government of Kenya/National Agency for the Campaign Against Drug Abuse (NACADA) (2003) *Youth in Peril; Alcohol and Drug Abuse in Kenya: A Report of the National Baseline Survey on Drug and Substance Abuse Among the Youth in Kenya.* Nairobi: NACADA.

Institute of Policy Analysis and Research (IPAR) (2004) HIV scourge in Nyanza Province: Poverty, Culture and Behaviour Change. *IPAR Policy Brief Volume 10, Issue 11, 2004.*

Ministry of Health (2005) *AIDS in Kenya: Trends, Interventions and Impact, 7th Edition.* Nairobi: Ministry of Health.

Ministry of Health and Ministry of Planning and National Development (2005) *Adolescent Reproductive Health and Development Policy Plan of Action, 2005–2015.* Nairobi: Ministry of Health/Ministry of Planning and National Development.

Muganda, RO (Ed.) (2001) *Adolescence in Kenya: The Facts.* Nairobi: Centre for the Study of Adolescents and the Kenya Association for the Promotion of Adolescent Health.

Muganda, RO, Agwanda, AT, Khasakhala, A and Rae, GO (2003) *Improving Adolescent Reproductive Health Programmes in Africa: Lessons from Kenya*. Nairobi: Centre for the Study of Adolescence.

National AIDS and STI Control Program, Ministry of Health, Kenya, July 2008. *Kenya AIDS Indicator Survey 2007*: Nairobi, Kenya.

National Council for Population and Development (2003) *Adolescent Reproductive Health and Development Policy,* May 2003. Nairobi: NCPD.

UN HABITAT (2005) *Situation Analysis of Informal Settlements in Kisumu*. Cities Without Slums Sub-Regional Programme for Eastern and Southern Africa. Kenya Slum Upgrading Programme.

Appendix

Appendix 1: Tabulations

Table 1: Content of sexuality counselling (n=30) Nairobi

Content	N/A %	Not covered %	Poor %	Fair %	Good %
Asked client if used protective methods	0	10	0	0	90
Client asked number of partners	0	63.3	33.3	0	3.3
Information concerning HIV testing process	8.7	0	0	0	93.3
Information concerning window period	3.3	0	0	0	96.7
Discussion of meaning of HIV results	3.3	0	0	3.3	93.3
Capacity to cope with HIV-positive results assessed	6.7	0	0	0	93.3
Discussion of partner involvement	3.3	0	0	0	96.7
Informed consent given	0	0	0	0	100
Discussion of personal risk reduction	0	0	3.3	0	96.7
Adoption of ABC approach discussed	0	0	0	20	80
Follow-up arrangement discussed	0	0	0	0	100
Discussion on positive living	3.3	23.3	0	0	73.3
Discussion on disclosure of HIV results	0	10	0	0	90
Discussion on personal risk reduction	0	3.3	0	0	96.7
Discussion on sexuality and sex safe methods	0	3.3	0	6.7	90.0
Discussion on gender-based violence	0	96.7	0	0	3.3
Discussion of sexual pleasure	0	100	0	0	0
Discussion of sexual pain	0	100	0	0	0
Discussion of sexual identity	0	93.3	0	0	6.7
Checked availability of immediate adequate support	0	10	0	0	90
Immediate plans, intentions and actions reviewed	0	3.3	0	0	96.7
Follow-ups discussed and referrals made	0	3.3	0	3.3	93.3

Source: Observation guide

Table 2: Content of sexuality counselling (n=30) Kisumu

Content	Not covered %	Poor %	Fair %	Good %
Asked client if used protective methods	5	0	0	95
Client asked number of partners	3.3	0	0	96.7
Information concerning HIV testing process	0	0	3.3	96.7
Information concerning window period	0	56.7	0	43.3
Discussion of meaning of HIV results	0	0	6.7	93.3
Capacity to cope with HIV-positive results assessed	3.3	0	13.3	83.3
Discussion of partner involvement	33.3	3.3	26.7	36.7
Informed consent given	3.3	0	0	96.7
Discussion of personal risk reduction	3.3	0	0	96.7
Adoption of ABC approach discussed	0	0	20	80
Follow-up arrangement discussed	0	0	0	100
Discussion on positive living	3.3	3.3	6.7	86.7
Discussion on disclosure of HIV results	0	3.3	6.7	90
Discussion on personal risk reduction	0	0	0	100
Discussion on sexuality and sex safe methods	6.7	3.3	30	60
Discussion on gender-based violence	76.7	10	10	3.3
Discussion of sexual pleasure	73.3	6.7	10	10
Discussion of sexual pain	73.3	10	6.7	10
Discussion of sexual identity	80	6.7	6.7	6.7
Checked availability of immediate adequate support	3.3	6.7	3.3	86.7
Immediate plans, intentions and actions reviewed	0	0	6.7	93.3
Follow-ups discussed and referrals made	6.7	0	13.3	86.7

Source: Observation guide

Table 3: Quality of sexuality counselling (n=60) Kisumu and Nairobi data combined

Quality	N/A %	No %	Poor %	Fair %	Good %
Privacy	0	0	0	15	85
Sitting arrangement	0	0	0	0	100
Face-to-face interaction	0	0	0	1.7	98.3
Level of interruption	0	0	26.7	18.3	55
Clients greeted in a culturally appropriate way	0	0	0	0	100
Counsellors introduced himself/herself before the counselling sessions	0	0	0	3..3	96.7
Counsellor relaxed	0	0	0	11.7	88.3
Counsellors enquired who made the decision to seek) counselling services (couple counselling	88.3	1.7	0	0	10
Counsellors assured clients of what they would do to help them overcome their situations	0	0	0	10	90
Counsellor assured clients of confidentiality	0	0	0	3.3	96.7
Counsellor encouraged clients to speak	0	1.7	0	10	88.3
Counsellor encouraging both couples to describe the problem	91.6	0	0	1.7	6.7
Counselees were encouraged by the counsellor to listen to each other during the sessions	0	0	0	0	100
Clients helped to express their emotions	0	0	0	11.7	88.33
Counsellor listened to clients effectively	0	0	0	6.7	93.3
Use of kind and warm tones and counsellor respectful	0	0	0	0	100
Counsellor supportive to client	0	0	0	3.3	96.7
Counsellor non-judgemental	0	0	0	2.7	98.3
The counsellors praised clients for the courage to come	0	0	0	6.7	93.3
The counsellors kept eye contact appropriately	0	0	0	6.7	93.3
Used non-verbal communication appropriately	0	0	0	2.7	98.8
Counsellor nodded when necessary	1.7	35	0	0	63.4
Counsellor used both hands and facial expression	1.7	58.3	0	0	40
Counsellor used appropriate balance of closed and open ended questions	0	0	0	11.7	88.3
Counsellor use clear and understandable language	0	0	0	0	100
Counsellor found out about what the client knew about the problem	0	0	0	5	95
Counsellor built on what client knew	0	0	0	16.7	83.3
Counsellor allowed group members to participate	0	0	1.7	10	88.3
Counsellor directed the discussion properly	0	0	1.7	10	88.3
Counsellor allowed client to absorb information and respond	0	0	0	8.3	91.7
Counsellor asked clients to clarify information/probe appropriately	0	0	0	10	90
Counsellor made necessary clarification	0	0	0	5	95
Counsellor provided factual information based on needs of clients	0	0	0	5	95
Counsellor used encouragers	0	0	0	1.7	98.3

