A Case Study of the Development of a Counselling Skills Training Program for Kenyan Nurses in the Prevention of Sexually Transmitted Diseases

BY

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A CASE STUDY OF THE DEVELOPMENT OF A COUNSELLING SKILLS TRAINING PROGRAM FOR KENYAN NURSES IN THE PREVENTION OF SEXUALLY TRANSMITTED DISEASES

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ABSTRACT

Control of Sexually Transmitted Diseases, including AIDS, relies on primary prevention strategies which encourage individuals to practice disease preventive sexual behaviours. In Kenya counselling is regarded as a potentially effective intervention to assist people to practice safer sex behaviours. To assess the merits of counselling as an intervention to encourage safer sex practices among clients diagnosed with an STD, nine community health nurses in Nairobi were trained in a simple approach to counselling. Ninety STD clients received counselling and responded to a pre-counselling and post-counselling questionnaire of knowledge, attitudes and intentions to change sexual practices. Results of the study indicate a short training programme in counselling can influence nurses' counselling practices. A brief counselling intervention does not by itself lead to clients changing sexual practices but may be effective to teach clients how to use a condom and reinforce safer sex messages. More research is needed to evaluate counselling as a primary prevention strategy to control STDs and AIDS.

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LIST OF TABLES

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical Research and Education Foundation
BAC	British Association for Counselling
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
HPV	Human Papilomavirus
KAP	Knowledge, attitudes and practices
NACP	National AIDS Control Programme
NGO's	Non-Governmental Organizations
NCC	Nairobi City Commission
NSC	National STD Committee
PID	Pelvic Inflammatory Disease
STC	Special Treatment Clinic
STD	Sexually Transmitted Disease
STDs	Sexually Transmitted Diseases
TOT	Training of Trainers
WHO	World Health Organization

CHAPTER I

EPIDEMIOLOGY OF SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) are infections primarily of the genitalia and reproductive tract in both males and females, which are spread between individuals through intimate contact, usually sexual intercourse. Gonorrhoea, syphilis, *Chlamydia trachomatous*, chancroid, human papilloma virus (HPV), herpes, and more recently human immunodeficiency virus (HIV, the causative agent of AIDS), are the most common STD infections (Aral and Holmes, 1990).

Although STDs represent a major health threat throughout the world, the prevalence of STDs in East-Central Africa is among the highest in the world (Lamptey and Piot 1990; Meheus, Schultz, and Cates 1990). One in ten persons attending a public health centre in Nairobi is seeking treatment for an STD (Kenya Ministry of Health 1990). In Kenya, data on STD incidence and

prevalence are incomplete. Data that are available pertain to selected urban populations, namely antenatal clinic attenders and groups considered "core transmitters" (Yorke, Hethcote and Nold 1987). "Core transmitters" are defined as persons who are sexually active and have a high frequency of partner change and who therefore help to maintain an infectious disease in a population. Prostitutes and long distance truck drivers have been identified in East Africa as core transmitter groups for STDs (Yorke, Hethcote and Nold 1987).

Prevalence rates obtained from populations of pregnant women attending antenatal clinics are considered the best available, although imperfect, measure of STD prevalence in the sexually active population at large. However, given that infertile women are excluded from these samples, prevalence rates may be lower than the rate in the population as a whole. Women attending antenatal clinics in Nairobi in 1992 were found to have a prevalence of gonococcal infection of 4%, and positive syphilis serology of 12% (Plummer 1992). Seroprevalence rates for HIV infection among antenatal clinic attenders have increased dramatically in recent years. In 1988, 4% of the antenatal sample were HIV positive, whereas in 1992, 12% of women attending antenatal clinics were HIV positive (Plummer 1993).

Rates of infection in core transmitter populations in Kenya are extremely high. Studies of a group of low income female prostitutes in Nairobi in 1986 found gonococcal infection among 45% of the women sampled, active syphilis

in 55%, genital ulcers in 42% and HIV infection in 66% (Kreiss and others 1986). A study using a sample of female prostitutes from the same area in 1992 found 90% to be HIV-positive (Plummer 1993).

Studies of STD prevalence in long distance truck drivers have been carried out along major trucking routes in East Africa. In 1988, of 331 truckers sampled along the Mombasa - Kisumu highway in Kenya, 4.6% were positive for syphilis, and 18% were HIV positive (Bwayo and others 1991). Tests carried out on a similar population in 1992 found that 30% of the truckers sampled were HIV positive (syphilis data not available) (Bwayo 1992).

Distinctive Features of STD Epidemiology

Risk factors for STDs are affected by a combination of personal behaviours, consequences of previous behaviours and environmental circumstances. Risk factors include: exposure to multiple sexual partners, sexual intercourse without condoms, previous infection with a STD, and sexual contact with populations considered "core transmitters" (Over and Piot 1990).

In the developing world, risk factors for HIV infection parallel factors associated with other STDs. Risk factors for HIV include: multiple sex partners, being single, history of STDs, sex with prostitutes or being a prostitute, urban residence, and lack of circumcision in males (Quinn 1990). In Africa, it is estimated that over 80% of HIV infected persons contracted the

infection through heterosexual exposure (Over and Piot 1990). Whereas sexual transmission is the primary mode of HIV infection, parenteral exposure to blood and blood products, and vertical transmission from mother to newborn are also transmission modalities. Parenteral transmission through a blood transfusion is the most efficient mode of acquiring HIV infection. Receipt of HIV infected blood by transfusion will result in acquiring HIV infection in 100% of cases (Lamptey and Piot 1990). In Africa it is estimated that up to 10% of infected adults may have acquired HIV infection through blood transfusion (Lamptey and Piot 1990). Perinatal transmission of HIV infection is estimated to infect 25-40% of infants born to HIV positive mothers (Lamptey and Piot 1990).

In the course of the AIDS epidemic, parallels between AIDS and other STDs have become more striking. STD and HIV infection are transmitted by the same routes, affect the same population groups, and the resources deployed in prevention of AIDS are the same needed to prevent STDs. STDs that cause genital ulcerations, such as chancroid and syphilis, have been found to increase the host's susceptibility to HIV infection (Plummer 1988; Greenblatt 1988). Progression of AIDS and other STDs also appears to be interactive. STD infections can accelerate the progression to AIDS in HIV-infected individuals by further compromising the immune system (Wasserheit 1992).

The highest rates of STDs and AIDS are found among people between the ages of 15 and 35 years (Lamptey and Piot 1990). This has serious economic and development implications for Third World countries. STDs,

including AIDS, affect the most educated, economically productive, and traditionally the healthiest age group in developing countries. Not only does this age group comprise the primary wage earners, but it carries the economic responsibility for supporting the very young and the very old. According to a report published by the Panos Institute,

> AIDS may cause mortality rates among the economically and socially most productive age groups to double, triple or rise even higher, meaning that each surviving adult would have to support a larger number of children and elderly dependents, and making economic growth less likely (The Panos Institute 1990, 81).

STD Morbidity and Sequelae

STDs can be divided into two broad categories, STDs caused by bacterial infections and STDs caused by viral infections. Generally, bacterial STDs are curable with proper treatment while STDs caused by viruses are not curable. The most common bacterial STDs are gonorrhoea, syphilis, *Chlamydia trachomatous*, and chancroid. The common viral STDs are genital herpes, hepatitis B, genital human papilomavirus, and HIV. STDs can be further classified by whether they cause ulcerations of the genital tract. Genital ulcer infections are caused by both bacterial and viral STDs. The most common genital ulcer infections are caused by syphilis, chancroid, and genital herpes. Gonorrhoea and *Chlamydia trachomatous* infections are the most common inflammatory STDs (Wasserheit 1989).

In men, genital ulcers are painful and even with proper treatment can take up to three months to heal. Morbidity associated with gonococcal and chlamydial infections in men include urethritis and acute urinary retention. Acute and chronic epididymitis occurs in 1-10% of cases of urethritis and is associated with male infertility (Over and Piot 1990). Treatment of these complications is difficult, expensive, and time consuming.

In women, complications of cervical infection can lead to pelvic inflammatory disease (PID) and infertility in the absence of prompt and effective treatment. Gonorrhoea and *Chlamydia trachomatous* are major causes of morbidity and reproductive complications in women in both developed and developing countries (Wasserheit 1989). A world wide survey carried out by the World Health Organization (WHO) on the etiology of infertility found 50% of cases of infertility in Africa was caused by tubal occlusion secondary to infection (Piot and Tezzo 1990). This compares to 11 - 20% of cases in other parts of the world (Piot and Tezzo 1990). Ectopic pregnancies are also caused by complications of STDs (Bergstrom 1990; Piot and Tezzo 1990).

Infants born to mothers infected with STDs are at risk for neonatal conjunctivitis, respiratory infections, or death. If untreated, neonatal conjunctivitis, also known as *Ophthalmia neonatorum*, can lead to blindness. In a prospective study done in Nairobi, infants born to mothers infected with gonorrhoea had a 42% chance of developing gonococcal ophthalmia while infants born to mothers infected with *Chlamydia trachomatous* had a 37%

chance of acquiring chlamydia ophthalmia (Ronald and others 1991). Maternal - child transmission of chlamydia infection also has been associated with respiratory complications in the first six months of the infant's life (Datta, Laga and Plummer 1988).

Infection with HIV, the causative agent in AIDS, leads to destruction of the individual's immune system. With a compromised immune system, the individual is susceptible to infections which slowly lead to a decline in general health. As the immune system deteriorates, the individual develops more serious, life-threatening infections such as tuberculosis, and eventually dies as a result of these 'opportunistic infections'. The terminal nature of HIV infection has contributed to a rapidly expanding research industry seeking for a cure or at least a vaccine to prevent HIV infection. In the absence of cure or vaccine, however, the chief means of control of HIV infection remains prevention.

CHAPTER II

PREVENTION OF SEXUALLY TRANSMITTED DISEASES

The fact that sexually transmitted diseases are communicable diseases means that preventing or curing one case leads to the prevention of other potential cases. For an STD to be sustained in a population, it must infect a host who, on average, transmits infection to at least one other person (Ronald and others 1991). Efforts to control the spread of STDs have traditionally focused on prompt diagnosis and effective treatment to interrupt disease transmission. In the control of STDs, these aims are accomplished through: (1) early detection of infection, (2) prompt and effective treatment of both symptomatic and asymptomatic infections, (3) reducing exposure to infection by educating individuals with STDs to reduce the number of sexual partners and avoid sexual intercourse until cured, and (4) promoting the use of condoms (Meheus, Schultz, and Cates 1990).

Primary and Secondary Prevention of STDs

Primary prevention refers to actions that limit exposure to a harmful agent so that healthy persons at risk modify their behaviour or environment to reduce the likelihood of exposure. In STD control, primary prevention relies on health education strategies that encourage persons at risk for STDs to change their risky sexual practices. In East Africa, primary prevention messages encourage: (1) monogamous sexual relations, (2) use of condoms and spermicides in non-monogamous relationships, (3) reduction in the number of sexual partners, and (4) avoidance of sex with "core transmitters" such as prostitutes and long distance truck drivers.

Secondary prevention refers to actions that lead to the early detection of disease, appropriate treatment, and follow up of sexual contacts. In STD control, secondary prevention has been the mainstay of control strategies (Stone, Grimes, and Magder 1986). Secondary prevention strategies promote recognition of symptoms of disease and treatment seeking behaviours.

With the curable bacterial STDs, for which diagnostic and treatment measures are available, health education messages promoting treatment seeking behaviours are strongly advocated. However, with the emergence of incurable viral STDs, the emphasis in STD campaigns has shifted to primary prevention strategies.

This shift is important in developing countries where diagnostic and

treatment services are not sufficient to meet the demand for these services. Certain bacterial infections in women, for example, chlamydia, are difficult to diagnose and treat. In these situations, the bacterial STDs are comparable to the incurable viral STDs and efforts to control their transmission must rely more heavily on primary prevention through health education and behaviour change than on secondary prevention efforts such as early diagnosis and treatment (Piot and Tezzo 1990).

Safer Sex

The term 'safer sex' refers to sexual practices that reduce the possibility of transmitting an STD. The term 'safer' as opposed to 'safe' refers to the reduction of risk of STD/HIV transmission in contrast to the elimination of risk. Sexual practices considered safer sex are: (1) mutually faithful sexual partners, (2) limited number of sexual partners, (3) use of condoms in non-monogamous relationships, and (4) non-penetrative sexual practices (Stone, Grimes, and Magder 1986).

In a mutually faithful monogamous sexual relationship the couple has a virtually zero probability of transmitting a sexually transmitted disease. Risk only occurs if one of the partners has an asymptomatic infection from a previous exposure. For example, people infected with HIV can be asymptomatic for several years.

Limiting sexual partners reduces the probability of exposure to an infected person. One study of persons repeatedly infected with gonorrhoea showed a lower reinfection rate for those who reduced the number of sexual partners over the nine-month study period when compared with matched controls who did not reduce the number of sexual partners (Stone, Grimes and Magder 1986). As long as the prevalence of infection is low in the population, limiting sexual partners can slow the rate of disease spread. However, in populations where the prevalence is high, limiting sex partners has minimal impact on overall infection rates. The efficacy of limiting sexual partners has not been thoroughly studied but considered theoretically effective to reduce exposure to STD infections in low prevalence populations (Stone, Grimes, and Magder 1986b)

Condom promotion has been the cornerstone of most STD prevention programmes. The efficacy of the male latex condom as a barrier to gonorrhoea, syphilis, mycoplasmas, chlamydia, trichomoniasis, genital herpes and HIV has been demonstrated in numerous studies (Population Information Programme 1989). Effectiveness of the condom as a barrier to infection is dependent on the users. Condom use places a considerable burden on the users. It requires the male partner's consent and often his initiative. To be an effective barrier to disease, a condom must be used with each sexual encounter. Incorrect use of the condom and/or breakage hinders its effectiveness. Recently, condoms for women have been developed. The female condom allows women to have

greater control over personal protection against STDs and pregnancy. To date, however, they have not been widely distributed or tested with the general public.

Programme Considerations in STD Prevention

In planning an effective control programme for sexually transmitted diseases, the planner must take into account three issues unique to the prevention of STDs. The first is that primary prevention of sexually transmitted diseases involves addressing behaviours that are personal, intensely private, socially determined and culturally sanctioned (Zabin 1991). Secondly, the decision to practice safer sex involves at least two individuals. Unlike health behaviours to prevent other diseases, decisions about preventing STD transmission rely on both partners adopting the preventive behaviour (Darrow and Siegel 1991). Thirdly, persons infected with an STD may be asymptomatic yet able to transmit the infection (e.g. chlamydia infection in women or HIV infection in men or women). In addition, symptomatic persons may be aware of the presence of an infection, but due to the stigma associated with STDs, may not disclose this information to their sexual partners.

Introduction to the Case Study

Control of STDs through health education strategies has assumed greater importance in recent years (Aral and Holmes 1990; Over and Piot 1990; Stone, Grimes, and Magder 1986). STDs are among the leading causes of morbidity among young adults in East Africa. The emergence of acquired immunodeficiency syndrome (AIDS), a fatal STD, makes effective preventive strategies a health priority in many countries (Aral and Holmes 1990; Over and Piot 1991). To reduce the incidence of STDs, health education messages encourage individuals infected with an STD or at risk for contracting an STD to practice safer sex.

Health education is "any combination of learning experiences designed to facilitate voluntary actions conducive to health" (Green and Kreuter 1991, 17). Health behaviours are not simply isolated acts over which a person has autonomous control, rather, health behaviours are "socially conditioned, culturally embedded, economically constrained patterns of living" (Green and Kreuter 1991, 12). To effect change in health behaviours, these social, cultural and economic determinants must be considered. This is especially true for health education strategies to effect changes in sexual practices. The private nature of sexual relationships coupled with strong social and cultural mores about sexual relations results in sexual practices that are extremely difficult to change (Coates and Meheus). Effecting change in sexual practices is also

complicated by the fact that sexual behaviour is dyadic and strongly reinforced.

The complex nature of sexual behaviours requires approaches that impact on individuals' knowledge, attitudes, and practices to help foster social and physical environments that support safer sex. Health education through counselling has been promoted as an effective strategy to influence sexual behaviours (WHO/GPA 1990).

Counselling, simply stated, is a "face-to-face communication in which one person helps another make decisions and act on them" (Population Information Program 1987, Series J, Number 35, 1). Counselling has been endorsed by the WHO as an intervention to slow the spread of HIV infection. In 1990, the World Health Organization (WHO) issued "Guidelines for Counselling People About Human Immunodeficiency Virus" (WHO/GPA 1990). Counselling is recommended as a mechanism to educate persons at risk about the modes of transmission, and to provide psychological support to persons already infected with the virus.

Several programmes designed to train individuals in counselling skills as a method to control the spread of HIV infection are being developed in Kenya in response to the WHO position on counselling. There is no consensus among the programmes about what counselling training should include or what STD/HIV counselling is. Counselling programmes are in formative stages of development and remain untested.

This case study involved developing, implementing and evaluating a

training programme for community health nurses in counselling skills to promote safer sex practices among persons infected with an STD. The study took place in Nairobi, Kenya as part of a Canadian International Development Agency funded project "Strengthening STD/AIDS Control in Kenya" (CIDA Project).

The CIDA Project is a joint venture between the University of Nairobi, Department of Community Health, and the University of Manitoba, Department of Community Health Sciences. The goal of the CIDA Project is to reduce the incidence and prevalence of STDs in the Kenyan population by integrating diagnosis, treatment and prevention services into local government-sponsored community health centres (CIDA Project Proposal 1989). In Nairobi, the major provider of public health services is the Nairobi City Commission (NCC). The NCC operates 54 health centres throughout the city of Nairobi serving a population of over 40,000 people. Clinical officers and nurses provide diagnostic and therapeutic services in community health centres. Health workers may see as many as 200 clients per day, and therefore spend only a few minutes with each client. In 1991, the CIDA Project started training clinical officers and nurses in management of STDs in three pilot health centres. Diagnostic and treatment algorithms for STDs have been developed. Training workshops for clinical officers and nurses had been conducted and the health workers had been providing STD services in the pilot centres for several months prior to this study.

A learning needs assessment carried out in early 1991 indicated that

these health workers wanted more training in STD/HIV counselling skills (Ngugi and others 1991).

