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Impact of counselling services on sexual behaviours of persons with HIV/AIDS in Kenya

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Abstract

This study purposed to determine the impact of counselling services on sexual behaviours of HIV/AIDS victims in Kenya. The study used a case study design. The target population was 300,000 people affected and infected by HIV and AIDS epidemic within Kisii Municipality. From an accessible population of 500 people, a sample size of 239 was purposively selected, out of which 128 PLWHAS were support group members, whereas 74 were not, and 25 were family caregivers. Data were collected using questionnaires. A pilot study was done to determine the reliability of the instruments. The questionnaires yielded a reliability coefficient of 0.7815. SPSS version 12.5 was used to analyse data. The t-tests were employed to establish any differences between support group attendances, gender and stress levels of PLWHAS. On the other hand, the Chi-square test was n employed to establish any association between Mwanyagetinge Community-Based Care and counselling services and the sexual behaviour of PLWHAS. The study concluded that the provision of counselling services in the Mwanyagetinge centre was adequate. After infection, the majority of PLWHAS had their sexual interest reduced considerably. An attribute that can be exploited to embrace positive sexual behaviour like abstinence and the use of condoms. This study recommends that support group therapy be encouraged in churches and schools to avoid isolation and loneliness to sustain positive behaviour and prolong the lives of PLWHAS.

Key terms: Counselling services, sexual behaviour, community based programme.

INTRODUCTION

HIV/AIDS is a silent epidemic spreading worldwide and rapidly posing a major threat to humanity. However, an infected person's lifespan can be prolonged through positive living, which implies counselling, care provision, support and nutrition (Tuju, 1996). The cure or vaccine against this viral disease is yet to be found, but antiretrovirals (ARVS) slow the replication of HIV to the extent that the viral load in the blood is reduced to undetectable levels (UNAIDS, 2008). UNAIDS (2006) conducted a study and found that combining therapy with three drugs reduces the risk of death by 85per cent and declines the trends in incidences of opportunistic diseases. The death rate of persons living with HIV/AIDS (PLWHAS) has been reduced in developed countries where ARVS are readily available. However, the case is different in developing countries. The situation in developing countries is the pressing need to provide treatment essential to alleviate suffering and mitigate the devastating effect of HIV/AIDS (UNAIDS, 2007). The transmission in expectant mothers in developing countries can be reduced by ART to 50 per cent.

LITERATURE REVIEW

In principle, control of HIV/AIDS in Kenya is easy, for it simply requires mainly sexual abstinence. However, as in all countries where HIV is endemic, there exist human behavioural practices which facilitate the disease transmission in humans. Therefore, an HIV/AIDS community-based programme is, therefore, an indispensable strategy that will seek to raise people's awareness to bring about change in such habits. Experience, however, shows that such a change takes time to be realised, and information has to be a long-term measure. To combat HIV/AIDS pandemic, it is important also to bring HIV/AIDS issues into the family by introducing these issues into the community-based care programme. Once the people know, they can adequately participate in other community outreach programs. Teaching local communities, outreach programs, counselling and voluntary testing, and care and support for infected and affected are ongoing but must be strengthened and coordinated at all levels.

Extensive research in the USA has indicated that those infected couples that use condoms to avoid re-infection live longer before coming down with full-blown AIDS (Tuju, 1996). The most dangerous sexual practices, therefore, would be those in which HIV-infected blood or semen gets into direct contact with the blood of a seronegative person. These practices include intercourse between a man and woman or two men. In all these practices, semen from a man is deposited into the vagina or anus. Those who are already infected should use a condom to protect themselves from re-infection and control the increase in viral load that may result in the hastening of full-blown AIDS. When condoms are properly used, they are effective in preventing HIV transmission. However, they are not 100 per cent effective since they sometimes break and may not always be available or accessible to everyone about to be engaged in sex. Condoms can have holes and leaks; however, they provide a good measure of protection for most people. PLWHAS have only two choices to make; to abstain from the sexual relationship or use condoms to guard against re-infection and prolong life as a positive living measure.

