Exploration into the Influence of Task Shifting on Counselling and the Related Services including HIV-AIDS at the Counselling Agencies in Kenya

"Experiences of Counsellor Administrator-Managers"

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Anastasia C. Wanjiru Ndiritu

Manchester Institute for Education

School of Environment, Education and Development

TITLE: The influence of Task shifting on Counselling and the related services Including HIV-AIDS at the Counselling Agencies in Kenya.

ABSTRACT

The study explored the influence of Task shifting on counselling and the related services including HIV-AIDS from the experiences of 7 Counsellor administrator-managers. The study used a qualitative approach with the Deductive-Inductive Thematic Analysis Methodology where 7 participants were interviewed using semi structured interviews. Data analysis was undertaken according to thematic analysis guidelines whereby four main themes and twelve sub-themes were identified. Findings illuminated that under the Task shifting context counselling was misunderstood, misinterpreted, and misrepresented by a cross-section of the local community within the areas studied. A need for formalization of counsellor-support systems was revealed to boost the Counsellor-Task-shifters' professional identity in their enduring journey of hope and determination in supporting their counselling careers and for the advancement of the counselling profession in Kenya. The implications of the findings on the Influence of Task Shifting on Counselling were further explored.

DECLARATION

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DEDICATION

To my grandchildren - May you find inspiration in life

To all of us as we journey on into the future

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CONTENTS

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A LIST OF TABLES AND FIGURES

A LIST OF ACRONYMNS AND ABBREVIATIONS

AMPATH Academic Model for the Prevention and Treatment of HIV

ANT	Antenatal Care
ART	Anti-Retroviral Therapy
CBHWs	Community based Health Workers
CCC	Community Care Coordinators
CPDC	Continuous professional Development Courses
DPMPA	Depot Met Roxy Progesterone Acetate
EU	European Union
FP	Family planning
HB	Hemoglobin
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HRH	Human Resource
HRH	Human Resources for Health
I& D	Incision and Drainage
IDP	Internally Displaced persons
IV	Intravenous
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAIS	Kenya Aids Indicator Survey
KCA	Kenya Counselling Association
KCPA	Kenya Counselling and Psychological Association
KIPC	Kenya Institute of professional Counselling
KNASP	Kenya National HIV and AIDS Strategic Plan
KpsyA	Kenya psychological Association
MCH	maternal Child Health
MOH	Ministry of Health
MSF	Medicines' Sans Frontiers
NACC	National Aids Control Council
NASCOP	National AIDS STIs Control programme

NGOs	Non-Governmental Organizations
OPD	Out-Patient department
PDAs	Preprogrammed Personal Digital Assistants
PEPFAR	President's Emergency Plan for Aids Relief
PEV	Post-Election Violence
PHC	Primary Health Care
PHIV	Person with HIV
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMC	Perinatal Maternal Child
RDT	Rapid Diagnostic Tests
RPR	Rapid Plasma Reagin Test
SEE	South Eastern Asia
SGBV	Sexual and Gender Based Violence
TB	Tuberculosis
TS	Task Shifting
UNAIDS	United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health organization

CHAPTER 1 – INTRODUCTION

1:0. Introduction

This chapter introduces the thesis which explores the influence of task shifting on counselling and related services including HIV-AIDS, from the experience of counsellor administrator- managers working within agencies in Kenya. It begins with a provision of the researcher positioning thus giving a glimpse into the researcher's early encounter with task shifting, followed by the researcher's reflexivity, a brief overview of ontology and epistemology, motivation, the choice of participants, cultural influence on the researcher's background, the study process followed by a presentation of the aims, rationale and objectives of the study.

Finally, a structure of the thesis is provided.

1:1. Overview

This chapter introduces the thesis which explores the influence of task shifting on counselling and related services including HIV-AIDS, from the experience of counsellor administrator- managers working within agencies in Kenya. It begins with a provision of the researcher positioning thus giving a glimpse into the researcher's early encounter with task shifting, followed by the researcher's reflexivity, a brief overview of ontology and epistemology, motivation, the choice of

participants, cultural influence on the researcher's background, the study process followed by a presentation of the aims, rationale and objectives of the study.

Finally, a structure of the thesis is provided.

1:2. Researcher Positioning - A glimpse into my early encounter with Task Shifting

Peer-discussion groups were a major learning-tool during my registered nurse training. Particularly, I remember holding shared nurse-theory sessions with in-servicing students who had been trained at Enrolled Nurse/Midwife levels and were now upgrading with our class to a registered nurse level. These Enrolled nurse-midwives' stories though enlightening, were both frightening and often times intimidating. They would vividly describe "no doctor-like episodes" as core nurses' roles in the District Hospitals, insight born and grounded of their lived experience.

Though our registered nurse-theory training at the time was emphasizing to inform the doctor and/or call the doctor, these enrolled nurse-midwives promised us that most times in the District Hospitals the doctors were hard to come by. I (we) learnt to appreciate and respect these in-servicing nurse-midwives and chose to learn as much from them because we were aware of the fact that following our registered nurse training, we would be posted out to manage the various government hospital departments (and even the hospitals). We were bracing ourselves for Task shifting.

By and by, the nurse-midwives' stories did translate to actual task-shifted practice at times quite scary during my later practice as I worked in the government hospitals as a young registered staff nurse. And because of our constant presence in the clinical area, such tasks did seem to fall on us

nurses so that the entire experience left some negative marks. The grass-root nurse-midwives were an asset, for example, I had learned to perform the episiotomy and deliver the baby while taking charge of the District Hospitals' night shift, even before I ever did my midwifery training.

Over the years I would be the one to provide equivalent examples to young community nurses under my mentorship because I had by then acquired the necessary without-the-doctor skills from other clinicians like suturing fresh wounds, aligning fractured limbs or inserting and running intravenous fluids. Task Shifting seemed well ingrained into our daily practice. Hence from my own reflections since nursing school, Task Shifting could well be described as primarily focused on nurses.

However, from a brief review of the literature and my long experience as a training coordinator and programmes manager within the HIV-AIDS projects in eastern and southern African region, I see that in recent years and more so during the era of HIV and AIDS, Task Shifting has been extended to other staff cadres. Within the health care system these include other medical and paramedical staff, but also lay people (Kara et al., 2009; Selke et al., 2011).

As I start my research journey to explore Task Shifting therefore, I am keenly aware that I carry a load of task-shifting baggage from my basic background as a nurse and midwife, and through my career path for many years. I will maintain an insider-outsider view in this study in order to allow unique insights grounded in a self-reflexive approach which I will endeavor to maintain through the research process.

1:3. Reflexivity

> *"...the researcher is required to participate, in the course of her research, in activities which are also the object of that research. She produces knowledge claims about the production of knowledge claims; she aims to explain how explanation is done, to understand how understanding is produced, and so on." (Woolgar 1988: 23)*

In his argument Woolgar, (1988) identifies a continuum of reflexivity ranging from radical constitutive reflexivity to benign introspection/r reflection. The theory behind this may also help answer the question many people ask: 'what is the difference between reflection and reflexivity?' Reflexivity means that the researcher is aware of being part of the whole research process, and as Giltrow, (2005 p.209) puts it, *"... it's impossible to be a disembodied researcher"* because any interaction with any part of the research; access, researcher-researched relationship, and the researcher's world view, which influences the questions asked, the lens used to construct meanings and how these are reported and disseminated.

My insider-position and familiarity could obscure in-sightedness by imposing my own values, beliefs, and/or perceptions on Task Shifting (Drake, 2010). According to Bradbury-Jones, (2007) reflexivity is commonly viewed as the process of a continual-internal dialogue and critical self-evaluation of researcher's positionality. It calls for an explicit recognition that the researchers' personal characteristics be it gender, affiliation, age, personal experiences, beliefs, preferences, theoretical, political and ideological stances as well as their emotional responses to the participant etc., may all affect the research process and outcome.

Hence reflexivity calls for my deliberate effort to listen to the participants' stories of experience through their own lens, and not through the lens of my own experience as my self-appraisal in research which implies researcher-lens being reverted to the person of the researcher;

> *"to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation, (Berger, 2013 p.2).*

Further, Mauthner and Doucet, (2003 p.425) suggest *"need to recognise that a profound level of self-awareness and self-consciousness is required to begin to capture the perspectives through which we view the world, and that it may be impossible to grasp the unconscious filters through which we experience events"* since the researcher's inner faculties and intentions are inaccessible to both readers and possibly to themselves also.

Reflexivity therefore challenges the view of knowledge as a product independent of the researcher producing it, or knowledge as objective and enhances plausibility by securing research trustworthiness (Koch and Harrington, 1998; Padgett, 2008). Because reflexivity is a researcher's conscious and deliberate effort to be attuned to one's own reactions to the participants and to the way in which the research account is constructed, it helps identify and explicate potential or actual effect of personal, contextual, and circumstantial aspects of the process and findings of the study. Therefore I endeavor to remain aware of the baggage I carry on Task shifting and will consciously remain reflective from both my insider and outsider perspectives consciously reflecting on my research-journal throughout my study process in my continuous attempt at reflexivity, always seeking trustworthiness in the research findings.

1:4. Ontology and Epistemology – Brief Overview

Ontological and epistemological questions concern a person's worldview i.*e.,* a comprehensive conception or apprehension of the world especially from a specific standpoint, in their attempt to make sense of the world. According to McLeod, (2001) the ontological and epistemological perspectives underpin qualitative research and provide a theoretical basis for understanding the nature and form of reality of the phenomenon to be studied, *"what can be known"* in order to justify the approaches employed to the study. In (Lincoln and Guba, 1985) ontology asks related to the need of finding out the nature of a phenomenon, epistemology focus is on the relationship between the researcher and what is known while methodology is the process or the approaches to gaining the knowledge of the world.

According to Bateson (1972 p.314) the researcher is *"bound within a net of epistemological, and ontological premises which, regardless of ultimate truth or falsity-become partially self-validating"*. Guba, (1990a p.17) argues that all research is interpretive as guided by a set of beliefs and feelings about the world and how it should be understood and studied. Each interpretive paradigm makes particular demands on the researcher, including the questions that are asked and the inter-pretations that are reached.

Bruner, (1990) argues that meaning-making is at the core of human experience because people possess the ability to actively make sense of their experiences and of others even though this sense-making is constrained by the world and our existence in it. However as Finlay (2003b, p.108) further clarifies (Gadamer's theory);

"Our understanding of 'other-ness' arises through a process of making ourselves more transparent. Without examining ourselves we run the risk of letting our un-elucidated prejudices dominate our research. New understanding emerges from a complex dialectic between knower and known; between the researcher's past pre-understandings and the present research process, between the self-interpreted co-constructions of both participant and researcher. Between and beyond…"

I take my epistemological and ontological view of reality from the "Social constructionism" in that meaning is dependent on experience.

According to Berger and Thomas Luckmann, (1966) Social Constructionism emphasizes the cultural and historical aspects of phenomena widely thought to be exclusively natural. The emphasis is on how meanings of phenomena do not necessarily adhere in the phenomena themselves but develop through interaction in a social context. It emphasizes how the meaning and experience of phenomena is shaped by cultural and social systems. Social Constructionism' is multi-faceted (though not in a systematic way). According to Hacking, (1999) Social Constructionism should be judged on how urgent it is the social constructionism cycle may be viewed through 4 steps thus; a reality taken for granted / inevitable / self-evident, that taken for granted truth is not as it is and is not inevitable, (at present) or, that reality is quite bad as it is and society would be better off if that reality was done away with or if that truth is radically transformed.

While systems may help, by having such systems in place to support the Task shifters, it may not necessarily follow that the actual operations (counselling and related services) will automatically

run smoothly because such mechanisms or systems operate in an open and complex context within the diverse embedded Task shifting environment.

1:5. Motivation

My motivation to do this study therefore began with awareness that Task Shifting is mainly being used as a strategy to counter the severe shortage of health personnel in Kenya and other resource-limited countries. From both my own experiences of the phenomenon and from literature during my thesis proposal development stages (2009) Task shifting was more pronounced in the delivery of HIV and AIDS counselling and related services, as detailed in the review of the literature, (Chapter Two). Hence an initial review of the literature (Kiragu, 2006) shows that tasks normally handled by professionals are shifted to other health-worker levels including lay counsellors as a viable solution for scaling up services, particularly within the public health facilities.

As Selke et al., (2010) specifically observe where structures of authority are inadequately defined and upgrading training skills and mentoring support lacking, the task-shifting process usually becomes stressful to staff with inevitable burnout, therefore compromising the quality of counselling and related services. This situation may be more marked with the absence or inadequate counsellor support supervision**.**

1:6. Choice of participants

My wish was to get a view of the lived experiences of the counsellors from their natural perspectives, but because Task Shifting is so generalised, I needed to make a decision on the counsellors' staff-cadre of I would interview, so as to explore this phenomenon. There were those counsellors; 1) who actually provided counselling to clients and patients on the ground, 2) those who in addition to "actual counselling", also "oversaw", i.e., managing, administering and /or supervising the counselling activities in their area of work, and yet there were others, 3) who supervised not only the counselling services as in (2), but also other health-related care services, (especially within the hospital context). I note here that there were grey areas in-between.

Among these three levels, I made a deliberate choice to recruit the second cadre of counsellors, (those who in addition to actual counselling, also oversaw", the counselling activities in their area of work) because they were more likely to provide me with information that could illuminate gaps in "the organization and management of counselling services on the ground" from their lived experience, under the Task Shifting environment in the Kenyan context.

To do this, I aimed to identify such counsellors from the different counselling agencies from the capital city of Nairobi, (which is under the Nairobi County) but also from other reachable counties within its environs. Being aware of the kind of the institutions where counselling services were embedded in our country, I aimed to include as far as possible one counsellor from each of the following areas; the public sector, the private sector, and the community-based establishments. By focusing on these counselling agencies, I hoped to understand the context under which counselling services including HIV-AIDS were being offered in Kenya. I therefore set out to identify

the counsellor administrator-managers as my participants (Table 1) and in the process, identify the counselling agencies; (centers, units or facilities) where they worked (Section 3.8).

1:7. Influences of my cultural background

According to Wandibba, (2001) culture encompasses the learned behaviors, beliefs, attitudes, values and ideals that are characteristic of a particular society or population and people are born to this complex phenomenon which strongly influences how they live and behave throughout their lives. Kenya is a multi-ethnic and multi-racial country and comprised of a national culture. However, these cultures have also evolved over time, with adaptation of other practices and beliefs both from within, but also from external changes. Hence, even though the cultural groups in the country may still hold on to their core cultural values, people have adjusted through the developmental, religious and educational-communication interactions both at the local and international levels.

The Kenyan ethnic cultures have evolved with these inevitable changes including through inter-marriages which are a common phenomenon, to some more so than others.

1:8. African storytelling culture - Stories and Riddles

Africans today as in the past, are primarily oral peoples, and their art forms are oral rather than literally so that stories are orally composed and transmitted.

The Oral arts of Africa are rich and varied, developing with the beginnings of African cultures, and they remain living traditions that continue to evolve and flourish today (Kenya Folklore – Easter

Africa Living Encyclopedia). Each ethnic group has a large store of riddles, proverbs and sayings, which are still an important aspect of daily speech. Riddles were usually exchanged in the evening (because telling riddles during daylight was taboo) before a storytelling session which was supposedly competitions with the competitors fictionally betting villages, or cattle, and other items of economic value on the outcome.

The Kikuyu value proverbs and riddles, and rhetoric and verbal games are both entertainment and skill development with music and dance being strong components of Kikuyu culture (Kenya Folklore- Eastern Africa Living Encyclopedia).

My wish to share the journey of my study through a storied form was therefore, a natural decision for me because story-telling is ingrained in the Kenyan culture and storing therefore, is in my roots, among the Kikuyu community in Kenya. The youth are still often taught through stories and other traditional teaching methods which are especially so among the rural communities.

And so, my early socialization was mainly through oral-storied analogies. I did not know much else since I, we, did not have any form of technology even the radio, probably until just before I started going to school at about the age of five years. I had begun by writing first on the dusty floor, on scripts of paper and later on, in exercise books. Then we encountered the radio and it was so fascinating! I even believed the stories we were told that tiny people lived inside the box-like structure. This changed quickly through school radio programmes, and later on through upper Primary school, and through high school as I took on English literature lessons, and then we discovered the television.

Table 1: Participant background summary

Participant (Pax)	Name of Participant	Family Status (Married)	Level of Counselling Training	Counselling Base & Experience
1	Caring	3 children	Higher Diploma in Counselling.	Freelance - School guidance & counselling / Church-Based counselling
2	Cute	3 children	Higher Diploma in Counselling,	Freelance - All types of clients & mainly Institution-linked students, Experience with internally displaced persons (IDPs)
3	Glas	3 children	Bachelor of Science (BSc) in Child and Adult Psychology	Privately-managed Community Care Centre (All forms of counselling services & informal training PHIV (women)
4	Lil	3 children	Peer Mentor- Educator (Lay Counsellor)	Community-based liaison in rape/defilement (other forms of abuse)
5	Sawela	2 children	Higher Diploma in Counselling.	Freelance & Part-time volunteer HIV-AIDS Counsellor (Level 3, Public Health Facility)
6	Tasha	5 children	Higher Diploma in Counselling & Nurse Counsellor	General & HIV counselling, Level 6 Public Health Facility
7	Theru	4 children	Nurse Counsellor	HIV counselling, Level 4 Public Health Facility Comprehensive Care Centre for HIV and AIDs (CCC)

However, the storing continued among our family and community structures and telling and listening to stories remained part of our family evening routine for as long as I can remember.

1:9. The Study process

In order to explore the influence of Task Shifting on counselling services in Kenya, I first needed to identify interested participants from among counsellors engaged in the counsellor administrator-manager pivotal role from a range of counselling centers and units embedded within different agencies or facilities/institutions in the country. In my case, as I eventually found out, (Table 1) these comprised of counsellors based within the public health system, privately managed facilities, the local community and freelance-based counsellors (Republic of Kenya, 2011; Wanjau et al., 2012).

1:10. Aim and Rationale for the Study

In this study, I aimed to find out the influence of Task Shifting on counselling and related services where such services are offered in Kenya as reflected in the research question (Section 1:11.) below, using deductive – inductive thematic analysis approach.

My intentions are that the findings of this study illuminate the differences and/or unearth the unique ways of looking at the Task Shifting phenomenon and also understand the issues involved from within this context. In this way, I will be contributing to the pool of knowledge in the area by partly filling the gap to the literature on Task Shifting from this perspective.

1:11. Research Question

My research question is - “What are the experiences of the counsellor administrator-managers regarding the influence of Task-Shifting on counselling and the related services including HIV-AIDS at their agencies in Kenya?”

1:12. Task shifting as used in this study

From a Global-scale, Task shifting is used by the national governments and the public health community as a strategy to address human resource shortages (Zachariah et al., 2009) particularly in addressing the HIV demand for health services and in scaling-up HIV care management, as demonstrated through the experiences of the study participants. In support several studies in Kenya (Tanui, 2006; Kenya AIDS Indicator Survey, 2007; Selke, 2011; Taegtmeryer et al. 2011) and other documentation (Republic of Kenya, 2009) have shown that in Kenya Task shifting is a major strategy especially within HIV and AIDS care-management, although further evidence reveal its use in other areas in an attempt to cope with the ever increasing need for human resource (Okore, Africa News - February, 19th 2013; Deller et al., 2015) a generality that compares well within this study. Though in its explicit form (Formal Task shifting) tasks were rationally re-distributed among the study participants to less specialised health care workers especially the lay counsellors and PHIV, (WHO 2006; World Health Organisation. 2007a; 2007b; 2007c. and 2008) and Table 2:2. The process of the delegation was constrained by inadequate skills and/or formal guidelines which were not always available to guide their service-delivery. Most of the participants especially the freelance counsellors used Task shifting as a pragmatic response to help cope with their emerging

care-roles. This approach has been documented as a coping mechanism in several country-countries (Munga and Maestad 2009; Dambisya, 2010; Selke 2010; Mehlomakhulu, 2010), therefore revealing challenges from lack of clear policy guidelines to address a common health work-force crisis. In the context of this study, challenges shared by the participants from either of the approaches are focused on a lack of clarity in roles and responsibilities, un-standardized Task-shifters' Training without which practice beyond professional scope was commonly encountered, resulting in conflicting roles in absence of organized individual counsellor-supervision. Regularization and standardisation in counsellor professional development was an expressed gap needing redress in marking the counsellors' career path for a positive counsellor-identity.

1:13. Significance of the study

It is obvious from the evidence in the literature that Task Shifting or the rational re-distribution of tasks among health workforce teams, (WHO, 2008) is being implemented globally within all care-providing professional services including counselling and one may wonder as to why I chose to do my study on this phenomenon. As discussed in the chapter on literature review, the practical implementation of Task shifting in its various forms befitting the environmental context is sometimes not so clear.

Philips, Zachariah and Venis et al., (2008) observe that tasks and workloads for the mid-level providers have become more excessive and complex in the midst of inadequate training, supervision and support with resultant stress and burn-out. In support of the argument, some authors warn that as a result, the quality of care is in the meantime being compromised and

communities may become suspicious of Task-Shifting in the midlist of poor financial remuneration for sustaining the health worker outputs (Leiter and Maslach, 2009; Berber, 2012).

By exploring this approach, I hope that the study will illuminate some emerging evidence on the forms of Task shifting and workable approaches suitable in different working counselling environmental contexts in Kenya (and beyond), including in HIV and AIDS where the strategy is reflected as a key component of service and care delivery (Stein et al., 2008; Taegtmeyer, 2011; Ferrinho, 2012).

1:14.A brief overview background on counselling services in Kenya

A brief background on counselling in Kenya will provide a link to Task Shifting, the phenomenon of my study but also show how Task shifting significantly shapes the context under which counselling is provided and the future expectations.

Biswalo, (1996) argues that the helping skills are increasingly being called upon to counter emerging trends linked to the ever increasing personal, socio-economic, educational and political challenges existing today, and the need to fill the void left by these experiences. Unlike in the western culture, such assistance in the past was a community responsibility (Mc Eachern and Kenny, et al. 2005; Okech, 2012).

> *"The contemporary Western concept of a counsellor is new and one that the wider Kenyan Community has been slow to embrace. Historically, the notion of consulting with a stranger about personal or family problems was an unusual concept and even frowned upon. Social challenges that might cast a shadow on the name and reputation of the family had to be*

resolved privately. A person who was experiencing an interpersonal problem would seek the help of a well-respected relative or a clan elder; in more serious cases, traditional healers were consulted. A key element to the success of this process was societal structural stability that resulted from geographical location and proximity" (Okech, 2012 p.1).

The early history of counselling in the 1970's Kenya began from the pioneer Christian institutions that lay the foundation to counselling service and training in the country (which is linked to the foundations of formal and religious education in the country in general). i.e.; the Family Life Counselling Association of Kenya (FLCAK), and the Amani Counselling Center and Training Institute (ACCTI) which is a main counselling training institution today (Amani Counselling Center and Training Institute, 2007).

Currently counselling services in the country including HIV and AIDS, are organized in an embedded form across many institutions in the public sector, the faith or church-based organizations; the educational establishments such as the universities, colleges and within various schools and private institutions some of which are owned by individual private-practitioners, but also among the indigenous or traditional practitioners. My study participants were based across some of such institutions as discussed in the section on the recruitment of participants (Section 3.8).

1:15. Counselling in HIV and AIDS

According to the report on the UNAIDS Global AIDS Epidemic (UNAIDS 2006), the rising numbers of persons living with HIV who require care and support over the years brings into focus the need for services provided by the counselling profession. For example, the number of people receiving

treatment in sub-Saharan Africa increased more than eight-fold (from 100 000 to 810 000), between 2003 and 2005, and more than doubled in 2005 alone. This was mostly as a result of increased treatment access in several countries in eastern and southern Africa; (Kenya, Uganda, Botswana, Zambia and South Africa).

In order to bring the health and related services closer to the people in Kenya, counselling care in HIV-AIDS and its accompanying chronic illnesses, (such as tuberculosis) are generally embedded in the health providing institutions in the country. These institutions are structured under six levels of the public health system for better coverage up to the grassroots i.e.; the Level 6, Level 5, Level 4, Level 3, Level 2 and the Community level 1 which is the entry point to the public health system at the grassroots. This is in addition to other providers (Kenya AIDS Indicator Survey Nairobi, 2007; Republic of Kenya, 2011; Wanjau et al., 2012).

Notably, the development of different counselling programmes has risen in an attempt to cope with the increasing need for HIV and AIDS care and support services (World Health Organization, 2007; Arthur, et al., 2005). The most prominent among these programmes are the voluntary counselling and testing, (VCT) and Counselling and Testing, (HCT) to raise awareness (Asante, 2007), Client Initiated Testing and Counselling (CITC) for those motivated to know their HIV status.

The Provider Initiated Testing and Counselling, (PITC) is a more recent strategy aimed at capturing patients for HIV testing through the health facilities (World Health Organization, 2007; Taegtmeyer et al., 2011). These events support the observation that helping skills are increasingly being called upon to counter challenges resulting from the rising social-economic challenges (Biswalo, 1996).

1:16. Influences of Civil Unrest

A more recent phenomenon that brought counselling into the limelight in Kenya is the civil unrest following 2007 disputed general elections arising from a need for coping strategies from accompanying trauma (Kanyinga, 2009). Some of the key protection concerns (Oluwafemi Atanda and John-Mark, 2011; Kanyinga and Walker, 2013) were linked to security challenges from unaddressed grievances among the internally displaced persons (IDPs) and their hosts' access to, and appropriateness of the available solutions.

The proceeding period resulted in bitter interethnic fighting, about 1,500 people lost their lives, an estimated 1 00,000 children were internally displaced in the country and over a quarter of a million adults fled their homes (Kanyinga, 2009; Okech, 2012). But the post-election violence (PEV) internally displaced persons (IDP) problem is more complex.

According to Kanyinga, (2009) several issues that required counselling among other interventions complicated the IDP social economic survival i.e.; inadequate involvement of IDPs, slow processes in provision of compensation, limited access to adequate shelter and land, prevalence of sexual and Gender Based Violence (SGBV), child protection rights and access to related documentation. These social-economic issues heightened a need for counselling in general but trauma-counselling in particular, raising the awareness about the need for not only adequacy in the numbers of counsellors but also counsellors trained in trauma counselling techniques (Kanyinga, 2009; Okech, 2012).

1:17. Policy Support Units Steering HIV-AIDS Health Services in Kenya

The Ministry of Health (MOH) is the key policy body for directing the establishment and implementation of health services in the country overall. The MOH oversees the HIV and AIDS programming through the designated support units for HIV and AIDS prevention and control in the country (Kenya Ministry of Health, 2005; Kenya AIDS Indicator Survey Nairobi, 2007).

1:17.1.The National AIDS STIs Control Programme (NASCOP)

The National AIDS STIs Control Programme (NASCOP) was established in 1987 to spearhead the Ministry of Health's interventions on the fight against HIV/AIDS following the first case HIV diagnoses in 1984 in Kenya. The NASCOP is mainly involved in the technical co-ordination of HIV and AIDS programmes in the country and in the implementation of the Kenya National HIV and AIDS Strategic Plan III (KNASP III). In marking the critical role of HCT, NASCOP has singled out the most important entry point into the HIV and AIDS continuum of care as HIV testing and counselling, (HCT), *"... if every Kenyan was tested for HIV and every person infected provided with appropriate treatment and counselling, then HIV will be brought under control"* (Taegtmeyer et al., 2011, p.6). NASCOP provides an overall enabling policy environment and is open to discussions with players and accepting a variety of financial contributions from key stakeholders (Eden and Taegtmeyer, 2003; Kenya Ministry of Health, 2005).

1:17.2.The National AIDS Control Council (NACC)

The National AIDS Control Council (NACC) established in 1999 is the next major body in the government for the HIV prevention and control policy. The functions of NACC include developing policies and guidelines relevant to the prevention and control of HIV-AIDS and mobilizing and granting resources for AIDS control and prevention to implementing agencies (Kenya Ministry of Health, 2005; Kenya AIDS Indicator Survey (KAIS) 2007). NACC coordinates and supervises the implementation of AIDS programmes in the country in collaboration with local and the international agencies working in this HIV and AIDS control, develops appropriate mechanisms for the Monitoring and Evaluation of AIDS and Sexually Transmitted Diseases (STDS) programmes and takes a leadership role in the advocacy and public relations for AIDS Council programmes.

NACC provides overall coordination of the multi-sectorial response to HIV and AIDS in Kenya (NACC, 2008).Though not significantly involvement in the processes, NACC sets targets for scale up. NACC is the key government body whose mission is to *"Provide policy and a Strategic framework for mobilising and coordinating resources for the prevention of HIV transmission and provision of care and support to the infected and affected people in Kenya"* (Taegtmeyer et al., 2011, p.7).

The functions of NACC (Kenya AIDS Indicator Survey Nairobi, 2007) include developing policies and guidelines relevant to the prevention and control of HIV-AIDS and mobilizing and granting resources for AIDS control and prevention to implementing agencies, coordinating and supervising

the implementation of AIDS programmes in the country (Developing appropriate mechanisms for the Monitoring and Evaluation of AIDS and Sexually Transmitted Infections (STIs) programmes) and taking a leadership role in the advocacy and public relation for AIDS Council programmes.

1:18. Early Task shifting initiatives

Eden and Taegtmeyer, (2003) inform that one of the early Task shifting responses was the unprecedented tailored skills-building training courses developed for health workers and lay counsellors, to help booster counselling and HIV testing services. These early Task Shifting initiatives raised concerns by the counselling associations and by the Kenya Medical Laboratory Technicians and Technologists Board about the length of training courses as well as the quality of services. The training manual on these training courses was eventually published in 2002 to lay a foundation for the training of health workers and the lay counsellors in the country.

In the late 1990s at a time when HIV prevalence was escalating among some of the key-populations in the Kenya, the government declared HIV/AIDS a national disaster in 1999.

Since then the accompanying heightened advocacy for prevention of new HIV infections and accompanying counselling services has made tremendous impact through the efforts of several programmes; key of which was HIV Testing and Counselling (HTC) (Taegtmeyer et al., 2011) and the availability of new easy to conduct rapid HIV testing technologies cutting down on the need for electricity and specialized laboratory training and personnel and waiting time for patients and clients. To accelerate VCT services in Kenya, a national taskforce was convened to oversee VCT Programme in the country and to actively promote Task Shifting. This distributed the work-load

from HIV counselling and testing among the various categories of staff maximizing the use of lay counsellors. A streamlined curriculum for health care professionals as well as lay counsellors was published by the NASCOP covering counselling skills, rapid HIV testing and quality assurance (Kenya Ministry of Health, 2005).

1:19. Counselling Training in Kenya

In Kenya as Okech and Kimemia, (2012) highlight, counsellor education is quite varied in all spheres. This includes the counselling curriculum, the institutions and organizations that offer counselling training, the actual level and duration of the many training programs which range from short certificate courses to non-graduate diplomas, undergraduate and postgraduate degrees in counselling. Both the public and private universities in the country are among the main institutions offering counselling training.

In the public sector, a reference framework-policy tool for counsellors has been provided in recognition of the value for professional counselling in the country (Ministry of State for Public Service, 2009). The public universities include Edgerton University, the University of Nairobi and Moi University. Among the private universities offering counselling training are; the African Nazarene, Africa International, Daystar, the University of East Africa Baraton and United States International University. Most of these institutions offer a diverse range of counselling programmes ranging from diploma-level training in Guidance and Counselling, Bachelor of Arts, Masters' and Doctorate Degrees in Counselling Psychology and Clinical Psychology in that order (Kenya Daily Nation. 27th March 2013).

1:20. Development of the Counselling Profession

Overall, the professional counselling associations and institutions have helped bring to light the "professional aspect of counselling" with the support of the government over the years. The collaborative efforts of the development partners have been encouragingly helping shape the future of the profession in the country through advocacy, policy development, training and service delivery. The US President's Emergency Plan for AIDS Relief Initiative, (PEPFAR) and other International and Bilateral Organizations form the bulk of support for HIV-AIDS programming in Kenya (The USAID Health Policy Initiative, Task Order 1. February 2010). The non-governmental organisations (NGOs) and privately run counselling institutions have played a significant role in the development of the counselling profession.

The Kenya Association of Professional Counsellors, (KAPC) an NGO based in Nairobi offers both certificate and diploma training and counselling services. In addition, KAPC has offered both Masters and Doctorate-level Counselling Degrees in collaboration with the University of Manchester in the United Kingdom.

The Kenya Institute of Professional Counselling, (KIPC) a privately run counselling institute, offers Continuous Professional Development Courses (CPDC) and provides counselling services on one to one basis and to groups. The Institute offers professional counselling courses at Higher Diploma and Diploma level to meet the rising demand for trained counsellors in the country. It also undertakes consultancy assignments in the field of counselling.

The Kenya Psychological Association, (KPsyA) founded in 1990 is another counselling body in the country which is currently agitating for accreditation

The Kenya Counselling and Psychological Association (KCPA) the umbrella organization whose aim is regulation of Counselling and Psychology practice in Kenya was formed in the 1980s. The association was formally registered with the Registrar of Societies as the Kenya Counselling Association, (KCA) in 1990. KCPA assumed office in 2012 and currently, it has a membership comprising of Counsellors and Psychologists with over 2500 members countrywide. The KCPA has opened branches in the various Counties, Universities and other tertiary institutions offering counselling and psychology in the country. The growth of the counselling profession is therefore expanding with further support of the Kenya Government.

In a culmination of a lengthy period, the government has just passed the Counsellors' and Psychologists' Bill by an Act of Parliament (2014-1) anchored in The Ministry of Health (MOH). This is a significant milestone for the counselling profession in Kenya. Hopefully, this new development will mark the future growth of the counselling profession through the collaborative-advocacy efforts of the Kenyan Government and the counselling and psychologists' stakeholders. As well, a bill for the regulation of the profession of Counselling and Psychology is under way.

1:21. Description of Study methods and participants

The study utilized a qualitative research methodology to explore the experiences of the counsellor Administrator-Managers regarding the influence of Task Shifting on counselling and related service including HIV-AIDS in Kenya. The Emphasis was on the participants' experiences in the Task Shifting Environment. There were seven (7) participants. The study used semi-structured interviews to collect data that was analyzed using a deductive-inductive thematic analysis approach.

1:22.The structure of the Thesis

This chapter has provided a background to my study on Task-Shifting, and an introduction to the subsequent chapters. An overview of counselling in Kenya is provided and its future expectations, considering the recently approved counsellors' and psychologists' Act of parliament, (2014-1) which will hopefully shape the way for the profession in reference to training, registration, licensing, practice and standards of counsellors and psychologists in Kenya.