The case study documented here involved: (1) the development and delivery of a training programme in counselling skills for community health nurses; (2) assessment of changes in the nurses' communication patterns with STD clients; and (3) assessment of changes in the clients' knowledge, attitudes and intentions to practice safer sex following a brief counselling session.

The objectives of the case study were as follows:

(1) To develop a culturally relevant training programme in counselling skills for nurses to promote the adoption of safer sex practices among STD clients.

(2) To assess the counselling training programme through verbal and behavioral feedback from the nurse participants.

(3) To assess changes in the clients' knowledge, attitudes, and intentions about adopting safer sex practices following a counselling session.

Study Limitations

Three major limitations of this case study need identification. Firstly, the training programme and follow-up assessments were developed for a specific group of community nurses working in busy health centres in low income neighbourhoods of Nairobi. Constraints on financial and personnel resources

in the clinics limited the amount of time nurses could be away from the health centres for training. Large numbers of clients attending the health centres each day restricted the amount of time each nurse could spend with any one client in health education. The training programme was developed in accordance with these constraints. Whether or not this programme is appropriate for STD counselling training in other situations is not examined in this study.

Secondly, the training programme in counselling was delivered only once to a small group of nurses. This implementation of the programme generated valuable information on aspects of the training that worked well and aspects that needed revising. Unfortunately, time limitations did not allow for another opportunity to deliver a revised version of the programme to other nurses and assess how well that version would work.

Thirdly, it was not possible to evaluate counselling as an intervention to facilitate the adoption of safer sex practices. Time did not allow for an extensive evaluation and follow-up of clients who received counselling through this study. Attempts were made to assess changes in clients' knowledge, attitudes and intentions to practice safer sex through a questionnaire administered through interviews immediately before and after the counselling session. The data obtained through the questionnaires provided no information on the impact of counselling on safer sex practices. The questionnaire focused only on information about STDs/HIV and self-reports of sexual behaviour and intention to change sexual behaviour. The validity of self-reported sexual

behaviour is questionable due to the social and cultural mores surrounding the discussion of sexual practices. Validation of self-reports through direct observation is not culturally appropriate with sexual behaviour. Other measures to validate self-reported sexual behaviour include biological markers such as urine samples to detect the presence of sperm to correlate reports of sexual intercourse, STD prevalence, and condom sales (Catania and others 1990). These measures are imprecise, expensive and not feasible within this study.

The author of this study attempted to measure changes in sexual practices following counselling through a repeat interview and questionnaire with a sample of clients who received counselling. Despite monetary incentives to return for follow-up, insufficient numbers of clients returned to complete the follow-up questionnaire to produce meaningful data about changes in self-reported sexual behaviour after counselling.

CHAPTER III

REVIEW OF LITERATURE

In the absence of effective vaccines to control the spread of sexually transmitted diseases, and without a cure for AIDS, control of these infections relies on interventions that encourage behaviour change, specifically, the adoption of safer sex.

Behavioral Interventions and Prevention of STDs/AIDS

According to Bruhn, "people are reluctant to alter patterns that represent powerful, predictable, and immediate sources of gratification which are deeply ingrained in social and cultural contexts" (Bruhn 1988, 79). Sexual behaviours are highly personal, immediately gratifying, and deeply ingrained in social and cultural mores. In addition, sexual activities are considered private in most

societies and not traditionally open to community discourse. The initiation and continuation of health behaviours is affected by pressures from family and friends (Bruhn 1988); however, community support for the adoption of safer sex behaviours or admonishment for risky sexual behaviours is not considered appropriate in most societies (Darrow and Siegel 1990).

People are more likely to adopt a behaviour that relieves them of pain or discomfort they are experiencing at the moment than a behaviour which avoids potential discomfort they may experience in the future. Compliance with any new health behaviour is difficult to sustain when there are few physical or social rewards for the behaviour change (Bruhn 1988). The lack of physical and social reward for safer sex practices is a major hindrance to initiating and sustaining these health behaviours. Safer sex practices are considered by many to reduce the physical pleasure of sex. Indeed, people may perceive significant response costs such as potential rejection by sexual partners, reduced eroticism in lovemaking, embarrassment with procurement of condoms or embarrassment about communicating with partner. In promoting safer sex practices, people are encouraged to alter behaviour they find pleasurable and reinforced by their social group, and initiate behaviour that may be less pleasurable, and for which they receive less reinforcement. To complicate matters more, people are encouraged to alter current behaviour to prevent a possible negative outcome some time in the future. Therefore, individuals choosing to sustain safer sex practices do so with little immediate positive feedback physically and socially.

A unique issue for prevention of HIV infection is the sustained commitment individuals must make to behaviour change. Unlike other health behaviours where the occasional lapse of preventive practices does not appreciably alter the person's risk for disease, a lapse in HIV-preventive behaviour is potentially fatal. In order to sustain behaviour change the individual must continue to feel at risk for acquiring the infection and must have the physical and social environment to support maintenance of preventive behaviour.

Another limitation of changing behaviour to prevent STDs is the fact that many sexual encounters occur in situations where drugs and alcohol are consumed. Bars and nightclubs are often where individuals meet casual sex partners. Even when an individual is committed to practising safer sex, this commitment may be easily forgotten under the influence of drugs or alcohol.

Many of the initial AIDS education campaigns used fear tactics to get people to change their sexual practices. Symbols associated with death such as coffins, graveyards, and skull and crossbones were used in early AIDS campaigns in North America (Family Health International 1991). This approach proved limited in reducing risky sexual activities. A certain level of fear or threat may help raise awareness about the need to change behaviour, however, messages that arouse extreme fear may raise levels of anxiety to the point where the impact of the message is lost (Population Information Program 1989). Health education messages evoking fear of the consequences of STDs

must be balanced with the information and skills people need to take positive action to prevent infection (Family Health International 1991).

STD/AIDS Prevention Programmes in Kenya

Strategies to promote safer sex practices in East Africa have been developed in the past few years in response to the AIDS epidemic. Most programmes target HIV - prevention; only a few programmes target STD - prevention in general. To date, the thrust of prevention programmes in Kenya has been on increasing awareness of how HIV is transmitted, how the virus is not transmitted, and methods of personal protection. Awareness campaigns appear to have been successful at increasing public knowledge of AIDS. Surveys conducted in a variety of populations reveal that knowledge of methods of AIDS transmission and prevention is high (Moses and others, unpublished). However, as Schopper notes in her analysis of AIDS interventions in developing countries, "there is little evidence of impact (of mass media campaigns) on risky behaviour" (Schopper 1990, 1266).

Prevention programmes are now moving away from awareness campaigns to programmes that increase knowledge and safer sex skills of particular groups of individuals, for example core transmitter groups, youth in and out of school, women's groups, and workplace programmes targeted primarily at employed men (UNICEF 1991).

In the first few years of AIDS prevention programmes, efforts to slow the spread of the disease in Kenya and other countries around the world were scattered and uncoordinated. At that time it appeared more important to do something quickly in an attempt to halt the epidemic rather than to plan carefully and to evaluate efforts (Schopper 1990). Recently there has been a desire among agencies delivering AIDS prevention programmes in Kenya to coordinate their efforts, recognizing that prevention and control of AIDS requires a comprehensive approach involving multiple sectors of society and evaluation of the impact of different strategies.

Prevention programmes specifically aimed at STD control have not been accorded the same degree of emphasis as programmes specific to the control of HIV and AIDS. However, with the recognition of genital ulcer disease as a co-factor in the transmission of HIV (Greenblatt, Lukehart and Plummer 1988) and the parallel health behaviours for preventing AIDS and STDs, more agencies have attempted to integrate STD and AIDS prevention activities.

National STD Committee (NSC) and National AIDS Control Programme (NACP) in Kenya

In Kenya, the National STD Committee (NSC) was set up in 1989 within the Division of Communicable Diseases in the Ministry of Health to coordinate STD control. The STD control unit was established as part of a medium-term

plan of the National AIDS Control Programme (NACP), which was formed in 1987.

The NSC was charged with formulating, initiating and coordinating STD prevention and treatment activities at a national level. Through the NSC, a special treatment clinic (STC) for people with STDs was opened in Kisumu (the third STC in the country) and a manual for health workers on the management of STDs was produced. A five year plan was developed for the period between 1989 and 1994 which included strategies for health promotion, treatment, improved diagnostic measures, contact tracing, patient counselling training, research and laboratory support for STDs (Ministry of Health, Kenya, 1990).

The NACP, in collaboration with the WHO Global Programme on AIDS (GPA), developed a medium-term plan for Kenya for the period between 1987 and 1991. The plan included health education strategies, improved laboratory and blood transfusion services, surveillance strategies, and clinical services (NACP, 1987). Late in 1991, the NACP developed a second medium-term plan for 1992-96. The focus of the next five years will be on community interventions through established community organizations such as church groups, womens' groups and childrens' groups, aimed at enhancing communication about sexual issues (UNICEF 1991).

HIV/AIDS Counselling Programmes in Kenya

In Kenya, counselling is considered integral to STD and HIV prevention and control efforts (Ministry of Health, Kenya 1990). A variety of agencies in Kenya are currently developing programmes to train individuals to provide counselling to persons with HIV infection. The Kenya Red Cross has been developing and revising a National AIDS Counselling training programme since 1989. The programme has targeted health professionals, and is based on a two week workshop. The programme provides information on the epidemiology of HIV infection and AIDS in Kenya, clinical manifestations of the disease, principles of counselling to individuals and groups, and an overview of different forms of counselling, for example, crisis counselling, problem-solving counselling, and preventive counselling (Kenya Red Cross Society 1989). The training programme is based largely on lectures by medical professionals and psychologists. There are a few opportunities for participants to work in small groups with case situations and role plays. A three volume training manual is distributed to participants at the end of the workshop, providing in narrative form the content of the training programme.

The Red Cross training attempts, in two weeks, to provide the health professional with psychological theories and principles employed by psychologists with extensive training in counselling. In this author's opinion, many of the concepts and principles introduced in this training programme

cannot be assimilated into practice through a short training programme. The programme introduces the participant to the concepts and principles of counselling but provides little opportunity to incorporate these concepts and principles into practice. Participants leave the programme knowing more about how a professional counsellor may approach a client with AIDS, but inadequately equipped to provide counselling themselves.

Whereas the Red Cross programme is the best known and most developed counselling training programme in Kenya, other agencies have developed similar training programmes for other target groups. Two international development agencies, Crescent Medical Aid and AIDSTECH, collaborate to provide training in counselling skills and community education for AIDS prevention to community based distributors (CBDs) in the slum areas of Nairobi and Mombasa (Kenya's two largest cities). CBDs are lay persons who are trained in basic disease surveillance and treatment; they are often volunteers in their community providing basic health services. Participants in the Crescent Medical Aid training programme meet for one week to learn basic information about AIDS and HIV infection. Participants then return to their communities in pairs for three months of practical work with weekly follow-up by programme facilitators. Following three months of practical work, the participants meet for another week where counselling skills are refined and additional issues arising from practical work experience are addressed (Lundeen 1991). A workbook complementing the training programme was developed

outlining the salient information about AIDS, STDs, health education, and counselling skills (AIDSTECH 1991). Several case studies were provided for the participants to carry out independent study after the training. The framework for counselling developed by the programme is based on four steps: (1) Building a Relationship, (2) Exploring, (3) Understanding, and (4) Action Planning (AIDSTECH 1991).

The African Medical Research and Education Foundation (AMREF) offers correspondence courses to medical practitioners in East Africa. Separate modules on STDs, HIV/AIDS, and counselling have been developed and distributed through the programme. Each module provides basic information on the topic, followed by a series of questions for the practitioner to complete and return to AMREF. In the counselling module, counselling is defined as:

> ...a problem - solving and decision making process, involving person to person communication. It is centred around a real problem to the person in need. Counselling assists him/her to make responsible decisions. Therefore, the choices for him/her must be clarified. (AMREF 1990, 1)

Fifteen principles of counselling and counselling skills are described in the module, for example, empathy, respect, genuineness, trust, confrontation and attending behaviour. The module provides an abbreviated overview of counselling but may be useful to practitioners in remote areas who are confronted daily with persons who are HIV positive in their practices. However, similar to the Red Cross programme, the AMREF programme provides little in the way of practical skill development.

The Norwegian Church Aid, another non-governmental organization,

provides one and two day seminars on AIDS prevention, education and HIV counselling training to community groups and service groups in both rural and urban Kenya. The programme was developed by many of the same persons involved in the Red Cross programme and is a condensed version of the Red Cross training. As a Christian organization, Norwegian Church Aid has been involved in AIDS education workshops to many Christian church groups around the country (Maingi 1992).

Counselling in Family Planning

Family planning programmes have been involved in providing information to potential users of family planning and in assisting clients to make a choice of family planning method based on their personal circumstances. The interaction between client and provider is called counselling by family planning programmes. Counselling in the context of family planning is defined as:

> ...any face-to-face communication between providers and clients that helps clients to make free and informed choices about family planning and to act on those choices (Population Information Program 1987, Series J, Number 35, p 2).

Many nurses trained in family planning counselling skills follow a step-by-step approach termed "GATHER" developed by the Population Information Program at John Hopkins University (Population Information Program 1987). This approach will be discussed further in the next chapter.

Counselling verses Counselling Skills

With the growing concern over AIDS in the past decade, counselling has received more support as an intervention to help persons prevent HIV infection and to provide psychological support for persons who are infected with the HIV. According to the World Health Organization (WHO) Global Programme on AIDS (GPA), "it is now generally held that AIDS control and prevention cannot and should not be carried out in the absence of counselling" (Carballo and Miller 1989, 117). The term counselling has been used to define a variety of interactions, from commercial settings where the potential customer is 'counselled' about his/her particular purchase, to employer - employee evaluation discussions, to legal or medical usage where the counsellor gives 'expert' advice (Bond 1990). Concerned with the diversity of meanings of counselling and the growth of agencies providing HIV counselling, the British Association for Counselling (BAC) in conjunction with the British Department of Health, conducted workshops in Britain in 1990 with professionals involved in HIV/AIDS counselling. The participants were asked to define HIV counselling and make recommendations for HIV counselling practice in Britain. According to the BAC:

> Counselling is the skilled and principled use of relationships which develop self-knowledge, emotional acceptance and growth, and personal resources. The overall aim is to live more fully and satisfyingly. Counselling may be concerned with addressing and resolving specific problems, making decisions, coping with crises, working through feelings and inner conflict, or improving relationships with others.

> The counsellor's role is to facilitate the client's work in ways that respect the client's values, personal resources, and capacity for self-determination (Bond 1990, 5)

The BAC definition of counselling refers to the activities of a specialized counsellor with extensive training. The BAC report recognizes that not everyone involved in HIV counselling will have this level of expertise. In an attempt to define counselling practice for persons not trained as professional counsellor, the BAC advocates making a distinction between counselling and the use of counselling skills.

> What distinguishes the use of counselling skills from these other two activities (counselling and listening skills) is the intentions of the user, which is to enhance performance of their functional role, as line manager, nurse-tutor, tutor, social worker, personnel officer, voluntary worker, etc. The recipient will, in turn, perceive them in this role (Bond 1990, 8).

Counselling skills delineated by the BAC include: "listening skills; reflecting back what someone says; use of basic empathy; and a framework for identifying the appropriate use of these skills" (Bond 1990, 51). The BAC contends that counselling skills are useful in a variety of caring situations to improve personal relationships or communications between two individuals. The BAC distinctions between counselling, counselling skills and listening skills are not clear. In fact, the report does not offer any definition of listening skills.

Confusion over the meaning of the term counselling will likely continue because the term is used in variety of circumstances with very different

meanings.

For the purposes of this study, a definition of counselling similar to the definition used in family planning was utilized (Population Information Program 1987). Counselling was defined as a face-to-face discussion between people where the counsellor helps the client make a health decision and act on the decision. This definition was chosen for its simplicity and emphasis on a discussion that is geared to problem resolution and decision making. In this study communication skills of active listening (attention to both verbal and non verbal communication), restating (paraphrasing the clients' comments) and checking (verifying if a message is understood accurately) were considered the key skills to effective counselling.

CHAPTER IV

DESCRIPTION OF THE CASE STUDY

The original research proposal developed in Canada emphasized an evaluation of counselling as an intervention to change sexual behaviour in STD clients. The proposal involved employing recommendations used in training family planning counsellors to train three health workers in counselling skills. The three health workers trained were to counsel ten clients each in the prevention of STDs for a total of thirty clients. Counselling would involve each client in at least five sessions with the trained health worker. Before leaving Canada the author was concerned that the proposed evaluation research might not provide a useful contribution to the ongoing work of the CIDA Project. The author understood that health centre staff involved with the CIDA Project in Kenya had little time to spend with individual clients. She was concerned that the model of counselling involving multiple sessions would not be sustainable

beyond the study period.

The author met with Dr E. Ngugi, co-director of the CIDA Project, at a conference held in Alberta in early October, 1991 and discussed the author's concerns about the study. Dr. Ngugi concurred that the multiple session approach to counselling would not be practical for the health centres the CIDA Project was targeting.

The author arrived in Nairobi on October 19, 1991. Shortly after arrival, she met with Dr. S. Moses, co-director of the CIDA Project. Concerns about the usefulness of an evaluation of a multiple session approach to counselling were discussed with Dr. Moses. Dr. Moses believed the research could generate valuable information, especially in light of widespread support for counselling as an STD prevention intervention, but agreed that research evaluating a multiple-session model of counselling would not contribute to the ongoing activities of the CIDA project.

The author met with Dr. G. Eldridge, a clinical psychologist working as behavioral consultant to the CIDA Project. Dr. Eldridge suggested possible revisions to the proposal that would incorporate counselling and contribute practically to the CIDA Project goals. An evaluation of nurses and clinical officers trained in STD management by the CIDA Project showed that health workers felt they needed more training in counselling skills (Ngugi and others 1991). A training programme in counselling skills that emphasized interpersonal communication was considered a priority for the CIDA project.

Through further discussions with Dr. Eldridge, Dr. Moses and Dr. Ngugi, it was decided the project would focus on the development of a training programme in counselling skills which could be used by health care workers in single brief counselling sessions. The final decision was to develop a training programme in counselling skills for nurses and clinical officers who work in health centres which are affiliated with the CIDA Project in Nairobi. It was planned that ultimately the counselling curriculum could be adapted by the CIDA Project Kenyan staff for training nurses and clinical officers and peer group educators in community programmes.