Using condoms requires consistency and skills to be effective (O'Leavy, 2002). The USA Congress, as part of the welfare reform Act of 1996, allocated $50 million from the year 1998 to 2002 for educational programs that teach the social, psychological and health benefits of not engaging in careless sexual activities. Over $100 million may be spent on abstinence programmes during the five years. However, abstinence is not possible for many sexually active people as they can choose to have sexual relations of the least risky types, argues O'Leavy (2002). The church generally preaches against the condom, as it wishes to protect the sanctity of life. However, in a marriage where partners are infected, preserving the life of the spouse requires using a condom. According to Jackson (2002), citing Fr. Michael Kelly, a Jesuit priest, states that in the case of discordant couples, the church can accept a condom. However, the church is convinced that the distribution of condoms encourages immorality and promiscuity.

Palliative care for PLWHAS is essential, and since the immune system is compromised, there will always be the management of opportunistic infections. Tuju (1996) points out that two alternatives that are open to an individual who tests positive for HIV are: either alienate yourself from the rest of the world or come to terms with the disease and live positively. The following are some of the elements of positive living for those infected: support group, avoiding smoking, change in sexual behaviour and eating a balanced diet. According to UNAID (1999), ART has been effective in prolonging the lives of those who can afford it and who have access to good health services. Breastfeeding mothers who are HIV positive should be discouraged from breastfeeding their children to prevent transmission.

House et al. Metzner (1982) found out that support groups could be a very useful resource for people with long-term illness or poverty. One way of handling stress related to HIV/AIDS sickness is to draw on social support. Those infected with the HIV/AIDS virus need support groups to share, encourage each other and develop spiritual and economic projects together. Their lives can be prolonged by the realisation that there are many people suffering from a similar problem.

METHODOLOGY

Questionnaires were used to collect data. One set of questionnaires was used for PLWHAS and the other for caregivers. They were structured to measure awareness level and prevention of HIV/AIDS, the impact of sexual counselling on their sexual behaviour, the extent of stigmatisation and adequacy of palliative care, the level of stress of caregivers and PLWHAS, gender, attitude and social discrimination of PLWHAS. The target population was 300,000 people who were affected and infected by HIV and AIDS epidemic within Kisii Municipality. From an accessible population of 500 people, a sample size of 239 was purposively selected, out of which 128 PLWHAS were support group members, whereas 74 were not, and 25 were family caregivers. Data were collected using questionnaires. The questionnaires yielded a reliability coefficient of 0.7815. SPSS version 12.5 for windows) was used to analyse data. The t-tests were employed to establish whether there were any differences between support group attendances, gender and stress levels of PLWHAS. On the other hand, the Chi-square test was employed to establish whether there were any association between Mwanyagetinge Community-Based Care and social discrimination; counselling services and sexual behaviour of PLWHAS; awareness and prevention of HIV/AIDS; Palliative Care Services and Mwanyagetinge Community-Based Care Programme.

RESULTS AND DISCUSSION

Impact of Counselling Services on the Sexual Behaviour of PLWHAS

1. **Adequacy of Counselling Services**

The research sought to establish the adequacy of the counselling services as rated by respondents to assess the effect of the Mwanyagetinge Community-based counselling services provided by the caregivers on the sexual behaviour of the PLWHAS. The sampled respondents were therefore asked to rate how adequate counselling services were at the Mwanyagetinge centre. The primary role of counsellors in the Mwanyagetinge care programme is to change destructive sexual behaviours that promote the spreading of the virus and promote positive living for those already infected. Trained community-based care programme counsellors provide these services to PLWHAS and their family caregivers. Counselling was reported by 55.7% of PLWHAS to be the most important service provided by Mwanyagetinge Community based care programme. Only when individuals learn of their HIV status and receive specific personal advice can they achieve the reframing of their previous thoughts and feelings, which significantly alters their sexual behaviour. The implications are that sexual behaviour change for PLWHAS is pivotal to the prevention of HIV/AIDS spread and increases the length of life for those already infected. During this study, the sexual behaviour characteristics of PLWHAS showed the impact counselling has had on their sexual life.

