KNOWLEDGE, ATTITUDE AND UTILIZATION OF PROFESSIONAL COUNSELLING SERVICES BY RESIDENTS OF KIBERA SLUMS OF NAIROBI, KENYA

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH AND EPIDEMIOLOGY OF KENYATTA UNIVERSITY

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Knowledge, attitude
and utilization of

JULY, 2003
DECLARATION

I, YOKOMORI KENJI hereby declare that this thesis is my original work and has not been presented for a degree in any other University.

Signed 横 森 健 治 Date 22 September 2003

This thesis has been submitted after examination with our approval as University Supervisors.

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DEDICATION

This thesis is dedicated to my Family: My wife, Ms. YOKOMORI KAYO and our children, HIKARU and TSUBASA, whose efforts and patience enabled me to complete my studies successfully.
ACKNOWLEDGEMENTS

I am deeply indebted to my supervisors, Prof. Alloys S.S. Orago and Dr. Isaac Mwanzo as well as the chairperson of the Department of Zoology, Dr. Peninah Aloo Obudho, all of Kenyatta University for their guidance and encouragement throughout the period of this work. I wish to express my appreciation to the many individuals who assisted in the data collection and analysis in one way or another, especially to Ms. Jacintah Nyokabi, Ms. Mary Kavata, Mr. Faraj Mohamed, Mr. Mohammed Saidi and Mr. Mark Mudennyo. Last but not least I must sincerely appreciate the residents of Kibera slums and the interviewees who gave the information to this study, this thesis could not have been completed without their contributions.
# ABBREVIATIONS USED IN THIS THESIS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMDA</td>
<td>Association of Medical Doctors of Asia</td>
</tr>
<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
</tr>
<tr>
<td>CSW</td>
<td>Commercial Sex Worker</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>KICOSHEP:</td>
<td>Kibera Community Self-help Programme</td>
</tr>
<tr>
<td>KNH</td>
<td>Kenyatta National Hospital</td>
</tr>
<tr>
<td>NA</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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ABSTRACT

Since the beginning of human history, counselling of one kind or another has always been in existence. With the advent of HIV/AIDS, professional counselling has emerged as an indispensable strategy in the prevention efforts.

This study investigated the knowledge, attitude and utilization of professional counselling services in Kibera slums, which is the biggest informal settlement in Nairobi City. The slum area has 12 villages. Using cluster and systematic sampling procedures, about 34 respondents were selected from each village. In total, the study involved 408 respondents, 12 counsellors and 19 participants in Focus Group discussions. Data was collected and analyzed by both quantititative and qualitative techniques. Quantitative data was handled with the help of Statistical Package for Social Sciences (SPSS) software, while qualitative information entailed content analysis.

The result of the study indicate that the awareness of professional counselling is quite high, though the majority of respondents think counselling is mainly for HIV/AIDS and health problems. About a half of respondents consult with family members before visiting counsellors. The utilization rates of counselling services are found as 23.3% for general counselling, 23.5% for VCT and 16.2% for indigenous doctor's service, 18.9%
for herbalist's service and 38.2% for religious counselling. That is, traditional counselling is also sought in the community. Those who had visited professional counselling centres were likely to express satisfaction with the services. The socioeconomic and cultural constraints in utilization of professional counselling were found as education, cost, occupation, sexuality and ethnicity.

Finally, the study suggests the need to: promote awareness of professional counselling; improve professional counselling services; expand VCT and general counselling services in urban and rural areas; train PLWHA as professional counsellors and research on outcomes of VCT services as well as traditional counselling.
CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.1 Introduction

Since the beginning of human history, counselling of one kind or another has always been in existence (Fuster, 1988). Thus, all societies the world over have mechanisms for helping and giving advice to people confronted by difficult situations. There are two main types of counselling, namely professional and traditional counselling.

With the advent of HIV/AIDS and increasing cases of terminal illnesses, professional counselling has gained unprecedented prominent in Africa (Salome, 2001). Besides this, there is also traditional counselling which is still crucially important and usually facilitated by lay people.

In Kenya due to strong commitment of the Government and NGOs, counselling centres and VCT centres have been increasing. Since most of the Nairobi residents stay in informal settlements called “Slums”, the majority of beneficiaries of such counselling services are people living in urban slums. However, researches with fulfillment of social science procedures have not been materialized, because of insecurity and severe political environment in there.
1.2 Literature Review

1.2.1 Definition of counselling

There exists a wide diversity in counselling practice, with the most prevalent forms being delivered through one-to-one contact, in groups, with couples and families, over the telephone and even through written materials such as books and self-help manuals (McLeod, 1998). So definitions of counselling range from being too exclusive to being over-inclusive. In this research, the following definition is applied, as commonly accepted by counsellors. "Counselling is the skilled and principled use of relationships to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources... The counsellor's role is to facilitate the client's work in ways that respect his/her values, personal resources and capacity for self-determination (BAC, 1989)."

Thus, the overall aim of counselling is to provide an opportunity for the client to work towards living in a more satisfying and resourceful way. The term 'counselling' includes work with individuals, pairs or groups of people, often, but not always, referred to as 'clients'. The objectives of particular counselling relationships vary according to the client's needs. Counselling
may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insight and knowledge, working through feelings of inner conflict or improving relationship with others (BAC, 1992; KAPC, 2002).

In the counselling relationship, the following categories of people are involved: a) professional counsellors who get trained and accredited, and paid for their services, for instance, counsellors, psychologists, and psychotherapists; b) voluntary counsellors who get trained in counselling skills and work on a voluntary basis; c) those helpers using counselling skills as part of their jobs, such as nurse, a teacher, priest, manager, lawyer and so on; d) informal helpers such as a partner, parent, relative, friend or work colleague; e) counselling and helping students who are on supervised placements as part of counselling and the helping services (Nelson-Jones, 2000a).

1.2.2 Types of counselling

Although there are more than 400 distinct models of counselling in the world (Karasu, 1986), it can be theoretically classified into the following 3 main approaches: Psychodynamic approach, Humanistic-existential approach and
Cognitive-behavioral approach. **Psychodynamic approach** refers to the transfer of psychic or mental energy between the different structures and levels of consciousness within people's minds. Psychodynamic approach emphasizes the importance of unconscious influence on how people function. In this case, therapy aims to increase clients' abilities to exercise greater conscious control over their lives. Analysis or interpretation of dream can be a central part of therapy. On the other hand, **Humanistic-existential approach** is based on humanism, a system of values and beliefs that emphasize the better qualities of humankind and people's abilities to develop their human potential. Humanistic therapists emphasize enhancing clients' abilities to experience their feelings and think and act in harmony with their underlying tendencies to actualize themselves as unique individuals. Existential approaches to therapy stress people's capacity to choose how they create their existences. Traditional behavioral therapy focuses mainly on changing observed behaviours by means of providing different or rewarding consequences. The **cognitive-behavioural approach** broadens behaviour therapy to incorporate the contribution of how people think in creating, sustaining and changing their problems. In cognitive-behavioral approaches, therapists assess clients and then intervene to help them to change specific ways of thinking and behaving that sustain their problems
1.2.3 Counselling process

Professional counsellors deal with a variety of issues including gender, race, sexual orientation, religion, career making, redundancy, unemployment, death, bereavement, sexual dysfunction, disability, chronic illness, HIV/AIDS, alcohol and drug problems, child abuse, trauma and post-traumatic stress disorder (Palmer, 1997).

The process of professional counselling is usually divided into three stages. The first stage entails exploration. In this stage, the clients need to determine the exact nature of the problem. The second stage entails understanding. The counsellor attempts to help the client understand what issues are involved in solving it. The third stage is for action. Once the issues have been identified and clarified, it is possible to prepare a plan of action that enables the client to tackle the problem. After confirming the success of the action and both the client and counsellor are satisfied that the programme has removed the client’s problem, then the counselling sessions can be terminated (KAPC, 2002).
The expected outcomes or benefits of counselling are self-awareness, self-acceptance, self-actualization, enlightenment, problem-solving, decision-making, crisis-management, psychological education, acquisition of social skills, cognitive change, behaviour change, empowerment and restitution (Nelson-Jones, 2000b; McLeod, 1998).

1.2.4 Researches on counselling in Africa

In Africa, most of the recent researches on counselling have been conducted in relation to HIV/AIDS. It is shown that prevention of infection and psychological support for both the infected and affected people are crucial roles of counselling (Green and McCreaer, 1989; Balmer, 1992; WHO, 1995). The prevention focuses on reduction of risky behavior. There are studies that have already shown change of sexual behaviour through counselling (Balmer, et al., 1998; Bentley et al., 1998; Gibson et al., 1998). Thus, there is close relationship between counselling and behaviour change.

In Kenya, since the inception of Voluntary Counselling and Testing (VCT), the government has continued to promote it as one of the prevention methods of HIV/AIDS (NASCOP, 2001a, b). Through VCT, a person receives the counselling needed to make an informed choice about whether or not to
undertake confidential testing for HIV (NASCOP, 2001a). This is based on the premise that there is overwhelming need of psychological support and care for PLWHA and their partner, family and friends (Evian, 1993). They may need counselling service to cope with HIV-positive status (Kusimba et al., 1996). Studies have also reported that counselling helps PLWHA to: disclose their HIV-positive status to others; adhere to positive health living; recover from shock, grief, anger, guilt, decreased self-esteem, loss of identity, loss of a sense of security, loss of personal control, fear, sadness, depression, obsession and compulsion (Green, 1989; George, 1989).

1.2.5 Socio-economic constraints and difficulties

Wide body of knowledge shows that because counselling is a human relationship between a counsellor and client(s), the utilization and outcomes are influenced by socio-demographic and economic factors. These factors include age, ethnicity, nationality, occupation, gender, religion, social status, disability, poverty and sexuality (Johnson & Vestermarl, 1970; Sue, 1981; Cartoux et al., 1998; McLeod, 1998).

It has also been reported that utilization and evaluation of outcomes greatly determine future behaviour. For example, a study in the USA shows that
Asian American, Blacks, Chicanos and Native Americans terminated counselling after only one contact at a rate of approximately 50% with sharp contrast to 30% rate for Anglo clients due to inappropriateness of interpersonal interactions (Sue, 1981).

1.3 Rationale of the study

1.3.1 Statement of the Problem

Despite the existence of different types of counselling services in Kenya, most studies have concentrated mainly on those meant for HIV/AIDS prevention. Yet counselling services are varied and address different kinds of problems. The decision to choose a professional counsellor is determined by a number of factors which may include evaluation of outcomes. It may also be influenced by the socioeconomic characteristics of clients. A study that explores such fields is long overdue.

1.3.2 Research Questions

This research poses the following questions;

a) Do people's knowledge and attitudes affect their Utilization of professional counselling services?

b) What are socio-economic and cultural constraints in utilization of
1.3.3 Justification

Reports about emerging and reemerging infections pose serious challenges to African continent already burdened by easily preventable diseases. Thus, some of the diseases affecting people could be prevented or ameliorated through counselling programmes tailored towards behaviour modification. It is, therefore, imperative to conduct a study that examines the knowledge about the potential benefits of professional counselling services, utilization levels and constraints.

Some studies have already shown that counselling plays an important role in reducing risk taking behaviour. The result of this research could provide insight into the people’s knowledge, attitude and utilization of professional counselling services. In addition, the result could show socio-economic, cultural constraints in people’s utilization of professional counselling services.

The findings may also be useful to planners, policymakers and implementation agencies in improving professional counselling services, as
well as to the clients who may get the services in future.

1.4 Null Hypotheses

a) There is no relationship among people's knowledge, attitude and utilization of counselling services.

b) There is no socio-economic and cultural constraint in utilization of professional counselling services.

1.5 Objectives of the Study

1.5.1 General Objective

To investigate people's knowledge, attitude and utilization of professional counselling services in Kibera slums, Nairobi.