The first step toward developing a counselling training programme was to gain an understanding of the work environment of nurses and clinical officers, the type of work they did, the type of clients they treated, their current approaches to counselling and their expectations for a counselling training programme. Following this, the author met with agency representatives who were involved in developing AIDS counselling training programmes in Kenya. After gathering baseline information from the health centre staff and from local experts the first draft of a curriculum and workbook for training in counselling skills was prepared.

Needs Assessment: Health Centres as a Source of Information

The author accompanied the CIDA Project nurses on their bi-weekly rounds of three Nairobi health centres affiliated with the CIDA Project: Baba Dogo, Dandora, and Kariobangi Health Centres. Over a six week period, she met with nurses and clinical officers involved in treating clients with STDs, discussed their work, and observed them interacting with clients. Most interactions between staff and clients were conducted in Kiswahili, the local language so the author was limited to observing these interactions. Interviews with staff were possible as most staff were fluent in English. The staff of the health centres were interested in the proposed research and were open to answering questions and allowing the author to observe them with clients.

In discussions with nurses about counselling, the author found that they viewed counselling as an important aspect of their work with clients in family planning, antenatal care, maternal-child health, medication compliance and prevention of STDs. This was substantiated by the observation that specific rooms in each clinic were designated as counselling areas with the word "counselling" written on the door. However, all the nurses interviewed felt they were not adequately trained in the skills necessary to counsel properly. The clinical officers also recognized counselling as an important aspect of their interaction with clients and felt they could benefit from more training in counselling skills.

A review of the health workers' previous training in counselling or counselling-related skills revealed little formal training. Most of the staff nurses in community health centres are trained as "Kenyan Enrolled Community Nurses". Their training incorporates the breadth of skills necessary for the nurse in the community health centre to carry out his/her duties. Nursing training involves skill development in maternal-child health, immunization, basic anatomy and physiology, pharmacology, family planning, and first aid. In both nursing and clinical officer training, communication skills are integrated into the curriculum and assessed within each specific clinical area (Muchiri 1992). Nurses trained in family planning reported their training emphasized the variety of contraceptives available and their potential side effects with little training in counselling, communication skills, or discussion of personal or sensitive issues.

A short review of counselling principles is included in the CIDA Project training programme for STD management. A two - hour session during a two - day workshop outlines key points in communication skills and gives participants the opportunity to work through a case study in small groups. Nurses and clinical officers felt this was not sufficient to equip them to counsel STD patients adequately.

From observations of both clinical officers and nurses in the health centres it appeared health workers interacted with clients from a position of authority. The relationship between the health worker and the client appeared hierarchical with the health worker directing the client from a position of power

and the client passively receiving the health workers' directives. Physical gestures of the health worker such as standing when the client is sitting, punctuating information by pointing at the client with the index finger, and "hands-on-hips" stance were observed frequently by the author. This kind of body language is considered hierarchical in most Western cultures, however, the author did not explore whether this body language has the same meaning in the Kenyan culture.

Informally, the author asked several of the nurses and clinical officers what they understood counselling clients with STDs to involve. Their response usually included telling the client to refrain from sex until treatment was complete, advising them to bring sexual contacts to the clinic, and recommending the use of condoms with casual sex partners. Both nurses and clinical officers described STD counselling as giving clients information. This approach is one-way from the health worker to the client; there is little or no exploration of the client's needs; and it presumes that one set of messages 'fits' every client situation. This approach is also consistent with a hierarchical relationship between health worker and client.

Through information collected through discussion with CIDA Project staff and consultants, the author was aware that clinical interactions with STD clients lasted two to three minutes on average. Direct observations by the author in the health centres verified this information.

Through discussions of these observations with the CIDA Project staff,

they agreed that counselling usually involved the nurse or clinical officer advising the client on symptoms of STDs and methods of personal protection during a brief session. The perception of counselling as a therapeutic discussion between the health worker and client was considered a new approach only recently being taught in nursing programmes, therefore most of the nurses involved in this study had not been introduced to this approach to counselling.

Privacy in health worker-client interactions did not seem to be as important as one would expect in similar situations in a Western setting. Clinic staff and CIDA Project nurses walked freely into the treatment room, interrupting the clinical officer and client. Similarly, clients for maternal-child care are seen in public rooms where two or three nurses worked with other clients in the same room. Clients awaiting their turn to be seen by a nurse sit close by, within sight and earshot. Here too, interruptions by other staff were common. Throughout observations by the author of the health workers interacting with clients, the client was never asked if it was acceptable to him or her for an observer to be present. At first the author attributed the lack of privacy to crowded working conditions. However, during the course of the project it was discovered that all three health centres had rooms that were not often used, which suggested that the organization of the clinics was based more on the needs of the health worker than the needs of the client. The rationale for the clinic set-up was not explored however. No information on the

client's expectation or needs for privacy was explored in this study and it is not known whether clients perceive a lack of privacy in the clinic.

The author met with the nurse-in-charge for each of the three health centres several times over the study period. They too felt that additional skill development in counselling was needed. All 3 were hoping to attend the two - week counselling training programme offered through the Red Cross. At first they were concerned that a shorter programme would not provide the level of expertise in counselling they believed necessary. Later, after reviewing the curriculum and workbook, they responded favourably to the proposed programme, feeling it provided staff with the fundamental skills to counsel STD clients and the confidence necessary to discuss sensitive, personal issues. The nurses-in-charge all commented favourably on teaching the nurses how to demonstrate condom use to clients.

It was evident through discussions with health centre staff and observations of their interactions with STD clients that counselling is considered an important aspect of their interventions with clients. Nurses cited counselling as part of their activities in the areas of family planning, maternal child health, and medication and treatment compliance, as well as STD control. However, counselling involved the health worker giving the client information and instructions about safer sex practices within a two to three minute time period.

Needs Assessment: Local Experts as a Source of Information

After gathering information about the nurses' and clinical officers' work environments and the health workers' approach to counselling clients about STDs, the author arranged to meet with representatives from a variety of agencies which were involved in counselling training programmes in Nairobi.

On November 15, 1991 the author met with Mr. Alan Ragi, a nurse/midwife, who is Education Officer for the Kenya Red Cross. As discussed previously, the Red Cross offers a two- week training programme in HIV/AIDS counselling for health workers. At the time of the interview, the workshop had been offered twice. The discussion included the possibility of using the Red Cross training for this project. Mr. Ragi believed the training offered by the Red Cross needed revision as it overemphasized the psychological foundations of counselling and underemphasized practical skill development. Mr. Ragi invited the author to attend a Red Cross counselling training workshop planned for the first week of December.

The author met Ms Alisa Lundeen, a private consultant, on November 20, 1991. Ms Lundeen had been involved in the development, implementation, and method for evaluation of the counselling training programme offered by Crescent Medical Aid for community based distributors. Based on her experiences with the Crescent Medical Aid programme, she recommended that counselling training should emphasize communication skill development, involve

a practice period at the workplace, and include a session on stress management for the counsellor.

On November 21, 1991, the author met with Ms Lois Lux, Resident Coordinator for AIDSTECH in Kenya. AIDSTECH is a project funded by Family Health International for developing AIDS prevention and support programmes. Ms Lux and AIDSTECH were involved in the development and implementation of the Crescent Medical Aid programme on counselling. In agreement with Ms Lundeen, Ms Lux emphasized the importance of developing communication skills in counsellor training. AIDSTECH had produced the training workbook for the Crescent Medical Aid training. The workbook included chapters in AIDS, STDs, how to provide education programmes to community groups, and counselling. Each chapter included a brief discussion of the topic and a story or case study with questions for the participant to work on independently. The workbook also included a glossary of terms and a list of organizations that could provide additional information or resources to the community based distributor. On the invitation of Ms Lux, many sections of the programme and workbook were incorporated into the programme developed for this study.

On November 25, 1991, the author met with Ms Stephanie Karangua, Distance Education Coordinator for AMREF. She provided copies of the distance education modules on STDs and counselling developed by AMREF. Similar to the Red Cross programme, AMREF training emphasized principles of counselling rather than the stepwise approach to counselling emphasized in the

Crescent Medical Aid and AIDSTECH programme.

The author met with Dr. Lillian Kimani on December 11, 1991. Dr. Kimani is a psychologist who specializes in HIV-counselling through a private counselling agency in Nairobi. Dr. Kimani was one of the main authors of the Red Cross counselling training programme. Dr. Kimani stressed the importance of teaching the principles of counselling such as empathy, genuineness, non-judgmental attitude, acceptance, and warmth. She also stressed the importance of providing participants with case studies to practice counselling skills during the workshop.

The author attended the Red Cross counselling training programme in early December, 1991. This workshop was offered for physicians and dentists working in clinical practice in Nairobi. Due to limited time participants could be away from their work, a five-day abbreviated version of the usual ten-day training programme was offered. The workshop involved lectures from a number of health professionals including an epidemiologist, physicians, and psychologists. The goal of the workshop was to provide participants with the skills to counsel clients who were at risk for HIV infection or who were HIV positive.

In summary, there was agreement among all the local experts interviewed that the demand for training programmes in counselling skills was great in view of the escalating rate of HIV infection. The local experts agreed that the principle aim of training health workers in counselling was to decrease

the incidence of HIV infection by improving communication between health workers and persons at risk for acquiring HIV infection and persons who were HIV positive. Two different approaches to training were evident; one approach was to describe and explain the activities of professional counsellors; the other approach emphasized training in communication skills. No evaluation of training programmes in counselling in Kenya had been done at the time of these interviews.

Development of Programme

Little published research exists on counselling as an intervention to control the spread of STDs. However, precedents for approaches to counselling exist in other prevention programmes in community health. Family planning initiatives have had to face similar challenges to those faced in prevention programmes for STDs. Similar to STD programmes, family planning programmes have had to reach young, healthy individuals, discuss deeply personal topics, and discuss individual sexual practices and issues of sexuality often considered taboo subjects (Zabin and others 1991).

The Population Information Program at John Hopkins University, School of Hygiene and Public Health, publishes 'Population Reports' on community health issues. The reports are designed to provide an overview of important developments in the population field. Three issues of 'Population Reports' have

been devoted to counselling and family planning. (Series J, Number 35, Nov. 1987; Series J, Number 36, Dec. 1987; and Series A, Number 8, May 1990). The December, 1987 'Population Report' is a guide to counselling skills in family planning and presents a six step approach represented by the word GATHER. The principles outlined in the report emphasize the importance of effective communication in counselling. Effective communication depends on good interpersonal skills which the PIP suggest are: (1) the ability to care for the client by demonstrating respect, honesty and understanding, and (2) to be able to provide clear information that clients can understand (Population Information Program 1987). The six steps to counselling are described briefly here:

G Greet your client warmly.

A Ask the client about herself and why she has come.

T Tell the client about each available family planning method. Then tell her more about the methods that most interest her.

H Help the client choose the method that is best for her.

E Explain how to use the method that the client chooses. Help her plan how she will use the method.

R Return for follow-up. Agree on a time to meet again.

For the purposes of this study and to reflect the information specific to

preventing STDs, the GATHER approach was adapted to a five step approach represented by the word GUIDE. Each letter of GUIDE refers to a key word in a phrase which outlines the actions of the counsellor. The word GUIDE is an acronym to assist the beginning counsellor to remember these five phrases to direct their counselling practice. The five step approach is outlined briefly here and discussed in more detail below:

G Greet each client warmly.

U Understand from each client what they know about preventing STDs.

I Identify what information the client requires to make a decision to practice safer sex.

D Discuss any difficulties the client may have with acting on the decision.

E Evaluate what the client has learned.

Encourage the client to return for follow-up.

Step one: "Greet your client warmly" is the same in both GATHER and GUIDE approaches to counselling. Demonstrating warmth helps create a climate conducive to building trust between the counsellor and the client. (PIP, Series J, Number 35, Nov., 1987; Kenya Red Cross 1989).

Step two: "Understand from each client what they know about

preventing STDs" encourages the counsellor to establish the knowledge level of the client with regard to prevention of STDs. This step employs the principle that people learn best by building on previous knowledge (Brundage and Mackeracher 1980, 98). Step two also attempts to reveal any misinformation the client may have with regard to STD prevention. Myths about the spread of AIDS are particularly widespread. It is popularly held in Kenya, for example, that mosquitos and public toilets are avenues for the spread of HIV and STDs (Moses and others 1992). Step two establishes what the client knows about the spread of STDs and establishes a baseline for the counsellor to build on through the counselling session.

Step three: "Identify what information the client requires to make a decision to practice 'safer sex'" involves identifying the client's priority learning needs. Where the client has little knowledge about STDs and how to prevent contracting an STD, the counsellor may need to provide some basic information. In the case where the client has extensive knowledge about STDs, the counsellor may identify skill development in condom use or negotiating safer sex practices with a sex partner as an area for further attention.

Step four: "Discuss any difficulties the client may have with acting on the decision" involves a discussion between the counsellor and the client of any impediments to changing sex practices the client identifies. Cates and Meheus state, "to have the greatest chance of success, behaviour modification approaches must promote and reinforce individual decision-making" (Cates and

Meheus 1990, 1026). Coates concurs with Cates and Meheus but adds that "individuals are more likely to adopt a new behaviour if they are offered choices among alternatives" (Coates 1991, 5). In discussion between the counsellor and client, alternatives are identified and the counsellor assists the client to choose among alternative actions to limit future exposure to an STD. If the client identifies reluctance to use condoms or to negotiate safer sex with a sex partner because he/she does not have the necessary skills, demonstrating how to use a condom or role playing a discussion with a sex partner about practising safer sex could help the client develop these skills.

Step five: "Evaluate what the client has learned, and encourage the client to return for follow-up" is similar to steps five and six in the GATHER approach. Evaluation of the client's learning involves asking the client to repeat any new information or demonstrate any new skill introduced during the session. Encouraging the client to return for follow-up provides the client with the opportunity to return for further clarification or support.

Development of Training Curriculum and Workbook

With the information gathered through observations and discussions with staff at the three health centres, discussions with individuals involved in developing counselling training programmes, attending the Red Cross counselling training programme, and the recommendations for counselling training outlined in the Population Information Program issues on counselling, the author prepared the first draft of the training curriculum and workbook. The general aim of training was to change the way health workers interacted with clients; to move away from providing general information about STDs in a one-way interaction to involving the client in a discussion which aims to establish what information, skills and support the client needs to make a decision to practice safer sex. Given the limitations on time for training the nurses and limitations on time in individual counselling sessions, the author felt the aims of the programme could be best achieved by focusing on the development of communication skills.

The author was advised by the directors of the CIDA Project that the workshop could not take staff away from a health centre for more than three days because of the heavy work load at each health centre and the absence of relief staff. The idea of a practice period between the first part of the training and the last part of training as in the Crescent Medical Aid programme was considered valuable and could be replicated. To accommodate the constraints

on the nurses' time away from the health centres, the programme was designed to include two days of training, three days of practice time in the health centres, and one day of follow-up training. This design allowed the participants to practice their new skills in the clinic environment and identify areas where further clarification and skill development was needed. Given that individuals learn better by actively participating in the learning process (Cranton 1989; Brundage and Mackeracher 1980), the third workshop day was designed around an open schedule where the participants would determine the day's agenda according to their needs for further training.

Workshop Set-Up

The first two days of training were held in a meeting room at the Silver Springs Hotel in Nairobi. The third day of training was held at Provide International, a non-profit outreach centre located in Korogocho, a slum area in Nairobi. People from Korogocho receive health services at the three health centres involved in the CIDA Project. The original plan was to hold all three days of training at Provide International to provide an opportunity for the nurses to learn about the resources available through Provide International as well as to support a community organization by using their facilities for training. However, the CIDA Project nurses cautioned this may not be welcomed by the participants as other CIDA Project workshops were held at the Silver Springs Hotel and the pleasant surroundings are considered one of the benefits for staff

attending workshops. The compromise was to hold two days at Silver Springs and one day at Provide International. These arrangements proved to be satisfactory.

In leading the training workshop the author was joined by Ms Anastasia Ndiritu (Kenya Registered Nurse, Kenya Registered Midwife, Kenya Registered Community Health Nurse with a Diploma in Advanced Nursing), the nursing team leader with the CIDA Project. Ms Ndiritu had taught diploma nurses for several years in rural Kenya and had facilitated at other CIDA Project workshops. As testament to Ms Ndiritu's ability as a workshop facilitator and perhaps to the clarity of the training curriculum, Ms Ndiritu was able to provide excellent facilitation following only a two hour meeting with the author to review the curriculum several days before the workshop. Ms Ndiritu's style of facilitation was similar to that of someone leading a religious revival meeting. For example, to maximize participation by the group, Ms Ndiritu would restate a response given by one of the participants and then say, "Isn't that the way it is?". The expectation was that the group would agree verbally. If they did not respond as a group she would repeat the statement a little louder. Using this style, she was able to generate a large amount of participation from the group. My Western style of stimulating discussion through indirect questioning did not render the same level of participation from the group. In addition, the fact that Ms Ndiritu was a Kenyan, and familiar to the participants most likely contributed to the higher level of participation she generated.

Selection of Training Participants

Selection of the health workers for training was carried out by the sisters in charge at the three CIDA Project health centres and by the Assistant Medical Officer of Health for the Nairobi City Commission, Dr Muhammid Ali. This method of selection of participants reflects the method employed by the City Commission for other continuing education workshops. The only selection criteria set out by the author was that the health worker chosen had previously received the basic training in STD management and was currently treating clients with STDs. It was initially suggested that both nurses and clinical officers would be included in the study; however, the sisters in charge at the health centres and Dr. Muhammid Ali felt the clinical officers' work schedules did not allow time for participation in the study.

Nine nurses were selected to participate in the training; six women and three men. In addition, a social worker newly hired by the CIDA Project to counsel commercial sex workers in the Pumwani area of Nairobi, and two CIDA Project nurses participated in the training programme.

Prior to the workshop, the author met with each participant individually and interviewed them briefly regarding their approach to counselling persons with STDs. Each nurse was asked the average number of persons counselled per day, the average time spent with a client in a counselling session, and the question: "If I (the researcher) were to come to you with a STD, how would you counsel me?" Responses focused on gathering demographic information

such as marital status, number of children, and occupation. Most of the nurses stated they would tell me to use condoms, avoid casual sex partners, and avoid having sex until completely finished treatment. The nurses reported they counselled an average of ten clients per day (mean 9.77, range 4-25, mode 10). The mean time spent with each client to diagnose, treat and counsel was three minutes.