2. **The Level of Sexual Interest among PLWHAS**

The next step to establish how the sexual behaviour patterns of the PLWHAS had been affected by their status was done by examining how their sexual interest had changed. The results are presented below:

Table 1: The Level of Sexual Interest

Level of sexual interest	Frequency	Per cent
Increased	1	0.5
Decreased	151	74.8
Remained the same	50	24.8
Total	**202**	**100**

From data presented in table 1, about 74.8% of the respondents indicated that their sexual interest had decreased due to their status. It was established that 24.8% of the respondents' sexual interest had remained the same, while 0.5% indicated that their status had triggered increased interest in sex.

Frequency of Sexual Intercourse among PLWHAS
The research also sought to establish the frequency of sexual intercourse among the PLWHAS. The results are presented in Table 2.

Table 2: Observed Frequency of Sexual Intercourse

Frequency of sexual intercourse	Frequency	Per cent
Once Weekly	92	45.6
Once Monthly	80	39.6
Once Yearly	30	14.9
Total	**202**	**100**

Table 2 indicates that the majority of PLWHAS were sexually active. About 45.6% reported that they usually had sex on a weekly basis, 39.6% stated that they had sex on a monthly basis, and 14.9% had sex once on a yearly basis.

i. Frequency of Having Safe Sex among PLWHAS
The study established that 69.3 per cent of the PLWHAS did not use condoms all the time they had sex. They gave reasons for declining to use this protective method, and the result is presented in table 3. As has already been mentioned above, 69.3 per cent of PLWHAS engage in a sexual relationship almost weekly. Such a high frequency of engagement in sexual intercourse results in re-infection hence hastening the onset of the AIDs stage. Introducing negotiation in the use of condoms in a sexual relationship is a sensitive reproductive health issue, which may be interpreted to mean distrust of a sexual partner. Early diagnosis of HIV infection should encourage the individual to seek treatment and change sexual behaviour to the less risky ones (Jackson, 2002). The challenge of sexual behaviour change was appreciated in the group discussion. The factors below highlighted as the hindering change of sexual behaviour even when one's sexual partner has died of HIV/AIDS virus include;

(i)The psychological and emotional emptiness that follows the death of the partner was too overwhelming, and men especially found it hard to adjust to the role of the wife in the family. They are easily weighed down by social pressure from peers to remarry.

(ii)There are sexual myths related to the HIV/AIDS virus borne out of ignorance, like beliefs that sores in the genitals of those infected with the virus can be cured by sexual intercourse. Such beliefs undermine the need for abstinence.

(iii)Cultural pressure among many African Societies that family is perpetuated through procreation, and that one is immortalised when renamed in newborn children, reproduction is seen as a duty that PLWHAS must fulfil hence many remarried to conform to cultural demand of marriage; as a result children are born by PLWHAS an effort to uphold these cultural

obligations. A couple that openly confessed to practising abstinence in their relationship confessed that:

"We live in the same house. After counselling, we decided to abstain. Mwanyagetinge community-based care service providers gave us a mattress so that we can make a second bed and hence sleep separately. Our relationship has been reduced to that of brother and sister". (Interview notes 3/11/2010)

Another family interviewed had this to say:
"To manage sexual abstinence in our family has been a very difficult exercise. My husband is still in self-denial despite all the clinical signs we have manifested. To ensure we keep our physical distance apart, I am harsh and cruel so that our affection does not regenerate again. (Interview notes 20/10/2010)

The two incidents indicate that abstinence is a challenge to many sexually active PLWHAS, especially in the context of marriage. This view is supported by reviewing the literature on research in the USA that found out that emotions of love, romance and passion often over-rode health concerns, which implies that abstinence in the context of marriage is a challenge.

