INFLUENCE OF GUIDANCE AND COUNSELLING ON HIV/AIDS PATIENTS: THE CASE OF PUMWANI CLINIC, NAIROBI.

BY:

CAROLINE M. GORETY AKINYI

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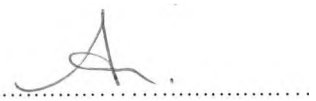
DECLARATION

This thesis is my original work and has not been presented for an award of a degree in any other University.



Caroline M. Gorety Akinyi

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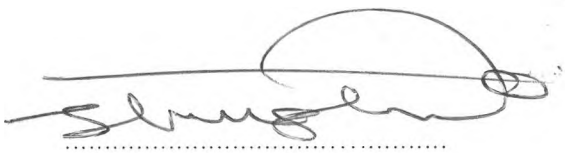
This thesis has been submitted for examination with my approval as a University Supervisor.



Dr. S. M. Nangendo

25/10/2004

Date

DEDICATION

To my husband, Eng. Gilphas Otieno Apiyo and my children Florence Anyango, Maryanne Aketch, Francis Apiyo, Martin Abuya, Mathew Ochieng and Pascal Ogwel, who had to bear with long periods of my absence while pursuing this work.

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ABSTRACT

This study investigated the influence and effectiveness of guidance and counseling on HIV/AIDS patients. This study was conducted in Pumwani Division in Nairobi and the specific site was the Pumwani Health Clinic. The field work was carried out between February 2003 and July 2003. The study sought to find out the kind of people that attended counseling, to describe knowledge, attitudes and practice of counseling information provided on HIV/AIDS, to describe the goals of counseling that have been achieved and to discuss the benefits of counseling that is provided at the Clinic.

A total of twenty-five participants were selected through purposive sampling technique. The methods used in obtaining data for this study included participant and direct observation and interviews.

The data was analyzed using qualitative as well as quantitative methods and the information presented in the form of tables and descriptive accounts respectively. Conversely the study used Affective Approaches to counseling.

The research findings revealed that counseling had positive influence on the patients as both groups reported more positive than negative of the AIDS pandemic. Patients reported that counselors who were my main informants demonstrated knowledge of their work while carrying out counseling and respected patients privacy and confidentiality. However, patients said that counselors were over burdened with the work which resulted in long waiting time at the clinic. Another finding was that there was a conducive atmosphere provided for counseling and this contributed to the effectiveness of counseling. The study recommended that measures be formulated for training more counselors in order to cope with the increasing numbers of AIDS patients. It also recommended the restructuring of the counseling process by encouraging peer counseling in order to target youths to visit Clinics.

Finally, the study recommended for more Social Science research on a wider area to cover issues on gender roles, religion and culture and how negative it impacts on women since very few women attend Clinic regularly and no Muslim woman attends Clinic.

LIST OF ABBREVIATIONS

ABBREVIATIONS

PLWSHAS	-	People Living With HIV/AIDS
I.V	-	Intravenous
HIV	-	Human Immuno deficiency virus
AIDS	-	Acquired Immuno deficiency Syndrome
CHW	-	Community Health Workers
K.N.H	-	Kenyatta National Hospital
K.A.P	-	Knowledge, Attitude and Practice
F.G.D	-	Focus Group Discussion
S.T.D	-	Sexually Transmitted Disease
WHO	-	World Health Organization
ARV	-	Anti-Retrovirals
VCT	-	Voluntary Counseling And Testing
CD	-	Cene dene
STI	-	Sexually Transmitted Infections
USAID	-	United States Agency for International Development
UNAIDS	-	The Joint United Nations Program on HIV/AIDS (UNICEF. WFP.UNDP.UNFPA.UNODC.WORLD BANK)
PMCT	-	Prevention from Mother to Child Transmission

TABLE OF CONTENTS

CHAPTER THREE: METHODOLOGY

CHAPTER FOUR: COUNSELING ON HIV / AIDS PATIENTS

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

CHAPTER ONE

INTRODUCTION

1.0 Introduction

HIV/AIDS is a scourge which has had a devastating effect on its victims (Kangethe 2001;Ntozi-Kitrunga 1998; Government of Kenya 2001; Ankisola 2000). It has had devastating effects especially in developing countries where it has adversely affected the economy, population structure and social-dynamics (Ntozi-Kitrunga 1998; Government of Kenya 2001; Ankisola 2000). It has also brought in new problems of orphans and increased expenses of health care. It is indeed an expensive disease (Government of Kenya 2001; Ankisola 2000). This is because one requires money to buy medicine to treat opportunistic diseases since HIV/AIDS reduces body immunity. Infected people also require a balanced diet in order to build up the body cells. This is not affordable by a majority of people in the third world countries like Kenya who live on less than a dollar per day.

The disease affects people of all ages and has caused much psychological stress and uncertainty in life. It has brought in new concepts about STD control especially on conditions causing genital infection. There is a new dimension in the use of family planning especially towards efforts to preserve pregnancy in HIV/AIDS patients. With this has come the need to introduce guidance and counseling in relation to HIV / AIDS to help promote behaviour change. Otherwise this most devastating epidemic in human history may never be diverted. It is every human beings concern and duty to play a role. (Lamptey 2002; Ankinsola 2000). During counseling, the counselor requires to respect basic characteristics such as personal feelings and to deal with clients problems with dignity and individuality. This if observed will influence the clients perception of counseling by giving guidance, direction, advice, help and also steering fulfillment. Counseling is an approach which helps people adapt essential and effective mechanisms to cope with life more especially those infected and

affected with HIV/AIDS. Counseling should help one understand himself or herself. Counseling should therefore use procedures and processes to create a helping relationship and involve services that assist clients to make and carry out adequate plans such as writing will, living positively and saving so as to achieve satisfactory adjustment to life. Counseling is a life long process in which a person (client) gets knowledge and techniques to identify and handle problems as they come and even provide for developmental needs by not just resigning to life and wait for the eventuality which is common to one who is told he or she is HIV positive. Counseling should promote self-understanding and expand the understanding of others (Oketch-Gumba 1991). Counseling is a single activity which encompasses several professional skills. No two people understand counseling in exactly the same way. It is a personal face-to-face relationship between two people in which the counselor by means of this relationship and his or her special competence provides a learning situation where the counselee (Client) is helped to know himself or herself and his or her present and possible future situation. (Oketch-Gumba 1991).

Counseling is a process by means of which a person who is professionally prepared to counsel, attempts to help another person in matters of self understanding and decision making. Its outcome is greatly dependent upon the quality of counseling. Counseling is part of the guidance process which essentially helps normal individuals to deal with or remove frustrations and obstacles that interfere with their daily lives. It is an occupational process occurring when there is a problem or a need affecting the adjustment process of the client. It is a professional service rendered by a trained and competent person to another person who is normal and seeks advice on problems which he or she cannot cope with. It is a learning teaching process where the client learns new behaviors and attitudes such as behavior change to avoid further spread to HIV/AIDS for those clients who are HIV positive. It involves change or modification of ones way of thinking and doing and this may affect:

1. The client himself or herself
2. His or her attitude towards others in his or her life.
3. His or her personal adaptation to the cultural environment in which he or she finds himself or herself (Oketch-Gumba 1991).

1.1 Problem statement

Despite concerted efforts by many world bodies, government programmes, non-governmental organizations, social systems, private institutions and individuals, HIV/AIDS is still spreading worldwide. (Ntozi-Kitrunga 1998; Government of Kenya 2001; Lamptey 2002; Ankisola 2000). In some areas it has threatened to wipe out whole populations. Infact, it has had serious and devastating effects on many Nations in sub-Saharan Africa, for example, Uganda, Malawi, Zimbabwe, South Africa and Botswana (Ntozi-Kitrunga 1998).

Globally, there is hardly any country without HIV/AIDS cases. It has become a world pandemic. The number of confirmed HIV/AIDS cases in Kenya and the attendant death cases, has continued to rise despite efforts put in place to control it. The spread has also increased in areas such as Busia, Kisumu, Suba, Siaya and Thika Districts where the disease was formally not so widely spread. Changing patterns of the epidemic is emerging in Kenya and threatening to get worse with the disease cutting across the entire social strata as opposed to earlier notions of affecting target groups like prostitutes. The sexually active age group which happens to be the most productive members of the society are the most vulnerable. This results into great economic loss to families, communities and the nation (Government of Kenya 2001).