1.5.2 Specific Objectives

a) To determine people's knowledge and attitude toward professional counselling services in the slums.

b) To determine utilization patterns of professional counselling services in the slums.

c) To identify the socio-economic and cultural constraints in utilization of professional counselling services in the slums.
CHAPTER 2: MATERIALS AND METHODS

2.1 The study area

Kibera slums are located to the southeast of Nairobi City, around 7 km away from the city centre (Figure 1, 2), and is the largest informal settlement in East Africa. The area covers 225.6 hectares of land (Matrix Development Consultant, 1993). Its estimated population was 500,000, with a population density of 2000 persons per hectare in 1997 (UNDP-World Bank, 1997). There are 12 villages in the slums. Majority of the residents have low incomes and public services such as water and sanitation are poor (Matrix Development Consultant, 1993).

2.2 The study population

The study population consisted of the people who live in Kibera slums. A determined number of households was selected systematically in order to be involved in the study. In order to avoid biases, Key socio-demographic parameters were considered in the selection.
Figure 2: Map of Kibera slums.

LEGEND

0  1  2  3  4  5  6  7  8  9  10  11


Scale: 1:10,000
2.2.1 **Inclusion criteria**

a) The residents who consented to be enrolled in the study.

b) Those who were 15 years old and above.

c) Those who had lived for at least 6 months in the slums.

2.2.2 **Exclusion criteria**

a) Those who didn't agree to join this study.

b) Those who were under 15 years of age.

c) Those who had lived for less than 6 months in the slums.

2.2.3 **Ethical considerations**

The research permit was granted by Kenyatta University, the Ministry of Education, Science and Technology and the local authority. In addition, consent of the interviewees was sought and specified.

2.3 **Study design**

This is a descriptive cross-sectional study. The study was conducted at one point in time in order to gather data about the people in different circumstances.
2.4 Sampling and Sample size determination

Given that the population of Kibera slums was greater than 10,000, the sample size is calculated by the formula as used by Fisher et al. (1998).

Sample size \( n = \frac{2}{\frac{Z^2}{p(1-p)}} \rightarrow n = 384.16 \rightarrow 408 \) samples

\( Z = 1.96 \) \hspace{10pt} (95% confidence level)

\( p = 0.5 \) \hspace{10pt} (proportion in target population)

\( q = 0.5 \) \hspace{10pt} (q = 1-p)

\( D = 1 \) \hspace{10pt} (no comparison and no replication)

\( d = 0.05 \) \hspace{10pt} (degree of accuracy, usually 0.05)

According to the calculation, at least 385 respondents were supposed to be needed, at last 408 were selected due to the procedures in the following.

2.5 Data collection Method and Research Instruments

(a) Structured questionnaires

The structured questionnaires were used to elicit quantitative data from 408 informants in 12 villages of Kibera slums. About 34 informants were selected from each village by systematic sampling as follows. The first informant was
selected randomly from the central point of each village. From this point, the 10th household was selected in all possible directions to reach the anticipated figure of 34 informants. In this study, the household is defined as the people who live together in one house and share essential resources. To hasten the process of data collection, 4 research assistants (2 males, 2 females) were recruited and trained in all aspects of the research.

(b) **Key Informant Interviews**

In addition, Key Informant interviews for 12 counsellors and 3 Focus Group Discussions (19 participants in total) were conducted to gather more, and in some cases specialized, information on process of counselling, interaction between a counsellor and client(s), outcomes and constraints in counselling.

2.6 **Data Management**

2.6.1 **Data cleaning and entry**

During the data collection, data of structured questionnaires, interview with counsellors and focus group discussions were screened at the end of each day to select relevant information. The data entry of statistical data was input into personal computer with support of a statistician.
2.6.2 Storage and Retrieval

The necessary precautions were undertaken to safeguard the data. Accessibility to the collected information was restricted only to the researcher and the statistician. Following data entry and analysis, the information was kept in a floppy disk and deleted from the computer.

2.6.3 Analysis and Presentation

All the data was entered into personal computer. Statistical data was analyzed with the help of Statistical Package for Social Sciences (SPSS) software, in which cross tabulation, Chi-square test were applied. Qualitative information was processed by thematic analysis.

The data that was analyzed quantitatively includes the rate of awareness, attitude and utilization of counselling services as well as statistically significant associations between utilization and other influencing factors. The other data that was analyzed qualitatively relates to description, definition and explanation of counselling services. Accordingly, the result of the analyses is presented in form of tables and figures of frequency, percentage and chi-square significance.
CHAPTER 3: RESULTS

In this chapter statistical and qualitative information acquired from Kibera residents are presented. Firstly, demographic and socioeconomic characteristics are presented. Then respondents' knowledge, attitude and utilization of professional counselling services are demonstrated. Lastly, socioeconomic and cultural factors influencing utilization of professional counselling are examined.

3.1 Demographic and socioeconomic characteristics

This study involved 408 respondents out of whom half were male and the rest were female. The age range was from 15 to 70 years, majority (78.2%) falling in the category of 15 to 34 years. Those who are 65 and above comprized only 0.7% (Figure 3).
3.1.1 Marital status

More than a half of the respondents were married (52%) (Figure 4). The number of spouses varied from 0 to 3. Half of them had no spouse, while the majority had one spouse (48%). Only a small portion (2%) had 2 spouses and 1% had 3 spouses (Figure 5).
Figure 4: Marital status of the respondents

- Married: 52%
- Single: 44%
- Others: 4%
Figure 5: The number of spouses

- 2 spouses: 2%
- 3 spouses: 1%
- 1 spouse: 48%
- No spouse: 49%
3.1.2 The number of Lovers

The result shows that the number of lovers is widely varied from 0 to 6. However, the vast majority were not engaged in intimate relations. Figure 6 presents the summery.

Figure 6: The number of lovers
Whereas the majority of the respondents had no child (176: 43%), about 11.5% (47) reported to have one. The others were mainly having 2 (59: 14.5%), 3 (37: 9.1%) and 4 (38: 9.3%) children (Figure 7).

Figure 7: The number of children
3.1.3 Occupation of the respondents

Table 1 presents occupation of respondents. About 17.4 % were jobless, 10.5 % were students. People in full time occupations includes traders (20.1 %), non skilled general workers (9.3%) and house wives (9.1%).

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trader</td>
<td>82</td>
<td>20.1</td>
</tr>
<tr>
<td>Non skilled general worker</td>
<td>38</td>
<td>9.3</td>
</tr>
<tr>
<td>Private company worker</td>
<td>27</td>
<td>6.6</td>
</tr>
<tr>
<td>Watchman</td>
<td>13</td>
<td>3.2</td>
</tr>
<tr>
<td>Teacher</td>
<td>13</td>
<td>3.2</td>
</tr>
<tr>
<td>CSW</td>
<td>12</td>
<td>2.9</td>
</tr>
<tr>
<td>Street vender</td>
<td>11</td>
<td>2.7</td>
</tr>
<tr>
<td>NGO worker</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Government worker</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>Health worker</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>Pastor/Priest</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Farmer</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Others</td>
<td>28</td>
<td>6.9</td>
</tr>
<tr>
<td>Jobless</td>
<td>71</td>
<td>17.4</td>
</tr>
<tr>
<td>House wife</td>
<td>37</td>
<td>9.1</td>
</tr>
<tr>
<td>House help</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Student</td>
<td>43</td>
<td>10.5</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 1: Occupation of respondents
3.1.4 Level of Education

Figure 8 demonstrates educational level of the respondents. Slightly below a half (48%) had secondary education, and 36% received primary education, 12% receive post secondary education. Only 4% had not received any type of formal education.

Figure 8: Level of education
3.1.5 Ethnic classification

Most of the respondents belong to ethnic groups such as Luo (22.1%), Luhya (18.6%), Kamba (17.9%), Kikuyu (16.4%), Nubian (11.0%) and Kisii (9.6%) (Figure 9).

Figure 9: Ethnicity of the respondents
3.1.6 Religious background

Figure 10 presents religious background of Kibera residents. Most of them were Christians (79%), the vast majority being Protestants (51%). Muslim constitute 14%.

Figure 10: Religion of the respondents
3.1.7 Income and expenditure in households

In Figure 11 and 12, monthly income and expenditure of a household are classified. The majority of households have monthly income ranging between Ksh 1-4,999 (50.5%) and Ksh 5,000-9,999 (37.6%). The households with a monthly income of Ksh 50,000 or more are quite few (0.7%). Similarly most of households have monthly expenditures in the range of Ksh 1-4,999 (58.3%) and Ksh 5,000-9,999 (36.7%).
Figure 11: Monthly income in a household

Proportion of respondents (%)

Ksh/month

1-4,999 5,000-9,999 10,000-49,999 50,000 or more

50.5 37.6 11.1 0.7

1-4,999 5,000-9,999 10,000-49,999 50,000 or more
Figure 12: Monthly expenditure in a household

Proportion of respondents (%)

<table>
<thead>
<tr>
<th>Ksh/month</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4,999</td>
<td>58.3%</td>
</tr>
<tr>
<td>5,000-9,999</td>
<td>36.7%</td>
</tr>
<tr>
<td>10,000-49,999</td>
<td>4.3%</td>
</tr>
<tr>
<td>50,000 or more</td>
<td>0.6%</td>
</tr>
</tbody>
</table>
The monthly personal income varied from Nothing (18%) to Ksh 10,000 – 49,999 (5%). Almost a half of the respondents have income in the range of Ksh 1-4,999 (49%) and second majority falls between Ksh 5,000-9,999 (28%) (Figure 13).

Figure 13: Monthly personal income
The most common income sources are small-scale trading/business (24.5%), family support (23.8%) and salary (23.2%). The income from rent was only 5.3% (Figure 14).

Figure 14: Source of income
3.2 Knowledge of Professional Counselling services

3.2.1 Awareness of existence of professional counselling centres

Most of the respondents are well aware of the existence of general counselling (60%) centers and VCT (84%) centres (Figure 15). A significant number mentioned KICOSHEP (83: 20.3%), followed by AMREF (41: 10%), AMDA (29: 7.1%) and Kenyatta National Hospital (KNH) [27: 6.6%] (Figure 16).

Figure 15: Awareness of counselling centres
Figure 16: Awareness of Professional Counselling Centers

The main sources of information about counselling services are sign post (20.5%), friends (18.5%), poster (12.7%), mass media (11.1%) and health workers (3.0%) followed by Family member (1.6%) and relatives (1.6%) (Table 2).

Table 2: Source of information about counselling centres

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass media</td>
<td>62</td>
<td>11.1</td>
</tr>
<tr>
<td>Friends</td>
<td>104</td>
<td>18.5</td>
</tr>
<tr>
<td>Family member</td>
<td>9</td>
<td>1.6</td>
</tr>
<tr>
<td>Relative</td>
<td>9</td>
<td>1.6</td>
</tr>
<tr>
<td>Poster</td>
<td>71</td>
<td>12.7</td>
</tr>
<tr>
<td>Sign post</td>
<td>115</td>
<td>20.5</td>
</tr>
<tr>
<td>Health worker</td>
<td>17</td>
<td>3.0</td>
</tr>
<tr>
<td>NA</td>
<td>174</td>
<td>31.0</td>
</tr>
<tr>
<td>Total</td>
<td>561</td>
<td>100.0</td>
</tr>
</tbody>
</table>
3.2.2 Issues of professional counselling services

The vast majority reported that health problems (35.8%) were main issue of counselling followed by HIV/AIDS (18.4%), difficulties in relationships (7.8%), psychological problems (6.1%) and pregnancy/family planning (4.2%) (Table 3).