Table 3: Why PLWHAS Avoid Using Condoms during Sex

Reason for not using condoms	Freq.	Per cent
Church teachings	36	18%
Information about its effectiveness	65	32%
Apathy by partner	66	33%
Any other reason	25	12%
Total	**202**	**100**

As indicated in table 3, the greatest reason for avoiding the use of condoms during sex was apathy by the partner, which accounted for 33 per cent of the respondents. Other reasons involved lack of adequate information on their effectiveness which accounted for 32 per cent. Church teaching accounted for 18 per cent, while other reasons for not using condoms accounted for 12 per cent.

Behaviour change is not completely a matter of personal decision but is governed by societal factors that dictate a person's sexual behaviour. PLWHAS can adopt an "ABC" approach for a healthy sex life that's; abstinence, "being faithful", or use of a "condom". The Catholic and Muslim religions vehemently oppose condom use. Critics of the church's stand argue that using condoms can be equated to seat belts used in cars. Seat belts do not guarantee 100 per cent safety; neither do condoms with sex. The Catholic Church is not justified in rejecting condoms on the grounds that they are not 100 per cent a vaccine because it is thought to be less than 100 per cent effective (Jackson, 2002).

HIV/AIDS is a challenge to human sexuality. AIDS touches all sensitive areas of human feelings and beliefs. The disease hits hard at the crossroad of love, death, sex, tradition and pride. The church has a role in setting ideals for society. Realistically, abstinence is not an absolute solution to PLWHAS, especially in the urban environment among resource-constrained members of society. The church may need to be more open on which guidelines to offer PLWHAS, whose number is increasing rapidly. It will remain a contradiction if church leaders keep preaching from the pulpit about ideals of sexual morality and then burying the dead. Father Bernard Joined, who first developed the 'Fleet of Hope" concept, remains ambivalent about using condoms. He says, "The condom and affection are poor bedfellows" Jackson (2002). The reality of HIV/AIDS is like a flood in which people will drown unless they keep out of the water and get in the boats. The rescue boats available are fidelity, chastity and condoms. Provided people stay in one or the other boat and more safely between them, they will survive the floods. This is a more liberating concept than dictating which boat everyone should be in. Condemning those who chose the condom boat by

the church is retrogressive. However, knowledge of one's sexual partners zeroes status is essential in negotiating safety measures in a sexual relationship. For many women, whatever their cultural contexts, to suggest that a sexual partner use condom may be seen as evidence of a woman's infidelity.

Significance of the Change in Sexual Behaviour

The study sought to establish whether the effect of counselling services provided by the Mwanyagetinge community-based caregivers was statistically significant. A cross-tabulation between the level of sexual interest and frequency of sexual interest was carried out to examine the relationships.

Table 3 above indicates that of those PLWHAS whose level of sexual interest increased, 100 per cent had sexual intercourse on a weekly basis. Data generated from the research indicated that of the respondents whose sexual interest had decreased, 49 per cent had sex on a weekly basis, 39.7 per cent had sex on a monthly basis, and 11.3 per cent had sex on a yearly basis. About 34 per cent of the respondents whose sexual interest had remained the same had sex on a weekly basis, 40 per cent had sex on a monthly basis, and 26% had sex on a yearly basis.

Table 4: Influence of the Level of Sexual Interest and Frequency of Sexual Intercourse

			Frequency of Sexual Intercourse			
			Weekly	**Monthly**	**Yearly**	**Total**
Level of sexual interest	Increased	Count	1	0	0	1
		% within the level of sexual interest	100.0%	0.0%	0.0%	100.0%
	Decreased	Count	74	60	17	151
		% within the level of sexual interest	49.0%	39.7%	11.3%	100.0%
	Remained the same	Count	17	20	13	50
		% within the level of sexual interest	34.0%	40.0%	26.0%	100.0%
Total		**Count**	**92**	**80**	**30**	**202**
		% within the level of sexual interest	**45.5%**	**39.6%**	**14.9%**	**100.0%**

A Chi-square test to establish the significance of the change (association) in sexual interest level and frequency of sex was carried out. This was done by generating an implied null hypothesis that the change in sexual interest level does not affect the frequency of sexual intercourse. Table 4 exemplifies the significance of sexual interest level and frequency of sex among the PLWHAS.