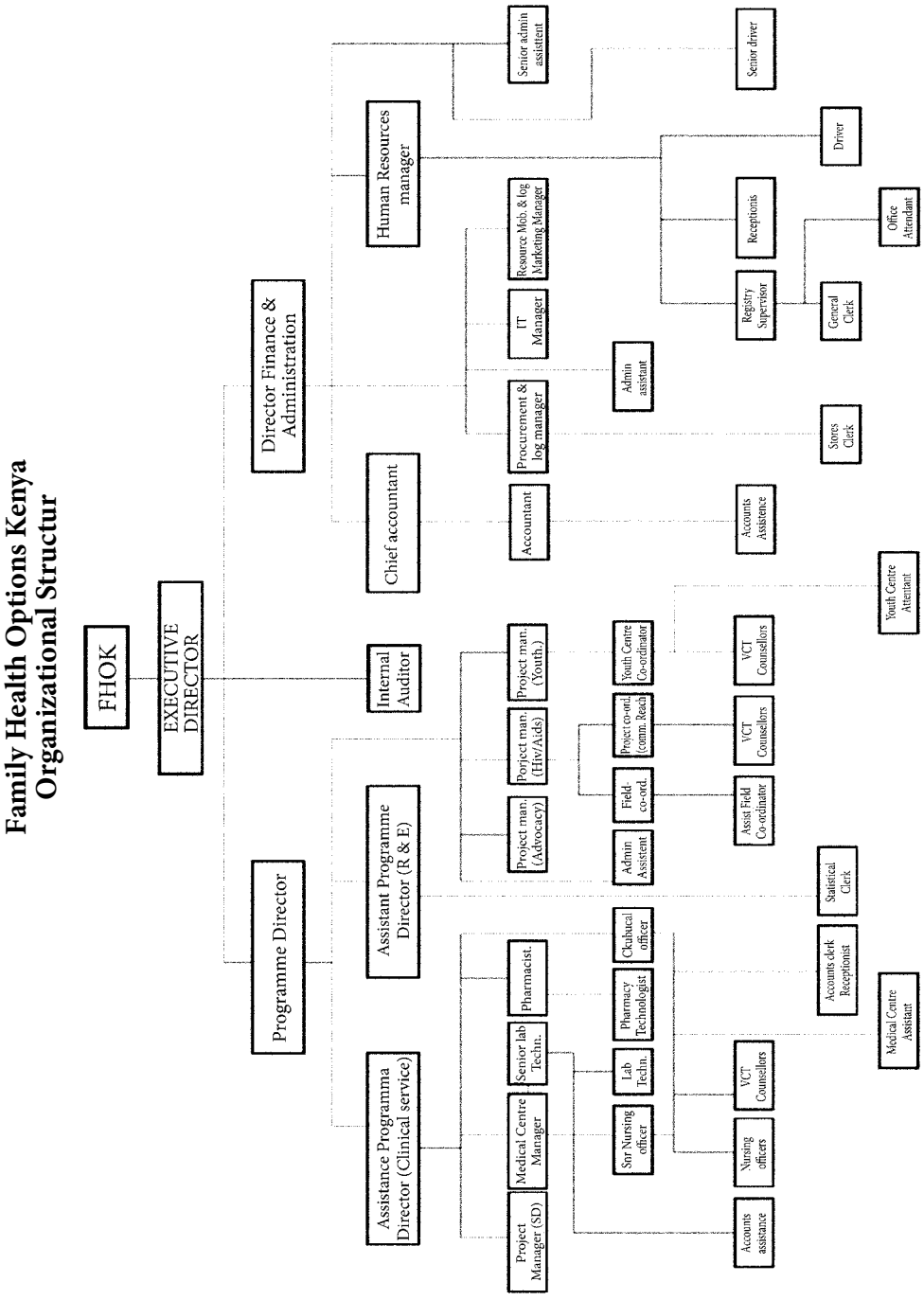
Source: Observation guide

Table 4: Provider characteristics

	Nairobi		Kisumu	
How the client was received at the centre	Yes	No	Yes	No
Did the counsellor greet the client?	100	0	96.7	3.3
Did the counsellor assure client of confidentiality?	100	0	96.7	3.3
Did the counsellor encourage the client to speak?	100	0	100	0
Did the counsellor listen attentively?	100	0	100	0
Was the counsellor non-judgemental?	100	0	100	0
Was the counsellor supportive?	100	0	100	0
Was the counsellor respectful?	100	0	100	0
Did the counsellor use clear and simple terms?	100	0	100	0
Did the counsellor use a kind and warm tone?	100	0	100	0
Did the counsellor give the client time to absorb information?	100	0	100	0
Did the counsellor ask client to clarify any information?	100	0	100	0
Did the counsellor allow client to seek clarification?	100	0	100	0
Did the counsellor correct client's misconceptions?	96.7	3.3	96.7	3.3
Did the counsellor repeat and reinforce important information?	100	0	100	0
Did the counsellor give clients time to think through issues?	100	0	100	0
Did the counsellor summarize the main issues discussed?	100	0	96.	3.3
Did the counsellor enquire about client's reason for attending?	100	0	100	0
Did the counsellor find out client's knowledge about HIV and modes of transmission?	100	0	86.7	13.3
Did the counsellor ask questions about clients exposure to HIV	100	0	90	10
Did the counsellor discuss client's HIV status and having sexual relations?	100	0	86.7	13.3
Did the counsellor give client information about HIV status?	100	0	90	10
Did the counsellor discuss clients partner involvement?	100	0	83.3	16.7
Did the counsellor discuss client's personal plan to prevent infection?	100	0	93.3	6.7
Did the counsellor find out client's knowledge about prevention of pregnancies?	20	76	16.7	73.3
Did the counsellor ask client about knowledge of safe abortions?	6.7	90	13.3	86.7
Did the counsellor discuss client's partner involvement in reproductive health?	16.7	80	33.3	66.7
Did the counsellor discuss client's life skills to negotiate a safe sexual life?	90	10	43.3	56.7
During counselling				
Was the client able to discuss the issues he/she wanted to discuss?	100	0	100	0
Was the client allowed time to share his/her worries and concerns?	100	0	100	0
Did the counsellor enquire if the client was sexually active?	83.3	13.3	70	30
Did the counsellor discuss other sex-related issues?	33.3	63.3	76.7	23.3
Did the counsellor check for availability of adequate and immediate support?	86.7	13.3	93.3	6.7
Did the counsellor review immediate plans and emotions?	96.7	3.3	100	0
Was the client referred or asked to come back for a service?	76.7	23.3	86.7	13.3
Did the client need any referral?	10	90	3.3	96.7

Source: Exit interview

Appendix 2: Organizational diagram



Appendix 3: Research instruments

1. Desk review

The objective of the desk review is to locate published and unpublished secondary sources that enable us to contextualize the counselling services related to sexuality provided into the wider service and environmental context, and to review published and unpublished secondary sources with respect to sexuality counselling.

Checklist for topics covered in the desk review
The relevant published and unpublished secondary literature at national, institutional and intervention level includes the following:

National/state context:
- ☛ Analyses of existing laws, policies and guidelines on sexuality and sexual and reproductive health and rights
- ☛ Studies (Situation Analysis Studies, anthropological, sociological and health system studies)
- ☛ Description of sexual practices, SRH and HIV/AIDS situation
- ☛ Cultural and religious diversity in society or catchments area
- ☛ Service delivery guidelines and protocols, Codes of Conduct for professionals.

Institution (NGO):
- ☛ Baseline data
- ☛ Description of other existing interventions and services addressing sexual health and sexuality, and how the service is linked to others
- ☛ Project and programme policy documents
- ☛ Donor assessments
- ☛ Research reports with respect to SRHR, HIV/AIDS, abortion, sexuality, etc.
- ☛ (Health) information statistics
- ☛ Training materials on counselling (curriculum, manuals, guidelines etc.)
- ☛ Monitoring and evaluation reports
- ☛ Five-year plans and annual reports
- ☛ Service delivery guidelines and norms on counselling
- ☛ Any other document related to the project under assessment
- ☛ Logistical infrastructure
- ☛ Equipment and supplies
- ☛ Proportion of overall budget for counselling services.

