

The meaning and challenge of voluntary counselling and testing (VCT) for counsellors — report of the Kenya Association of Professional Counsellors (KAPC) conference for sub-Saharan Africa

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ABSTRACT

A large number of voluntary counselling and testing (VCT) sites are being opened in sub-Saharan Africa. The services provided by these sites are playing an increasingly important role in the prevention of HIV/AIDS. The sites offer many possibilities and it is crucial that they provide the optimum services for clients. Counselling is an integral part of these services, yet it receives little attention. Counsellors need to be consulted if the optimum services are to be provided, but they are rarely consulted for their professional opinion. Accordingly, the Kenya Association of Professional Counsellors (KAPC) organised a 3-day conference in September 2002 to provide counsellors, drawn from the sub-Saharan region, with a forum to identify VCT-related issues and discuss their implications. The main aim of the conference was for counsellors to arrive at a consensual position regarding HIV/AIDS and what improvements they thought could be made for the VCT services to clients. The counsellors identified the issues that they considered important and this paper presents those issues together with recommendations regarding improvements.

Keywords: Voluntary counselling and testing (VCT), conference report, sub-Saharan Africa.

RÉSUMÉ

Un grand nombre de sites de consultation et de dépistage volontaires (VCT) sont mis en place en Afrique subsaharienne. Les services pourvus dans ces sites jouent un rôle encore plus important dans la prévention du VIH/SIDA. Les sites offrent beaucoup de possibilités et il est crucial qu'ils pourvoient des services les meilleurs aux clients. La consultation psychologique fait partie intégrante de ces services, malgré qu'elle reçoit très peu d'attention. Les conseillers psychologiques doivent être consultés si on veut optimiser les services fournis. Malheureusement, ils sont rarement consultés pour leur opinion professionnelle. En conséquence, l'Association des Conseillers Professionnels du Kenya (KAPC) a organisé une conférence sur 3 jours, en septembre 2002, afin de donner aux conseillers, venus de la région subsaharienne, un forum à l'intérieur duquel ils peuvent identifier les problèmes et discuter leurs implications. Le but principal de cette conférence était de permettre les conseillers à se mettre d'accord sur le VIH/SIDA d'une manière unanime et de proposer une amélioration de services de VCT mis à disposition des clients. Les conseillers ont identifié des problèmes considérés primordiaux. Cette communication présente ces problèmes et les recommandations liées aux améliorations proposées.

Mots clés : Consultation et dépistage volontaires (VCT), rapport de conférence, Afrique subsaharienne.

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Introduction

Voluntary counselling and testing (VCT) has become a basic component in the provision of HIV/AIDS services, and the number of VCT sites in sub-Saharan Africa is increasing rapidly. Most of these sites are regulated and controlled by Ministries of Health and given the present state of the epidemic their primary concern is prevention (Ministry of Health, 2001). However, counselling is an important component of VCT and if counsellors were more directly involved the service could be more client friendly. Counselling, as a dedicated profession, is still a relatively new concept in sub-Saharan Africa. However, given the geographical and social changes in the region the demand for counselling services is growing. In response to this demand the Kenya Association of Professional Counsellors (KAPC) was formed. It has been active since 1991 and seeks to promote counselling as a professional service. These services include counsellor training, counsellor supervision, personal and professional development, and research. In addition, KAPC holds an annual conference to provide an opportunity for counsellors to meet and discuss issues of current importance. After consultation with members, colleagues, organisations and donors a need was recognised to hold a conference on the theme of 'The Meaning and Challenge of VCT for Counsellors'.

The demand for this conference arose from a number of concerns. HIV/AIDS confronts the region with some of its greatest challenges and the consequences are dramatic and far-reaching (De Cock, Mbori-Ngacha & Marum, 2002). Attention needs to be given to providing adequate and effective HIV/AIDS services and these needs should include counselling (Kipp, Kabagambe & Konde-Lule, 2002). Usually the services are controlled and directed by the Ministries of Health in the region and the agenda is mainly prevention. Consequently, the role of counselling is acquiescent and not given sufficient recognition. But counselling issues relating to confidentiality, condoms, orphans, families, cultural beliefs and knowledge are of critical importance and need to be addressed.

Initially, the aim of HIV testing was to give the client a sero-status test result and promote behaviour change. This was done largely through information and education procedures. However, the critical importance of counselling as a means of behaviour change has been acknowledged. One of the research studies in

which KAPC participated was to evaluate counselling and testing (C&T). This was the first randomised controlled study that showed that C&T helped change behaviour (Balmer *et al.*, 2000; Voluntary HIV-1 Counselling & Testing Efficacy Study Group, 2000). Since then few studies have tried to assess the quality of VCT services (Ginwalla *et al.*, 2002).