The Curriculum: Initial Draft, Feedback and Revisions

To ensure that the training programme was culturally relevant and that the content and instructional methods were appropriate, the curriculum and workbook were distributed to eleven persons with expertise in counselling and training programme development for review and feedback. For ease of description, I will present first an outline of each session of the curriculum; second, a discussion of the rationale for including specific content; third, recommendations for changes offered by expert judges; fourth, a brief discussion of how each session was received by the participants; and finally, a discussion of the instructional methods used at the workshop held February 4, 5, and 11, 1992.

DAY 1 - WEEK 1
Session I **MEET AND GREET**
0830-0930

Objectives of the session: a) Participants will get to know one another. b) Participants will review the objectives and schedule of the workshop. c) Participants will develop personal objectives for workshop. d) Participants will become familiar with the workbook. e) Participants will establish rules and roles for the workshop.

ICE BREAKER
OVERVIEW OF TRAINING SCHEDULE
PERSONAL OBJECTIVES FOR TRAINING
PURPOSE AND FORMAT OF WORKBOOK
RULES AND ROLES

Discussion and Rationale

An 'ice breaker' is an activity often used to start off a workshop. The purpose of an 'ice breaker' is to help participants and facilitators get to know one another and ease the tension that is often present at the beginning of a training programme. To "break the ice" for this workshop, the group separated into pairs with someone they had not met before. Each person was to learn their partner's name, some personal information, such as marital status or number of children, how long they had been working for the Nairobi City Commission, and what they hoped to learn from the workshop. The group was given approximately ten minutes to complete this task. After ten minutes, each participant was asked to introduce the person they had just met, giving some information about the other person's life and his/her expectations for the workshop.

Following the ice breaker, the facilitator reviewed the training schedule with the group. Each participant was given a copy of the schedule, which was also printed on a flip chart.

Next, the participants were asked to write personal objectives for the training workshop. Principles of adult learning identified by Brundage and Mackeracher support providing the adult learner with the opportunity to identify his/her own learning needs and objectives (Brundage and Mackeracher 1980, 105). It was explained that the third day of training would be open for the participants' suggestions for content so that any objectives not met through the first two days of training could be incorporated into the third day. Participants were given the opportunity to share their objectives with the rest of the group or to keep them private. All chose to keep them private.

A bound workbook was provided for each participant. The workbook followed the content of the first two days of training, including objectives and questions for discussion. The workbook included additional detailed information for participants who wanted to do extra independent study. The format of the workbook was based on the workbook developed by AIDSTECH for the Crescent Medical Aid training programme. Similar to the AIDSTECH workbook, this workbook included case studies with study questions and a glossary of terms. The workbook was handed out and described to the group by the facilitator. Participants were encouraged to use the workbook as a resource to facilitate learning.

The activity entitled 'Rules and Roles' is an activity participants in this programme were familiar with from other CIDA Project workshops. Participants are asked to suggest guidelines to be followed by the group throughout the

workshop. The purpose of establishing guidelines is to establish group expectations for participant behaviour and participation. Often however, the guidelines are used to set conditions so that quiet, less active members of the group can be comfortable speaking out. Rules such as 'speak clearly', 'participate actively', and 'arrive on time' are examples of rules and roles suggested by the participants.

Input from Expert Judges

In the original draft of the curriculum, the first session included a pre-test of baseline counselling skills. It was intended that participants would complete a brief written test on communication skills. One reviewer pointed out that not all participants have good writing skill in English. With this fact in mind, the author met with each participant the week before the workshop and asked each participant a series of questions on the number of clients they counsel per day, the length of time involved in an average counselling session, their current approach to counselling skills, their knowledge of communication skills, and their personal learning goals for the workshop. (See Baseline Questions Form, Appendix A)

Session Implementation

The first two days of the workshop were held in a large, well lit, well ventilated meeting room at the Silver Springs Hotel in Nairobi. Tables were set

up in an open square with participants and facilitators seated around the outside facing one another. Two flip charts were at one end of the room, one flip chart listed the objectives for the session in progress, the other held blank pages with discussion questions printed on the top and space beneath for participant responses. The opening session was led by Ms Ndiritu, co-facilitator for the counselling workshop. Ms Ndiritu was well known to the participants and it was felt her familiarity would alleviate any initial nervousness among the participants.

An hour was allotted to this session. Due to congestion in bus routes that day, several of the participants did not arrive until ten minutes to nine. However, despite the late start, the designated tasks were completed within the hour.

0930-0945 TEA

Session II **PREVENTIVE HEALTH BEHAVIOURS**

0945-1130

Objective of the session: a) Participants will recognize their own personal difficulties with practising preventive health practices. b) Participants will identify difficulties people have with practising 'safer sex'.

Introduction

TO PREVENT STDS, PEOPLE MUST CHANGE SEXUAL BEHAVIOURS

With prevention of STD/HIV people must change the way they "play sex" (Note: "play sex" is a common phrase in Nairobi used to refer to sexual intercourse). Why is changing behaviour difficult?

Activity: Discussion

1. Let's talk about our own lives. List some everyday activities that prevent injury or sickness.
2. What preventive practices do you follow in your own lives all the time?
3. What preventive practices do you not follow all the time? Why not?
4. List practices we know of that prevent the spread of STDs? (Safer sex practices)
5. What are the cultural factors that make it difficult for people in Kenya to practice safer sex?
6. What are positive measures we can take to change risky sexual behaviour in Kenya?

Discussion and Rationale

A comment one of the CIDA Project staff nurses made after returning from the health centres lead to the genesis of Sessions II and III. She said, "Health education does not work, you tell people how to prevent STDs and yet they continue to play sex with many people" (paraphrased). The author believed other health workers may have similar frustrations and felt that a discussion of the complex nature of health behaviours would be best accomplished through an analysis of the participant's own health and risk behaviours. The discussion would help nurses recognize that knowing what one ought to do was not sufficient for behaviour change to occur or be sustained. By focusing on the participants' lives, the author hoped the nurses would become sensitive to the difficulties clients have in changing sexual behaviours.

Input from Expert Judges

The draft of the curriculum distributed to the reviewers included a list of

possible responses to the questions posed. With question one for example, the following were listed as possible responses:

> seat belts; turning off cooker, check bath water temperature, eat well, quit smoking; avoid alcohol; eat breakfast; adequate rest and exercise; immunize children; maintain traffic safety.

The list was included only for ease of understanding the concepts behind each question. One of the Kenyan reviewers pointed out that this list would not likely match the participant responses. As it turned out the reviewer was correct. Below are the responses to question one generated by the workshop participants:

> Bathing; eating well; cleaning teeth; clean home environment; using toilets; mosquito nets; clean water; immunize children; use insecticides; secure medicine cabinets; early treatment of the sick; obey traffic rules.

Session Implementation

This session generated a lot of discussion among the group members. However, question six, 'What are the positive measures we can take to change risky sexual behaviour in Kenya?' led the group into an unanticipated discussion. The intention of the question was to involve the group in a discussion about strategies they could personally employ as health workers to facilitate their client's individual decisions to practice 'safer sex'. Through discussion it was hoped they would identify that giving advice to clients was not sufficient to produce behaviour change. Instead, the participants interpreted this question to mean "what communities should do to change risky

sexual behaviour", and identified community education on human sexuality through the schools; churches and community leaders encouraging individuals to "stick" to one partner; discouraging cultural sexual taboos; and encouraging parents to allow youth to date before marriage. This was an interesting discussion but did not elicit much information about what health workers could do to promote safer sex practices. Another question such as "What can we as health workers do to help clients choose to practice safer sex?" should be added after question six to elicit this kind of information.

Session III **WHAT IS HEALTH EDUCATION?**

1130-1215

Objective of session: Participants will identify a variety of methods by which people learn about health practices and the advantages and disadvantages of group verses individual learning.

Activity: Discussion

1. What is health education?
2. List ways health messages are presented.
3. Identify advantages and disadvantages of health education to groups versus health education to individuals.

Discussion and Rationale

The purpose of this session was to identify the different channels through which individuals receive health education messages and to identify advantages and disadvantages of education to groups verses one-to-one counselling. After defining health education, the group was asked to list

various media through which people learn. The facilitator wrote the answers on the flip chart categorizing them as methods that address populations or methods that reach groups and individuals.

Input from Expert Judges

In the original draft of the curriculum, the author planned to provide participants with a definition of health education as an introduction to the session. One reviewer suggested it would be better to ask the participants to define health education in their own terms and in that way encourage active learning rather than passive, rote learning.

Session Implementation

Participants easily identified a large variety of channels through which people learn about healthy behaviours and the advantages and disadvantages of group versus individual health education strategies.

Session IV **COMMUNICATION**

1215-1300

Objective of session: Participants will identify the four essential components of communication and practice the skills of active listening, restating and checking.

Introduction If we examine what happens when people communicate, we notice four essential parts:

1. A sender
2. A channel

3. A message
4. A receiver

Communication is the most important skill
to good counselling.

Specific communication skills are used in counselling. These are:

Active listening: This means you listen with your ears, your eyes and your body.
Restating: This means you should repeat back to clients what you understood them to say.
Checking: This means that after you restate the message you heard from the client you ask them, "Is that what you meant?" or "Did I understand you correctly?"

Activity: Two-way communication

Facilitators will demonstrate active listening, restating and checking . Following the demonstration, ask participants to break into pairs. Give the following instructions: In partners, face one another. Partner A will begin by telling partner B what he/she thinks are the major health problems in Kenya. Partner B will actively listen to partner A, restate and check the message with partner A. Next, partner B will tell partner A what he/she thinks is the most important health problems facing Kenya. This time partner A will actively listen, restate, and check. Be sure the message sent is exactly what is understood.

Following the exercise participants will share their thoughts about the activity.

Discussion and Rationale

The four components of communication (sender, channel, message and receiver) were recommended for training family planning counsellors. The skills of active listening, restating and checking are known by different words (e.g., clarifying and paraphrasing), but are considered to be foundation skills in communication (PIP 1987; AIDSTECH 1991; Bond 1990).

Input from Expert Judges

The discussion question chosen for the activity was one that required clarification of points between the partners. The author had originally suggested a question on political issues facing Kenya. The CIDA Project staff nurses advised against a political question. They felt that open discussion of political issues was too new in their country to be appropriate in this setting. The question on Kenyan health care was their suggestion.

One reviewer suggested all three days of the workshop should be devoted to learning the skills of active listening, restating and checking. In hindsight, more time spent on communication skills may have improved the participants' interactions with clients in counselling. However, devoting all three days of the workshop to communication skills would not have satisfied the participants' expectations for training in counselling.

Session Implementation

The information on the components of communication was familiar to all participants through their professional training. This model of sender, channel, message and receiver inadvertently reinforces the notion of one-way communication which is not what the author wanted to encourage. Future workshops should delete this information in favour of more analysis and practice of the communication skills: active listening, reflecting and restating. This could be accomplished through demonstration, showing a video, and providing more opportunities for participants to practice these skills through role

play exercises.

The activity chosen for this session worked well but perhaps would work better if each pair demonstrated their interaction to the larger group and solicited feedback. This may provide participants who have more difficulty with this exercise the opportunity to model their verbal and non-verbal communication skills on participants who were more skilled. However, the risk of exposing some participants to performance anxiety by asking them to demonstrate in front of the group may outweigh the potential benefits of group modelling.

Feedback from the participants following the session shows that they were sensitive to how the client would feel when the counsellor employed these communication skills. Feedback from the participants following the exercise included: "Client will feel you are more attentive", "client feels wanted", "client will open up", "be more comfortable", "use of these skills will help achieve the goals of counselling", "client will feel more motivated to change", "counsellor will be able to find out the 'real' problem". Later, however, when participants began to practice counselling during the training workshop, they had difficulty integrating these skills into their counselling actions. This is not surprising given the brief practice time provided in this session compared with the well - entrenched communication strategies used in their daily clinical practice. These skills were introduced again on day two of the workshop.

1300-1400 LUNCH

Session V **COUNSELLING**
1400-1545

Objective of session: At the end of the session participants will be able to define what counselling is and the essential components of good counselling.

Activity: Discussion

1. How would you define counselling?
2. Why as a health worker are you in a good position to do counselling?
3. Why is counselling important in prevention of STDs?

Good counselling depends on good communication skills. In the session before lunch we practised communicating with partners using three essential skills for good communicating. They are:

- active listening
- restating
- checking

The main purpose of counselling is to get clients to talk openly with you. Before clients talk openly about sexual matters they must be able to trust you. To help your clients trust, the health worker should:

Show the client you care, and
Give clear and accurate information.

TRUST

When a client trusts the health worker the client will:

- feel more secure
- talk to the health worker about personal problems
- listen to the health worker's information
- come back for help with other health problems

When a client trusts the health worker and talks openly, the health worker learns:

- the client's health needs
- what the client knows about STDs
- what worries the client
- what wrong information the client may have about STDs.

Activity: This session involved a lot of information and lists. To review the information we will complete a small quiz. I shall ask some questions and each

of the participants will write the answers on a piece of paper. To check the answers participants will exchange papers and review each others' answers.

Questions:
1. List the key words in a definition of counselling.
2. Why are health workers in a good position to be counsellors? (list 3 reasons)
3. Counselling is important to helping people practice 'safer sex' because: (list 3)
4. What are the three skills to good communication?
5. Why do you want clients to trust the health worker?
6. What can you the health worker do to help people develop trust? (list two)

Discussion and Rationale

The information in this session was adapted from the PIP recommendations for training counsellors (PIP, Series J, Number 35, Nov., 1987). In the design of the present curriculum, this session was intended to integrate communication skills practised in the last session with the rationale for using good communication skills in counselling client with STDs. Establishing trust through listening, helping the client problem-solve by reflecting, and checking the client's perceived barriers to practising safer sex are key components to counselling. The statements about the benefits of health workers as counsellors and the statements about why counselling may help people practice safer sex were intended as motivational information for the participants. The intention of the activity chosen for this session was to facilitate retention of the information introduced during the previous session.

Input from Expert Judges

As in Session II when a definition of health education was explored, the

original draft of the curriculum provided a definition instead of soliciting ideas from the participants on a definition. On the advice of one reviewer, the components of a definition of counselling was explored first by the group.

Session Implementation

This was the most difficult session of the curriculum. The session occurred right after a large meal when everyone felt drowsy and the room was warm. The session was a departure from the style of facilitating that sought participation by the group and included more lecture material by the facilitator which was not appropriate for either the time of day or the information introduced in the session.

The activity did not appear to contribute to learning about counselling, although that was difficult to assess. The participants seemed comfortable with the exercise as evidenced by the ease with which they carried out the exercise. The author was expecting discussion over individual responses to give some indication of participants' comprehension of the information. However, no discussion took place.

In future workshops, changes to this session should be made: While retaining the objective and exploration of what counselling is, the information about why health workers make good counsellors and why counselling is important to preventing STDs should be omitted as this information is neither completely accurate nor important. Instead, include either a video or film or

demonstration of counselling that can be interrupted for discussion by the group. This could be an opportunity for the participants to identify good counselling and see models of good counselling in practice. The quiz should also be omitted in future workshops.

1545-1600 TEA

Session VI **COUNSELLOR BAGGAGE**
1600-1700

Objective of session: Participants will identify values and personal biases that may affect how they counsel people.

Introduction

We all carry 'personal baggage'. 'Personal baggage' is past experiences and deeply held feelings that affect how you feel about certain people and certain situations. In counselling, 'personal baggage' can interfere with how the counsellor counsels. If the counsellor can identify how he or she feels in certain circumstances, the counsellor can overcome these feelings with clients.

Activity: Values Clarification Exercise

As a group or in two smaller groups the participants will discuss the following case situations and or situations from their own experience where they have experienced biases.

Symbols
1. Draw a picture of a woman wearing a cross around her neck. Ask the participants what they think about this person just by looking at her. What values do the participants associate with someone wearing a cross? What would the participants think if the person were HIV positive?

2. Show a photograph of a mazungu (white person), a mahindi (an Asian person), and a Kenyan. Ask participants to discuss the differences they associate with different ethnic groups. Explore where these perceptions come from.

Lifestyles

1. A 17-year-old girl left home three months ago to find work in the city. She did not complete secondary school and has had difficulty finding work. She comes to the health centre with vaginal discharge which you suspect is an STD. a) What does this situation bring to mind? b) How does this situation make you feel?

2. A 40-year-old man comes to the health centre with an ulcer on his penis. He is married and has five children at home in the country. He has not been home to see his family for two months but is planning to go home this weekend. a) How does this situation bring to mind? b) How do you feel abut this man?

3. A 14 year old boy comes to the health centre with pain when he passes urine and a discharge from his penis. He is a 'parking boy' (youth who lives on the streets of Nairobi and collects paper or tin scraps for recycling). a) What does this situation bring to mind? b) How do you feel about this boy?

4. Rev. Father Christopher, 42 years old, has HIV infection through sexual contact. He is very sick and may be close to death. a) What does this situation bring to mind? b) How do you feel about this man?

Discussion and Rationale

Providing an opportunity in training for reflection of personal biases and feelings about sensitive issues through values clarification exercises is recommended by the PIP documents on counselling training (PIP 1987). The Red Cross and AMREF programmes on counselling also discuss 'non-judgemental attitude' as an important characteristic of a counsellor (Red Cross 1989; AMREF 1990). The author felt the values clarification exercise would provide more concrete insight into participants' attitudes than a discussion of what a non-judgmental attitude would provide. The cases were derived from situations observed in the health centres and case studies used in the CIDA Project workshops.

Input from Expert Judges

One reviewer suggested this session should be omitted altogether. He suggested the exercise could potentially elicit emotions that the group could not deal with in the short time of the workshop. The author sought the opinions of the CIDA Project nurses on this issue. They felt strongly that the session should be included based on their observations of the health workers' approaches to some clients who were treated in the health centres.

Session Implementation

The session began by showing a drawing of an empty kiondo (Kenyan sisal basket) and a general discussion about biases and prejudices. The participants freely talked about other people's biases and prejudices during a general discussion but responded with personal biases and prejudices when introduced to an actual picture of someone or something. The only picture available was of a nun which brought out lively discussion among the participants. The picture was a hand sketch of a woman in a nun's attire and very red lips as though she wore lipstick. Spontaneously, the participants gave the woman in the picture a name and attributed to her a number of characteristics. In future workshops slides or large photographs should be included. The use of case studies and images were effective methods to raise awareness of personal biases and values held by the participants.