Table 3: Issues presented to counsellors

<table>
<thead>
<tr>
<th>Issues</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td>146</td>
<td>35.8</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>75</td>
<td>18.4</td>
</tr>
<tr>
<td>Difficulties in relationships</td>
<td>32</td>
<td>7.8</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>25</td>
<td>6.1</td>
</tr>
<tr>
<td>Pregnancy/family planning</td>
<td>17</td>
<td>4.2</td>
</tr>
<tr>
<td>Sexuality</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Employment problem</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>Educational matter</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>Marriage</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Drug/alcohol problem</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>NA</td>
<td>87</td>
<td>21.3</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

3.2.3 Awareness of need of counselling

When asked experience about specific health issues requiring counselling, 41% of respondents admitted that (Figure 17). The vast majority mentioned health problems for the reason (Table 4). Others answered psychological problems, sexuality, marriage and difficulties in relationships and HIV/AIDS.
Figure 17: Awareness of health issues requiring counselling service

Yes 41%

No 59%
### Table 4: Specific issues requiring counselling services

<table>
<thead>
<tr>
<th>Issue</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td>77</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>38</td>
</tr>
<tr>
<td>Sexuality</td>
<td>23</td>
</tr>
<tr>
<td>Marriage</td>
<td>21</td>
</tr>
<tr>
<td>Difficulties in relationship</td>
<td>20</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>19</td>
</tr>
<tr>
<td>Pregnancy/family planning</td>
<td>12</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>8</td>
</tr>
<tr>
<td>Drug/alcohol problems</td>
<td>5</td>
</tr>
<tr>
<td>Employment problems</td>
<td>4</td>
</tr>
<tr>
<td>Education matter</td>
<td>3</td>
</tr>
<tr>
<td>Grief/bereavement</td>
<td>2</td>
</tr>
<tr>
<td>NA</td>
<td>246</td>
</tr>
<tr>
<td>Total</td>
<td>478</td>
</tr>
</tbody>
</table>

With regard to family members, 34% of the respondents reported that health issues of their family members might have required counselling (Figure 18).
The reasons why the family members might have required counselling are almost same as their own case. But this case reason as HIV/AIDS (33: 7.2%) is higher than the previous one (19: 3.9%) (Table 5).
Table 5: Reasons for family members to see a counsellor

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td>81</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>33</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>18</td>
</tr>
<tr>
<td>Pregnancy/family planning</td>
<td>11</td>
</tr>
<tr>
<td>Difficulties in relationships</td>
<td>10</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>8</td>
</tr>
<tr>
<td>Marriage</td>
<td>6</td>
</tr>
<tr>
<td>Sexuality</td>
<td>3</td>
</tr>
<tr>
<td>Drug/alcohol problem</td>
<td>3</td>
</tr>
<tr>
<td>Education matter</td>
<td>2</td>
</tr>
<tr>
<td>NA</td>
<td>278</td>
</tr>
<tr>
<td>Total</td>
<td>453</td>
</tr>
</tbody>
</table>

3.2.4 Awareness of availability of VCT

Around 66% of the respondents answered VCT centres are not available in their area (Figure 19). The rest admitted the availability of VCT in some villages.
Figure 19: Availability of VCT centres

Yes 34%

No 66%
3.2.5 Accuracy of knowledge about professional counselling

In terms of accuracy of information, around 71% (288 respondents) had correct information over VCT services (Figure 20). But when asked more precisely about the difference between counselling and VCT, 20% answered that there was no difference between the two services (Figure 21).

Figure 20: Function of VCT centres
Figure 21: Knowledge on the difference between general counselling and VCT

- No difference: 20%
- VCT is only for testing HIV status: 11%
- Counselling is only for mental illness: 1%
- Counseling is to solve psych. problems/ VCT is counselling & HIV test: 58%
- Others: 10%
3.3 Attitude toward Professional Counselling service

3.3.1 People deserving counselling

With regard to who needs counselling, an overwhelming majority (79.9%) mentioned that everybody deserves to visit counselling centres (Table 6).

There should be no exceptions.

Table 6: The people deserving counselling services

<table>
<thead>
<tr>
<th>People</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anybody</td>
<td>326</td>
<td>79.9</td>
</tr>
<tr>
<td>Youth/adolescent</td>
<td>24</td>
<td>5.9</td>
</tr>
<tr>
<td>Those with health problems</td>
<td>15</td>
<td>3.7</td>
</tr>
<tr>
<td>Those with HIV/AIDS</td>
<td>14</td>
<td>3.4</td>
</tr>
<tr>
<td>Those with problems in relationships</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>Jobless people</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Poor people</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Those who have psychological problem</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>NA</td>
<td>19</td>
<td>4.7</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100</td>
</tr>
</tbody>
</table>
3.3.2 Need of counselling

Then when they were asked about need of counselling, nearly 30% were aware that they need counselling now (Figure 22). Most of them selected health problems (11.0%), psychological problems (4.9%) and difficulties in relationship (3.2%) for the reasons (Table 7).

Figure 22: Need of counselling
Table 7: Reasons of need of counselling

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td>45</td>
<td>11.0</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>20</td>
<td>4.9</td>
</tr>
<tr>
<td>Difficulties in relationships</td>
<td>13</td>
<td>3.2</td>
</tr>
<tr>
<td>Employment problems</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Sexuality</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>Marriage</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>Drug/alcohol problem</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Pregnancy/family planning</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Educational matter</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Grief/bereavement</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>NA</td>
<td>296</td>
<td>72.5</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100</td>
</tr>
</tbody>
</table>
3.3.3. Attitude to counsellors

An overwhelming number of respondents (80%) answered the best person who offers counselling service is professionally trained person followed by religious counsellors (10%) (Figure 23). They valued experience and technical knowledge of the professional counsellors (Figure 24).

Figure 23: Best person to offer counselling services
Figure 24: Reasons for rating the best person to offer counselling services
They describe ideal counsellor in terms of religion and age. Only 3% mind gender and 1% mind ethnicity (Figure 25).

Figure 25: Important points to choose the ideal counsellor
Constraints and hindrance to counselling

Regarding to hindrance of counselling, 37% of the respondents reported that there are hindrances of counselling (Figure 26). They mainly attribute to: limited time (15.4%); lack of information about location of the counselling centres (9.6%); cost of services (5.4%); lack of transport fees (2.7%) and fear to know HIV status (1.7%) (Table 8).
Figure 26: Awareness of hindrance of using counselling services

- Yes: 37%
- No: 63%
Table 8: Reasons hindering the use of counselling services

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of service</td>
<td>22</td>
<td>5.4</td>
</tr>
<tr>
<td>Don’t know where it is</td>
<td>39</td>
<td>9.6</td>
</tr>
<tr>
<td>Fear to know HIV status</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td>Lack of trusting counsellors</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Lack of transport fees</td>
<td>11</td>
<td>2.7</td>
</tr>
<tr>
<td>Limited time</td>
<td>63</td>
<td>15.4</td>
</tr>
<tr>
<td>NA</td>
<td>264</td>
<td>64.7</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

3.3.5 Decision making process

When asked whom they could consult before visiting a counselling centre, a half of them would at least like to get permission from family members as shown by figure 27 and Table 9. The reasons were for the sake of family stability and respect for social hierarchy of decision making (Table 10).
Figure 27: Consultation before going to counselling

- No: 49%
- Yes: 51%
Table 9: The family member to whom consult.

<table>
<thead>
<tr>
<th>Family member</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband</td>
<td>65</td>
<td>15.9</td>
</tr>
<tr>
<td>Wife</td>
<td>51</td>
<td>12.5</td>
</tr>
<tr>
<td>Brother</td>
<td>12</td>
<td>2.9</td>
</tr>
<tr>
<td>Sister</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>Mother</td>
<td>21</td>
<td>5.1</td>
</tr>
<tr>
<td>Father</td>
<td>17</td>
<td>4.2</td>
</tr>
<tr>
<td>Grandparents</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>NA</td>
<td>235</td>
<td>57.6</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 10: Reasons for consultation with the family member

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of family</td>
<td>53</td>
<td>13.0</td>
</tr>
<tr>
<td>Responsible</td>
<td>15</td>
<td>3.7</td>
</tr>
<tr>
<td>Reliable</td>
<td>11</td>
<td>2.7</td>
</tr>
<tr>
<td>Helpful</td>
<td>34</td>
<td>8.3</td>
</tr>
<tr>
<td>Experience</td>
<td>10</td>
<td>2.5</td>
</tr>
<tr>
<td>To maintain good relationship</td>
<td>76</td>
<td>18.6</td>
</tr>
<tr>
<td>NA</td>
<td>209</td>
<td>51.2</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

85% of the respondents answered it is not wrong to discuss certain health matters with outsiders (Figure 28). Only 15% mentioned it was wrong, with reasons including “bad things will occur if secret is disclosed” and “fear to bring bad name to the community” (Table 11).
Figure 28 Avoidance of discussion over certain health matters with outsiders

Yes
15%

No
85%
Table 11: Reasons for avoiding discussion about certain health matters with outsiders

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS with stigma &amp; Discrimination</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>STI brings shame</td>
<td>3</td>
<td>0.7</td>
</tr>
<tr>
<td>Fear to bring bad name to the community</td>
<td>21</td>
<td>5.1</td>
</tr>
<tr>
<td>Bad things will occur if secret is disclosed</td>
<td>22</td>
<td>5.4</td>
</tr>
<tr>
<td>NA</td>
<td>358</td>
<td>87.7</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In terms of counselling situation, attitude of the secrecy slightly goes up as compared to general outsiders. 20% of the respondents express they cannot talk with counsellor over certain health-related topics because of feeling of shame and a concern about the confidentiality which is not guaranteed (Figure 20 and Table 12).
Figure 29: Avoidance of talking about certain health-related topics with counsellors
Table 12: Reasons for avoidance of talking about certain health topics with counsellors

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of discrimination</td>
<td>10</td>
<td>2.5</td>
</tr>
<tr>
<td>Confidentiality is not guaranteed</td>
<td>25</td>
<td>6.1</td>
</tr>
<tr>
<td>Feeling of shame</td>
<td>37</td>
<td>9.1</td>
</tr>
<tr>
<td>NA</td>
<td>336</td>
<td>82.4</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>
3.3.6 Cost of counselling

Slightly more than a half of the respondents reported that counselling centres are too far from the residence, even though the majority’s estimation from their residence to the nearest counselling centre was within 1Km (Figure 30, 31).

Figure 30: Long distance to counselling centers

No
44%

Yes
56%
Figure 31: Estimation of the distance to the nearest counselling center

Distance

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 500m</td>
<td>82</td>
</tr>
<tr>
<td>&lt; 1km</td>
<td>172</td>
</tr>
<tr>
<td>&lt; 5km</td>
<td>87</td>
</tr>
<tr>
<td>&lt; 10km</td>
<td>14</td>
</tr>
<tr>
<td>10km or more</td>
<td>3</td>
</tr>
</tbody>
</table>
Most of the respondents reported that VCT is free. But nearly 24% answered it requires 50 Ksh (Figure 32). In Kibera slums, operating VCT centres charge either free or 50Ksh.

Figure 32: Cost of counselling services
3.3.7 Evaluation of counselling services

Almost all respondents positively evaluated services of counselling centres and VCTs. However, there was much variety in VCT services and satisfaction level as well (Figure: 33 and 34).

Figure 33: Evaluation of counselling services
Figure 34: Evaluation of VCT services

- Excellent: 14%
- Very good: 54%
- Good: 24%
- Fair: 7%
- Bad: 1%
- Very bad: 0%
After visiting counselling centres, clients have given high appreciation to them. The respondents who have been to counselling service are likely to score high in evaluating the counselling service. There appears statistically significant association between experience of counselling services and its evaluation (Table: 13, chi-square value: 51.014, df 3, p<0.01).

