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# Performances of sexuality counselling: A framework for provider–client encounters

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ABSTRACT

*Objective:* Adequately assessing quality of care poses enormous challenges. While conducting fieldwork, we were struck by the need for a framework that encapsulates provider–client encounters. Little evidence exists concerning the most effective training, and management of health staff engaged in sexuality, reproductive health and HIV related health services. This paper proposes a framework for analysing these encounters.

*Methods:* This paper is based on five studies. Mixed method studies were carried out in Uganda and Kenya. Two additional studies looked into the effect of HIV on health worker performance in Uganda and Zambia. As a result of the findings, a desk review looked into factors affecting provider–client encounters in order to improve the responsiveness of programs.

*Results:* Positive encounters between provider and client are built on trust and respect, consist of communication, practice and process, and are influenced by space, place and context. Combining these facets allows for a better understanding of their interactions.

*Conclusion:* A holistic perspective in which the breadth of dynamics and processes are described should be used when assessing the quality of provider–client encounters.

*Practice implications:* Within training, management and human resource planning, these dynamics need to be utilized to realize the best possible care.



## 1. Introduction

In this paper we discuss the core issues at stake within the encounter between providers and clients in a health care setting. In particular, we focus on interactions around sexuality, reproductive health and HIV. More than in other encounters, moralities and identities of the provider and clients meet when discussing these topics, but they do not always match.

While conducting research for four related studies – two on sexuality counselling and two on HIV and health worker performance – we were repeatedly struck by the need for a framework that more thoroughly encapsulates the provider–client encounter. Given the evidence we had already gathered in the field, we then conducted a desk review to establish whether our conclusions were observed by others as well. We found fragmented support for our conclusions, but nowhere had a comprehensive framework been clearly formulated. Through these studies, we have determined that a positive encounter is built on trust and respect, consist of communication, practice and process, and are influenced by space, place and context, described in the article. Here we first describe the methodologies of the studies that this framework draws upon, before articulating the framework itself with illustrative examples from our fieldwork and the literature.

## 2. Methods

The present article synthesizes key findings from five studies: two from a study on sexuality counselling in Uganda and Kenya, two on the effects of HIV on health worker performance in Uganda and Zambia, and finally a desk review on provider–client encounters.

### 2.1. Sexual health and sexuality counselling in Uganda and Kenya

The two studies we draw on here were part of a larger research project, "Gathering evidence to promote sexual health" [1–4]. In Uganda, the study examined sexuality counselling practices at The AIDS Support Organization (TASO), while in Kenya it looked at Family Health Options Kenya (FHOK). In Uganda, in-depth interviews were conducted with counsellors ($n = 10$), clients ($n = 21$), and key informants ($n = 11$); sixty-five exit interviews were also conducted. Six focus group discussions were held, and 130 counselling sessions were observed, either directly or via audio

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recording. Finally, two facility interviews were conducted. In Kenya, 60 counselling sessions were observed, and 60 exit interviews were carried out. In-depth interviews were held with key informants ($n = 12$), counsellors ($n = 7$), clients ($n = 9$) and trainers ($n = 4$). Additionally, four focus group discussions were held with clients and two with counsellors. Finally, an organizational mapping and institutional questionnaire were administered.

### 2.2. HIV and health worker performance in Uganda and Zambia

We also draw on two studies that looked into the effect of HIV and AIDS on health worker performance in Zambia and in Uganda [5,6]. In Zambia, two rural districts were selected where purposively sampled health service providers ($n = 23$), managers ($n = 6$) and volunteers ($n = 5$) were interviewed with respect to the impact of HIV on their work. This was complemented by a cross-sectional survey ($n = 82$) in the selected facilities, and burnout was measured using the Maslach Burnout Inventory. In Uganda, four district hospitals were selected in which managers ($n = 12$), health service providers ($n = 22$) and support staff ($n = 6$) were interviewed, data were collected about human resource management activities and a cross-sectional survey ($n = 237$) was implemented in the selected facilities. The studies revealed increased workload, fear of infection, fear of stigmatization and discrimination when disclosing one's status, and feeling incapable of performing HIV and AIDS related tasks when not trained for it.