Counselling intervention:
- ☛ Describe type of counselling services provided and description of how counselling services are organised (group, individual, client flow)

- Strategies to improve accessibility of counselling services (bearing in mind costs, gender, vulnerable groups, acceptability)
- Profile of clients
- Criteria for staff selection (counsellors)
- Process for setting criteria for selection
- Training of counselling staff (time, duration, curriculum, content method)
- Supervision and support systems (including debriefing, prevention of burnout)
- Standards of work conditions of counsellors (salary, hours)
- Functioning M&E system of counselling
- Workload (patient–provider ratio)
- Referral (number and to where)
- Payment for counselling services
- Confidentiality contracts

2. Facility Questionnaire

Questionnaire Number:

Name of facility: **KISUMU** Facility No:**02**___ Date _____
Time interview started _____ ended_____
Name of Data Collector:_____Code:_____
Seek informed consent_____
Respondent number_____ (to be filled in advance)

Personal information:
What is your position? ___
How long have you worked in this position? _____
1. Accessibility of your facility

a) How many days per week are counselling services offered at this facility?_____
b) What is the size of your catchment's population?_____
c) What kind of counselling services do you provide (please list them)?
_____
_____
_____

d) What are the general characteristics of clients (sex, age, socio-economic status, ethnicity, marital status, religion – *ask for summary if available*)?
_____
_____

e) Do patients have to pay for services? If yes, then what services do they pay for? How much does each service cost?
_____

2	Give an overview of the personnel in your facility		
		Total No. in the facility	**No. received training counselling**
a)	Number managers		
b)	Number of doctors		
c)	Number of nurses		
d)	Number of counselors		
e)	Number of social workers		
f)	Number of lab technicians/technologists		
g)	Number of administrators/clerks		
h)	Community health worker		
i)	Others (specify)		
j)	What are the criteria for counsellor staff selection?		
k)	Recruitment procedures?		
l)	Training: what, how often, contents?		
m) Are there staff shortages in this facility?		Yes=1	**No=2**

3	*PLEASE ASK TO SEE THE WAITING AREA FOR CLIENTS AND INDICATE WHICH OF THE FOLLOWING ACTIVITIES ARE ROUTINELY CARRIED OUT THERE.* *PLEASE NOTE THE CONDITION OF COUNSELLING LOCATION:* -Cleanliness_____ -Privacy (no open areas for others to view counselling session in progress)_____ -Confidentiality-How are clients' records and forms stored? _____ -Setting (comfortable surroundings conducive to counselling environment)_____

4.	**Do (providers routinely perform the following activities OR are clients referred to another provider or location?**	**Yes, routinely performed**	**Refer to another provider in same facility**	**Refer to another facility**		
a)	Voluntary counselling for HIV/AIDS	1	2	3	98	
b)	Voluntary testing for HIV/AIDS	1	2	3	98	
c)	Prevention of Mother to Child Transmission of HIV (PMCT)	1	2	3	98	
d)	Testing for STIs	1	2	3	98	
e)	Blood test for syphilis	1	2	3	98	
f)	Treatment of Sexually Transmitted Infections (STI)	1	2	3	98	
g)	Information on contraceptives incl. birth spacing (FP)	1	2	3	98	
h)	Preventive anti-malarial medication (IPT)	1	2	3	98	
i)	ANC	1	2	3	98	
j)	Conducting group health education sessions	1	2	3	98	
k)	Sexuality counselling	1	2	3	98	
l)	Post Partum/ Abortion Care	1	2	3	98	
m)	Other:					
5.	**Availability of different services**	**Daily**	**Twice**	**Once**	**Not offered**	
a)	How many times a week do you offer PMCT services?	1	2	3	98	
b)	How many times a week do you offer youth friendly services?	1	2	3	98	
c)	How many times a week do you offer (sexuality) counselling services?	1	2	3	98	
d)	How many times a week do you offer voluntary counselling for HIV/AIDS?	1	2	3	98	
e)	How many times a week do you offer family planning services?	1	2	3	98	

f)	How many times a week do you offer treatment for STI?	1	2	3	98	
h)	Other services provided (specify)?	1	2	3	98	
i)	One or more languages available?	1	2	3	98	

6.	**Counselling**	**yes**	**no**
a)	Are individual counselling sessions offered?	1	2
b)	Are group counselling sessions offered?	1	2
c)	Are guidelines/ protocol followed?	1	2
d)	Is referral available if necessary?	1	2
e)	Is referral to VCT available?	1	2
f)	Is referral to other services available?	1	2

7.	**Infrastructure for Consultation/Examination**	**Yes**	**No**
a)	Counselling waiting area is a comfortable waiting space shaded and with seats	1	2
b)	Private space for counselling session	1	2
c)	Confidentiality contracts signed	1	2
d)	Proper, clean toilets accessible	1	2
e)	Source of clean water in the clinic	1	2
	Registers, cards, guidelines	**Yes, seen**	**Not, seen**
8.	Is there a register where information on (clients' visits is recorded? (IF YES, ASK TO SEE THE REGISTER)	1	2
9.	Is there a standard guideline or protocol for providing focused sexuality counselling? If yes, ask to see the guideline	1	2
10.	Do you follow a specific protocol especially describing the counselling interventions?	1	2
11	Do you follow national guidelines especially describing the counselling interventions?	1	2
12	Do you follow a (gender) protocol specifically describing the counselling interventions with respect to sex of the counsellor versus sex of the client?	1	2
13	Do you follow a (gender) protocol specifically describing the counselling interventions with respect to same-sex counselling?	1	2
14	Do you follow protocol specifically describing the counselling interventions with respect to couple counselling?	1	2
15	How many counselling visits (both new and repeat) took place during the	New visits	

	previous 12 complete months?	Revisit	
		Not Applicable	98
16	Supervision and support systems • How? • How often? • Debriefing? • Feedback?		
17	Describe the contents of the counselling interventions	Topics discussed	
18	What do you see as the strong elements of the counselling sessions provided?		
19	What are the weak elements of the counselling session?		
20	Do you encounter any problems or constraints in attending these counselling sessions?		

Below is a list of possible outcomes of counselling sessions. Could you please confirm whether or not, in your opinion these outcomes can be seen as a result of your counselling services?

	Personal and behavioural outcomes:	**Yes**	**No**
	Increase in self-esteem	1	2
	Increase of better negotiating skills	1	2
	Increase of reports of satisfying sexual relationship	1	2
	Increase of contraceptive use	1	2
	Increase of demand for STI treatment	1	2
	Decrease of demand for menstrual regulation or abortion services	1	2
	Decrease of risky sexual behaviour	1	2
	Decrease in HIV/AIDS transmission among discordant couples	1	2
	Increase of demand for ARV	1	2

	Health outcomes:	**Yes**	**No**
	Decrease in STI rates	1	2
	Decrease in unwanted pregnancies	1	2
	Others		
	Service delivery and health system outcomes:	**Yes**	**No**

	Increased use of health services by all groups in need of sexuality counselling	1	2
	Increase in demand for contraceptives	1	2
	Increase in demand for STI/HIV testing	1	2
	Increase in partner-notification	1	2
	Decrease in repetitive STI infections	1	**2**
	Increase in adherence to treatment	1	2
	Improved capacity of health delivery system (training of staff and support, policies' implementation, referral systems, etc.)	1	2
	Increased written resources on sexuality counselling, including policies and protocol	1	2
	Other outcomes or 'changes'	1	2

3. Counsellors' FGD Guide

Hypothetical Sexuality Scenario for the group to solve

We are going to talk about Bob now. I would like you to help me make a story about him. Bob is 20 years old, single and living with HIV. Bob recently started ART and his health is now good. Bob looks cool and handsome and has started attracting the attention of women. Bob has sexual feelings and desires to have sex, be in a relationship and eventually marry and become a father.

What can you do to help Bob satisfy his sexual needs and desires? *(Probe about the process, issues to tackle, etc)*

We are going talk about Betty now. I would like you to help me make a story about her. Betty is 35 years old, a married woman living with HIV whose partner is discordant and they have one eight year old child together. Betty is getting a lot of pressure from the in-laws to have other children and she has genuine concerns that her partner may desert her for another woman. Betty started ART and her health is good. Both Betty and her partner now desire to have at least one more child, but the partner is scared of getting infected.

What can you do to help Betty satisfy his sexual needs and desires? *(Probe about the process, issues to tackle, etc)*

We are now going to talk about John. I would like you to help me make a story about him. John is a young man who has strong attraction towards other men. John has several friends, but none of them is a female. His male friends have started teasing him about not being man enough to find a girlfriend. John has strong sexual feelings for another young man and strongly desires and dreams of having sex with him.

What can you do to help John satisfy his sexual needs and desires? *(Probe about the process, issues to tackle, etc)*

1. What influences the norms and beliefs around sexuality (religion, age, family beliefs, spiritual, education level, culture, peer pressure, etc.)?
2. What kind of information on sexuality counselling do you offer clients in general? How would you rate the quality of the information?
3. Can you explain why anyone would seek help related to sexuality? Probe (dating, love, relationships, marriage, self esteem, assertiveness, decision making, pleasure, sex, achieving sexual and reproductive health goals, fertility and prevention of pregnancy, unwanted pregnancy, sexual identity, gender relations, sexual violence)
4. In your experience do the clients' backgrounds influence their decision on where to seek services? (If yes) How?
5. From your experience, what could be the outcome/ benefits of counselling on issues related to sexuality?