Table 13: Experience of counselling service and its evaluation

<table>
<thead>
<tr>
<th>Experience</th>
<th>Evaluation of the services offered in the counselling centres</th>
<th>Total number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Excellent</td>
<td>Good</td>
</tr>
<tr>
<td>Yes</td>
<td>23</td>
<td>66</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>77</td>
</tr>
</tbody>
</table>

3.3.8 Recommendations and suggestions for professional counselling

Recommendations are given by the respondents to improve services. For the counselling centres, extension of the services in rural area (24.3%) is the most expected improvement, whereas, free service is the most expected one to VCT centres (Table 14, 15).
Table 14: Recommendations for counselling centres

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time extension</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Issuing certificate</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Weekend service</td>
<td>5</td>
<td>1.2</td>
</tr>
<tr>
<td>To reduce waiting time</td>
<td>17</td>
<td>4.2</td>
</tr>
<tr>
<td>To have more many counsellors</td>
<td>27</td>
<td>6.6</td>
</tr>
<tr>
<td>To extend services in rural area</td>
<td>99</td>
<td>24.3</td>
</tr>
<tr>
<td>NA</td>
<td>254</td>
<td>62.3</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 15: Recommendations for VCT centres

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free service</td>
<td>75</td>
<td>18.4</td>
</tr>
<tr>
<td>Keeping secret/confidentiality</td>
<td>18</td>
<td>4.4</td>
</tr>
<tr>
<td>High skills of counselling</td>
<td>23</td>
<td>5.6</td>
</tr>
<tr>
<td>Support for PLWHA</td>
<td>15</td>
<td>3.7</td>
</tr>
<tr>
<td>Support for orphan</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>Extension to rural place</td>
<td>62</td>
<td>15.2</td>
</tr>
<tr>
<td>Everyday service</td>
<td>9</td>
<td>2.2</td>
</tr>
<tr>
<td>Time extension</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>NA</td>
<td>194</td>
<td>47.5</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Comparing other suggestions between the two services, providing more information to the public and having many referral places are thought to be important to attract more people (Table: 16 and 17).
Table 16: Suggestions for general counselling centre

<table>
<thead>
<tr>
<th>Suggestions</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>By providing more information about counselling to the public</td>
<td>136</td>
<td>33.3</td>
</tr>
<tr>
<td>By having many referral places</td>
<td>114</td>
<td>27.9</td>
</tr>
<tr>
<td>Free service</td>
<td>86</td>
<td>21.1</td>
</tr>
<tr>
<td>By having many skilled counsellors</td>
<td>48</td>
<td>11.8</td>
</tr>
<tr>
<td>By providing psychological support</td>
<td>6</td>
<td>1.5</td>
</tr>
<tr>
<td>By extending time of service</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>By offering therapeutic outcome</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>NA</td>
<td>13</td>
<td>3.2</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 17: Suggestions for VCT centres

<table>
<thead>
<tr>
<th>Suggestions</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>By having many referral places</td>
<td>116</td>
<td>28.4</td>
</tr>
<tr>
<td>By providing HIV/AIDS info to the public</td>
<td>113</td>
<td>27.7</td>
</tr>
<tr>
<td>Free service</td>
<td>77</td>
<td>18.9</td>
</tr>
<tr>
<td>By having many skilled counsellors</td>
<td>49</td>
<td>12.0</td>
</tr>
<tr>
<td>By providing social support to PLWHA</td>
<td>31</td>
<td>7.6</td>
</tr>
<tr>
<td>By extending time of service</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td>By offering therapeutic outcome</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>By providing psychological support</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>By providing accurate testing results to clients</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>NA</td>
<td>8</td>
<td>2.0</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100</td>
</tr>
</tbody>
</table>

3.3.9 Demand on expansion of services

The following figures (35, 36, 37, 38) demonstrate high expectation of having more counselling centres. Nearly 95% of the respondents feel that there is need for expanding counselling services of whatever form in Kibera. The services, at the moment, have not covered huge population. Almost all
respondents (98%) also answered that introduction of VCT in Kibera would be a good idea, because it would: increase accessibility to VCT and HIV/AIDS awareness; and reinforce HIV prevention and control.

Figure 35: Need of expanding counselling services
Figure 36: Reasons for the need to expand counselling services

- It should reach many more people: 64%
- It has not covered big population yet: 15.90%
- To make people have choices of it is necessary: 8.30%
- Not all counselling centers are functioning: 0.70%
- Others: 11%
Figure 37: Attitude to an introduction of VCT

- Yes: 98%
- No: 2%
Figure 38: Reasons for introducing VCT

- To access to VCT easily: 160
- To increase HIV awareness: 125
- HIV prevention and control: 52
- Benefit from free counselling: 20
- Behaviour change: 18
- To know HIV status: 18
- To reduce anxiety: 1
- Others: 14

Reasons for introducing VCT.
3.4 Utilization Patterns of Professional Counselling Service

One of the most interesting findings of this research is the trend that indicating how many respondents had visited both professional and traditional counselling (Figure 39).

Figure 39: Utilization rate of counselling services in Kibera slums
3.4.1 Types of counselling services

There are traditional and professional counselling services found in Kibera slums. Traditional counselling is provided by indigenous doctor, herbalist and religious counsellors such as priest, pastor, faith healer. The professional counsellor, in this context, consists of general counsellor and HIV/AIDS counsellor.

3.4.2 Traditional Counselling

3.4.2.1 Support and help from Indigenous doctor and herbalist

In Kibera slums indigenous doctor and herbalist have some similarity in practice contrasting to religious leaders. For example, they heal illness by medicine, learning skills from respected old healers, keeping secret of the healing. The main issues presented by the clients to them are health problems, psychological problems and pregnancy problems. Married people and those who have many children with low level education are their main clients.

But there is also some difference between indigenous doctor and herbalist.
For instance, according to our statistical data, utilization ratios are different, as 18.9% of herbalist and 16.2% of indigenous doctor.

Generally in Kibera slums, people think that indigenous doctors are the medical practitioners who heal patients by using supernatural power. They are also thought to be good at dealing with love affairs. Herbalists are perceived as the medical practitioners who use herbs to heal patients.

Let me present a brief outlook of the indigenous doctor using interview information. According to a male indigenous doctor in Mashimoni Village, he cannot disclose his process of healing to outsiders due to oath. He has taught his skills to the limited family members and some disciples who promised to keep the secret. In Kibera usually clients visit him at night so that others do not easily see them. Due to attachment of sorcery to indigenous doctors, people are likely to hide that they have visited them. Especially in the churches sorcery has been criticized for a long time, once they are known as Christian, it is difficult for them to disclose their experience with indigenous doctors.
3.4.2.2 Religious Counselling

This counselling is observed in the churches and mosques in Kibera. The population benefiting from the religious counselling is much bigger than that of traditional healing (indigenous doctors and herbalist). In the religious counselling, counsellors don't use medicine for help. They use God's power to their followers, mostly with prayers.

This study shows 38.2% of the respondents mentioned that they had visited religious counsellors. There are few big mosques and many small churches in Kibera. When members of the religion have problems they visit the religious counsellors for help.

According to a pastor who answered in the interview, church members bring him various personal issues including domestic violence, dispute in workplace, marriage and family problems, health problems and poverty. He offers religious counselling to help them with a power of God. Now, HIV/AIDS is a big issue even in his church. Mostly they promote prevention of the HIV infection by being faithful to one non-infected person. Therefore, before
signing marriage certificate, the pastor confirms documentation of HIV status. If results from the couple are same, he shall sign the certificate, but if the results are discordant, he shall not sign it.

In the mosque, Imam is a leader among Muslims. He can be counsellor when his believers come for advice from him. But in case of HIV/AIDS, PLWHA are marginalized in the Muslim society, due to stigma of promiscuity. They are often blamed for committing adultery, which is strictly prohibited in the religion. In the mosques of Kibera it is difficult for them to talk about HIV/AIDS issue freely.

3.4.2.3 Types of professional counselling

Professional counselling which Kibera residents use can be divided into general and HIV/AIDS counselling. The following table 18 shows their availability and services.
Table 18: Types of professional counselling

<table>
<thead>
<tr>
<th>Type</th>
<th>No. of Available centres</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>6</td>
<td>One-one counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Couple counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group counselling</td>
</tr>
<tr>
<td>HIV/AIDS (VCT)</td>
<td>9</td>
<td>One-one counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Couple counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group counselling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIV test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PLWHA support</td>
</tr>
</tbody>
</table>

3.4.2.4 General Counselling

Nearly 23.3% of respondents reported having visited general counselling centres such as KICOSHEP (36.8.8%), AMREF (15.3.7%), KNH (10.2.5%), AMDA (2.0.5%), AMANI (2.0.5%), Mbagathi District hospital (2.0.5%) and others (Figure 40). Almost 18.6% said that their family members had been to counselling centres before.

In such counselling centres, professionally trained counsellors offer general counselling. They help clients to know themselves and to solve their problems by exploring and choosing options. One counselling session take from 30 minutes to one hour. Counselling fees vary from free to 500 Kenya Shillings.
Most of the professional counsellors have qualifications such as certificate and diploma issued from counsellor training institutions. In the training they have learned three main theories of counselling, namely, Humanistic-existential counselling, Cognitive-behavioral counselling and Psychodynamic counselling. Accordingly they use such theories in actual counselling sessions.

The issues of general counselling are broad. Clients present issues of depression, anxiety, substance addiction, marriage, relationship with
parents, domestic violence, child abuse, rape, abortion, suicide, poverty, education, sexuality, pregnancy, HIV/AIDS, STI and others.

Table 19: Reasons for visiting general counselling centres

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health problems</td>
<td>38</td>
<td>8.7</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>8</td>
<td>1.8</td>
</tr>
<tr>
<td>Difficulties in relationship</td>
<td>5</td>
<td>1.1</td>
</tr>
<tr>
<td>Marriage</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Sexuality</td>
<td>10</td>
<td>2.3</td>
</tr>
<tr>
<td>Pregnancy/family planning</td>
<td>16</td>
<td>3.7</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>23</td>
<td>5.3</td>
</tr>
<tr>
<td>Drug/alcohol problem</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Education matter</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>NA</td>
<td>330</td>
<td>75.7</td>
</tr>
<tr>
<td>Total</td>
<td>436</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Many professional counsellors feel that HIV/AIDS issue is most difficult among others. Other difficult issues for them are child abuse, depression with suicidal tendency, alcohol addiction, adultery and domestic violence.

Sometimes they refer clients to other institutions and counsellors such cases as: their friends or relative ask for counselling; a clients comes to deeply depend on the counsellor; a client be sexually attracted by the counsellor; a value of the counselor is so different from that of the client; a client needs
other supports.

Normally process of counselling is explained to clients in a contract made in the first session. The clients can terminate the counselling anytime as they want, though the counsellor may suggest finalizing it when clients is empowered and solve their problems.

3.4.2.5 HIV/AIDS counselling (VCT)

Slightly over 23.5 % reported that they had visited VCT centres. About 48 informants (11.8 %) had visited KICOSHEP VCT centres, followed by KNH 19 (4.7 %), AMREF 13 (3.2 %), AMDA 2 (0.5 %), Mbagathi District hospital (Figure 41).
Figure 41: VCT centers visited by the respondents

<table>
<thead>
<tr>
<th>VCT Centre</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>KICOSHEP</td>
<td>48</td>
</tr>
<tr>
<td>KNH</td>
<td>19</td>
</tr>
<tr>
<td>AMREF</td>
<td>13</td>
</tr>
<tr>
<td>AMDA</td>
<td>2</td>
</tr>
<tr>
<td>MBAGATHI</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>12</td>
</tr>
</tbody>
</table>
When asked about reasons for visiting the VCT centres, the responses were as follows: To know HIV status (7.8%), For HIV/AIDS awareness (5.6%) and To know Health status (5.4%) (Table 20).

Table 20: Reasons for visiting VCT centres

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>To know HIV status</td>
<td>32</td>
<td>7.8</td>
</tr>
<tr>
<td>To know health status</td>
<td>22</td>
<td>5.4</td>
</tr>
<tr>
<td>For HIV/AIDS awareness</td>
<td>23</td>
<td>5.6</td>
</tr>
<tr>
<td>Requirement for job</td>
<td>4</td>
<td>1.0</td>
</tr>
<tr>
<td>Requirement for education</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>NA</td>
<td>325</td>
<td>79.7</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>

For those who had not been to VCT centres, the following responses were given: No risk of infection (15.7%); Not yet ready to visit (15.7%); “I don’t know about VCT (13%); “Too busy (11.3%); Fear to know HIV status (7.4%) (Table 21).