Dr.Sobbie A.Z. Mulindi (The Weekly Review, June 4th 1993) supports the above scenario by saying that it is not the magnitude of statistics concerning the AIDS situation in Kenya or what they stand for that is significant. The most critical reality is that many important Kenyans are dying daily from AIDS. It is a serious problem

which requires to be addressed with urgency, cooperation, collaboration, advocacy and commitment at all levels. Advocacy which can be equated with guidance and counseling is therefore top on the list to help influence behavior change.

A USAID brief reports that Kenya is one of the nine countries hit hardest by the HIV/AIDS epidemic. According to UNAIDS, at the end of 2001, an estimated 2.5 million Kenyan adults were living with HIV/AIDS, representing a prevalence of 13.5 percent. In 2004 the latest prevalence rate stands at nine percent (UNAIDS 6th Global Report 2004).

Part of the effort to reverse this disturbing trend in Kenya is through guidance and counseling of HIV/AIDS patients targeting largely behaviour change. Guidance and Counseling has been credited with reduction of infection and re-infection rates through abstinence and/or use of condoms, prevention of mother to child transmission through PMCT programmes; successful campaigns against undesirable cultural practices like wife inheritance especially among the Luos of Kenya, patients attitude change and self acceptance with increased life expectancy and less stigmatization of the disease among other benefits.

This study therefore sought to understand the effectiveness of this important tool of guidance and counseling to those who are infected with HIV/AIDS. It is this group that if thoroughly counseled can stop further spread of HIV/AIDS.

Dr.Sobbie A.Z. Mulindi (The Weekly Review, June 4th 1993) views sex as a very powerful instinct and with or without AIDS people will still engage in it. It is in this light that guidance and counseling sessions on those infected need to be studied to check how effective they are carried out as a matter of urgency.

This study therefore sought to answer the following questions:

1 What are the kind of people that attend counseling?

2 What KAP of counseling information is provided on HIV / AIDS?

3 What are the benefits that people get out of the counseling at the clinic?

4 What are the goals of counseling that have been achieved?

1.2 Research Objectives

1.2.1 General Objectives

The overall objective of this study was to investigate the influence of counseling and guidance on proven patients with HIV/AIDS in Pumwani Division in Nairobi.

1.2.2 Specific Objectives

1 To identify the kind of people that attend counseling.

2 To describe knowledge, Attitudes and Practice of counseling information provided on HIV/AIDS.

3 To describe goals of counseling that have been achieved.

4 To discuss benefits of counseling that is provided at the clinic.

1.3 Justification for the study

Although much work has been done on HIV/AIDS in this country, especially on epidemiology and prevention, little has been done to evaluate the patients' perceptions about the services of personnel who provide counseling.

There is a need for behavior change to slow and prevent the disease from spreading. There is also a need for clients who are already infected with HIV/AIDS to have a deeper realization of their status and circumstances to live more positively with the disease. This is because they have a role in preventing the spread of HIV/AIDS. This is more due to the fact that HIV/AIDS patients at the window period are largely unaware of their condition and thus can promote the spread of HIV/AIDS.

Counseling is probably the best option to ensure the community and victims of HIV/AIDS play their role in issues relevant to stopping the spread of HIV/AIDS. These issues prompted a need for this study.

1.4 Scope and Limitations of the study.

The study was carried out at Pumwani Health Clinic in Pumwani Division, Nairobi. It is a specialized institution catering for the counseling of HIV/AIDS patients. The clinic may, therefore, not represent the type of patients seen in the rest of the country. Translation of the findings to reflect what is applicable for the best of HIV/AIDS patients' in the rest of the country may therefore be used as a yardstick. Due to limited time and funds the study was conducted for six months. Since HIV/AIDS patients are stigmatized it was very difficult being with them as an outsider who is not even a counselor or a patient and sit with them in a group therapy. However, the researcher explained the nature of the study to clear the air and build confidence on them. Because of limited time to undertake ethnographic study, the study limited itself to the objectives.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

HIV/AIDS was first recognized in sub-Saharan Africa in Rakai District in Uganda between fishermen and traders and their families in 1982. This was one-year after a similar illness had been identified among homosexuals and I.V drug users in U.S.A. After the first fifteen years, the disease has now spread worldwide but particularly in sub-Saharan Africa. The nature of the epidemic differs in developed and developing countries. For instance, in developing countries, people are still fighting poverty since majority of people live below poverty line and survive on less than a dollar per day and cannot afford to fight the disease because of lack of enough health facilities and money to access medical assistance when sick. Because of poverty which is mainly felt by women, females have taken to prostitution as a source of income in developing countries especially in Pumwani area (Majengo) where the study was carried out and this has increased the rate of infection. (Thior 1997; Ntozi-Kitrunga 1998). The incidence is continuing to rise globally (Avid-Okol 1997; Ankisola 2000).

Out of the 28 million people in the world with HIV infection in 1996, 19 million (68% of Global total) was in sub-Sahara Africa. Here the spread is predominantly sexual transmission. This is promoted by heterosexual promiscuity, free flow of travellers, high-risk sexual behavior, prostitutes and their clients, STDs and genital infections (Onwubalili 1988; Olobuyide 1995; Van de Pare-Heteo 1991; Avid-Okolo 1997; Ntozi-Kirunga 1998; Ankisola 2000).

Male and female ratio of those infected in sub-Saharan Africa is one to four. This has led to many cases of pediatric HIV/AIDS transmission from mother to child, which occurs in 25 percent – 35 percent of pregnancy of infected mothers. Due to this

infection rate sub-Sahara Africa accounts for 90 percent of the world pediatric HIV/AIDS cases (Ntozi-Kitrunga 1998).

Social and economic repercussions of HIV/AIDS are well recognized. It is an expensive disease and it involves highly controversial issues. Some believe it is a consequence of religious apathy to morals or end of time signs (Olubuide 1995). Some believe it means "American idea to discouraging sex" (Ankisola 2000). Others believe they are immune to disease. The fact is AIDS is entirely preventable. However, once contracted it is untreatable and death is inevitable (Olobuyide 1995; Ankisola 2000).

AIDS is a threat to the health of the nation and it reduces productivity in trade, farming, industry and other enterprises of economic importance. It is a threat to the country's financial, administrative and social infrastructure. Also it is a threat to the livelihood of thousands of people and the welfare of families even those not directly infected with HIV/AIDS (Olobuyide 1995). This is because it mainly affects a productive age group of between 20 to 59 years (up to 85%).

Family planning and HIV/AIDS have influences on each other in a number of ways. There is an influence on choice and usage of family planning, for example greater promotion of the use of condoms to prevent spread of HIV/AIDS and to also prevent conception. AIDS has a drastic effect on the population either way. For instance, the population of Uganda is projected to be 24.5 million in 2010 due to AIDS which is a reduction from 33 million when there was no AIDS in 1982. This negative growth has an effect on family planning practices especially the use of condoms.

In UK family planning centers counsel HIV patients to have abortions. This is because pregnancy is thought to hasten progression of the disease. Fertility rate in HIV/AIDS patients has also been found to be less (Ntozi-Kitrunga 1998).

2.1 HIV/AIDS situation in Kenya

In Kenya the problem of HIV/AIDS was first met with skepticism by the government and the attitude that it was a disease of some minority groups like prostitutes. Later it was realized that AIDS was a danger to the whole population, but some valuable time was lost by then. Government in its prevention efforts by promoting the use of condoms was opposed by churches especially the Catholic Church, and this sent mixed signal to the public (Ntozi-Kitrunga 1998).

Presently it is estimated that 2.2 million Kenyans have HIV infection. This is only a representation of the cases reported. This is because some AIDS patients do not go to hospitals. Others are not tested or not reported due to lack of test kits, stigma or failure on health institution to report cases of HIV/AIDS infection or death related cases. By the end of 2000, 1.5 million Kenyans had died of AIDS (Government of Kenya 2001).

The range of AIDS in Kenya is from the neonatal age to over 60 years with the peak at 0 to 4 years and 12 to 39 years. AIDS death has occurred in estimated 900,000 people and is expected to reach 1.5 million by 2005. Its devastating effect in Kenya is like in other developing countries. This prompted declaration of HIV/AIDS as a National disaster in November 1999 (Government of Kenya 2001).

2.2 High risk behavior in HIV/AIDS

Risky sexual behavior has been reported by men and women (Onwubalili 1998; Olobuyidi 1995; Van de Pere-Heteo 1991; Thior 1997; Avid-Okolo 1997; Ntozi-Kitrunga 1998; Government of Kenya 2001).In Kenya 16 percent of married men have reported having extra marital sexual partners. Of the single people, 60 percent of men and 40 percent of women reported that they were sexually active. About half of single men reported to have more than one sexual partner. This was 14 percent in respect to women (Olobuyide 1995; Government of Kenya 2001).