Table 5: Significance of Sexual Interest Level and Frequency of Sex

	Value	**df**	**Asymp. Sig. (2-sided)**
Chi-Square	8.556	4	0.073

The Chi-square value of 8.556 in the results presented in Table 5 indicates that the association between the level of sexual interest and the frequency of sexual intercourse on a two-tailed significance test has a p-value of 0.073, which is not statistically significant $P > 0.05$. It was inferred that change in the level of sexual interest did not significantly affect the frequency of sexual intercourse among the PLWHAS of the Mwanyagetinge centre.

The researcher further cross-tabulated data on the level of sexual interest and the provision of community-based care counselling services to explore the relationships. The results indicate that 100% of those whose sexual interest had increased strongly agreed that their community-based caregivers provided counselling services. Among those whose level of sexual interest had decreased, 1.3% strongly disagreed that there was the provision of counselling services, 2.6% agreed, while 96% strongly agreed on the provision of the services. Within the group of respondents whose sexual interest remained the same, none of them disagreed that there was any provision of counselling services, 2% disagreed, and 98% strongly agreed that there was the provision of counselling services by community-based caregivers. The results of the cross-tabulation are presented in table 6.

Table 6: Level of Sexual Interest and Provision of Community-Based Counselling

			Provision of community-based counselling			**Total**
			Disagree	Agree	Strongly Agree	
Level of sexual interest	Increased	Count	0	0	1	1
		% within the level of sexual interest	0.0%	0.0%	100.0%	100.0%
	Decreased	Count	2	4	145	151
		% within the level of sexual interest	1.3%	2.6%	96.0%	100.0%
	Remained the same	Count	0	1	49	50
		% within the level of sexual interest	0.00%	2.0%	98.0%	100.0%
Total		**Count**	**2**	**5**	**195**	**202**
		% within the level of sexual interest	**1.0%**	**2.5%**	**96.5%**	**100.0%**

A Chi-square test for the strength of the effect was conducted, and the results are presented in Table 6.

Table 7: Significance of Association between Level of Sexual Interest and Provision of Counselling Services

	Value	**Df**	**Asymp. Sig. (2-sided)**
Chi-Square	0.78	4	0.94

From table 7, χ^2 indicates the association between the level of sexual interest and provision of counselling services, which yielded $\chi^2 = 0.78$ and a p-value of 0.94, which is greater than α - level of 5% and therefore, the association was not statistically significant. It was therefore inferred that the provision of counselling services did not significantly affect the level of sexual interest of PLWHAS.

A cross-tabulation between the frequency of sexual intercourse and provision of counselling services indicated that 1.1% of PLWHAS who had sex on a weekly basis and 1.3% of those who had sex on a monthly basis disagreed that the counselling services were provided. None of the respondents who had sex on a yearly basis disagreed that the counselling services were provided. Only 2.2% of those who had sex on a weekly basis, 2.5% of those who had sex on a monthly basis and 3.3% of those who had sex on a yearly basis agreed that the counselling services were provided by the community caregivers. About 96.7% of respondents who had sex on a weekly basis, 96.3% of those who had sex on a monthly basis and 96.7% of those who had sex on a yearly basis strongly agreed that the counselling services were provided by community-based counsellors. From this data, we conclude that counselling services were adequately provided to the PLWHAS by the Mwanyagetinge Community-based caregivers. A summary of the findings is recorded in table 8.