6. Can you describe the challenges/ problems associated with sexuality counselling?
7. How can these challenges/ problems be overcome?
8. Are there any support mechanisms for counsellors?
   How?
   When?
   Why?
9. Do clients have preference for counsellors' sex, religion, age, dress code, etc.?
10. Do you have suggestions for good sexuality counselling?

4. In-depth interviews with counsellors

Respondent number ……..

Client background information:

Sex 1) Female 2) Male

Age: …… years

Marital status:

1) Single never married
2) Married or cohabiting a) monogamous b)polygamous
3) Separated/divorced
4) Widowed

Education:

1) None
2) Primary
3) Secondary
4) Tertiary/University

Site Name :……

Counsellor

1. How long have you been a counsellor here at the centre?
   Have you been a counsellor before?
2. What made you become a trainer?
3. Where have you been trained to be a counsellor?
   By whom, when, how long?
4. Do you get any on-going training, supervision and/or support?
5. Is this support sufficient?
   Did you/have you experienced any problems? Do you have any suggestions for improvement?
6. Can you tell me about the working conditions of the counsellors, including working hours, salary, training opportunities etc,?
7. Do you have experiences with burn-out? What is the institution putting in place to avoid burn-out symptoms?

Counselling

8. What kind of counselling service(s) do you provide here?
9. According to you, what are the reasons for people requesting counselling?
10. What are the key issues discussed during counselling?
11, Do you notice changes over time in counselling needs of clients?
12. Can you explain these changes, and what are the implications for counselling?
13. What other support do you give to patients (fees, transport, food) who come to the clinic?

Counselling and sexuality

14. What are the most common issues related to sexuality that clients want to discuss with you?
15. What kind of issues related to sexuality do you feel the clients have more difficulties talking about?

16. What kind of issues related to sexuality do you have difficulties talking about? How do you deal with that?
17. What is your personal belief about the outcomes of sexuality counselling?
18. What do you think is a good counselling service related to sexuality?

Counselling and quality

19. What do you think clients feel about the counselling services provided at your clinic/facility?
20. What aspects do clients like about these counselling services? Why?
21. What aspects do clients not like about these counselling services? Why?
22. What do you think about the client provider interaction (reception, continuity, discrimination, attitude, competence of provider, language, confidentiality and privacy)?
23. How is confidentiality and privacy of clients guaranteed? *(ask to see the chart if mentioned)*
24. What do you think about: duration time (waiting time for different aspects of service provision)?
25. What do you think about: convenience (geographical location, opening hour, administrative procedures)?
26. What do you think about: accessibility (decision making, gender, cultural beliefs, payments and location)?
27. What do you think about: information (sources of information, follow up, referral, choice of treatment location, continuity of care)?
28. Are there any things you do not like in providing counselling services? Why?
29. What do you find important (???) about the counselling services?
30. What would you like to see changed? How? What are your own suggestions for change?
31. Do you think it is important to include sexuality related issues into the training curriculum? Why?
32. What are the most common issues related to sexuality do you think should be included in the curriculum?

Below is a list of possible outcomes of counselling sessions. Could you please confirm whether or not, in your opinion these outcomes can be seen as a result of your counselling services?

	Personal and behavioural outcomes:	**Yes**	**No**
	Increase in self-esteem	1	2
	Increase of better negotiating skills	1	2
	Increase of reports of satisfying sexual relationship	1	2
	Increase of contraceptive use	1	2
	Increase of demand for STI treatment	1	2
	Decrease of demand for menstrual regulation or abortion services	1	2
	Decrease of risky sexual behaviour	1	2
	Decrease in HIV/AIDS transmission among discordant couples	1	2
	Increase of demand for ARV	1	2

	Health outcomes:	**Yes**	**No**
	Decrease in STI rates	1	2
	Decrease in unwanted pregnancies	1	2
	Others		

More general

33. Are there any local/traditional forms of sexuality counselling you know of?
34. What counselling related to sexuality and sexual health and sexual rights issues is provided in the area?
35. What is the general public opinion about sexuality counselling? Is it possible to speak openly or consult about such issues?

Thank you for your cooperation

5. Interviews with (key) informants and/ or stakeholders

Topic guide for Key Informants (and Stakeholders)

Respondent number ___ to Date of Interview and time interviews begins
_____

Name of Respondent's Organization _____
Position within the Organization_____
Length of time with organization ___ / __ (months/years)

Link of the Organization to (Name of Organization under assessment) _____

1. In your opinion, what are the reasons people might seek counselling?

2. What topics do they cover in sexual health and sexuality related concerns?

3. What topics do you think they should cover in this type of counselling?

4. In what contexts or for whom do you think this "sexuality or sexual health counselling" should be offered?

5. In terms of outcomes or benefits to the client, what in your opinion have been/are the outcomes of the sexuality counselling?

6. What are the positive/exemplary aspects of sexuality counselling that should be emulated or replicated/scaled up?

7. What do you think are the greatest constraints to offering sexuality and sexual health counselling within an organization like Family Health Options? (e.g. time, privacy, cost, skills, provider discomfort with talking about sex, etc.)

8. What do you think are the greatest external constraints to Family Health Options providing this type of service? (e.g. legal barriers, social, cultural or religious opinions or barriers, etc.)

9. Do you have anything else you would like to say/add?

Time interview ends_____

Thank You

6. Exit interview with Client

Circle the appropriate answer(s) if there are choices given.
If there is a dashed line, write the correct number(s) neatly on the lines.
If there is a blank line, print the answer neatly on the line.

IDENTIFICATION		
1. Code		
2. Name of site		
3. Study site number		
4. Name of Interviewer		
5. Interviewer number		
6. Interview ID number		
7. Date	**__ __/__ __/200__** **day/month/year**	
8. Beginning time of interview	**__ __: __ __ (AM/PM)** ***(circle accordingly)***	
9. Language of interview	English……	1
	Kiswahili……	2
	Dholuo……	3
	Others (specify) ……	4
10.Counselling Service type	VCT	1
	Youth counselling	2
	Telephone line	3
	FP counselling	4
	PMCT	5
	Post-abortion	6
	STI Counselling	7
	Sexuality counselling	8
	Other (specify)	9

01. Is this your first visit to this centre?		Yes	No
02. How did you learn about services in this facility	1) VCT mobilization at my institution	1	2
	2) Youth Health Centre	1	2
	3) Radio	1	2
	4) Newspaper	1	2
	5) Promotional brochure	1	2
	6) Peer/Spouse/sibling	1	2
	7) Family	1	2
	8) Church	1	2
	9) School	1	2
	10) Others_____		
03. Why did you come to the centre (here) today ***(multiple response possible) probe***		Yes	No
	1) Wanted information	1	2
	2) Came for counselling	1	2
	3) Wanted to know my HIV status	1	2
	4) Wanted to be tested before marriage	1	2
	5) Wanted to be tested before having a child	1	2
	6) Issues arising from an HIV test taken some time ago	1	2
	7) Because of illness	1	2
	8) Because of sexual issues	1	2
	9) Wanted information on Family Planning	1	2
	10) Came for STD services/ information	1	2

	11) Other issues (specify) _____		
04. How did you choose to come to this specific Centre today?		Yes	No
	1) Was referred from a health centre	1	2
	2) Was recommended by peers, spouses, parents, neighbours, friends	1	2
	3) The service is youth friendly	1	2
	4) Has qualified staff/quality service	1	2
	5) This is the only place which has the services I wanted	1	2
	6) Other (specify) _____		
05. What counselling services did you receive today? (Multiple responses possible) probe		Yes	No
	1) Sexual relationship	1	2
	2) Marriage	1	2
	3) Self-esteem/decision making	1	2
	4) Sexual pleasure	1	2
	5) Sexual identity	1	2
	6) Gender relations	1	2
	7) Sexual violence	1	2
	8) Unwanted pregnancy	1	2
	9) Fertility	1	2
	10) HIV counselling	1	2
	11) VCT counselling	1	2
	12) STI counselling	1	2
	13) FP counselling	1	2
	14) General counselling for youth	1	2
	15) PMCT counselling	1	2
	16) Abortion	1	2
	17) Other (specify) _____		
06. **(Ask only those who had an HIV test)** Did a healthcare provider talk to you about the HIV test before your blood was drawn?	Yes 1	No 2	N/A 9
COUNSELLING **Interpersonal relationship** Think through the consultation you had today beginning with reception:			
07. How were you received at the centre on arrival?	Friendly welcome……		1
	Unfriendly welcome……		2
	No welcome……		3
	Other (specify) _____		4
08. At the beginning of the consultation, did the counsellor greet you?	*Yes* 1	*No* 2	
09. At the beginning of the consultation, did the counsellor assure you of confidentiality?	1	2	
10. During the consultation, did the counsellor encourage you to speak?	1	2	
11. During the consultation, did the counsellor listen attentively (both verbally and non-verbally)?	1	2	
12. During the consultation, was the counsellor non-judgemental?	1	2	
13. During the consultation, was the counsellor supportive?	1	2	
14. During the consultation, was the counsellor respectful?	1	2	
b) Gathering and Giving Information ***During the consultation did the counsellor:***			
15. Use words (language) you could understand (clear and simple terms)?	*Yes* 1	*No* 2	*NA*
16. Use a kind and warm tone?	1	2	9
17. Give you time to absorb information and to respond?	1	2	9
18. Ask you to clarify information (probing)?	1	2	9
19. Allow you to seek clarification about information given?	1	2	9
20. Respond to your concerns and worries satisfactorily?	1	2	9