Table 21: Reasons for not visiting VCT centres

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not yet ready to go</td>
<td>64</td>
<td>15.7</td>
</tr>
<tr>
<td>Fear to know HIV status</td>
<td>30</td>
<td>7.4</td>
</tr>
<tr>
<td>No risk of HIV infection</td>
<td>64</td>
<td>15.7</td>
</tr>
<tr>
<td>Too busy</td>
<td>46</td>
<td>11.3</td>
</tr>
<tr>
<td>Don’t know about VCT</td>
<td>53</td>
<td>13.0</td>
</tr>
<tr>
<td>NA</td>
<td>151</td>
<td>37.0</td>
</tr>
<tr>
<td>Total</td>
<td>408</td>
<td>100.0</td>
</tr>
</tbody>
</table>
VCT was introduced into Kenya in 1990s in order for people to know their HIV status with support of counselling. It also promotes counselling and HIV testing to the clients who voluntarily visit the VCT centres, since forced and mandatory HIV testing is still observed.

In the VCT centre, clients are registered by numbers and during the counselling session client's name is not used. At the first contact, a counsellor assures the client that confidentiality be maintained. Then they proceed to Pre-test counselling, HIV test and Post-test counselling. It takes around one hour all together. Most of VCT centres take one session only. If a client needs confirmation test he/she may come again. If the client needs other supports he/she will be referred to various institutions.

In the VCT centres counsellors should do another work of HIV testing by using rapid tests. In Kenya the people who trained as VCT counsellors only take blood from the client's body for this purpose apart from medical practitioners. Using two different types of rapid test kits, the client can get
the result in 15 minutes. It enables the client to get the result same day.

In the pre-test counselling, the counsellor and the client explore risks of HIV infection and preparedness for the test. After the HIV test, based on the result, the counsellor offers post-test counselling to the client.

If the client gets negative result, the counsellor helps the client realize window period in which the test kits can not detect HIV, usually it take three months from the most recent HIV exposure to the detection. Then the counsellor may help the client to maintain the negative status by providing proper information for protection.

If the client finds him/herself HIV-positive, the counsellor helps the client to live positively. The counsellor may offer psychological support to accept the result and give some information for living positively such as stress management, balanced diet, healthy life style, medical care, PLWHA support groups.
Some of the VCT centres have own support and care systems for HIV positive clients. They include the Post Test Club (both HIV-positive and negative members) and Group counselling (HIV-positive members only).

3.5 Socioeconomic and Cultural Factors Influencing Utilization of Professional Counselling services

3.5.1 Socioeconomic factors

There are some socioeconomic factors relating to professional counselling practice. They include educational background, economic situation, occupation, and number of sexual partner.

According to Table 22, The respondents who have no formal education are not likely to visit VCT centres. The people who have got higher education seem to visit VCT, in the Post secondary level, more than half of them have already visited VCT as compared to other educational level.
Table 22: Level of education and utilization of VCT

<table>
<thead>
<tr>
<th>Experience of VCT</th>
<th>Education level</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>124</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>144</td>
</tr>
</tbody>
</table>

(chi-square value: 30.663, df=3, p<0.01)

Economic situation is also an important factor in the context of utilization of counselling. When we asked about the actual utilization of counselling centres and income of household, respondents in the second highest income level (10,000-49,000 Kenya Shillings) are more likely to be visiting counselling centres as compared to those in the other levels (Table 23). In this level, the number of respondents who had visited counselling centres is higher than that of those who have not visited them.

Table 23: Income and utilization of counselling centres

<table>
<thead>
<tr>
<th>Experience of general counselling</th>
<th>Income</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-4.999</td>
<td>5,000-9,99</td>
</tr>
<tr>
<td>Yes</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>No</td>
<td>108</td>
<td>79</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>102</td>
</tr>
</tbody>
</table>

(chi-square value: 31.256, df=3, p<0.01)
As demonstrated by Table 24, the jobless people feel the need of general counselling more than other occupation. The other categories include traders, housewives and unskilled general workers.

Table 24: Occupation and need of general counselling

<table>
<thead>
<tr>
<th>Occupation</th>
<th>At the moment, are you in need of seeing a counsellor?</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Private company worker</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Unskilled general workers</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>Street vender</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>House wife</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Watchman</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Pastor/priest</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>House help</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Student</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Trader</td>
<td>22</td>
<td>58</td>
</tr>
<tr>
<td>Farmer</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Government worker</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Health worker</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>NGO worker</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Jobless</td>
<td>27</td>
<td>44</td>
</tr>
<tr>
<td>CSW</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Others</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>117</td>
<td>286</td>
</tr>
</tbody>
</table>

(Chi-square value: 30.306, df:16, p<0.05)
The findings show that the number of sexual partner has influences on utilization of VCT. A higher proportion of those who had no lover had not been to VCT, compared to those with 3 to 5 lovers. This suggests that those who have many lovers are more likely to go for VCT (Table 25).

Table 25: Number of lovers and utilization of VCT

<table>
<thead>
<tr>
<th>Been to VCT?</th>
<th>How many lovers do you have?</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Yes</td>
<td>52</td>
<td>30</td>
</tr>
<tr>
<td>No</td>
<td>218</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>270</td>
<td>101</td>
</tr>
</tbody>
</table>

(chi-square value: 22.373, df6, p<0.05)

3.5.2 Cultural factors

There exists multi ethnic groups in Kibera slums. More than 10 ethnic groups reside there. The findings show that ethnicity influences the choice of the ideal counsellor. Table 26 shows that respondents of Luo and Nubian origin seem to value the age of the counsellor. By contrast, the Luyha, Kikuyu and Kisii are likely to consider religion of the counsellor. Despite the differences, the skills and experience are considered as critical points for an
ideal counsellor.

Table 26: Ethnicity and an ideal counsellor

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Ideal counsellor in terms of what?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age</td>
<td>Gender</td>
</tr>
<tr>
<td>Luhya</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Luo</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Kikuyu</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Kamba</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Kisii</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Masaai</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nubian</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>12</td>
</tr>
</tbody>
</table>

(chi-square value: 64.867, df: 28, p<0.01)
CHAPTER 4: DISCUSSION

This study aims at understanding knowledge, attitude and utilization of professional counselling services by residents of Kibera slums. In the previous chapter the emphasis has been mainly on the presentation of quantitative data from 408 respondents. In this section, the focus is on data interpretation supported by qualitative information from focus group discussions, Key Informant interviews and relevant literature.

4.1 Knowledge of professional counselling

The awareness of general counselling centres and VCT centres is high in Kibera. More informants were aware of VCT service (84%) than the general counselling services (60%). There was a research conducted in Thika district, Kenya in 2002. It also shows relatively high rate of awareness of VCT services among secondary school student, which is 69.2 % (Kibunja, 2002).

This can be attributed to advertisement on mass media and commitment of the Government and NGOs. In mass media, information about VCT services is broadcasted on TV, Radio and big sign posts everyday. Most of the people come across the message encouraging them to visit the VCT centres. Also
the Kenyan government and NGOs closely cooperate in promotion and implementation of VCT services. They have, on several occasions heard of VCT, which provides counselling and HIV test. Thus HIV test and counselling are closely related in their view.

The result of this study demonstrate that the respondents associate general counselling centre with HIV/AIDS (18.4%), as well as health problems (35.8%). This explains why those who mentioned difficulties in relationship (7.8%) and psychological problems (6.1%) were fewer. I will discuss it further in the subsequent sections.

When asked about availability of VCT, around 66% reported that VCT centres were not available in their area. This agrees with our observations as we noted response of VCT centres only in Kichinjio, Laini saba and Mashimoni villages. There were two KICOSHEP VCT centres, AMREF general counselling centre and AMDA's VCT and general counselling centre within the three villages.

In terms of services and size, KICOSHEP is the biggest local NGO, which
has three VCT centres inside the slums and two outside the slums. AMREF provides general counselling centre in their clinic. AMDA, an international NGO, runs VCT centre and general counselling centre in Mashimoni village.

With regard to the necessity of counselling services at the time of study, 41% of respondents reported specific health topics requiring counselling service in their life. Nearly 30% were in need of counselling. Thus, again, points to the importance of expanding counselling centres in the area. When this question was explored through focus group discussions to understand what prompts people to professional counselling, main problems mentioned included HIV infection, sexuality, communication with children and difficulties in the work place. However, the vast majority admitted they did not have correct knowledge about what services are provided by professional counselling. Taken at face value, most people might not make maximum use of the facilities due to lack of understanding of the services provided.

4.2 Attitude toward Professional counselling

The majority of respondents feel that anybody can benefit from counselling services. They do not specify certain types of people that deserve it. When in
need of counselling, 51% of the informants indicated that they would consult with family members before visiting counsellors. A general trend is that women often consult with husband and mother compared to men who are likely to consult with wife, brother and father. The main reasons being respect for family is that headship and to maintain good relationship with family members. This approach reflects the influence of patriarchy in decision making. In sub-Saharan Africa women's subordinate position within the home is deeply entrenched in both the traditional and current legal, religious and social structures (KANCO, 2000).

However, the situation in VCT centres is different from this. Most of clients, according to some counsellors interviewed, visit VCT secretly. In situation involving couple, the majority prefers the outcome of the test to be confined to individuals. This could be due to the potential effects of the positive result that is largely associated with stigma and rejection (KANCO, 2000; Tuju, 1996).

For those who have been to the centres, the majority of them feel satisfied with the services offered by both general counselling and VCT centres. They
also appreciate the professionally trained person as the best one to offer counselling services.

Over 95% of respondents reported the need to introduce and expand professional counselling service in the area. In their view, this could increase accessibility. In Kenya VCT and general counselling services are fewer. And the more disadvantaged people are those in low income and rural areas. Hence these services need to expand to reach more people (LSTM, 2001; MOH Kenya, 1988).

4.3 Utilization of Professional counselling

With regard to utilization of counselling services, the findings show that 23.3% had been to general counselling, while 23.5% to VCT. Some respondents had been to indigenous doctors' service (16.2%), herbalists' (18.9%) and religious counselling (38.2%). The implication here is that the expansion of professional services may not be completed to substitute traditional approaches. The preference for a counselling service, as is commonly the case in health seeking, may be determined by a variety of factors.
Traditional counsellors including indigenous doctors, herbalist and religious counsellors still play significant role in helping and supporting people in Kibera.

The indigenous doctors and herbalists can be categorized as traditional healers because both of them heal illness by using local medicine. They have other similarity such as learning skills from respected healer and keeping secret of the healing. The main issues presented by the clients to them are health problems, psychological problems and pregnancy problems. Married people and those who have many children with low level education are their main clients. The clear difference between them is that indigenous doctor associated with super natural powers. For this reason, people tend to hide the fact that they visit them.

Another source of help comes from religious counsellors. Pastors, priests, faith healers and imam are key players in this counselling service. However they don't use medicine for help. They profess to use divine power to help their followers, mostly through prayers. As it has been argued elsewhere,
faith healing is an indispensable strategy of dealing with problems in poor communities. For instance this study shows that 38.2% of the respondents had visited religious counsellors. Given that 93% of respondents are Christian or Muslims, they are considered potential clients of this counselling. When members of the religion have personal problems they visit the religious counsellors for help. However, with regard to HIV/AIDS this counselling is not likely to support their members, instead the PLWHA are sometimes marginalized (FHI, 1996; House and Walker, 1993).

As mentioned previously, most of the Kibera residents feel counselling is for HIV/AIDS. In fact, counsellors feel that it is the most difficult aspect of their work. VCT centres play core roles in HIV/AIDS counselling to both infected and non-infected people.

The purpose is mainly change of sexual behavior and introduction of care and support, especially for coping with HIV positive situation. VCT counsellors have skills of HIV testing. Most of VCT centres take one session only. It takes around one hour all together. The fees for VCT services are from free to 50 Kenya shilling in most centres. All these factors influence
the current level of utilization (23.5%).

The reasons for visiting VCTs were to know HIV status (7.8%) and to increase HIV/AIDS awareness (5.6%), and to know health status (5.4%). By contrast, some respondents did not visit VCTs, because: No risk of infection (15.7%); Not yet ready to visit (15.7%); “I don’t know about VCT (13%)”; “Too busy (11.3%)”; Fear to know HIV status (7.4%). The reasons provided here are actually the same ones that seem to impact an HIV/AIDS prevention effort.