Recent developments in HIV testing technology now provide opportunities to explore new approaches. These technologies have liberated testing from laboratory dependence and the new rapid-test methods no longer have to be medicalised. This provides an opportunity to evaluate client-centred counselling, which is a recognised motivator to changing behaviour (Voluntary HIV-1 Counselling & Testing Efficacy Study Group, 2000). These changes also provided an opportunity for counsellors to reflect upon recent developments and to consider the implications for counsellors working in VCT sites.

Conference organisation

The conference was organised by the KAPC Conference Committee, who drew up the official conference programme. Sponsors were sought and the Center for Disease Control and Prevention (CDC), FUTURES Group and the Ford Foundation agreed to support the conference. It was decided to invite the Kenyan Minister of Health to officially open the conference. Keynote speakers were identified and invited to make seminal presentations and abstracts were invited. A total of 364 participants registered, coming from Kenya, Uganda, Somalia, Burundi, Nigeria, Sudan, Zambia, Zimbabwe, Malawi, Botswana, the Democratic Republic of Congo, South Africa and the United Kingdom. The majority of the participants were from the helping professions, including counsellors, teachers, social workers and medical workers.

Sixty-five abstracts were submitted, of which 48 were accepted and categorised into various themes. There were four sessions per day, three of which were dedicated to presentations on different topics of VCT including keynote speakers and paper presentations, and one session was dedicated to open discussion. In contrast to many conferences there were no parallel sessions and as a consequence most participants attended most sessions.

During the three sessions two rapporteurs kept a record of the presentations, discussions and questions.

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The rapporteurs were experienced, but as this was not a research study no attempt was made to track the inter-rater reliability of their separate observations. From these observations a list of the main issues was compiled in consultation with the conference committee. In the open session the rapporteurs reported on the main issues that emerged and conference participants were invited to give their comments. From these open sessions tentative recommendations were generated from the conference discussions. At the end of each day these recommendations were refined and during the final session of the conference they were presented to the conference body for validation. Each recommendation was discussed and a final consensual recommendation arrived at regarding the position of counsellors in the area of HIV/AIDS and what improvements could be made for the services to clients. The validation process allowed a list of main issues to be ratified by the conference participants. The list was circulated to all conference participants and sponsors. A copy was placed in KAPC's library to be consulted by members and students.

Themes and recommendations

The following themes were identified and discussed during the conference:

- training
- supervision
- career structure and job description
- human rights
- young people
- gender
- referrals and outreach
- counselling models in VCT.

Training

It was recognised that there was an urgent need to increase the number of trained counsellors. However, the imperative to rapidly expand the number of VCT centres should not be a justification for reducing the length or quality of counsellor training. The urgency of providing effective counselling services should be an argument for ensuring that professional standards are maintained. There were presentations from Nigeria (Yahaya, 2002), Malawi (Kampira, 2002) and Uganda (Nyanzi, 2002) that stressed the need for professional training. Examples of counsellors being trained for 1 week were quoted and this was deemed to be inadequate.

It was also felt that counsellors should hold a minimum

of a certificate in general counselling, before specialising in VCT counselling. A certificate course usually required approximately 150 hours and gave a sufficient grounding in theoretical foundations and practical skills. General training followed by specialisation is the norm in medical training and this model should be adopted for counsellor training. In Kenya the national VCT counselling guidelines stipulate that a minimum of 124 hours is required (NASCO, 2002).

To accommodate these training issues, it was felt that the client-centred model of counselling was the most appropriate. This model is rooted in the theoretical writing of humanistic counselling that focuses on the person as a unique and singular individual. A distinction needed to be made between the meanings of 'client-centred' in counselling parlance as opposed to medical settings. Instances were given of individualised risk reduction plans as representing client-centred counselling. While this is generally accepted in medical settings it has a different connotation in counselling. Distinguishing who determines the agenda for the interaction can best highlight the difference. In counselling circles it is the client who principally sets the agenda, but in VCT the agenda is set by the needs of the medical services. However, it is possible to address the client agenda and still meet the service agenda. Studies in counselling and testing show that clients' satisfaction is in direct proportion to the extent that they are able to set the agenda. One presentation from the UK discussed the possibilities that the client-centred method brought to VCT and the implications for training (Robson, 2002).