Men and women still believe they are not at risk or have no accurate knowledge of how to prevent infections (Olobuyide 1995; Government of Kenya 2001).

Not everybody is undergoing behavior change to adopt to healthy sexual practices (Government of Kenya 2001). The use of condoms has not been accepted by all (Ntozi-Kitrunga 1998; Government of Kenya 2001). These confounding factors, among others, make high-risk behavior still prevalent.

Other than prostitution and keeping extra sexual partners, other high risk behavior include drug addiction, quacks and wife inheritance. Wife inheritance as a cultural practice is a high risk behavior because it is a practice deeply entrenched in certain cultures of the World especially among the Luos of Kenya who strongly believe that a woman has to be inherited when the husband dies despite the nature of his death (Ker Paul Mboya 1997).

2.3 HIV/AIDS awareness in Kenya

Many people in Kenya may not know that they are infected with HIV as opposed to countries such as Uganda and Tanzania where awareness level is very high (Statistics from KICOSHEP). It is this group of people who may not know their status that spread the virus to their sexual partners and children, continuously adding new cases of HIV to the reservoir. Some will become sick and develop AIDS. Many adults do not, however, develop symptoms of AIDS for five to ten years or even longer (Government of Kenya 2001; KICOSHEP).

During this symptomless period, that is between 5-10 years, an infected person can infect another person unknowingly. HIV positive (not tested) people have few or no symptoms and, therefore, not aware that they have the virus and can infect. This contributes to the spread. As the AIDS develops, a person becomes very infectious due to the increase in viral load. (Government of Kenya 2001).

Most of the devastating effects on HIV/AIDS, with its social and economic constraints, come to people as a shock. They are not aware of its existence until it starts taking toll on their health and life situations (Government of Kenya 2001).

2.4 History of counseling

Throughout human history, men and women have been communicating with one another. In the process of this communication it is difficult to ascertain when men and women first sought and received help, advice and instructions to deal with different everyday situations.

Throughout the ages, human beings have sought the advice and counseling of a god or gods believed to possess superior knowledge, insight and experience. Certain old or privileged men were believed to have close association with supernatural beings and were also visited for advice.

Counselors today could be equated with oracles, soothsayers, fortunetellers, medicine men, chieftains and elders. People turned to counselors for help and advice. It turned out that people always sought counseling from older people or people of the same age or sex, later on it was sought from people of the same occupation, for example, hunters to hunters, farmers to farmers and so many others.

In the early civilizations, the philosophers, priests and other representatives of the gods and religions assumed the function of advisers and offered counseling for example the Romans turned to Jupiter and lesser gods, Greeks turned to Zeus and his lesser gods, the Egyptians turned to Ra and his "divine" family. Of the early Greek "counselors" who were philosophers, Plato is recognized as the earliest individual to organize psychological insight into a systematic theory that is, he examined the psychology of individual in the following manner: -

- In relationship to moral issues.
- In terms of education
- In relation to society

Plato did this by asking the following questions:-

1. What makes a man virtuous – his or her inheritance, his or her upbringing, or his or her formal education?

2. How can children be most effectively taught?

3. Which techniques have been successfully used in persuading and influencing people in their decisions and beliefs?

Aristotle is the second great counselor. He was Plato's student.
He made numerous and significant contributions to what was to become the field of psychology by building on questions his teacher Plato asked.

Later in ancient Hebrew society, individuality and the right of self-determination was assumed. The early Christian societies emphasized humanistic ideas, which later became basic to democratic societies and in this century to the counseling movements.

The Mental Health movement emerged in America as a consequence to the contributions made by Plato, Aristotle and early Greek counselors to form the modern Approach to counseling. This movement owed much of its impetus to efforts of one man called Clifford Bears, a wealthy man hospitalized in a mental institution because of schizophrenia. After three years in hospital, he wrote a book "A mind that found itself" (1908) sharing his experiences and observations on how mental patients were inhumanly treated and, therefore, they needed counseling. This was later taken up by Carl Ranson Rogers who also started a movement after his client-centered therapy in

1942 with the publication of his book "Counseling and Psychotherapy". In his book counseling was client oriented where the client was the one to change himself or herself most effectively and no one could do it so deeply and permanently. The counselor was just a facilitator.

2.5 Principles of Counseling as proposed by Arbuckle and others (1966)

Human beings are basically self-determining creatures. This means that, "You can be what you want to be" (Oketch-Ngumba 1991). Human beings have an innate desire for self-direction and every person aspires to, and usually achieves, independence and autonomy. A human being has the ability and capability to control his or her destiny and be fully responsible for his or her actions.

A client should constantly move towards a greater level of acceptance and self-understanding. This means that clients themselves do not settle for less but extent themselves to become more. A human being should realize that limited awareness and understanding of the self means limited freedom. Therefore, one should know who one is and what one is capable of becoming. This is because many problems faced by men and women are self-imposed, for example, biased perceptions resulting in distorted realities and harmful attitudes leading to self-destruction. The first step in the healing process is to understand oneself. Then one will be on the road to living a fuller and more meaningful existence. This means that the one who seeks counsel is in a dynamic process of change and, in order to be fulfilled as an individual, One should be ready to accept who one is and where one wants to go in order to improve one's relations with others and with one's environment.

A person who is ready to accept advice soon develops a greater length of honesty, particularly honesty towards self. This means that the clients' real self resembles more and more his or her experiences. The client must understand his or her

experience. The client must understand his or her repressed tendency and distorted experiences and share these with others who can provide positive feedback.

What must be considered first in counseling is the clients need and not the counselors need. Counseling should be "client-centered" not "counselor -centered".

If a person does not or cannot satisfy his or her physiological and psychological needs this may lead to frustrations and hostility as well as deep personal dissatisfaction (Oketch-Ngumba 1991).

2.6 Significant influence of counseling in the world

Many factors have combined to foster an accepting environment for counseling in the U.S.A. and in other parts of the world including Kenya. This includes the following:-

Social Factors

The movement of people from rural to urban settings where there is no adequate system meeting the varied needs of all individuals has resulted into strained social amenities such as roads, houses, health care and schools. People have become legally free after colonization. They have a right to look for jobs and a right to self-determination. Migration takes place from one geographical location to another. This has created a need to adjust different cultures, social norms and political situations. There is increasing concern about inequalities. Everybody needs to enjoy pleasures of the society. This creates concern for social reforms.

Economic Factors

The world has experienced increased industrialization and diversification. Depressions, recessions and inflations have affected our welfare. The loss of security

through unemployment has made individuals question their ability to live fulfilled lives. Many seek to rebuild their lives.

Scientific Factors

The human race has seen much progress in areas such as transportation, healthcare, communication and research. All these developments have increased human contacts and survival and created new situations that require decision-making and counseling.

Ideological Factors

Human beings are getting more and more concerned about the rights and welfare of all individuals. Various organizations have established clear channels to assist those who are disadvantaged. This ensures fair play (Oketch-Ngumba 1991).

2.7 Professional counseling and guidance in Kenya

Professional counseling started in Kenya in the 1970's. Before this, it was more or less a private family affair. Parents, relatives or older members of the family used to counsel children on all matters of life management and problem -solving.

In serious family problems, counseling was done by a specially organized panel of elders or an experienced person who was recognized by the community as competent in handling that specific problem.

Professional counseling in Kenya originated from the first guidance conference (career conference) in 1967. This was followed by the establishment of a guidance and counseling unit in 1971 by the Ministry of Education. The late 70's and the 80's saw a tremendous growth of counseling services in the community. This is spearheaded by governmental and non-governmental organizations and the private sector. Due to the ever-increasing pressures of life in the country because of the

various factors, needs for the counseling will ever increase. This is even more so with the onset of disease such as HIV/AIDS (Oketch-Ngumba 1991).

2.8 Factors influencing guidance and counseling in HIV/AIDS

"Other than perhaps AIDS no area of medical endeavor seems to elicit greater emotions in the general public than the knowledge that he or she has been to a psychiatrist". This brings up the comparable problem of the stigma which patients having both mental illness and AIDS face (Onwubalili 1998).

There are many psychiatric complications of AIDS. There are problems of adjustment to diagnosis and the stigma attached to it. Reactive depression, potential suicide, personality problems and frank dementia (due to AIDS dementia complex) are some of the additional problems. These psychiatric problems are due to the infection of the brain, a reaction to diagnosis, reactions to other peoples' reaction, pre-existing personality or emotional problems (Mari 1999).

Many individuals who know they have HIV conceal their HIV status. They are afraid of being rejected by friends, family, neighbors and co-workers as well as discrimination and dismissal from employment (Olubuyide 1995).