	11) Other issues (specify) _____		
04. How did you choose to come to this specific Centre today?		Yes	No
	1) Was referred from a health centre	1	2
	2) Was recommended by peers, spouses, parents, neighbours, friends	1	2
	3) The service is youth friendly	1	2
	4) Has qualified staff/quality service	1	2
	5) This is the only place which has the services I wanted	1	2
	6) Other (specify) _____		
05. What counselling services did you receive today? (Multiple responses possible) probe		Yes	No
	1) Sexual relationship	1	2
	2) Marriage	1	2
	3) Self-esteem/decision making	1	2
	4) Sexual pleasure	1	2
	5) Sexual identity	1	2
	6) Gender relations	1	2
	7) Sexual violence	1	2
	8) Unwanted pregnancy	1	2
	9) Fertility	1	2
	10) HIV counselling	1	2
	11) VCT counselling	1	2
	12) STI counselling	1	2
	13) FP counselling	1	2
	14) General counselling for youth	1	2
	15) PMCT counselling	1	2
	16) Abortion	1	2
	17) Other (specify) _____		
06. **(Ask only those who had an HIV test)** Did a healthcare provider talk to you about the HIV test before your blood was drawn?	Yes 1	No 2	N/A 9
COUNSELLING **Interpersonal relationship** Think through the consultation you had today beginning with reception:			
07. How were you received at the centre on arrival?	Friendly welcome……		1
	Unfriendly welcome……		2
	No welcome……		3
	Other (specify) _____		4

08. At the beginning of the consultation, did the counsellor greet you?	*Yes* 1	*No* 2
09. At the beginning of the consultation, did the counsellor assure you of confidentiality?	1	2
10. During the consultation, did the counsellor encourage you to speak?	1	2
11. During the consultation, did the counsellor listen attentively (both verbally and non-verbally)?	1	2
12. During the consultation, was the counsellor non-judgemental?	1	2
13. During the consultation, was the counsellor supportive?	1	2
14. During the consultation, was the counsellor respectful?	1	2

b) Gathering and Giving Information ***During the consultation did the counsellor:***			
15. Use words (language) you could understand (clear and simple terms)?	*Yes* 1	*No* 2	*NA*
16. Use a kind and warm tone?	1	2	9
17. Give you time to absorb information and to respond?	1	2	9
18. Ask you to clarify information (probing)?	1	2	9
19. Allow you to seek clarification about information given?	1	2	9
20. Respond to your concerns and worries satisfactorily?	1	2	9

21. Correct any misconceptions you had?	1	2	9
22. Repeat and reinforce important information?	1	2	9
23. Give you time to think through issues?	1	2	9
24. Summarize the main issues discussed?	1	2	9
25. Enquire your reason for attending?	1	2	9

27 – 32h: for a HIV related setting ***During the consultation did the counsellor:***

	Yes	**No**	**NA**
27h. Find out your knowledge about HIV and modes of transmission	1	2	9
28h. Ask questions about your exposure to HIV – ie. Risk assessment	1	2	9
29h. Discussed with about HIV status and having sexual relations?	1	2	9
30h. Give you information about HIV status	1	2	9
31h. Discuss involvement of your partner?	1	2	9
32h. Discuss with you a personal plan to prevent infection and/or re-infection?	1	2	9
27- 31s for a SRH setting			
27s Find out your knowledge about prevention of pregnancies and contraceptive choice?	1	2	9
28s Ask you questions about your using any preventive methods?	1	2	9
29s Ask you question about your knowledge of safe abortions?	1	2	9
30s Discuss your partner involvement in reproductive matters?	1	2	9
31s Discuss issues of your life skills to negotiate a safe and healthy sexual life?	1	2	9
Content of the counselling			
33. Were you able to discuss the issues you wanted to discuss?	1	2	9
34. Were you allowed time to share your worries and concerns?	1	2	9
35. Did you and the counsellor discuss sexual relationships?	1	2	9
36. Did the counsellor enquire if you are sexually active?	1	2	9
37. Did the counsellor discuss any other sexual related issues: Same sex relations, Teenage pregnancy, Abortion, Pleasure	1	2	9
38. Did the counsellor check for availability of adequate immediate support (if needed)?	1	2	9
39. Did the counsellor review with you your immediate plans and intentions?	1	2	9
d) Referrals			
40. Were you referred to or asked to come back for any service by the counsellor?	1 ***(If yes, skip to 43)***	2	9
41. If you were not referred, do you think that you needed to be referred?	1	2 ***(Skip to 46)***	9

42. What services would you have liked to be referred for? ***(Multiple responses possible) Probe***		Yes	No	N/A
	1) Sexuality counselling	1	2	9
(Go to 46 if N/A)	2) HIV counselling	1	2	9
	3) HIV testing	1	2	9
	4) Family planning support	1	2	9
	5) Post-test support and care	1	2	9
	6) PMCT	1	2	9
	7) Treatment	1	2	9
	8) STD Services./Information ___	1	2	9
	9) Abortion	1	2	9
	10) Other (specify)_____			
43. What services were you referred/asked to come back for? ***(Multiple responses possible)***				
Probe	1) Sexual relationship	1	2	9
	2) Marriage	1	2	9
	3) Self-esteem/decision making	1	2	9
	4) Sexual pleasure	1	2	9
	5) Sexual identity	1	2	9
	6) Gender relations	1	2	9
	7) Sexual violence	1	2	9
	8) Unwanted pregnancy	1	2	9
	9) Fertility	1	2	9
	10) DTC counselling	1	2	9

	11) VCT counselling	1	2	9
	12) STI counselling	1	2	9
	13) PMCT counselling	1	2	9
	14) FP counselling	1	2	9
	15) General counselling for youth	1	2	9
	16) Abortion	1	2	9
	17)Other (specify) _____			

	Yes	No	
44. Did the counsellor tell you where to get the referral service?	1	2	9
45. Did the counsellor tell you when to come back for this service (if applicable?)	1	2	9
Views on sexuality counselling environment			
46. Were you counselled in a private place?	1	2	9
47. Were you served by the same counsellor as before?	1 ***(If yes skip to #50)*** ***If new client skip to 50***	2	9
48. If NO, would you have preferred to be served by one counsellor or it doesn't matter?	Prefer to be seen by one counsellor…		1
	Doesn't matter		2
	Other (Specify) _____		3
49. Were you comfortable with the counsellor(s) during the counselling session?	Yes		1
	Somewhat		2
	No		3

50. What kind of a counsellor would you prefer? ***(Multiple responses possible) read out the choices***		*Yes*	*No*
	a) Different sex	1	2
	b) Same sex	1	2
	c) Young	1	2
	d) Old	1	2
	e) No preference	1	2
	f) Other specify)_____		
51. Do you feel confident that the counsellor you saw today would not share information about you with anyone else?		Yes	No
	Very confident	1	2
	Confident	1	2
	Not confident	1	2
	Other (specify)		
52. *(If sexually active or married/cohabiting)* Would you have preferred to be counselled together with your partner? *(if not currently accompanied by partner)*		1	2
53. What aspects could the counsellor have done better?			