DAY 2

Session VII **FIVE STEPS TO COUNSELLING - GUIDE**

0830-1000

Objective of session: Following the session participants will be able to describe the five step process to counselling and demonstrate the first two steps through role-play exercises.

Summary Day 1

We have learned that counselling is a face-to-face discussion between a health worker and a client where the health worker helps the client make a health decision and act on the decision. We also learned that good communication skills are essential for good counselling. The communication skills we identified were active listening, restating and checking. We learned that by showing the client that we care and by giving clear and correct information, the client will come to trust us and talk openly about their sexual practices. In the last session yesterday we discussed some of our personal values and biases that may affect the way we counsel clients.

Today we will practice counselling using a five step process. Following these five steps helps the health worker remember methods of how to help the client feel comfortable, how to help the client trust the health worker, how to help the client talk openly, how to help the client make a health decision and act on the decision.

Introducing GUIDE

To help the health worker remember the five steps of counselling, each step is designated by a letter. The five letters form the word GUIDE. To GUIDE someone is to show the way. As a counsellor you will be guiding the client towards making a decision to practice healthy sexual behaviours. The five steps are described briefly here:

G Greet each client warmly

U Understand from each client what they know about STDs.

I Identify the information the client requires to make a decision to help the client stay healthy.

D Discuss any difficulties the client may have with acting on the choices.

E Evaluate what the client has learned. Encourage the client to

return for follow-up.

We will now examine each step more closely.

Step 1 **GREET each client warmly.**

Activity: Discussion

1. List some ways people greet one another. List both words and actions.
2. List some ways we could ensure privacy when we counsel.

Step 2 **UNDERSTAND from the client what they know about STDs**

Activity: Discussion

1. Why do we want to understand what the client knows?
2. We use open and closed-ended questions to find out what the client understands. What is the difference between open and closed-ended questions?
3. Let's think of some examples of open-ended questions we could ask.
4. List some possible closed-ended questions and situations where you would use them.
5. When do we want to use open-ended questions?

Activity: Role-play step 1 and 2, GREET and UNDERSTAND

Character Cards

The participants will divide themselves into three groups. Each person in the group will be provided with a card that describes the character of a client. Each participant in the group will take a turn at being the client described on their card as one of the group members acts as counsellor and the other acts as observer. The counsellor will practice greeting the client and understanding from the client using open-ended questions. The client will have specific instructions not to respond unless they feel comfortable and only when the questions asked are open-ended. The observer observes the interaction between client and counsellor and provides feedback.

Discussion and Rationale

A general introduction to GUIDE and a more detailed discussion of the first two steps forms the major content of this session. The bulk of the session is devoted to recognition of the distinction between open-ended and

closed-ended questions and their appropriate use in a counselling situation. The goal of the activity was for the participants to practice greeting clients and practice using and identifying open-ended versus closed-ended questions. The person that takes the role of the client has information he/she is free to reveal only after he/she has been greeted warmly and when open-ended questions are asked. Other information can be divulged when closed-ended questions are asked.

Input from Expert Judges

On the issue of securing a private place in the health centres for counselling, the author was concerned this may not be feasible in the clinic settings. The CIDA Project nurses assured me that even the most congested clinic, Kariobangi, would be able to designate space for private sessions.

Session Implementation

The participants had no difficulty identifying ways and places in their clinic environments where they could ensure privacy with their client. They suggested that a room in each clinic could be set aside with a sign on the door for no interruptions. They also suggested that a place outside under a tree would be an option for a private conversation. They also suggested that if clients did not live too far from the clinic, they could be asked to come back to the clinic in the afternoon when the health centre was not as crowded.

The activity in this session to practice Steps 1 and 2 of GUIDE using character cards was not well understood by the group. Some of the groups shared all of their individual character information with each other prior to role playing while other groups recognized the roles of counsellor and client well but not the role the observer was to play in arbitrating whether a particular question was closed-ended or open-ended. In future workshops it would be helpful for the facilitators to demonstrate first how the activity is done. More discussion as a total group about the distinctions between open-ended and closed-ended questions would also be beneficial.

Step 2 'Understand what the client knows about STDs' was interpreted by the participants to mean "What does the client understand about the clinical manifestations of STDs?" For example, counsellors would ask the client for the symptoms of syphilis. The facilitators explained to small groups during the activity that Step 2 was to focus on what the client understood about preventing STDs. Despite that, most participants continued to ask for clinical signs and symptoms of STDs. This was consistent with their approach to family planning counselling where the client lists the family planning methods they have heard of and the counsellor describes other methods available. This approach was particularly difficult to change. It was discussed later in the sessions on Day 2 and during the practice period in the health centres. On Day 3 of the workshop, following a group discussion of the purpose of Step 2 the step was reworded to read: 'Understand from the client what he/she knows

about preventing STDs'.

1000-1015 TEA

1015-1300 **STEPS 3,4, AND 5**

STEP 3 I **IDENTIFY what the client requires to make a decision to help the client stay healthy.**

In step 2 we gathered information from the client about what the client understands about preventing STDs. Now we must identify any new information the client may need to help him or her practice 'safer sex'.

Activity: Discussion

1. How do people learn?

STEP 4 D **DISCUSS the difficulties the client may have with acting on the decision.**

Information and knowledge do not by themselves lead to behaviour change. Think back to our first session when we looked at preventive practices in our own lives. Many of us knew of preventive practices that we should do in our own lives but for some reason did not. Remember too, that changing sexual behaviours is even more complex than changing other health behaviours.

Each client will have personal life situations that make adopting 'safer sex' practices easier or more difficult to do. Through counselling, the health worker and client discuss the client's personal concerns and problems with practising 'safer sex'.

Activity: Discussion

1. What are the reasons people give for not practising 'safer sex'?

2. How can we help them resolve these difficulties?

Activity: Condom Demonstration

Following a discussion and demonstration by the facilitator on how to apply a condom, the participants will practice condom demonstrations in groups of three. Each participant is given a condom and a banana to use as a demonstration model. Emphasize the fact that a demonstration is not complete until the client returns the demonstration correctly.

STEP 5 E **EVALUATE what the client has learned, ENCOURAGE the client to return for follow-up**

To be sure the client has understood, ask the client to repeat the information to the counsellor. This is also true for instructions about taking medications to treat the STD. If a demonstration has been done, remember the demonstration is not complete until the client returns the demonstration back.

As a counsellor you should feel satisfied if you successfully pass on one piece of new information the client feels he/she can use.

Arrange to see the client again to reinforce the new behaviour and provide new information or support as the client desires.

Activity: Putting GUIDE into Practice

Read the story of Ruth and Zapora in the workbook. As a group we will role-play this situation using the five steps of GUIDE.

Discussion and Rationale

This session introduced the participants to the remaining three steps of GUIDE. This session was based on principles of learning such as: people learn best if new information builds on old information (Brundage and Mackeracher 1980, 99), people can only learn one or two new things in a limited amount of time (Brundage and Mackeracher 1980, 108), and people are more likely to learn something if it reduces individual concern (Brundage and Mackeracher 1980, 102). Factors that motivate individuals changing behaviours such as feeling 'at risk', feeling confident, feeling secure, and having access to supplies was also introduced in this session. Participants were encouraged to refer to their workbook for further reading on motivating factors.

The condom demonstration activity was included as a result of discussions with the nurses prior to the workshop. The nurses revealed they had not had any training even in their family planning workshops in how to use

a condom. The CIDA Project nurses also said that a condom demonstration had not been done in CIDA Project workshops before. The purpose of this activity was to help participants overcome inhibitions they may have in handling condoms and to develop skills in correct condom use.

Input from Expert Judges

One reviewer suggested this session was too long and should be broken into two or three sessions. Concerned with wanting to devote most of the time to practising GUIDE, the author choose not to heed this suggestion.

The CIDA Project felt the condom demonstration exercise was important to include, but was concerned with how the participants would receive the exercise. Lengthy discussion about what to use as a demonstration model took place between the CIDA Project nurses and the author. One concern with using bananas was that this may be considered misuse of good food. The CIDA project nurses did not believe this would be a problem, however. The decision to use bananas was based on the fact that they were readily available.

Session Implementation

The length of the session was a hindrance to learning. There was too much information which the participants were expected to passively receive. However, the condom demonstration activity provided a change that helped keep the participants' attention.

When the condom demonstration exercise was introduced, the participants were reluctant to participate. Tension was eased when the facilitator demonstrated how to apply a condom and reviewed the teaching points that should be included in the demonstration. The participants were given the option of whether or not they would participate in the exercise. Following the demonstration by the facilitator, the group appeared more relaxed and all took part in the exercise. By the end of the exercise, participants were observed examining the condoms carefully and appeared to be quite comfortable handling them. Following this workshop, the CIDA Project staff arranged for wooden models of an erect penis to be made for use in future workshops.

The final activity in this session was a role-play of the GUIDE approach using the discussion borrowed from the Crescent Medical Aid workbook about a counsellor named Ruth and her client Zapora. The counselling session included in the workbook is an example of poor counselling where the counsellor fails to listen to the client. For this session, the participants suggested ways that the counselling session could be improved following the five steps of GUIDE. A useful addition to future workshops would be a role-play of the Ruth and Zapora scenario demonstrating good counselling and using the GUIDE approach.

1300-1400 LUNCH

Session IX **PRACTISING GUIDE**
1400-1530

Objective of session: Participants will feel confident with the five step approach to counselling clients with STDs through role-playing exercises.

Activity: Role-plays in three groups of three
- 1 - client
- 1 - counsellor
- 1 - observer

Every half hour the participants will change roles so that each participant will play each role at least once.

Discussion and Rationale

An adult learning principle identified by Brundage and Mackeracher and others states that adults develop skills by practising the new skill in a non threatening environment (Brundage and Mackeracher 1980, 104). The purpose of dividing the participants into groups of three instead of two was to allow the two facilitators to spend time with each group and to have one of the participants acting as an observer, providing feedback to the two participants involved in the role-play. Given that some participants in the group would be more capable in the skills needed than others, the role of observer would provide participants the opportunity to share their expertise.

Nine case studies were available for the participants to practice. Some of the case situations were adapted from the Crescent Medical Aid Programme and some were developed by the author and Ms Ndiritu. The participants were encouraged to complete as many of the case studies as possible in the time

allotted. Within each thirty minute time period each participant could practice GUIDE with two to three different client situations.

Input from Expert Judges

Case studies for the role-plays were gathered from a variety of sources, including the AIDSTECH workbook, Red Cross materials, CIDA Project materials, and situations that the CIDA Project nurses were aware of from experiences in the health centres. Both AIDSTECH and the Red Cross encouraged use of their materials for this workshop.

Session Implementation

Only ninety minutes were allotted to this session in the curriculum. After the ninety minutes, the participants wanted more opportunities to practice GUIDE with the case studies. The session was extended an additional 150 minutes with a fifteen minute break for tea. The participants were instructed prior to the role-play exercises on the role of the observer. As expected, some participants provided a lot of feedback while they were in the role of observer, while others provided very little feedback to the group members. The role of observer provided the opportunity for the participant to practice identifying "good" and "bad" examples of counselling. When the participant acting as observer felt comfortable with their own skills as counsellor they provided useful feedback to their group members. Participants

who felt less confident in their own counselling skills were less likely to offer feedback to their peers.

Session X **HOW TO KEEP A LOG**
1630-1700

Objective of session: Following the session, participants will be able to properly record a counselling session in the log.

Everyone who works in health care is familiar with keeping reports. Usually we write reports so the City Commission or CIDA Project can know that we are doing our job properly. Keeping a log is similar to a report except that a log keeps track of personal experiences or impressions of a situation. For the next month or so you will keep a log of the counselling sessions you do with clients who have an STD. The log will be a way for us to know how you are doing your job as a counsellor but also it will be a way for you to think about your feelings about counselling people with STDs. The more information you write in the log the more helpful it is to us and maybe the more helpful it will be to you personally. It is like keeping a diary.

Activity:
1. Each participant will be provided with several copies of the counsellor log form. As a group, we will review the counselling session between Ruth and Zapora. This time we will record the relevant information in the log.

2. Over the next few days as you practice using GUIDE in the health centres, we would like you to fill out the log for each person you counsel about preventing STDs. The information you write in the log will be more valuable if you write it immediately after each counselling session. When we meet next week we will review the logs and discuss any difficulties you had with using GUIDE.

Discussion and Rationale

The purpose of keeping a log was to gather information on the nurses' counselling approach with each client. The log provided the counsellor with space to comment on each of the five steps to GUIDE for each counselling session. The form also included a question asking whether a demonstration

was done during the session, and one asking the approximate length in minutes for each session.

Input from Expert Judges

It was suggested by one reviewer that in addition to completing the log forms, the counsellors should be observed in one or two counselling sessions. Data gathered from the observer's records could be used to verify the accuracy of the counsellors' notes for those sessions that were observed. Two of the CIDA Project nurses observed each nurse-counsellor in at least two counselling sessions and recorded their observations on a form similar to the nurses' log.

Session Implementation

Maintaining the log proved to be useful during training to facilitate discussion of individual counselling situations on day three of the workshop. Encouraging the participants to keep a log during the practice days provides a useful tool in training and should be included in future workshops. Despite the heavy work loads experienced by the nurses, they did not express any difficulties with completing the logs.

Over the three work days between Day 2 and Day 3 of the workshop, the participants were encouraged to counsel as many clients with STDs as they could. The sisters in charge at each health centre were aware of this plan in advance of the workshop. The workshop facilitators visited each health centre

each day during the practice period to respond to any questions or concerns the participants had with implementing the GUIDE approach.

DAY 3 - WEEK 2

Session XI 0900-1000 **GROUP REVIEW & PLAN FOR THE DAY**

Activity:

In a group, the participants and facilitators will discuss any problems and concerns encountered during counselling sessions using GUIDE. Participants will be invited to share their experiences over the past few days with counselling clients who have an STD. Each participant will receive feedback from other group members.

Through the discussion, participants will define areas where more learning or practice is needed. Together, the participants and facilitators will plan the schedule for the day.

1000-1015	TEA
1015-1300	OPEN
1300-1400	LUNCH
1400-1515	**HIV/AIDS Discussion**
1515-1530	TEA
1530-1615	OPEN
1615-1700	**WIND-UP and PRESENTATION OF CERTIFICATES**

Discussion and Rationale

The purpose of the sessions on Day 3 was to provide the participants with the opportunity to discuss difficulties encountered while using the five steps of GUIDE to counsel clients about safer sex. The schedule for the day was open for the participants to determine their own agenda based on their personal learning needs. Providing adults with the opportunity to direct their

own learning is an important principle in adult learning (Cranton 1989; Brundage and Mackeracher 1980). Cranton notes that adults are often not self-directing in new situations, with new skills, or if they have no previous experience with self-directed learning (Cranton 1989). She recommends however, that the adult learner be provided with the opportunity in every learning situation to direct his or her own learning agenda (Cranton 1989).

Input from Expert Judges

The idea for the group discussion and open agenda on the last day of training was taken from the Crescent Medical Aid training programme for community based distributors. Facilitators of the Crescent Medical Aid workshop found this to be a valuable approach to training counselling skills.

Session Implementation

The group discussion involved each participant describing one or two of the counselling situations they had encountered over the preceding three days of practice. Discussion involved both a description of the particular situation as well as how the nurse-counsellor responded to the situation. The role of the facilitator for this session was to encourage discussion among the participants. Often one participant's description of a situation prompted other members of the group to describe a similar situation. The group discussion lasted over three hours. From the discussion, the participants identified that they wanted

more information on HIV infection and AIDS and they wanted to complete the session called 'Counselling in Tough Situations' that had been omitted in favour of practising GUIDE using role-plays on Day 2.

It was obvious through observation of the group discussion that the participants felt secure with one another and willing to risk discussing areas where they did not feel competent. Giving the participants the freedom to plan the day's activities worked very well at this stage of the training.

Session XII **HIV/AIDS**

This session gave the participants the opportunity to ask questions about HIV infection or AIDS. Training workshops on STD management provided through the CIDA Project had not included detailed information on HIV or AIDS. Examples of the questions asked by the participants were: What is the difference between HIV infection and AIDS?; Why is it some babies born to HIV positive mothers do not have AIDS?; What happens to a person's immune system when he or she has HIV infection?; Should HIV positive mothers breast feed their infants? The facilitator responded to these questions by providing a brief explanation of the pathophysiology of HIV infection as the virus reproduces in an individual. The author provided most of the leadership for this session with assistance from Dr Elizabeth Ngugi, CIDA Project co-director, who was present to pass out certificates to participants at the end of the last session.

Session XIII **COUNSELLING IN TOUGH SITUATIONS**

Objective of the session: a) Following the session participants will be able to identify personal expressions of stress, b) Participants will discuss as a group experiences with tough counselling situations.

Counselling is hard work.
Counselling takes time.

Activity: Discussion

1. Counselling is hard work and it takes time and energy of the counsellor to do it. Sometimes as counsellors we will feel stress or tiredness with counselling. How does our body tell us when it is feeling stressed?

2. If you identify you are feeling stress you can help relieve the stress by learning how to focus on yourself. This means you concentrate on yourself and the activities that give you pleasure. What are some of the activities you enjoy doing?

You cannot help others unless you have enough energy for yourself. Try to listen to your body and take time for yourself when you need it.

3. The facilitator will invite the participants to share any tough situations in counselling they have had and want to explore with the group.

Discussion and Rationale

Including a session on the signs of stress and strategies to alleviate stress was considered valuable in the Crescent Medical Aid counselling training (Lundeen 1991). The content of this session was taken from the Crescent Medical Aid training workbook produced by AIDSTECH.

Session Implementation

This session was originally scheduled for the afternoon of Day 2. The participants wanted more opportunity to practice GUIDE with case studies

using role-play. It was included on Day 3 at the request of the group.

The discussion of tough situations focused on counselling sessions the participants had with persons newly diagnosed with HIV infection. Two of the health centres had been involved in HIV screening of antenatal mothers and these participants had been asked to counsel the women whose tests were positive. These counselling sessions were particularly difficult because the women had not been counselled prior to the blood test being taken. During discussion of these sessions, participants recommended that more of their colleagues should receive counselling training to reduce the frequency of this kind of situation happening in the future.