This thesis is divided into six chapters. Chapter one contains the introduction of the study. The second chapter contains the literature review and focuses at contextualizing the study but within the existing literature. The usefulness of the key literature relating to the study is briefly discussed. The third chapter explores the methodology and methods adopted for the study, the participant recruitment procedures and the ethical considerations. The fourth chapter discusses the research findings in reference to the research question. The limitations of using thematic analysis in this study are briefly discussed. The fifth chapter is a discussion and the summary of the key findings. In this chapter, I reflect on the data analysis in comparison to the relevant findings from the literature. Here, I point out the limitations in undertaking this study and my recommendations, including some possible areas for further studies. The sixth chapter is the conclusion in which recommendations and possible future research areas are highlighted. The constraints of doing this study are also noted.

These six chapters are followed by a list of References, Figures, Tables and Appendices. This chapter has provided a background to my study on Task shifting, and an introduction to the other thesis chapters. An overview on counselling in Kenya is provided and its future expectations,

considering the recently approved counsellors' and psychologists' Act of parliament (2014-1) which will hopefully shape the way for the profession in reference to training, registration, licensing, practice and standards of counsellors and psychologists in Kenya.

CHAPTER 2 - LITERATURE REVIEW

2:0. Overview of the Chapter

This chapter entails a review of the literature that set the stage for the study on the Exploration into the Influence of Task Shifting on Counselling and the Related Services including HIV and AIDS at the Counselling Agencies in Kenya as reflected in the Research Question (Section 1:11.). The chapter also provides an introduction to literature that will help contextualise the findings.

Finally, a conclusion to the chapter is provided.

2:1. The Literature review

This section commences by looking at what the literature review involved, the inclusion and exclusion criteria, my theoretical underpinning/lens and what was put in place to conduct this review.

Machi and McEvoy, (2012) define literature review as:-

> *"A written document that presents a logically argued case founded on a comprehensive understanding of the current state of knowledge about a topic of study. This case establishes a convincing thesis to answer the study's question."*

The purpose of the literature review is to acquire an understanding of the topic, what has already been done in the field and the key issues in the area of research, and to effectively review the literature and determine the efficacy of intervention in the systematic review.

The criteria used for including and excluding studies and other supportive documents, form the operational definition of the problem (Abrami, Cohen and d'Apollonia, 1988) and provide a clear guideline as to the standards of research that will be used to determine the efficacy of speech and language interventions. It is important to explicitly determine the criteria for inclusion and exclusion before the researcher begins the search process of identifying, locating and retrieving the research articles needed to address the problem of evidence-based practice in reference to the research question(s). The criteria may be subject to change since some of the criteria are fundamental to collecting a rigorous and defensible set of data for the review, as the systematic review progresses through the stages of the process.

Mugenda and Mugenda (2003) posit that the purpose of a literature review is to sharpen the theoretical framework of research while Liz Ballinger, (2014) argues for transparency concerning the researcher stance in decision-making and in their involvement in all stages of the research process which supports the impossibility of being "...*a disembodied researcher"* (Giltrow, 2005 p.209). From my epistemological world view based on the "social constructionism" paradigm, I believe in the subjective interpretation of the multiplicity of reality and the ability to unearth the deeper and wider meanings as shaped by the environmental context in which it occurs.

In line with this, I commence with an introduction on Task Shifting which links up with the definition provided in Chapter 1 (Section 1:12), followed by the background which looks at a broader perspective on Task Shifting and its genesis. In using this approach, I provide some insight

into the historical aspect of Task Shifting which helps situate my study within the massive academic field within which the Task shifting phenomenon occurs. In broadening the understanding on this phenomenon I will be providing my readers with a wider view on the topic under study as well as showing that extensive research has been undertaken on Task shifting especially within the sub Saharan African region and in Kenya where my study is based. Through this review, the readers are able to locate the study within the academic framework and deepen an understanding of the issues involved.

The review also provides literature available on, the impact of HIV-AIDS on human resource, broader categories of Task shifting by WHO, an overview of the task shifting approach, modalities in systematic delegation of tasks especially on HIV-AIDS, Sub Saharan countries experiences with Task Shifting, Kenya's experience with Task Shifting and finally experiences from out of the Sub Saharan Africa.

The research studies reviewed demonstrated both the negative and positive perceptions on the influence of Task Shifting and counselling and the related services including HIV-AIDS.

I included only those studies that were written in English in my review because I was familiar with the language. In keeping with the current trends in my field of study, I focused on studies that were published between the year 2000 and 2016 as the year of publication was an important factor to consider in the identification of current trends.

The focus of this study was on qualitative research. Studies undertaken prior to 2000 were excluded unless they were addressing key theoretical aspects as a way of identifying current trends in the field of study. Specific studies on patients, the government or caregivers were

excluded as the phenomenon may have been experienced differently. Studies that were not written in English were excluded.

I follow by providing the strategies I used to search for the literature in the next section.

2:2. Literature search strategies

In order to identify literature for this study, a systematic literature search to establish the relevant literature that addressed my research question (Section 1:11) namely, electronic resources such as journals, e-books, and articles via the University via the University of Manchester library. This led me to credible databases like Pub med and Medline, Google scholar that were relevant in my field of study.

I would begin with the general terms like; task shifting, shifting, task-shifters, substitution, delegation, resource constrained, sub-Saran African region, research/reviews, counsellor managers/administrators, Kenya, HIV-AIDS, etc.

- For journal articles, I would key in the specific titles. Tracking reference-leads provided by authors yielded further cross-referencing.
- The Google Scholar yielded book chapters.
- PubMed yielded free access journal articles.
- More recently, I have been able to access the University of Manchester Library through which I can track missing literature from previous searches and also do further searches. I have been able to use Shibboleth for some of the references.

- The World Health Organization (WHO) reference documents on task shifting appeared mostly in form of reports, policy guidelines/briefs, and recommendations. The reference list provided links to other references including research articles.

In this chapter, I present an overview of the Task Shifting phenomenon in general so as to show how this model is used as a strategy during the era of HIV-AIDS epidemic particularly in the sub Saharan African-region, including Kenya where my study is based.

2.3. Introduction

As elaborated in Section 1.12. Task Shifting in its formal approach is the process of rational redistribution of tasks among a mix-cadre of health teams for more efficient use of available staff cadres (WHO, 2007c; Lehmann et al., 2009).

Currently, Task-Shifting in HIV and AIDS counselling is being defined as shifting tasks to lower cadres of staff; from the doctor to the nurse from the nurse to the community worker or person living with HIV (PLWA/PHIV).

As reflected in the WHO, Treat, Train, Retain plan (WHO, 2007b) under the Global recommendations and guidelines, it is proposed that the Task Shifting approach be expanded through improved training-skills (Table 2.1.) as one method of strengthening and expanding the health work-force to rapidly increase access to HIV and other health services. The WHO broad categorization on the Task shifting strategy for national and /or local adaptation is shown in Table 2.2.

Table 2.1: - WHO, Treat, Train, Retain plan

Treat	**A package of HIV treatment, prevention, care and support services for health workers.**
Train	**Measures to expand the human resource pool, maximise the availability of more highly skilled workers, and empower health workers to deliver universal access to HIV services, including pre-service and in-service training for a public health approach.**
Retain	**Strategies to enable public health systems to retain workers, including financial and other incentives, occupational health and safety, and other measures to improve the workplace, as well as initiatives to reduce the migration of healthcare workers.** **Adapted from WHO, 2007b.**

Task-Shifting is therefore a commonly used approach to the delivery of counselling and related health services for patients and clients (Petersen and Swartz, 2002; Pope et al., 2005; Tanui, et al. 2006) and is continually highlighted as a common model of providing strengthened health service-delivery to counter the deflated health personnel (Asiimwe et al., 2005; Asante, 2007).

As reflected in Session 1:12, an expansion of a pool of human resource could benefit from a package of incentives inclusive of the WHO Teat, Train and Retain Task shifting strategy (Table 2.1.), aimed at increased job motivation and retention of health workers under the WHO evidence-based categorization (Table 2.2) as further elaborated in below (Section 2:5.1).

As well, consideration should be given to Task shifting in its commonly utilised formal (explicit) approaches (Hongoro and McPake, 2004; WHO, 2007b) but with specific tasks being moved as appropriate, from highly qualified health cadres to those with lower qualifications in order to make more efficient use of the available human resource (WHO, 2007b; 2008).

The Global development professional network (GDPN) hence views Task Shifting as a rational re-distribution of tasks among health workforce teams, and as a low-cost solution to tackling health gaps in health service-delivery in the low-resource countries.

The need to address underlying barriers through clear laws, regulations and collaborative policies has been highlighted for instance; perceived focus on HIV and AIDS, professional-protectionism and boundaries in order to positively steer the Task shifting strategy (WHO, 2008) in order to steer the strategy forward.

In Kenya, the Task shifting model of care has been more pronounced in the HIV and AIDS programming especially in its formal (explicit) forms (Taegtmeyer et al., 2011). But as in other countries bordering Kenya within Eastern Africa (Munga and Maestad, 2009) and across sub-Saharan Africa, (McCourt and Awases, 2007; Zachariah et al., 2009; Callaghan et al., 2010) Task Shifting has been used in many contexts both formally and informally as a response to the health-worker crisis.

The literature on Task Shifting is massive. There are a lot of similarities on the approach and many challenges as well. However, some countries have registered success stories, for example, Zambia in the southern African region (Morris et al., 2009). My main purpose in this chapter is to find out how Kenya fits into this larger picture within the massive information that exists on the Task Shifting phenomenon. This will pave a way for me to further explore “The Experiences of Counsellor Administrator-managers” regarding the influence of Task-Shifting within their counselling environment.

2:4. Background

By 2006 the world was lacking at least 4.2 million health workers from the World Health Organization (WHO) calculations on 'minimalist' densities of 2.28 medical doctors, nurses/midwives combined per 1000 population which implies that the actual figures today could be much larger than these projections (O'Brien and Gostin, 2011).

One contributing factor to the shortages of health workers is immigration which depletes areas of much-needed resources with widespread effects on the education and training of health workers, a costly and time-consuming venture given their lengthy training. The major portions of these immigrating health workers' education and training would most likely, have been financed by their country of qualification. Therefore their migration, although a personal right, represent a loss of investment for the country in question which had invested their services in return. As a review of evidence highlights (Zachariah et al., 2008);

> *In sub-Saharan Africa the situation constitutes a human resource crisis due to significant emigration of trained professionals; difficult working conditions; poor salaries; low motivation and a high burden of infectious diseases, particularly HIV/AIDS, among the workforce. Sub-Saharan African countries are hardest hit in terms of emigration of trained health staff, both to South Africa as well as to countries in the West, (p.550).*

2:5. Impact of HIV-AIDS on human resource

According to the WHO estimates, a shortfall of the key personnel (doctors, nurses and midwives) in the African region highlight a need for more than double the workforce among these

professional categories. Some of these cadres; doctors, nurses, midwives (and pharmacists) would take several years to train, unlike the Para-professionals and technicians who take shorter periods (WHO, The World Health report, 2006). This chronic shortage of trained health workers is complicated by the rising demand for healthcare as HIV and AIDS epidemic continues to fuel the health workforce crisis. This situation in return calls for a strengthening of the health systems that would deliver a wide range of health services on a much larger scale.

The fact that about 95% of HIV-positive people live in resource-constrained countries and a nearly two-thirds are in the sub-Saharan Africa, this is a major barrier to the prevention and management of HIV-AIDS according to the World Health Organization report (WHO/PEPFAR/UNAIDS, 2008). The WHO recommends that an ideal Task shifting approach considers safety in its application, efficiency, effectiveness, equitability and factors for ensuring that the approach would be sustainable within the specific countries in the long run (WHO/PEPFAR/ UNAIDS, 2008).

Further and in consideration that the HIV epidemic is increasingly having a direct impact on the acute shortage of health workers through attrition from a vicious cycle of increasing workloads under poor working conditions (Lehman and Sanders, 2007) the implications for other essential health care including HIV counselling services need to consider the critical input by the non-professional health workers and specifically by lay counsellors PHIV through the formal and informal approaches to Task shifting as their contribution have been well recognised (Lehman and Sanders, 2007; Mullan and Frehywot, 2007; Sanjana et al., 2009). But Dovlo, (2004) argues that inadequate remuneration, perceived and actual risks of occupational transmission of HIV and its accompanying infections like tuberculosis contribute to stress and eventual burn-out doubling an

already strained human resource crisis and that these factors need to be considered in sustaining the Task shifting approach.

2:5.1.The WHO Broad Categories of Task Shifting

In view of the strained public health systems and increasing health inequalities, Task Shifting has been recognized as an appropriate approach to health care management because of the rapidly increasing care needs as a result of the HIV/AIDS epidemic (Human resources for health, 2004) mainly because of the human resource crises particularly in many resource-constrained countries. The aim is to formalise these approaches in support of the Task Shifting model as national strategies for organising the health workforce by the different countries (WHO, 2007b). The WHO recommendations and guidelines on Task Shifting have been developed in the context of efforts to rapidly increase access to HIV services across communities down to the grassroots and in order to progress as far as possible towards the goal of universal access to HIV services, (Table 2.2.).
As Dovlo, (2004) and Damshiye, (2010) further argue in support of the potential for the Task Shifting model, the impact of Task Shifting approach would not be restricted to HIV service delivery because the strategy is workable across the specific country needs depending on the prevailing demand for services. The implications for other essential health services and the potential for wider health systems strengthening are therefore recognized (WHO, 2007) as evidenced in past national practices**.**

2:6.An Overview of the Task Shifting Approach

Lehmann et al., (2009) observe that the delegation of tasks from one cadre to another, (previously called substitution) has been used in many countries over many years in response to emergency needs and also as a method of reaching out to communities with both primary and secondary level care in remote rural facilities to enhance quality.

Considering the length of training to qualify doctors and nurses as compared to the amount of time it takes to train community health workers (CHW) in specific tasks, Task Shifting could be especially beneficial (Buchan, 2002 and Dal-Poz, 2002). However, the strategy should be supported with proper training and supervision for CHW to deliver a range of services shifted to them which would expand the reach of health services.

Table 2.2: - The WHO Broad Categories of Task Shifting

(Source: WHO, 2007b)

Task shifting I*:*	**The extension of the scope of practice of non-physician clinicians in order to enable them to assume some tasks previously undertaken by more senior cadres, for example, medical doctors.**
Task shifting II:	**The extension of the scope of practice of nurses and midwives in order to enable them to assume some tasks previously undertaken by senior cadres for example non-physician clinicians and medical doctors.**
Task shifting III:	**The extension of the scope of practice of community health workers, including people living with HIV/AIDS, in order to enable them to assume some tasks previously undertaken by senior cadres like nurses and midwives, non-physician clinicians and medical doctors.**
Task shifting IV:	**People living with HIV/AIDS, trained in self-management, assume some tasks related to their own care that would previously have been undertaken by health workers.**

Key in supporting Task Shifting are all those health cadres who are tasked with ensuring the reach of health services to its intended levels of care, which include those who primarily make the diagnosis, those who treat diseases, and those who engage in health promotion and preservation as in counselling.

The management function though not a universally defined role, some of the administration/managerial responsibilities are undertaken by staff across cadres, for example, nurse-managers, counsellor-managers, and doctors depending on the context under which services are delivered. Hence Task Shifting has also been extended to other cadres that do not traditionally have a clinical function; pharmacists, pharmacy technicians or technologists, laboratory technicians, administrators and managers including counsellors depending on their actual counsellor-roles. The cadre that assumes the new task becomes the defining factor for Task Shifting types (WHO, 2007).

Thus, in addition, staff cadres who, even though not directly involved in health service delivery oversee the management and support components for the smooth running of the health services, become key among this mix of staff cadres. The WHO report (WHO/PEPFAR/UNAIDS Report, 2008) suggests that Task Shifting would foster linkages between health facilities and communities as well as create jobs opportunities for people living with HIV (PLHIV /PHIV).

In support of the argument Dovlo, (2004) observes that the approach of Task Shifting has been in existence in many countries and for several decades mainly as a response to emergency needs or as a method of ensuring primary care in understaffed rural and urban facilities, as evidenced in the literature. Therefore, some forms of Task Shifting have been adopted informally with various approaches being successfully implemented in various countries using available staff cadres, such

as in the examples from Uganda (Dambisya, 2010) and Swaziland (Mehlomakhulu, 2009) in response to human resource needs even in absence of policy guidelines.

In order to ensure that shifting down of tasks does not defeat its intended purposes, the informal sector health workers notably the community health workers, volunteers and traditional healers need to work in a mix of professionals to enhance skill synergy and so as to ensure both coverage and quality of services at all levels (WHO, the World Health report, 2006).

2:7. Modalities in systematic delegation of tasks especially in HIV-AIDS

The debate pointing at the modalities surrounding the systematic delegation of tasks to less-specialised cadres emphasises patient self-management and community involvement (Zachariah et al., 2006).

In order to address both the causes and the effects of HIV and AIDS on the health worker force, a package of HIV treatment, prevention, and care and support services for health workers (WHO, 2007; 2007b) was developed. This package proposes a public health approach by empowering health workers to deliver universally accessible HIV services by providing financial support and also other incentives plus putting measures that improve the workplace. Initiatives to reduce the attrition by migration of healthcare workers and also to strengthen and expand the health workforce are also part of the WHO “Treat, Train, Retain” Strategy guideline (Table 2.1.).

To address the major challenges facing communities, one of which is increasing coverage into the periphery with basic health care services calls for the urgent strengthening of the primary healthcare systems. This is in addition to a strong cycle of specialised support-supervision and a systematic management and coordination among and between the different staff cadres. As well,

clear roles and responsibilities for each of the specific tasks to be shifted should be put in place and/or strengthened (WHO 2007a; Zachariah et al., 2008) in order to balance the acute shortages and maldistribution of health workers both geographically and professionally.

In support Huicho et al., (2008) comprehensive commentary on a study of Task Shifting comparing results across countries showed that health workers with shorter training duration performed at least as well and sometimes substantially better than those with a longer duration of training in clinical roles; assessing, classifying, and managing routine childhood illness as well as in counselling the children's carers.

These findings support Macinko et al., (2006) in which Task Shifting in health care delivery was found to lead to improvements in access, coverage and quality of health services at predetermined acceptable cost. For the overall ownership (Lewin et al., 2005; Marchal et al., 2005; Walker and Jan 2005), advancing an active participation of mixed group-cadres of task shifters is a most critical recognition for sustainability of the Task Shifting approach in health delivery (Campbell et al., 2008).

Dovlo, (2004) provides a workable example from a health team approach in which responsibility in the provision of a broad range of primary health care services was assigned to family health teams; (one physician, one nurse, a nurse assistant and four or more community health workers), to take responsibility for providing a broad range of primary health care services in an assigned geographical area. Using a local model of Task shifting has been documented from Asia's success in Task Shifting as a result a large number of local mid-level worker-categories of health workers whose roles were developed not for conventional health professionals (doctors, nurses,

pharmacists and etc.) but to respond to their specific country needs ranging from birth attendants to health assistants.

Such modalities in Task Shifting have been found to lead to improvements in access, coverage and quality of health services at predetermined acceptable cost. Macinko et al., (2006) however note that even such innovative approaches as observed earlier, require a systematic implementation as part of an overall human resources strategy for long-term sustainability. These views support Walt, (1989) earlier observations for the need to involve the whole spectrum of the personnel sector from the policy level, right down to the community levels for the purposes of enhancing coverage and improving the overall outcome depending on the varying prevailing circumstances in different countries.

Macinko et al., (2006) further reiterate that without a health team approach, the introduction of new cadres or delegation of tasks will invariably remain a fragmented and unsustainable "add-on" devoid of the much-needed support systems. The regulatory bodies, in general have been seen to be obstructive of recognition of Task Shifting by lower level trained heath personnel sending contradictory messages on this model of care. For example, Uganda sites the Professional Council of Pharmacists opposing the introduction of training for pharmacy assistants, while the Nurses and Midwives Council opposed the accelerated training of nurse assistants and failed to support the conversion of traditionally enrolled nurse training to enrolled comprehensive nurse training, a move designed to reduce specialization (Uganda Episcopal Conference, 2005; Macinko et al., 2006).

In the Brazilian Medical Association example, nurses were eventually stopped from prescribing drugs so that the implementation of the Integrated Management of Childhood Illness programme

eventually became non-functional (Hongoro and McPake, 2004; Uganda Episcopal Conference, 2005).

To build sustainable, cost-effective and equitable health care systems Lehmann, et al., (2009) urge countries that are undertaking Task Shifting to tap and learn from the potential of countries that have had a positive experience like Mozambique and Zambia in the southern African region.

2:8.Task Shifting in Sub Sahara Africa

Task Shifting (TS) in most sub-Saharan African countries was an outcome of similar or comparable factors. These experiences are summarised with example country case studies from Southern Africa, Western Africa and within Eastern Africa inclusive of Kenya.

A review of evidence on Task Shifting consistently shows that delegation of tasks can lead to improvements in access, coverage and quality of health services at comparable or lower cost than traditional delivery models (Dovlo, 2004 and Huicho, 2008). Formal (explicit) Task shifting has hence been recorded both from doctors to non-physician clinicians including nurses; and from nurses to nursing assistants, nurse aides, to non-professional or lay health workers and even patients. Nursing assistants are observed to be cheaper to train and pay than qualified nurses, midwives or doctors.

Using an example from rural Zimbabwe Hofmeyr et al., (2009) report that nurse aides were trained to conduct low-risk deliveries with an outcome of 57% of all deliveries and a perinatal mortality rate of 5 per 1000. While this suggested that the nurse aids could attend appropriately identified low-risk births in this setting to enable midwives and doctors to manage high-risk deliveries and other obstetric emergencies the intra-partum supervision was recommended.

According to Ferrinho, et al., (2012) the outcome supports the expansion of nursing assistant-cadre within the health facilities to free time for the health workers with higher level training; (nurses, midwives and doctors) to provide care that requires more expertise including counselling. From the feedback it was obvious that incentives for the task-shifters were a felt need which should be given due consideration;

> *As the auxiliary nurse carries almost the same tasks as a mid-level nurse … it would be right if that auxiliary nurse could be promoted to mid-level nurse by a distance learning course*
> (Nampula Rural Hospital)

Introducing Malawi Huicho et al., (2008) highlight a country with a severe crisis in the shortage of medical staff and Task Shifting as showing a long potential for reviving primary health care approach for decentralised services for greater equity and accessibility because the approach stimulates multidisciplinary teams. The model was recommended for scaling up of HIV services to enable more people to access to HIV care and other related services.

In an example, the health worker crisis in Malawi prompted Medicines' sun Frontiers (MSF) in collaboration with the Ministry of Health in the country to adopt Task Shifting. Some of the medical tasks were delegated from doctors to nurses, to extend HIV treatment activities from the hospital to 10 health centers in two districts (Huicho et al., 2008). The six-month appointment system for stable patients significantly reduced the workload of health staff and minimized the cost for patient follow-up care with gradual spill over to other districts. MSF continued support for HIV services to the Ministry of Health with mentorship staff for scaling-up of treatment and

improvement of the accessibility of services for quality of care to ensure sustainability (Huicho et al., 2008).

In order to address Zambia‘s presenting health-worker needs (Morris et al., 2009) the Formal Task Shifting strategy (Table 2:2) tailored to the transfer of specific clinical responsibilities to well-trained middle level providers, was structured as a comprehensive three-pronged approach i.e.; hands-on training, on-site clinical mentoring, and continuous quality assurance supported by the Ministry of Health (Zambia Ministry of Health, 2006).

The aim was to sustain ART programming on specific evidence-based support interventions targeting both pediatric and adult HIV management especially treatment, adherence counselling and also nurse-triaging for smooth coordination of the services in Lusaka, the capital of Zambia. A practical mentorship model and clinical care quality assessment was successfully implemented (2005-2007), with recommendations for further scaling up so as to impact on the human resource crisis including dealing with the brain-drain for retention of the health personnel in the country (Zachariah et al., 2008; Morris et al., 2009). The results showed that when Task shifting is supported with appropriate training, mentoring, systematised quality monitoring, well-organized client flow and adequate remuneration, the model holds the potential to the human resource gap in the sub-Saharan Africa as in this example from Zambia. In relation to the country’s priority needs; positive outcomes included capacity building for the middle-level health workers, the community workers and the patients who support HIV care initiatives with emphasis on quality of clinical care which is aimed at rapid scale up of HIV services which is a key priority in Zambia (Morris et al., 2009).

In this study, remuneration factors which in most cases contribute to human resource attrition through immigration by undermining the motivation of the health workers were addressed in support of expanded health care for HIV clients and improved working conditions for government health professionals.

In spite of the positive findings, the authors noted a recurring need for central coordination voiced among the different staff-cadres including;

- Urgent need for additional resources,
- Need for strategies to further engage with Ministries of Health, (MOH) for long-term sustainability of such programmes,
- Human resource shortage still a critical barrier to the rapid scale of ART services,
- The need to involve various stakeholders to explore further innovative strategies in order to fully realize the public health benefits associated with rapid scale-up of HIV services for lower morbidity and mortality outcomes.

The authors re-emphasized the need for national governments to seek long-term sustainable solutions to reduce staff brain-drain and chronic provider burnout as evidenced elsewhere by advocating for improved and regularised working conditions for the mixed cadres of Task Shifters (community-based workers and the health professionals).

But Philips, Zachariah and Venis et al., (2008) and Davies et al., (2013) cautioned against burnout among Task shifters especially nurses from insufficient staffing, high staff turnover, complex and unmanageable workloads from additional responsibilities;

- Heightened target-related performance pressures

- An increasingly unpleasant working environment
- Growing resentment because the nurses perceived task-shifting away from doctors as an 'abuse' of their role; *"...we are only three [sisters]. We have ANC [antenatal care], child services, PHC, family planning, TB. All this basket of services to be rendered".*

Ferrinho, et al., (2011) observed that Task Shifting approaches among staff including nurse-counsellors were commonly used in both Mozambique and Zambia;

- All categories of health workers in *Mozambique* receive training in minor clinical /surgical procedures and clinical officers as surgical technologists (técnicos de chirurgie) (Kruk, et al., 2007) so tasks could be shifted around.
- The medical doctors at their health institutions also shifted certain tasks to nurses to reduce their own workloads (unfortunately, the nurses did not have the liberty to shift their tasks so they continued to become overloaded) (Philips et al., 2008).

Amidst all these initiatives however, Lynch et al., (2008) noted the high turn-over of staff affecting the different mix of mid-level and general practitioners (nurses and nurse-midwives, nurse auxiliaries, medical or clinical officers, medical or health assistants and community-based health workers) which was contributing to the crumbling health systems. As in the Zambia study (Morris et al., 2009) nurses in particular, migrate into the richer countries and other better-paying institutions including the Non-Governmental Organizations (NGOs), more physicians moved into private practice while other staff moved to other institutions perpetuating the human resource crisis in health care.

In addition as discussed in Hongoro and McPake, (2004) the regulatory bodies, in general, have been considered obstructive in recognition of utilisation of lower level trained health personnel in Task Shifting. Such contradictory and conflicting messages on the Task shifting model of care need to be addressed collaboratively with the relevant representatives (Lehmann et al., 2009) in support of the Task Shifting model of care.

In spite of this however a more recent study in Mozambique and Zambia, Ferrinho et al., (2012) indicate that in absence of written instructions health workers continued to practice beyond the scope of their professional practice, in order to ensure that their patients receive the level of care that they termed as due to them which according to Lynch, et al., (2008) elude to crumbling health systems.

Nurses/nurse-counsellors experts from Task shifters in Zambia and Mozambique (Ferrinho, et al., (2012) show clearly the extent of Task Shifting challenges (that other countries could learn from).

> *As enrolled nurses, we are not supposed to be delivering (in the labor room, but we do it). We are also doing [patient] screening [in OPD] … MCH activities [which] are supposed to be done by a qualified person … suturing and doing cannulation …, minor surgery – I&D [incision and drainage]… giving IV drugs…we even do death certification [on behalf of the clinical officer]. We also do the counselling and testing for HIV… and also testing for Hb, RPR and RDT [rapid diagnostic tests] for malaria … administrative work … we don't even know our job description. These other extra duties take most of our time"* (Zambian Rural Health Centre)

The managers acknowledged that informal Task Shifting involved risks for them and that overall, staff members were unhappy because in most cases those working overtime or assuming new functions were neither recognized for additional roles nor were they rewarded financially because of the Ministries of Health restricting policies (Ferrinho et al., 2012).

> *…maybe the lack of financial rewards is not the worst of it. Also, there is a lack of recognition of the add-on work that they assume… (Maputo General Hospital, Mozambique)*

> *We notice that workers are not happy… (Maputo General Hospital)*

> *…when we had maternal deaths, it wasn't only the nurses who were asked to write a report, even the sister-in-charge, even the nurses who were there when the mother died, they also wrote the report. So management is also liable [for the hazards resulting from task-shifting]* (Lusaka Health Centre, Zambia)

Reflecting on the managers in Zambia (Ferrinho et al., 2012) the situation of deficit prevents proper in-service training;

> *… The problem is that we are so short of staff that even training is difficult, in-service training which was supposed to be routine is lacking because there is no time to remove staff from their posts, but we know that that is the only way to overcome the quality crisis …* (Mpanshyia Hospital)

Hospital technical staffs consider that the staffing shortage in hospitals is critical and the overload is affecting both the skilled and unskilled staff categories, resulting in significant shifts of tasks among different categories of health workers;

> *"We have five staff members involved with patient screening. We see so many patients, too many patients. I believe that each day each one of us sees up to 75 or even 85 patients. That is too much…"* (Maputo Health Centre, Mozambique)

To improve access to essential care to remote populations in Ghana, Task Shifting was used long before the term came into being, taking several forms. For instance, *the role of medical assistant* was introduced in the late 1960s with one-year training that focused on diagnosis and treatment of common disorders in places where doctors were scarce (Ghana Ministry of Health, 2002).
In many rural hospitals, *doctors trained nurses* to take on some of the tasks that they normally performed such as draining small abscesses, monitoring of vital observations, activities that were not part of the national policy. By the early 1990s however, *midwives in Ghana* were trained for the first time in procedures such as the manual vacuum aspiration to control uterine bleeding. In addition, a training curriculum was developed *for health assistants* whose role would be to support nurses, although delays resulted into uncoordinated local adoption for its national implementation. But as in other countries these initiatives in Ghana were often resisted by professional bodies, for example, the Health Assistants were initially called nursing aides but the Nurses and Midwives Council resisted any association of this less trained cadre with the label nurse.

In an observational multi-country study comparing results across four countries supporting the principle of Task Shifting *(here defined as the allocation of tasks in health-system delivery to the least costly health worker capable of doing that task reliably)* (Huicho et al., 2008) health workers who had undergone shorter periods of training performed at least as well or sometimes even better than those with a longer duration of training. These authors warned that professional associations that seek to block such initiatives to deliver effective essential care for the marginalized and remote areas could eventually lose public trust. And therefore, in order to counter resistance to the appropriate and safe delegation of tasks there is need to accumulate supportive evidence through research, consultation and constructive negotiations with the professional and regulatory bodies for example over the different staff cadres job titles, ethical guidelines and remuneration.

Support systems need to be in place for the success of Task shifting. A Task Shifting Study for emergency obstetric surgery for district teams through the Ministry of Health and the University of Dakar Senegal, only about half of those teams trained were functioning by five years (De Brouwere et al., 2009). Because training was not happening rapidly enough to cover all the districts, unmet needs persisted even in districts with teams in place.

Though the surgical teams appreciated the training and their new roles especially from the feedback received from their communities as well as the observed lower morbidity and mortality outcomes overall, a lag period between the training and actual theatre operations was noted from inadequate coordination during the actual period of the study (Morris et al., 2009). The teams were also dissatisfied with the poor remuneration and the lack of career progression in absence of policy guidelines necessary in putting in place a more comprehensive Task Shifting model as

observed elsewhere for the provision of emergency and essential surgery (De Brouwere et al., 2009).

Similarly within the eastern African region (as highlighted by examples from Tanzania, Uganda and Kenya) as among other sub-Sahara African countries Task shifting has diversified to become a major strategy involving a cross mix of health personnel cadres (Zachariah et al., 2008). This need has been driven by the high demand of unequally distributed healthcare services especially among the lower social-economic population (Munga and Maestad, 2009).

From its background, Tanzania has been reported by the WHO (WHO, World Health Report, 2006) as having the lowest health personnel ratio of 0.02 physicians per 1000, with an average of 1.4 total health workers per 1000 and even lower in the remote districts. This comprises of the highly unskilled cadre of "Medical Attendants" in a range of 40.2% and a range of 27.8% for Nurses who form the largest proportion of the total skilled health workforce in Tanzania most of them in urban areas resulting in a highly disadvantaged rural population.

A qualitative study by Munga and Maestad, (2009) at national and district level revealed that Task shifting has occurred informally in Tanzania for many years and could lead to increased retention of health workers especially in the remote and underserved districts in Tanzania. However one major concern was the importance of prioritising guiding-policies related to personnel management, infrastructure and systems of coordination so as to develop and maintain the quality of services.

As observed elsewhere other expressed needs included additional resources for the continued capacity building of the different mix of Task shifters as well as support-supervision necessary for long-term sustainability of the programmes country-wide (Munga and Maestad, 2009).

Underlying health workforce shortage inequitable distribution, poor performance and the inefficient use of health workers are the driving factors in Task shifting in Uganda and the resultant high demand for healthcare services. Hence even with no official policy or guidelines, Task Shifting was taking place on a wide scale and at various levels of care primarily through internal institutional arrangements (Ministry of Health Report Uganda, 2009; The USAID | Health Policy Initiative. Task Order 1: February 2010). Findings from a study by (Banerjee et al., 2005) show that "Task shifting 1 and 11" (WHO 2007b) in surgical obstetric tasks and other emergencies while the maternal child health (MCH) services were performed by clinical officers and the midlevel personnel; (clinical officers, midwives and nurses) spontaneously in support of Task Shifting. This was in addition to the provision of about 24% of the deliveries by traditional birth attendants (TBAs) hence enhancing inequities in access to critical care among the disadvantaged populations, especially in rural Uganda.

The absence of regulatory mechanisms however deter nurses from taking on more responsibilities (Dambisya, 2010) because of the nursing regulatory bodies concerns that the skills integral to the nursing profession were being handed over to less skilled workers hence diminishing the nursing role (Buchan and Dal Poz, 2002) as in the example of nursing assistants who, though being the majority at the lower levels of service delivery, were not regulated (USAID, 2003).

Mugisha, (2003) also argued that the poor remuneration for the Health workers in government facilities as compared to their counterparts working within projects are additional factors that draw health workers away from government facilities that are already understaffed particularly at the grassroots where a majority of the community live.