The crisis following diagnosis include an overwhelming feeling of uncertainty, guilt, fear in the face of impending death, shame, loss of source of income, bitterness, depression, stigmatization, alienation, anger and sadness (Mari 1999; Olubuyide 1995).

People predisposed to AIDS are from marginalized groups, people with high-risk sexual behaviors (due to difficult circumstances or pressure) and people with long-standing economic or emotional status (Mari 1999). They are in need of public education and pastoral care so as to effectively help them cope with traumatized feelings and draw from the spiritual resources. They get services from the general

practitioners, clinical officers, nurses, psychiatrists, counselors, traditional healers and trained volunteers such as Community Health Workers (CHW) from the community (Mari 1999).

To meet this service need the traumatized requires giving the necessary support and assistance in the form of counseling. A counseling workshop was held in Nairobi in June 1987 to train trainers of counseling and a series of workshops in several provinces were organized (Mari 1999).

Counseling draws on the psychological, social and material support to patients, their families or people concerned with the care of the clients and therefore should aim at modifying behavior, limiting psychological disability, and transmission in order to extend the period of the patients adequate functioning in the family and community since HIV Aids either affects or infects (Mari 1999). Due to these virtues counseling becomes highly relevant to the patients care.

2.9 Application of guidance and counseling in HIV/AIDS

In two years, infection doubled in sub-Saharan Africa in 1996 despite intervention strategies by the international community, national Governments, non- governmental organizations and individuals. Interventions targeted behavior change, advocating abstinence, monogamous relations and the use of condoms (Ntozi-Kitrunga 1998). About 90 percent of HIV cases in Africa occur in East and Central Africa (37 percent), South Africa (37 percent) and Western Africa (15 percent). There is, therefore, much need for counseling to divert people from high-risk sexual behaviors and adopting safe practices (Mari 1999; Olubuyide 1995; Ntozi-Kitrunga 1998). This was effectively applied in Uganda and they have succeeded in achieving positive behavior change (Ntozi-Kitrunga 1998).

Many patients do not attend STD clinics. Therefore, screening for STD or AIDS outside specialized clinics is encouraged. One to one counseling sessions help in this

regard. Health workers give information tactfully, effectively and with due understanding in these clinics (Olubuyide 1995). Counseling is in fact done in many sectors within communities by different cadres of health workers such as HIV and traditional health workers (Mari 1999).

In Kenya counseling have been developed further to look into the need for voluntary testing and confidentiality (Government of Kenya 2001).

2.10 Theoretical framework

The theoretical framework on which this study is based is Affective Approaches to Counseling. The Affective approach focuses on the feelings and emotions of clients. Emotions are seen as influencing how people respond to events around them. The observable behavior and conscious thoughtfulness of people are also influenced by the feelings and emotions.

Affective Approaches to counseling Theory aims at changing behavior by changing the way the clients feel about himself or herself and have the following characteristics and concepts;

a) The client knows best because he or she is the one in direct experience with his or her problems. The primary responsibility of the counseling process is placed on the client.
b) Belief in the dignity and worth of each individual. Individuals are independent and self-directing.
c) Perceptual view of behavior tendency towards self-actualization.
d) Belief that people are basically good and trustworthy.

The goals of person-centered therapy are that the client:

a) Becomes more open to the experience.
b) Learns to trust him or herself
c) Accepts himself or herself to be in the process of changing.

2.11 Relevance of the theory

HIV/AIDS is a highly emotional concept. It is associated with much stigma and stress and those infected are faced with the inevitable reality of death with no possibility of cure. He or she looks at her or his upheavals, rejection and dejection. The counseling approach for such a person should be that which restores confidence, self esteem and social adjustment which can best be achieved by client-oriented or centered approach. This results into giving the client a new hope in life. That is why Affective Approaches to counseling has been decided upon as the most suitable and applicable in this study.

2.12 Assumptions

In view of the literature reviewed and the theological framework stated, the following assumptions were advanced for the study:

1. People of both genders attend the clinic.
2. There is adequate information on KAP.
3. The benefits of counseling positive.
4. The goals of counseling help HIV/AIDS patients to live positively with their status.

2.13 Definition of terms

Adults - Persons legally allowed to sign consent. These are persons at 18 years and above.

Educational Level - Completed level of education.

Marital Status - Legally designated marital status as defined by marital laws.

Attitude - A way of thinking or feeling. A position of the body.

Independence - Freedom to think or acting for oneself. Not relying on someone for support, guidance etc

Feeling - Sense of touch, emotion spoken with great feeling. affection, belief and expression.

Self -Directing - Having self-drive to do something

Prevention - To hinder and stop from happening or taking place.

Counseling - Giving advice to someone or somebody

Effectiveness - Producing desired effects on counseling

Emotions - Feelings that disturb the mind like being told you are HIV Positive.

Behavior - How someone acts towards his or her own emotions for example sexuality.

Psychology - The study of human mind

Problem - A matter difficult to deal with or a task, which require a solution.

Rationalization - To think of a good reason for so as not to feel guilty about it.

Opinion - What someone thinks or believes.

- Professional Judgment or point of view.

- Judgment of the value of someone or something.

Capability - Skills, the ability or potential to do something.

Destiny - What is destined to happen or ones fate

Belief - What someone thinks to be true or having faith in something.

Control - To take charge or have power over in this case HIV/AIDS.

Rapport - A good relationship, sympathy.

Discordant Couples - This is a situation where one of the couple is HIV positive and one is negative.

CD4 - Another name is T – helper cells. These are white blood cells, which organize the immune system's response to some micro-organisms, including bacteria, fungal infection and viruses.

- The CD4 count is the measurement of the number of CD4 cells, in a cubic millimeter of blood (not the whole body).

Viral Load - This is the term used to describe the amount of HIV in ones blood.

CHAPTER THREE

METHODOLOGY

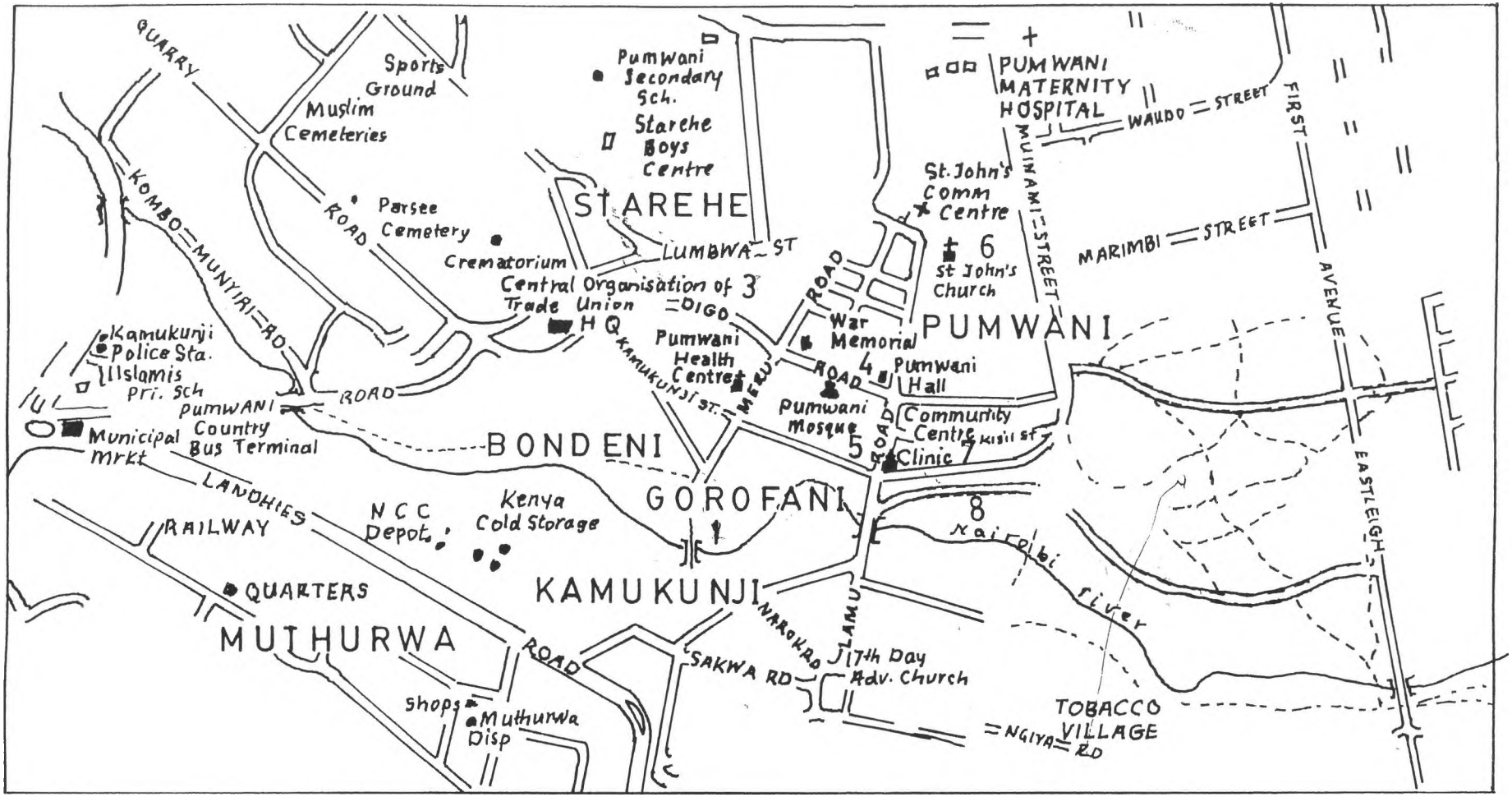
3.0 Introduction

This chapter describes the research site, population, sampling techniques and methods of data collection and analysis. The problems encountered are highlighted and solutions used in solving them given. Ethical issues also have a section in this chapter.