Participant Evaluation

Participant were asked to complete an evaluation form at the end of the workshop (see Appendix B). All the participants stated that they achieved their personal learning objectives during the workshop. Four rated the sessions as 'excellent', four felt they were 'good' or 'well done' and four felt the sessions were 'satisfactory'. Answers to the question: What session(s) did you find particularly good? listed many sessions without one being mentioned more than others. To the question: "What session could be improved?" participants answered that they wanted more information on HIV/AIDS and counselling clients and families about HIV infection. All agreed use of the flip chart was helpful to learning, but felt that including films and videos would also facilitate

learning. As an overall recommendation the participants wanted to see more health workers participate in a counselling training workshop.

CHAPTER V

RESULTS

This chapter will present evaluation data on the counselling training programme, the impact of the counselling training programme on the nurses' counselling practices and the impact of STD preventive counselling on client knowledge, attitudes and intention to adopt safer sex behaviours.

The original intent of this study was to carry out an evaluation of STD preventive counselling on knowledge, attitudes and practices of individuals at risk for acquiring a STD. Upon arriving in Kenya it became apparent that training health workers in counselling skills was necessary before an evaluation of the impact of counselling on clients was possible. The emphasis in the study shifted to the design and implementation of a training programme in counselling skills. With the need to develop a training programme in counselling skills, evaluation of the design and content of the training programme became

a necessary component of this study.

Evaluation of health education efforts can be classified into three interrelated levels of evaluation. Green and Kreuter (1991) classify programme evaluation into three categories: process, impact, and outcome evaluation. Green and Kreuter (1991) state that process evaluation is useful during programme development to suggest ways to improve the design and operation of the programme. Impact evaluation assesses the immediate effect of the programme on target behaviours (Green and Kreuter 1991). Outcome evaluation according to Green and Kreuter (1991) measures health status and quality-of-life indicators or longer term effects of a health programme.

The counselling training programme developed in this study was evaluated at two levels, process evaluation of the design and content of the training programme and impact evaluation of the effects of the training programme on the participants' counselling behaviours. While an evaluation of the impact of a one-to-one counselling session on clients' knowledge, attitudes, and behaviours was not carried out in this study, a pre-post test of general knowledge, attitudes and behaviours before and immediately following counselling was done. This test was not matched to the content of the counselling session therefore, it is not possible to attribute any changes solely to the counselling session.

First, this chapter will present data from evaluation of the design and content of the training programme. Second, the data gathered to evaluate the

impact of the training programme on the nurse participants counselling behaviours will be presented. Third, the data collected from health centre clients through pre and post-counselling questionnaires on client knowledge, attitudes and intended practices will be presented.

Process Evaluation: Training Programme

Lewy (1977) identifies three sources of data for process evaluation of a new programme: judgmental evidence by experts on programme content and methodology, data from observations of the teaching-learning situations, and student opinions, observations and reactions. In this study, feedback from local experts involved in training programmes for prevention of STDs and AIDS was sought and incorporated during the development of the training programme in counselling skills. Data on the teaching-learning situations were gathered through observations by the researcher during the programme implementation. Participant feedback on the programme content and instructional methods was gathered through a participant evaluation form completed at the end of each programme day.

Feedback received from expert judges is described in detail in Chapter 4. In summary, feedback from the expert reviewers was favourable towards the goals and objectives of the counselling training programme. Criticisms of the training programme were content specific and the content was modified prior

to the training workshop according to the recommendations of the reviewers.

Data from the author's observations of the teaching-learning strategies during implementation of the training programme also are described in detail in Chapter 4. In summary, the design of the training programme which emphasized skill practice and learning in small groups and within the larger group worked very well. Although most of the training programme worked as intended, more emphasis on basic communication skills and the opportunity to observe good counselling skills in practice would be valuable additions to future counselling training programmes.

Data from participant evaluations are presented in Table 1.

Table 1. Participant feedback on programme design and content (N = 13)

		Day	1	2	3
1. Level of presentation		Appropriate	12	11	2
		Too technical	0	0	0
		Too simple	1	2	1
2. Manner of presentation		Clear	13	13	13
		Confusing	0	0	0
3. Programme content was:		Clear	13	13	13
		Confusing	0	0	0
4. The content was:		New	4	4	8
		Some old/Some new	9	9	5
5. Content to be added to programme?		None specified			
6. Content to omit?		None specified			
7. Suggested audiovisual aids:		Posters	4	0	0
		Slides	2	0	0
		Video	1	1	0
		Pamphlets	1	0	0
8. Content presentation interesting					
		Strongly agree	7	7	8
		Agree	6	6	5
		Disagree	0	0	0
9. Presenter elicited questions					
		Strongly agree	9	8	9
		Agree	4	4	4
		Disagree	0	1	0
10. Content useful to me		Strongly agree	10	12	13
		Agree	3	1	0
		Disagree	0	0	0

In summary, feedback from the participants was favourable towards the content and format of the training programme. Many participants felt that other audiovisual aids such as videos or films would be valuable additions to the training programme.

Impact Evaluation: Nurses Counselling Behaviours

To assess the effect of the training programme on the counselling practices of the nurse participants, data were gathered via: (1) logs completed by every counsellor for each client counselled; and (2) observations by CIDA Project staff nurses of two counselling sessions per counsellor. The author did not observe any of the counselling sessions as they were conducted in Kiswahili, the local language.

The format of the log record followed the five steps of GUIDE. The nurse counsellors were asked to record the content of the counselling session and comment on what went well during the session and on what they would do differently. (See Log Data Form, Appendix C).

The format of the CIDA Project nurses' observer record was similar to the format for the log data and followed the five steps of GUIDE. The observer record divided each step of GUIDE into the skills associated with each step. The observer recorded whether each skill was present in the counsellors' approach to the client. (See Observer Notes Form, Appendix D).

Log Data

The original intention of the log was to provide an avenue for the nurse counsellors to analyze their own counselling behaviour during a counselling session and comment on the usefulness of the GUIDE approach. The type of information recorded by the nurse counsellors however, listed their actions for each step of the process. This information suggests the nurses followed the GUIDE process as outlined during the workshop. The log data cannot be used as indicators of behaviour change in the nurses' counselling practice since the format of the Log Data form provided the counsellor with prompts which may have reminded the counsellor of the five steps to counselling and thus triggered behaviour.

The log was useful for analysis of the nurse counsellors' interpretation of each step in GUIDE. Review of the log data during the practice days between day two and three of the training programme revealed that the nurses interpreted step two, 'Understand from each client what they know about STDs', as a step to find out from each client their knowledge of clinical signs and symptoms of STDs. The purpose of this step was to gain an understanding of the client's level of knowledge about how to prevent an STD. The log indicated further clarification was required. Step two was discussed during the group discussion on day three of the programme. Through discussions with the nurse counsellors, step two was reworded to read, 'Understand what the client knows about preventing STDs'. This change

clarified for the nurse counsellors the kind of information they should seek from the client.

Two items on the log forms indicate changes in the nurses' counselling practice. An item asking the nurse to indicate whether a demonstration was done during the counselling session and an item asking the nurses to indicate the length of time for each session provided an indication of a change in the nurses' counselling practices. Analysis of the demonstration item reveals 54% of the 90 individuals (49/90) who received counselling through the study participated in a demonstration of how to use a condom. Prior to the counselling workshop, the nurse counsellors reported that they had never before carried out a condom demonstration with a client.

Condom demonstration according to the GUIDE approach falls under step D: "Discuss any difficulties the client may have with acting on the decision to practice safer sex". The nurse counsellor would ask the client if he/she knew how to use a condom. If the client did not know how to use a condom but considered using one to prevent the spread of STDs, the nurse would demonstrate how to apply, remove and dispose of a condom and then ask the client to repeat the demonstration.

Other information derived from the log is the time spent in each counselling session. Baseline data from interviews with the nurses prior to training indicated the average time spent counselling persons on preventing STDs was 3 to 5 minutes. According to the log, the average length of time

spent with each client in counselling during the study period was 18.5 minutes (standard deviation 7.8 minutes). The range of time among the ninety counselling sessions was between 7 and 45 minutes. The length of each counselling session was at the discretion of the nurse counsellor in conjunction with the client. At no point in the training was direction given as to a specific period of time required to counsel clients.

All but one of the response items on the log data form were completed by the nurse counsellors for each client counselled. The one item that was not always completed was the question: What difficulties did the client say he/she had with practising safer sex?. Six of the nine nurses counselling clients completed this response item for each client. The other three nurse counsellors did not complete this item for each client. One nurse responded to this question for six of the ten clients counselled, one nurse responded for four of the ten clients counselled and one nurse responded to this item in only three of the ten clients counselled. These three nurses all worked at the same community health centre.

The item on the log that pertains to identifying a client's perceived difficulties in practising safer sex is a key element in understanding and thereby practising effective counselling techniques. The essential difference between instructing a client on how to practice safer sex versus counselling a client on practising safer sex is the ability of the nurse to relate the safer sex information in the context of the clients' day-to-day life. The fact that three of the nurse

counsellors failed to respond to the question identifying client difficulties with practising safer sex may indicate these nurse counsellors did not explore the implications of practising safer sex with the client.

Data from Observations by CIDA Project Staff Nurses

Two CIDA Project staff nurses observed each nurse counsellor in at least two counselling sessions and recorded their observations on a form similar to the format of the nurses' log. The observer data indicate the nurse counsellors followed the GUIDE process in counselling clients and demonstrated the skills introduced through the counselling training programme. The observer data verify whether a demonstration was done during the session and whether the client was asked to return the demonstration to the nurse. The observer data also verify the length of the counselling session. However, the observer data do not include any information on the client's perceived difficulties with practising safer sex. (The observer forms had space for the observer to record the client's perceived difficulties but due to shortage of time, the observers did not record this information.)

The strength of agreement between the log data and the observer data was calculated for the demonstration item and the length of the counselling session in minutes. For the demonstration item there was 83.3% agreement between the counsellor's response and the observer's response. For the item

on the length of time for the counselling session, there was 77.8% agreement between the counsellor and the observer. (In calculating agreement for the time item, a difference of five minutes or less was considered as agreement whereas a difference in response greater than five minutes was considered disagreement.)

Summary of Impact Data of Training Programme on Nurses Counselling Practices

In summary, data from logs completed by the nurse counsellors indicated the nurses were using GUIDE in their practice in most cases. One item regarding the client's perceived difficulties in practising safer sex was not always recorded by three of the nurses involved in this study, which suggests that the distinction between instructing versus counselling clients may not have been well understood or the step omitted all together by these three nurses.

The data from the logs indicate that condom demonstrations were done in 54% of the counselling sessions included in this study. The fact that the nurse counsellors had never done a condom demonstration with a client prior to this study indicates a significant change in these nurses' practices. The log data also indicate the nurse counsellors took more time counselling clients after the training programme. Prior to the training programme, the nurse counsellors indicated they spent from 3 to 5 minutes counselling an STD client. (The nurses

were asked to estimate how much time they spent counselling a STD client. All nine nurses stated 3 to 5 minutes.) Following training, the nurses spent on average 18.5 minutes counselling STD clients. From the client's perspective this may be viewed positively, whereas from the perspective of the management of the health centre the additional time spent counselling may be viewed negatively as it will reduce the number of clients the nurse may see in a day.

The data collected through observations of the counsellors by CIDA Project nurses indicate the counsellors demonstrated most of the skills introduced through the counselling training programme during the observed sessions. Through calculations for two items on the log and observer forms, agreement between the counsellor's record and observer's record was close to 80%.

Client Knowledge, Attitudes and Practices

Client knowledge, attitudes and practices were examined using pre-post counselling questionnaires including items on STDs, AIDS, and sexual behaviours administered by fourth year medical students who had previous experience as interviewers for the CIDA Project (See Pre/Post Questionnaire, Appendix E). The items for the questionnaire were taken from questionnaires developed for other KAP surveys carried out by the CIDA Project. Items were

selected if they appeared in more than one questionnaire previously and if the item dealt with information likely to be addressed in a counselling session, for example how STDs/HIV are transmitted, methods of personal protection, and commonly held myths about STDs/AIDS.

The questionnaire was reviewed by several individuals with expertise in the area (see List of Reviewers, Appendix F) and items added or eliminated according to their suggestions. The questionnaire was translated into Kiswahili, one of the official languages of Kenya, and translated back into English to verify the translation.

The questionnaire was pre-tested twice. The first pre-tests were done by nurses working in clinics where individuals with STDs and AIDS receive counselling. The pre-tests were carried out in Kiswahili with clients who were diagnosed with an STD. Through this pre-test, the researcher learned that the questionnaire took approximately 20 minutes to administer and that the majority of questions were well understood. Determining whether a question was well understood was based on responses elicited by open ended questions and feedback from the interviewers involved in administering the pre-test. Questions that were poorly understood were revised, translated into Kiswahili and back into English. The second pre-test was carried out

by the three medical students hired to administer the questionnaires in the health centres where the study was to take place. The medical students had previous experience with administering questionnaires pertaining to sexual

practices. From this second pre-test, questions that remained poorly understood were eliminated.

The items selected were considered adequate based on the fact that most of the questions had been used by the CIDA Project in previous surveys, the opinion of expert judges, and information gathered through pre-testing the questionnaire. The questionnaire items were not psychometrically validated, nor was their reliability assessed. It also should be noted, that the questionnaire was not matched to the content presented in the counselling sessions. Therefore, not all the changes in knowledge, attitudes, and behaviours can be attributed to the counselling session.

Procedures

Persons who were at least 18 years of age and who presented to one of the three health centres with an STD between February 12, 1992 and February 26, 1992 were invited to participate in the study. A consent form, which explained the nature of the study and the expectations for the clients, was read to each client by an interviewer and any concerns or questions the client had about the study were addressed by the interviewer. After the client signed the consent form, the interviewer administered the pre-counselling questionnaire. Information on client's knowledge, attitudes, current sexual behaviours, and demographic information was gathered during the pre-counselling questionnaire.

Immediately following the counselling session, the interviewer administered the post-counselling questionnaire which included the same knowledge and attitude questions as the pre-counselling questionnaire as well as a question about what the client planned to do in the future to prevent another STD.

Characteristics of the Sample

Ninety people were enroled in the study 41 males (45.6%) and 49 females (54.4%). One person (male) refused to participate in the study. The client who refused to participate subsequently received counselling by one of the counsellors in training. The sample ranged in age from 19 to 45 years; the mean age was 25. Fifty-one per cent were married; 48.9% were single, separated or widowed. Forty-four per cent of males were married whereas, 57% of females were married. Of the total sample, 85.5% had completed at least primary school and 25.5% had completed secondary school. Fifty-two per cent of the sample reported paid employment.

The fact that the proportion of males to females is not equal may be a sampling artifact or due to the fact that women are more likely to seek treatment at a public health clinic than men. A household survey a month prior to this study in the same geographic area found that women were more likely to seek treatment through the public health sector than men. Men were more likely to seek treatment from the private health sector (Moses and others 1992, in press).

Data From Pre/Post Questionnaires

The number of clients who responded correctly to knowledge questions on the pre and post counselling session questionnaires is summarized in Table 2.

Table 2. Frequency of correct responses to knowledge questions by pre and post-counselling (n = 90)

Item	Pre (%)	Post (%)
1. AIDS is a type of STD	85 (94)	89 (99)
2. Children can contract STDs from mother before birth	80 (89)	86 (96)
3. You can get STDs from public toilets	28 (31)	39 (43)
4. Insects such as mosquitos can transmit AIDS virus	41 (46)	46 (51)
5. Using birth control pill can prevent infection from a STD	50 (56)	61 (68)
6. People who look clean cannot have STD/AIDS	72 (80)	83 (92)
7. You can know if a person has an STD by looking at them	78 (87)	79 (88)
8. A person with AIDS can look healthy	34 (38)	30 (33)
9. You can catch STD/AIDS through touching someone with AIDS/STD	70 (78)	73 (81)
10. You can catch STD/AIDS by kissing someone with STD or AIDS	43 (48)	50 (56)
11. You can catch STD/AIDS by re-using needles for injection	56 (62)	56 (62)
12. You can catch STD/AIDS by sharing food or utensils with infected person	3 (3)	3 (3)
13. You can catch STD/AIDS by having sex with prostitutes	90 (100)	89 (99)
14. You can catch STD/AIDS by having sex with many people	87 (97)	88 (99)
15. You can catch STD/AIDS by sharing razors or circumcision knives	76 (84)	83 (98)
16. You can catch STD/AIDS by having sex with someone who has AIDS or STDs	89 (99)	89 (99)
17. You can catch STD/AIDS by having sex with someone who looks healthy	58 (64)	64 (71)

As is evident from Table 2, knowledge about STDs and AIDS in this sample was high prior to counselling. It is interesting to note the items on the questionnaires that showed some increase (more than 5%) between pre and post counselling. Items 2, 3, 5, 6, 10, 15, and 17 show an increase in correct responses in the post counselling responses compared to the pre counselling responses. The information represented by these items may have been discussed during the counselling sessions and therefore may have resulted in the higher values. The items that did not change appreciably between pre and post counselling may not have been discussed during the counselling session.

Many of the low scoring knowledge questions on the pre counselling questionnaire refer to common myths, for example, that HIV is transmitted via mosquitos (41%), STDs are transmitted via toilet seats (31%), STDs and HIV are transmitted by kissing (48%), and STDs and HIV can be transmitted by sharing food utensils (3%). Knowledge that a person infected with an STD or AIDS can look healthy was not well known in this sample (e.g, only 38% of the sample responded correctly this item on pre-test and 33% on post-test).

Only modest differences between knowledge levels at pre counselling verses post counselling are evident. This may be due to a 'ceiling effect' that is, knowledge about STDs and AIDS in the sample was relatively high to begin with, (with the exception of common myths discussed previously); therefore large changes in knowledge are unlikely after such a brief counselling session.

The fact that a few knowledge items increased between pre and post

counselling may be because this information was discussed during the counselling session while knowledge items that did not change appreciably between pre and post-counselling were not addressed during the counselling session. It is reasonable to assume that the nurse counsellors did not address all the information pertaining to STD and HIV transmission referred to in the knowledge questions in a brief, 20 minute counselling session. If more detail about what was actually discussed during the counselling session was included on the nurse counsellors' log data form, changes in knowledge between pre and post-counselling could have been assessed in relation to what was actually discussed.