Task Shifting guiding regulations both its formal and informal approaches are a necessary benchmark for streamlining the Task-shifters' roles so as to motivate health workers to serve in their communities where they are most needed. But more specifically as revealed in the USAID Policy Initiative Task shifting "Case Study" (The USAID | Health Policy Initiative. Task Order 1: February 2010) Task Shifting enabling policy, regulations, quality assurance and/or legal protection need to be addressed at national levels for the personnel who undertake additional tasks as proposed for Task Shifting in Uganda (WHO, 2007).

2:8.1. Task Shifting in Kenya

In Kenya, the Task shifting model of care has been more pronounced in the HIV and AIDS programming, especially in its formal forms. But as in other countries in the eastern African region but also, across the sub-Saharan Africa (Hongoro and McPake, 2004; Mullan and Frehywot, 2007) Task Shifting has been used in many contexts both formally and informally as a response to the health-worker crisis.

2:8.2. Task Shifting in HIV – A Brief overview history

Since the early 2000 when HIV was declared a national disaster, the Task Shifting approach has been used in scaling up the HIV-AIDS programming mostly aimed at coping with the massive workloads among the health workers as a result of the high HIV prevalence rates in the country and the marked regional variation, (Kenya Demographic Health Survey, 2003-2004).
The Formal Task Shifting initiative was triggered through the 2000 consultative meeting on voluntary counselling and testing (VCT) to discuss the scale-up of the counselling services and to

outline the government strategy (Arthur et al., 2005). This initiative included the use of rapid tests by lay personnel in primary health facilities and particularly the lay counsellors in order to cope with additional work created by HIV counselling and testing.

A national taskforce formed to oversee the VCT services in the country (NASCOP, 2001) had set out to promote Task Shifting so that the burden of extra work created by HIV counselling and testing would be distributed throughout the different categories of staff for maximum benefit from the use of VCT lay counsellors (Arthur et al., 2005). One major concern by the regulatory bodies and professional associations was the quality of training and/or the actual testing by the lay (Eden and Taegtmeyer, 2003); Arthur et al., 2005; Taegtmeyer et al., 2011). Nevertheless, over 2500 VCT counsellors and 900 new VCT sites were created most of which were embedded within government (public) health. Resulting from the training and certification in support of this accelerated HIV counselling scale-up initiative the Task Shifting strategy using the lay counsellors with same-day HIV results was nationalized through the National AIDS and STD Control Program (NASCOP) (Taegtmeyer et al., 2011). Following this initial initiative, the mother to child HIV testing in antenatal clinics and hospitals was initiated and eventually the provider-initiated HIV testing and counselling (PITC) as a routine standard of care.

According to a follow-up community-based study Selke et al., (2010) tasks were shifted from health care workers to community-based workers (CBWs) who were persons living with HIV (PHIV) using the formal Task shifting III-WHO Broad Category approaches (Table 2:2), (WHO 2007b) in which an additional reduction of 50% in the number of HIV client HIV-clinic visits was observed. Similarly, a study by Kara et al., (2009) utilized trained PHIV and community care coordinators (CCCs) to provide care “to their stable peers” on a monthly basis with quarterly clinic visits. The

shifted care for patient support and the antiretroviral therapy (ART) dispensing tasks by PHIV was acceptable among the local community and had the advantage of enhancing the team's understanding of the psychosocial issues that impinge on an individual client's care.

According to Kara et al., (2009) and Selke et al., (2010), although these formal Task Shifting approaches utilizing PHIV were deemed acceptable at the grassroots, the additional computerized support *(preprogrammed personal digital assistants - PDAs)* and related referral-systems would require enhancement in order to minimise observed complexity for sustainability (WHO, 2007b; Kara et al., 2009; Selke et al., 2010).

In both studies, however, the training levels for the Task shifters were unspecified.

2:8.3. Utilisation of Task shifting in other areas

Even though the Formal Task shifting has potentially been highlighted within the HIV-AIDS service delivery in the country, over the years the approach has also been used in other areas including in its varying informal approaches. Other such areas have been in Family planning (FP) and more recently in Mental-health (Sections 2:8.4 and 2:8.5.).

2:8.4. Task Shifting in Family-planning - FP

Kenya recently extended the Task Shifting strategy in several programmes for example on 27th of November 2011, the Kenya Ministry of Public Health and Sanitation through a circular, (MOPHD/ADMN/2/VOL.1, 27th November, 2011) extended the provision of the injectable family planning "Depot Met-Roxy Progesterone Acetate (DPMPA)" by specially trained community health

workers (CHWs) i.e., using the WHO Task-shifting 11, in step with the WHO recommendations on Task Shifting (WHO, 2007; 2007b), (Table 2:2).

At the beginning of 2011, 90 CHWs were accepted by Academic Model Providing Access to healthcare (AMPATH) to start work on basic health care at Kosira division in Nandi County. They visited various homes in the region monitoring pregnant mothers, monitoring immunization growth and nutrition of children under 5, advice on proper diet and sanitation, monitoring the terminally ill within the community and acting as the link between the community and health facilities. This is an initiative stipulated in the Kenya Government Essential Package for Health (KEPH) of 2006 which is being implemented in part of Nyanza regions, Western Kenya and the North Rift Valley.

Initially, the role of CHWs was not only seen as primarily health care providers, but also as advocates for the community and agents of social change. CHWs core responsibilities include health promotion, disease prevention, basic curative care and referrals, monitoring of health indicators and creating vital linkages between community and formal health systems (WHO, 2007).

Task Shifting has also been going on in Kenya, in Embu district from 2007 to present in Johns Hopkins program for International Education in Gynecology and obstetrics (jhpiego) whereby the task of postpartum FP, including provision of post-partum intrauterine contraceptive devices and PMC, was shared with obstetricians/gynecologists) or shifted to the cadre of midwives (Deller et al., 2015).

2:8.5. Task Shifting in Mental Health

A comparable initiative was extended to mental health through skills' upgrading training for a mixed cadre of the faith healers and traditional healers (as community-based health workers - CBHWs) in a mixed cadre with the health facility personnel.

The formally shifted tasks included performing basic psychiatric tasks i.e.; identifying symptoms, diagnosing conditions and most importantly referring patients to mental health services.

According to a news posting (Okore, Africa News - February, 19th 2013) the preliminary findings from a pilot study in closing the gap for mental health delivery in Kenya revealed an upward trend in the number of clients with mental health either referred or treated by the informal CBHWs.

Though Formal Task Shifting had not been tried in mental health services in Kenya before preliminary findings for the year under review (2011-2012) indicated a substantial number of clients correctly identified to be having a mental illness at the health facilities and put on treatment among the referrals made by the CBHWs noting;

> *"The critical role that lay health workers can play in improving access to mental health services in Kenya," as "... a positive indicator to the use of non-psychiatric health workers and informal health workers in increasing the uptake of psychiatric services in the community".*

The findings indicated an upward increase in the number of self-referral patients during the year under review in the rural and urban locations (Kibwezi and Kangemi) in the country. Considering

the increased community sensitisation, awareness creation and mobilization by the informal CBHWs workers this finding pointed at the likelihood of reduced stigma in the study sites. With only 78 psychiatrists in Kenya, the researchers argued for the need to continue looking at other options to cope with mental health in the country (along with training of psychiatrists and other graduate mental health workers). In addition, the study marked the Formal Task Shifting approach (WHO, 2007b) as an ideal strategy but called for more support from stakeholders.

2:9. Brief overview of experiences from outside sub-Saharan African region

In reference to brain-drain Zachariah et al., (2008) propose that lessons from across other countries beyond the region could become reference points for workable solutions as discussed in the report on European workforce (Sanco, 2009). Further Kundacina et al., (2010) argue for an increased skilled healthcare workforce across the public and private healthcare sectors to ease the overburdening of the health systems. This status is attracting highly trained and qualified health professionals from low- and middle-income South-Eastern Europe (SEE) countries with resultant manpower loss. In recognition of this mobility, the out-migration states urge for the establishment of a workable/collaborative system steered through formal agreements and codes of best practice between “the sending and receiving countries” so as to promote sustainable healthcare systems. The European Union (EU) aims to ensure that; sending countries do not permanently lose some of their best-trained health professionals, by encouraging circular migration and supporting the WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organization, 2010). An equivalent arrangement often lacking in resource-poor countries could be the introduction of a code binding employers and employees as in the European Union (World

Health Organization, 2010). The binding arrangement enables UK to recruit registered nurses and other healthcare professionals that are regulated by appropriate professional bodies in both countries by HOSPEEM, a European Non-governmental organization to guide health-worker engagement. Canada, for instance developed bilateral agreements on recruitment of nurses with the Philippines and several Canadian provinces (British Columbia, Alberta, and Saskatchewan). Such Agreements, Conventions and Memoranda of Understanding and other regulatory systems are noted to have a direct impact on international mobility of health workers and mutual recognition of qualifications as formal evaluations of such agreements (often lacking especially in sub Saharan Africa) (World Health Organization, 2010).

Ultimately, therefore, the successful implementation of Task Shifting needs to be aligned with the broader strengthening of the health regulatory systems for long-term sustainability (World Health Report, 2006). This report marks the critical concern for the national governments' need to also acknowledge the necessity to review and/or change specific national and international policies that contribute to the crumbling health systems for a renewed public health approach, with the involvement of the communities as its backbone (WHO. World Health Report, 2006; WHO/PEPFAR and UNAIDS, 2008).

2:10. Usefulness of the key literature relating to the study

For me to achieve my objective for a systematic review of literature on the Task shifting phenomenon, I focused on the key issues raised and addressed within existing research studies and other supportive documents on Task shifting mainly from the year 2000, in order to

understand the current trends and to maintain relevance to my research question and the topic of my study (Sections 1:11 and 1:12 - Chapter 1).

> "What are the experiences of the counsellor administrator-managers regarding the influence of Task-Shifting on counselling and the related services including HIV-AIDS at their agencies in Kenya?"

In the need to place the study findings within a practical perspective, I viewed Task shifting as a realistic and rapid approach in delivering services to clients by engaging counsellors in a mix of staff cadres who include the lay personnel and PHIV, using examples of the phenomena from views expressed in the massive literature reviewed from across the sub-Saharan Africa region, (Dovlo, 2004; Hongoro and McPake, 2004; Mullan and Frehywot, 2007; Callaghan et al., 2010), specific studies done on the Task shifting strategy including from Kenya (Khan and Weiss 2006; Kiragu, 2006; Kruk et al., 2007; Huicho, 2008; Lewin et al., 2008; Munga and Maestad 2009; Zachariah et al., 2009; Morries, 2009; Selke, 2010; Ferrinho, 2012; Okore, George. AfricaNews, 2013) plus additional documentation and country case-studies (WHO, 2008; Mehlomakhulu, 2009; The USAID Policy Initiative Task Shifting Case Study" - February 2010) which focus on the general overview, success stories and useful global and national insights from the country experiences with the phenomenon.

In order to find an equivalent slot in the definition of Task shifting that compare well with the experiences of the different levels of counsellors who participated in my study, systematic reviews (Mullan and Frehywot, 2007; Callaghan et al., 2010) highlight opportunities in the Formal approaches from higher to lower staff-cadres in health service provision (WHO, 2007).

Similar to experiences of the participants, the review illuminated a lack of clarity in roles and responsibilities of the Task-shifters, Task shifters' practice beyond their professional scope without recognition or commensurate remuneration (Government of Kenya, 2001; NASCOP, 2001; Arthur 2005; Ghana Ministry of Health, 2002; De Brouwere et al., 2009) which reflect the contextual equivalent under which participants in this study offered their counselling services.

A history of difficulties in engaging with regulatory bodies for policy decisions in professional enhancement, echo the participants voices in the need to advance their counselling careers, and the key role of the regulatory bodies (NASCOP, 2001; Eden and Taegtmeyer 2003, Ministry of Health, 2001; Arthur 2005; 2007; Taegtmeyer et al., 2011).

Despite challenges, progressive growth has been marked in Task shifting within and beyond HIV-AIDS programming (Deller et al., 2015; MOPHD /ADMN/ 2/ VOL.1, 27th November, 2011; Okore, Africa News – February, 19th 2013) as also revealed through the participants' diverse counselling experiences.

Mullan and Frehywot, (2007) and Callaghan et al., (2010) demonstrate that Task shifting could effectively addresse human resource deficits but un-standardized Task-shifters' Training and the resultant conflicting roles must be addressed and commensurate compensation and remuneration provided across countries (NASCOP, 2001; Ghana ministry of health, 2002; Eden and Taegtmeyer, 2003; Arthur et al., 2005; Zachariah et al., 2009; De Brouwere et al., 2009; Dambisya, 2010; Ferrinho, et al. 2012; Okore, Africa News - February, 19th 2013) need to be addressed in collaboration with professional and regulatory bodies (Morries 2009; Huicho et al., 2008; Munga and Maestad 2009; Dambisya, 2010; Selke et al., 2010).

These findings compare with the participants' practice beyond professional scope without adequate compensation or remuneration and particularly the freelance counsellors in this study. The need for structured skills upgrading and a standardized professional development structure to mark the counsellors' career path would serve to salvage and booster their undermined counsellor-identity. Several studies found that Task shifting including in its Informal approaches is openly practiced across the region (Zambia Ministry of Health, 2006; Kiragu, 2006; Mehlomakhulu, 2009; Munga and Maestad 2009; Morris et al., 2009; Dambisya, 2010; Selke et al., 2010).

Weak or absent structured guideline systems and regulations was a marked feature amongst the participants in this study but particularly among the freelance-counsellors, where the Informal Task shifting approaches were the norm. Considering the large group-counselling-sessions in absence of organized individual counsellor-supervision, stress and burn-out were commonly voiced by most participants across the different counselling-facilities.

Matching comparable experiences with most of the participants in this study the need to focus on increasing the number of low- and middle-level cadres (equivalent to this cluster of participants) tailored training at the lowest possible levels as in the case of Namibia (McCourt and Awases, 2007) a more efficient allocation of resources would likely be realized. With additional management training in supervision and mentorship, this recommendation parallels the participants' contextual experiences of inadequacy in both numbers and skills in school guidance and counselling, trauma counselling, HIV counselling and testing within public health facilities, unlinked to the 'Comprehensive Care Centre for HIV-AIDS – CCC', and in addressing a myriad of issues amongst the local communities in absence of the necessary training skills and supportive mechanisms.

If localized, McCourt and Awases, (2007) proposal would serve to fill specific Task shifting gaps according to identified Task-shifters' needs in the specific country as in the examples cited amongst participants in this study. In support and considering the role of policy in counsellor-regulatory systems, Zachariah et al., (2009) specifically argue for the need to address the commonly encountered professional and institutional resistance so as to sustain motivation and performance particularly among 'Informal Task-shifters', in an attempt to sustain quality and safety in care delivery within the Task shifting context.

Comparably the Task shifters' morale and particularly those using the approach informally to cope with their non-aligned role-responsibilities, continually experienced undermined relationships among other healthcare professionals from ethical dilemmas due to the undermined counselling context, (Rutenberg et al., 2003; Kiragu 2006; Khan and Weiss 2006). Inevitably stress and burnout from role confusion, conflicting role expectations and undermined professional identity were a commonly reported feature. It will be critical for all staff levels involved in Task Shifting to be formally recognized and to receive commensurate remuneration and structured salaries as recommended (WHO, World Health Report, 2006; WHO/PEPFAR/UNAIDS, 2008).

The example of a well-defined career structure for counselling personnel in the Civil Service in Kenya (Republic of Kenya Scheme of Service, 2009) to facilitate suitability and retention of qualified counsellors could be emulated not only in support of the counsellor Task-shifters in this study but across the health-worker skills'-mix in general. Such supportive structures are stipulated in the new Counsellors and Psychologists Act (Counsellors and Psychologists Act - Kenya 2014) through the Kenya Ministry of Health.

From the African perspective, many authors called upon the engagement of a diverse community of learners to collaboratively address the Task shifting challenge from a national perspective in reference to African understandings of counselling training and practice (Oluwatosin, 2004; Bojuwoye, 2005; Nsamenang, 2005; 2006; Gichinga, 2007; Levers, Radomsky and Shefer 2009; Nsamenang and Tchombe, 2011). Considering the participants' experiences with clients among the local community this would be supportive of local understandings within the African health-care settings (UNAIDS, 2000; WHO, 2004).

As findings illuminate in participants' comparable examples, the literature review marks positive results with progressive scale-up of the Task shifting strategy in many countries across the region through mentorship-support among the diverse mix of health personnel, community involvement and the utilization of lay personnel including PHIV, (NASCOP, 2001; Ghana ministry of health, 2002; Eden and Taegtmeyer, 2003; Arthur et al., 2005; Zambia Ministry of Health, 2006; Morris et al., 2009; Zachariah et al., 2009; De Brouwere et al., 2009; Dambisya, 2010; Selke et al., 2010; Okore, Africa News - February, 19th 2013).

From an international perspective the review brought to focus the necessity to have Task shifting aligned with the broader strengthening of the health regulatory mechanisms for long-term sustainability (WHO, World Health Report, 2006), illuminating the absence of workable regulatory systems across the sub Saharan Africa. According to *the European Workforce for Health* (Sanco, 2009) as well as the WHO, such systems have been known to have a direct impact on international mobility of health workers and mutual recognition of qualifications as formal evaluations of such agreements (World Health Organization, 2010) that help ease health manpower loss from low and middle-income, to high-income countries. In support, Zachariah, et al. (2008) proposes that

success in using the Task shifting strategy would counter the compounding national and international brain-drain.

To this end the review of literature marks the World Health Organization and Bilateral Organizations' advocacy role on the national governments' need to review and/or change specific national and international policies that contribute to the crumbling health systems for a renewed public health approach (UNAIDS, 2000; WHO, 2004) but with the critical involvement of the communities as its backbone; Levers, Radomsky and Shefer 2009; Nsamenang, Tchombe, 2011).

Reflecting on my nurse-student day's experiences and the follow-up practice years, the review of literature re-confirmed that the Task Shifting model of care is now well ingrained into the general health worker practices across and beyond the region, and more significantly among lay people especially PHIV (Netshandama and Dhavhana-Maselesele, 2007; Kara et al., 2009; Selke et al., 2011) unlike then. Surprisingly, though, it appears like the Task-shifters' skills and their career pathways, in general, have been inadequately developed across the sub-Saharan region (Kiragu 2006; Khan and Weiss 2006; McCourt and Awases, 2007; Ferrinho, et al. 2012) including from among the counsellor administrator-managers represented in this study.

From the shared experiences of the participants, Task shifting is formally and informally well-established into the health-delivery care systems including within counselling and particularly in HIV-AIDS services which compared well with the review of the literature. More significantly in view of this study, the Informal Task shifting holds potential for application in counselling from its various perspectives, the key of which is 'how to streamline the approach through regularization

in collaboration with the diverse stakeholders so that its conceptual and contextual applicability can be explored including through research.

2:11. Conclusion –Chapter 2

This chapter has explored the Task Shifting model of care with examples across the sub-Saharan Africa but with specific examples from countries across the region.

The review of the literature has provided success stories on Formal (explicit) and Informal (implicit) approaches to Task shifting with country examples from across the sub-Sahara African region and a few other countries. Both approaches, however, have registered many challenges, one of the main ones being the need to localize the Task shifting approach to the national context (Samb et al., 2007; Munga and Maestad, 2009; Zachariah et al., 2008 Dambisya, 2010).

From the study findings, the review has helped to contextualize the counsellor administrator-managers' (participants') shared experiences within the national-Kenyan context (Section 2.8). More specifically the review has illuminated the local approaches and challenges encountered from the varying embedded forms of counselling-Task shifting in the participants' specific areas of practice comparable within the sub Saharan region.

Overall, Philips, Zachariah and Venis et al. (2008) warn that in the midst of inadequate training, supervision and support, the quality of care is being compromised from Task Shifters' excessive and more complex roles in the midlist of poor financial remuneration for sustaining the health worker outputs among communities (Marge, 2009).

Before Task shifting is fully realized, the approach should become part of an overall strategy, to remedy public health services at the national level in collaboration with key bilateral organisations (WHO, The World Health Report 2006; WHO, 2007; WHO / PEPFAR / UNAIDS, 2008).

From the review, it is imperative that health workforce strategies be focused on matching the skills of workers to the local profile of health needs.

Effectively training formal mid-level cadres and integrating Task Shifting into formal curricula with recognition of expanded roles via certification, legal support, and professional regulation including remuneration structures should be considered for support as an innovative model (Morris, et al., 2009).

However, considering the rapidly changing health environment compounded by a high HIV and AIDS burden, proposed remedial strategies need to explore other knowledge systems beyond the conventional (Bojuwoye, 2005; Levers, Radomsky and Shefer, 2009) to raise new possibilities worthy of negotiation with the relevant national regulatory and statutory health professional bodies for ease and flexibility (Hirschhorn, et al., 2006; WHO. World Health Report, 2006; WHO, 2007; WHO / PEPFAR / UNAIDS, 2008).

CHAPTER 3 – METHODOLOGY

3.0. Introduction

In this chapter, I focus on research methodology. I tell you what motivated me to choose Task Shifting as the topic of my study; I explore my epistemology and ontology and discuss why among other qualitative methods I have chosen to use Thematic Analysis to analyze my data. I discuss the Ethical considerations, my choice of participants and why I chose to report my Thematic Analysis findings in story form.

3.1. Overview of research question and Methodology

The research question that I sought to answer through the methodological choices made was-

"What are the experiences of the counsellor administrator-managers regarding the influence of Task-Shifting on counselling and the related services including HIV-AIDS at their agencies (units, centers, facilities) in Kenya?" (Section 1:11.)

Sanders and Wilkins, (2010) observe that qualitative research is driven by a desire to understand other people's experiences and interpretations of phenomena through the stories they tell. Because human beings live in a subjective world, reality is whatsoever people perceive it to be according to the shifting dynamics of time and experience. Hence, for a valid interpretation and

sharing of the study findings, there is need to take into consideration the inevitability of both the researcher's and the participants' values influencing the research process.

According to Denzin (1994; 2005), qualitative researchers deploy a wide-range of interconnected interpretive practices that describe routine and problematic moments and meanings in individuals' lives. The source data materials originate from a diverse source of empirical materials including case studies, personal experiences, life stories, interviews, artifacts and a variety of observational, historical, interactional, and visual texts. From these sources, qualitative researchers aim to get a better understanding of the phenomenon although each practice makes the world visible in a different way. Hence, there is a possibility of using more than one interpretive practice in any study.

3:2. Motivation to study Task Shifting

I have always task shifted for as long as I can remember for being in the nursing profession made sure of this; since the nurse being right there in the middle of the action within the health system, becomes an available target to perform not just the roles for what 'they' were trained and mentored to perform, but many others including the clinicians roles… which brings to mind one of the nightmare-"like" night duty shifts I encountered as a young staff nurse, and I read;

> *"I see a flow of accident patients and no doctor on sight and; taking that role and diagnosing emergency patients, diagnosing, making prescriptions, taking patients' blood for cross-matching, fixing intravenous fluids, mobilizing fractured limbs… until long hours later, when we could raise the doctor, the clinical officer and the laboratory personnel on*

call. God was on our side because there being no complications encountered; the policy level congratulated the night shift "as we dragged ourselves to our houses for more than needed sleep praying that we did not encounter a similar shift the following night".

From both my own experiences of the phenomenon over the years as well as from literature, I had become aware that Task Shifting was being used as a strategy to counter the severe shortage of health personnel especially in the delivery of HIV and AIDS counselling and related services in Kenya and other resource-limited countries. This background influenced my decision to do this study on Task shifting.

3:3. Choice of qualitative methodology

As I set out to explore approaches that would provide me storied data, I concentrated on a number of inductive approaches (see below) that seemed to support my intention to retain my reflexivity (Etherington, 2004) through an awareness of my involvement with the research, and the possibility of influencing the study process. By positioning myself as an instrument within the research process this would enhance the possibility of the interpretations and conclusions I make to arise directly from the in-+depth data co-created with the participants (Clandinin and Connelly, 2000; Riley and Hawe, 2004; Morrow, 2005).

3:3.1.Grounded Theory (GT)

A major feature of Grounded Theory (GT) is the spontaneous collection and analysis of data so that the data analysis process starts at the same time as the data collection process in order to

allow for further data collection that is grounded on what has been previously analyzed (Strauss and Corbin 1990). This approach guides the researcher in carefully scrutinising the data for similarities and/or differences (Glaser and Strauss 1967) instead of focusing on the theoretical presuppositions (Charmaz, 1990).

Strauss and Corbin, (1990) encourage researchers to be more sensitive to the nitty-gritty conditions and consequences born of the actions or interactions of a phenomenon (such as Task Shifting), with the purpose of reorganising such consequences into theories. The open process allows for a simultaneous collection of data, data coding and analysis through an interrogation and questioning of arising inconsistencies to fill the data gaps until all the data has been logically accounted for. This supports the view that the participants' accounts of the phenomenon of interest (such as Task shifting), would ground the theory into the data (Strauss and Corbin, 1990; 1998; West, 2001).

I find complementarity in the induction process of GT, and the researcher reflexivity which is facilitative to the research process (Etherington, 2004; West, 2010), and the recommendation of Glasser, (1978) on researcher patience and creative insight born of tacit ways of knowing (West, (2010). The researcher reflexive insights allow the emergence of new concepts from the data through a discovering and surprising process outside of the researcher awareness. This process is experienced as intuition and hunches (embodiment gut feeling) and conceptualization born of total immersion into the transcribed data (Strauss and Corbin, 1990; West, 2010).

Charmaz, (1990) encourages researcher patience to avoid unobvious connections between data and the research questions, not to force-fit the data by prior theorizing, which could inhibit the formation of fresh ideas and surprising connections. In order to minimise presuppositions Charmaz, (1990; 2000; 2005) proposes that the researcher avoids a review of the literature.

GT could be applicable in analysing the rich interview data from my study on Task Shifting through conceptualization born of total immersion into the transcribed data (Strauss and Corbin, 1990; West, 2011) so as to illuminate the participants' concerns born of a diverse and complex task-shifting context. According to Glaser, (1978, p. 3) the researcher would begin *"with as few predetermined ideas as possible ..."* so as to *"remain open to what is actually happening"* within the data (Piko, 2014).

On-going researcher reflexivity would, therefore, minimize related task-shifting preconceptions from my past experiences and enhance research credibility (Piko, 2014). In consideration of the "multi-mix approach within which embedded forms of counselling occurs within the health sector, the GT could explore new workable concepts or new theories for assessing the counsellors' and other human resource needs.

Sanders and Wilkins, (2010) observe that the objective of GT is to arrive at an understanding of the lived experiences. GT could study the participants' experiences on Task Shifting without generalizing through theory. However, from an insider perspective, both the researcher's and participants' voices seem inevitable but GT could be is specifically suited in generating new theories that are grounded in the participants' experiences.

GT would be suitable for my study on Task Shifting influences on counselling in general and HIV and AIDs in particular but similarly in generating theories as to Task Shifting is sustained; what makes it flourish particularly in HIV counselling, or how the model could be supported for the benefit of those who, like the counsellor-administrator-managers find themselves working under the Task Shifting context.

3:3.2. Heuristic research

Heuristics involves exploration and interpretation of experience and uses "the self of the researcher". The methodology is demanding because it draws from the researcher's deep understanding of the phenomenon of study (West, 2013), which is centered on the tacit levels of knowing (Moustakas, 1990; West 2011) and therefore deeply drawing on the individual for data. Under this methodology topics of social significance are studied at the personal level using self-inquiry to develop a complete picture of personal experience covering both the researcher and the participant.

The researcher has had a direct encounter with the phenomenon they want to study, and with a specific question they want to illuminate, both at a personal and social level, but could also be of universal significance (Moustakas, 1990). This results in a composite depiction from which a synthesized meaning is developed. Heuristic research could be useful in identifying individual participant opinions from the wider counselling influences so as to illuminate the interrelationship (Moustakas, 1994). However, the data generated could raise ethical concerns and implications as to how much the respondent reveals self, who reads the reports etc. (West, 2013). Careful

consideration must be made regarding these issues. I find heuristics unsuitable for my study design although it could be useful in case of an individual case study on a specific issue on Task Shifting.

3:3.3. Thematic Analysis

According to Yardley, (2000) and Marks and Yardley, (2004) Thematic Analysis provides the researcher with an opportunity to analyze and understand the deeper meaning of the study phenomenon by "*identifying and describing both implicit and explicit ideas and linking these up for code co-occurrence in order to display code relationships."* (Namey et al., 2008 p.138).

Several approaches to Thematic Analysis have been described and used. Holloway and Todres, (2003) for example, describe thematising meanings as one of a few shared generic skills across qualitative analysis but emphasise need to show both its theoretical assumptions and process. Similarly, Ryan and Bernard, (2000) locate thematic coding as a process in the main qualitative methods such as in grounded theory, while Boyatzis, (1998) describes Thematic Analysis as a tool that is used across different research methods.

Beginning to depart from generality Aronson, (1994) describes Thematic Analysis as a method that follows a step-wise approach, from the collection of data to the formulation of a valid story line which is backed up by the review of relevant literature. Hence, according to this approach Thematic Analysis focuses on identifiable themes and patterns of living and/or behavior. From the first step of data collection, transcribing the interviews and identifying patterns of experiences and also expounding it with real data by combining all related patterns into sub-themes from

fragments of ideas or experiences including from recurring activities, meanings and feelings so as to build a valid argument to justify the themes. A further argument is done through reviews and referencing from the related literature and making inferences from the interview so as to link the relevant literature, and interweave or pierce together the relevant literature with the findings into a coherent and meritable story line. In so doing, a comprehensive picture of the participants' collective experience is illuminated.

In a version of a modified form of Thematic Analysis, Attride-Stirling, (2001) the use of Thematic networks approach is elaborated, accompanied by elaborate thematic maps showing the reduction of data under three phases and across six steps. This thematic analysis approach follows similar logic (Aronson, 1994) from coding of the data to interpretation.

Braun and Clarke (2006) portray Thematic Analysis as a flexible qualitative data analytic methodology which is becoming widely recognized and popular, along with other established qualitative methods. The authors point out that even though Thematic Analysis is poorly demarcated or claimed as a methodology, its flexibility makes Thematic Analysis quite popular because it is not tagged to any pre-existing theoretical framework. This means that Thematic Analysis can be used within several frameworks to reflect and to unravel the surface of reality by examining the ways in which events, realities, meanings, experiences are the effects of a range of discourses operating within society, for example, politics, education, religion, among others discourses. This means taking into consideration that individuals' experiences are influenced by the broader social context.

3:3.3.1.The Inductive Thematic Analysis

In the Inductive Thematic Analysis, the data has been collected using qualitative methods for instance through the interview (Kvale and Brinkman, 2009) but specifically for the research and in order to answer the specific research question(s). The data is coded in line with the researchers' epistemological world view as opposed to an analysis done according to a pre-existing coding frame or the researcher's preconceived framework. This means that the themes identified by using the Inductive Thematic Analysis are strongly linked to the data which parallels the Grounded Theory (GT) in that the methodology of data analysis is data-driven (Braun and Clarke, 2006).

3:3.3.2. Deductive Thematic Analysis

In contrast, the Deductive Thematic Analysis dwells on the particular aspect of the data-set within the study phenomenon that is of interest to the researcher. Because the deductive thematic analysis is researcher driven, it comprises a detailed description of the particular component of interest overall (Boyatzis, 1998).

3:3.3.3. Thematic Analysis Methodology of choice

According to Braun and Clarke, (2006) Thematic Analysis is a research methodology for analyzing either a particular dataset the researcher is interested in, (deductive thematic analysis) or the data corpus /whole of their data, (Inductive thematic analysis) in order to answer the research question(s). This gives the researcher the choice of a methodology that provides a flexibility in approaching the research analysis either inductively (latent thematic analysis) or deductively (i.e.

theoretically), to identify the patterns within the data (Frith and Gleeson 2004). While Thematic Analysis is hence a methodology that utilizes data collected from various qualitative data sources such as interviews (Kvale and Brinkman, 2009) to identify, analyze and report the subjective qualitative findings grounded in the participants' experiences (Braun and Clarke, 2006) this methodology is more than just a method that the researcher can use to identify, analyze and report patterns (themes) in the data.

Braun and Clarke, (2006) emphasise the need for the researcher to declare their epistemological and ontological view of reality and the assumptions they make about the nature of the data, and what such data represent from their world view. This provides the audience with a base or framework for their subjective interpretation of the participants' lived experiences for credibility of the research findings, (see Epistemology and Ontology (Section 3:7. below).

Following my review and further reflection on the approaches to thematic data analysis, (Aronson, 1994; Boyatzis, 1998; Ryan and Bernard 2000; Attride-Stirling, 2001; Holloway and Todres, 2003; Braun and Clarke 2006) the flexibility of the Thematic Analysis methodology (Braun and Clarke, 2006) portrayed the ability to illuminate deeper and wider meanings and implications of participants' experience such as under the Task-Shifting environments (Patton, 1990; Braun and Clarke 2006). Through its clearly elaborated steps in analysing the data and its portrayed ability to unearth the deeper and wider meanings, this approach of data analysis provided me with the avenue for analysing interview data gathered from the counsellor administrator-managers' (participants) shared experiences so as to answer my research question that explored the

participants perceptions on the influence of Task-Shifting on counselling and the related services including HIV-AIDS at their agencies (unit, Centre or locations) in Kenya.

Thematic Analysis methodology (Braun and Clarke, 2006) accommodates my subjective interpretation of the multiplicity of reality from a "social constructionism" paradigm in that meaning is dependent on experience, *"which is subjectively knowable and social in nature as shaped by the historical and/or cultural environmental influences in which it occurs"* (Ritchie, et al., 2013, p. 21). The Inductive Thematic Analysis methodology would provide me the opportunity to analyze the counsellor-administrator-managers' shared experience overall; while through the Deductive Thematic Analysis I would analyse specific data components (for example the data highlighting the informal 'opaque' approaches to the Task Shifting phenomenon) and compare the meanings illuminated from the seven participants' unique experiences with relevant findings from literature.

The recommendations emanating from this study findings would be grounded in the perspective of the participants' practice within the diverse counselling contexts in Kenya.

3:4. Researcher reflexivity

Reflexivity may be defined as an attitude of attending systematically to the context of knowledge construction, in regards to the effect of the researcher at every step of the research process. Although among researchers' bias or skewedness in a research study is seen as undesirable, Malterud, (2001) suggests that unless the researcher *"fails to mention* p*reconceptions, they should not be interpreted as the same as bias",* (p. 484) because a

phenomenon may be studied from various angles leading to varying understanding or new knowledge of the same phenomenon but from a different perspective. From my ontological and epistemological perspective, I believe in different ways of knowing and in multiple realities, (Section 3:7.) with richer and more developed understanding of complex phenomena.