Recommendations:

- VCT counsellors should be trained to at least certificate level in general counselling before specialising in VCT.
- VCT counsellor training should incorporate client-centred approaches where the client's agenda is addressed.
- Special attention should be given by governments, ministries and parastatels to the selection of responsible and willing candidates for VCT training.

Supervision

As the numbers of clients seeking VCT counselling increases so the need to supervise the counsellors is vital to ensure quality counselling. This supervision is different to managerial supervision, although it has been recognised that supervision can improve working relationships where a supervisory role is concerned.

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Supervision in VCT sites can provide a number of useful functions including: preventing burnout, giving support, guaranteeing quality assurance, providing professional self-regulation, and ensuring personal and professional growth. Consideration was given to the amount of time devoted to supervision. Most people felt that supervision should be provided on a weekly basis. Supervision should be provided by suitably qualified counsellors using ethical procedures for helping the counsellors. It was evident that some countries were further advanced in offering supervision than others, and all needed to be brought to par.

Recommendations

- *Supervision should be mandatory for all VCT counsellors, including VCT counsellor-supervisors. It has improved the quality of the client-counsellor relationship and prevented counsellor burnout.*
- *Supervision should be provided on a regular basis and not less than once every 2 weeks.*

Career structure and job description

The issues mentioned above relating to training impact upon the position and career structure of counsellors. Counsellors have a professional voice and it should be recognised. One method of gaining recognition is through an autonomous and self-regulating professional status based upon professional training. The Minister for Public Health commented about the position in Kenya. He said: 'I am also aware that the Ministry of Health does not have a professional cadre of HIV counsellors, which leaves counselling to be done by other health workers, who are trained as, and perform the duties of counsellors, in addition to their normal duties. The Ministry is addressing this anomaly as VCT is viewed as a major service which should be managed on its own.' (Ogeri, 2002, pp. 10–12).

Recommendations

- *Counsellors should be included in policy making and advising on the role of counselling in VCT. Counsellors are the only people who can adequately and accurately represent the professional opinion of counsellors.*
- *Counsellors should be provided with an accurate job description.*
- *There is an immediate need for a career structure within government ministries that permits professional development and recognition.*

Human rights

More attention needs to be given to the issue of human rights and confidentiality in medical settings, as well as how it is managed and maintained. In VCT the counsellors are the people who give the result of a test to the client and this can cause conflict with the rest of the medical staff. Often clients confide information to the counsellors that the doctors want to know, but the counsellors cannot divulge because of confidentiality.

In the region there are many instances where people are tested in a way that violates human rights.

Examples were cited of immigrants, couples seeking to marry, children being adopted, military personnel and people wanting insurance. These examples often include breaches of confidentiality that reinforce stigma and increase discrimination. Laws should require specific informed consent for testing, and failure to obtain voluntary consent is a violation of personal liberty and privacy.

The role of the VCT counsellor is critical in protecting the human rights of clients, and counsellors should represent clients when policy decisions are being made. The counsellor should also be offered some protection, but currently there is no legal definition, in any of the countries, of who is a counsellor. It would be very difficult to proscribe a cadre of people who alone were allowed to conduct counselling. However it would be possible to regulate those people who can give an HIV test.

Recommendation

- *The client's human rights should be sacrosanct in all counselling relationships, not just VCT, and counsellors should be present at forums when this issue is being discussed.*

Young people

Young people are a specific target group for VCT, but they are notoriously fickle in their attitude toward adults. An adolescent gave a keynote address on 'VCT and the voice of adolescents' (Aloyo, 2002). He outlined the concerns, fears and opinions of adolescents in the face of adult pressures and noted that adolescents tend to look at adults with suspicion.

It is estimated that in less than 5 years there will be 1.5 million AIDS orphans in Kenya (De Cock, 2002). VCT services should also be available for them so that they can address the issue of behaviour change and not just

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be given information or advice. Young people seek reassurance that nothing untoward will happen to them when presenting at VCT sites. The conference participants thought that it is much easier to make a stand-alone VCT centre youth friendly than one integrated into a traditional health care setting. Providing intermediary services like telephonic, postal, e-mail or internet channels for VCT should help adolescents. Currently there is a basic lack of trust on the part of young people that must be overcome if they are to present at VCT centres. It may help if centres provide individual counselling that is specific to their needs, including sex, drugs and STIs.