### 2.3. Desk review on provider–client encounters

After reviewing the findings from the above research projects, a desk review was carried out to identify the factors that build trust and respect between providers and clients, and to describe how quality of care and the provider–client encounters are interrelated [7]. In this study, Pubmed/Medline, Embase, Google Scholar and Google were searched, as were reference lists of relevant articles. Furthermore, websites from organizations such as WHO, UN and EnGenderHealth were searched for country-specific information, human rights articles and documents on client-oriented provider-efficient services. Articles were selected according to the following inclusion criteria: published between 2003 and 2008, English or other European language, concerning LMIC and a combination of key words applicable to patient-client encounters. After a search of abstracts and titles, 68 studies were selected. Twenty-one articles were excluded on the basis of relevance and availability, leaving 47 studies in the review.

## 3. Results

### 3.1. Understanding provider–client encounters to achieve high quality counselling

All services have "quality" and whether it is "high" or "low" quality is a matter of judgment and perspective [8,9]. In the 1990s, Donabedian added structure, process and outcome indicators to his earlier quality of care model, to better analyse quality [10]. Since then, there have been numerous advances in understanding clients, for instance through anthropological models, which have encouraged the development of appropriate tools to measure quality of care from a client's perspective. This has resulted in studies looking at client satisfaction [11,12] and attempts to connect explanatory models of professional, lay and folk perceptions of care [13,14]. "High quality" counselling sessions are client-based and non-discriminatory, enabling primary care providers to discuss issues of sexuality with their clients in a safe and open atmosphere [4].

In the desk review, we found numerous examples of studies in which clients reported the importance of both internal and external factors in creating a satisfying counselling experience [15]. A study on the quality of health care in Uganda [16] assessed quality based on courtesy and concern shown by staff, the provider making the client comfortable, and allowing the provider to adequately explain the illness, diagnosis and treatment. Similarly, other sources reported that staff attitudes and the quality of health services did not always correspond to people's expectations of appropriate health services [17,18]. Although relatively good quality counselling is attributed to careful selection and thorough training of counsellors, providers are only able to use their skills and knowledge in an enabling environment. The studies in Zambia and Uganda [5,6] showed the importance of good working conditions and supportive supervision, as well as the need to provide a caring environment for HIV-positive health workers and a secure environment in which difficulties encountered in care provision can be discussed, such as dealing with terminally ill patients or with religious or cultural norms in a care setting. Contextual cultural norms, values and gendered identities influenced not only clients' access and adherence to counselling services [4], but also the performance and presentation of providers within the encounters [19]. Good human resource management practices and client feedback are crucial to creating an institutional setting that allows high quality care provision. A provider who is skilled in showing respect, informing and supporting client involvement can transcend issues of sex and race to establish a relationship with the client, which might contribute to greater client satisfaction, commitment to treatment and trust [11,20,21]. Gilson et al. [22] provided a useful framework to analyse provider–client trust, which has barely been studied in the African context; here trust involves respectful and fair treatment which is rooted in interpersonal trust and the provider's trust in the system.

It is essential when discussing sexuality counselling to note the additional challenges posed by culturally sensitive issues such as sexuality, disclosure, young people's access to sexual and reproductive health care, and the attitudes and morals of providers. In most studies on quality of care, the influence that the perspectives of clients and providers have on an encounter is acknowledged, but the agency and perspectives of both actors are not adequately taken into account. We therefore propose a framework where both sides, clients and providers, are valued and analysed in order to allow for the best possible care.

### 3.2. A new framework

A respectful and trusting relationship between providers and clients is the cornerstone of a successful counselling session [23–25] for two reasons. Firstly, the uncertainty of clients concerning health conditions requires them to have confidence in doctor's decisions and motives. Secondly, it facilitates supportive communication which enables people to make use of services [24,26,27].

Trust between clients and providers is built, damaged or sustained through face-to-face encounters, and usually increases in long-term provider–client relationships [26]. Clients view trust as an iterative process; they test their providers against their own knowledge and expectations [24]. Studies have demonstrated that trust in providers was based on the delivered quality of care, including technical competence and interpersonal communication [26].

Respect for the health care providers and respect for clients' autonomy emerged as the other fundamental aspect of high-quality care [28–30]. Respect involves recognizing, paying attention to and considering the needs of individual clients. Disrespect was indicated as a lack of understanding of the client's standpoint, for instance "irrational" discomfort during an intimate procedure [31].