Another area of interest for this study was to describe the different types of counselling services available to PLWHA. The findings show that there are two types of HIV/AIDS counselling offered to PLWHA, namely, one-to-one counselling and group counselling. One-to-one counselling is usually introduced at first, then a client may join group counselling. Sometimes both counselling are simultaneously used to help the client. In the group counselling, two kinds of grouping methods are known. One is grouping with only PLWHA. The other consists of PLWHA and HIV negative people.
A study conducted in Kenya on the group counselling for PLWHA shows that there are outcomes such as insight, interpersonal action, acceptance by group members, self-disclosure, catharsis, guidance, universality (the person appreciates that others share their problems), altruism (the person becomes important for others), vicarious learning, instillation of hope (Balmer 1993; Coman et al., 2002). Among the outcomes mentioned above, some of the PLWHA in the focus group discussions confirmed acceptance by group members, self-disclosure, catharsis and instillation of hope coming out of the group counselling.

The responses documented here seem to agree with the expectations of Cognitive-behavioral approach. This approach focuses mainly on changing observed behaviours by means of providing different or rewarding consequences (Nelson-Jones, 2001). The group members encourage behaviour change of other members and if that behaviour change appears, then they give the clients reward of blessings and praise. This kind of continuous motivation strengthens the change.

However, outcomes of the group counselling among the infected and
non-infected people are not known so far. This type of grouping is now being encouraged by some NGOs. The purpose is to promote mutual support between non-infected and infected people by HIV/AIDS. The evaluation of outcomes of VCT services together with that of the mixed group is needed.

Those who have visited mostly suggested that VCT centres should keep secret/confidentiality, support for PLWHA, support for orphan, start every day service and extend the time of service. All these suggestions are challenging to managers and counsellors in the VCT centres.

4.4 Socioeconomic and cultural constraints in utilization of professional counselling

Nearly 37% of respondents reported that there are constraints and hindrance to utilization of counselling services.

Some of the critical socioeconomic and cultural factors that influence professional counselling practice are: education, cost, occupation, sexuality and ethnicity.
In the previous chapter it is shown that those who have no formal education are not likely to visit VCT centres but those with higher education seem to visit them. At the same time traditional counselling attract less educated people. To get clear explanation of this mechanism, there is need of more research on the relationships among factors such as languages used in counselling and image attaching to counselling.

In order to get counselling services, clients have to pay fees for the service and transport to reach the centre. This research already revealed that respondents in the second highest income level (10,000-49,000 Kenya Shillings) are more likely to visit counselling centres compared to those in the other levels. It seems that they can afford to pay the costs.

Occupation is closely related with economic situation. Jobless people, trader, house-wives, unskilled general workers feel that they need counselling. They are the same people who have low income. But reference to the above mentioned relationship between income and utilization, they don't seem to use the counselling services due to the costs, even though they feel the need.
With regard to sexuality, there is a tendency that shows those who have many lovers are more likely to go to the VCT. But the meaning of sexuality and economic disadvantage differ in socio-cultural context. Examination of counselling theory and practice in relation to three groups (economically disadvantaged; gay, lesbian and bisexual; religiously committed) shows that members of these groups have had to struggle to have their experience and values taken seriously by the counsellors (McLeod, 1998). They may doubt that the counsellors surely understand their experience and values.

Ethnic background influences on choice of the ideal counsellor. The result of this research shows that the Luo and Nubian seem to mind age of the counsellor, on the other hand, the Luhya, Kikuyu and Kisii are likely to mind religion of the counsellor. These are factors that cannot be ignored as they are embedded in culture.
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

a) Both Traditional and Professional counselling play significant roles in offering psychological support and therapeutic outcomes to residents in Kibera slums. The traditional counselling consists of traditional healing and religious counselling, whereas professional counselling consists of general counselling and HIV/AIDS counselling.

b) The awareness of professional counselling is quite high in Kibera due to advertisement on mass media, and commitment of the Government and NGOs. However, the majority of Kibera residents think general counselling centre is mainly for HIV/AIDS and health problems.

c) About a half of respondents consult with family members before visiting counsellors. Those who have been to the centres express satisfaction with the services offered by both general counselling and VCT centres. Thus, the demand on expanding of professional counselling service is quite high.

d) One of the original findings of this study is the utilization rates of counselling services among Kibera residents. It shows 23.3% for general counselling,
23.5% for VCT, 16.2% for indigenous doctor's service, 18.9 for herbalist's service and 38.2 for religious counselling.

e) Kibera Residents mainly use professional counselling centres such as KIKOSHEP, AMREF, AMDA and KNH for general counselling and VCT services.

f) The socioeconomic and cultural factors, to varying degrees, affect the utilization of professional counselling. The main ones are education, cost, occupation, sexuality and ethnicity.

g) Professional counselling seemed to have increased with the advent of HIV/AIDS. The HIV/AIDS is the most difficult issue in the professional counselling. Thus, counsellors are likely to be associated with HIV/AIDS even in cases where they are working on different issues.

5.2 Recommendations

5.2.1 Promoting awareness of professional counselling services
Professional counselling has much broader range of help and support than people think. The issues involved in professional counselling are not only health
problem. To increase the utilization of such an essential service, intensive awareness campaign is needed.

5.2.2 Improving services of professional counselling centres

Improvement of the services should embrace support for people living with HIV/AIDS, support for orphan, every day service and extension of time of service. Each of them requires huge energy and time. Nevertheless, in order to attract more public interest in professional counselling, such improvements are indispensable.

5.2.3 Expanding VCT and general counselling services in urban and rural place

The demand of expanding the services is quite high among the respondents. On the basis of this, the services of professional counselling should reach most vulnerable population.

5.2.4 Training of professional counsellors among PLWHA

Some NGOs have already started this training for PLWHA. The purposes are to develop potential of PLWHA to become professional counsellors. At the same time the existence of such counsellors encourages other PLWHA to live positively and happily. This kind of training helps them have hope in life.
5.2.5 Research on Traditional counselling

It is necessary to conduct further research on traditional counselling including traditional healing and religious counselling. They play irreplaceable roles for the communities in the low-income areas. Particularly in-depth interview research to understand aspects of their practice.

5.3.6 Research on outcomes from VCT services

Research on the outcomes of VCT service is essential as huge resources and time have been spent for the operation. At the same time new method of mix group counselling has started in some VCT centres. The outcomes of these interest to the public policy makers.
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APPENDIX I: Structured questionnaire (Interviewees: Kibera residents)

Questionnaire No. __________________________
Date of Interview __________________________
Village __________________________
Name of Interviewer __________________________

1 Initial of Name __________________________
2 Sex ( Male, Female)
3 Age ( years old)
4 Village of residence in Kibera ( )
5 Marital status ( Single, Married, others { })
6 How many partners do you have (spouse ____/lover ____)?
7 How many children do you have? (Boys ____/Girls ____)

8 Occupation (Kazi)
a) Teacher (mwalimu)
b) Private company worker (mfanyi kazi asiye wa serikali)
c) Jua Kali job (mfanyi kazi wa jua kali)
d) Street vendor (Muuzaji wa mtaa)
e) House wife (Mwanamke wa nyumbani)
f) Watchman (Mlinzi wa mlango/usiku)
g) Pastor/priest (Mhubiri/padri/Kadhi)
h) House help (Msaidizi wa nyumbani)
i) Student (mwanafunzi)
j) Trader (Mfanyi biashara)
k) Farmer (Mkulima)
l) Government worker (mfanyi kazi wa serikali)
m) Health worker (Mfanyi kazi wa afya)
n) NGO worker (Mfani kazi wa makundi yasiyo ya serikari)
o) Jobless (Mtu asiye na kazi)
p) Other ( )

9 Highest level of education (Kiwango cha juu zaidi cha masomo)
a) No formal education (Hakuenda shule)
b) Primary education (Shule ya msingi)
c) Secondary education (Shule ya upili)
d) Post secondary education (Zaidi ya shule ya upili)
e) NA

10 Ethnic group (Kabila)
a) Luhya
b) Luo
c) Kikuyu
d) Kamba
e) Kisii
f) Maasai
g) Nubian
h) Others ( )
11 Religion (Dini)
   a) Catholic
   b) Protestant
   c) Muslim
   d) Others ( )

12-1 Are you aware of the existence of counselling centres?
   Uko na habari yoyote kuhusu kuweko kwa vituo cha ushauri?
   a) Yes
   b) No
   c) NA

12-2 If yes, which counselling centres do you know? Kama ndio, ni kituo ngani cha ushauri unachojua?
   ( )

12-3 If yes, how did you come to know about the existence? *Multiple answers
   Kama ndio, ulipataje kujua juu ya kuweko kwa hicho kituo?
   a) Mass media (TV, radio) (Wanahabari)
   b) Friends (Marafiki)
   c) Family member (Watu wa Jamii)
   d) Relative (Jamaa zako)
   e) Poster (Vibandiko vya kuelimishana na mapango)
   f) Sign post (Vibandiko vilivyopingiwa mahali maalum)
   g) Health worker (Mfanyikazi wa kiafya)
   h) Others ( )

13-1 Have you been to a counselling centre? Umewahi kutembelea kituo cha ushauri?
   a) Yes
   b) No
   c) NA

13-2 If yes, which centre have you been to? (Umetembelea kituo gani?)
   ( )

13-3 Explain reasons. Kama ndio, ni kwa nini? *Multiple answers
   a) Health problems (Shida za kiafya)
   b) Psychological problems (Shida za mafikara)
   c) Relationship difficulty in family, relatives and workplace
       (Shida za kushirikiana katika familia, jamaa na mahali pa kazi)
   d) Marriage (Ndoa)
   e) Sexuality (Kimapenzi)
   f) Pregnancy/family planning (Mimba/kupanga/uzazi)
   g) HIV/AIDS (Ukimwi)
   h) Drug/alcohol problem (Kuadhiriwa na madawa ya kulevya)
   i) Domestic violence (Dhuluma za kijamii)
   j) Grief/bereavement (Kufiwa)
   k) Educational matter (Masomo)
   l) Employment problem (Kazi)
   m) Others ( )
14 How do you rate the services offered in the counselling centre?
    Huduma inayotolewa katika kituo ulichotembelea ni?
    a) excellent--------- Nzuri sana
    b) good-------------- Nzuri
    c) fair---------------- Kadiri
    d) poor--------------- Mbaya
    e) NA

15 Has any member of your family been to the counselling centre?
    Mtu yeyote wa jamii yako amewahi kutembelea kituo cha ushari?
    a) Yes
    b) No
    c) NA

16 What is your recommendation for counselling centres?
    Ungependa huduma itolewe kwa njia gani katika kituo ulichotembelea?
    a) Weekend services (Huduma za mwisho wa Juma)
    b) Time extension (Kuoneza wakati)
    c) Issuing certificate (Kipeana Shahada)
    d) To reduce waiting time (Kupunguza muda wa kungojea)
    e) To extend services in rural area (Kueneza huduma mpaka sehemu za mashambani)
    f) To have many more counselors (Kuwa na washauri wengi)
    g) Others ( )

17 What issues do people present to counsellors? Ni shida gani ambazo watu hupeleka kwa washauri?
    a) Health problems (Shida za kiafya)
    b) Psychological problems (Shida za mafikara)
    c) Relationship difficulty in family, relatives and workplace
        (Shida za kushirikiana katika familia, jamaa na mahali pa kazi)
    d) Marriage (Ndoa)
    e) Sexuality (Kimapenzi)
    f) Pregnancy/family planning (Mimba kupanga uzanzi)
    g) HIV/AIDS (Ukimwi)
    h) Drug/alcohol problem (Kuadhiriwa na madawa ya kulevya)
    i) Domestic violence (Dhuluma za kijamii)
    j) Grief/bereavement (Kufiwa)
    k) Educational matter (Masomo)
    l) Employment problem (Kazi)
    m) Others ( )

18 Who are the people deserving to visit counselling centres?
    Ni watu wa aina gani ambao wanafaa kutembelea washauri?
    a) Anybody (Mtu yeyote)
    b) Youth/adolescent (Watu wa umri wa makamu)
    c) Pregnant women (Akina mama wanjawazito)
    d) Men (Wanaume)
    e) Old people (Wazee)
    f) Widow/widower (Wajane)
    g) Those who have health problems (Watu walia na shida za kiafya)
    h) Those who are living with HIV/AIDS (Watu wanaoishi na ukimwi)
    i) Those who have drug/alcohol problem (Watu walia na shida za madawa za kulevya)
    j) Those who plan to marry (Watu wanaokusudia kuoa/kuolewa)
    k) Those who have relationship problems in marriage, family, relatives and workplace
        (Watu walia na shida za ushirikiana katika ndoa, jamii, jamaa, na mahali pa kazi)
l) Those who lost important person (Watu waliopoteza wanaowapenda)
m) Those who have problem of sex (Watu walio na shida za kimapenzi)
n) Those who have psychological problem (depression, anxiety, anger, grief, loneliness, stress, frustration) (Watu walio na shida za kimaisha (Kufikiria sana katika maisha, Kutarajia sana, kuomboleza, Kufikiria sana. Shida nyingi))
o) Poor people (Watu maskini)
p) Jobless people (Watu ambao hawana kazi)
q) others ( )

19 Has any member of your family experienced any health problem(s) of late that might have required counselling?
   Jamaa wako yeyote amekuwa na shida ya/za kiafya hivi majuzi ambazo zingehitaji ushauri?
   a) Yes
   b) No
   C) NA.