Recommendations

- *VCT centres need to develop adolescent-friendly policies to attract young people to come and test. Individual counselling should always be available for young people. The centres should also address their specific needs appropriately, including sex, drugs and STIs.*

Gender

Gender inequality was an important topic discussed during the conference. The position of females in sub-Saharan Africa is generally a subservient one. This sense of subservience is present at birth and is reinforced as the girl-child matures at puberty and eventually is contracted into marriage. The norms that affect the expression of female sexuality undermine the position of women and prevent them from active and positive decision-making. This subservient position makes females more likely to be abused than males. Abuse takes many forms, both physical and psychological: physical abuse includes rape and violence, while psychological abuse includes coercion, intimidation and terrorising.

Client-centred counselling can give females the opportunities to explore the circumstances of their lives and to consider alternatives. VCT sites should actively encourage women by strengthening their self-esteem and giving them assertiveness skills. Assertiveness skills however should not promote confrontation, but rather mediation and compromise. This obviously has consequences for men, who, wherever possible, should participate in counselling. Men should recognise that their behaviour can be the result of rigid and stereotyped roles and they should be encouraged to engage in mediation and compromise, and recognise that this is a mark of strength. The aim of improved gender counselling is for couples to

explore their relationship and arrive at a new understanding of it and the needs of their partners and themselves. For this to happen women should become stronger so that they can engage in dialogue as equals, and men should become stronger by being empowered to reduce their rigid authority role.

Recommendations

- *Counselling in VCT centres should give special attention to the needs of the girl-child, young women and married women. VCT centres should also address the issues of violence, abuse, rape and family planning. Training in self-esteem and assertiveness should be available for this group of clients.*

Referrals and outreach

As the demand for VCT increases more stand-alone sites will be established. These stand-alone sites will not be able to offer the full range of medical services. The majority of clients who attend stand-alone sites are healthy, and generally require only knowledge of their HIV status for behaviour change. In Kenya 85% of the general population will receive a negative result. However it is equally important that their behavioural needs are addressed. In some instances needs are both dependent and independent of HIV status, for example, in the case of family planning. These needs either should be addressed at the site or the client should be referred. Each site should prepare a list of referral agencies to which clients can be directed where necessary. In rural communities, such as Rakai in Uganda, it is recommended that VCT services be delivered directly into homes (Ssemanda, 2002).

Clients who receive an HIV+ result should be supported, together with those who receive an HIV- result and wish to have further counselling. Even if medical services are not available, psychological means of support should be on site. This may take the form of individual or group counselling. Clients should be helped to address issues such as partner notification. The aims should be to achieve positive and sustained behaviour change.

Recommendations

- *Referrals and outreach services should be available at the VCT counselling centre. Particular attention needs to be given to support groups for people who are HIV+.*

Counselling models in VCT

It was agreed that no one model of VCT was

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appropriate to all regional settings, but that the type of model would be determined by the services. It was clear that counselling focussed on different activities in different settings, i.e. information, advice and counselling. Counselling was still a relatively new concept in the sub-Saharan region and people were not sure what to expect from counsellors. In addition, there was an element of confusion regarding the nature of services, particularly in VCT. VCT counselling is most commonly understood in the context of information and advice and the services appear on a continuum ranging from information, advice, to counselling.

The discussions established that from counsellors' experiences of VCT the most elementary and least demanding form was information. Generally clients sought information about the test and its implications. The relationship of client and counsellor was not so critical and there was no theoretical foundation that guided it. Information could be given in pamphlets, posters, leaflets or books, and such information campaigns have been remarkably successful. The vast majority of the population are aware of the pandemic. However the counsellors could find no correlation between providing information and changing behaviour.

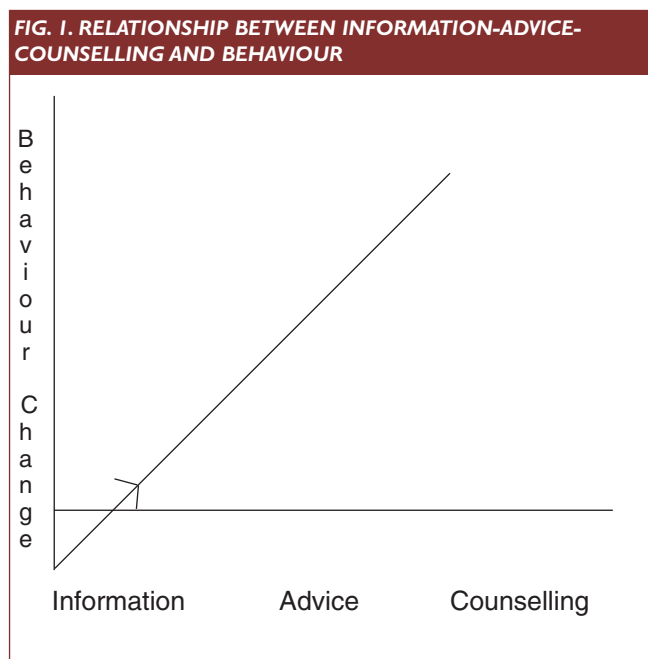
Giving advice, as opposed to information, was a traditional practice in sub-Saharan Africa. People with problems were used to consulting elders or community leaders who advised them. The elders or leaders needed to be trusted and respected if the advice was to be accepted. If the relationship was nurturing and the individual accepted the argument, then s/he accepted the advice and acted upon it. Many VCT counsellors participating in the conference gave examples of advising clients about risk reduction strategies. Such discussions helped clients to understand the implications for their own behaviour, but there was little evidence that they actually changed their behaviour. No doubt different countries would adapt counselling methods to the prevailing social circumstances.