		Yes	No
	1. Short / No waiting time before being counselled		
	2. Privacy / Confidentiality	1	2
	3. Sufficient time allowed / not rushed	1	2
General Recommendations	4. Able to discuss my worries	1	2

General Recommendations			
59. What can be done to improve sexuality counselling at this centre/facility? Please state 2 possible way counselling.	1.		
	Others (specify)		
60. What services would you desire to be p clinic services that you received today?			
Socio-demographic Information			
60. ***(Do not ask)*** Record sex of respondent			
61. What is your age in years?			
62. Where do you live? ***(Usual residence)***			
63. What is your marital status? ***(Probe for actual status)***			
64. What is your religion?			
65. Who do you live with currently?			
66... Do you have any additional remarks?			
67. Ending time of interview			
54. What did you like most about the counselling session you attended today? (multiple responses possible)			
55. What did you dislike most about the counselling session you attended today? ***(multiple responses possible)***		*Yes*	*No*
	1) Long waiting time before being counselled	1	2
	2) Limited space (people around us)	1	2
	3) Limited time (rushed)	1	2
	3) Not able to discuss my worries/concerns	1	2
	4) Unfriendly, judgemental counsellor	1	2
	5) Poor/insufficient information given	1	2
	6) Other (Specify) _____		
56. Were your expectations of this type of service delivery met?	Fully met …….		1
	Partially met.……..…….		2
	Not met at all ……...		3
57. Please, explain your answer			
58. Would you recommend the counselling service to a friend?	Yes 1	No 2	

SIGNATURE: _____

DATE: _____

7. Clients' FGD Guide

1. (From) where do you learn about sexuality related issues/information?
   (Dating, love, relationships, marriage, self esteem, assertiveness, decision making, pleasure, sex, achieving sexual and reproductive health goals, sexual desires, fertility and prevention of pregnancy, unwanted pregnancy, sexual identity, gender relations, sexual violence).

2. When you think about the things we have just discussed (above)?

   What do you mostly worry about?

3. Why would anyone seek help related to sexuality counselling?

4. Have you received information/counselling about these issues?

   ☛ From where?

   ☛ What specific information or counselling (on what issues) did you receive?

   ☛ Was it helpful?

   ☛ Is there something else you would have liked/or would still like to learn about?

   ☛ What did you feel about the counsellors / service providers?

5. Do you know of any traditional/private sexuality counselling services?

6. What problems do you experience while seeking sexuality counselling? *(Access, cost, distance, language, privacy, confidentiality, provider attitude)*

7. What influences the (current) norms and beliefs around sexuality *(religion, age, family beliefs, spiritual, education level, culture, peer pressure, etc.)*?

8. What are the benefits of sexuality counselling / how does counselling help an individual?

8. In-depth interviews with Clients

These interviews will be carried out by the researchers and will be recorded either in written notes, or through taped recordings, depending on the context and the preferences of the respondent.

Client Checklist

Respondent number ……..

Client background information:

1. Age: …… years
2. Sex 1) Female 2) Male
3. Marital status:
   - ☛ Single never married
   - ☛ Married or cohabiting a) monogamous b)polygamous
   - ☛ Separated/divorced
   - ☛ Widowed
4. Education:
   1) None
   2) Primary
   3) Secondary
   4) Tertiary/University

Counselling contents:

5. What topics did you discuss in the first time?
6. What topics did you discuss in the following sessions (what subjects came up)?
7. What issues did you raise?
8. What issues did the counsellor raise?
9. What advice were you given?
10. Did you have fears, concerns or worries?
11. Did you discuss these fears, concerns or worries with anyone?
12. Do you feel better after the counselling sessions?
13. Do you feel any improvements?
14. Were there topics you wanted to raise but you didn't discuss?
15. Why, and what would have helped you to raise the issue?
16. Have you ever experienced difficulties related to sexual matters that you desired to talk about with someone?
17. Did you discuss about those difficulties with the counsellor?
18. If no, why not?
19. Have you (or the counsellor) raised any issues related to sex, your relationship with your partner sexuality, or issues such as *(Dating, love, relationships, marriage, self esteem, assertiveness, decision making, pleasure, sex, achieving sexual and reproductive health goals, sexual desires, fertility and prevention of pregnancy, unwanted pregnancy, sexual identity, gender relations, sexual violence)* during the counselling sessions?

20. Can you tell me about your experience in discussing sexuality related issues in the counselling sessions, if any?

FOR YOUNG PEOPLE (15 to 24 years), ASK FIRST

21. As you have been growing up, how have you learned about how your body changes during puberty?
22. Have you ever asked for advice during counselling sessions about how your body is developing or about anything related to sex?
23. Can you tell me about your experience?
24. Have you always been counselled by the same counsellor?
25. How do you judge your counselling interactions with him/her?
26. Do you think about the information provided (sources of information, follow up, referral, choice of treatment location, continuity of care)?
27. Did you receive the information you wanted?
28. What aspects of counselling do you appreciate the most?
29. Are there any things you do not like in these counselling services? Why?
30. What do you find important about the counselling services?
31. What would you suggest they change? How? What are your own suggestions for change?
32. Are there any local/traditional forms of counselling here?
33. Are there any other things you would like to mention? Or do you have any questions yourself?

9. In-depth interviews with trainers

These interviews will be carried out by the researchers and will be recorded either in written notes, or through taped recordings, depending on the context and the preferences of the respondent.

Organization: …….

Counsellor Checklist

Respondent number …….. (to be filled in advance)

1. Sex 1) Female 2) Male

2. Age: …… years

3. Marital status:
   Single never married
   Married
   Separated/divorced
   Widowed
4. Site Name:……

Training

5. How long have you been a trainer on counselling?
   What made you become a trainer?
6. Where have you been trained to be a trainer?
7. What kind of counselling training have you received?
   By whom?
   When was this?
   For how long?
8. Have you received in-service training?
9. How often do counsellors get trained, is there any follow-up training, what kind of support systems has been put in place for the counsellors?
10. What material and/or curriculum do you use?
11. Was the training ever evaluated?
12. Can you tell me about the working conditions of the counsellors, including working hours, salary, training opportunities, etc?
13. Do you have experiences with burn-out of counsellors? What is the institution putting in place avoid burn-out symptoms and conditions?
14. Do you think it is important to include sexuality related issues into the training curriculum?
15. What are the most common issues related to sexuality that you think should be included in the curriculum?

16. What kind of issues related to sexuality do you feel the clients have more difficulties talking about?
17. What kind of issues related to sexuality do you think counsellors have difficulties talking about? How do you deal with this in the training?
18. What is your personal belief about the outcomes of sexuality counselling?
19. What do you think is a good counselling service related to sexuality?
20. What issues related to sexuality is included in the training curriculum material?
21. Have you had changes over time in connection to the content of the training? What changes and why?

More general

22. Are there any local/traditional forms of counselling here?
23. What sexuality counselling related to sexual health and sexual rights issues is provided in the area?
24. What is the general public opinion about sexuality counselling? Is it possible to speak openly about it?
25. Are there any other things you would like to mention? Or do you have any questions yourself?

Thank you for your cooperation

10. Observation Guide

Sexuality counselling

IDENTIFICATION					
001. 4-digit link number	__ __ __ __				
002. Name of Site	_____				
003. Site ID number	__ __				
004. Type of site/service	VCT……..1 Youth centre……..2 FP service……..3 Post-abortion service……4 Telephone (hot) line……..5 Outreach……6 VCT outreach at youth institution……7 STI Services…….. 8 Other (specify)……..9				
005. Name of observer	_____				
006. Observer number	__ __				
007. Observation number	__ __				
008. Today's date	__ __ /__ __ /2006 day / month / year				
0009. Sex of counsellor	Male = 1 Female = 2				
010. Counsellor background	Nurse……. Clinical officer…….. Social worker…… Peer educator…… Post test club volunteer…… Other (specify) _____	1 2 3 4 5 6			
Session and Client Information					
011. Session composition	Individual counselling…… Couple/partner counselling……. Group counselling…….. Pre-test VCT……..… Post-test VCT……..… Other (specify)_____	1 2 3 4 5 6			
012. If individual counselling, is client male or female?	Male = 1 Female = 2				
013. Client's age	_____ years				
014. If group counselling, what is the composition? ***(If not group counselling, skip to 015)***	Male only …… Female only…… Male and female……	1 2 3	9		
015. What is the language used during the counselling session?	English…… Kiswahili…… Luo…….. Others (specify)_____	1 2 3 4			
016. What services did the client receive today? *(Multiple responses possible)*		Yes	No		
	a) HIV information	1	0		
	b) HIV counselling	1	0		
	c) HIV test	1	0		
	d) STI service	1	0		
	e) FP service	1	0		
	f) General counselling for youth	1	0		
	g) Sexuality counselling	1	0		
	h) Sexual rights	1	0		
	i) Other (specify) _____	1	0		
	Score *3 = good, 2=fair, 1=poor, 0 = No, N/A = 9				
017. How adequate was the privacy? (Separate room/ closed door/ out of earshot)	**Good** 3	**Fair** 2	**Poor** **1**	**No** 0	**N/A** **9**