20 Why did he/she need to see a counsellor? *Multiple answers
   Kwa nini alihitaji kuona mshauri? Au kwa nini alihitaji ushauri?
   a) Health problems (Shida ya kiafya)
b) Psychological problems (Shida ya mafikara)
c) Relationship difficulty in family, relatives and workplace (Shida za Kushirikiana katika familia, jamaa na mahali pa kazi)
d) Marriage (Ndoa)
e) Sexuality (Kimapenzi)
f) Pregnancy/family planning (Mimba/kupanga/uzazi)
g) HIV/AIDS (Ukimwi)
h) Drug/alcohol problem (Kuhadhiriwa na madawa ya kulevya)
i) Domestic violence (Dhuluma za kijamii)
j) Grief/bereavement (Kufiwa)
k) Educational matter (Masomo)
l) Employment problem (Kazi)
m) Others ( )

21-1 Is there need for expanding counselling services of whatever form in this area?
   Kuna haja ya Kupanua utoaji wa huduma za ushauri zozote zile katika eneo hili?
   a) Yes
   b) No
   c) NA

21-2 If Yes, explain reasons. Kama ndio, kwa nini?
   a) Not all counselling centres are functioning. (Sio vituo vyote vya ushauri vinafanya kazi)
b) Counselling services should reach many more people. (Huduma za ushauri zinafaa zifikie watu wengi)
c) Counselling services have not cover big population yet. (Huduma za ushauri hazijafika watu wengi)
d) To make people have choices of counselling services is necessary. (Ni muhimu kuwezesha watu kuwa na uchaguzi katika huduma za ushauri)
e) Others ( )

21-3 If No, explain reasons. Kama ndio, kwa nini?
   ( )
22 Have you heard about VCT (Voluntary Counselling and Testing)?
Una habari yoyote kuhusu kujitolea kushauriwa na kupimwa?
a) Yes
b) No
c) NA

23 What does VCT do? Kujitolea kushauriwa na kupimwa inahusu nini?
a) HIV testing and treatment of AIDS by doctors and nurses
   (Kupumwa na kutibiwa ukimwi na madaktari na wauguizi)
b) Counselling and HIV test
   (Kushauri na kupima watu virusi vya ukimwi )
c) Health education and HIV test
   (Kuelimisha watu juu ya afia na kuwapima virusi vya ukimwi)
d) Others ( )

24 Are these VCT centres available in this area?
Kuna hivi vituo vya kujitolea kushauriwa na kupimwa katika eneo hili?
a) Yes
b) No
c) NA

25-1 Have you ever been to a named VCT?
Umewahi kutembelea kituo cha kujitolea kushauriwa na kupimwa?
a) Yes
b) No
c) NA

25-2 If yes, which VCT centres have you visited? Kama ndio, ni kituo ngani ulichokitembelea?

25-3 Explain reasons for the visit. Kama ndio, kwa nini?
a) To know HIV status (Kujua hali yangu ya ukimwi)
b) To know health status (Kujua hali yangu ya kiafiya)
c) For marriage (Kuhus ndoa)
d) For delivery (Kuzaa)
e) For HIV/AIDS awareness (Kuwa na fahamu kyhusu ukimwi)
f) Requirement for job (Ilitakikana kazini)
g) Requirement for education (Ilitakikana kwa masomo)
h) Others ( )

25-4 If No, Explain reasons. Kama la, kwa nini?
a) Not yet ready to go (Siko tayari kwenda)
b) Fear to know HIV status (Kuogopa kujua hali ya ukimwi)
c) No risk of HIV infection (Hakuna hali mbaya ya kupata viini vya ukimwi)
d) Too busy (Nina kazi nyingi)
e) Don't know about VCT (Sinjui kuhusu kituo cha kupeana ushauri)
f) Others ( )

26 How do you rate the services offered in the VCT centre?
Unaionaje huduma ambayo inatolewa katika kituo hiki cha kujitolea kushauriwa na kupimwa?
a) Excellent (Nzuri zaidi)
b) Very good (Nzuri sana)
c) Good (Nzuri)
d) Fair (Kawaida)
27 What is your recommendation for VCT centres?

Ungepanda huduma inayotolewa katika kituo kituio ulichokitembea itolewe kwa njia gani?

a) Free service (Huduma ya bure)
b) Keeping secret/confidentiality (Kudumisha siri)
c) Documentation of result (Kuhifadhi matokeo)
d) High skills of counseling (Kushauri kwa hali ya juu)
e) Support for People living with HIV/AIDS (Kuwasaaidia watu waliowabukizwa virusi vya ukimwi)
f) Support for orphan (Kusaidia watoto mayatima)
g) Medical care (Kupeana tiba)
h) Extension to rural place (Kueneza katika sehemu za mashambani)
i) Every day service (Huduma za kila siku)
j) Extension of time of service (Kuoneza muda wa kuhudumu)
k) Others ( )

28-1 Do you think the introduction of VCT in this area is a good idea?

Unafikiria kuanzishwa kwa kituo cha kujitolea na kupimwa katika eneo hili ni wazo nzuri?

a) Yes
b) No
c) NA

d) To increase HIV awareness (Kuongeza elimu juu ya ukimwi)
b) HIV/AIDS prevention and control (Kuzujia na kuingia kutokana na ukimwi)
c) Behaviour change (Kubadilisha tabia)
d) To know HIV status (Kujua hali yangu ya ukimwi)
e) To access to VCT easily (Kupata huduma za kujitolea na kupimwa kwa urahisi)
f) To reduce anxiety (Kupunguwa wasiwasi)
g) Benefit from free counselling (Kufaidika kutokana na ushauri wa bure)
h) Others ( )

29-1 Have you visited an indigenous doctor for help?

Umewahi kutembelea daktari wa kienyeji/kiasili kwa usaidizi?

a) Yes
b) No
c) NA

29-2 If yes, what issue have you shared with the indigenous doctor?  *Multiple answers

Kama ndiyo, milijadiliana kuhusu nini?

a) Health problems (Shida za kiafya)
b) Pregnancy problems (Shida za mimba)
c) Witchcraft/sorcery (Uchawi)
d) Exorcism of spirit (Kutoa mashetani)
e) Marriage (Ndoa)
f) Problem of education (Shida za masomo)
g) Relationship in family, relatives and workplace (Kushirikiana katika jamii, jamaa na mahali pa kazi)
h) Financial problems (Shida za pesa)
i) Psychological problem (Shida ya mafikara)
j) Forecast of future (Kuangazia siku za usoni)
k) Religious matter (Mambo ya kidini)
30-1 Have you visited a herbalist for help?
Umewahi kutembelea daktari wa miti shamba kwa usaidizi?

a) Yes  
b) No  
c) NA

30-2 If yes, what issue have you shared with the herbalist? Kama ndio, mlijadiliana kuhusu nini?

a) Health problems (Shida za kiafya)  
b) Pregnancy problems (Shida za mimba)  
c) Witchcraft/sorcery (Uchawi)  
d) Exorcism of spirit (Kutoa mashetani)  
e) Marriage (Ndoa)  
f) Problem of education (Shida za masomo)  
g) Relationship in family, relatives and workplace (Kushirikiana katika jamii, jamaa na mahali pa kazi)  
h) Financial problems (Shda za pesa)  
i) Psychological problem (Shida ya mafikara)  
j) Forecast of future (Kuangazia siku za usoni)  
k) Religious matter (Mambo ya kidini)  
l) Others (  )

31-1 Have you visited Faith healer/Pastor/Priest/Imam for help?
Umewahi kutembelea mponyaji wa kiroho kwa usahidizi?

a) Yes  
b) No  
c) NA

31-2 If yes, what issue have you shared with him/her? Kama ndio, mlijadiliana kuhusu nini?

a) Health problems (Shida za kiafya)  
b) Pregnancy problems (Shida za mimba)  
c) Witchcraft/sorcery (Uchawi)  
d) Exorcism of spirit (Kutoa mashetani)  
e) Marriage (Ndoa)  
f) Problem of education (Shida za masomo)  
g) Relationship in family, relatives and workplace (Kushirikiana katika jamii, jamaa na mahali pa kazi)  
h) Financial problems (Shda za pesa)  
i) Psychological problem (Shida ya mafikara)  
j) Forecast of future (Kuangazia siku za usoni)  
k) Religious matter (Mambo ya kidini)  
l) Others (  )

32-1 Who is the best person to offer counselling services?
Ni mtu gani anafaa kutoa huduma za ushauri
a) Herbalist/Indigenous doctor (Daktari wa miti shamba/ wa kieyeji/wa kisili)  
b) Pastor/Priest/Faith healer (Muhubiri/padri/mponyajiwa kiroho)  
c) Friend/Relative/Teacher (Rafiki/Mtu wa ukoo wangu/Mwalimu)  
d) Professionally trained person (Mtu ambaye amepata mafuzo ya kutoa ushauri)  
e) Others (  )

32-2 Explain reasons for your answer.
Toa maelezo kuhusu jibu lako.
He/She has; (Akona ;)

a) Tolerance (Kufumilia)

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33 How would you describe the ideal counsellor?
Kwa maoni yako, mshauri mzuri ni kulingana na?
In terms of:
  a) age ----------------Umri/miaka
  b) gender ------------Jinsi (mwanamke,mwanaume)
  c) ethnicity ---------Kabila
  d) religion -----------Dini
  e) any others -----Yoyote ingine (  )

34-1 Are there certain health-related topics that you cannot talk with counsellors?
Kuna maswala yoyote yanayohusiana na afya ambayo huwezi kujadiliana na washauri?
   a) Yes
   b) No
   c) NA

34-2 If Yes, explain reasons. Kama ndio/la, kwa nini?
   a) Confidentiality is not guaranteed (Siri Haijathibitishwa)
   b) Feeling of shame (Kuona haya)
   c) Fear of stigmatization (Kuogopa yale ambayo wengine watasema)
   d) Others (  )

35-1 Is it wrong in your community to discuss certain health matters with outsiders?
Kulingana na utamaduni wako, kuna ubaya wowote kujadiliana na watu usiowajua vizuri maswala yanayohusiana na afya?
   a) Yes
   b) No
   c) NA

35-2 If yes, explain reasons. Kama ndio/la, kwa nini?
   a) HIV/AIDS with stigma and discrimination (Watu wenye uwanatengwa na kusemwa vibaya)
   b) STI brings shame (Mangonja ya zinaa yana haya)
   c) Fear to bring bad name to the community (Kuogopa kuleta jina mbaya kwa jamii)
   d) Bad things will occur if secret is disclosed (Mambo mbaya yatatendeka ukitoa siri)
   e) Others (  )