According to Malterud, (2001) beliefs and values of the researcher is an issue in all research but especially in qualitative research because the researcher is an instrument in the research process and their perspective will shape all kinds of research since;

> *"A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (p.483-484).*

As eluded to in the introduction, my awareness of Task Shifting began years ago during nursing school but I carried it along as a qualified nurse and midwife because my experiences took me through comparable paths, after all, I was working in similar health-providing environments. I provided a more extended background of 'a me-the' researcher in the introduction (Chapter 1) so as to open up awareness at what might influence the perceptions, and interpretation of my research encounters with the participants. In this way, I provide a framework that can be used to mark the subjectivity in my research process, in order to achieve new levels of understanding through reflexivity (Etherington, 2004).

During recruitment of participants and beginning with the pilot within the health sector I became more aware of my insider status (Hellawell, 2006) because of having to work with nurse-counsellors, i.e., (counsellors whose first professional training had been in nursing before they ever became counsellors) and other counsellors whose counselling base was within the different levels of the health sector in Kenya. According to Drake, (2010) such familiarity carry the risks of blurring boundaries by imposing own values, beliefs, and perceptions by a researcher.

Reflexivity calls for an explicit recognition that the researchers' personal characteristics be it gender, affiliation, age, personal experiences, beliefs, preferences, theoretical, political and ideological stances as well as their emotional responses to any such component, may all affect the research process and outcome. In order to keep their perspective, reflexivity maintains the researcher's continuous internal dialogue and critical self-evaluation of their researcher's positionality (Bradbury-Jones, 2007).

One such positionality is the insider perspective which Breen, (2007) has defined as *"being one who has chosen to study a group to which they belong"*. Smyth and Holian, (2008) suggest that being an insider researcher has the advantage of having a greater understanding *"of the culture being studied; maintaining the natural flow of social interaction and having an established intimacy which promotes both the telling and the unearthing meanings"*. By being an insider researcher one tends to naturally understand the politics of the situation and how things work or how to best to approach people-knowledge**.** As it turned out, 4/8 participants whom I interviewed (including for the pilot), held this kind of background making me even more aware of the importance of my own reflexivity. Where the researcher and the participants share experiences

Daly, (1992 and Padgett, (2008) argue for the researcher reflexive awareness and use of the participant's lens to guide the researcher-participant interaction so as to refrain from insinuation and assumptions over the participants' realities.

As a self-reflective critical awareness on own potential subjectivity and predispositions, a reflexive state provides the researcher with a continuous and progressive check through the whole research process. As Giltrow, (2005, p.209) puts it, *"... it's impossible to be a disembodied researcher"* because any interaction with any part of the research influences the access, researcher-researched relationship and the researcher's worldview. The process influences the questions asked, the lens used to construct meanings and how these are reported and disseminated, thus providing a balancing of voices involved i.e., those of the researcher and the participants' for research representativeness.

Having worked within the Ministry of Health (MOH) system as a Registered Nurse and a Registered Midwife and subsequently as a Community Health Nurse Tutor in the Medical Training College for over 15 years, and being familiar with the embedded forms of counselling particularly in HIV-AIDS counselling in Kenya, I could be viewed as an insider. This situation could obscure in-sightedness by imposing my own values, beliefs, and/or perceptions on Task Shifting (Drake, 2010). In this way, I could lose the in-sightedness (Smyth and Holian, 2008) of this study by unconsciously making wrong assumptions about the research process based on my prior knowledge and experience of service delivery under the Task-Shifting context (Hewitt-Taylor, 2002). Since I had not known or worked with any of the counsellor administrator-managers (participants), prior to recruitment (Breen, 2007), being a researcher potentially makes me an outsider because we are both

collaborators in this research journey. Our perspectives need to be incorporated into the findings (Alvesson and Sköldberg, 2000) and hence reflexivity calls for my deliberate effort to listen to the participants' stories of experience through their own lenses, and not through the lens of my own experience which implies;

> *"to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied, questions being asked, data being collected and its interpretation" (Berger, 2013 p.2).*

Being reflexive challenges the view of knowledge as a product independent of the researcher producing it or knowledge as objective and enhances plausibility by securing trustworthiness in the research. In order to encourage greater reflection and accountability on my part as a researcher, Siltanen, (2001) proposes that the researcher is self-conscious in articulating their role in research process so as to construct illuminated meanings in view of the participants' experiences. Hence by maintaining reflexivity through a deliberate effort to be consciously aware of my own reactions to the participants' accounts, potential or actual effect of personal, contextual, and circumstantial aspects of the research process in the interpretation of findings are brought to the focus.

3:5.Locating myself within the research process

According to Bateson, (1972, p. 314) the researcher is *"bound within a net of epistemological and ontological premises which regardless of ultimate truth or falsity becomes partially self-validating"*. Guba, (1990a, p.17) argues that all research is interpretive as guided by a set of beliefs

and feelings about the world and how it should be understood and studied. How the researcher views the world is related to interpretive paradigms which make particular demands on the researcher and include the questions that are asked and the interpretations that are reached.

My audience needs to understand the lens (frame of reference) through which I view the world in order for them to understand what motivated me to do the research on the particular phenomenon, how I studied the topic or the methodology I used, and how the methodology sits with me in reference to my view of the world (Sanders and Wilkins, 2010).

3:6. Qualitative versus Quantitative Research

Denzin (1994, 2005) in their introduction to the discipline and practice of qualitative research argue that qualitative research is difficult to define since multiple disciplines and paradigms (or world view) claim use of its research strategies and methods. From their view, the word qualitative implies an emphasis on the qualities of entities and/or processes and meanings which are not examinable experimentally in terms of their quantity, amount, intensity, or frequency. From this perspective, qualitative researchers emphasize instead, the socially constructed nature of reality. This encompasses the close relationship between the researcher, and the subject of study which inevitably includes the value-laden nature of inquiry which encompasses the situational/contextual constraints (Denzin, 2005).

Qualitative researchers' emphasis is in finding answers to how social experience is created and given meaning and work from an interpretivist paradigm, focusing on the inter-subjectivity of reality where our interactions with the world and the contextual representation are bound by

time, and place. From the qualitative perspective (Woolgar, 1988) the relationship between objects in the world and those who live in that world is no longer one of separateness; *"representation and object are not distinct, they are intimately interconnected"* (p. 20) and reality is fluid and constituted in and of the moment as it is lived. In contrast, quantitative studies emphasize the measurement and analysis of causal relationships between variables and not processes. The positivist position maintains a fixed objective reality that is a separate entity 'out there' to be discovered and a straightforward relationship between an object in the world and the way it is represented. A brief comparison of the qualitative versus the quantitative methods is reflected (Figure 3.1).

Figure 3.1: Qualitative versus quantitative methods

Adapted from Denzin and Lincoln, (2005, p.11)

Qualitative Researchers	**Quantitative Researchers**
Rich descriptions of the social world	**Developing generalizations**
Materials and approaches	
Historical narratives, first-person accounts, still photographs, life history, fictionalised "facts," and biographical and autobiographical materials	**Mathematical models, statistical tables and graphs**
First person prose	**Third-person prose**
Encourages multiple representations of a situation to display multiple forms of reality (Denzin and Lincoln, (2005, p. 10).	**Evidence has to be produced, constructed, and represented since the politics of evidence cannot be separated from the ethics of evidence" (Morse, 2006 p. 415 - 416; 'They' (i.e., the politics of evidence) permeate every phase of the research process). Denzin and Lincoln, (2005, p. 11)**

3:7. Epistemology and Ontology

According to McLeod, (2001, p.55), the ontological and epistemological perspectives underpin research, and provide a theoretical base in understanding the nature and form of reality of the phenomenon to be studied, *"what can be known"* in order to justify the approaches employed to the study.

Ontology has been defined as *"a branch of philosophy concerned with articulating the nature and structure of the world*" (Wand and Weber 1993 p.220); *"as a set of terms and their associated definitions intended to describe the world in question"* (Uschold, 1995 p.1) or *"the nature of human knowledge and understanding that can possibly be acquired through different types of Inquiry, and alternative methods of investigation"* (Hirschheim et al., 1995 p.20). Ontology has also been defined as the study of being i.e.; the nature of existence and how reality is structured (Crotty, (1998).

This relationship between the world and the meaning we give to it, determines one's approach to reality for example Lincoln and Guba, (1985, p. 14-15) explain that ontology asks the "what is" questions with a need to find out the nature of a phenomenon as in; *"what being is the human being? What is the nature of reality?"* Epistemology on the other hand seeks to find out the relationship between the inquirer and what is known, while methodology is concerned with how we know the world or gain knowledge about what we seek and the nature of that relationship, such as my interest to explore the influences of task shifting on counselling and related services

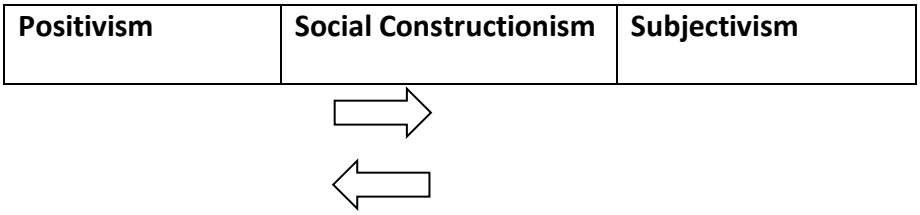
including HIV-AIDS in their agencies (units, centres, locations) in Kenya from the perceptions of counsellor administrator-managers in comparison to relevant knowledge from literature.

According to Crotty (1998, p.5), epistemology is defined as *"the theory of knowledge, especially with regard to its methods and validation."* From a linear scale, this branch of philosophy may be displayed as Positivism on one extreme and Subjectivism on the other, with positivism seeking knowledge through observation and experimentation with the complete removal of the human element. In doing a study, the researcher may progress from either an objectivistic perspective or a subjectivist perspective depending on the appropriateness of the intended purposes of the proposed research, and their view of reality (Figure 3.2).

From the opposite end of the model, subjectivism is portrayed as in all meaning occurring through both personal and societal experience, and that there can be no objective results. From this model, *"social constructionism"* sits in the middle, so that in many research occasions a relationship is seen to exist where meaning is dependent on experience, and that observed phenomena are both objective and subjective (Crotty, 1998).

Figure 3.2: Epistemological theories of Knowledge

(Modified from Crotty (1998, p.5; In Mavin, 2010)



The epistemological questions therefore, are concerned with the nature of the relationship between the knower or would-be knower (researcher) and what can be known about the phenomenon i.e., constructing meaning about it (Crotty, 1998).

According to Boland and Tenkasi, (1995) production of knowledge could allow for the incorporation of ideas from both worldviews as in mixed methods (Creswell, 2007). Seeming to agree Malterud, (2001) proposes that when different researchers approach a study situation from different positions or perspectives, equally valid understandings of a particular phenomenon are illuminated so that these different ways of knowing provide a richer, more developed understanding of complex phenomena such as Task Shifting in its various forms.

In doing a study the researcher may progress from either, and/ or these epistemological and ontological perspectives depending on their world view of reality and the appropriateness of the intended purpose for the proposed research (Bateson, 1972, p. 314; Guba, 1990a). To support the choice of my qualitative methodology I take my epistemological and ontological view of reality from the "social constructionism" perspective in that meaning is dependent on experience (Crotty, 1998).

According to McLeod, (2001) the question of the nature and form of reality presupposes that there is a reality that can be known.

In doing this study on Task Shifting, I considered myself as a human research instrument collaborating with these participants envisaging multiple realities being illuminated on Task-Shifting from these counsellor-administrator-managers' differing experiences and from within

their varying but natural environmental context under which each delivered their counselling services (Lincoln and Guba, 1985).

Engaging with the participants' storied data enabled me to appreciate how these counsellors make sense of their reality within the often complex Task Shifting context, and to co-construct that reality from within the different contexts (Crotty, 1998) as also influenced by who they are, including their social-cultural backgrounds as reflected in the participants' background (Table 1).

3:8. Participant recruitment procedures

Based on my Research Question, (1:11.) my wish was to get a view of the lived experiences of counsellors whose activities involved administration-management or supervisory roles within a Task shifting context. I aimed to identify such counsellors from within the different counselling establishments based within the public health system, the privately-managed facilities and the community based environment. The agencies were located within the capital city of Nairobi, (which is under the Nairobi County) and other reachable counties within its environs.

In order to answer my research question and to ensure that the approach fitted the methodology, my world view, and that I would get rich interview data, I decided to do a trial pilot study and set out to identify the counsellor administrator-managers befitting my description (Section 1:6) for recruitment. In the process I identified the actual centers, units and facilities within which the counsellors provided their counselling services. By focusing on these counselling establishments, I hoped to understand the context under which counselling services including HIV-AIDS were being offered in Kenya.

3:8.1. The Piloting process

I introduced myself as a part-time Doctorate student of the University of Manchester and explained my request and asked for her consent to participate in a pilot interview for my doctorate-thesis proposal development on "the influence(s) of Task shifting on counsellors and counselling" based on her experience.

I further explained that this was in preparation for my Doctorate Counselling Degree and that if she agreed to willingly participate in my study based on her training and experience, both as a counsellor-provider and programme manager, we would agree on an open/ongoing consent, based on the Interview Guide (Appendix 4:) which I read out to her and provided a copy to read and keep as reference.

I explained the procedure and the ethical implications and reiterated that by giving an open-on-going consent to the pilot, the consenting counsellor would be freely agreeing to participate in my pilot study through a face to face interview which I would record down. By participating, they would be contributing to clarifications of the interview guide for the main study.

Following approval by University of Manchester Ethics committee in January 2012, (Appendix 3: - the Copy: Ethical Approval Email) the pilot became a basis for my thesis study.

3:8.2. Process of recruiting participants for the main study

Having identified the source facilities and establishments where counselling services were embedded, I embarked on the process of recruiting participants for the main study. I located the Counsellor Administrator-managers and introduced myself as a part-time Doctorate Student from

the University of Manchester UK. I briefly introduced my study on Task shifting and acquired appointments for face to face interview-sessions with those counsellors who showed interest in participating, using the Participant Information Sheet (Appendix 1).

At the first session we discussed the interview format which included a written on-going consent for tape-recorded face-to-face interviews. I requested those who remained interested in participating to take time to think about the study and to let me know in the next coming two weeks, if they still maintained their interest, and wanted to participate.

For those who confirmed their decision, we organised a face-to-face interview at our convenient time – this included interviews on Saturdays, for those who were available on that day. I committed to providing transport money to the agreed venue (at a maximum).

For those individual counsellors who maintained their interest in participating, I acquired the second appointment, and arranged and agreed on the venue(s) for the actual interviews using the Interview Guide (Appendix 4). At this second interview, I explained my main interest in gathering their views on Task shifting at their counselling facilities from their lived counselling experiences. I emphasized that I was interviewing them in their capacity as consenting individual counsellors and not as representatives of any institution of organisation. I would be posing questions and giving each an opportunity to give me their own views or perceptions on their experiences of the influences of Task shifting on counselling including on HIV-AIDS.

Two would-be participants – who were both male, did not confirm the appointments.

I requested and was given written on-going consent to tape-record the interview(s) by each of the consenting counsellor administrator-managers who agreed and confirmed participation. This allowed us to capture the experiences fully for transcription and later referencing so as to ensure that the experiences were captured accurately (or to address any areas of omission, concern or any questions following the interview).

I interviewed one participant after another according to the appointments until no further new information was coming up (Glenn and Bowen, 2008) to a total of 7 participants. l then transcribed the interview data as soon as was possible within the next week or so for analysis and contacted each participant again to share and have each review their transcripts as agreed at the face to face interview to provide an opportunity to add any further ideas or to clarify any areas for better understanding and accuracy of their transcript. A few of them made minimal comments which I incorporated for analysis.

3:9. Ethical Issues

Although the term consent implies acceptance, the concept also applies to the choice among other alternatives. As De Vos et al., (2005) points out, whereas pitfalls may not be identified beforehand, ethical issues need to be addressed prior to commencement of actual data collection, and need to address setting of distinct boundaries (Nelleke, 2004).

Using the BACP ethical guidelines for research in counselling and psychotherapy (Bond, 2004) we discussed each item with the counsellor administrator-managers and agreed that anyone was free to take part in my study without coercion.

Because Informed consent covers the whole research process, a participant holds the right to change their mind or withdraw from the study without providing any explanation. According to Sokol, (2009) the right to informed consent is an ethical duty which is central to respecting the freedom, autonomy and dignity of individuals. It is fundamental to the ethics of counseling and therapy, and as Jossey-Bass and Wiley, (2007) point out, language, age, cultural background, and other factors may influence the informed-consent process. Although the consent is ongoing it should be revisited regularly in case further understanding prompts the individual to withdraw their initial consent (West and Byrne, 2009).

McLeod, (2001) and West and Byrne, (2009) advise that consent be discussed with the individuals interested in participating in a study at three stages; initially, as process, and at closure of the intended study. I only requested for an on-going consent but confirmed that the interested counsellors were in a position to provide consent as individual-professionals. Each of them indicated their involvement in some counselling administrator-managerial roles and their professional credentials, cadre, their counselling focus and where they were based (Table 1.).

In a discussion on the ethical considerations, I explained the objective(s) for my intended study on Task Shifting, my research question and that I was 'aiming at recruiting and interviewing a small number of willing Counsellor Administrator-Managers as my participants.

According to Doug Johnson-Greene, (2007) the importance of informed consent has been underestimated but a full appreciation for the parameters of the researcher/participant professional relationship forms the basis for the study and can never be over-emphasized.

3:10. Choice to participate

For me to abide by the University Of Manchester School Of Education's Ethical Protocol, I confirmed with the participants that they had volunteered to participate as individuals but not as representatives of their employer organisations. I committed to preserve the research integrity throughout the whole research process, including at the level of documentation and communication of the findings; *the British Association for Counselling Psychotherapy, (BACP) ethical guidelines for research in counselling and psychotherapy;* (Bond, 2004, p.8; Denzin 2005, p.1084).

We discussed the need for me to use tape-recorded interviews and to use a one on one narrative interview using semi-structured questions, lasting to a maximum of one hour (Appendix 4). (West and Byrne, 2009) remind us that research participants deserve their right and freedom to withdraw at any time hence, before each of those who committed to participate in the tape-recorded interviews signed the agreed on-going consent, we agreed that each could opt out of the study at any time if they so wished.

3:11. Confidentiality

We discussed the data gathering process i.e.; interviewing each of them in privacy of a mutually selected venue. The objective was to interview each participant to a point when no further new data was forthcoming and to a maximum of one hour (Glenn and Bowen, 2008) and in case of any eventualities, for example failed tape-recording to a maximum of three interviews per participant. I would however ensure that the tape recorded data was stored securely under lock and key, using

their selected study names for un-identifiable data, under pass-word protected computer for the duration of the study process. I also discussed my need to share the transcribed data with my supervisors for guidance, but in order to ease uncertainties regarding protecting their identities, I informed each that I would not share the actual interview tapes (Etherington 2004).

We agreed on the need to maintain honesty and integrity and how to balance power issues and this included protection of both their and my own human rights (Karim et al., 1998) and to communicate on specific telephone numbers' at study-level, within mutually agreed office hours and at familiar location(s). Either public and/or private transport would be used (and that I would compensate for transport at agreed rates to a maximum of 20 US$ per appointment).

3:12. Data protection

In order to maintain integrity, confidentiality and anonymity, we discussed how the data would be collected, stored and shared and maintained for the period of the study and agreed that all the identifiable information (their actual names or actual names of places) was either removed and / or names changed. Because the open-ended nature of the inquiry could lead to self-disclosure (Etherington 2004; Kale and Brinkman 2009), each of the participants was given a chance to read their transcript and to listen to their audio-tape (at a second appointment following initial interview as agreed prior) so as to counter-check for such identifiers, to adjust and /or to confirm if the intended meaning is maintained. No ethical dilemmas were identified.

Under the auspices of the Data Protection Act and the University of Manchester Data Protection Policy, I informed and promised to ensure that all data would be handled confidentially and

securely and that, “the only publication/output from this research would be the assignment or dissertation unless consent has been obtained from participants for further dissemination”. http://www.education.manchester.ac.uk/intranet/ethics

3:13. Supervision

The importance of informed consent has been discussed. In reference to counsellor supervision, contractual agreement need to be signed by the counsellor supervisor, and the client (counsellor supervisee) at the outset, so as to acquire clear information about that to which they are agreeing, and to minimize risks and maximize gains; academic, licensure, or certification requirements depending on the objective of counsellor supervision (Thomas, 2007).

In order to take care of our wellbeing during the period of the study we would ensure avenues were available to each participant (and to the researcher) for counsellor supervision according to need. I would maintain an on-going consultation with my professional supervisors (Karim et al. 1998).

3:14. Researcher Stance

From immersion in the interview data, participants’ experiences exposed diverse approaches to the Task Shifting phenomenon cutting across the data corpus, a finding that was helpful in my decision regarding my researcher stance (West, 2013). It was clear that from the process of data analysis I wished to unearth the underlying meanings from the participants’ experiences to both

the formal and informal Task Shifting as influenced by the social and environmental context within which that reality occurs (Ritchie, et al., 2013).

In this case, the Inductive Thematic Analysis methodology provided me the opportunity to code and categorize across the data corpus and to unearth themes and show relationships that reflected the logical chain of evidence in context. By using the Deductive Thematic Analysis on the other hand, the specific data-set that illuminated the overt (explicit) but also the opaque (implicit) forms of the Task Shifting phenomenon was unearthed to illuminate its complexity. Hence, in my researcher stance, I made a deliberate choice to adopt an Inductive-deductive Thematic Analysis. This meant that although I would lean towards the Inductive Thematic Analysis for complexity, I would describe other supportive data for logic, using the deductive thematic analysis.

3:15. Data Analysis

My first intention during the transcription phase was to fully familiarise myself with all the details in my data corpus, following the first step of Braun and Clarke, (2006) and in reference to my research question. As I read, typed in and listened to each of the participant's tape-recorded audio-taped interviews, I put a numerical label to the participants' given names along-side the their background information so as to link the transcripts to the interview guide and to participant's voices. I started noting each participant's language structure and form, but also, probable data excerpts that I could use verbatim for more vivid pronunciation of meaning.

Some of the probable data-excerpts were short, others long and continuous while yet others were more dialogic with MH, Ok, MH, Yak, he, iii, etc. interjected into our interview dialogue. I inserted

3 dots (...) in their place, *because trying to differentiate them did not seem to add value to the data, since there was no consistency in their use* (as portrayed in the excerpts in support of findings). I noted that I had maintained this form of dialogue to avoid undue influence on the participants' stories.

3:15.1 Semantics

In Kenya, people commonly use some mixture of languages and dialects to some degree (Figure 3.3.). Hence, although I had conducted the interviews in English, some of the participants used a mixed dialect of English/Kiswahili or English/Kikuyu, which has been translated into English and such sections within the excerpts placed beside the mixed dialect in brackets.

Figure 3.3: Participants' use of a mixed-dialect

Participant given names	Serial number	Language dialect	Translated into English
Cute	**2**	**Substantial amount of Kiswahili**	**Yes**
Glas	**3**	**Kikuyu and a little Kiswahili**	**Yes**
Other Participants	**1, 4, 5, 6 & 7**	**Used English**	**-**

I marked and tracked this aspect of the data through immersion into the transcripts (listening to the specific sections several times) and translating these immediately as evidenced in some of the excerpts used verbatim in support of the findings.

From their body language, it seems each of these participants portrayed a need to be well understood whenever they reverted to a mixed direct. Cute (pax2) for instance would lean

forward and emphasis her points or show displeasure whenever she communicated a negative aspect on how counselling was portrayed, and Glas (pax3) would appear reflective and vary her voice or use gesture.

3:15.2. Data-Coding

According to Boyatzis (1998) a good code highlights the initial qualitative richness of the phenomenon of interest but for completeness Braun and Clarke, (2006) argue that the theming process is illuminated from the coded data-extracts which originate from the whole set of data. From this view, I coded the transcribed data as captured in the participants' voiced experiences by attaching labels to important features, concepts and the relevant data excerpts reflecting the participants' language, (Figure 3.3) as appropriate. For completeness of the theming process I began marking data extracts that sounded relevant to some specific areas using the participants' excerpts to exemplify the theory underpinning each of the themes from the broader contextual perspective.

As I further studied and coded and re-coded the data using steps adapted from Braun and Clarke, (2006) I began to identify and / or confirm similarities that I had begun to note earlier, repeating this step across the data and labeling the coded sections that seemed to hang together so as to put my first labels to the themes - Table, 3:1. During stage 4 of this inductive thematic process, the themes I had labeled from the coded data clusters appeared to reflect their interrelatedness and what appeared to be an overarching theme (Hope and Determination).

Table – 3.1: Stages of data-coding

(Adapted from Brown and Clarke, 2006)

Stage 1	**Stage 2**	**Stage 3**	**Stage 4**	**stage 5**	**Stage 6**
Immersion into the data	Theoretical conceptualisation; (data coded, cross - referenced against marked text-excerpts).	Initial labelling of themes (from confirmed coded data-patterns).	Further theme abstraction done towards deeper/broader complexity & interrelatedness.	Defined the main themes &Sub-themes, (the proposed overarching theme obscured).	Four main Themes & 12 sub-themes identified. (Table 4.1/Figure 4.1: - Main themes)
Internalised participant's voices, language.	Marked excerpts under concepts & in next row.	Initial theme-clusters abstracted	Major thematic clusters & an overarching theme identified	Main themes &Sub-themes Defined	

Guided by Braun and Clarke, (2006; 2013 – in the press) I took a step back to re-examine the data in a back and forth process, counter-checking each coded section against the participants' specific counselling experiences (Figure 3.3) in reference to the research question (1:11.).

As the developing themes clustered around the coded data-set (Braun and Clarke, 2006), meaningful patterning illuminated the revised main themes and interlinked sub-themes as reflected in the stages of data-coding table above (Table 3.1) and also in the of detailed participants' raw and analysed data (Figure 3.4) below, hence obscuring the initially proposed overarching theme.

Figure 3.4: Data Coding – Raw and Analysed data

4:1.1. Theme One - A Need for Role Clarity	
4:1.1.1. Understanding of what counselling is	
Data Extract	**Coded for**
… Many people that I have met, and maybe I have counselled … it should be made, (pause). ... People should be empowered with counselling… (Sawela pax5)	A lack of clarity
4:1.1.2. Counsellors with required skills	
Aaa, let me say I have aa, good counsellors … Or aa, knowledgeable counsellors, because what I did, I got most of my counsellors, from the general hospital. ….Nurses who have done counselling. And for them mostly, they specify for HIV-AIDS."(Glas, pax3)	Supportive background-experience Specificity
4:1.1.3. Counselling Context	
… How people feel, what will people say, it is a curse! Now that is what am following up... (Lil pax4)	Community values
4:1.2. Theme Two - Formalisation of Counsellor-support Systems	
4.1.2.1 Ability to make choices and to organise own work	
Data Extract	**Coded for**
...So, there is triaging. Triaging is done by a nurse. Triaging is whereby a nurse is able to filter the clients… So sometimes they can come even when it is not their day of appointment. (Theru pax7)	Ease in service provision
… And so for the time being, the counsellor has to handle the desperate clients… Because those are the ones we handle right now before people know. (Cute pax2)	Diminishing ability to choose
4:1.2.2. Supportive mechanisms and guidelines	
… So they are about 40. … 20, 20 to go with somebody, (supervisor) … So you are able may be to, to be able too, respond, to all these concerns…	Capacity concerns

(Tasha pax6)	
4:1.2.3. Regularisation	
...unless you are really known, ee, there's ... I don't think It will really work ... if you really have to open one, it has to be big… big as you can handle various clients like, (Cute pax2)	Codes of practice Credentialing
4:1.3. Theme Three - Counsellor Identity	
4:1.3.1. Recognition of a legally qualified counsellor	
Data extract	**Coded for**
… But I tell them, not at the moment, I can't be able to see you... So, I feel if we can have counsellors at that time, they can help those who are ready ... (Caring, pax1)	Recognition of own limitation
4:1.3.2. Professional development	
… Counsellor training? – At least Bachelor Degree (BSc) counsellors ... 'Siwapuuzi' (I am not undermining them) because I have been there. … And I know the kind of information and knowledge I lacked (Cute Pax2)	Prerequisites
4:1.3.3. Positive counsellor identity	
I have also incorporated the churches, because you find that the people don't think that the hospital is necessary so they go for the spiritual part of it. … Of late am working with pastors of this area to see how we can, to see how we can help both" (Lil, pax4)	Collaborative role
4:1.4. Theme four - Hope & Determination under Task shifting (T/shifting) context	
4:1.4.1. Flexibility in the planning and delivery of shifted tasks	
Data Extract	**Coded for**
... They just pass by and say 'oh, let me go in I can ask something'… So we even get them, (clients)	Accommodative

through "passing by"… And that way you are not embarrassed (Glas pax3).	
4:1.4.2. Towards a professional counselling approach	
… I ring my fellow counsellors and then I go and present the issues... (Caring pax1)	Recognized need for counsellor support supervision
4:1.4.3. An Enduring-positive drive	
… I didn't know that! Because you know "tulikuwa tumeokotwa huko tu mepelekwa" (we had just been collected from there and taken!) (Cute px2)	Reflective endurance
…and you know just, peer mentor. Mentoring this person to know about a rape survivor … (Lil pax4)	Experiential support

For validity and trustworthiness of the findings, I used the data excerpts as supportive verbatim-quotes to reveal the uniqueness of each theme and to reflect a significant story that is based on these counsellors' subjective experiences with the Task shifting phenomenon, but also to maintain the interrelatedness across the diverse embedded forms of counselling Task shifting in the Kenya.

I am eventually convinced that the finalized themes and sub-themes (Table 4.1 and Figure 4.1.) illuminate internal coherence and point to a significant story that helps maintain the voices of the participants. Through the Thematic Analysis process proposed by Braun and Clarke, (2006; 2013), I believe the finalized themes illuminate the story of these counsellors' experiences, that the relationships between the themes and the data corpus is identifiable in the stories described under findings, and that the discussion reflects the research question (1.11).

3:16. Conclusion

In this chapter I have focused on research methodology, I explored my reflexivity, my epistemological and ontological views and discussed Thematic Analysis comparing its different forms, but also why I chose Thematic Analysis Methodology (Braun and Clarke, 2006) as my methodology of choice in analyzing my data. I discussed the ethical considerations and my choice of participants and described my actual data analysis using the Inductive Thematic Analysis, (the latent approach) and the Deductive Thematic Analysis to illuminate the informal (opaque) forms of Task Shifting guided by the steps adapted from (Braun ad Clarke, 2006).

3:17. Introduction to Chapter 4 – The Findings

In the following chapter I will presented the summary of my thematic analysis findings generated from Inductive-deductive Thematic Analysis in a story form, guided by the steps adapted from Braun ad Clarke, (2006).

CHAPTER 4 – RESEARCH FINDINGS

4:0. Introduction

This chapter presents study findings from the study on Task Shifting using Thematic Analysis (Braun and Clarke, 2006). The findings are presented in a story form to answer the research question (Section 1.11).

The environmental context, under which the seven counsellors (participants) told their stories, is reflected Table 1 i.e., their personal and social background (family, education and counselling training).

The synthesised interview data were generated from the participants' transcripts through a process of reflective-immersion, using an Inductive-Deductive Thematic Analysis approach and guided by the steps adapted from Braun and Clarke, (2006).

4:1.A Brief overview

The findings are an outcome of Inductive-deductive thematic analysis (Section 3:3.3.1 and 3.3.3.2), under which process I identified the 4 main themes and 12 sub themes as representing the participants' interrelated experiences (Table 4.1). This interrelationship is further reflected in Figure 4.1., (The Figure of main Themes).

In order to unearth the underlying features, the identified themes were conceptualised in relationship to the formal (explicit) and or informal (implicit) context so as to make broader

assumptions regarding the influence of Task-Shifting on counselling and the related services within the facilities where the participants provided their services in Kenya. This information is reflected in the participants' background (Table 1) using numerical numbers in alphabetical order under their given names.

Whereas the stories do not necessarily follow this order so as to maintain a storyline, the participants' unfolding story of experiences overall illuminates the interrelatedness between the themes and further reflects the uniqueness and complexity of the formal (explicit) and/or the informal (implicit) Task Shifting contexts under which counselling services were embedded.

Under the informal (implicit) Task shifting contexts a rather fuzzy role clarity and poor counsellor-identity appeared to be linked to a lack of organised counsellor support. As reflected in figure 4.2, the actual form and availability of counselor support for each of the 7 counsellors are exhibited in different ways i.e., from colleagues, as organised through the employer organization, and/or from the participant's own initiative.

Comparably, a clearer specification was observable under the formal (explicit) Task shifting contexts within which formalised counselor support (and particularly counsellor group-supervision) was availed to counsellors by the employer institutions. As illuminated under the themes, this finding was particularly marked within the HIV-AIDS counselling delivery facilities.