3.1 Description of study area

This research was conducted at Pumwani Health clinic situated in a slum area in Pumwani Division, Nairobi. The area is popularly known as Majengo which is an informal settlement started in 1919 after the first world war to house women from mainly Tanzania. The women were supposed to keep soldiers from war who were settled at Kariokior just in the neighbourhood "happy" by providing sex. This explained the large number of commercial sex workers found in the area. Pumwani Health Clinic is surrounded with villages namely Gikomba, Bondeni, Mashimoni, Sofia, Highrise, Gatanga, Ndigo, Vutui and Gorofani. According to the 1999 census, it has a population of about 201,000 people; 109,000 of whom are male. The people living in this area are of very low social and economic status living below a dollar per day due to lack of most essential facilities such as education, health and infrastructure.

MAP OF NAIROBI



Key:

1	Gikomba	▭	Schools
3	Mashimoni	+	Hospital / Clinic
4	Sofia	▲	Mosque
5	Gatanga	▮	Church
6	Highrise	~	River
7	Digo	=	Road
8	Kitui		

Map 1: Pumwani area

Educational facilities

Educational facilities are scarce with only two nursery schools which are private because they are community owned. No secondary school exists in the area. There are no primary schools either. This kind of scenario can seriously affect the people of the area negatively since education is key to life and highlights issues such as knowledge on HIV/AIDS and other health related matters. Seeking education in far places makes education very expensive to area residents thus forcing them to spend on education more at the expense of other areas such as health.

Infrastructure facilities

This area, has dilapidated infrastructure. It has very poor roads with an inadequacy of telephone, electricity, clean water and sanitation. Poor infrastructure slows down development which in turn increases cost of living and yet the area is inhabited with people of low socio-status. Sanitation if poor, breeds diseases such as diarrhea, dysentery, cholera and typhoid which easily adds to the list of opportunistic diseases suffered by HIV/AIDS patients.

Health facilities

The population of about 201,000 people according to the 1999 census, is only served by Pumwani Health Clinic run by City Council of Nairobi. It cannot serve the people of this area adequately. As such many programmes and organization have been established by the private sector in the area to assist people. These include St. John's Community Centre, Single Mother's Association, Undugu Society, Crescent Medical Aid, Pumwani Scouts Zone Council, MS Belgium,Urban Slum Development Project, Pumwani Village Health Committee and Eastern Deanery. Many of these organizations are involved in STD, STI and HIV/AIDS prevention activities. Despite this, STD, STI and HIV/AIDS prevention activities, these diseases are spreading at an alarming rate in this area. The fact encouraging the spread include the large

population of destitute people who subject themselves to high-risk behavior such as having several sexual partners, having sex without protection and engaging in drug abuse. Other factors that encourage the spread include engaging in commercial sex as a means of earning a living without protection and in adequate knowledge about STD, STI and HIV/AIDS. The organizations especially MS Belgium also provide very good care and support to people living with HIV/AIDS (PLWHA'S).

3.2 Study population and unit of analysis

The study population was derived from the population universe through purposive sampling. This was because the study focused on different groups of people who were considered to be key players in HIV/AIDS. These groups include HIV/AIDS patients, counsellors, family members of the patients and the community. The researchers concentrated on Pumwani Health Clinic though visits were made to other VCT centres, KNH and villages around Pumwani Clinic in order to compare notes. During visits, interviews and observations on selected groups by way of informal observations and interviews was done.

3.3 Population Sample

Adult male and female patients seen at Pumwani Health Clinic and were positive were considered for the study. A total of nineteen individuals were put under study and six key informants were interviewed. The FGD under the group therapy was done once a week.

3.4 Sampling Procedure

In the study, the participants were selected through the purposive sampling technique since it was a purposive study that focused on a specific population.

3.5 Methods of data collection

The following data collection methods were used in the study; secondary sources, non-standardized interviews, key informants, oral interview during group therapy and direct observations.

3.5.1 Secondary data

This method utilized secondary literature from the books and journals from libraries such as The Institute of African Studies Library, University of Nairobi Library at Kenyatta National Hospital, Institute of Development Studies Library, Jomo Kenyatta Library and Department of Nursing – University of Nairobi Library, Ministry of Lands and Settlement Library and Herufi House Library. The information obtained was used for identifying the missing gaps as well as acting as the yardstick to measure findings with what has been documented.

3.5.2 Primary data

This method of data collection formed the core of the study. It utilized focus group discussions, which included patients and the key informants who were counselors.

(i) Focus Group Discussions

The Focus Group Discussions were organized in two groups consisting of 11 married men and 8 married women. Men and women participated in the discussions separately because of their sexes and the nature of their problems. The FGD was designed to bring clarity to issues arising during the counseling due to sensitive nature of the disease as contained in Moderator's guide and sample questions in the Appendices.

(ii) Participant and Direct Observations.

These methods were employed throughout the study and served as a pointer between knowledge and practice. The researcher attended all counseling sessions that were conducted three times a week for a period of six months. As a participant observer, the researcher attended HIV/AIDS workshops, fora and related talks on guidance and counseling. The researcher also visited HIV/AIDS patients in their homes so as to make observations and to listen to their families and communities at large give testimony as to whether or not counseling at the clinic is of any help to them.

(iii) Interviews

Interviews with key informants were undertaken. These were people who had information relevant to the study since they were specifically counselors trained on HIV/AIDS related matters only. This method was to provide additional information to that obtained through other methods such as questionnaires given to HIV/AIDS patients. Key informants provided in-depth information on how counseling was started and what has been achieved, the challenges faced and the way forward.

3.6 Data processing and analysis

Qualitative and quantitative methods of data analysis were employed. The quantitative methods of data analysis involved the use of descriptive statistics such as distribution tables to present results on KAP on sex and HIV/AIDS. Qualitative methods were used in discussing data collected through participant and direct observations, informal interviews and key informants. The information elicited by the above methods was arranged and categorized according to the objectives of the study. Qualitative data analysis also included the presentation of quotes from different respondents.

3.7 Problems encountered in the field and their solutions

In the course of the study, the researcher encountered some problems for example due to the sensitive nature of the disease some HIV/AIDS patients in the sample population turned down their participation which I took positively as part of strong areas which required counseling. Others never participated in the whole process. This to me was not strange because of the stigma attached to the disease, which require further counseling. However, efforts were made to make the patients feel comfortable to ensure privacy and observance of confidentiality to establish rapport and seek for informed consent. Another problem was that of suspicion which slowed the study at the beginning because respondents were not willing to accept the researcher in their midst during group therapy which is exclusively for the patients. The researcher solved this by constant reassurance of keeping their HIV status secret and also telling them "if one is not infected these days he or she is affected" and both need counseling.

There were some respondents who wanted payment especially when the researcher gave out the questionnaires to be filled. However, the researcher overcame this by telling them that the study was being carried out without sponsorship or grant from any quarter and the information they give will go a long way to improve counseling services if not immediately but in future. Otherwise the study was successful despite the problems mentioned.

3.8 Ethical issues and considerations

The researcher handled the respondents as per the requirements of medical ethics and culture. All HIV/AIDS patients included in the study consented and confidentiality was maintained, for example, names were not filled in the questionnaire. The researcher applied participant and direct observations in data collection in order to be part and parcel of the respondents in their feelings and to map out the way forward. The researcher gave sincere contributions during group therapy and identified with

the patients in and outside the clinic and developed genuine friendship which really helped a lot in seeking information freely.