018. Was the seating arrangement for both client(s) and counsellor appropriate?	3	2	1	0	
019. If setting was inappropriate, comment how so.					
020. What was the level of interruption?	3	2	**1**	0	
Interpersonal relationship Did/was the counsellor:					
021. Greet client(s) in a culturally appropriate way?	3	2	**1**	0	9
022. Introduce himself/herself?	3	2	**1**	0	**9**
023. Relaxed?	3	2	1	0	9
024. *(Couples only)* Enquire who initiated the decision to come?	3	2	1	0	9
025. *(Couples only)* Enquire who made them come now?	3	2	1	0	9
026. Assure client(s) of how and what s/he will do to help?	3	2	1	0	9
027. Assure client(s) of confidentiality?	3	2	1		**9**
028. Encourage client(s) to speak?	3	2	1		
029. *(Couples only)* Ensure that each describes the problem?	3	2	1		9
030. *(Couples only)* If they express differences reflect them neutrally?	3	2	1		9
031. *(Couples only)* Help each to listen to the other during the session?	3	2	1		9
032. *(Couples only)* Help them to express their emotions?	3	2	1		9
033. Listen effectively (both verbally and non-verbally)?	3	2	1		**9**
034. Use kind and warm tone?	3	2	1		9
035. Was the counsellor respectful?	3	2	1		9
036. Was the counsellor supportive?	3	2	1		9
037. Was the counsellor non-judgemental? (Verbally or non-verbally e.g. facial expression)	3	2	1		**9**
038. Did the counsellor praise client(s) for the courage to come?	3	2	1		**9**
039. Keep eye contact with client(s)?	3	2	1		9
040. Use silence appropriately?	3	2	1		**9**
041. Use non-verbal communication appropriately? ***[Explain what the counsellor did]***	3	2	1	0	**9**
042. Use appropriate balance of open and closed questions?	3	2	1		
Gathering and Giving Information *Did the counsellor:*					
043. Use clear and understandable language?	3	2	1		
044. Find out what client knows about the problem?	3	2	1		
045. Build on what the client(s) knows?	3	2	1		
046. (*Group & Couple counselling only)* Allow all members to participate?	3	2	1		9
047. *(Group & Couple counselling only)* Direct discussion properly?	3	2	1		9
048. Allow clients time to absorb information and to respond?	3	2	1		
049. Ask clients to clarify information/probe appropriately?	3	2	1		
050. Allow clients to express yourself/themselves and seek clarification about information given?	3	2	1		
051. Make the necessary clarification?	3	2	1		
052. Provide factual information based on client's(s) needs?	3	2	1		
053. Use encouragers? (Giving of courage, confidence and hope e.g. nodding one's head, saying "yes, I see, go on, please, mm, hmm" etc) ***[Explain what the counsellor did]***	3	2	1		
054. Respond to clients concerns and worries?	3	2	1	0	
055. Correct any misconceptions you/participants had?	3	2	1	0	
056. Repeat and reinforce important information?	3	2	1	0	
057. Ask client to repeat important instruction/ information to check for understanding?	3	2	1	0	
058. Did counsellor emphasize positive aspects and achievements?	3	2	1	0	
059. Summarize main issues discussed?	3	2	1	0	
060. Avoid premature conclusions?	3	2	1	0	
061. Have up-to-date knowledge about HIV?	3	2	1	0	
062. Accommodate language difficulty?	3	2	1	0	
063. *(Group counselling only)* Accommodate differences in the group?	3	2	1	0	9
064. Talk about sensitive issues plainly and appropriately to the culture?	3	2	1	0	
065. Prioritize issues to cope with limited time in short contact?	3	2	1	0	
066. Manage client(s) distress?	3	2	1	0	
067. **(Couples only)** Was the counsellor flexible in involving partner or significant other?	3	2	1	0	9

068. ***(Couple and group)*** Counsellor did not take sides?	3	2	1	0	9
During the session were the following covered?					
069. Reason for seeking counselling?	3	2	1	0	9
070. Previous experience with counselling?	3	2	1	0	9
071. Knowledge about HIV and modes of transmission explored?	3	2	1	0	9
072. Assessment of personal risk carried out? ***[Explain what the counsellor did]***	3	2	1	0	9
073. Information concerning the HIV testing process	3	2	1	0	9
074. Information concerning window period	3	2	1	0	9
075. Discussion of meaning of HIV-positive and HIV-negative results and possible implications	3	2	1	0	9
076. Capacity to cope with HIV-positive result assessed	3	2	1	0	9
078. Discussion of partner involvement	3	2	1	0	9
079. Informed consent/dissent given freely	3	2	1	0	9
080. Discussion of a personal risk-reduction plan ***[Explain what the counsellor did]***	3	2	1	0	9
081. Follow-up arrangements discussed	3	2	1	0	9
082. Client(s) thanked for cooperation, patience and time	3	2	1	0	9
General counselling environment (score appropriately)					
083. How adequate was the privacy? (Separate room/ closed door/ out of earshot)	3	2	1	0	
084. Was the seating arrangement for both client(s) and counsellor appropriate	3	2	1	0	
085. Explain your observation in 83 and 84					
086. What was the level of interruption?	3	2	1		
Interpersonal relationship (score appropriately) Did the counsellor:					
087. Greet client(s) in a culturally appropriate way?	3	2	1	0	**9**
088. Make any welcoming gestures such as standing up, shaking hands, ask client(s) to sit down?	3	2	1	0	
089. Assure client(s) of confidentiality?	3	2	1	0	
090. Keep eye contact with client(s)?	3	2	1	0	
091. Engage client(s) in a conversation/encourage the client to speak?	3	2	1	0	
092. *(Couples only)* Help each to listen to the other during the session?	3	2	1	0	9
093. *(Couples only)* Help them to express their emotions?	3	2	1	0	9
094. Use kind and warm tone?	3	2	1	0	
095. Was the counsellor respectful?	3	2	1	0	
096. Was the counsellor supportive?	3	2	1	0	
097. Was counsellor non-judgemental?	3	2	1	0	
Counselling content *During the session have the following occurred?*					
098. Results given simply and clearly	3	2	1	0	9
099. Time allowed for the results to sink in	3	2	1	0	9
100. Discussion of the meaning of HIV test results to the client	3	2	1	0	9
101. Checking for understanding of HIV results	3	2	1	0	9
102. Discussion of the window period	3	2	1	0	9
103. Discussion of partner involvement	3	2	1	0	
104. Discussion on living positively	3	2	1	0	
105. Discussion on disclosure of HIV results	3	2	1	0	
106. Discussion of personal risk reduction plan	3	2	1	0	
107. Dealing with immediate emotional reactions	3	2	1	0	
108. Discussion on sexuality and safe sex methods	3	2	1	0	
109. Discussion of gender based violence and consequences	3	2	1	0	
110. Discussion of sexual pleasure	3	2	1	0	
111. Discussion of sexual pain	3	2	1	0	
112. Discussion of sexual identity	3	2	1	0	
113. Checking availability of adequate immediate support	3	2	1	0	
114. Immediate plans, intentions and actions reviewed	3	2	1	0	
115. Follow-up plans discussed and referrals made	3	2	1	0	9
Closure					
116. Does the provider follow guidelines or a protocol?	Yes = 1	No = 2			
117. Are education or other materials used to support education and information?	Yes = 1	No = 2			
118. Does the provider ask the client to repeat the agreements made?	Yes = 1	No = 2			
119. What were the strengths observed in the counselling session?					
120. What were the weaknesses observed in the counselling session?					
121. Extra comments by observer:					

Time Observation ended: _____ (AM /PM)

Appendix 4: Consent Forms

KONINKLIJK INSTITUUT
VOOR DE TROPEN

ROYAL TROPICAL INSTITUTE

1. Informed consent for observation of counselling session

Explanation of the study and the purpose of the observation

Hello, My name is ……. You have agreed to talk with me about your possible participation in a study we are doing to find out about the quality of the counselling services provided to you by Family Health Options. I am from Population Council. The purpose of our study is to better understand how the health workers/counsellors are talking with women, men (couples) who use this service about any health concerns they may have. We would like to better understand how the health workers/counsellors talk with you and how easy they make it for you to talk about your concerns about your sexual life and health. We hope that this information will help to improve this service and other counselling services provided to people in other places. In order to gather this information we would like to request your permission to observe your counselling service.