36-1 Do you need to consult anybody in your family to see a counsellor or visit a counselling centre?
Huwa unaitajika kupata ushauri kutoka kwa mmoja wa jamaa zako kabla ya kutembelea mshauri au kituo cha ushauri?
   a) Yes
   b) No
   c) NA
36-2 If Yes, who is the person? Kama ndio, jamaa huyo ni nani?
   a) Husband (Bwana)
   b) Wife (Bibi)
   c) Brother (Ndungu)
   d) Sister (Dada)
   e) Mother (Mama)
   f) Father (Baba)
   g) Children (Watoto)
   h) Grand parents (Babu/nyanya)
   i) Others ( )

36-3 Explain reasons. Kwa nini unajadiliana naye kwanza?
   a) Head of family (Mkuu wa familia)
   b) Responsible (Kuwa na jukumu)
   c) Reliable (Anatumainiwa)
   d) Helpful (Anasaidia)
   e) Experience (ana ujuzi)
   f) To maintain good relationship (Kuwendeleza uhusiano mwema)
   g) Others ( )

37-1 Are there specific health issues in your life that make you require counselling services?
   Kuna maswala Fulani maishani mw'ako ambayo yanahitaji huduma ya ushauri?
   a) Yes
   b) No
   c) NA

37-2 If Yes, explain. Kama ndio, toa maelezo.  *Multiple answers
   a) Health problems (Shida za kiafya)
   b) Psychological problems (Shida ya mafikara)
   c) Relationship difficulty in family, relatives and workplace
      (Sdida za kushirikiana katika familia, jamaa na mahali pa kazi)
   d) Marriage (Ndoa)
   e) Sexuality (Kimapenzi)
   f) Pregnancy/family planning (Mimba kupanga uzanzi)
   g) HIV/AIDS (Ukimwi)
   h) Drug/alcohol problem (Kuadhiriwa na madawa ya kulevya)
   i) Domestic violence (Dhuluma za kijamii)
   j) Grief/bereavement (Kufiwa)
   k) Educational matter (Masomo)
   l) Employment problem (Kazi)
   m) Others ( )

38-1 At the moment, are you in need of seeing a counsellor?
   Kwa wakati huu, unahitaji kuona mshauri?
   a) Yes
   b) No
   c) NA

38-2 If yes, explain reasons. Kama ndiyo/la toa maelezo.
   a) Health problems (Shida za kiafya)
   b) Psychological problems (Shida ya mafikara)
   c) Relationship difficulty in family, relatives and workplace
      (Sdida za kushirikiana katika familia, jamaa na mahali pa kazi)
   d) Marriage (Ndoa)
Sexuality (Kimapenzi)

Pregnancy/family planning (Mimba kupanga uzanzi)

HIV/AIDS (Ukimwi)

Drug/alcohol problem (Kuadhiriwa na madawa ya kulevya)

Domestic violence (Dhuluma za kijamii)

Grief/bereavement (Kufiwa)

Educational matter (Masomo)

Employment problem (Kazi)

Others (

Do you have specific reasons that hinder you from visiting a counselling centre?
Kuna sababu zozote ambazo zinakuzuia usiweze kutembelea kituo cha ushauri?

a) Yes ,
b) No
c) NA

If yes, explain reasons. Kama ndiyol la, toa sababu.

a) Cost of service (Malipo ya huduma)
b) Don’t know where is it (Sijui iko wapi)
c) Fear to know HIV status (Kuogopa kujua hali ya ukimwi)
d) Lack of trusting counselors (Kutoamini mwenye kutoa ushauri)
e) Lack of transport fees (Shida ya pesa ya kusafiria)
f) Limited time (Kutokuwa na wakati wa kutosha)
g) Others ( 

How can counselling attract many more people?
Ushauri unawenzaje kuvutia watu wengi?

a) By providing more information about counselling to the public (Kupeana ushauri wa kutosha kwa watu)
b) By providing psychological support (Kupeana usaindizi wa mafikara)
c) By offering therapeutic outcome (Kutoa matokea yenye uponyaji)
d) By extending time of service (Kuongeza muda wa ushauri)
e) By having many skilled counselors (Kuwa na watalaamu wengi wa kupeana ushauri)
f) By having many referral places (Kuwa na vituo vingi vya kuwatuma wateja kwa usaidizi zawadi)
g) Free service (Huduma za bure)
h) Others ( 

How can VCT attract many more people?
Vituo ya ushauri vinawezaje kuvutia watu wengi?

a) By providing HIV/AIDS information to the public (Kupeana masomo ya ukimwi kwa watu)
b) By providing psychological support (Kusaidia watu kimafikara)
c) By providing social support to People living with HIV/AIDS (Kusaidia watu wanaishi na ukimwi)
d) By providing accurate testing result to clients (Kupeana matokea kamili ya kupimwa)
e) By offering therapeutic outcome (Kutoa matokea ya uponyaji)
f) By extending time of service (Kuongeza muda wa ushauri)
g) By having many skilled counselors (Kuwa na vituo vingi vya kutuma wateja kwa usaidizi zawadi)
h) By having many referral places (Kuwa na mahali kwingi kwa kupeleka watu)
i) Free service (Huduma za bure)
j) Others ( 

What is main difference between counselling and VCT?
Ni tofauti ngani iliyoko baina ya kushauriwa na VCT

a) There is no difference. (Hakuna tofauti)
b) VCT is only for testing HIV status.

(VCT ni ya kupima hali ya ukimwi)
c) Counselling is only for mental illness (Kushauriwa ni kwa watu wenye akili punguani)
d) Counselling is to help people solve psychological problem and VCT offers the counselling and HIV test.
   (Kushauri ni kusaidia watu kutatua shida za kimafikara, VCT ni kushauriwa na kupimwa virusi vya ukimwi)
e) Others ( )

43 How much total income is in your house per month? (Ksh.)
   Mapato ya nyumba yako kwa mwezi mmoja ni pesa ngapi?
a) 1-4,999  
b) 5,000-9,999  
c) 10,000-49,999  
d) 50,000 or more  
e) NA  
f) NA

44 How much income do you have by yourself per month?
   Ni Kiasi gani cha mapato hayo unachopata kwa matumizi yako mwenyewe?
a) 0  
b) 1-4,999  
c) 5,000-9,999  
d) 10,000-49,999  
e) 50,000 or more  
f) NA

45 What is the source of your income? (Ksh.)
   Mapato yako wewe mwenyewe yanatokana na nini?
   *Multiple answers*
a) No income source  
b) Salary (Mshahara)  
c) Rent (Malipo ya nyumba)  
d) Family (Jamii yako)  
e) Small scale Trading or business (Biashara ndogo ndogo)  
f) Others ( )

46 Concerning expenditure, how much money does your family spend a month at the moment? (Ksh.)
   Kuhusu matumizi, ni pesa kiasi gani mnachotumia kwa nyumba yako kwa mwezi?
a) 1-4,999  
b) 5,000-9,999  
c) 10,000-49,999  
d) 50,000 or more  
e) NA  
f) NA

47-1 Are counselling centres too far from where you live?
   Vituo vya ushauri viko mbali sana na mahali unapoishi?
a) Yes  
b) No  
e) NA

47-2 If yes/no, in your estimation, what is the distance from here to the nearest centre?
   Kama ndiyo/la, ni kama umbali gani kutoka hapa mpaka kituo cha ushauri kilicho karibu?
a) <500m  
b) <1km  
c) <5km  
d) <10km  
e) 10km or more  
f) NA
48. Do you feel seeing a counsellor is an expensive exercise?  
Kulingana na wewe, kutembelea mshauri ina gharama kubwa?

a) Yes  
b) No  
c) NA

49. How much would it cost you to get the nearest counselling centre?  
Itakugharimu pesa ngapi kufika katika kituo cha ushauri kilicho karibu nawe?

a) No cost  
b) <10Ksh  
c) <50Ksh  
d) <100Ksh  
e) 100 Ksh or more  
f) NA

Thank you so much for your cooperation.  
Asante sana kwa ushirikiano wako.
APPENDIX II: Key Informant Interview Guide

Date of the interview __________________________________________
Place of the interview ________________________________________
Name _______________________________________________________
Sex _________________________________________________________
Age _________________________________________________________
Place of training _____________________________________________
Duration of being as counsellor _______________________________
Fees of counselling __________________________________________
Duration of a counselling session ______________________________

1. What type of counselling do you offer?
2. How do you explain what counselling is to lay people?
3. How did you decide to become a counsellor?
4. What kind of outcome do you expect from your counselling service?
5. What category of people comes to you for counselling?
6. Who should come to your counselling sessions?
7. What is the difference between your services and others (pastor, priest, faith healer, herbalist, indigenous doctor, teacher, professional counsellor)?
8. What is your assessment of client's knowledge and attitude towards counselling?
9. What do you think hinders people from seeking counselling services in Kenya?
10. How much impact does culture have on outcomes of counselling?
11. How do economic factors influence outcomes of counselling?
12. What is social influence on outcomes of counselling?
13. What has been the most difficult case in your counselling session before?
14. What has been the most impressive session in past counselling session?
15. When do you refer client to other counsellors?
16. What is the most difficult issue for you in counselling?
17. How do you manage to counsel someone who experienced what you have not experienced?
18. How do you counsel people who are affected and infected by HIV/AIDS?
19. How do you decide to end the counselling sessions?
20. Your recommendation about counselling services in Kenya. Is there any need to expand certain counselling services to Kenyan?
APPENDIX III: Guide to Focus Group Discussion

1. What kind of counselling have you got?

2. Who provide the counselling?

3. When do you get the counselling services?

4. Who is counsellor?

5. What kinds of skills are applied?

6. Before you get the counselling, what did you know about counselling?

7. After you have got the counselling, how do you explain about counselling?

8. What is outcome of counselling?

9. What do you think of aware of counselling in Kenya?

10. How does counselling help People living with HIV/AIDS?
APPENDIX IV: Research Authorization

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

Yokomori Kenji
Kenyatta University
P.O. BOX 43844
NAIROBI

Dear Sir

RE: RESEARCH AUTHORISATION

Following your application for authority to conduct research on 'knowledge Attitude and utilization of Counselling services by Residents of Kibera slums in Nairobi Province, I am pleased to inform you that you have been authorised to conduct research in Nairobi for a period ending 30th August, 2003.

You are advised to report to the Provincial Commissioner Nairobi and the Provincial Director of Education Nairobi before embarking on your research project.

You are further advised to deposit four copies of your research report to this Office upon completion of your research project.

Yours faithfully

A. C. KAARIA
FOR: PERMANENT SECRETARY/EDUCATION

CC
The Provincial Commissioner
Nairobi
The Provincial Director Education
Nairobi
Abstract Form

Surname (Family Name): YoKoMoK
First Name: KENJI

Mailing Address: P.O. Box. 10453
Town: Nairobi
City: GPO

Contacts: Tel: 575188
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Institution: AMDA (Association of Medical Doctors of Asia)

This Abstract Form must be received by 30th June 2003 accompanied by Registration Form and Fee.

Title of Abstract: Knowledge, Attitude and Utilization of Counselling in Kibera Slums, Nairobi.

Introduction/Background: There are both traditional and professional counselling services in Kibera slums. Residents of Kibera visit these counselling services for seeking many kinds of help. But their knowledge, attitude, and utilization patterns are not well known.

Methods/Descriptions:
1) 408 respondents were selected from 12 villages in the slums to get quantitative data.

2) 10 counsellors and 19 informants were interviewed to get qualitative information.

Results/Findings:
There will be presentation of knowledge, attitude, and utilization of professional and traditional counselling in the form of Frequency Table, bar chart, Pie chart, and Chi-square values of association between socioeconomic and cultural factors and utilization of counselling services.

Outcomes/Conclusions:
1) In the traditional Counselling services, traditional healing (indigenous doctor and herbalist) and religious counselling are popular in the slums.
2) In the professional counselling services, general Counselling and VCT are used.
3) The majority of the respondents associate Counselling with HIV and AIDS.