CHAPTER FOUR

GUIDANCE AND COUNSELING ON HIV/AIDS PATIENTS

4.0 Introduction

This chapter focuses on findings about influence and effectiveness on proven cases of HIV/AIDS patient's counselors and counseling set up. This was based on questions asked about HIV/AIDS patients attitude towards sex, how HIV/AIDS spreads and what they feel about their status and whether the counseling they have received after testing HIV positive has been of any help. The counselors' knowledge on the subject of HIV/AIDS was probed and indirect observations carried out on how they handle patients who came to the clinic and how they displayed counseling techniques.

4.1 Background information on respondents

There were twenty-five respondents who participated during the research. This was broken down as follows; Six key informants who were female and counselors. Apart from key informants there were nineteen others composed of eleven males and eight females. Their mean age was thirty-three years. A half of them (52 percent) have had primary education. 52.6 percent of the respondents reported belonging to low level of income while 46.3 percent belonged to just above average level income. Most of the respondents were Christians (89 percent). A small number (11 percent) are Muslims and no Atheist. There was no Muslim woman. About half of the respondents (58 percent) are married and living with a sexual partner(s), 10.5 percent of respondents are separated. While widowed and those leading single lives were 10.5 percent and 16 percent, respectively. Female and male respondents reported having about 2 children 2.3 percent, 2.7 percent alive, respectively. Female respondents reported one child dead while male respondents reported only two.

4.2 Knowledge, Attitude and Practice on sex and HIV/AIDS

All the respondents have heard and know what HIV/AIDS is. On attitude towards sex 55 percent of male respondents reported positive attitude while 20 percent of female counterparts reported the same. The rest were either neutral or did not respond at all. Those who had positive attitude towards sex said among other things that:

> sex was normal
> not bad
> good in marriage or
> advocated fear or use of condoms

Apparently no male respondent had negative attitude towards sex. There was uniform response on abstinence observed which was more influenced by the disease-taking toll on males than females as expressed by one male who said:

> This disease has taken toll on me. I can no longer rise to the occasion however much I try. The other day a female friend tried all means to make me 'rise' but I failed. Besides I do not have the strength. All my energy is gone despite good eating. Therefore, one just has to abstain.

On the other hand, the females responded positively to abstinence. One said;

> In my life I have only gone out with one man and he is the one who married me. When he died I felt lost and devastated. After sometime I was inherited according to the Luo customary laws by my brother in law. He too died. I was again inherited by another brother in law who had two wives. After

three years one of the wives died. I also became sick. When my sister told me to visit her in Nairobi for treatment, I came quickly. After treatment I was counseled and tested given the nature of my sickness. The result was that I was HIV positive. I was shocked beyond words. Then one day, word came from home that my brother in law who inherited me and being the one I left with the children at home wanted me back at home and said I was lying that I had HIV/AIDS. He said I should go back home. I am not ready for sex but I know he would demand it as soon as I set my foot at home. What do I do with my 'shemeji'? (In the group therapy this lady was nicknamed Shemeji).

Females mentioned blood transfusion and sex as some of the ways of spreading HIV/AIDS but never mentioned mother to child transmission. On the other hand, males mentioned sex, mother to child, blood transfusion, accidents, unsafe sex, open wound contact, many ways as means of spreading HIV/AIDS. A majority of the informants responded that HIV/AIDS is spread through sex and unsafe, unprotected sex and blood transfusion. There is also psychological rejection towards HIV/AIDS since only two respondents mentioned HIV/AIDS as a killer disease. Ten percent (10%) of males advocated for abstinence as compared to twenty – five percent (25%) of females.

4.2.1 Knowledge on HIV transmission

High knowledge levels of HIV transmission were noted. For example 100 percent (19) of all respondents know at least one or more ways in which HIV can be transmitted and how they got infected. They stated that it could be transmitted by unprotected sex, blood transfusion, open wound contacts, exchange of body fluids and mother to child.

However no female respondent mentioned mother to child as a way of transmission. There is a high correlation between education level and knowledge of transmission.

4.2.2 Knowledge of HIV prevention

All the respondents' 100 percent (19) have good knowledge of how transmission can be prevented. 36.4 percent and 9.1 percent of males advocated for abstinence and faithfulness respectively as compared to 62.5 percent and 37.5 percent of the females. Males therefore, require more counseling in this area. This showed that knowledge alone is not adequate in HIV/AIDS prevention. Counseling is needed to change the attitude. One male said:

> It is very difficult for a man to stick to one woman
> since God created us (men) to have more women.
> We are polygamous by nature. It is simply not
> possible and that is even the reason why there
> are more women than men in the world.

A majority of the male respondents advocated for the use of condoms as a means of HIV prevention while no female respondent associated condom use with HIV prevention besides they said that they do not feel like having sex in their lives.

Table1: Prevention of HIV/AIDS spread

Prevention methods cited

Gender	Abstain from sex		One faithful partner		Use condoms		Total
	Frequency	%	Frequency	%	Frequency	%	Frequency
Female	5	62.5	3	37.5	0	0	8
Male	4	36.4	1	9.1	6	64.4	11
Total	9	47.3	4	21.1	6	31.6	19

4.2.3 Cultural and popular beliefs associated with HIV/AIDS

As observed informally, nearly all the respondents (100 percent) said there are no cultural beliefs associated with their being HIV positive meaning they adhered to the biomedical model of causation. This is good for AIDS prevention and a sign that counseling they have received is effective.

4.2.4 HIV/AIDS patients' perception about their status

Majority of the male respondents (9) do not fear AIDS anymore and accept their status with such comments:

> Normal, to be coped with, nothing to worry, there
> should be medicine, infection like any other,
> problem of life and so many others.

Female respondents, as observed and through responses, had negative perception of their status and said:

> Not good, negative attitude, killer disease,
> fears, terrible disease, dislike, hate, its real.

There is psychological rejection towards HIV/AIDS since none of the respondents mentioned it by name. The closest to it was; " it is a killer disease", as expressed by one female respondent

4.3 Counseling Achievement

4.3.1 Patients perception about counseling

Almost all the respondents liked coming for group therapy organized every week by counselors. They expressed more positive comments than negative.

The following comments illustrate this:

Positive comments

1. It has made me accept my status.
2. It has made me to be good.
3. Nowadays I practice abstinence.
4. It has made me live a healthy life since I now know what to eat.
5. I feel relieved.
6. I am not alone.

Negative comments

1. I feel confused.
2. It is too much.
3. It pains.

Looking at the above comments, respondents perception on their HIV/AIDS status was positive and they are willing to carry on with their life except a few respondents who are still harboring negative feelings about their status even after counseling. It is, therefore, clear from the above comments that counseling was effective and with time even those negative shall have changed their perceptions about counseling, although emotionally still traumatized.

4.3.2 Benefits of Guidance and Counseling to HIV/AIDS patients

Men and women interviewed expressed satisfaction about the counseling received. They are ready to take control of their destiny by prolonging their life through the use of condoms, practice abstinence and eating well. As observed during the group therapy, each respondent shares with each other new leads on nutrition and herbs which help sort out opportunistic infections and can be controlled by eating certain foodstuffs or using certain herbs known to a few. On condom use and abstinence one male respondent said during the interview that:

> I am no longer going to practice unsafe sex with
> my wife since I tested positive and my wife
> testing negative. If anything I will abstain
> altogether to let her live to take care of our children.

Men and women were open to counseling and accepted that they have self trust and capable of living positively. Both male and female still requested for more

counseling in order to get more advice and answers to their problems and challenges related to HIV/AIDS. One female respondent said:

> I wish we could meet quite often so that we share
> our experiences and get to know inventions coming
> up like medicine so that we can use them to help
> us prolong life. Besides I feel I am not alone.
> There are others with similar problem.

About 90 percent males and 75 percent females interviewed after counseling expressed hope for better life and confessed having benefited from counseling.

4.3.3 Achievements of goals of guidance and counseling

So far responses received gave credit to the work done by counselors and what they have achieved during the period of the study. All respondents were in agreement that counseling has helped them to manage their HIV status. This could not have been positive if the counseling given was not effective. The respondents also liked the conducive atmosphere accorded to them during counseling given the sensitive nature of the disease.

Below are tables illustrating feelings HIV/AIDS patients have about the counselor and how they feel psychologically after they have undergone several sessions of counseling.

Table 2: Feelings about the counselor by clients

Response	Male No.	Female No.
The counselor knew best	10 (90.9%)	6 (75%)
You know best	1 (9.1%)	1 (12.5%)
No reply	0 (0%)	1 (12.5%)
Total	11 (100%)	8 (100%)

Table 3: How HIV/AIDS patients feel psychologically.