The fact that the pre and post counselling questionnaires were administered with only a brief time span in between may have resulted in the client becoming sensitized to the questions and therefore influence their responses.

Attitudes are abstract constructs and therefore difficult to measure. Henerson, Lyons Morris and Taylor Fitz-Gibbon state that "attempting to measure attitude change is probably the most difficult of all evaluation tasks" (Henerson, Lyons Morris and Taylor Fitz-Gibbon 1987, 11). These authors caution that when measuring attitudes one must rely on "inference" since it is impossible to measure attitudes directly; there is no guarantee that the attitude being assessed will "stand still" long enough for a one time measure to be reliable. When attitudes are studied, we do so without universal agreement on

their nature (Henerson, Lyons Morris, and Taylor Fitz-Gibbon 1987, 13). For these reasons, the authors warn against measuring attitudes of individuals but suggest that measuring attitudes within a group of people can provide useful information about prevailing attitudes in a group. Attitudes are often influenced by circumstances. Many of the attitudinal questions included on the questionnaire were formatted with forced responses, e.g., "agree"/"disagree", "yes"/"no". With this format there was no opportunity for clients to respond within a particular context or set of circumstances. When there is no opportunity for the client to respond to a question within specific circumstances, the client may choose the response they believe is the prevailing attitude in the community when their own attitude is not represented in the responses.

Table 3 provides a summary of responses to questions that may be considered primarily attitudinal. The separation of questions into knowledge verses attitude is somewhat artificial. Responses gathered through these questionnaires may reflect personal attitudes or they may reflect knowledge of prevailing attitudes.

Table 3. Frequency of responses to attitude question by pre and post-counselling (n = 90)

	Pre-Counselling			Post-Counselling		
	Agree	Dis-agree	Don't know	Agree	Dis-agree	Don't know
1. AIDS is not as big a problem as media say it is	13 14%	75 83%	2 2%	12 13%	77 86%	1 1%
2. I would be embarrassed to come to the health centre to ask for condoms	25 28%	65 72%	0	26 29%	62 69%	2 2%
3. I am worried about getting AIDS	80 89%	9 10%	1 1%	80 89%	8 9%	2 2%
4. Condoms get in the way of good sex	46 51%	30 33%	14 16%	37 41%	41 46%	12 13%
5. Some people will get AIDS no matter what they do	36 40%	42 47%	12 13%	36 40%	45 50%	9 10%

Table 3. continued

	Pre-Counselling				Post-Counselling			
	Agree	Maybe	Maybe not	Dis-agree	Agree	Maybe	Maybe not	Dis-agree
6. I would feel embarrassed to ask my partner to use a condom	16 18%	6 7%	31 34%	37 41%	17 19%	6 7%	30 33%	37 41%
7. I trust my partner is having sex with only me	33 37%	7 8%	18 20%	32 36%	34 38%	7 8%	24 27%	25 28%
8. Many people are changing sexual habits because of STDs	74 82%	8 9%	8 9%	0	84 93%	3 3%	2 2%	1 1%
9. If I don't protect myself there really is a chance I could get AIDS	82 91%	4 4%	3 3%	1 1%	88 98%	1 1%	1 1%	0
10. Having one committed partner is important to me	84 93%	3 3%	3 3%	0	89 99%	0	1 1%	0
11. If my partner is having sex with other people he/she should tell me	78 87%	5 6%	4 4%	3 3%	80 89%	1 1%	5 6%	4 4%

Little differences are noted in responses to the attitude questions between the pre and post counselling questionnaires. A smaller number of clients agreed that condoms reduce sexual pleasure post-counselling than had agreed to that statement prior to the counselling session. For the item on the need to protect oneself to avoid contracting AIDS, more clients responded with the "strongly agree" option post-counselling compared to pre-counselling. However, responses to the statements that may be considered a reflection of attitudes, changed little if at all between the pre and post-counselling sessions. This may be due to the fact that attitudes are formed over a period of time and therefore not easily altered by a brief intervention such as the counselling intervention in this study.

Sexual Practices

Data gathered during the pre-counselling questionnaire on sexual practices are summarized in Tables 4 and 5.

Table 4. Number of sex partners per month by gender

Number of partners per month	N	0	1	2-5	6-10	10+
Males	40	2 (5%)	18 (45%)	19 (48%)	1 (2%)	0
Females	49	4 (8%)	34 (69%)	10 (20%)	0	1 (2%)
Total	89	6	52	29	1	1

Table 5. Prior use of condoms to prevent STDs by sex

	N	Yes	No
Males	41	23 (56%)	18 (44%)
Females	49	11 (22%)	38 (78%)

The information gathered on sexual practices found 50% of the males reported having more than one sexual partner in the past four weeks whereas 22% of the women reported more than one sexual partner in the same time period. Out of the total sample, only one woman reported more than 10 sexual partners in the last one month. Fifty-six per cent of men reported they had used a condom sometime in the last month to prevent an STD whereas only 22% of the women reported use of a condom to prevent an STD.

To assess individual clients' intentions to practice safer sex after the counselling session, clients were asked the open ended question in the post

counselling questionnaire: "What do you plan to do now to prevent another STD infection?". Responses to the open ended question on current sexual practices are summarized in Table 6. Data summarizing responses to the post counselling questionnaire regarding intention to protect self from further infection are summarized in Table 7.

The procedure used to summarize responses to open ended questions involved first grouping similar responses together and designating a category for each set of similar responses. For example, for the question "How are STDs transmitted?", five different categories of responses were derived from the statements given by the clients: (1) STDs are spread through sexual contact; (2) STDs are spread through casual contact such as sharing common items; (3) STDs are spread by insects; (4) STDs are spread through blood and skin piercing instruments; (5) Other than above. Two separate individuals working with the ungrouped data were asked to assign each response to one of the five categories. Agreement between the two individuals in placement of responses among the five categories was then analyzed. The two lists of categories were compared for similar placement of responses. Similarity of categorization of responses greater than 80% was considered adequate for summary purposes.

Table 6. Current safer sex practices
(Clients may have given more than one response)

	Frequency of response	
	Total	Male/Female
Limit self to one sex partner	35	13/22
Use condoms	20	16/4
"Nothing"	26	8/18
Limit the number of sex partners (through careful selection)	19	14/5
Other than above	1	1/0

Table 7. Intended practices to prevent reinfection
(Clients may have given more than one response)

	Frequency of response	
	Total	Male/Female
Communicate with sex partner	17	2/15
Use condoms	49	29/20
Limit self to one sex partner	49	25/24
Limit number of sex partners (through careful selection)	15	12/3
Other than above	12	6/6

The number of clients responding they had done "nothing" to protect

themselves from STDs (26) is relatively high but not surprising given that everyone included in this sample had been diagnosed with an STD prior to entering the study. The number of responses indicating they have sex with only one person (35) may be a reflection of partnerships where one partner is faithful to the relationship and the sexual partner is not. The response "use condoms" was given predominantly by males (80%). Responses categorized as "Limit self to one sex partner" included statements by clients that indicated they had sex with a single sex partner or a spouse as a means to reduce chance of acquiring a STD. For responses included in the category "Limit the number of sex partners (through careful selection)" clients had stated methods such as 'choose sexual partners carefully', 'don't have sex with girls in bars', 'choose partners who are clean looking'. The distinction between these two categories is whether the client stated the importance of having sex with only one partner or emphasized care in choosing a partner who would be unlikely to have an STD or HIV infection. Table 7 shows the frequency of responses to the question on the post-counselling questionnaire "What do you plan to do now to prevent another STD?". Seventeen people responded they would 'communicate with sex partner' as a method to prevent another STD. Fifteen women responded they would talk to partner whereas only two men gave this response. The intention to use condoms and limit sex partners to one were responses given by more than half of the study sample. Examples of the responses included in "Other than above" included 'don't know', 'limit beer

intake', 'bring husband to clinic for treatment', and 'use capsules for prophylaxis'.

The differences between the responses given by males verses females provides some interesting information. Many more women (22/49, 45%) than men (13/41, 32%) indicated pre- counselling that they protect themselves by limiting themselves to one sex partner. Post-counselling, the number of men who stated that they planned to limit themselves to one sex partner increased to (25/41, 61%) while the number of women giving this responses stayed relatively constant (24/49, 49%). The number of men reporting condom use as a prevention strategy (16, 80%) pre-counselling as compared with the number of women (4, 20%) is not surprising given that condoms that are available are designed to be used by men and men typically control whether or not condoms will be used. However, it is interesting to note the number of women who indicated on the post-counselling questionnaire (20, 41%) their intention to use condoms, and the increase in the number of men who stated post-counselling that they intended to use condoms. Instructing both men and women on the proper use of condoms may be an important aspect to counselling.

In comparing responses in Table 6 and Table 7, communication with sex partner emerges as a new response post-counselling while the response, "nothing" does not occur post-counselling. During the counselling training workshop, the importance of couples communicating with each other about

safer sex practices was emphasized. The emergence of "communicate with sex partner" post-counselling indicates the importance of communicating with one's sex partner was likely discussed during the counselling session. Use of condoms and limiting self to one sex partner were more frequent responses in the post-counselling questionnaire. Overall, clients gave more responses to the question "What do you plan to do to prevent another STD?" (142) than they did to the pre-counselling question "What do you do now to protect yourself from getting an STD?" (101) which may indicate clients at least heard the nurse's recommendations for safer sex practices. The responses do not however, give any indication about actual change in sexual practices.

Impact Data: One Month Follow Up of a Sample of Counselled Clients

To assess actual changes in sexual practices relative to stated intentions, 36 clients were randomly selected to return to the health centre on a specific date approximately one month following their initial counselling session to complete a questionnaire containing many of the knowledge and attitude questions on the pre and post-counselling questionnaires and questions about whether or not they were able to carry out their intentions to practice safer sex. The one month follow-up questionnaire also asked people to comment on what they remembered from the counselling session and what they thought health

workers could do to help people avoid getting a STD.

Follow up of clients who received counselling one month later was not successful despite monetary incentives to return for follow-up and several attempts to locate clients through their stated address or phone number. Of the thirty-six, only four clients returned to complete the final questionnaire. As an incentive, each client invited to return for follow-up was offered 100 Kenyan shillings (the equivalent of two days pay for the average labourer). One of the reasons for the low response was poor communication about which health centre the client was to return to. The envelopes containing the invitation to return for a follow-up assessment were mis-coded and therefore handed out to clients at the wrong health centre at the completion of the post counselling questionnaire. As a result, clients were asked to go to a health centre other than the centre at which they were seen originally. All three health centres were in the same section of the city but not readily accessible by public transport routes. Distance to travel and poor access to public transport to the designated health centre no doubt contributed to the low response rate. The researcher also learned that some clients had returned to the health centre on dates other than those indicated by the letter. Unfortunately, no record was kept of these individuals nor did they receive any clarification by the health centre staff at the time. Where an address or phone number was included in the demographic data for the client the researcher attempted to find several of the clients who failed to return for follow-up. All attempts to locate the

individuals by telephone or going directly to the home or place of work were unsuccessful. It appeared many of the addresses and phone numbers were inaccurate.

In the follow-up questionnaire, clients were reminded what they said during the post counselling questionnaire and asked whether these behaviours were indeed what they tried to do to avoid another STD infection. They were then asked if there were some aspects of these behaviours that were difficult to carry out and some aspects that were easier. All four clients who responded to the follow-up questionnaire indicated no difficulty in carrying out the behaviours as intended.

Clients responding to the follow-up questionnaire were also asked what they felt health workers could do to help people prevent STDs. The most common response encouraged health workers to provide educational seminars to people about STDs at health centres, schools and workplaces on safer sex practices.

Summary of Impact Data of Counselling on Client Knowledge, Attitudes and Practices

The data gathered to measure the impact of counselling practices relied on self report responses to pre and post-counselling and follow-up questionnaires.

The data indicate that there were slight increases in knowledge for some of the questions following the counselling session. Many knowledge questions and most of the questions related to attitudes showed no change pre- to post-counselling.

The responses to open ended questions regarding current safer sex practices and intention to adopt preventive sexual behaviours post counselling show an increase in the number of people intending to use condoms and limiting the number of sexual partners to one. Communicating with the sex partner was cited by many women as a mechanism to reduce risk of reinfection.

It appears from the data that counsellors were advising clients about safer sex practices and the importance of communicating with sex partners. It also appears many clients were able to recall safer sex messages immediately following the counselling session. This study was not able to assess clients' long term recall for these safer sex messages. Again, it is important to note, the impact of counselling on client's knowledge, attitudes and practices was limited because the pre-post counselling questionnaire was not specifically matched to and linked to actually what occurred in the counselling sessions.

CHAPTER VI

DISCUSSION AND CONCLUSIONS

This study involved two major components: (1) the development of a training programme for nurses in STD preventive counselling skills and assessment of the nurses acquisition of these skills and, (2) an evaluation of the impact of a brief counselling intervention on STD clients' knowledge, attitudes and intention to practice safer sex behaviours. The two study components will be discussed separately in this chapter followed by a discussion of the implications of the results of this study on future research in the area.

Development and Evaluation of Counselling Skills Training Programme

The process used to develop the counselling skills training programme involved observations and discussions with nurses in the health centres, discussions with persons in Nairobi who had expertise in the area of counselling training programme development and participation by the author in a counselling training programme.

Through discussions with the nurses in their work settings, the author learned that nurses considered counselling an integral part of their work but felt they lacked the skills to counsel clients properly. The nurses viewed counselling as an important aspect to their work in STD management, medication compliance, maternal health and family planning. Through observations of nurses counselling clients it appeared that nurses provided information to their client with little opportunity for the client to ask questions or contribute to the interaction.

From these discussions and observations, the author concluded a training program which (1) encouraged nurses to determine what clients knew and felt about different safer sex strategies and (2) provided nurses with skills to help clients choose to practice safer sex was needed.

The author met with persons involved in developing counselling training programmes for health workers. Two distinct approaches to counselling

training were evident. One approach involved exposing the health worker to concepts and principles employed by professional psychologists in counselling. The other approach emphasized training health workers in communication skills. The two different approaches reflected the professional training of the people responsible for developing the programmes. In the author's opinion the training programmes that emphasized the concepts and principles employed by professional psychologists succeeded in describing what counsellors can do but failed to develop basic skills for participants to use as counsellors. The training programmes that emphasized communication skills did not include principles of adult education. Therefore, none of the programmes already developed appeared suitable for the community health nurses targeted in this study.

The author participated in a counselling training programme offered by the Kenyan Red Cross for physicians. The Red Cross programme provided participants with up to date information on the epidemiology of HIV infection in Kenya but provided little opportunity for participants to develop skills to counsel patients who may be infected with the AIDS virus. From this experience the author concluded a training programme that provided opportunities for participants to practice counselling skills through role-plays would be beneficial.

Based on the assessed needs of the nurses, a programme that trained nurses in communication skills and principles of adult education was considered necessary to enhance the ability of these nurses to provide health education to

clients which in this context was termed counselling.

The term counselling is used in a variety of contexts to refer to a number of different activities. Within the prevention and control of STDs and AIDS, counselling has not been clearly defined. In this study, the term counselling was defined as a face-to-face discussion where the counsellor helps the client make a health decision and act on the decision. Based on the specific circumstances of this study, this operational definition of counselling was considered appropriate and attainable.

The training programme developed for this study was reviewed by people in Nairobi with expertise in the area of counselling and STD/HIV prevention and revised according to their feedback.

The training programme was implemented from February 4, 1992 to February 11, 1992. Eleven nurses and one social worker participated in the training workshop. Nine of the nurse participants were involved in evaluation of the impact of the training programme on the nurses' counselling behaviours and measurement of the impact of the counselling intervention on knowledge, attitudes and practices of STD clients.

To evaluate the impact of the counselling training on the nurses' counselling skills each nurse completed a log for each counselling session which outlined key elements in the counselling intervention. In addition, each nurse was observed during at least two counselling sessions and a form completed for each session observed. Evaluation of the counselling training

indicated the nurses integrated much of the content of the training programme into their approach to counselling clients with STDs. Two significant changes in the nurses counselling practices were the time spent with each client and condom demonstrations.

Condom demonstrations were provided to 54% of the STD clients where previously the nurses had never carried out a condom demonstration. The fact that the nurses provided condom demonstrations is significant both because of the change in frequency (from 0 to 54%) and because demonstrating the proper use of a condom involves talking about actions that must be taken during the process of sexual intercourse. A condom demonstration involves discussion of activities that are not often discussed within an intimate relationship and even less often outside an intimate relationship. To initiate a condom demonstration, the nurse needs to feel confident with the skills necessary to carry out a condom demonstration and comfortable with discussing specific components of a sexual encounter.

The second significant change in the nurses' counselling practices was the amount of time spent with each client. The average amount of time each nurse spent with a client following the training was 18.5 minutes where prior to the training a counselling session lasted an average of 3 minutes. In the health centres where these nurses worked, a long line up of people waiting to be seen by the nurse was common. When the average time per counselling session was 3 minutes the nurse could manage the long line of people needing

attention. A counselling session that lasted 18.5 minutes however, would mean that the nurse would not be able to see all the people waiting during normal work hours. The data gathered to assess the impact of the training programme on the nurses' counselling skills indicate the training programme was successful at enhancing the counselling skills in this group of nurses. The success of this programme demonstrates that a three day training programme coupled with work site skills practice was an effective method to train these health workers in counselling skills.

Evaluation of the Impact of Counselling on Client Knowledge, Attitudes and Intentions

The data gathered to measure the impact of the counselling intervention on client knowledge, attitudes and intended practices relied on pre and post-counselling questionnaires.

The counselling intervention in this study was brief and therefore large changes in clients knowledge, attitudes and intended practices were not likely. The purpose of the counselling intervention was to inform clients who were not aware of how to prevent STDs, reinforce the importance of practising safer sex behaviours, and help clients who lacked skills to implement safer sex practices learn the necessary skills. Awareness of safer sex practices was high in this study population prior to the counselling intervention. Modest changes in

knowledge were evident between the pre and post-counselling session questionnaires except with areas of knowledge affected by commonly held myths. Little or no changes in knowledge were evident in questions referring to transmission of STDs through mosquitos, public toilet seats and food utensils. The question on the post-counselling questionnaire designed to measure what clients intended to do to prevent another STD produced responses that parallel safer sex practices. These responses indicated clients heard the recommended methods to prevent STDs but does not give any measure of whether the client would act on the recommendations.