Table 4:1. Table of Main themes

THEMES			SUB-THEMES
Theme 1			
4:1.1.	**A need for role clarity**	**4:1.1.0.**	**Understanding of what counselling is**
		4:1.1.1.	**Counsellors with required skills**
		4:1.1.2.	**Counselling Context**
Theme 2			
4:1.2.	**Formalisation of counselor support systems**	**4:1.2.0.**	**Ability to make choices and to organise own work**
		4:1.2.1.	**Supportive mechanisms and guidelines**
		4:1.2.2.	**Regularization**
Theme 3			
4:1.3.	**Counsellor Identity**	**4:1.3.0.**	**Recognition of a legally qualified counsellor**
		4:1.3.1	**Professional development**
		4:1.3.2	**Positive counsellor identity**
Theme 4			
4:1.4.	**Hope & determination under Task shifting (T/Shifting) context**	**4:1.4.0.**	**Flexibility in the planning and delivery of shifted tasks**
		4:1.4.1.	**Towards a professional counselling approach**
		4:1.4.2.	**An Enduring-positive drive**

Figure 4.1.: Figure of Main Themes

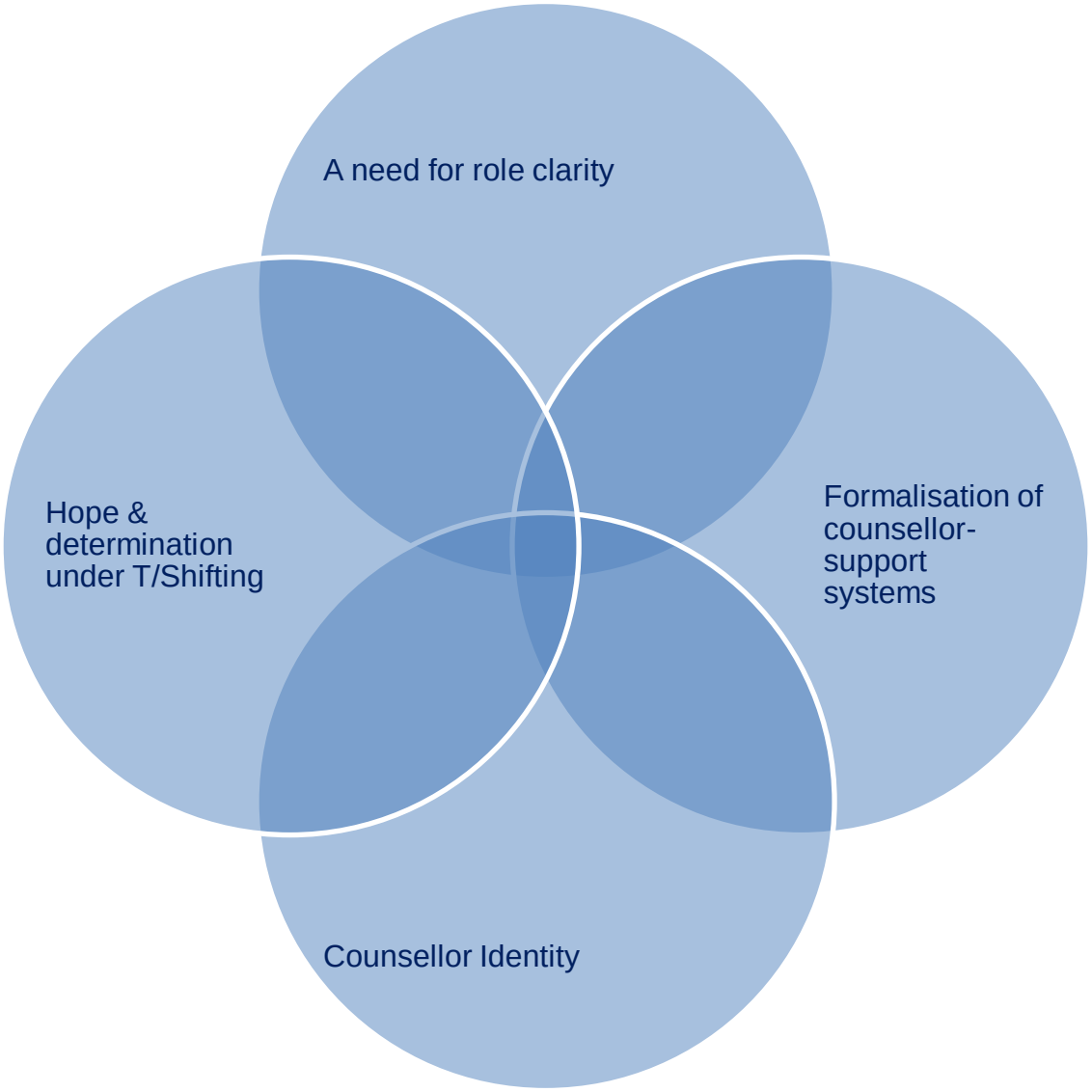


Figure 4.2.: Diverse approaches to participants' Counsellor Support Supervision

Participant	Facility/Agency Base	Approaches to Supervision	Form of supervision	Initiative
Pax1	Freelance	Counsellor supervision	Individual	Participant from felt need and likely ability to pay
Pax5	Freelance	Counsellor supervision		Participant from felt need and likely ability to pay
Pax1 & Pax2	Freelance	Consultation	Consultation with Colleagues	Participant from felt need
Pax2	Counsellor trainee	Consultation	A counseling college trainer	Participant from felt need
Pax3	Private Community Centre	Informal	Informal group-supervision organised privately for staff mainly part-time nurse-counsellors (every 1/2 months). Ability to counsel self.	Facility manager (Self)
Pax4	Liaison Peer counsellor/mentor	Formal	Peer-Support-groups(s)	Facility management
Pax5	Public Health facility (level 3)	Formal (Speculated)	Individual	Participant Speculation
Pax6	Public Health facility (level 6)	Formal/Informal	Regular Group Counsellor supervision	Facility management
Pax7	Public Health Facility (level 4)	Formal	Formal Regular Group Counsellor supervision	Facility management

Participants' excerpts are used to exemplify the theory underpinning each of the themes from a broader contextual perspective. Each theme is reflected from the perspective of one of the 7 counsellors but supported by the findings from some of the other participants.
Interview quotes tagged to the sub-themes under each of the themes will show how these counsellors' positive and/or negative experiences maintain their hope and determination in supporting their counselling careers alongside the progressive advancement of the counselling profession in Kenya. This aspect is discussed further in the next chapter (Chapter 5 - the research findings).

4:1.1. Theme 1 - A need for role clarity

The Sub-Themes	
4:1.1.1.	**Understanding of what counselling is**
4:1.1.2.	**Counsellors with required skills**
4:1.1.3.	**Counselling Context**

An expressed need for role clarity was illuminated in the findings despite the participants' persistent determination in offering counselling services within their diverse Task shifting environments. The counsellors' role was constrained by the local community's poor understanding of what counselling entails and the shortage of counsellors with the required skills within the specific counselling contexts under which each of them provided their services as reflected in Table 4:1.1 under 3 sub-themes.

4:1.1.1. Understanding of what counselling is

In general, counselling is not understood within the local community which leaves people confused as to who the counsellor actually is, or what counselling really entails.
The counsellor appeared to be anyone who could give counsel including members of their own community hence the term counsellor could actually be anyone particularly the respected members of the local community such as the religious people and the administrators.

Again, people seeking for counseling, did not seem to differentiate who has been trained in counselling or at what level of counselling training. Those requiring marital counselling would seek help from the chief who would often reprimand them or the pastor so that they could be prayed for. By the end of such encounters, the underlying issues still remain unaddressed.

Cute's (pax2) experience forms around inadequate knowledge and skills and a lack of counselor support. Her story is accompanied by challenges as a freelance counsellor when pushed to the periphery *by informal counsellor Task-shifters* and even prior, as a counselor trainee among the trauma clients;

> *"You are told (by their teacher) you can do it! ... We were just there! That is what you are, (ignorant)... I don't believe that! I don't believe that, no, no, no, (laughs). It is knowledge you need! To handle the client, it is not 'ati' (you know), the posture you need. Ok, the posture will help..." Cute (pax2)*

Cute draws her examples from the local context to explain the perception of the local women who have shared with her about their interpreted understanding about what counselling is and who

the counsellor is perceived to be. To do this Cute reverts to a mixed dialect of English and Kiswahili (the second national language in Kenya) for emphasis;

> *"... nawamama wale nimeongea nao wananiambiaga (the women I have talked with tell me), "Counselling? 'nikunje unimbembeleze; kwanininilifanya hivio yenye nilifanya nauniambie nisirudie' (I come so you can try to soothe me as to why I did whatever I did, telling me not to repeat it) 'Mhh...'" Then you tell them no, 'counselling is kuongelesha mtu' (discussing with someone)" Cute (pax2)*

From the women's perspective, it is apparent that counselling was not understood and neither did they seem to generally know what would lead one to seek counselling. In her view, until the whole spectrum of what counselling actually entailed was re-clarified, other members of the community would still step in to fill the counselling gaps;

> *"… Ya. And I think counselling, needs to be demystified like counselling is doing this and that. ... The issues to be taken to counselling, again I think people don't know, what kind of an issue you need to have, to take for counselling...." Cute (pax2)*

From a different angle, the findings illuminated a lack of understanding in reference to counselling training. Apparently the local community was confused as to who the counsellor actually is, or what counselling really entails because when people seek counselling they do not seem to differentiate who has been trained in counselling or at what level of counselling training-skill;

"... They don't know if that person has gone for 2 weeks training, they don't know whether this person is actually trained? But as long as you tell them you know I can counsel, 'am a counsellor... Those people will go there." Cute (pax2)

As if in an attempt to shed more light on this disorientating situation Cute reverts to the mixed dialect to further explain that those requiring counselling services continued to seek counselling assistance from the other members of their local community such as the religious members or from the local administration depending on the essence of their problem;

"Then 'wakati wanaenda kwa pastor, niwaende wakaombewe' (when they go to the pastor, it is so they can be prayed for)". Then you tell them no, counselling is kuongelesha mtu" (discussing with someone.) So they really don't know what is counselling" Cute (pax2)

Cute remained reflective and also sounded challenged as she summarily and surprisingly concluded;

"But the issues 'Siko!' (Remain!)...I don't know how to put it, (laughs), I thought that, but there are no counsellors. There are no, no really qualified counsellors. But there aren't, 'Hakuna!' (There aren't!)... People don't know what is counselling, especially here in (she names the city), let me not talk about Kenya". Cute (pax2)

Because the local community's understanding about counselling was minimal and the qualified counsellors reportedly non-existent, those who needed some form of intervention among them

still continued to seek counselling services from those known to have the ability to provide it among themselves. Supposedly no resolve was reached following such counselling encounters.

Cute presented the disorienting inadequacy of counselling from two points of view; the local community's perspective as well as from her own view;

> *" … Well, it's a way of counselling but 'ni mwenye hajui ataenda wapi, nakama ata ana- attend counselling, hajui ni nini' (but it's those who do not know where they could go. And even though one' attends counselling, they do not understand what it is... and at what particular moment you, you feel you have an issue, you want to go for counselling" Cute (pax2)*

Though sounding contradictory, this finding illuminates role confusion between the self / community-designated counsellors and the trained counsellors who in the meantime were getting crowded out from their counselling role;

> *"… So these people beat about the bush, 'wako huko wanapiga maroundiii' (they are there doing their roooounds) (a metaphor representing 'many rounds of counselling'). So by the end of the day, the counsellor does not have anybody to counsel! Cute (pax2)*

Cute's story reveals raises concerns about addressing the identified gaps in reference to what counselling is and who the trained counsellors are. Through such a process factors that are associated with the identified gap in role-clarification between and among the counsellors would be brought to the fore for redress.

Additional training through a bilateral organisation for the nurse-counsellors specifically hired from the level 5 public health facility mainly to provide HIV counselling from within the Community Care Center was viewed positively Glas' (pax3);

> *"... Aaa, let me say I have aa, good counsellors ….Nurses who have done counselling. … Most of them have trained with (Name of the organisation)" (Glas Pax3)*

In other cases counsellors were described as requiring further counselling empowerment (Sawela's pax5). This experience points at peoples' general views about counselling and counsellors, gaps in counsellors' skills and an apparent need for addressing gaps within the counselling professional approaches;

> *"Because many, many people that I have met and maybe I have counselled … it should be made, (pause). ... People should be empowered with counselling... "(Sawela (pax5)*

But still, a feeling of satisfaction was expressed regarding the influence of training (Tasha, pax6) in the quality of counselling services at the level 6 public health facility;

> *"The counselling here is quality … because, people are trained …*
>
> *From Higher Diploma..." (Tasha Pax6)*

Having well-separated roles at the level 4 public health facility served to improve the organisation of counselling and related shifted-tasks between staff-cadres and particularly between the lay and the medically oriented counsellors;

"We have Lay counsellors, and also we have the medical oriented, counsellors... Peer Educators who usually help us when we have crisis of our patients who may be having denial" (Theru Pax7)

4:1.1.2. Counsellors with required skills

The 7 participants in this study on counselling Task shifting shared some similarities in their background counselling training credentials (Table 1). However, the findings illuminated diverse experiences through which these counsellors had gathered their training upgrading-skills including lay counsellors living with HIV (PHIV /PLWAS.

Sawela (pax5) reveals a passion in supporting clients particularly positive to HIV through improved quality counselling. Her most concern is related to the inadequate HIV pre and post-test counselling skills among the lay counsellor-staff cadres who were tasked with providing services to the HIV clients at the level 3 public health facility. As shown in the following excerpts the HIV skills'-building training offered to the lay counsellors at this facility appeared inadequate in helping them handle their task-shifted counselling roles;

"This, this work has been given somebody else, who is not qualified. … Personally I don't like it. Yes, I have seen it happening. …" Sawela, (pax5)

"The numbers, you know now the ones they call counsellors for HIV, they are counsellors who have been taught for 3 weeks. … So they are inadequate. …" Sawela, (pax5)

It also appears that pre-test counselling is not provided to clients and as such, they could be unprepared for their eventual HIV results.

> *"Mhh... Just there and then at times, the, they don't have time to, to ask you questions. …They don't have. … It's you come in, do you want to be tested, yes, why do you think you want to be tested, bring your hand, you are tested, and that is it!" Sawela, pax5*

> *"… They are told to come in many of you, they harvest blood on you. … There is, there, no that process of counselling somebody. … Them, they don't, in most cases they don't. … So they feel left out. …" Sawela, pax5*

Apparently, from Sawela's observations confidentiality was not maintained and there appeared to be no guiding steps nor were any protocols mentioned for use during HIV testing and counselling at this facility;

For Lil (pax4), a peer educator/mentor her role centres on liaison activities among the local community. For this purpose, she practices beyond her trained-skill level as in the following example in which mentors take on group-facilitation roles seemingly on ad hoc arrangements which illuminate challenges considering that different groups would require some different set of skills.

> *"And that day the counsellors are not many, there are a few mentors … So we are given different groups ... different categories; … there are the youth, for children, the women you know, … the females, … then the caregivers, … So they are div,*

they are divided in different categories, … and the mentors are told to run then they are regrouped…" Lil, Pax4

Need for skills-upgrading in counselor supervision skills was apparent at the higher levels of the public health facility and at the Community Care Center even though group supervision was organised regularly for all counsellors. Shortcomings were a challenge in that there were very few trained counsellor-supervisors so that part of this task would be formally and/or informally shifted to experiential-counsellors some of whom were lay counsellors;

"But all in all … even if you have not specialised in supervision… You have the Knowledge … including, how to handle the problems - If they come..." Tasha, Pax6

"… Me who is qualified, I will go out with that one … And leave the peer counsellor to continue..." Tasha, Pax6

In absence of trained counsellor-supervisors, informal sessions on counsellor group supervision were used at the Community Care Center (Glas, pax3) so as to ensure that the counsellors had received some form of supervision;

"… At times like aa, every a month or 2 months, depending on the time … we go sit over a drink. … And explore our areas of a. a, of need. …, 'because most of us have got our own cons, psychos, (laughs) psychosocial needs, needs or problems..." Glas, pax3

In reference to skill-level improvement for staff-cadres the level 4 public health facility had in place skills-upgrading sessions for the lay counsellors and for clinical staff dealing with HIV patients particularly in reference to ARVs;

> *"They are as I have told you they are PLWAS, who live with HIV. … And they are, they get, they are trained. They receive some training, on how to handle the client..." Theru, Pax7*

> *"Ok, aaa there are; ART training, that is Anti-retroviral, they are trained on Anti-retroviral drugs. … For one week, one week training. …Yes because you are dealing with retroviral drugs, you need to know about them, the side effects, especially," Theru, Pax7*

As the findings illuminate skills' development was supportive particularly among the staff cadres coping abilities in providing shifted tasks to the HIV clients in specific areas. Therefore a system of skills' upgrading would appear to fill up the identified skills'-gaps and in improving HIV counselling services among counsellors.

4:1.1.3. Counselling Context

The environment within which counselling was provided unearthed the formal Task shifting approaches particularly in HIV counselling but also a system of implicit forms of Task shifting. An apparent lack of privacy was commonly encountered under crowding environments within which it was impossible to maintain client confidentiality which presupposed disregard for the clients'

dignity and their human rights. The emerging informal Task shifting approaches commonly observed under such constraints negatively influenced the lay counsellors' attitudes.
Under such an environment Sawela (pax5) sounded frustrated by the counselling crowded environment at the level 3 public Health facility where she worked part-time. Her experience working with lay counsellors at the facility was reportedly difficult and very trying. Clients pushed each other in an attempt to get into the counselling room, regardless of the quality of time spent with them by the service providers. The long waiting time from crowding and long queues in addition to the negative attitude towards clients particularly those who required HIV services was exhausting;

> *"And everyone wants to come in. … And if one wants to ask something, 'you cannot ask'. … Eh, and you know there is that issue of, you know, 'people are so harsh! "Sawela, pax5*

Illuminating the apparent lack of privacy Sawela marks the disregard for client confidentiality under the strenuous informal task-shifting counselling context and somehow distances herself from the environment;

> "... they don't come like, you are alone in that room ... you know in government facilities, it's, it's, (she laughs). It's funny, and you know me 'am not there permanently, I am just doing volunteer work. … I have just decided to volunteer …" *Sawela, pax5*

In spite of her attempt to distance herself from this Task shifting environment the findings focused at some collectively failed responsibility in Sawela's summary, which implies a need for team involvement and collaboration;

> *"… They don't think they got time, even, presence … we are failing. … I think there is something that is failing somewhere". Sawela, pax5*

Glas' (pax3) voiced health-worker resource shortages as the rationale for the formal approaches to Task Shifting which was in contrast to the counselling practice at her privately managed Community Care Centre;

> *"I think in the institutions yes. … But to me, I tend to think the … Just due to lack of personnel … you, not because of aa, because of something else. …, But like in our case when you do it like when my counsellors shift to mee, … think it is because it is not easy for them to handle. … So I think it a bit differs …" (Glas, pax3)*

Singling out institutions to rationalise Task shifting, Glas provides a comparison from her Community Care Center in which she has control and choice over the running of the facility. Their prerogative to offer privacy to clients and to link them to referral points on appointment basis according to schedule are a valuable support;

> *"And even the person who came to talk about her HIV-AIDS positiveness, … or her Drug and Abuse Status, … kind of thing, … comes in confidently, … and goes out confidently because no one knows where they are coming from" (Glas pax3)*

The findings illuminated an inbuilt cross-client referral system within the level 4 public health facility for comprehensive care management at the CCC (pax7);

> *"We deal with counselling services, we deal with clinical care, outreach services that is, home-based care … we also provide nutrition care for them..." Theru, pax7*

In this case, tasks are shifted to other staff-cadres with specialised skills as internal referrals or between and across institutions and/or between departments to ensure comprehensive care as in the example below.

Still, within the HIV context, Tasha's (pax6) provides examples from in referral of clients who originate from their homes and/or other out-stations, which all influenced the counselling Task shifting context. For instance, the counselling staff-cadres trained skills at those points of care could vary, marking the importance of continuity in client counselling service delivery;

> *"… Find out where she is (at) … Now that she is positive, how does she feel about it, and how has she taken it? … What she has been told there (from the point of referral), then we build on what has been already counselled..." Tasha pax6*

Other influences of the counselling context tended to originate from the community-level of care (Lil, pax4). According to Lil the social stigma linked to instances of rape and defilement could further complicate the context under which clients are managed as well as the counselling intervention particularly within the community-informal Task shifting context;

"... and, especially when in a family thing you know, they are protecting the family, how people feel, what will people say, it is a curse! Now that is what am following up..." Lil, pax4

Across the different forms of counselling facilities represented in this study, counsellors' whose roles were linked to the Comprehensive Care Centre (CCC) for HIV and AIDS (Table 1) expressed the Centre's supportive contextual-role (pax3, pax6, pax7) through either approach to Task shifting, but particularly within the Formal approaches.

But in the overall, the findings suggest that counsellors require other formalized support in reference to either of the approaches to Task shifting environmental contexts.

4:1.2. Theme 2 - Formalisation of counselor support systems

The Sub-Themes	
4:1.2.1	**Ability to make choices and to organise own work**
4:1.2.2.	**Supportive mechanisms and guidelines**
4:1.2.3.	**Regularisation**

As reflected above, the participants' expressed challenges in the apparent unclear supportive mechanisms and guidelines and a lack or minimal involvement in either the organisational function and/or in the administrative function in shifted tasks. This finding illuminated constraints among these counsellors in making choices and in their ability to organise and plan their Task-shifted counselling services, therefore, unearthing a need for formalisation of counselling systems which seemed obscure.

Formalised counselling systems would serve as the bench-mark and guiding tool against which the different levels of counsellors practice. This includes ethical codes of conduct, training curricula, accreditation, registration procedures and legal guidance in the practice of counselling.

4.1:2.1. Ability to make choices and to organise own Task Shifted role

One key structure that is supportive of the individual counsellor is a clear role to enhance their ability to make choices and organize their own service delivery to clients, supported by clear system-guidelines. The counselor, however,does not work in isolation especially when the counselling services are facility/ based.

At the level 4 public health facility (Theru, pax7) the formal Task-shifting model of care appeared to positively influence the counselling service delivery by enhancing the smooth running of the services. This approach eased the different staff-cadre work-overload, but also provided the opportunity for them to make choices and organise their own shifted roles. Through a triaging system of service delivery, responsibilities were well allotted to the different staff-cadres; the clinical issues to the Clinical Officer and the nurse-management roles tasked to the Medical-counsellors who were nurses.

> *"...So, there is triaging. Triaging is done by a nurse. Triaging is whereby a nurse is able to filter the clients… So sometimes they can come even when it is not their day of appointment. …" Theru, pax7*

The Lay-peer counsellors' explicit-Task shifted role was positively reported to transverse between the Comprehensive Care Centre (CCC) for HIV and AIDS at the level 4 public health facility and the HIV-AIDS clients within the local community.

> *"They will talk with the clients … and they will reveal their status to the client, so in the meantime, the client feels, 'so 'am not alone'. …The acceptance … at home. …" Theru, pax7*

At this facility, however, the findings illuminated two major constraints contributing to the counsellors' inability to make choices and to organise their Explicit-Task Shifted roles. 1). Among the Voluntary Counselling and Testing (VCT) counsellors need to serve the "working-class" clients requiring services during odd hours, an arrangement that reflected a sense of powerlessness for the VCT group of counsellors;

> *"Because the, most of the nurses are female nurses, they feared to be alone with clients when the rest … most hospital staff were not around… so they were stressed. We are trying what we ... How we can resolve the issue…" Theru, pax7*

And 2), the constrained counselling-space at the out-patient department impinging on confidentiality;

> *"... Inadequate space has been a problem. … So they feel, they were not maintaining the confidentiality of the patients … sharing space … they are counselling … more than one patient in one room. … So at least... was able to partition the rooms … and they were in a way comfortable." Theru, pax7*

Examples from other participants support this finding for instance, in spite of feeling crowded out by self-designated counsellors among the local community in this informal approach to Task Shifting within which Cute (pax2) hangs on to hope for an enlightened people in reference to counselling;

> *"… And so for the time being, the counsellor has to handle the desperate clients. This person is again trying to commit suicide, this person is brought to you. You know you start with those serious ones because those are the ones we handle right now before people know." Cute, Pax2*

Lil (pax4) links clients referred through the local community for counselling services through the chief's office and children's office. She does not seem to have much choice about the diverse client issues or problems she has to handle regardless of her minimal training on rape. These findings illuminate Lil's persistent hopeful initiative despite the implicit forms of Task Shifting;

> *"Ok, in the children's' office, … Eh, you know the people going in the office … You know what happens maybe there is something that has happened in the community … and they have to report it may be to a chief..., but the people who work in that office call me. So I, it is my initiative" Lil, Pax4*

Considering the diverse forms of counsellor support-supervision, (Table 4.2) the constraints these participants experience in making choices and in their ability to organise and plan their shifted tasks are a constant source of frustration and ground for stress and eventual burn-out. This brings to focus the need for formalisation of counselling systems and the constant need for counsellor supervision.

4.1:2.2. Supportive mechanisms and guidelines

From Theru's (pax7) experience, the findings illuminated a well laid out system of dealing with the HIV clients at the level 4 public health facility CCC for HIV-AIDS. These included a systematised admission process for HIV client comprehensive management through a general process of formal triaging by a designated nurse-counsellor who filters the clients according to their specific needs. The process has been observed to cut down on client waiting time and possible confusion and frustration among clients and counsellors particularly in situation where crowding prevails;

> *"..He or she is to receive all the comprehensive services. … … So, there is triaging.*
>
> *"... Because some, most of our clients keep on having opportunistic infections. …*
>
> *So sometimes they can come even when it is not their day of appointment. …"*
>
> *Theru, pax7*

The initial formal counselling-role tasked to the lay counsellors PHIV provides peer-mentoring support;

> *"… But when she is properly counselled! (With emphasis) before initiation and*
>
> *she is ready … the patient goes very well … and he will have that positive living..."*
>
> *Theru, pax7*

Because the admission routine is formally systemized, the client is referred to the next stage for general medical assessment;

"... And then the clinician will see the client, 'clerk the client', … and then, baseline tests may be prescribed, …is prescribed prophylaxis, ... the patient is given an appointment, may be 2 weeks, 1 week, according to how the client is" (Theru, pax7).

In addition, engaging a treatment-supporter is supportive of the client's adherence to HIV treatment;

" ... We always ask the patient to come with a treatment supporter … And preferably a relative, or a close person... for the reason that ARV is not like other drugs... They are drugs one will take for live" Theru, pax7

The supportive mechanism of Group Counsellor Supervision formally routinized on a weekly basis discussed arising concerns and helped counsellors deal with stressful counselling issues;

"... I also need to take care of the other counsellors. … Aaa, because they also get burnout. With HIV, those counsellors who are dealing with the HIV ... they are also affected … So to me … the support supervision is very important. …" Theru, pax7

These findings illuminate clearly laid down structures within a Formal Task Shifting model of client care at the level 4 public health facility which provided a supportive mechanism for the comprehensive care management for HIV clients.

"Because you get feedback … from all the counsellors… So I will just liaise … And may be wherever there are gaps, you will be able to go through with them. …

And wherever there is a problem, may be administratively… Because me 'am just managing the, the CCC (comprehensive care Centre) not the facility" Theru, pax7

The key role of Counsellor-supervision is illuminated in the individual counsellors' views. From Tasha (pax6) the unmanageable numbers of counsellors turning up for group supervision is clearly illuminated;

"But, you find they come like 30, 40. ….. We have cut down … So they are about 40. … 20, 20 to go with somebody, (supervisor) … So you are able may be to, to be able too, respond, to all these concerns…" Tasha, pax6

For Lil's (pax4) her main extended peer-mentor liaison role and her description of the shifted clients she has to handle way beyond her formal task in rape and defilement unearths further need for Counsellor-supervision;

"There is also physical violence, abusive marriages, even child abuse … And also people living with HIV and AIDS …But in cases of that persons living with HIV and AIDS they normally have their own support groups …" (Lil pax4)

Cute's (pax2) experience illuminates frustration from a lack of counsellor support among trauma-clients at the IDP camp;

"You don't know now what to do, 'unamwambia mwalimu unaona ananiambia PTSD (post-traumatic stress disorder) (You inform the teacher and you see, he tells me PTSD), and then what is PTSD!?... And you are just there looking at the person. Now how do you help this person?" Cute pax2

Sawela (pax5) expressed need for counsellor supervision while working part-time at the level 3 public health facility reveals a vagueness in the availability of counsellor supervision service, in whichever form at the facility;

> *"Because I was wondering, I have just been wondering, do I see a supervisor who, who deals with these other counselling, or do I just see somebody who has covered HIV area …" Sawela, pax5*

Glas, (pax3) does not appear to have attended any counsellor-supervision specifically in reference to herself in the brief that she had the experience and ability to counsel herself**;**

> *"'Nii Nihotaga gwikomforti' (I have an ability to comfort myself) in many, life, (pause), areas. … I believe, it is a talent, Ya. … I think 'am extra talented on that. … I think I have seen so many things whereby they are, I find them to be extra challenging. …And I am able to handle them". Glas pax3*

However, Glas ensured that some informal of counsellor group-supervision was in place at her Community Care Centre especially for the nurse-counsellors hired from the level 5 public health facility. Though these sessions appeared widely spaced, the arrangement sounded beneficial to the group;

> *"When you are exhausted, you have nothing to offer. … When you are, you have got your own issues, you won't be able to offer. … … So it's like aa, they need that kind of support. … When we don't have clients, we have our time out here. …every a month or 2 months … And explore our areas of aa, of need. …" Glas pax3*

Though diverse in nature, these findings illuminate the value counsellors placed on counsellor support-supervision. The form of counsellor support available to them however, appeared to have been linked to its availability by employer institutions and/or the individual counsellor excess level of stress and/or verge of burn-out as in the following examples;

> *"I do it when I need it. … Sometime I, I don't feel I have burn out, I feel so tired. … Or sometimes I have a lot... especially, last week, no last week but 2, ... so for the time we meet she talked like for 45 minutes, non-stop. She talked about suicidal and she talked about rape so I was trying to tell myself, what 'am I going to do." Caring, pax1.*

> *"… Mhh so, I had to go for supervision. … Because when we met the fourth time, it was like I was not (laughs) I was, I was not able to move the session" Sawela, pax5.*

Individualised counsellor-supervision through employer institutions was not unearthed in these findings.

The expressed ability to self-counsel and the illuminated delay in seeking individualised counsellor-supervision up to a point of burn-out allude to some other underlying factors which require investigation. Probably from the Kenyan social-cultural context, such delays could originate from the cultural ways of coping in a time of difficulties and/or the counsellor's ability to pay for individual counsellor-supervision.

These findings illuminate that all counsellors valued counselor support and specifically counsellor-supervision which was commonly available through employer organisations in group form, but using different formats (pax3, pax4, pax6, pax7). The individual counsellor-supervision was

generally unavailable within the facilities although some individual freelance-counsellors had sought individualised counselling of their own initiative but at the verge of burn-out, (pax1, and pax5).

In the overall, therefore, counsellor-supervision was highlighted as a very important supportive mechanism for counsellors which requires redress under both the explicit (Formal) and the implicit (Informal) forms of Task Shifting. To ascertain that all counsellors received counsellor supervision and on time, it appears necessary that this form of support be regularised for the task-shifters.

4.1:2.3. Regularisation

These findings did not clearly illuminate awareness about regulations to conditions of practice and the ethical code of conduct governing matters affecting the operations/practices of the counsellors. However, at the higher levels of the public health facilities (level 4 and level 6) some workable systems were reportedly available with additional supportive role of development partners (pax6 and pax7). These included a structured counselling protocol to guide the counselling process within the HIV-AIDS context and the enhanced role of lay/peer counsellors living with HIV (PLHIV/PHIV). Comparably the findings did not unearth such supportive systems within the lower level 3 public health facility (pax5).

The use of a counseling guide (used to ensure thorough assessment in all areas of care) appeared to serve as an additional supportive tool in easing the counselling process;

> *For client counselling, a specific counselling tool is used ... we have a tool, we follow a tool… in counselling ...” Theru, pax7*

Additional supportive counselling-role by persons living with AIDS/HIV (PLWAS /PHIV) and the support of other close persons served as a basis for the clients' positive living with HIV.

"They don't deal with the medical part of the patient. … Lay Counsellors … Peer Educators... usually help us when we have crisis of our patients who may be having denial" There, pax7

Additionally, the experiences of some of the participants; the peer-mentor/educator (pax4), the freelance-counsellors (pax1, pax2) a gap in regularisation in counselling was exhibited from their different perspectives.

Caring, pax1, for instance had lingering concerns regarding what counselling entailed;

"... They say they do counselling, can a couple do counselling?" Caring, pax1

Though Cute, pax2 expressed feelings of being pushed to the periphery in her attempt to run a private counselling-clinic apparently due to a lack of general awareness ofthe local peoples' understanding regarding counselling, her experience points to a lack of regularisation and or ethical guidelines in the practice of counsellors;

"...unless you are really known, ee, there's ... I don't think

It will really work" Cute, pax2

In absence of ethical guidelines Lil, pax4 reverted to own intuition to guide her decisions in reference to her community liaison role when handling clients referred to her with multiple problems, thus illuminating a lack of regularised procedures when dealing with shifted tasks beyond the lay counsellor's basic training;

"That one I think, maybe you can look at somebody ... Who is breaking down ...?" Lil, pax4

Therefore from the experiences of these participants, it appears that counsellors working under the diverse Task shifting contexts could benefit from clearly laid-down supportive-regulatory systems through clear guidelines for improved implementation of counselling services across the different counsellor-levels.

4:1.3. Theme 3 - Counsellor Identity

The Sub-Themes	
4:1.3.1.	**Recognition of a legally qualified counsellor**
4:1.3.2.	**Professional development**
4:1.3.3.	**Positive counsellor identity**

Counsellor identity was expressed through the counsellors' rather poorly defined roles, employment structure and probable remuneration under the constrained Task-shifting environment. Several factors were illuminated as contributing to the local community's inability to recognise the differences between practising self-designated counsellors and the legally qualified counsellors by training. All the participants expressed a need for further professional development to bolster a positive counsellor identity, (Table 4:1.3.).

Whereas the findings revealed the training credentials in the participants' background (Table 1.) and to some extent, the skills-upgrading gaps for the different staff providing counselling at the different facilities where counselling services were embedded, the counsellors' training credentials

for legal registration requirement(s) are not clearly illuminated. Also, the findings did not unearth who among these counsellors have been registered with any counselling organisation. Their urge for recognition illuminated arising gaps encountered in practice highlighting the need for a structured and regularised counselling legal framework.

From Caring's (pax1) and several other participants' experiences, several regulatory gaps that impact on the counsellors' identity are reflected in the findings as shown below.

4.1:3.1. Recognition of a legally qualified counsellor

Caring (pax1) is a freelance counsellor with a higher diploma in counselling (Figure1). Her employment (contractual) arrangements with the specific organisations seemed unclear thus pointing to a need for regularisation in the counsellors' employment structure and/or remuneration packages and particularly for freelance counsellors.

This example drawn from a church-based informal Task-shifting environment reveals her challenging role as a group counsellor. Her expressed inability to immediately follow through the client's request for individual counselling reveals a counselling gap in the availability of qualified counsellors. But on the other hand by sharing an awareness of impending stress and possible burn-out related to timelessness in scheduling group follow-up counselling sessions portrays an expression of a positive counsellor identity;

> *"… but I tell them, not at the moment, I can't be able to see you... So, I feel if we can have counsellors at that time, they can help those who are ready ..." Caring, pax1*

The possibility for an alternative seemed remote and comparably stressful, considering her voiced counsellor shortages within the church counselling system. Caring's role as a church-based counsellor did not appear to hold any administrative role that would have enabled her to influence such informal task-shifting counselling challenges;

> *"... Because even sometimes when you tell them to call you, may be if they are 3 or 4 … May be only one or none who will call. So maybe I see if they try to be helped may be immediately?" Caring, pax1*

The findings are not explicit if the expressed gap on the need to have additional counsellors was shared or discussed with the church administration for implementation. The contradiction in Caring's limited choices seemed to contribute to her impending stress which she compensated by shifting the individual counselling-tasks to an uncertain future and for an unpredictable number of clients.