Response	Male No.	Female No.	Total
Better	11 (100%)	7 (87.5%)	18 (94.7%)
Worse	0 (0%)	0 (0%)	0 (0%)
No change	0 (0%)	0 (0%)	0 (0%)
Never imagined	0 (0%)	1 (12.5%)	1 (5.3%)
Total	11 (100%)	8 (100%)	19 (100%)

Looking at the above tables, both groups of male and female patients reported that counselor's demonstrated knowledge about counseling. This achievement was supported by the privacy that the counselors demonstrated during counseling

sessions. In addition the patients said that they trusted counselors because there was evidence of confidentiality. For example, one male patient said:

> I trust them because I have not heard the
> things we discuss here mentioned by members
> of my family, not even my partner.

On the other hand, a woman patient said:

> I like this counseling because I sit inside
> the room with the counselor only as we
> discuss. That makes me feel free to talk
> about my health. That is the right climate.

The above responses can be corroborated with the table below on the right climate during counseling.

Table 4: Right climate given during counseling

Response	**Male No.**	**Female No.**	**Total**
Yes	11 (100%)	7 (87.5%)	18 (94.7%)
No	0 (0%)	0 (0%)	0 (0%)
Total	11 (100%)	7 (87.5%)	18 (94.7%)

Note that one respondent never gave the response on the right climate given during counseling.

A majority of the patients have confidence in counselor knowledge. Both males and females felt that counseling has helped them a great deal. For example, one female said:

> Before I knew my status, I could date and infect
> men since prostitution was normal to me.
> However, since I joined FGD after being sick
> and testing positive, I have resolved never
> to go on infecting and getting reinfected
> because I want to live longer.

A male patient in FGD said:

> After attending several counseling sessions,
> I was able to inform my family members
> about my status and I have now planned
> my income and investments to take care of
> them in case I succumb to death.

Even though most goals of counseling were achieved, counseling has not managed to control emotions of some patients; since they are traumatized as expressed in responses such as:

> "I feel confused"
> "I feel idle"
> "The realization is too much"

The respondents also applauded the right climate accorded to them during counseling. According to the majority, the right climate was given during counseling since only one respondent declined to respond. Even though the right climate was given during counseling, other aspects of counseling were not taken into account such as not

providing all the answers to the respondents in relation to their health. For example, counselors referred all patients to other laboratories for CD4 count and to collect food ratio from other points of distribution. Given the nature of HIV/AIDS these should be available in one place so that patients reduce the risk of being exposed to many people knowing about their status. The HIV/AIDS patients are stigmatized thus require privacy and confidentiality. This therefore requires that counselors be equipped with all that patients require under one roof. Eighty one percent males and forty six percent females still express the need for more advice and answers meaning counseling is not yet adequate in some areas despite the right climate.

4.4 Challenges counselors encounter in their work

Most counselors were happy with their work and showed a willingness to continue despite challenges they encounter in the course of their duties one said;

> At the beginning of counseling, not very many
> people used to come for voluntary counseling
> and testing but nowadays the number of
> clients is on the increase which sometimes forces
> me to hurry with the counseling process.

This was witnessed during one of the sessions when a patient sought to know why she was feeling the way she was and the counselor, because of limited knowledge on medicine, was unable to help and instead referred her to Kenyatta National Hospital for specialized treatment. This happened more than once.

Another challenge they encounter is that the counselors found it difficult to release results to discordant couples since they often fight, trade insults and accusations at each other before the counselors.

As observed there was one female respondent who took her husband to the area chief for having been spending nights with another woman and was not ready to welcome him home again. After lengthy talks, the chief advised the couple to visit the clinic for HIV/AIDS test. The result was that the lady was positive while the accused was not. It was a scene and the man said he no longer wants to see her again in his house.

Counselors also feel challenged when they see their patients who are their neighbors still go on dating despite their health status. On one occasion, a counselor said during one of the meetings they hold to review their work:

> Tell me what should I do to this client of mine
> who every other day entertains women in
> his house which is just a door away from mine?
> He has become a spender and women are least
> suspecting him. It pains me because I cannot
> divulge this information lest I break the promise of confidentiality.

Another counselor said:

> Today I was forced to go against counseling ethics
> when I lied to my client that I am also HIV
> positive since she threatened to commit suicide
> when I released the results to calm her down.
> I know I empathize a lot but tell me what do
> I do to correct the situation because soon she
> may realize that I was cheating her or how
> do I put the records straight.

During the study especially in group therapy, there are a few things I observed which need to be considered as some of the factors affecting effectiveness and influence of counseling of HIV/AIDS patients.

There is a language barrier in communication due to the level of education of the respondent during counseling sessions thus hindering effective communication and yet counseling depends very much on language for it to be effective. Language also denies both the counselor and the counselee to express certain problems or feelings in the best way possible. This is because the study region is a cosmopolitan area and, therefore, only Kiswahili and English can be used and not the mother tongue. One patient caused laughter when he said:

> Usiku nikilala sipati usingizi mwili yangu,
> inaniuma sana ... (I do not sleep well at night
> because my body aches all over).

The above comments caused laughter because of the manner of expression when pronouncing the words with difficulties and trying to translate the meaning in her own dialect directly into Kiswahili.

Counselors get disturbed a lot with tests performed on patients if they turn out to be HIV positive. They are usually at a loss dealing with life. At times they feel like quitting their jobs and I quote some of their remarks:

> Today you counsel and the patient feels okay,
> the following day, the patient is mad with you
> may be due to illness or pressure of life.

One has to keep on counseling, it is a continuous process. When it comes to spouses, counseling becomes difficult since they normally attend counseling sessions separately, if not, only one attends group therapy thus making it difficult to make counseling effective because certain things discussed requires both to hear and how they may be carried out. On the other hand it is again difficult to counsel couples in matters of health together because of individual rights, that is, to keep secret on health matters of an individual according to World Health Organization convention.

Discordant couples prove a bit difficult to handle by the counselors since it shifts focus on sickness to family issues, which young counselors cannot solve effectively.

Counselors told me the following about what they do not like in their jobs and I quote:

> The number of patients with HIV/AIDS is increasing everyday and thus forcing them to talk a lot during counseling.

> Releasing results to patients is not one of the best because it pains more especially when the cost of drugs is expensive and maintaining balanced diet is difficult for many to afford.

> Counseling becomes difficult when one comes to the clinic in the last phase of HIV/AIDS. At this stage, very little can be done to sustain one.

> Long working hours aimed at seeing all patients who come in a day is strenuous and at times it is not possible to see all clients who visit the clinic or if seen, not given quality time.

Counseling in the line of HIV/AIDS is a new thing in the society. Therefore, it should be given adequate time before, after testing and during group therapy. There were no male counselors at all yet clients were both male and female. The average age of counselors was 20 years while that of counselees was 33 years.

Finally, I also noted during the study that counseling sessions have been used a great deal in providing free medication to fight opportunistic infections and, to some extent, a number of counselees have been put on ARVS. This should continue.

CHAPTER FIVE

Conclusions and Recommendations

5.0 Introduction

This chapter discusses and provides conclusions from the study findings obtained during the research. It also provides recommendations on issues affecting counseling which require further exploitation in order to make counseling effective on HIV/AIDS patients.

5.1 Conclusion.

From the foregoing, it is evident that counseling is effective and has influenced HIV/AIDS patients in a number of ways. Results suggested that counseling had a positive influence on the patients as both men and women reported more positive perceptions than negative ones. HIV/AIDS is a preventable disease and, therefore, the use of condoms and spermida, the promotion of social and economical alternatives for female prostitutes and changing their behavior to observe safe sexual practice was advocated by counselors. It also needs total community concerted efforts even though counseling is having a major role in this respect to combat HIV/AIDS or to reduce its effects and complications.

Another important finding was that the patients reported that counselors demonstrated knowledge of their work and respected patients' privacy and confidentiality. However, patients said that counselors were over-burdened with work, which resulted into long waiting hours at the clinic and interruptions during FGDs from calls from outside the counseling room. Another finding was that there was a conducive

atmosphere provided for counseling thus contributing to effectiveness of counseling and achieving research objectives.

There were more male than female respondents in the study. This could have been also due to males having time as opposed to their female counterparts who are bogged down with female triple roles of reproduction, production and rearing as expressed by women who attended counseling sessions. More females should be encouraged to spare time however short and come for counseling.

As observed, males were more motivated than females during interviews and in completion of questionnaires. They talked freely and without reservation.