A major drawback to this study was the failure to procure any meaningful data from a random subset of clients one month following the counselling intervention. In the original design of the study, at least 18 clients were expected to complete the follow-up questionnaire, however, only 4 clients returned to complete the questionnaire (out of a possible 36 clients). Errors in communication contributed to an insufficient number of clients returning to complete the follow-up questionnaire. If more data from the one month follow-up questionnaire had been available, valuable qualitative information may have been generated. Information on what the clients remembered from the counselling session, information on actual behaviour changes relative to stated intentions, and perceived barriers to modifying sexual practices would have provided useful information for measuring the impact of the counselling intervention as well as information on factors that motivate or inhibit persons

to change sexual practices.

In attempting to measure the impact of the counselling intervention to modify sexual behaviours, issues of measurement reliability and validity were apparent. The author attempted to enhance the reliability and validity of the measurement tools by using questions developed for other questionnaires on knowledge, attitude and practices related to sexual behaviours. In addition, validity was enhanced by having several people with expertise in the field critique the content and structure of the questionnaires. The instrument was piloted in two centres where persons with STDs including HIV infection received counselling and the instrument was piloted at the health centres where the study took place. The purpose of these pilots was to ensure the questions were understood by clients and the flow of the questionnaire reasonable.

In piloting the questionnaires, clients were administered the questionnaire only once; not prior to and after an intervention as was the method used in the actual study. Had the questionnaires been piloted in a pre and post-intervention manner, the author may have learned that questions about attitudes were not readily altered by a single intervention. Despite the efforts taken to enhance the reliability and validity of the questionnaires, the measurement tools used in this study relied too heavily on quantitative information about STD and AIDS knowledge and attitudes. Knowledge of STDs and AIDS transmission and prevention was high in this population prior to the intervention, therefore, little new information would have been introduced during the counselling session.

Attitudes are influenced largely by culture and community norms. Social change is necessary to change individual attitudes. Counselling can aid the process of social change by encouraging individuals to question prevailing attitudes that are not conducive to health.

A measurement instrument which gathered more qualitative information about clients perceptions about STDs and AIDS pre and post-counselling would have been more useful in this study. Open-ended questions about the client's perceptions of the seriousness of STDs and AIDS in their community, their sense of personal vulnerability to infection and information from the client on the usefulness of the counselling intervention to influence individuals to practice safer sex behaviours may have provided more valuable information on the impact of the counselling intervention. As Willms et al note, "qualitative methods are suited to interpreting the semantics of human experience, the social determinants of cultural meanings, and the processes of individual and social change (Willms and others 1990, p 392).

Implications of Study for Future Research on STD Preventive Counselling

This study was able to demonstrate only modest changes in STD clients knowledge, attitudes or intentions to practice safer sex behaviours following a brief counselling session. There is not sufficient evidence in this study to

recommend counselling as an effective intervention to promote safer sex practices among clients at risk for STDs and HIV. Researchers in the area of HIV counselling recognize there have not, to date, been sufficient research to establish the efficacy of HIV counselling to prevent STDs and AIDS (Carballo and Miller 1989; Bor 1989; Silverman, Perakyla and Bor 1992). Carballo and Miller (1989) suggest the lack of clear definition of HIV counselling is one of the reasons efficacy studies have been delayed. This study was able to demonstrate positive effects of a brief training programme on counselling skills of a group of community health nurses. This study was not able to isolate what characteristics of a counselling intervention are considered important by clients who receive STD preventive counselling. This information from clients is critical to understanding the breadth of skills counsellors need to provide STD preventive counselling.

The World Health Organization's endorsement of counselling to slow the spread of AIDS and provide psychological support for persons affected by AIDS has led a number of agencies in Kenya to develop counselling training programmes. From the literature reviewed for this study and through discussions with persons involved in developing counselling training programmes, there is no consensus on what AIDS preventive counselling should include or what skills persons providing counselling should possess.

Recently preliminary studies have been reported in the literature that examine the effectiveness of a variety of counselling approaches in STD/HIV

prevention (Strader and Beaman 1992; Silverman, Perakyla and Bor 1992). Strader and Beaman (1992) suggest effective counselling to encourage safer sex practices should reinforce clients' attitudes and normative influences. What their research showed, however, was that counsellors most often responded to clients with moralistic messages (Strader and Beaman 1992).

Silverman, Perakyla and Bor (1992) compare different forms of communication used in a counselling session and examine which communication strategy leads to the greatest participation by the client. Their findings suggest an information-delivery format is the easiest form of communication for the counsellor but evokes the least participation on the part of the client. An interview format, where the client is asked to respond to a variety of closed and open-ended questions provides for greater participation on the part of the client and allows the client to offer their own views. The authors argue that gaining the client's point of view leads the counsellor to provide information specifically tailored to the recipient (Silverman, Perakyla and Bor 1992).

More research on the effectiveness of different communication strategies to counsel clients is urgently needed to better understand what skills counsellors should possess. Although the research carried out by Strader, Beaman and Silverman et al provide a necessary first step, research that examines effective communication strategies in counselling from the client's perspective is necessary. A research design based on qualitative methods

could provide insight into clients' experience of counselling interventions and help delineate which approaches are effective and which are not.

A brief counselling intervention in a clinical setting as described in this case study will not alone produce significant changes in sexual practices. A brief one-to-one interaction between a health worker and client may help reinforce for the client the importance of taking actions to prevent an STD infection but will not by itself lead to behaviour change. The fact that sexual behaviours are intensely private, susceptible to the preferences of a sexual partner, and influenced by strong social and cultural mores means that efforts to influence sexual practices need to come from a variety of sources. Coordinated efforts by government, community leaders and community institutions to support social norms conducive to safer sexual practices is required before significant changes in sexual practices are realized.

Counselling could be an effective strategy to helping individuals acquire skills to prevent STDs. Silverman, Perakyla and Bor state that knowledge and fear arousal are generally ineffective at producing behaviour change whereas acquiring skills rather than just knowledge, and peer-group support and pressure are powerful motivators of change in health behaviour (Silverman, Perakyla and Bor 1992, p 69). This study showed that many STD clients lack skills in how to use condoms and nurses can be trained to provide condom demonstrations. Counselling may also indirectly influence peer-support for safer sex practices by reinforcing social norms that are supportive of safer sex practices.

Providing health workers with skills that improve their ability to communicate with clients about sensitive, personal issues and therefore lessen feelings of powerlessness is another important contribution of counselling. The WHO support for counselling may reflect this need for health workers and others who work with persons affected by AIDS to have resources available to them to do something in the face of a horrendous epidemic like AIDS.

In a country like Kenya where infection with STDs and HIV infection is as high as 20% in some populations, it is important that resources are used to fund efficacious, cost effective interventions. Group counselling interventions may be more efficacious and cost effective than one-to-one counselling. Group counselling has the advantage of being able to address many people at one time with one resource person. Interventions with groups may be more effective than individual counselling to influence social factors so that safer sex behaviours become socially sanctioned and normative and risky sexual behaviours socially unacceptable.

Conclusions

Effective interventions to prevent the transmission of STDs, especially viral STDs are urgently needed. One-to-one counselling is purported to be an effective strategy to influence individuals to practices safer sex behaviours yet to date, there is little evidence to support this position.

This study was unable to demonstrate any impact of a brief counselling intervention to influence STD clients to practice safer sex behaviours. This study demonstrated a short training programme for nurses that emphasized communication skills and tailoring preventive messages to clients' stated concerns was considered useful to a group of nurses and led to the nurses spending more time with each client and initiating condom demonstrations with clients.

Further research is needed to evaluate counselling as an intervention to promote safer sex behaviours. Different models of counselling ie. group verses individual counselling, should be evaluated. Research is also needed on the skills counsellors need to address the complexity of sexual behaviours. This research needs to include studies that evaluate counselling strategies from the recipient's perspective. Research in these areas is urgent. If counselling is proven beneficial, the essential ingredients of an effective counselling intervention must be disseminated quickly in both the developing and developed world.

APPENDIX A

BASELINE QUESTIONS FORM

1. How many STD clients would you counsel in one day?

2. How long do you spend counselling a client with STD?

3. If I came to you with an STD, how would you counsel me?

4. What do you hope to learn from the counselling workshop?

5. What do you find difficult about counselling STD clients?

6. What do you remember about communication skills?

7. What do you remember about barriers to communication?

8. What barriers do you find with clients who have STDs?

APPENDIX B

PARTICIPANT EVALUATION FORM

Circle the word that best describes your response to the statement.

1. The session was presented at a level that was

   appropriate too technical too simple

2. The session was presented in a manner that was

   clear confusing

If you circle confusing, please comment:

3. In terms of the most common working situation of the participants, the content included in the session was

   relevant not relevant

If you circle not relevant, please comment:

4. The content presented was

   old new some old/some new

5. What content would you have added to the workshop?

6. What content would you have omitted from the workshop?

7. What audiovisual aids would have helped?

Please circle the word that best describes how you feel.

8. The content was presented in an interesting way.

   strongly agree agree disagree strongly disagree

9. The presenter elicited questions from the group.

strongly agree agree disagree strongly disagree

10. The content will be useful to my work.

strongly agree agree disagree strongly disagree

Please add any additional comments:

APPENDIX C

LOG DATA FORM

For each counselling session you do with a client with a STD please respond to these questions:

Why did the client come to the health centre today?
To be seen in ante natal clinic_____
To be seen for family planning_____
For treatment of a STD_____
For treatment of another problem
but a STD was discovered_____
Follow-up for a STD_____
Other reason, please specify_____

Understand
What did the client know about preventing STDs?

Identify
What was the client's main concern(s)?

Treatment	_____
Pain from STD	_____
Fear of telling partner	_____
Ignorant of STD	_____
Fear of HIV/AIDS	_____
Ignorant of safer sex	_____
Lack of condoms	_____
Takes alcohol or drugs	_____
Other, please specify	_____

Discuss

Did you demonstrate how to use a condom? yes/no

What did you and the client discuss?

- How STDs are transmitted _____
- How HIV/AIDS is transmitted _____
- Safer sex practices:
  - faithful to one partner _____
  - use of condoms _____
  - abstain from sex during treatment _____
  - avoid casual sex partners _____
  - avoid alcohol or drugs _____
- Follow-up of sexual contacts _____
- Other, please specify _____

What difficulties did the client say he/she had with practising safer sex?

- Ignorant about using condoms _____
- Fear of asking partner to use condoms _____
- Wife/Husband lives away from Nairobi _____
- Condoms reduce pleasure in sex _____
- Enjoys many sexual partners _____
- Fear of talking to sex partner _____
- Other, please specify _____

Evaluate

How did you evaluate the client's learning?

- By asking questions of client _____
- By client asking questions of nurse _____
- Asking client to repeat information _____
- Asking client to repeat demonstration _____
- Other, please specify _____

What did the client decide to do to prevent another STD?

How many minutes did the session last? _____ minutes

APPENDIX D

OBSERVER NOTES FORM

Greet

Greet client by name?	y/n
eye contact?	y/n
quiet/private place?	y/n
provide chair for client and self?	y/n
sit next to or opposite client?	y/n

Understand

Use of open ended question? y/n
List open ended question asked.

Knowledge of STDs prevention according to client.
List in order given

Counsellor restate client's statements? y/n

Identify

What was the client's most important concern?

How did the counsellor identify the client's concern?

Discuss

What was the focus of the discussion?

Did the client contribute new information during discussion?
Specify

What teaching aids did the counsellor use?

Was demonstration done?

Evaluate and Encourage

If demonstration done, did client return demonstration?
y/n

Was the return demonstration done correctly? y/n
If no, did the counsellor repeat the demonstration? y/n

Did the counsellor check that new information was understood by the client?
y/n

Did the counsellor plan with the client for follow-up? y/n

Demonstrate Care

Did the counsellor show care for the client? y/n

Information Clear and Correct

Did the counsellor use words understandable by client? y/n
If no, specify.

Was the information given by the counsellor accurate? y/n

Length of session _____ minutes

APPENDIX E

PRE AND POST SESSION QUESTIONNAIRE

Interviewer's Name_____ Health Centre_____

Counsellor Letter _____ Client # _____

I am going to read you some questions; for example, "I need to know a lot more about sexually transmitted diseases". If the statement is the way you feel, say "True", and if you do not feel that way say "False".

1. AIDS is a type of Sexually Transmitted Disease (STD)	True/False
2. Children can contract Sexually Transmitted Diseases from an infected mother before or at birth	True/False
3. You can get STDs from public toilets.	True/False
4. Insects such as mosquitos can transmit the AIDS virus	True/False
5. Using the birth control pill can prevent infection from a STD	True/False
6. AIDS is not as big a problem as the newspapers, radio and TV say it is.	True/False
7. My friends at times make me do things I know I should not do.	True/False
8. I would be embarrassed to come to the health centre to ask for condoms.	True/False
9. I am worried about getting AIDS.	True/False
10. Condoms get in the way of good sex.	True/False
11. Some people will get the AIDS virus no matter what they do.	True/False

12. People who look clean cannot have an STD/AIDS True/False

I will read a question and then a list of possible answers. Please choose one answer.

13. If you were concerned that your partner has a STD do you think you could talk to him/her about using a condom for sex?

1. Yes definitely
2. Yes, I think I could talk to my partner
3. It would depend on the circumstances
4. No

14. Can you know if a person has an STD by looking at them? Yes/No

If the client answers Yes:

14 a) How can you know?

15. Do you think someone who has the AIDS infection can look healthy? Yes/No

16. Please tell me how Sexually Transmitted Diseases are spread?

17. Please tell me how AIDS is spread?

18. Could you catch AIDS or other STDs in these ways? Please answer yes or no.

a. by touching someone who has AIDS or STDs?	y/n/dk
b. by kissing a person with AIDS or STDs?	y/n/dk
c. by re-using needles for injections	y/n/dk
d. by sharing food or utensils with someone who has AIDS	y/n/dk
e. by having sex with prostitutes	y/n/dk
f. by having sex with many people	y/n/dk
g. by sharing razors or circumcision knives	y/n/dk
h. by having sex with someone who has AIDS or STDs	y/n/dk
i. by having sex with someone who looks healthy	y/n/dk

19. After I read the following statements please tell me if you strongly agree with the statement, somehow agree, disagree with the statement or strongly disagree with the statement.

	Strongly Agree	Somehow Agree	Disagree	Strongly Disagree
a. People who wash regularly are less likely to have a STD.	1	2	3	4
b. My partner would reject me if I suggested we use a condom	1	2	3	4
c. Using a condom takes all the fun out of sex for me	1	2	3	4
d. I would feel embarrassed asking my partner to use a condom	1	2	3	4
e. I trust my sex partner is having sex with only me	1	2	3	4

f. Many people are changing their sexual habits because of STDs	1	2	3	4
g. If I don't protect myself there really is a chance I could get AIDS	1	2	3	4
h. Having one committed partner is important to me	1	2	3	4
i. If my partner is having sex with other people he/she should tell me	1	2	3	4

Pre-Counselling Only:

20. What do you do now to protect yourself from STDs and AIDS?

    1.

    2.

    3.

21. How many different sexual partners have you had in the past one month? (including your spouse)

    a. ___ One

    b. ___ Two to five

    c. ___ Five to ten

    d. ___ More than ten

22. Can you tell me how many times in a week on average you have sex?

23. Have you ever used a condom to prevent STDs or AIDS? Y/N

For those who say yes to condom use:

23 a. Of the _____ times you have sex in a week, how many times on average do you use a condom? _____

(If less than all the time ie 100% ask the following:)

23 a i. With which sex partners do you use condoms with?

24. Do you personally know of anyone who has AIDS? Y/N

Post counselling session only:

What do you plan to do now to prevent another STD infection?

1.

2.

3.

INTERVIEWER:

Is the client code marked on each page?
Have all questions been answered?
Name of interviewer?
Name of health centre?
Demographic Data form completed?

APPENDIX F

LIST OF REVIEWERS

Elizabeth Agoki, Nurse/Counsellor, Owen House, Nairobi (Proposal, Curriculum, Questionnaire, Log Form)

Dr. Don Balmer, Psychologist/Counsellor/Educator, Faculty of Education, University of Nairobi, Nairobi (Proposal, Curriculum, Workbook, Questionnaire)

Dr. Gloria Eldridge, Behavioral Psychologist, University of Manitoba, Winnipeg (Proposal, Curriculum, Workbook, Questionnaire, Log Form, Observer Form)

Dr. Alan Ferguson, Biostatistician, Division of Family Health, Nairobi (Proposal, Questionnaire, Log Form)

Dr. Lillian Kimani, Psychologist/Counsellor, Personal Growth Centre, Nairobi (Proposal, Curriculum, Workbook, Log Form, Questionnaire)

Lois Lux, Resident Coordinator, AIDSTECH, Nairobi (Proposal, Curriculum, Workbook, Questionnaire, Log Form)

Jacinta Maingi, Psychologist, Norwegian Church Aid, Nairobi (Proposal, Curriculum, Workbook, Questionnaire, Log Form)

Dr. Stephen Moses, Co-Director, "Strengthening STD/AIDS Control in Kenya", Nairobi (Proposal, Curriculum, Workbook, Log Form, Observer Form, Questionnaire)

Dr. Esther Muia, Professor, Department Community Health, University of Nairobi, Nairobi (Proposal, Curriculum, Workbook, Log Form, Questionnaire)

Dr. Sobbie Mulindi, Director Information, Education and Communication, Kenya National AIDS Control Programme, Nairobi (Proposal, Curriculum, Workbook, Questionnaire)

Dr. Elizabeth Ngugi, Co-director, "Strengthening STD/AIDS Control in Kenya", Nairobi (Proposal, Curriculum, Workbook, Questionnaire, Log Form, Observer Form)

Mrs. Susan Nzuba, Professor, Faculty of Nursing, University of Nairobi, Nairobi (Proposal,Curriculum)

Dr. Joyce Olenja, Anthropologist/Lecturer, Dept. Community Health, University of Nairobi, Nairobi (Proposal, Curriculum, Workbook, Questionnaire)

Alan Ragi, Director Health Education, Kenya Red Cross Society, Nairobi (Proposal)

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