Lessons learnt

- Both have an external motivation: a counsellor wants to become a better counsellor; a male client seeks help because in most cases his partner wants to divorce if the violence will not stop.
- The experience from the pilot shows that when counsellors, either male or female, are competent in applying certain methods such as the 'stages of change model' and the principle of impartiality, the sex of the counsellor is less important than his/her technical competence.
- The set-up of a support system for men after counselling is vitally important. However, the first outcomes of the pilot phase are promising, motivating and innovative. ■

Programme wins PSO Innovation Award

Meanwhile, WPF and her partner organisations Mosaic (South Africa), Rifka Annisa and Perempuan Women Crisis Centre Bengkulu (Indonesia) have won the Dutch PSO Innovation Award 2009 for their male involvement project.

The citation read: "Clear in identifying what needed to be changed. The presentation showed the innovation in terms of changing the intervention strategy, as well as the implications for the capacity of partner organisations. There was also a focus on learning for the wider community on this topic." PSO groups 60 Dutch development organisations. The association focuses on capacity development of civil society organisations in developing countries. This was the second time PSO was offering the Innovation Award. ■

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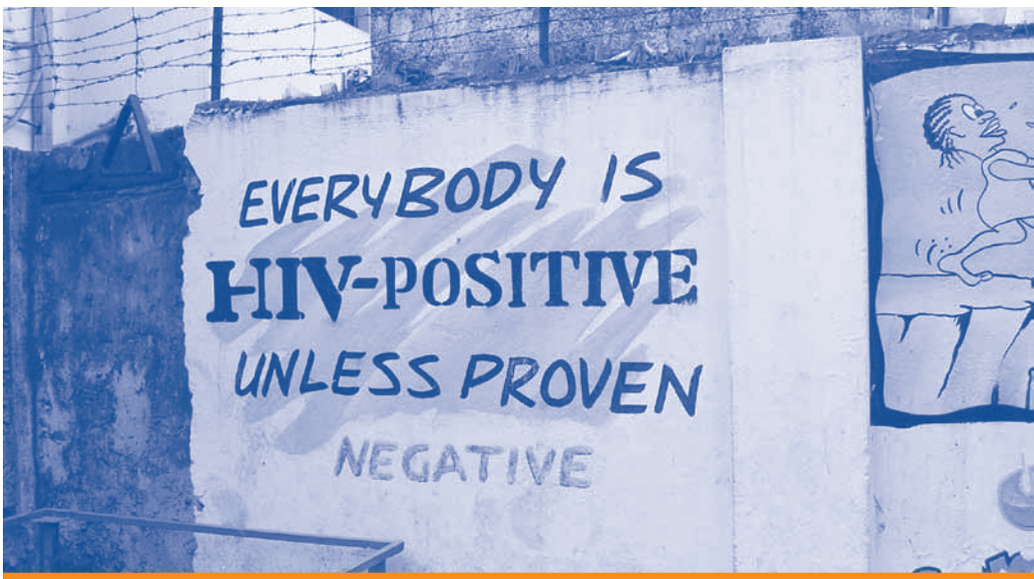
Spotlight on fears of Kenyan youth

By Jerusha Ouma



Message encouraging people to go for VCT on a wall in Nairobi, Kenya. *(Picture by Anke van der Kwaak)*

A study of Family Health Options Kenya (FHOK), an organisation providing sexuality counselling services in Kenya, was carried out between December 2006 and March 2007 in Nairobi and Kisumu youth centres. The study sought to assess the content and quality of sexuality counselling provided by FHOK and its contributions to improved sexual health. The external research team conducted desk reviews and obtained primary data through key informant interviews (17), focus group discussions (4), direct observation of counselling sessions (60) and exit interviews (60). Data was analysed using quantitative and qualitative methodologies. The author was the principal investigator in this study.