From her school-based guidance and counselling role, Caring (pax1) once again encounters comparable ethical dilemma for instance in the use of illicit substance in the school(s) and in such instances which appear to originate from an unpreparedness in shifted tasks she reverts to book-referencing to deal with the ethical conflict;

> *"Sometimes we break the confidentiality for the sake of the school …" Caring, pax1*

> *"But most of the time I refer to books …Very good books that are written by counsellors, sometimes I refer to them when 'am called by a group..." Caring, pax1*

In this case, her ethical-conflict appears to originate from the need to maintain client-confidentiality (the student-information source) and shared confidentiality with the school administration, which is the custodian of institutional discipline and the overall guidance and counselling programme in the school.

Though not specifically spelt out in the findings, referencing illuminates a positive professional practice and the need to fill in the gap counsellors may encounter in practice. However, Caring's experiences in such a complex social issue illuminate a gap and a need for specific ethical protocols or guidelines in support of the counsellors' ethical codes of conduct in diverse cases.

The findings revealed other participants' role-dilemma as legally qualified counsellors. For instance, Cute (pax2) portrays a negative role-identity born of her inability to support clients at the internally displace persons' (IDP's) camp born of a felt inadequacy in information and skill in an informal Task shifting trauma-counselling environment.

> *"You are told (by the teacher) you can do it! ... We were just there! That is what you are, (ignorant)... (Reflective silence). I don't believe that! I don't believe that, no, no, no (laughs). It is knowledge you need! To handle the client, it is not 'ati' (you know), the posture you need. Ok, the posture will help..." Cute Pax2*

From a different perspective, Glas' (pax3) experience is suggestive that the patients' presenting problems and/or the low remuneration levels for the nurse Task-shifters could have impacted on counsellor-identity as reflected in the nurse-counsellors' (sourced from the level 5 public health facility where explicit forms of Task shifting is common practice) comparative attitudinal behavior.

This observation reveals the complexity of the Task shifting environment which may require redress;

> *"...I don't know whether it's because of seeing so much there … or it's because of the nature of their aa, the quality, of thee, 'of the what?' of the kick-back (remuneration) … The emotional, (laughs) … touch, is not the same..." Glas Pax3*

From the experiences of these counsellor administrator-managers the findings illuminate a need to inform the trained counsellors' registration requirements through standardised and accredited counsellor training, a guiding employment and remuneration structure for Task-shifters as well as for the different counsellor-levels overall.

Within these various areas, the silent Task-shifting guidelines under the explicit (formal) and the implicit (informal) Task shifting context would be necessary tools at the level of implementation so as to guide counselling practice in the meantime.

4.1:3.2. Professional development

These findings reveal that despite the diverse Task-shifting counselling experiences from within the formal and informal approaches, all participants (Pax1 to pax7) shared a need and hope in furthering professional skills for self and/or other counsellors centring on their counselling role-responsibilities. Key among these needs was their currently identified skills gaps but also additional support that would help in furthering their future careers in the long-term.

For Cute (pax2) a need in self-development and decision to pursue a bachelors' degree (BSc) seemed to have been prompted by some of her most overwhelming episodes; the experience that

plunged her into trauma counselling at an IDP's camp with neither knowledge nor the skills, and her encounter with trauma clients whom she was unable to assist. Her experience sounded more overwhelming from lack of the necessary support, as she shares in a mixed dialect;

> *"… So when I explained to him "akaniambia" (he told me), that is PTSD. "Nikamuuliza," (I asked him), what is PTSD? ... You see he is not even telling me." Cute, pax2*

> *"Now I am making this woman even more traumatised! Because if she can tell me, and I am calling myself a counsellor, "na ana expect nimsaidie nimwabie hii ni nini!" (And she expects me to help, and tell her what the condition is!)" Cute, pax2*

Cute proposed a higher basic-training level for counsellors in reference to her expressed counselling gaps under the informal Task shifting trauma counselling environment;

> *"… Counsellor training? – At least Bachelor Degree (BSc) counsellors ... 'Siwapuuzi' (I am not undermining them) because I have been there. … And I know the kind of information and knowledge I lacked" Cute Pax2*

Other participants' experiences revealed the counsellors' professional development needs from varying perspectives i.e., in reference to self but also to others (pax7, pax1, pax3, pax4, pax5, pax6) but all aimed at the need to provide better counselling services and/or to advance their counselling careers; for Theru, (pax7) the lay counsellors' skills gaps revolve around the continuum of care for the PHIV based in the Comprehensive Care Centre for HIV and AIDS where she takes

charge, Caring (pax1) (a freelance counsellor) sites her own need to further her counselling career, Glas' (pax3) concern focused on counsellor-support for the nurse-counsellor Task-shifters she hired from the level 5 public health facility to provide HIV counselling at her privately run Community Care Centre, Lil (pax4) focused on her very minimal training on rape, Sawela's (pax5) concern pointed at the low level of HIV training-skills for the lay counsellors at the level 3 public health facility where she works part-time while Tasha (pax6) would like to advance her counselling training to a degree level so as to better deal with clients counselling issues.

These counsellors' views are illuminated in the following quotes;

> *"PLWAS, who live with HIV. … And they are, they get, they are trained. ...They receive some training … On how to handle the client ... the rules of the hospital … confidentiality issues ... know how to approach the family. …" (Theru Pax7)*

> *"I would like; may be, to go on with my studies. I have done now a higher diploma … I would like to continue, but at the moment, financially, 'am trying to, stabilize myself…," (Caring Pax1)*

> *"… Oh ya. They do! … They do, they do, because I think aa, our kind of work because it's not like aa, it's not like what? Capacity rendering … kind of work. When you are exhausted, you have nothing to offer. … When you are, you have got your own issues, you won't be able to offer. … So it's like aa, they need that kind of support. …" (Glas Pax3)*

"Ya, I have done one in rape care … For one week … Ya. Then a few workshops I have been attending ... And I think in my line of work I, I encounter more physical abusive homes, than rape..." (Lil, pax4)

"… I think it gives me fulfilment to see that, I can change a life … That if 'am more trained ... I can do better" (Lil, Pax4).

"Either, they have a course that is done … for that … but as much as it is taught, (with emphasis), that counselling, that part, that bit of the counselling is taught, … It is not enough for this, for the ones who give the counselling to the HIV people. …" (Sawela Pax5)

"… So that when you are inside the room with the patient … And she has questions ….. You are ready to answer. … You can guide her or give her proper information ... I am yearning to …. A degree" (Tasha, Pax6)

These findings are focused on gaps in knowledge and training needs aimed at compensating the currently identified skills gaps in support of these counsellor administrator-managers' (participants') and/or their counterparts' counselling role-responsibilities within the different Task shifting contexts. But the findings also unearth a major gap on the need for a standardised professional development for counselors, which are important in furthering the counsellors' careers in the long-term, and in strengthening the counselling profession in the country.

4.1:3.3.Positive counsellor identity

Findings illuminate that only about half of the counsellors in this study group were employed, with 4 out of 7 on regular employment. One, (pax3) was self-employed, pax4 was working on a short-term contractual basis and pax6 and pax7 were on regular employment within the public health service while three of them (pax1, pax2 and pax5) were freelance counsellors, although pax5 also worked part-time at the level 3 public health facility.

Despite the often trying counselling experiences so far shared by the 7 participants under the complex and often challenging formal and/or informal Task Shifting context, these counsellor administrator-managers still maintained positive views about counsellors, regarding counselling, their counselling Centers, Units and /or Facilities and about themselves, which portrays a positive counsellor identity.

In her introduction, Tasha (pax6) informs that the counselling services at the level 6 public health facility are positively maintained by a team of well-trained counselling staff-cadre;

> *"The counselling here is quality… because, people are trained. …They, they don't employ people with certificate- counselling, … It is just as I said, they give specialised, ee, quality counselling because they are trained, … from Higher Diploma to Degree" (Tasha, pax6)*

To point out that they provide counselling services in a renowned establishment Tasha mentions a diverse source of clients which reflects a positive regard in the counselling services at the level 6 public health facility;

"Eee some come, self-referral from home… and others also come either from outside the town or provinces, some are referred from the wards, ….. and some come through … they are referred to us for counselling". (Tasha, pax6).

Findings from other participants' examples also illuminate that despite the diverse constraints under each form of Task-shifting, these counsellor administrator-managers nevertheless maintained their positive regard in hope for the future development of the counselling profession;

"…And in counselling, let me say for sure, it is not, it's not a medical ..., it is not aaa medication-therapy but in counselling when you mishandle a client you totally mis, mislead him or her. … (She claps her hands as a symbol/metaphor of finality)" (Glas pax3)

"Ama hii" (Or even that), already "hii imefika mahali" (this issue has reached a level), this one I can't even handle, "hii sasa, hii ni ya daktari" (this one now, this one is for the doctor's attention)" (Cute, pax2)

"I have also incorporated the churches because you find that the people don't think that the hospital is necessary so they go for the spiritual part of it. … Of late am working with pastors of this area to see how we can, to see how we can help both" (Lil, pax4)

"...we were told to learn about HIV and AIDS, and then we went to do the session for at least for 5 days … But we were told we were to be called again so that we

can be given a certificate. …That was the (name of an organisation)... that was training us. … But up to now, they have not called us again" (Caring pax1)

According to the findings, these counsellors' positive self-regard was supportive in sustaining each within their area of counselling, considering the often complex Task Shifting environment under which their counselling services were embedded.

Hence as illuminated in these findings, enhancing structures i.e.; supportive regulatory systems, implementation of the ethical code of conduct through clear guidelines, streamlined professional development, counsellor role clarification and regularised counsellor supervision would appear supportive of a strengthened counsellor-identity.

But while these measures it seems could be supportive of the development of the counselling profession in Kenya in the long-run, a discussion of these findings in comparison with findings from the literature will reveal to what extent this would be practically possible.

4:1.4.Theme Four - Hope and determination under Task shifting Context

The Sub-Themes	
4:1.4.1.	**Sustaining Flexibility under Task shifting**
4:1.4.2.	**Towards a professional counselling approach**
4:1.4.3.	**An Enduring-positive drive**

As findings so far show providing services within the diverse Task shifting environments was reportedly challenging for all the participants.

Theme 4 illuminates these counsellors' enduring positive drive through their contrasting counselling experiences under either the formal (explicit) and/or the rarely defined and often complex informal (implicit) Task-shifting counselling context as elaborated through 3 sub-themes (Table 4:1.4.).

Each of the three sub-themes is elaborated first under one participant's experiences, followed by the experiences of other participants.

4:1.4.1. Sustaining Flexibility under Task shifting

The ability and/or the possibility to remain flexible appeared supportive of the participants' counselling service delivery. As in previous themes, each of the three sub-themes is elaborated first, under one of the participant's experiences, followed by the experiences of other participants. From the privately-run Community Care Center (Glas, pax3) shifting client counseling sessions to the nurse-counsellors by client-appointment plus the proximity of the Center enhanced flexibility;

> *"Because like aa, I told you the way we do it … we can do home based counselling. We can, we can visit you wherever you are. …" (Glas, pax3)*

> *"…. Again as you have seen … we are on our way from the general hospital... they just pass by and say 'oh, let me go in I can ask something'… So we even get them, (clients) through "passing by"… And that way you are not embarrassed" Glas, pax3*

Reportedly the conducive environment and the formal/informal approach to counselling Task shifting *(through a duty-roaster)* at this privately-managed Community Care Counselling Center

(pax3) was positively appraised as a flexible approach from both the clients' and the counsellor's points of view;

> *"… So it could be at times we have sessions for a 1 or 2 hours … So I have a duty roster like aa, depending on the appointments". (Glas, pax3)*

> *"For now, the office set up … it is a bit conducive … and not from my own view… But from the view of most people who come around, that is what they say. … It's quiet … and aa, I think so" (Glas, pax3)*

Other participants' comparable flexibility ascertained that counselling services were provided despite constraints from varied focused approaches.

Lil (pax4) mainly worked with children through outreaches in schools to talk about sexual violence and educate the school children about this menace. More specifically her shifted liaison services as a Peer-educator and Mentor among the people focused on the children but also other clients of rape through organised support-groups;

> *"For rape survivors, it is done once a month, and make sure they attend the support group ..." (Lil, Pax4)*

However, her shifted tasks depended on the general issues reported by the local community members. Despite the unpredictability of such tasks, however, Lil sounded fulfilled with a shared hope at the outcomes of her efforts;

> *"… I think it gives me fulfilment to see that, I can change a life … Even my neighbours! They know that, Hii! (Oh).That lady that is what she does … You*

know even standing there and talking to these boys and girls …have made an impact. ...” (Lil, Pax4)

According to Tasha (pax6) readjustments to incorporate trained counsellors and lay counsellors with experience in supervision through ad hock mentorship, had helped ease the constraints experienced in ensuring that all the counsellors who would turn up at each session from the various departments within the level 6 public health facility received counsellor supervision. This was despite the massive numbers of counsellors and the shortage in trained counsellor-supervisors;

“... They also come in as counsellors. .. So if you are 2 counsellors there, you take them as counsellors because they are widely being trained also …” (Tasha, pax6)

“We have about 6. … So we work hand in hand with them. . … We support them but whoever who is not able to take the floor... Me who is qualified, I will go out with that one … and leave the peer counsellor to continue listening and putting down small notes so that we are able to respond to them. …” (Tasha, pax6)

In Sawela’s (pax5) experience from the level 3 public health facility HIV clients needed to be provided with some space to absorb /internalise the meaning of their HIV test results;

“… After the patient has been tested, you give them room to see the results themselves they interpret the results themselves, before you interpret the results to them. …” (Sawela, pax5)

But as the findings illuminated however, the lay counsellors at this crowded public facility had the mandate, the current informal Task shifting practices among them did not offer room for such flexibility during the process of providing HIV testing and counselling services to the clients;

> *"... So these are the people who are given the mandate … to do the work ..."*
>
> *(Sawela, pax5)*

> *"… Maybe you are 10, then you are told to go out, then they call you one by one,*
>
> *"take your results" just like that! …" (Sawela, pax5)*

4:1.4.2.Towards a professional counselling approach

Within the diverse Task Shifting context, a counsellors' background knowledge and/or specialisation were specifically voiced as valued assets towards a professional counselling approach (pax2, pax3, and pax1).

Using her experience from among teacher-client referrals Cute (pax2) proposed that those who were aspiring to become counsellors require a positive attitude and rapporteur understanding adjustable or moldable towards a professional approach in counselling within the informal Task shifting contexts;

> *"... but me most of the cases I get, they are from teachers, teachers those whom*
>
> *'am training ..." (Cute, pax2)*

"Anything else I can add? (Reflectively) Is that I think teachers have got a lot of issues. … Because those cases I have dealt with … they are from teachers... "(Cute, pax2)

"… Ok, there are again 2 cases, 2 kids who have committed suicide 'hio ili' (that one), 'aaa ilisucceed' (aaa succeeded). 'Walikufa kambisa!' (They actually died!) … And, after knowing later that they committed suicide, those were at least, mhh they (teachers) tried, to get assis, counselling, for those ones also. Ya. Ok, the teachers, they have that knowledge. (Silence) … Ya. (Cute, pax2)

"They (teachers) have got knowledge. … And even if it's very, not good, maybe they are the ones who will now seek for the counselling because they understand a bit, what it is all about. … But the rest are, are there! (Do not understand)" (Cute, pax2)

Because knowledge regarding the HIV Task shifting was explicitly available among the local community in her experience, Glas (pax3) cited those who needed to know their HIV status as seeking such counselling services voluntarily because, in her view, they seemed well informed. As well, specialised knowledge was valuable among the care providers while providing counselling to clients who presented with such specific counselling needs;

These days I think aa, me I would think today … Most HIV-AIDS testing and counselling … is coming from the people themselves. They are coming voluntarily. (Glas, pax3)

"... Aaa, let me say I have aa, good counsellors … Or aa, knowledgeable counsellors ... ….Nurses who have done counselling. … And for them mostly, they specify for HIV-AIDS."(Glas, pax3)

In her experience delivering the group guidance and counselling sessions to students across the schools in her county single-handedly, was challenging (Caring, pax1). One such challenge seemed to emanate from unexpected questions from students considering that she was conditioned to pre-arranged student sessions by the school;

"… In schools sometimes they just tell; about; self-awareness, about adolescence, about career choice … about someone anxiety … Ya. … And about parenting" (Caring, pax1).

"... then, later on, they want to see you personally…" (Caring, pax1)

"… I ring my fellow counsellors and then I go and present the issues..." (Caring, pax1)

These findings unearth Caring's deeper need for extended support comparable to the shifted school guidance and counselling responsibilities, highlighting a need for more counselor involvement in the organisation of the school guidance and counselling programme as well as the availability of individual student counselling to address personal concerns and counsellor supervision.

4:1.4.3. An Enduring-positive drive

The findings reveal specific challenges expressed by this cluster of counsellors under the Task Shifting counselling environment. This sub theme, therefore, is exhibited from a threading context to unearth each of the participants' counselling focus, thereby illuminating their persistence in carrying out their counselling services sometimes at the verge of burnout.

A gap in both knowledge and experience had placed Cute, (pax2) in a precarious position among the internally displaced persons as a counselor trainee under circumstances beyond her control as stated here;

> *"And you know it was so easy if I knew to tell the mother, you know, this kid is suffering from PTSD (post-traumatic stress disorder)… I didn't know that! Because you know "tulikuwa tumeokotwa huko tu mepelekwa" (we had just been collected from there and taken!"*
>
> *(Cute, pax2)*

However this negative example unearths probable future possibilities under such informal Task shifting environments in that, re-structured training experiences for counsellor trainees plus on-sight mentorship could present a likely alternative for future practicum placements for counsellor trainees which was pax2's concern.

Glas (pax3) presents a comparable experience in that the nurse-counsellors' she hires part-time from the level 5 public health facility appear mechanical in their counselling service delivery;

"...Most of them are on duty. … She is there to do her job … so long as she does it right" (Glas, pax3)

The exposed gap in these nurse-counsellors' attitude could likely be born of constant Task shifting as earlier illuminated (that *doctors tasks were shifted to the nurses (pax3) without structured guidelines).* However, through collaborative efforts between the facilities involved, this finding unearths hopeful potential for the improvement of both formal and informal Task shifting approaches through structured guidelines and regulatory mechanisms as proposed earlier (theme 2) that could positively influence the nurse-counsellors' attitudes and work environment or others exposed to similar Task shifting environments.

In Lil's (pax4) shared experience the unpredictability and diverse nature of the informal Task shifting approach were quite challenging. Unstructured shifting of tasks involved assessing the diverse clients' presenting problems and thereafter connecting each to counsellors and to specific support groups at the main public health facility;

"There is also physical violence, abusive marriages, even child abuse … And also people living with HIV and AIDS …" (Lil, pax4)

"...you know in the support group you know you will share your experiences, you know you are not in this alone, and you know just, peer-mentor. Mentoring this person to know about a rape survivor …" (Lil, pax4)

"... Because the main aim of coming to the support group is for this person to, to, go back to their normal life. ... But I would say it's a journey. I cannot be there in one day... " (Lil, pax4)

Lil wished if she could get more training because in addition, she also took up the more challenging responsibility of informally Task-shifted tasks, by following up clients presenting with diverse problems (beyond her basic training in rape) through home visits to track their progress and liaise their care-management accordingly.

Observably, Sawela (pax5) expressed hope as experienced through the level 3 public health facility was that counsellor-responsibilities within both the explicit and implicit Task shifted roles would be comparable to their qualifications;

> *"... This, this work has been given somebody else, who is not qualified. …"*
>
> *(Sawela, pax5)*

> *"But there is someone who is in charge of that, now that section, of VCT. … But even her, she has not been trained about the HIV, the HIV testing and counselling … It has not been done. … Ya." (Sawela, pax5)*

Tasha (pax6) shared hope from the level 6 public health facility is focused on the enduring-supportive counselling for HIV clients through formal PHIV-peer-support mentorship;

> *"… We also refer this person to, patient, too, support group. … coming together with one common thing, … to hear, to share experiences; some 10 years, some 20, even some have been on (Septrin for 20 years! … ….. some are not learned, some are learned, lecturers, pastors, they are all with us. …" (Tasha, pax6)*

In view of lingering stigma and discrimination Theru (pax7) shares a comparable concern and hope that centres on the need for HIV clients' formal/informal Task shifting support;

"Soooo, they need a lot of support … they need nutritional support, drugs, even psychosocial support … at home. … Because due to stigma and discrimination before they are accepted by the family … you need really to, to go to that home. … Although not all of them have problems. …" (Theru, pax7)

Whereas these findings illuminate the different challenges expressed by each of the 7 counsellor administrator-managers (participants), their shared enduring persistence and determination in providing counselling within the diverse Task shifting environments also carry a thread of hope towards a counselling profession in Kenya.

4:2. Conclusion - Findings

In this chapter I have presented the summary of the Thematic Analysis findings in story form from my qualitative study that explored the experiences of a cluster of 7 counsellor administrator-managers (participants) on the influence of Task Shifting on counselling and related services, including HIV-AIDS, at their agencies (units, centres, facilities) in Kenya.

I used the Inductive-Deductive Thematic Analysis guided by the steps adapted from Braun ad Clarke, (2006). The findings presented here reflect the research question (Section 1:11) and the synthesised interview data through which the participants' determination in providing their counselling services is reflected from four main themes and twelve interrelated sub-themes (Figure 3.4, Table 4.1 and Figure 4.1), supported by verbatim quotes.

From the subjective experiences shared by these participants, the contextual influence of the formal (Explicit) and informal (Implicit) Task Shifting approaches on counselling and related services is illuminated in diversity from within the embedded forms of counselling in the country.

A comparison of these findings with other findings from literature in Kenya and other countries in sub-Saharan Africa (or elsewhere) will reveal to what extent these or other factors compare with other reported experiences with Task Shifting.

4:3. Limitations of Thematic Analysis as it relates to this Study

Overall I spent adequate time to complete all phases of the Thematic Analysis but felt constrained by the word count over the length of my Thesis because my data-corpus from the semi-structured interviews (Appendix 4) was massive (Kvale and Brinkmann 2009). Braun and Clarke (2006) warn about the potential difficulties to the researcher using Thematic Analysis in trying to decide what aspects of their data to focus on despite its flexibility.

Based on my "Social constructionism" world view that meaning is dependent on experience, I adopted an Inductive-deductive Thematic Analysis and focused on the subjective meaning of the participants' views as expressed through their unique experiences with Task shifting.

Thematic Analysis illuminated overlaps in the unfolding story from the interrelatedness between the themes (Table 4.1 / Figure 4.1). An attempt at capturing the individual counsellor's subjective accounts within the data excerpts helped maintain the story-line in reporting the findings, but I inevitably lost the sense of continuity from the individual stories in the overall analytic process (Braun and Clarke 2006).

Although not from an analytical perspective, I ensured an overall view of the participant's mix of local language and dialects in Kenya (Figure 3.3) but as proposed in Braun and Clarke (2013 – In Press) such expertise could help unearth a deeper understanding of the counsellors' subjective use of language in context.

Probably other qualitative methods that propose that the researcher remains open to the data (Charmaz, 1990; 2005; Piko, 2014) might have minimised the overlaps in the themes as discussed in the section on choice of qualitative methodology (3:3.1).

To enrich the interpretative research process, further participant collaborative involvement through enhanced qualitative data-verification-session(s) to replace my "implied member-check" following the initial face to face interviews (Section 3.13), may serve to verify the original research data and to strengthen the findings and the research validity (Reason and Bradbury-Huang, 2007; West, 2013). Further participant input for data dissemination at appropriate forums (seminars, conferences etc.) could strengthen research feedback.

4:4. Introduction to Chapter 5

The next chapter is the discussion in which I use evidence from literature in support of these research findings under both the formal and the informal task shifting context.

CHAPTER 5 – DISCUSSION

5:0. Introduction

This chapter discusses and presents the Thematic Analysis findings from this study in light of relevant literature, in order to respond to the research question;

> *"What are the experiences of the counsellor administrator-managers regarding the influence of Task-Shifting on counselling and the related services including HIV-AIDS at their agencies in Kenya?"*

In reflection on my researcher's world-view, I remained consciously aware that any interaction with any part of the research process, including access to the interviews and my overall relationship with the participants all influence the questions asked, the lens used to construct meanings and eventually how these are reported and disseminated (Yardley, 2008).
In locating myself within the research process I further reflected on Guba, (1990a) argument in that all research falls into interpretive paradigms and therefore how the researcher views the world makes particular demands including the research questions and the interpretations that are reached according to their *own view of the world (reality / knowledge)* and how this should be understood and studied.

Hence in doing this study on the experiences of participants (counsellors) with Task shifting, I am guided by my epistemological and ontological view of reality from the "Social constructionism" (Crotty, 1998) in that meaning will depend on shared experiences by my participants.

By taking into consideration that the individuals' experiences are influenced by the broader social context, the Thematic Analysis methodology (Braun and Clarke, 2006) allowed me the flexibility to apply it into my ontological and epistemological world-view because the methodology is not tagged to any pre-existing theoretical framework as discussed earlier (Section 3.5). Thematic Analysis would therefore reflect and unravel the surface of reality by examining the ways in which the study events on Task shifting, realities and meanings from the participants' (counsellors') shared experiences are the effects of a range of discourses operating within society for example; local culture, level of education and/or training, politics, or religion, (among others) as influenced by the broader social context within which the participants' Task shifting experiences occurred (Section 3.4 & 3.7).

Overall the findings revealed that there was concern about the counsellors' skill levels, the actual physical space/arrangements available for the provision of counselling services, the availability and form of counsellor support availed /available to them, concern on the need for counsellors to have a spelt-out minimum baseline-level of knowledge that would spell out who should be designated the title of a counsellor, concern in reference to lay counsellors ,challenges in the apparent unclear supportive mechanisms and guidelines and minimal involvement in organizational or administrative functions in shifted tasks.

To begin with, the organization of the discussion is elaborated.

5:1. Organization of my discussion

In this study I have used Task shifting as a focus for exploring the counsellors' (participants) experiences.

In reference to the definition of Task shifting in the context of my study, (Section 1:12) I highlight the links illuminated between and across the different themes (Table 4.1 and Figure 4.1). In so doing I reflect on these 7 counsellors' efforts to maintain their professional approach in hope and determination despite the constraints from gaps in their counselling practice under the formal and/or informal (explicit and/or implicit) Task shifting context.

During this discussion process I will maintain a reflective approach on the counsellors' experiences and a reflexive awareness of my own potential subjectivity and predispositions in an attempt to illuminate a balancing of the counsellors' voices in the research representativeness as reflected in my final reflexivity (Session 6:6.).

5:2.Counselling in the Task shifting environment

This discussion is centered on the prevailing circumstances within which the 7 counsellors' shared-experiences were rooted within either the formal (explicit) and/or informal (implicit) context. According to the findings these include the counsellors' skill levels, the actual physical space/arrangements in diversity, the availability and form of counsellor support available to them in particular forms of counsellor-supervision but also the related influencing factors to counsellor-supervision.

The participants in this study voiced concerns about the counsellors' skill levels, the actual physical space/arrangements available for the provision of counselling services, the availability and form of counsellor support availed /available to them (in particular the forms of counsellor-supervision) but also the influencing factors to counsellor-supervision.

As shown in her initial view on informal Task Shifting Cute (pax2) experiences of crowding-out by self-designated counsellors among the local community illuminated her concern on the need for counsellors to have a spelt-out minimum baseline-level of knowledge that would clearly indicate who should be designated the title of a counsellor in Kenya. To overcome her expressed inadequate knowledge shared from experiences in trauma-counselling in her view, the standard baseline level of accredited counsellor education for legal-registration and for counsellor practice should be at a bachelor's degree (BSc) in counselling.

Sawela, (pax5) expressed concern at the level 3 public health facility regards the lay counsellors' formerly shifted-tasks in HIV counselling and testing (HTC) services, versus this cadres' minimal skill-levels. In her observation, the three-week training they undertake on HIV-AIDS appeared to have had minimal effect on their exhibited poor counselling skills, marked stress in both clients and the staff as illuminated by their negative attitudes towards clients and exhibited frustration. The administrative-poster (board) served as a constant reminder for the counsellors to move the perpetually long queue, prompting the patients and clients to push each other to get into the HIV counselling-room for services. The additional frustration exposed an ethical dilemma especially in reference to confidentiality.

As demonstrated in the findings, pax5's frustration centered on the resultant poor client HIV counselling and the un-availability of counsellor support supervision at the level 3 public health

facility. In her view it would be critical that the lay-counsellors' roles be clearly spelt out in reference to their specific HIV counselling and testing (HCT) shifted-tasks. From her expressed concerns, the lay counsellors would require not only skills-assessment in consideration of their role- re-adjustment in line with their shifted tasks, but also counsellor-support. But on the other hand, the perpetual crowding environment required management evaluation so as to improve access to client-privacy and the overall improvement of the quality of HIV testing and counselling services at the public health facility. This would in turn contribute to reducing both staff and client frustration and stress and burn-out amongst counsellors.

Unfavorable working environments have been documented as key challenges to quality of care services (Davies et al., 2013) leading to frustration, amounting stress and a sense of powerlessness over Task shifting work-environments. In this study mounting frustration and disappointment was observed in nurse task-shifters who reported on-going struggle to cope under the unpleasant working environment, impacting the quality of counselling and confidentiality in particular as in Pax5's experience at the level 3 public health facility.

Similarly from Kenya, comparable findings are reported (Selke et al, 2010) in which tasks were shifted from health care workers to lay counsellors living with HIV (PHIV) in an environment with inadequately defined structures of authority, and neither mentoring support nor any upgrading training skills. The resultant stressful Task-shifting process with inevitable burnout compromised the quality of counselling and the related services which support Pax5's concerns at the level 3 public health facility. Crowding at the facility with resultant long queues was stressful to staff but

especially to lay counsellors who exhibited inadequate skills in HIV testing and counselling services.

This was in contrast to Callaghan et al., (2010) study which showed that Task shifting in HIV management that included persons living with HIV (PHIV) was an effective approach in addressing staff shortages with comparable quality of care. This is comparable to pax5's experiences in that the authors emphasize the need to prioritize skills'-upgrading and the adjustment of the Task shifters professional roles, in acknowledgement of the additional shifted tasks.

The observations are supportive of arguments in several studies (Dovlo, 2004; Mullan and Frehywot, 2007; Callaghan et al., 2010) in that integrating the Task-shifters into new roles would enhance substitution in support of the Task shifting strategy with improved results.

Comparably Petersen and Swartz (2002) argued for additional resources for infrastructural requirements coupled with appropriate counsellor-training and counsellor support supervision. This strategy aimed at minimizing perpetual stress and imminent burnout from formally shifted tasks in HIV-AIDS as guided by the Global recommendations (World Health Organization, 2007; 2008).

However, the adjustment of professional roles was not illuminated in the findings, and could have been one of the factors contributing to poor attitudes at this public health facility.

In order to fit the prevailing Task shifting context, such proposed measures need to be tailored to specific local-needs for instance in consideration of further collaborative approaches for instance the administration at the level 3 public health facility could opt to engage community lay counsellors living with HIV (PHIV) but who have been recommended by the local community for

peer-support, as per the Global recommendations and as is the common practice elsewhere in the sub-Saharan Africa region and in Kenya (Petersen and Swartz 2002; World Health Organization, 2008) and also as demonstrated in this study at the levels 6 and 7 (pax6 and pax7).

In a different study in Kenya Samb et al., (2007) argue that a more comprehensive, more organized and standardized training through well regulated systems would be beneficial in improving the clients' quality of care by the various health professional-levels. Such an approach would be supportive of Oluwatosin, (2004) suggestion in that there appears to be a need to develop culturally-sensitive approaches and methods that are in tune with the local cultural norms in the sub-Saharan Africa region such as the inclusion, input and the involvement of the indigenous counselling approaches.

More importantly the importance of the supportive role of the regulatory bodies in deliberations on the most feasible approach within the diverse Task shifting contexts (Dovlo, 2004; Mullan and Frehywot, 2007; Samb et al., 2007; Callaghan et al., 2010) has been marked as a critical factor in addressing the regional challenges faced at implementation level.

These arguments are supportive of the experiences of some of the participants in this study.

5:3. Need for role Clarity

An expressed need for role-clarity was illuminated in the findings despite the participants' persistent determination at offering counselling services within their diverse Task shifting environments. The counsellors' role was constrained by the local community's poor understanding of what counselling entails and the shortage of counsellors with the required skills

within the specific counselling contexts under which each of them provided their services as reflected in Table 1.

There appears to be a contradiction from the study-participants' views and the local-community views in regard to "who the counsellor is, and what counselling is all about...?" In general counselling appeared to be misunderstood, leaving the people confused as to who the counsellor actually is, or what counselling really entails. From the findings, the counsellor seemed to be anyone who could give counsel and this included members of the local community. Notably, the term counsellor could actually be anyone but particularly the respected members within the local community such as the religious people and the administrators (Cute pax2)

But more significantly, people seeking counselling did not seem to differentiate who had been trained in counselling or at what level of counselling training. Those requiring marital counselling would seek help from the pastor who would pray for them, or from the chief who would often reprimand them so that by the end of such encounters (pax2), the underlying issues still remained un-resolved? However from the African-Kenyan perspective the findings unearthed a need to find out why the local-community tend to seek counsel from among their own people
According to Gichinga (2007) 80% of the African client has a lot of faith in traditional therapy which is in agreement with UNAIDS, (2000) reports that a similar percent relies on indigenous healing especially at the local level. These findings expose a need to explore the conflicting perspectives between the local-community counsellors and the conventional-counsellor, or why the local-community tend to seek counsel from among their own people.

An in built sense of frustration and apparent low self-esteem from perceived excessive client work-load and conflicting roles was apparent between staff-cadres despite the system of group supervision being in place. In this example from explicit Task shifting internally labeled as *"task-shifting play-game"* (pax6) clients were shifted from one staff-cadre to another in avoidance of provision of the required services.

This finding supports Oluwatosin, (2004) argument for the development of culturally-sensitive approaches and methods to counselling Task shifting that are in tune with the local cultural norms in the sub-Saharan Africa. Locating the most workable Task shifting approaches through collaborative efforts of different stake-holders would help improve the quality of counselling and accompanying services to clients. This discussion is taken further in the section on Adjusting Training approaches.

5:4. Inability to organise own work

At least half of the participants expressed challenges in the apparent unclear supportive mechanisms and guidelines and a lack or minimal involvement in either the organizational function and / or in the administrative function in shifted tasks (pax1, pax2, pax4, pax5) particularly under the Informal (implicit) Task Shifting environment. These constraints made it difficult for them to organize and plan their counselling services from a lack of, or unclear counselling guidelines which suggest a need for formalized counselling systems in support of the embedded forms of counselling in their specific environments.