Many conference participants reported that they tried to provide counselling, but while it was appreciated that the quality of the client/counsellor relationship was crucial, some found it difficult to achieve. Much of the VCT literature failed to mention the relationship and instead stressed information. Counsellors also found themselves under pressure to add other services

for sexually transmitted infections (STI), tuberculosis (TB), family planning (FP) and mother to child health (MCH) to their counselling. The very nature of the added services may make it impossible for the counsellor to offer quality time to the client for sufficient self-exploration of their sexual behaviour and possible options. However in the case of prevention of mother-to-child transmission (PMTCT) in South Africa it has been successful (Mokgohloa, 2002).

Many participants gave examples of how the counselling process led to behaviour change. Regarding theoretical orientation it was felt that the client-centred model, with its emphasis on empathy, genuineness and warmth, was the most appropriate to govern the client-counsellor relationship.

The graph illustrates that there is a relationship between the information-advice-counselling axis and the behaviour change axis, although there is no evidence to prove that there is a linear relationship. This relationship emerged from the discussions during the conference.



In his opening remarks Kevin De Cock, Regional Director, CDC, said that 'It may be fear of AIDS that brings clients into your counselling rooms — but they can leave the counselling session with new knowledge and skills to empower them to have more fulfilling personal relationships with their sexual partners and others, as well as influence the others' behaviour (De

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Cock, 2002, p. 6). This is a considerable demand to place upon counsellors and to satisfy it they need to be operating at the counselling end of the continuum.

Recommendations

- *The counselling model needs to be distinguished from the medical model in offering help to VCT clients. It is the basic tenets of the counselling model that should determine practice in VCT sites.*
- *VCT centres can operate outside medical centres and stand-alone sites are welcomed by clients.*
- *VCT is one method of offering HIV testing that can be incorporated into the client-centre model of counselling and this has the potential of improving behaviour change.*

Conclusions

Counselling has been gaining acceptance in sub-Saharan Africa and has a growing professional recognition. This recognition should permit counsellors to define legitimate counselling activities and how they can be incorporated into VCT. The conference helped to define the meanings and challenges that VCT has for counsellors.

The recommendations from the conference have identified some of the activities that need to be introduced or altered in VCT centres. They represent the consensual opinion of counsellors and are therefore worthy of consideration. The participants found the conference an exciting experience, largely because they had been able to come together and exchange experiences. Many found that others shared the isolation that they suffered at work and the exchanges had been therapeutic. The discussions that took place at coffee and lunch breaks were also important. There is evidence that VCT counselling is changing behaviour and if the above recommendations are addressed it could be further improved. It is hoped that those responsible for VCT will implement these recommendations.

One positive outcome was that a committee to formulate a scheme of service for counsellors was constituted, chaired by KAPC and NASCOP and employed by the Ministry of Health. This committee has reviewed issues concerning training, selection, accreditation, employment, and salary and career structure for counsellors and is finalising its recommendations.

Carkhuff, a counselling theorist, commented that 'Counselling is never a neutral intervention, it either has a positive or negative effect.' (Carkhuff, 1969, p. 27). Counsellors in the region are anxious that counselling in VCT sites should have a positive effect and they wish to collaborate in ensuring this outcome. They will actively work in partnership with other professionals, but feel that they have a unique and singular contribution to make.

From the discussion of the meanings and challenges of VCT for counsellors, it is clear that counselling needs to be grounded in theoretical approaches and not just in the provision of medical education. The theoretical approaches need to be refined and tested in VCT sites and the conference has helped to facilitate that process.

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