FHOK has been at the forefront of SRH programming for young people in Kenya since 1977. It started 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 in Nairobi, Mombasa, Nakuru, Eldoret and Kisumu urban centres.

The centres are managed by the young people themselves, who are trained Peer Youth Educators, 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 organised peer education and community outreach activities.

By doing so, they hope to contribute to the vision of young people living healthy lives. During the 12 months preceding the study, they recorded 2,016 new visits and 1,056 repeat visits made at the Nairobi youth centre, while the Kisumu centre recorded 3,028 new visits and 1,012 repeat ones.

Content of sexuality counselling

When asked to state reasons for visiting the youth facility on the day of the interview, HIV counselling and testing was the most mentioned reason (39.7% / 83.3 cases). Other reasons included seeking information on sexual

relationship (17.5% / 36.7 cases), marriage (23.8% / 50 cases), STI services (4% / 8.3 cases), family planning (4% / 8.3 cases) and others came for counselling on body growth and development 4.8% / 10 cases.

The research team conducted direct observations during counselling sessions to assess the quality and appropriateness of content. Content was rated as poor, fair or good using a standard checklist developed from literature review. The results indicate that most counselling sessions (over 90 per cent) 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 counsellors and these included sexual identity, which was not discussed with up to 93.8 per cent of clients observed in Nairobi and 80 per cent of those observed in Kisumu; sexual pleasure, which was not mentioned at all during counselling sessions in Nairobi while in Kisumu it was not mentioned by 73.3 per cent clients observed. On the other hand, gender-based violence was not mentioned by 96.7 per cent of clients observed in Nairobi and 76.7 per cent of those in Kisumu.

Sexuality issues were better addressed in Kisumu than in Nairobi. A follow-up with centre coordinators to understand why such areas were not adequately covered showed that some counsellors needed further training to bridge the knowledge gap. They also admitted that more attention was given to HIV and AIDS counselling due to the fact that they received more clients in need of such services as opposed to other areas. There was a general consensus among counsellors during FGD sessions that people usually sought counselling services at the youth centres 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.

A male client in Nairobi said: "I am happy with the way I was counselled. The counsellor 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 any time they are depressed with some problems."

Quality of sexuality counselling

Factors such as privacy, confidentiality, provider-client relationship, usage of verbal and non-verbal language among others, which contribute to quality sexuality counselling, were also assessed in this study.

Privacy was rated as good in 85 per cent of the counselling sessions observed. Researchers were supposed to assess if the counselling room was secluded and sessions could not be overheard. Key informants indicated that in the context of HIV and AIDS, usually privacy is protected by observing confidentiality in carrying out HIV testing, disclosing results and keeping

records. In nearly all (96.7 per cent) of the counselling sessions, counsellors assured clients of confidentiality.

Regarding provider-client relationship, all the counsellors were welcoming, kind and respectful to clients, besides being non-judgmental (98.3 per cent). Non-verbal communication was rated as good for most (over 90 per cent) of the sessions. These included keeping appropriate eye contact with the client, counsellor nodding when necessary, appropriate facial expressions and other 'encouragers'. Of the clients in the study, 81.7 per cent were either referred to another service provider or asked to come back. FHOK has formed strong collaborative networks and linkages with various government ministries and community-based and non-governmental organisations to address clients' needs.

"I'm free with the counsellor since nobody hears what we are talking about and the fact that I've never heard anybody talk about the things I discussed with her is quite encouraging to me. And because they offer many other services, nobody will know if I came for VCT or STI treatment or family planning services," a female client in Kisumu said.

Exit interview results show that many clients in Nairobi have no preference of counsellors, while most clients in Kisumu would prefer a counsellor of different sex.

Teenage mothers (Kisumu) in their FGDs confirmed 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. On further probing, they explained that a counsellor of different sex tended to take keener interest on issues affecting clients.

A Kisumu teenage mother said: "The age of the service providers also matters a lot, especially when one is seeking counselling on sexual issues. 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."