Despite her initial enthusiasm in providing school guidance and counselling within the schools in her county Caring, Pax1 was challenged by the unmanageable student-group sessions to the one

counsellor ratio. She would have wished for additional counsellors and /or more frequent /individual counselling sessions to support the students' counselling concerns (for instance the use of illicit substances among the students) but the tight time schedules seemed linked to inadequate resources for guidance and counselling programme across the schools. For the moment Pax1 sounded worried about her teenage children in reference to her school guidance and counselling experience*s "I try, very much, for my children not to know what is happening, when I remember, the cases 'am facing. …"* however as the findings reveal, she hoped to upgrade her counselling credentials in the future when her finances stabilized probably to better cope with such counselling challenges and probably to shield her children from similar experiences in some way as well.

According to the findings the ability for the participants to make choices and to organize own work was influenced by the counsellors' ability to manage the Task-shifted roles. In her liaison work among the local community Lil pax4 was involved in identifying and reporting problems related to child abuse and defilement through the local community children's administration office, for enrollment of clients into the relevant support groups through the counselling Centre at the main hospital. These challenges point to the need for peer-counsellor /mentors' professional development so as to align additional roles and the new responsibilities, but also supportive guideline-mechanisms around the liaison-cycle for ease of related client care in addition to regularized counsellor supervision. Pax4 wished she could have further training because in addition, the process of care for the abused children was complicated by the level of social support and her minimal training-skills which impinged on her ability to fully manage her complex Task shifted liaison role. This informal approach to her Task Shifted role was constrained by a lack

of guidelines at the local level, in addition to her minimal basic training skills on rape. In the absence of client-ratio guidelines (BACP, 2007) between the local communities, the child guardians, the administrative offices, the counselling unit and other referral-points of care for each specific child according to need, marked constraints were unearthed in the informal approach to Task Shifting.

Though a need to involve guardians for the immediate and long term support in cases of sexual abuse was illuminated in the findings, the women were reportedly afraid of male abusers to protect the family name, *(how people feel, what will people say, it is a curse etc.)* according to Lil (pax4). Comparably a study in Botswana, South Africa revealed that lay counsellors often engaged in tasks beyond their acquired formal training skills and mandate. This not only limited the time they spent undertaking their task-shifted roles, but also concerns about the quality of services and legal accountability for the tasks undertaken (Ledikwe, Kejelepula and Maupo, et al., 2013).

The state of inadequate budgets for guidance and counselling in schools has been noted in other studies. In a study of primary schools in one of the counties in western Kenya (Owino and Odera, 2014) and in a different study in secondary schools in a state in Nigeria, West Africa (Nweze and Okolie, 2014) the recommendations urged the school management (boards) to ensure essential resources for guidance and counselling. The Government of Kenya, (2002) through the Kenya Institute of Education (KIE) (KIE, 2004) recommends that guidance and counselling programmes be accorded adequate time-lines and budgets so as to enhance the quality of services provided through open communication, trustworthiness and confidentiality for the student-clientele.

In the country, the government of Kenya report (GOK, 1999) highlights the need for the administrative system within the learning institutions to create and maintain the right atmosphere for co-operation and support of guidance and counselling with the aim of strengthening these counselling services in schools. Considering that the findings reported here are from schools within one of the counties in Kenya, it is likely that the school guidance and counselling programme-budgets were inadequate in that specific county pointing at a need for further support.

5:5. Stress and Burn-out

These findings illuminated large client loads per counsellor which is comparably high in the embedded forms of counselling environments represented in this study where the counsellors did not appear to have alternative strategies except; postponement of counselling tasks to unpredictable future (Caring pax1), extremely high counsellor to counsellor-supervisor ratios (1:20 or higher) and ad hock task shifting to the lay-counsellors (Tasha, pax6) and/or use of group-discussion approach in place of group-supervision (Theru pax7). From an example from South Africa and as compared to the British Association for Counselling and Psychotherapy (BACP) guideline of a maximum client load of just 5 clients per day (BACP, 2007) the client ratio is at least 50% higher (11 clients per day) and under minimal resources, with resultant secondary trauma and job burnout among the HIV lay counsellors.

Whereas all the participants in this study shared experiences of stress and impeding burn-out from their Task Shifting roles this complexity was particularly marked under the informal Task shifting counselling contexts within which Caring, pax1, Cute, pax2 and Sawela, pax5 provided

their counselling services. In Glas' (pax3) situation, excessive stress originated from her being the main referral point of care especially for personally known clients at her Community Care Centre. For the freelance counselors a lack of a direct and/or minimal involvement in the overall organisation of thespecific counselling programme, and in the coordination of own work-schedules, was a compounding source of stress.

From Cute's (pax2) examples of traumatising experiences as a counsellor-trainee among internally displaced persons (IDPs) whom she was expected to counsel with no prior preparation, centered on the need for counsellor-support. As findings show she had particularly encountered clients suffering from extreme forms of trauma (Post-traumatic Stress Disorder, PTSD) without an actual understanding of the disorder coupled with scanty mentorship and no on-site attached system for counsellor supervision.

Cute's (pax2) experiences seem related to McCann and Pearlman, (1990) description of overwhelm among Carers or vicarious traumatisation. According to Pearlman and Saakvitne, (1995b.) description, those who undertake the caring-role like counsellors, could exhibit signs and symptoms similar to those experienced by clients experiencing trauma, from being exposed to narratives about abuse of trust, lack of safety and powerlessness through empathic engagement with the clients' traumatic experience.

As findings show, the freelance counsellors who shared particular moments of impending burnout from their counselling experiences (Caring, pax1 and Sawela, pax5) had on their own initiative sought individualized counsellor-supervision. Other counsellors attended and/or organized and participated in institutionally-based group counsellor-supervision (Glas, pax3, Tasha, pax6, Theru, pax7) or client-support groups organized at the clients' referral points (Lil, pax4) where this form

of support was available. The highlights of the diverse approaches to counsellor (support) supervision that the participants used from the management (for those employed) or from own initiatives are shown (Table 4.2.).

For some of the challenging experiences and/or situations beyond their skill-ability most of these counsellors in addition utilized referral (pax2, pax3, pax4, pax6, pax7) while others, informally shifted tasks to the unpredictable future (pax1, pax3) (implicit Task-shifting) in an attempt to cope with the current stressors. According to Etherington, (2000) and Way et al., (2004) these approaches have been recommended particularly among inexperienced practitioners such as trainees or those new to trauma counselling who may be at particular risk of developing traumatic symptoms, which appears to fit pax2's experiences at the IDP camp.

In view of finding alternative approaches to the counselling profession in Africa, Levers, Radomsky and Shefer, (2009) argue for alternative approaches towards the professionalization of counselling and counsellor training in sub-Saharan Africa in particular, which include Kenya, but also in related service-delivery for example in HIV/AIDS. This argument is supported in the UNAIDS, (2000) and WHO. (2004) reports in that despite the advancement of modern medical systems, the majority of those most at risk at the grassroots are never adequately reached with services due to rising costs and complexity. The reports mark the need to move beyond conventional approaches to health-care and observe at least 80% of Africans depending on traditional healing and herbal medications.

One potential area according to Levers, Radomsky and Shefer, (2009) is increasing the cultural awareness in general by raising the voice of the indigenous people in the designing and implementation of relevant counselling training and practice because this could help in rooting -

counselling practice in the region. Such programmes they further argue could be aligned to parallel health service-delivery for example, in line with both the formal and informal approaches to the Task shifting strategy across the African settings in including in Kenya as illuminated in the findings.

According to BACP, (2007) ethical guidance the counselor's (practitioner's) *"well-being is essential to sustaining good practice"*.

Findings from this study highlight a need to have formalised and regularized counsellor supervision, in consideration of the additional constrains from the large numbers of counsellors that attend the 1-2 weekly group counselling sessions where these are availed to counsellors through the employer, the severe shortage of trained counsellor-supervisors (pax6 and pax7), and the informal group counsellor-supervision (pax3). In addition, the unavailability of individual counsellor supervision expressed by these counsellors (unless for those who could make individual arrangements, (pax1 and pax5) seemed to be linked to their ability to pay for the services.

The terms under which the participants sought counsellor supervision were not clearly spelt out in the findings. But those counsellors who were formally employed within the public health facilities (pax6 and pax7) attended regular 1-2 weekly group counsellor supervision or the various clients' support-groups (pax4). Some of the freelance counsellors (pax1 and pax5) however sort individual counsellor-supervision at the verge of burn-out which appears to be linked to the ability to pay for the services. Pax1 also sort consultation with colleagues for stressful challenges and in her words *"I would feel that I have been supervised".* Pax 2 did not elude to any forms of supervision except from her college- trainer during her impromptu trainee period at the IDP camp. Other than through her organized informal-group supervision mainly for the nurse-

counsellor Task shifters, Pax3 expressed her ethnic-ability to counsel herself from her extended experience with life challenges; *"Nii Nihotaga gwikomforti" (I have an ability to comfort/ counsel myself) in many, life, (pause), areas. … Many. …"*

This is not surprising from the Kenyan Cultural context where children were (some still are) brought up to brace themselves against life issues considering the often difficult social-economic context they have to grow under. Those forms of coping abilities are emphasized throughout the growing child's lifespan *"don't cry like a baby... you are grown up now ... life is not easy ... things will get better ... if God wishes... you have to learn to cope with life.. Life is difficult etc."* Individuals brought up with emphasis on and / or actual experience in having to actually cope with life could show the tendency to call upon their rapporteur experiences at times of life-stressors expressed by these counsellors.

From guidance and counselling context, Caring pax1 was challenged not only by the extremely large student groups that turned up at the sessions (400 and above) but also from her inability to provide follow-up individualised counselling to those students who lined up for counselling and to mothers who required individualised counselling follow-up (in a church-group-counselling context). But even more markedly as further illuminated in the findings, Caring would revert to her colleagues' support when experiencing excessive stress and individualised counselling on occasion, but at the verge of burn-out from these encounters.

In a qualitative study through informants McCourt and Awases, (2007) argue for the need to have more staff at higher-levels trained in supervision. From the counselling perspective, counsellors with the required credentials could be trained in counsellor-supervision so as to provide this much needed professional counsellor-support. From the findings, having supportive structures in place

for the support of counsellors (guideline systems, standards and regulations for registration for example membership to a counselling association) include counsellor-supervision.

From my experience in HIV-AIDS Training programming both in Kenya and in the Eastern and Southern Africa region, these challenges are commonly encountered both in Kenya and in the sub-Saharan Africa within embedded forms of counselling under the diverse forms of Task shifting. Short training courses in counselling and counsellor supervision (in which I was involved) were developed in collaboration with the relevant counselling organizations for instance the Kenya Association for Professional Counsellors (KAPC) to counter the challenges emanating from the shortage of counsellor-supervisors as well as the accompanying stress and imminent burn-out among counsellors in the short-term.

The unavailability of institutionalized forms of counsellor supervision appeared to be a drawback for most of the participants in this study. Where this was available, it was observed that the two institutions had the support from development partners related to HIV-AIDS programming, but even within these, the group supervision was challenged by the large numbers of counsellors and availability of trained counsellor-supervisors (pax3, pax6 and pax7)In addition to the ability to pay (pax1 and pax5) for individual counsellor-supervision.

From a comparable example from Nigeria, Oluwatosin, (2004) illuminated socio-cultural contradictions in client counsellor self-disclosure for the young people, expected to openly talk to counsellors in a context where children are socialized to treat adults with deferential respect and obedience. The examples point out the need to develop culturally-sensitive approaches and methods that are in tune with local cultural norms in the sub-Saharan region within where Kenya is located.

Though the newly approved counsellors and psychologists Act of parliament in Kenya (Counsellors and Psychologists Act, 2014) is yet to be enacted (Gikundi, KAPC – personal communication, July 18th 2016) all counsellors registered under the Act to practice as counsellors in the country are required to undergo the stipulated form and structure of counsellor-supervision under the new Act.

Given the experiences of the counsellors (participants) in this study however, the form and structure that counsellor-supervision takes, would need to take into consideration the prevailing circumstances for instance, the cultural and socio-economic contexts under which the counsellors live and practice in Kenya.

The ACA maintains that Counsellor Professional-supervision is a contractual agreement made between a Supervisor and a Supervisee who are registered as such with a recognized counselling body or are eligible for registered membership to the professional association. In this case, the counsellor has completed required post qualification counselling experience, the minimum hours of post qualification supervision, and has undertaken a supervisor training course that meets the designated standards. In addition, the counsellor-supervisor undergoes regular supervision as a Supervisor as well as the accumulated hours during attendance over a period of time, so as to gauge the supervisees' ability to function professionally.

5:6. Role Conflict

In this study, role conflict was apparent amongst staff seemingly from an inbuilt sense of frustration and apparent low self-esteem from perceived excessive client work-load and

conflicting-roles along the counselling chain, despite the system of group supervision being in place. In this example from explicit Task shifting internally labeled as *"task-shifting play-game"* (pax6) clients were pushed from one staff-cadre to another in avoidance of the required services. To resolve the conflict, the need to enhance role re-clarification with supportive ethical guideline-protocols for use by the counsellors to enhance communication had been raised with the relevant staff and the management.

Almost, (2006) describes the conflict process as involving two or more people who perceive the opposition of the other as in this case (pax6) two different cadres of staff were fighting over their conflicting roles. According to the author the process is characterised by the individual, interpersonal as well as organisational factors and the end result affect or is affected by either of these levels. Danna and Griffin, (1999) further argue that the negative effects from persistent conflict could become detrimental to the psychological well-being of the counsellors but also to the organization by undermining the inherent coordination and collaboration among different staff- cadres. Pax6 expressed-concern was the resultant delays in provision of counselling and related services but more significantly, the experience was infringing on the clients' right to quality services.

Counsellors require enhanced counsellor-support systems and guidelines and more specifically a Counsellor Supervisory system that examined and considered the prevailing local as well as the national context for workable systems that were attuned to the social-cultural prevailing background, under the diverse Task- Shifting context. Relevant approaches in support of counsellors and their collaborating staff-cadre-mix would help reverse frustration, overwhelm and role-confusion between the different staff cadre-mix which appeared to fuel conflict among staff

as well as avert stress and reverse burnout among them. Locating the most workable approaches would help improve the quality of counselling and accompanying services for clients.

Findings in this study illuminated grey areas in the different staff roles pointing out the need for role re-clarification. In the community-liaison informal Task-shifting context (pax4) and in the provision of HIV testing and counselling by the lay counsellors (pax5), the Task-shifters were often tasked to perform the counselor's role beyond their trained skills.

Un-aligned roles within the formal Task shifting context were marked in the findings with the nurse performing the doctor's role (pax3) but no indication was unearthed from the findings as to whether nurses shifted their own tasks in this case, hence implying work overload. Comparably Philips et al., (2008) found that nurses became overwhelmed with shifted-tasks because the medical doctors managed to shift some of their tasks to them to reduce their own workloads, but the nurses had few options in shifting their own tasks at their health facilities which was stressful to them. No options were revealed from among the counsellors (participants) in this study to shift their counselling tasks despite overwhelming shifted-tasks shared by some of them (pax1, pax2, pax4).

Mullan and Frehywot, (2007) argue for the importance of having the various roles and conditions of service (such as level of education and regulatory requirements) under which each staff-cadre are most effective revisited through clear policies. Through standardized training and through mentorship for masterly of learnt-skills, this process would support the alignment of the Task-Shifters' role-expectations by minimising work overload and improving the quality of counseling related services.

In a case study the HIV care programme in Swaziland (WHO. 2007a.), positive outcomes from Informal Task-shifting experiences were documented through clearly laid out referrals with strengthened links across the care continuum up to the local community levels. Observably with such supportive guidelines and counsellor supportive structures Task shifting could enhance client counselling and related care especially at the grassroots. Considering the diverse client source and the follow-up looping up to the local community levels (particularly for the HIV clients), the example of this case study in Swaziland appears comparable to the Task Shifting environments within which participants in the study provided their counselling services as illuminated in the findings. But this approach could be further enhanced utilising indigenous African approaches.

In this study, role conflict was apparent amongst staff seemingly from an inbuilt sense of frustration and apparent low self-esteem from perceived excessive client work-load and conflicting roles along the counselling chain, despite the system of group supervision being in place. In this example from explicit Task shifting internally labelled as *"task-shifting play-game"* (pax6) clients were pushed from one staff-cadre to another in avoidance of the required services. Counsellors require enhanced counsellor-support systems and guidelines and more specifically a Counsellor Supervisory system that examined and considered the prevailing local as well as the national context for workable guideline-systems under the diverse Task-shifting context. Such support for counsellors and their collaborating staff-cadres would help reverse frustration, overwhelm and role-confusion between the different cadres which appeared to fuel conflict among staff, as well as avert stress and reverse burnout among them for improved quality counselling and accompanying services for clients.

Linked to the discussion on role-conflict and in consideration of these counsellors' voiced determination and hope for a more systematised counselling profession in the country, a consideration for formalized systems is implied. However from the findings it appears that such systems require to be adjusted and molded around the professional counselling approach while at the same time taking into consideration both the Kenyan local and the national context. These according to Doh, (2009) should take cognizance of the African (Kenyan) social-cultural diversity under the embedded forms of counselling under both its formal (explicit) and the informal (implicit) counselling Task shifting contexts.

This would necessitate the collaboration and buy-in from the relevant stake-holders steered by the Ministry of Health, which is the hosting ministry for the newly approved Counsellors and Psychologists act (2014)(housed at the Psychiatry unit and yet to be enacted through an appointed National Board)(Gikundi, KAPC. Personal communication July 2016) and the relevant regulating bodies, voluntary counselling organizations in the country and also other collaborating institutions including local counselling implementing agencies. Through such processes, structures would be put in place in support of the alignment of the counsellor-task shifters 'professional roles and their revised role-expectations include the levels of remuneration in context.

5:7. Counsellor/Counselling Identity

Though the participants took pride in the counselling profession and looked forward to further professional development, factors beyond their immediate control both in the person of the counsellor and the counselling activity (service) were expressed through their rather poorly

defined roles, employment structure and unclear remuneration under the constrained Task-shifting environment, particularly for the freelance-counsellors.

The participants' designations were availed through the interviews (Table 1) but their training credentials for legal registration requirement(s) are not clearly illuminated in the findings. Also, the findings did not unearth whether any of these counsellors had been registered with any of the current local voluntary counselling (stake-holder) organizations that is; (Kenya counsellors and Psychologists Association (KCPA), Kenya psychologists Association (KPA), Amani Counselling and Training Institute – a private not for profit training and counselling organization, Kenya Association of Professional Counsellors (KAPC) which is a membership and training organization, neither the Kenya Institute of Professional Counsellors (KIPC)

Lack of Counsellor Identity was also expressed through the counsellors' rather poorly defined roles, employment structure and unclear remuneration under the constrained Task-shifting environment, particularly for the freelance counsellors. Several factors were illuminated as contributing to the local community's inability to recognize the differences between practicing self-designated counsellors and the legally qualified counsellors by training.

All the participants expressed a need for further professional development to booster a positive counsellor identity.

However, the participants urge for recognition illuminated arising gaps encountered in their counselling-practice highlighting the need for a structured and regularized counselling legal framework.

From the findings a counselor's perceived ability to cope with their work under the diverse Task-shifting environment seemed to influence the counselling identity, 1). Within the informal

contexts; Caring, pax1 in the school guidance and counselling and church-based group-counselling, Cute, pax2 among both the community-designated counsellors and the traumatized clients at an IDP camp, Lil, pax4 within a local community-liaison loop way beyond her trained skills in rape and 2). Glas, pax3 and Sawela, pax5 under the Community Care / HIV-AIDS formal Task shifting counselling contexts. In absence of professional self-development and counsellor supportive structures, these influences could become a constant source of stress and doubt, undermining professional growth and hence the counsellors' identify.

Pratt et al., (2006) argue that perceived competence by the professional helps the individual to move or transition into new roles and progressively acquire sub-identities which become aligned or fit in between their particular social /professional roles and role expectations. Comparable transitioning was exhibited by the participants in an attempt to cope within their diverse Task shifting challenges centered on the need for role clarity and formalization of counsellor-support systems. Caring, pax1 for instance tried to obscure the difficulties she encountered in school guidance and counselling from her children as if to protect her family and to postpone counselling tasks in both cases in absence of required support. Cute, pax2 expressed 'a wait and see approach' in hope that the local community would eventually understand who the rightful counsellor but at the IDP camp, she at one time lied to a client for lack information, experience or mentoring-support in trauma counselling.

Lil, pax4 used her initiative even though the liaison issues shifted to her from among the local community were way beyond her basic training-skills, while Sawela, pax 5 distanced herself from the poor counselling environment by voicing her volunteer role at the level 3 public health facility.

Surprisingly for participants whose managerial role was taking charge of all the counselling services at the unit or department (Tasha, Pax6 and Theru, pax7) and Glas, pax3, transitioning was exhibited rather differently from their over-all roles that is, by ensuring that other counsellors received group counsellor-supervision. This reflects the fact that the counsellor position-level at the unit or department influenced the transitioning process. However in Glas' (pax3) seemingly contradictory situation, while she had also put in place some informal group counsellor-supervisory support for her hired part-time nurse counsellors, she did not share such supportive measures for herself as in pax6 and pax7 case, she maintained that she would call upon her long-term cultural coping ability to counsel herself when dealing with complex client-issues referred to her by the nurse counsellor-Task-shifters. But even with this shared ability to cope, Glas still voiced symptoms of excessive stress from such experiences which reflects some need for additional counsellor support; *"So, it took me like 3 days to comfort myself, … And to counsel myself to, … To get the guilt out of me, … "*

5:8. Need to align staff roles

Linked to the discussion on role-conflict (Section 5.6) and in consideration of these counsellors' voiced determination and hope for a more systematized counselling profession in the country, a consideration for formalised systems is implied.

However from the findings it appears that such systems (for example, the implied counsellor-support supervision), require adjustment and molding around the professional counselling approach while at the same time taking into consideration prevailing circumstances at the local and the national levels. These are particularly influenced by the role of counselling organizations,

policy-holders and other collaborating-stakeholders' stand-points. Adjustment of counselling systems and regulations would most likely result to revised role-expectations, supportive to the counsellors' professional roles under the diverse forms of Task shifting, but tailored to the local and national context. As Mullan and Frehywot, (2007) argue, clear policies would be supportive of adjustments to roles and conditions of service, inclusive of regulatory requirements for a diverse health staff-mix.

5:9. Conflicting expectations

Findings show that conflict between staff can undermine client counselling and related services. Participants reported implicit /explicit conflict from conflicting role-responsibilities with differing expectations between staff-cadres (pax5 and pax6). The resultant stress and burn-out was accompanied by low quality counselling services in the case of the level 3 and level 6 of the public system as illuminated through staff negative attitudes towards clients and 'Task-shifting play game' at one of these levels.

The study findings reveal conflicting expectations from among the participants with resultant excessive stress and burnout under both the formal and informal Task shifting environments (pax1, pax2, pax3, pax4, pax5) compromising the quality of counselling and related services. These shortcomings were mainly the outcome of unmanageable counselling groups, (pax1, pax6) crowding at the public health facility, (pax5) inadequate training-skills, (pax2, pax5) and accompanying poor HIV counselling skills, (pax5) and mentoring-support (pax2).

Conflicting expectations between counsellors and clients have been documented (Buskens and Jaffe, 2008). In this study the clients received health education sessions against their anticipated consultation visits at the counselling-encounters.

The participants shared comparable conflicting encounters. For instance, a lack of the necessary counselling skills and mentoring support illuminated from the IDP trauma counselling environment and from the public health facility formal/informal Task shifting contexts (pax2 and pax5). These conflicting experiences were born of poor organization in counsellor-trainee field exposure in an emergency trauma situation, and non-alignment of shifted roles among lay counsellors with minimal training in HIV counselling and testing (HCT). The resultant stress and burn-out born of conflicting encounters could have been addressed through need based training (both at the basic and continuous-education levels) and tailored to the local situation, plus counselling-supportive structures to either prevent, minimize or resolve the stressful issues such as counsellor-trainee mentorship and counsellor-supervision within these specific contexts. For example, in a review case study of 47 countries among non-physician clinicians (NPC) Task shifters in sub Saharan countries Mullan and Frehywot, (2007) argue for standardised and need based training which is localized and practical so as to avoid and/or resolve conflicting roles, which eventually lead to burnout.

In the overall, the study findings support need for standardization and strengthening of counselling training with supportive guidelines and protocols adjustable to the local situation, so as to enhance the Task shifting strategy in counselling and in related client-care (Mullan and Frehywot, 2007; Buskens and Jaffe, 2008) under both its explicit and implicit forms.

5:10.Exploring possible solutions

Findings from this study show that formal Task shifting under a crowded environment were major factors in constraining the quality of HIV testing and counselling (HTC) services from the lack of privacy and inability to maintain confidentiality (pax5). The situation was complicated by the lay counsellors' inadequate counselling skills with resultant poor attitudes towards clients. In contrast a study by Samb et al., (2007) argued in support of formalized Task shifting noting that the experience of the facility in providing similar services through formalised approaches using specific supportive guidelines (under the supportive role of a well-organized staff-mix) had implications on the success of the programme (Samb et al., 2007; Kara et al., 2009; Selke et al., 2011).

In some of the situations the study findings also illuminated fairly well organised client service delivery systems (pax3, pax6, pax7) especially within the formal approaches to counselling Task shifting as observed in (Samb et al., 2007). But seemingly, this depended on whether the facility was privately managed (pax3) but surprisingly another factor that came to play within HIV-AIDS programming was also whether the facility received additional support from other sources (pax6, pax7). In both cases the support examples cited by the participants were in the form of skills-upgrading training in HIV treatment-management support, specifically the antiretroviral (ARV) therapy and knowledge and skills in dealing with specific counselling situations for instance adherence counselling and psycho-social client/family support.

In this study absence of guideline-protocols was illuminated and in such Task shifting circumstances the participants reverted to own initiative in handling the counselling issues; for counsellor-client contracting arrangements (pax1, pax3, pax4) in reference to general liaison-

counselling within the local community (pax4), the initial HIV counselling (pax7) in order to ensure services to clients and to improve the quality of counselling. But in group counsellor supervision (pax6) the informal shifting of tasks to senior lay counsellors was to ascertain that the exceptionally large groups of counsellors were reached with counsellor-supervision.

Other supportive factors to the findings in this study that influence Task shifting have been documented. In a study in South Africa on nurses' experiences (Netshandama and Dhavhana-Maselesele, 2007) a lack of privacy constrained timeliness, confidentiality and the quality of care for in- depth interpersonal interactions by multi-tasked over-stretched nurse-counsellors. This compares to the experiences of counsellors at the level 3 public health facility (pax5) and to some extent the level 4 public health facility (pax7) even though the issues of confidentiality were resolved through counsellor-support supervision at the latter.

In support of these findings Rutenberg et al., (2003) re-emphasized inadequate space as a key factor in compromising the counselling context by introducing ethical dilemmas involving third parties. These findings have been illuminated in two separate studies on Kenyan health workers' HIV-related challenges (Kiragu 2006; Khan and Weiss 2006) which support the need for standardized guidelines adjustable to the national and local influences with Task shifting within those levels.

5:11. Shifting Tasks to PLHIV/PHIV

As illuminated in the findings well-structured responsibilities were formally shifted to PLHIV/PHIV as lay/peer educators for awareness creation to different groups and also extending the supportive care to the clients at their homes through the privately managed Community Care

Centre (pax3). Within the level 6 and level 7 public health facilities (pax6 and pax7) the lay counsellors PHIV shifted tasks included role-modeling, counselling in denial of positive HIV test-results, adherence-counselling for the antiretroviral (ARV) treatment and lobbying for client-shared confidentiality with the client's family or close others, in support of the family member with HIV. In addition the use of a systematised and standardized counselling protocol at the level 4 health facility revealed ease and completeness in the delivery of counselling-encounters (pax7) for smooth follow-up care through triaging.

In comparison Green and Smith (2004) support the skills-upgrading for persons living with HIV (PLHIV/PHIV) as lay counsellors using the formal Task shifting approaches for the purpose of scaling up HIV services at the level four public health facility (pax7). This needs to incorporate specific aspects of prevention and care tailored to the national/local needs (Green and Smith 2004; Hirschhorn et al., 2006) as documented in the WHO guideline-recommendations (WHO 2007, 2008).

5:12. Formalisation of counsellor support systems

Unclear supportive mechanisms and guidelines and the minimal involvement in the overall organizational-function of the counselling services were apparent among participants in this study (pax1, pax4, pax5) especially among the freelance counsellors (pax1, pax2, pax5). This was evidenced by these counsellors' expressed constraints in the ability to make choices and to organize shifted-tasks exposing a dire need for formalization of counselling support systems particularly within informal Task shifting contexts and among the freelance counsellors which seemed obscure.

Formalized counselling systems would serve as the bench-mark and guiding tool against which the different levels of counsellors practice. This includes ethical codes of conduct, training curricula, accreditation, registration procedures and legal guidance in the practice of counselling.

Such systems were available to a certain level within the privately managed Community Care Centre (pax3) and levels 4 and level 6 of the public health facilities which reportedly had support of development partners within HIV Formal Task shifting environments (pax6, pax7).

In reference to professional regulations, findings from a case-study in Uganda, Dambisya, (2010) reports that the Task-shifters did not have legal protection for the additional tasks and therefore they hesitated to take on more responsibilities; *"If they want us to do the doctors' work, who will do ours? And what will the doctors then do?" (p. 20).*

But unlike in Dambisya, (2010) there were no indications of hesitance in the delivery of counselling services to clients among the participants but as discussed earlier, the counsellors in this study were often stressed and some suffered burnout through the process from inadequate numbers of counsellors (pax1) and poor skills among the lay/peer counsellors (pax4, pax5), as well as from excessive in-referrals (pax3) other than within the higher levels of the public health system (pax6, pax7). The absence of guideline tools and adequate counsellor support as a common finding in general.

A lack of recognition of the qualified counsellor and of counselling among the local community from a need of awareness creation was encountered according to (pax2) *"counselling needs to be demystified"* within informal Task shifting environments. As well, some of the freelance counsellors sighted in-adequate remuneration in the formally shifted tasks with resultant stress

and burn-out (pax1) and by losing valuable time in between dishonored appointments (pax5) within mandatory college-student counselling context, (explicit/formal Task shifting). The inadequate understanding about the qualified counsellor and counselling undermined the counselor's identity (pax2, pax4 and pax5).

Sawatzky et al., (1994) argued that a clear sense of identity would translate to having an internal sense and understanding of the self at both a professional and a personal level which can become empowering to the developing counsellor. But there were indications from the participants in this study that they all wished to further their counselling careers through professional development. Some of them linked the need for self-development to becoming more resourceful in dealing with clients; "*You are ready to answer. … You can guide her or give her proper information …"* (pax6). In other cases the counsellor wished to affirm their professional role (pax2) by enrolling into a higher counselling programme, while pax1 implied a lack of supportive structures in form of tools and guidelines within the counselling environment, by sighting use of reference books in the short term but with an indication to further her counselling career in the long-term (probably in hope of overcoming such shortcomings) within the informal counselling environment.

Supportive structures were more readily available for those counsellors whose services were linked to employer-institutions. But only about half of the counsellors in this study-group were on regular employment (4 out of 7) as reflected in participants background (Table 1). Pax3 was self-employed, pax4, the Lay Counsellor/Mentor was working on short-term contractual basis while pax6 and pax7 were on regular employment in the public health service. Pax1, pax2 and pax5 were freelance counsellors, although pax5 also worked part-time at the level 3 public health facility as a volunteer.

Notably the participant managing their privately-managed Community Counselling Centre institution (pax3) or those counsellors employed by a specific employer-institution (pax6, pax7) appeared to hold a clearer counsellor identity. But in other situations (pax1, pax2, pax4 and pax5) counsellor identity was expressed through the counsellors' rather poorly defined roles, employment structure and remuneration under the constrained informal Task-shifting environment. As expressed by pax2, the local community's inability to recognize the differences between practicing self and/or the local community designated counsellors and the 'legally' qualified counsellors by training, also appeared to undermine the counsellors' identity. This was in addition to the counsellors' minimal involvement and/or absence of guidelines in the overall organization and/or coordination of the Task shifted counselling services (pax1, pax2, pax4 and pax5).

Pelling and Whethan, (2006) argue that counselling is in a process of growing and establishing itself as a legitimate profession and therefore counsellors need to progressively cultivate and nature a clear sense of professional identity through self-development (Alves and Gazzola, 2011) in order to feel secure in the profession.

But notably the counsellors' training credentials for 'legal' registration requirement(s) in the country were not unearthed in the findings and therefore it remained unclear whom among the participants had been registered with the relevant counselling organization(s) in the country as stipulated in the new Act (Counsellors and Psychologists Act, Kenya 2014) and from examples from other countries (ACA Policy Document on Professional Supervision, 2013).

However from the information gathered at recruitment other than pax4 (lay counsellor and mentor) and pax7 (nurse-counsellor and counsellor-supervisor) the other six participants (pax1,

pax2, pax3, pax5, pax6) had a Higher Diploma in counselling or above (pax3), and are likely to have been registered as counsellors in Kenya (Table 1).

These contrasting findings illuminated a need for supportive structured guidelines and regularisation of training curricular for counsellor Task-shifters and within both the formal (explicit) and informal (implicit) Task shifting environments across the different levels of the embedded forms of counselling service-delivery in the country. Particularly, this need was more obvious within the freelance counselling context (pax1, pax2 and pax5), the informal local-community health liaison environment (pax4) but also within the lower level public-health facilities where infrastructural needs tended to be an additional constraint (pax3). Such enhancement would appear supportive in the alignment of the counsellors' skills-upgrading needs, which in turn could provide some bench-marks in support of regularisation of training-curricular for Task-shifters in accordance with the identified gaps.

The findings are supported by Morris et al., (2009) and Ferrinho et al., (2012) who argue that the Task shifting model holds potential overall, but alone the strategy would become undermined therefore marking the need for continued training for Task shifters among other needs;

> *"... especially if other issues are not addressed at the same time: inadequate facilities … and inadequate continuing education efforts, among others.* (Ferrinho et al., 2012 p. 6)

These concerns were raised by the participants i.e.; improvement of the Task shifting environment and the counsellors' training skills including for lay/peer counsellors (pax4; pax5), the streamlining of staff roles so as to minimize conflict (pax5, pax6), adequacy of qualified counsellors and supportive staff (pax1, pax2, pax3, pax4, pax5) and specifically the need for adequate trained

counsellor-supervisors and improved working systems (pax1, pax2, pax4, pax5) as could be observed at the level 6 and level 4 (pax6 and pax7) of the public health system. However from Cute's (pax2) additional views from a felt need for additional knowledge and skills, the professional training level for counsellors in the country needed to be stepped up to the Bachelor's Degree.