Procedures including confidentiality.

If you agree to participate in this study and have your session [name type of SRH service where the counselling is being provided] observed, another person will be physically present to observe the session. The session [State which] will be conducted as it is normally except that for the purpose of the study, your session with the health worker/counsellor will be observed by another person present. This person will not speak with you but watch and hear what is happening and may write down what the counsellor does and how you react to this.

The purpose of the observation is to observe the quality and content of the service being provided to you so that it can be improved for future clients. Everything that will be written down will be kept totally confidential. Your name will not be recorded and only the observer will know your face. The researchers who will read the notes for analysis will not know your name or your face

Risk, discomforts and right to withdrawal

During the counselling session everything will happen as it does otherwise. The only difference will be that there is another person present to observe what is happening. You can at any time during the talk ask the observer to leave. The counsellor will not mind you asking this and will be happy to do as you wish.

Benefits

This study will not help you directly but the results will help to improve this service and services in other places. If you do not want to take part in this interview you can refuse. If you do not want to participate you will receive the same service as always and nobody will hold this against you.

Sharing the results

After the assessment of the counseling is completed. We will be sharing ther results with the community and current and future clients of the service [state which] through a stakeholder meeting. In addition, the results will be available in written form through our organisations. If you would like to participate in the stakeholder meeting or would like to receive a copy of the report, please let us know and we will make this possile for you.

Consent and contact

Do you have any questions that you would like to ask?
Are there any things you would like me to explain again or say more about?
Do you agree to be observed during your [Session]?

Contact details:
If you have any other questions about this study later you can contact any of the follwing persons: (Provide contact details).
Jerusha Ouma – Tel. 0733584156

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from [state method used] at anytime without in any way affecting my medical care.

Print name of participant _____
Signature of participant _____
Date _____
Day/Month/Year

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the indiviudal has had the opportunity to ask questions. I confirm that the individual has given consent freely.
Print name of witness_____ AND Thumb print of participant
Signature of witness _____
Date_____
Day/Month/Year

A copy of this Informed consent form has been provided to the participant _____ (initialed by the researcher)

Population Council

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ROYAL TROPICAL INSTITUTE

2. Informed consent Exit interviews

Explanation of the study and the purpose of the exit interview with the provider

Hello, My name is ……. You have agreed to talk with me about your possible participation in a study we are doing to find out about the quality of the counselling services provided to you by Family Health Options. I am from Population Council. The purpose of our study is to better understand how the health workers/counsellors are talking with women, men (couples) who use this service about any health concerns they may have. We would like to better understand how the health workers/counsellors talk with you and how easy they make it for you to talk about your concerns about your sexual life and health. We hope that this information will help to improve this service and other counselling services provided to people in other places. In order to gather this information we would like to request your permission to audio tape your counselling service.

Procedures including confidentiality.

If you agree I will ask you some questions about what kind of questions the counsellor asked you, what you talked about during the session, what advice was given to you and how you felt during the counselling session. The interview will take about 20 minutes and will take place in ….(private space).

To make sure that I do not forget or change what you are saying to me I will write down the answers you give (tape the conversation). Everything that will be said, written down or taped will be kept totally confidential. Your name will not be recorded or written down. The researchers who will read the notes for analysis will not know your name or your face. The notes/tapes will kept in a locked space and the tapes destroyed after the content has been written down.

Risk, discomforts and right to withdraw

During the interview I may ask you things that you find personal or you may feel uncomfortable to talk about some topics. However, I do not wish you to feel uncomfortable and you can refuse to answer any question or stop the interview whenever you wish.

Benefits

This study will not help you directly but the results will help to improve this service and services in other places. If you do not want to take part in this interview you can refuse. If you do not want to participate you will receive the same service as always and nobody will hold this against you.

Sharing the results

After the assessment of the counseling is completed. We will be sharing ther results with the community and current and future clients of the service [state which] through a stakeholder meeting. In addition, the results will be available in written form through our organisations. If you would like to participate in the stakeholder meeting or would like to receive a copy of the report, please let us know and we will make this possile for you.

Consent and contact

Do you have any questions that you would like to ask?
Are there any things you would like me to explain again or say more about?
Do you agree to be interviewed following your counseling [Session]?

Contact details:
If you have any other questions about this study later you can contact any of the follwing persons:
Jerusha Ouma – Tel. 0733584156

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from [state method used] at anytime without in any way affecting my medical care.

Print name of participant _____
Signature of participant _____
Date _____
Day/Month/Year

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the indiviudal has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ AND Thumb print of participant
Signature of witness _____
Date_____
Day/Month/Year

A copy of this Informed consent form has been provided to the participant _____(initialed by the researcher)

Population Council

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ROYAL TROPICAL INSTITUTE

3. Informed consent focus group discussion with clients

Explanation of the study and the purpose of the focus group discussion

Hello, My name is ……. You have agreed to talk with me about your possible participation in a study we are doing to find out about the quality of the counselling services provided by Family Health Options. I am from Population Council. The purpose of our study is to better understand how the health workers/counsellors are talking with women, men (couples) who use this service about any health concerns they may have. We would like to better understand how the health workers/counsellors [do/should] talk with clients and how easy they make it for clients to talk about their concerns about their sexual life and health. We hope that this information will help to improve this service and other counselling services provided to people in other places. In order to gather this information we would like to request your permission to particiate in our study discussion about the counseling service.

Procedures including confidentiality.

If you agree I will ask you to participate in a small group discussion with other (women, men as applies) from this community. The discussion will be facilitated by two members of the research team. One person will write notes about the discussion., the other will facilitate the discussion. During this discussion we will ask questions about what men and women do if they have concerns or questions about their sexual relationships, about their sexual orientation, sexual practices. We do not want you to talk about your personal life but about what women and men do in this community. If you give examples of other people's experiences or your own we do not want you to say their names or otherwise identify them or yourself.

We will record the discussion in the group to make sure we do not miss anything you will say or record it wrongly. The tapes will not have your names and we will keep everything you say confidential. We will ask to group to also keep what is said confidential but we cannot control that after the discussion. After the discussion one of the members of the research team will note down what is on the tape and the tape will be destroyed. The notes will be kept in a locked space and nobody other than the researchers will be able to look at the notes. The discussion will take place in ….. and will take about 1 to 1.5 hour.

Risk, discomforts and right to withdraw

During the discussion you may feel uncomfortable to talk about some topics. However, we do not wish you to feel uncomfortable and you can refuse to answer any question or leave the discussion

whenever you wish. In addition, there is a slight chance that you may share information that is personal and or confidential with the group from the community that you did not want to share. We do not wish this to happen but we can not control the confidentiality of what we will talk about outside of this discussion. Please remember that you do not have to answer any question or take part in any or all parts of the discussion if you do not want to. We will encourage all participants in the group to respect the privacy of the other group members.

Benefits

This study will not help you directly but the results will help to improve sexual and reproductive health services in your area and services in other places. Although you will not be provided any financial benefit,you will receive money to pay the bus fare to attend the discussion session and a small snack during the meeting. If you do not want to take part in this interview you can refuse. If you do not want to participate you will receive the same service as always and nobody will hold this against you.

Sharing the results

After the assessment of the counseling is completed. We will be sharing ther results with the community and current and future clients of the service [state which] through a stakeholder meeting. In addition, the results will be available in written form through our organisations. If you would like to participate in the stakeholder meeting or would like to receive a copy of the report, please let us know and we will make this possile for you.

Consent and contact

Do you have any questions that you would like to ask?
Are there any things you would like me to explain again or say more about?
Do you agree to participate in the focus group discussion?

Contact details:

If you have any other questions about this study later you can contact any of the follwing persons:
Jerusha Ouma
0733584156
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand that I have the right to withdraw from [state method used] at anytime without in any way affecting my medical care.

Print name of participant _____
Signature of participant _____
Date _____
Day/Month/Year

If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the indiviudal has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ AND Thumb print of participant
Signature of witness _____
Date_____
Day/Month/Year

A copy of this Informed consent form has been provided to the participant _____(initialed by the researcher)