Muslim married males attended counseling session as opposed to their female counterparts: Role played by religion to bar women from health seeking should be explored as indicated in the background information of the respondents.

The study also revealed that employment and education had little influence on health seeking behavior. Employers therefore should assist in creating awareness on the need for counseling whether infected or not as observed informally.

Analysis reflected low socio-economic status of the study area. Females seek sex for economic gains while males seek sex as a social satisfaction thus promoting spread of HIV/AIDS despite counseling as informally observed during the study.

Females responded positively to abstinence because the bitterness and emotions about their HIV/AIDS status and did not accept condom use while males strongly advocated for use of condoms. However, females should be sensitized on condom use as a preventive measure to help reduce HIV infection and re-infection.

No male respondent had a negative attitude towards sex thus showing male aggression towards sex and taking more responsibility in sex matters unlike their female counterparts.

Females never mentioned mother to child transmission of HIV/AIDS while males did. This may be due to lack of knowledge or it is too painful to talk about it being mothers.

Counseling has not succeeded to change attitude on males since they were unwilling to be faithful and stick to one partner in marriage or outside marriage. However, with time, this attitude can be changed.

Counseling has helped in eliminating fear of psychological rejection because nearly all respondents after attending counseling session accepted to have self trust and are capable of living positively.

Counselors were young women. There were no men. Unmarried young patients felt out of place and never joined married males and females during counseling sessions. There was need for separate adolescent counseling and peer counseling in this respect.

5.2 Recommendations

Based on the findings of this study, the following recommendations have been formulated for programme improvement and future research. Counselors reported an increase of patients coming to the clinic to seek counseling after testing HIV positive and cannot therefore work effectively and give proper guidance because they are overwhelmed with work. I, therefore, recommend that measures be formulated for training more counselors to ease congestion at the clinic. For example, all trained nurses should undergo in-service courses related to counseling in HIV/AIDS. Those nurses in training should not graduate without counseling skills in this area.

Community leaders such as teachers, women groups, Church leaders and grassroots administrators such as assistance chief and village head persons should undertake short courses in counseling in HIV/AIDS related issues.

Even though the counseling of adult respondents was done separately, youths never participated in group therapy, thus, requiring a restructuring of the counseling process. This can further be done according to age groups and gender so as to focus specific attention on young men and women who may not feel free to discuss reproductive health issues in mixed grouping. This, therefore, strongly advocates for peer counseling where a young counselor does not counsel an old client and vice versa.

Counseling centres should be equipped with all facilities an AIDS patient may require such as well equipped laboratories to avoid movement from one clinic to another in search of lacking services. Finally, trained counselors should go for more refresher courses on knowledge of medicine so that when a client presents a problem, they should be able to give a solution even if temporary to help patients build more confidence in their work. Men should be encouraged to take courses in counseling since all my key informants were females and yet I had more male patients than females.

Finally, since the study is not exhaustive, there is a need to conduct research in other areas such as rural and small towns since it has only covered a small section of an area, Pumwani Division, Nairobi. The research should further focus on effect of community counseling in HIV/AIDS, women participation in use of condoms and knowledge on mother to child transmission, religion and culture on how negative it impacts on women to give and receive counseling services.

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APPENDICES

Appendix 1 - Focus Group Interview (Moderator's) Guide.

Introduction

Thank you for coming. I am _____ acting for Caroline M. Gorety Akinyi from University of Nairobi. With me is _____ from _____. The purpose of this discussion today is to learn what you think about effectiveness and influence of Guidance and Counseling on HIV/AIDS patients. The information you provide will help in planning for ways of improving guidance and counseling services.

I would encourage you to speak as freely and frankly as possible. The response you give in this discussion will be confidential. We would also like to record your answers in writing and using tape recording to help in the analysis of your answers. Do you mind this?

Please bear in mind that there is no harm in you participating nor is there a direct benefit in participating except that the information will be useful in policy-making. The discussion will take about one hour. Do you all agree to participate in this discussion.

Note you may leave at nay time during this discussion.

SAMPLE QUESTIONS DURING FGD

1. What are the common health problems?
2. How are you coping with your status?
3. How do you manage to come for Group Therapy?
4. Is Group Therapy of help to you?
5. What are some of the things you would want improved
   i. On fellow patients
   ii. Counselors
   iii. Government to help in HIV/AIDS counseling?

Appendix II Questionnaire guide for the respondents

Demography

Age_____

Sex _____

Religion _____

Educational level – None Primary Secondary College

Marital Status_____

Employment_____

Number of children Alive _____

Number of children Dead _____

Socio-economic status _____ low _____ middle _____ high

KAP on sex and HIV/AIDS

1. What is your attitude towards sex? _____
2. What has influenced your answer to 1? _____
3. How is HIV/AIDS spread? _____
4. What do you feel about HIV/AIDS? _____

5. How are you preventing HIV/AIDS spread? _____

6. What do you think people should do about HIV/AIDS _____

7. How best do you know about sex and its relationship to HIV/AIDS?

_____

_____

Counseling Achievement

8. How did counseling help you?

a) Your feelings? _____

b) Your emotions? _____

9. Did you feel that (tick one)

a) The counselor knew best? _____

b) You knew best? _____

10. How do you feel psychologically (tick one)

(a) Better (b) Worse (c) No change

If worse why? _____

11. Do you feel you were given the right climate during counseling?

Yes _____ No _____

12. If No to Question 11 why? _____

13. How do you feel now about the problem you have?

(a) Better _____ (b) _____

(c) No change if worse_____

14. Were you given a chance to form you own opinion/thought?

Yes _____ No _____

15. Do you now feel you are in control of your own destiny?

Yes _____ No _____

16. Do you feel independent or self-directing?

Yes _____ No _____

17. How do you perceive yourself? _____

18. How has NO. 17 answer influenced your behaviour?

_____

19. Do you feel you can maintain and enhance yourself?

Yes _____ No _____

20. Do you think you have been given the right conditions to maintain and enhance yourself? Yes _____ No _____

If No why? _____

Goals of Counseling

21. Are you now more open about your problems?

Yes _____ No _____

If No Why? _____

22. Have you accepted your problem without rationalization?

Yes_____No_____If No Why? _____

23. Are you still tense and rigid about your problem?

Yes _____ No _____

If No Why? _____

24. Do you trust yourself and your capabilities?

Yes _____ No _____

If No Why? _____

25. Do you still need more advice and answer?

Yes _____ No _____

If Yes which? _____

26. Do you now believe more in yourself?

Yes _____ No _____

If No Why? _____

27. Have you decided how you will change your behaviour?

Yes _____ No _____

If No Why? _____

28. Who made decision for your change of behaviour?

Self _____ others (specify)

29. Do you feel you have hope to better life?

Yes _____ No _____

If No why? _____

30. Are you expecting to have new experience in life?

Yes _____ No _____

If No Why? _____

If Yes which? _____

Counseling process

31. Was the counseling climate good?

Yes _____ No _____

If No Why? _____

32. Was the counselor's belief and attitude good?

Yes _____ No _____

If No, how? _____

33. Do you feel the counselor understood you?

Yes _____ No _____

If No, in what way? _____

34. Do you feel the counselor has good opinion about you?

Yes _____ No _____

If No, how? _____

35. What rapport (Close psychologist content) established between you and the counselor?

Yes _____ No _____

If No, how? _____

Appendix III

Key Informants Guide

- What are the common health problems in the Community?
- What are the common reproductive health problems?
- What is the magnitude of HIV/AIDS in you community?
- Among whom are HIV/AIDS most prevalent? (Probe on age, income, education status, occupation, gender)
- Why is HIV/AIDS common among this group? (Identify the common characteristics)
- How much guidance and counseling services is in your community?
- How effective are these services to the best of your knowledge?
- Why (in response to the above question).

Guidance and Counseling

- What are the different reasons why HIV/AIDS patients go for counseling? (Probe for reasons related to common characteristics in the group).
- Where do the patients go for HIV/AIDS guidance and counseling services? (Probe on cost, place, quality and accessibility).
- Who conducts these services? (Probe on qualifications for the service deliverers).
- How is guidance and counseling services conducted? (Probe on both traditional and modern methods).
- Who do HIV/AIDS patients talk to or get advice on what to do when they have HIV/AIDS?
- What is it that people do in preventing HIV/AIDS (Seek for practical activity being practiced).
- How do people perceive patients with HIV/AIDS? (Probe the reason for this perception).

- What is the current Kenyan Policy on HIV/AIDS?
- What is your opinion on this policy?

Recommendations

- What should people do to reduce the problem on HIV/AIDS?
- How can we get people to participate more in reproductive health matters?