Reduction in risky behaviour

Outcomes of sexuality counselling were reported from the perspectives of clients, providers, programme staff at FHOK and key informants outside FHOK. Results show that counselling contributes to behaviour change in terms of living positively with HIV, high self-esteem, reduction in risky behaviour, improved negotiating skills, increased demand for contraceptives, increased condom use and increased use of ARVs.

A Kisumu FGD participant had this to say:
"When I tested HIV-positive, I wanted to commit suicide. I didn't know how to disclose my status to others. When I came for counselling here, I realised I was not alone. I was told that I could live longer only if I lived positively with the virus. Slowly, I began to change my attitude. I later joined a post-test club here. I have now gone public about my status. The level of acceptance in the community has increased and people are beginning to talk freely about the disease. I look healthy and others are beginning to doubt if am really positive."

Teenage mothers reported having positive change of attitude to life after counselling because counsellors had been instrumental in addressing their worries and fears. Counsellors also noted that counselling had many benefits to clients. A counsellor in Nairobi said:

Two FHOK peer counsellors. ***(Picture by Anke van der Kwaak)***

"I have handled many clients who come here in desperate conditions but after undergoing a series of counselling, they begin to accept their conditions, especially HIV-infected clients. They get to understand that ARVs can improve their lives and so they adhere. We have young couples who had separated due to family disagreements but today they are living happily after counselling. Our records also show an increase in demand for condoms and other contraceptives."

Another teenage client in Nairobi reported: "When I got my menses for the first time I got worried because my friend had told me that I could now get pregnant if I slept with a man. I already had a boyfriend that I was seeing and since I was still going to school, I didn't want to get pregnant. When I came here for counselling I got so much information about bodily changes, pregnancy, contraceptive use, sexual relationship and love. Today I am glad because I'm able to make informed choices about my personal life".

"For me I feared that my girlfriend would abandon me because I had no money to take her for outings. The counselling was very useful because I was linked to an organisation that supports youth for vocational training. I am now working but I still belong to a post- test club here from where I have learnt so much about relationships, family and peers. I feel more confident and assertive in life and I have more friends than before," a male client from Kisumu, said.

However, it is important to recognise that it is not easy to attribute the reported behaviour change to the counselling services at FHOK alone, since there are many players in the sexual and reproductive health field in Kenya, including the government.

Privacy and confidentiality

Privacy and confidentiality were essential for sexuality counselling at FHOK. Clients opened up and discussed their sexuality issues better when they were assured of privacy and confidentiality. Support groups such as post-test clubs at the youth centres were useful in terms of offering psychosocial and spiritual support to clients.

The provider attributes and characteristics have an effect on client satisfaction with the counselling provided. The characteristics, however, can be enhanced through proper training, closer supervision and support, in addition to availability of a conducive working environment.

FHOK 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; observing a high degree of confidentiality; young people treated with dignity and respect; the use of the edutainment approach; and a comfortable environment for service provision.

Together with other quality assurance mechanisms like efficiency assessments, the quality of sexuality counselling services for young people at FHOK is above average.

However, it is important to note that health system limitations in resource-poor settings negatively affect the quality of counselling, including the capacity to integrate sexuality issues.

Lessons learnt

- To improve the utilisation 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, privacy, confidentiality, and hours of service.
- 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 a supportive environment.
- Linkages and collaborations between different SRH providers including the government are important for successful implementation of sexuality counselling.

However, FHOK needs to consider the following:

- Strengthen and promote couple counselling as a strategy to ensure active participation of men in sexual health.
- Build capacity for income-generation for young people.
- Put in place better support mechanisms for counsellors to prevent stress and burnout.
- Undertake further research to determine the extent and nature of influence of sexuality counselling on behaviour change and other positive sexual health outcomes. ■

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Relaxation exercise during a counsellors' training in Jakarta. ***(Picture courtesy of WPF)***