Table 8: Frequency of Sexual Intercourse and Provision of Counselling

			Provision of counselling services			**Total**
			Disagree	**Agree**	**Strongly Agree**	
Frequency of sex	Weekly	Count	1	2	89	92
		% within. If yes, how frequent?	1.1%	2.2%	96.7%	100.0%
	Monthly	Count	1	2	77	80
		% within. If yes, how frequent?	1.3%	2.5%	96.3%	100.0%
	Yearly	Count	0	1	29	30
		% within. If yes, how frequent?	0.0%	3.3%	96.7%	100.0%
Total		**Count**	**2**	**5**	**195**	**202**
		% within. If yes, how frequent?	**1.0%**	**2.5%**	**96.5%**	**100.0%**

A chi-square test for significance of the relationship between frequency of sexual intercourse and provision of counselling services yielded $\chi^2 = 0.485$ and $p = 0.98$, which is greater than the set alpha value = 0.05 and therefore association was not significant. It was therefore inferred that the provision of counselling services did not significantly influence the frequency of sexual intercourse.

Table 9: Significance between Frequency of having Sex and Provision of Counselling Services

	Value	**df**	**Asymp. Sig. (2-sided)**
Chi-Square	0.485	4	0.975

Across tabulation of frequency of sexual intercourse and the adequacy of counselling services revealed that 4.3 per cent of PLWHAS who had sex on a weekly basis, 3.8 per cent of those who engaged in sex on a monthly basis and 10 per cent of those who had sex yearly felt that provision of counselling services in the Centre was very poor. About 35.9 per cent of respondents who had sex weekly, 39.2 per cent of those who had sex monthly and 50 per cent of those who had sex yearly rated the adequacy of the provision of counselling services as just enough. About 59.8 per cent of those who had sex weekly, 57 per cent of those who had it monthly and 40 per cent of those who had it yearly thought the provision of counselling services was adequate. It was concluded that the provision of counselling services in the

Mwanyagetinge Centre was adequate. The results are presented in Table 10.

Table 10: Frequency of Sexual Intercourse and Adequacy of Counselling Services

			Adequacy of counselling services			Total
			Very poor	Just enough	Very good	
Frequency of sex	Weekly	Count	4	33	55	92
		% within the frequency of sex	4.3%	35.9%	59.8%	100.0%
	Monthly	Count	3	32	45	80
		% within the frequency of sex	3.8%	39.2%	57.0%	100.0%
	Yearly	Count	3	15	12	30
		% within the frequency of sex	10.0%	50.0%	40.0%	100.0%
Total		**Count**	**10**	**80**	**112**	**202**
		% within the frequency of sex	**5.0%**	**39.3%**	**55.7%**	**100.0%**

A chi-square test for significance of association yielded $\chi^2 = 4.59$ with P-value = 0.332, which is greater than the set alpha value = 0.05 and therefore not significant. It was therefore inferred that the adequacy of provision of counselling services did not significantly influence the frequency of sex among the PLWHAS of Mwanyagetinge.

Table 11: Significance of Association between Frequency of having Sex and Adequacy of Counselling Services

	Value	**df**	**Asymp. Sig. (2-sided)**
Chi-Square	4.59	4	0.332

CONCLUSIONS AND RECOMMENDATIONS

Conclusions: It was concluded that the provision of counselling services in the Mwanyagetinge Centre was adequate. After infection, the majority of PLWHAS had their sexual interest reduced considerably. An attribute that can be exploited to embrace positive sexual behaviour like abstinence and the use of condoms.

Recommendations: This study recommends that to sustain positive behaviour and prolong the lives of PLWHAS, support group therapy could be encouraged in churches and schools to avoid isolation and loneliness. In the absence of a vaccine, prevention efforts must focus on sexual behaviour changes that require knowledge of seropositive status and support from others. There is also a need to ensure full and active participation of PLWHAS in the implementation, design and evaluation of community-based programmes since they are resourceful in prevention, raising awareness and overcoming social discrimination.

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