However as Morris et al., (2009) argues long-term sustainable solutions and workable strategies could only be attained through the policy direction of the government through the relevant Counselling Organisations at the National level. In order to appropriately align the counsellors' roles and responsibilities with their educational and skill-level therefore, an adequacy of the different counsellor-levels within the Task shifting environments need to be increased, including trained counsellor-supervisors with *"the engagement with policy makers..."*(p.8).

Notably for the success in Task shifting overall as also stipulated in the WHO guidelines (WHO 2007, 2008; Morris et al., 2009; USAID Policy Initiative, February 2010) the formal (explicit) forms of Task shifting tend towards the use of a team-approach, through health staff-mix including in HIV-AIDS. The adjustment of the professional scopes of practice among the different staff-cadres would hence require the collaborative and supportive role of the professional and regulatory organizations, in addition to the support of the national-governments, for more effective shifting of tasks (substitution) among the different staff cadres for the success in Task shifting overall. Such collaboration within the country would call upon the supportive roles of the Kenya Ministry of Health, the para-medical associations (nursing, laboratory, pharmacy etc.) alongside the Counselling Association of Kenya and in addition to the relevant national and bilateral organizations in the country. In addition to the counsellors at the various levels including lay-

counsellors and PHIV, this would depend on the mix of staff-cadre requirement (Hongoro and McPake, 2004) within the different local and national Task shifting counselling-environments, among other considerations (Hongoro and McPake, 2004; Republic of Kenya, 2009; Ferrinho et al., 2012; Counsellors and Psychologists Act; 2014).

This study did not clearly illuminate the various participants' roles but these appeared to fit the Task shifting context under which each counsellor was providing services at the time of the interviews. A literature review study (Dovlo, 2004) however reveals that there is a need to understand the various roles under which each staff-cadre would be most effective in order to stream-line the professional scopes of practice for more effective Task-shifting within its diverse contexts, for the attainment of improved working environments especially appropriate training and mentorship. In comparison with the findings from this study, this author's suggestion parallels the need to align the participants' (counsellors') different roles in reference to the shifted tasks and their shared role-responsibility in context.

In their urge for recognition of the counsellor and counselling the participants' priority for improved counselling under the Task shifting environment and more so within the informal (implicit) approaches, pointed at the need for formalization of counsellor-support systems and more significantly counsellor-supervision. This was apparently focused at minimizing counsellor-stress and burn-out marked among the counsellors in this study.

In the long-term a structured and regularized counselling legal framework would appear significant in building a more positive counsellor identity and further counsellor professional development but more critically, in aligning the Task shifters professional roles. The supportive role of the recently approved counsellors and psychologists Act in the country (Counsellors and

Psychologists Act, Kenya 2014) would expectedly play a most significant role in collaboration with other professional organisations in Kenya and beyond.

Comparably, an example from the Kenya Civil Service counselling function has a clearly defined and well-structured scheme of service for the counselling personnel through regularization. In this case (Republic of Kenya Scheme of Service 2009) the counselling-staff roles and responsibilities are clearly spelt out with prior induction and opportunities for training to support the additional self-development needs for quality performance and progressive advancement within the Scheme of Service. In addition the counselling-staff within the Kenya Civil Service (counselling function) are encouraged to undertake additional self-development training and Counsellor Supervision *"so as to ensure quality provision of counselling services"* (Republic of Kenya Scheme of Service, 2009 *p.1)* through a structured scheme of service;

...Training opportunities and facilities are provided to assist serving officers acquire the necessary additional qualifications/specialization and experience required for both efficient performance of their duties and advancement within the Scheme of Service. (p.1)

In order to avoid conflicting expectations from the regulatory bodies whose collaborative support help anchor service delivery for the helping professions Hongoro and McPake, (2004) in a descriptive study in low resource countries, proposed the need for more research to better understand effectiveness and roles of the health-staff mix Task shifters (Ferrinho, et al., 2012) for better alignment of their role-responsibilities.

5:13. Adjusting Counsellors' skills through Training

In view of the findings from this study on Task shifting in addressing the counselling-training gaps for a cross-section of counsellors, and a diverse cluster of Task shifters within the environment where counselling services are embedded in Kenya, an approach that focuses on the co-construction of concepts and practices that are reflective of both the individual and the collective counsellor identities would be necessary.

According to Nsamenang, (2005) and Nsamenang and Tchombe, (2011) everyone has knowledge and experience that embodies own culture of origin and contemporary cultural identity. This reality is important in informing dialogue, related policy, decision-making, policy development, and renewal of educational /instructive strategies. In support of such embodied knowledge in an Africa's education landscape these authors argue that every facet of education/training and eventual curriculum is therefore deeply influenced by the local context.

The challenge is to be able to consult with holders of indigenous knowledge (Gichinga, 2007; Nsamenang and Tchombe, 2005; 2011) as there may be gate-keepers particularly if groups are involved, which may necessitate use of neutral mediators. In view of incorporating and/or the inevitable need to make adjustments to the existing curriculum, and so as to fill the identified gaps(both within HIV-AIDS and across other related areas within the current Task shifting counselling approaches), the holders of any general counselling and related curriculum but also other specific counselling-curriculum, and the relevant stake-holders would need to be involved in all the processes for restructuring, implementation, tracking of implementation-processes and the eventual sustainability for critical buy-in.

By creatively weaving the new information (knowledge's') generated in diversity from the study findings, relevant literature, existing curriculum, indigenous sources but also from the experiences of the stake-holders; (the indigenous knowledge-holders, regulatory bodies, policy-holders, the consumers and the trainers) and through a collaborative engagement process, adjustment of these realities would support the re-construction of a generative-curriculum that would become a culturally relevant-structure that reflects the Kenyan understandings of African counselling training and delivery systems. Through the engagement of a diverse community of learners (counselling and other students, clients and their families, the local community) and all the stake-holders and through a process of mentored-assessment and tracking, and evaluation of the delivery processes through an embedded guiding-policy the Generative Counselling Curriculum Model could make significant contributions towards professional counselling Task shifting approaches among the local communities in Kenya in an rapidly evolving world.

5:14.How the findings relate to and address the research question

I set out to answer the research question;

> *"What are the experiences of the counsellor administrator-managers regarding the influence of Task-Shifting on counselling and the related services including HIV-AIDS at their agencies in Kenya?"*

According to the findings, (Table 4.1 and Figure 4.1) experiences shared by the 7 counsellor administrator-managers (participants) are displayed under 4 main themes. These experiences were mainly dependent on the Task shifting context under which they occurred, while the context in turn, was influenced by the type and level of agency or facility within which the services were

embedded and whether the services comprised general counselling, and/or HIV/AIDS counselling related services, which in Kenya, were in turn linked to the supportive role of the Comprehensive Care Centre (CCC) for HIV-AIDS.

The approach to Task shifting adapted at each of the facilities influenced how the Task-shifted services were structured or managed, including any skills-upgrading for the mix cadres of staff, and the role adapted for the lay counsellors and /or PHIV which was more pronounced at the higher level public health facilities. Notably some of participants and particularly the freelance counsellors provided their services across different types or facility levels (Table 1).

From the participants' shared experiences, the actual Task shifting approaches adapted across these establishments were either formally recognised (Explicit Task shifting) particularly across the public health facilities; and /or informally applied as coping mechanisms so as to ensure that the required services were provided to clients, (Implicit Task shifting).

These forms of Task shifting as discussed, impacted on the participants' counselling experiences differently for instance, part of the local community would seek counselling services from among their own members (teachers, pastors or the local chief), other local community members voiced a lack of confidence in the trained counsellor from their counselling experiences. In other situations, the participants expressed some level of inadequacy in skills among counsellors and /or in numbers of those trained which from examples of literature reviewed, (Section 2.8) was a common finding across the sub Saharan region (Dovlo, 2004; Morris et al., 2009; Zachariah et al., 2009; Selke et al., 2010; Callaghan et al., 2010; Ferrinho, et al. 2012).

The participants' shared concern about their professional role under the deficient working environments, was often times masked under the auspices of the commonly perceived task-

overload and conflicting role-responsibilities, uniquely compounded by an inadequacy of supportive mechanisms and un-structured skills-upgrading for professional advancement. Observably as discussed in Chapter 5, cumulative *inability to make choices or to organize own work, was linked to* excessive stress and burnout from a lack of recognition of the legally qualified counsellor in the mildest of inadequate '*though much appreciated*' supportive counsellor supervision, the participants' professional identity was reportedly undermined (Session 5.7).

Overall, as also illuminated in the reviewed literature (Samb et al., 2007; Mullan and Frehywot, 2007) the findings revealed a concern about the counsellors' skill levels, the actual physical space, the availability and form of counsellor support, a need for counsellor-credentialing and professional development at the different levels including for lay PHIV. Under the apparent unclear supportive mechanisms, guidelines and systems in the administrative and management functions and roles in Task shifting, the challenges often times became overwhelming leading to stress and burn-out amongst participants (Session 5.5).

Despite these challenges, a reflective endurance in the future of counselling in Kenya was evident from among the participants' shared experiences overall, Theme 4:1.4., *'Hope and determination under Task shifting Context'*. Hence, some of the Task shifting approaches served to booster the individual counsellors' reflective endurance for the future of counselling in the country, for instance by calling upon *'informal Task shifting coping approaches, the supportive-role of the diverse forms of group counsellor support supervision and collaborative flexibility'.*
As illuminated in the review of literature (Chapter 2) locating the most workable Task shifting approaches through collaborative efforts of different stake-holders would support the

improvement on the general view about counselling Task shifting and the counselling profession. From this perspective, the participants' shared concerns illuminate a need to have counsellor support systems formalised (Session 5.12) in support of formal recognition of the counsellor through standardized training (Session 5.13). In addition, further collaborative initiatives to explore why the local people would choose to seek counselling services from amongst their own people (UNAIDS, 2000; Oluwatosin, 2004; Nsamenang and Tchombe, 2005) in place of the trained counsellor appear necessary, in view of exposing culturally-sensitive approaches and methods to counselling Task shifting that are in tune with the local cultural norms in Kenya and across the sub-Saharan African region.

5:15. Limitations of this study

I actually interviewed 7 women counsellors (Table 1), excluding the pilot participant. Although I had made efforts to include 2 interested male counsellors from different counties within the same region, they both declined to confirm recruitment appointments. Probably, male counsellors would have told their stories from a Kenyan-African male-gender perspective and provided insight into this cultural component.

Considering that I recruited, transcribed and analyzed the interviews myself, I acknowledge that I must have influenced the narrative findings in spite of my deliberate efforts to remain reflexive during the whole process (Section 6:6. – My Final reflexivity).

However, I did attempt to minimize this short-coming by interviewing one Counsellor Administrator-manager of comparable background. Instead of profuse note-taking, I adjusted my

approach to include use of tape-recorded interviews to counter the loss of aspects of the participants' stories through my dual role, "listening and note-taking" as I had done during the piloting process.

I gave a chance to all participants to read and comment on their original transcripts (through a second session) in order to provide an avenue for them to confirm, refute and or rephrase their stories. All 7 counsellors confirmed their choice of study-names and transcripts with few comments.

Notably, this is a small qualitative study in which recruitment of participants was purposeful using a snow-balling approach, findings are reflected through the lenses of seven counsellor administrator-managers' (participants') experiences under either the formal (explicit) and/or informal (implicit) Task shifting context.

While this qualitative study illuminates useful insights from the experiences of the 7 counsellors who shared them, these findings are only a part-representation of their experiences with Task Shifting from within Nairobi, Central and Lift-valley regions in Kenya's 3 / 47 counties. Therefore these views may not be representative of other counsellors' views in the country.

5:16. Limitations of Thematic Analysis as it relates to this study

Thematic Analysis has been described and used both as a tool and a methodology across different research methods (Aronson, 1994; Boyatzis, 1998; Yardley, 2000; Attride-Stirling, 2001; Holloway and Todres, 2003; Marks and Yardley, 2004; Braun and Clarke, 2006) both inductively and deductively to answer research question(s). Through sequenced steps (from the collection of data,

transcription, identification of cohesive themes) Thematic Analysis portrays patterned-findings of experience from which a valid comprehensive picture of the participants' collective experience is formulated in story form, backed up by relevant literature.

My study findings were an outcome of both the inductive-deductive approaches through which I identified comprehensive themes and specific data-extracts on specific data components of interest. Both during transcription and emersion, I gave adequate attention to all the participant-data extracts through the Thematic Analysis process so as to assess whether the themes I identified made practical-sense (internally coherent), consistent or distinct (Braun and Clarke, 2006).

Again, to illuminate the informal 'opaque' approaches to the Task Shifting phenomenon and the unique supportive roles by PLHIV (which were particularly tagged to specific modes of coping), I had to make decisions about which data-extracts were more vivid as data-excerpts (quotes) while at the same time counter-checking identified themes against each other to confirm or dismiss their interrelatedness. For instance, I had earlier categorised Theme 4 (Hope and determination under Task shifting context) as an overarching theme. But through repeated coding and re-categorisation of the coded data, I had eventually identified 3 distinct, though inter-related sub-themes that captured the contextual aspects of Task shifting in its diverse forms (Table 4:1.4) and its critical influencing-role in flexibility, professional counselling approaches and the enduring-positive drive among the participants.

However, my research topic on Task shifting phenomenon could have been studied from various angles and through other methodological approaches (Malterud, 2001) for instance, working in a

team of researchers (West, 1996; Reason and Bradbury-Huang, 2007) may have yielded richer data, diverse analysis and meanings in reference to Task shifting by including the active role of the participants and varying understanding or new knowledge of the same phenomenon but from a different perspective. Other Inductive approaches that I had explored for this study may have resulted in different understanding of the participants' lived experiences with Task shifting and or theoretical underpinnings, for instance grounded theory, (Sanders and Wilkins, 2010).

The next section provides a conclusion to the study, including a critique of the study while making suggestions for counsellor administrator managers. A proposition of ways to mitigate some of the issues identified in the study is offered and recommendations for future research made.

CHAPTER 6- CONCLUSIONS AND RECOMMENDATIONS

6:0. Introduction

This chapter provides a conclusion of the study, makes recommendations for further study and practice, discusses the original contribution to knowledge, and critiques the study.
Finally it includes concluding researcher reflexivity.

6:1. Overview of the study

The study looked at the experiences of the counsellor Administrator-Managers regarding the influence of Task Shifting on Counselling and the related services including HIV-AIDS at their agencies in Kenya**.** The study generated four main themes namely; A need for role clarity, Formalization of counsellor-support systems, Counsellor Identity and Hope and determination under Task shifting (T/Shifting) , and 12 representative sub themes (Table 4.1 and Figure 4.1).
The study has shown that Task Shifting is a widely documented approach in general and in counselling particularly in HIV-AIDS but also, in diverse counselling areas within the facilities where counselling services are embedded in the country. The findings revealed that counselling practice undertaken as a formal Task shifting strategy aimed to counter the human resource constraints while informal Task shifting was mainly used as a coping mechanism in the often complex and diverse counselling contexts.

The study used the counsellor administrator-managers' experts to capture their experiences as represented in the findings including their views on Task shifting, against the relevant literature. By following the threading between and across the different experiences this discussion has illuminated the counsellors' persistence in countering the diverse constraints in their determination to advance their counselling careers and profession, under both the formal and informal Task shifting contexts.

This small qualitative study showed that counselling in Kenya seemed misunderstood, misinterpreted, and misrepresented by a cross-section of the local community including those practicing as self-designated counsellors as well as their clients. A major community awareness could become necessary in order to counter this practice through the support of professional counselling organizations / professional regulatory bodies and legal entities with the aim of raising the counselling awareness and recognition.

The study illuminated the need to improve the work environment overall; to clarify the roles and responsibilities of counsellors at each level of the Formal (explicit) and Informal (implicit) Task shifting practice, so as to provide skills upgrading according to identified skills'-gaps among different cadres of counsellors.

The study unearthed a need to explore the adequacy of counsellor self-development, counsellor-support supervision and remuneration-packages across the different counsellor-levels within the different facilities where counselling is embedded under both the Formal and Informal Task shifting contexts.

6:2. Contribution to Knowledge made by the Study

By comparing the findings with literature on Task shifting in general, studies from across the sub-Sahara region, in Kenya and in a few other countries, this study shall contribute to knowledge by either affirming, illuminating the differences and/or unearthing other unique ways of looking at the Task Shifting phenomenon from the personal experiences shared by these 7 counsellors in Kenya.

6:3. Recommendations

The following recommendations are linked to some key areas illuminated in the findings; research-gaps; training-gaps, social-cultural influences and infrastructural factors.

I. In absence from literature of any specific studies on counsellors who administer/manage counselling services in the country a larger study on this cadre is needed.

II. Clearly defined counsellor-training credentials for legal registration requirement(s) with the relevant counselling organization in the country should be accessible as public information to enhance general public awareness regarding counselling.

III. All level of counsellors practicing within Task shifting contexts and beyond their capacity including the peer counsellor-mentors and the freelance counsellors, require an assessment of their professional development and support needs as a matter of priority considering the likely absence of professional support from anchor-employer organizations on these levels of counsellors.

IV. Because of the likely cultural influences on counselling from the gender perspective the findings support the need for a training package/ or a sand-wished component into related skills-building training courses for lay counsellor-mentors in order to support their liaison-roles across counselling programmes, where they are deployed under the diverse Task shifting environments.

V. There is need to create community-awareness in consideration of the potential for gender related abuse particularly on women and girls in view of cultural influences on counselling.

VI. Considering the priority placed on guidance and counselling across schools in support of the youth in Kenya, the adequacy of programme-budgets needs to be explored.

VII. The contributing factors to role-conflict under the Task Shifting context need to be identified and addressed in order to enhance the psychological well-being of counselor Task-shifters and their clients, and to curb the detrimental effects on the staff, the clients and the organization as a whole.

VIII. Considering that the findings are from a representation of diverse environments (Table1) the contextual influences of Task shifting to the quality of services need to be assessed in view of acquiring the necessary staff balance around counselling referral-services according to the form of Task shifting (formal/informal) and the type and capacity of the facility where counselling is embedded.

IX. Standardised and ongoing facility-based experiential and mentored training aimed at filling identified skills-gaps across all levels of counsellor-Task shifters and other supportive staff-mix should be considered in support of counsellors who are providing services under the Task shifting context but with follow-up tracking across points of client care.

X. The critical role of the lay PLHIV /PHIV as lay counsellors need to be strengthened through standardized skills up-grading across the counselling-points of care especially at the lower level public health facilities where their role was less clearly spelt out under the formal Task shifting context.

XI. The adequacy of resources in the overall to support the different counselling programmes as well as counsellor remuneration packages need to be evaluated in support of Task shifting.

Hoyle and John (1995) posit that the diversity of professions suggest that there are different ways of being defined as 'a profession' and identify three characteristics of professions: the possession and use of expert or specialist knowledge, responsibility to clients and wider society through voluntary commitment to a set of values that goes beyond those inherent in any employment relationship and the exercise of autonomous thought and judgment. These characteristics say nothing about how professionals are organised, trained, qualified though they apply regardless of whether the practitioner is 'a professional 'in the sense of being a member of a regulated occupation or a professional body.

Thus, in order to further the development of counselling practice (Levers, Radomsky and Shefer 2009) argue for the framework of African traditional healing practices which is misunderstood through the lens of modernity. According to the authors and also some counsellor-researchers (Bojuwoye, 2005) the system of indigenous knowledge is crucial to the understanding of aspects of contemporary African cultures and hence of counselling in African settings specifically (UNAIDS, 2000, Bojuwoye, 2005)

According to (Levers et al, 2009) the cultural voice of traditional healers in Sub-Sahara Africa and cultural understanding is highly relevant to the work of professional counsellors. Counsellors and other social science professions can best face the challenge of local and global participation through inclusive rather than exclusive means, by embracing the positive aspects of indigenous healing models, and understanding the cultural implications of the healing process, rather than maintaining elitist and artificial distinctions. Such impact can only be realized by encouraging a climate that is inclusive of traditional healers and other indigenous opinion leaders and in ensuring that healers have a collaborative role in designing and implementing culturally relevant counselling and culturally sensitive psychotherapeutic strategies. Culturally responsive counselling and counsellor training could positively enhance the counselling profession across the African region.

6:4. Areas of further research

As overall findings show the counsellors would benefit from supportive counselling regulatory mechanisms such as the one stipulated in the recently approved 'Counsellors and Psychologists Act Kenya' (The Counsellors and Psychologists Act 4th August 2014). It is envisaged that the newly approved Act will benchmark the implementation of regulatory systems in support of counselling profession in the country including counselling research, through the collaborative efforts of relevant professional organizations and associations in Kenya and beyond.

6:5. Proposed research areas

1. In absence from literature of any specific studies on counsellors who administer/manage counselling services in the country a larger study on this cadre is needed.
2. Research on the supportive-role of the relevant national regulatory bodies in a collaborative effort with the relevant national professional organisations should be considered.
3. Research on the expanded roles of the Task-shifters and the process of integrating their role into formal curricula through certification, legal support, and professional regulation should be considered.
4. Further research is suggested in reference to the legal protection of the client, the Task-shifters and the community at large under Task Shifting Strategy in view of the expected growth of the counselling profession in Kenya.
5. Further research should be considered on role conflict among counsellors and their related staff cadre-mix.
6. To better understand effectiveness and roles of 'the counsellor-staff mix' further research on a clear alignment of their role-responsibilities is proposed.
7. Research on the overall professional-development needs for the different levels of counsellors, would yield relevant information in regard to training and curricula.

As reflected in the introduction (Chapter 1) and in the *Reflections on my research journey,* I have provided my readers with an extended background on 'me-the researcher' so as to open up an awareness at what might influence the perceptions, and interpretation of my research encounters with the participants. In this way I provide a framework that can be used to mark the subjectivity in my research process, in order to achieve new levels of understanding and trustworthiness in the study findings through reflexivity (Etherington, 2004).

6:6. My Final Researcher Reflexivity

From my ontological and epistemological perspective, I believe in different ways of knowing and in multiple realities, (discussed in section on ontology and epistemology) with richer and more developed understanding of complex phenomena. I therefore tend to agree with Malterud, (2001) argument that since a phenomenon may be studied from various angles the findings will lead to the understanding or new knowledge of the same phenomenon from different perspectives. I also argue that because I am an instrument in this research process my beliefs and values in this qualitative study has shaped the research process;

"A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, p.483-484).

I interviewed 8 participants in total (1 as a pilot). As it turned out 3/8 participants (2/7) in the actual study were nurse-counsellors which kept me alert on the importance of my own reflexivity (Table 1.1, participants' background). My self-reflective awareness was raised by having to work

with task-shifters some of whom were nurse-counsellors from comparable environmental contexts within which I had been based under embedded forms of counselling at some point during my career journey in Kenya (and in the Eastern African region during my programming role within HIV/AIDS context).

The need to maintain a researcher's continuous internal dialogue and critical self-evaluation in researcher's positionality (Bradbury-Jones, 2007) came to the fore prompting my awareness in my own experiences with Task shifting and how this could influence the study process and hence the findings (Etheringtom, 2004). I maintained a critical self-reflective awareness, making a continuous and progressive checks on my own potential subjectivity through the whole research process, in an effort not to misinterpret the participants' experiences (O'Leary, 2004) until I arrived at the final stages in making recommendations that are grounded in the participants' experiences.

As Giltrow, (2005, p.209) puts it, *"... it's impossible to be a disembodied researcher"* because any interaction with any part of the research influences the access, researcher-researched relationship and the researcher's world view in order to provide a balancing of the researcher's and the participants' voices for research representativeness.

As discussed in the findings, the Task shifting environments were stressful from different angles which meant, listening to signs or expressions of stress and burn out and how the counsellors dealt with the issues(s). Sometimes a participant could prompt me, *"... like I told you ... As you saw...etc."* as if to confirm that the interview was a linked process. I therefore maintained psychological lens to explore the participants' deeper meanings from the transcripts *(how said,*

appeared / looked or sounded) including from the participants' tape-recorded voices. I have indicated where participants used mixed dialect (usually we in Kenya revert to mixed dialect for deeper understanding - kind of saying it as it is) in an attempt for clearer expression of meaning.

Being reflexive challenges the view of knowledge as a product independent of the researcher producing it or knowledge as objective and enhances plausibility by securing trustworthiness in the research. I therefore used comparisons from literature including current publications, shared my professional background and relevant experiences with the Task Shifting phenomenon in addition to excerpts from my research journal.

In order to encourage greater reflection and accountability on my part as a researcher I was consciously aware (Siltanen, 2001) of the proposal that the researcher be self-conscious in articulating their role in research process so as to construct illuminated meanings in view of the participants' experiences. Hence by maintaining reflexivity through a deliberate effort to be consciously aware of my own reactions to the participants' accounts, potential or actual effect of personal, contextual, and circumstantial aspects on the research process in the interpretation of findings are brought to focus.

According to Bateson (1972, p.314) the researcher is *"bound within a net of epistemological and ontological premises which regardless of ultimate truth or falsity become partially self-validating"*. And therefore in agreement with Sanders and Wilkins, (2010) my final research reflexivity is intended to assist my audience to understand the lens (frame of reference) through which I view the world and what motivated me to do the research on the Task shifting phenomenon, how I

studied the topic or the methodology I used, and how the methodology sits with me in reference to my view of the world.

6:7. Reflections

At the time of my research proposal development (2009) I was sharply aware of my subjectivity regarding Task Shifting, the phenomenon I had chosen to study.

My reactions and my perceptions to Task shifting were linked to the huge tasks that were shifted to me, sometimes without the much needed support or preparation, and at such times, I know I felt afraid and uncertain…, in spite of the often sharp and unpredicted developmental-learning curves, with eroded …and yet, strengthened self-confidence… (Anastasia RJ 2009)

So as I set out to explore the Task shifting I was very much aware of the baggage I carried into my thesis journey and my subjectivity from my past.

Storing is in my roots among the Kikuyu community of Kenya ... my early socialization was mainly through oral storied analogies... (Anastasia RJ 2011).

In my early exploration on how stories fitted into my proposed research on Task shifting, I found out that from a research perspective human beings individually and socially lead storied lives through interpretation of past stories (Connelly and Clandinin, 2000). I therefore selected the qualitative methods of research first exploring the narrative inquiry, but eventually choosing the Thematic Analyses Methodology expecting to gather detailed inter-related stories of participants'

experiences with Task shifting in order to get the underlying meaning in its complexity (Braun and Clarke 2006).

To remain reflexive I aimed to keep an awareness of my insider/outsider perspective as a nurse /midwife practitioner and the major roles I played in the development and evaluation of the short-form counselling training programmes through my programming work in HIV-AIDS in the eastern and southern African region.

As a collaborator with participants in my research journey (Breen, 2007) I aimed to remain consciously aware in a deliberate effort to listen to the participants' stories of experience through their own lenses, and not through the lens of my own experience.

I was surprised that the baggage I had carried all along on task shifting seems to have ebbed away somehow... (Anastasia RJ – undated)

I was prompted by something in these words from my Supervisor *(Anastasia RJ – undated);*

Recently, we have been involved in discussions about the extent to which undertaking research can constitute some sort of personal therapy or, at least, facilitate personal development. We urge our counselling students to maintain a reflective log in their counselling training, documenting shifts and changes in their responses to training, client work and personal development group activities so developing their reflective thinking and internal supervision. Research activities offer the same opportunity for self-development. Undertaking research does things to us; we can be grabbed by

the research because of something in the phenomenon that connects with us, (Lennie and West, 2010, p. 87).

This was a gradual process for me for and, I was not consciously aware of - or even that it was - I was healing... (Task shifting, my baggage - Healing… Anastasia RJ – undated)

I believe this process must have been going on subconsciously? But at some point I began to consciously go back to my life, retrace my live-steps so to speak. (Anastasia RJ At some point - undated)

Our parent's wisdom saw us through school and I had started at early age, away from home to live with relatives some of whom we only knew by name from the family tree. A confusing time for the young. For me. (Anastasia RJ – 2014)

At some point when I was still a young girl I would bring up the topic but my brother who went away with me to school would say in our language (Tondu uririkanaga maundu ma teene!" (Like why do you like to remember those old things 'that old story?) Many times he would put me off but occasionally he indulged me - We would discuss those times later with some misgivings and partly with painful nostalgia. (Anastasia RJ – 2014)

February-March 2016 - *I wondered why it had seemed so important and vivid to me before - Task shifting (Anastasia RJ 2015). There must have been something else connected to something deeper, distant and yet close and personal. (Anastasia RJ 2016).*

Was I, were we task-shifted, to relatives I mean? I value, has always admired mom and dad's wisdom to see us through school and college – it changed all (us 7 siblings) of our lives. Without it (education) we would have probably turned out as casual laborers in some firm like some of the other children we grew up with. But I loathed those early years! (Anastasia RJ 2014)

And yes we were task-shifted to some relatives too tied up with their own young families, for a couple of years. And then yes - we were a family again and then I seem to have forgotten? Until nursing school when it all began to come back, task shifting... (1970s). (Anastasia RJ 2016)

But it was difficult, indeed impossible to pin it down on anything personal or anybody in particular? As I write now I am aware that I healed of those old wounds since my nurse-student days? As I reflect on the literature, I know this had a lot to do with the changes I have all along experienced during this research journey.

And so, I embrace the task-shifting phenomenon, accepting it as an innovative model to ease the burden of human resource shortages in my country and in the world. I also take back my life for I have embraced and come to terms with it (task shifting) through the lows and the highs along with my relatives and my family as a shared responsibility from our African cultural context. (Anastasia RJ 2014-2016)

6:8.My experienced reflexivity

I saw my role in this research as a collaborator in the research process. I wished to retain the voices of my participants to illuminate their determined positive regard to counselling, their negative or even painful experiences *(At this point I would straggle with how much of these voices*

I could retain verbatim and was constantly straggling with how much I could include in my small study on the experiences of Task Shifting experiences).

As it turned out these counsellors' journey was also a journey of hope for their counselling career, counselling as a profession, counselling as work to earn their livelihood. But *in a special way some among them who were without anchoring employer organisational-support seemed more exposed to doubt.* This aspect illuminated the importance of regularization of counselling and the necessity of having hardy professional guidelines to support counselling practice within the Task shifting context.

As I reflect back on Lennie and West, (2010) urging counselling students to maintain a reflective journal for internal supervision and opportunities for self-development, I have to own up that I have grown through the experience - been molded by the journey. I can discuss Task shifting without my deep-rooted hang-ups from my past experiences.

In discussing my narrative findings I am consciously aware of my ontological and epistemological view of the world in urge for richer and deeper understanding in the complexity of the Task shifting phenomena through different ways of knowing and multiple realities.

As an instrument in the research process my perspective has inevitably influenced these findings – and so I have as much as possible retained the participants' voices in support of their experiences.

I know I would wish to retain the Thematic Analysis Methodology (Braun and Clarke 2006) in future projects for masterly. I would also wish to learn more collaborative methodologies to

qualitative research for further self-development. In particular I would wish to work in a qualitative study where participants are part of the interpretative research process (Reason and Bradbury-Huang, 2007; West, 2013).

Finally, I have learnt the importance of being consciously reflexive and in regularly inputting into my reflexive journal.

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PARTICIPANT RECRUITMENT PROCESS:

Appendix 1: Participant Information Sheet (Advertisement)

Student Anastasia C. W. Ndiritu DJK/DCouns (Kenya) / 7418750

Study Title Exploration into the Influence of Task Shifting on Counselling and the Related Services including HIV-AIDS at the Counselling Agencies *(units/ centers/ facilities* in Kenya - "Experiences of Counsellor Administrator-Managers"

I am planning to undertake this study for my doctorate studies with the University of Manchester UK. My interest is your experience on this topic and I shall be asking questions and giving you an opportunity to give me your own views or perceptions on the influences of task-shifting on HIV-AIDS agencies or centers.

If you are interested and willing to participate in my study, I will request that you take time to think about it and please give me your decision in the next two weeks after which we shall organize a face to face interview at our convenient time including on Saturdays;.

I will tape-record the interview(s) to allow us capture your experiences fully for our reference later in order to ensure that we have captured your story accurately and to address any areas of omission, concern or any questions that you may have following the interview.

I will then transcribe the interview data as soon as possible within the next week or so for analysis and contact you again so that I can share with you the transcribed interview for your clarification and to allow you an opportunity to add any further ideas or to clarify any areas for better understanding and accuracy of your story.

Confidentiality

To assist you in your decision to participate in my study, please note that during the whole research process I shall maintain confidentiality and anonymity by removing all the identifiers from the transcribed data and by not including your actual name, your employer organization or places that you may mention during the research process.

I shall not share the raw data i.e. identifiable information (tape-recorded transcripts or any written information).

I shall however share un-identifiable data with my doctorate supervisors for guidance and support but my supervisors will not have access to any of your identifying information.

Following my completion of the data analysis and after my thesis study has been approved by the University of Manchester; I shall destroy all raw data and tape-recorded transcripts within a stipulated period by the university.

Right to withdraw

I want to you to understand that your participation in my study is entirely on voluntary basis and that you have a right to change your mind or withdraw from participation at any stage without fear of any repercussions or giving me any reasons for your decision to withdraw.

Counsellor support during the study

Sharing experiences involves recall of information and at times this may become stressful to you during the process of the interview. If you choose to participate in my study, I shall request that you let me know in case the interview becomes distressful to you, if you would like to stop or to postpone the session or withdraw from the study.

I shall organize for a debriefing session with you following your participation, should you wish for me to do so.

Publication of Research Findings

I shall submit my study findings to the University of Manchester – UK, in fulfillment of my Counselling Doctorate Degree. The study may be submitted for publication in professional journals and I could present the findings at conferences and other professional forums in future.

I shall avail a summary of the research findings to you, if you so wish.

Should you choose to participate, you will do so on an on-going, verbal-informed consent. We shall review this consent at any time if you so wish in future and I will be happy to answer any questions regarding your participation in my study.

This information is given to you to enhance your understanding of my intentions for my planned study.

Do please sign here below to confirm that you understand and accept this information as guidance to participating in my study.

Participant's Name and signature:

You may reach me on this cell number below to inform me of your decision during the next two weeks:

Anastasia C. W. Ndiritu

Cell Number 0702 162 108

Researcher

Appendix 2: Consent to participate in the Pilot-study

Counselling Task-Shifting (TS) in HIV & AIDS Arena

An Interview Guide

I am a part-time doctorate student of the University of Manchester and wish to request you to participate in a pilot interview for my doctoral-thesis proposal development "the influence{s} of task-shifting on counsellors and counselling"

You have been identified as a key counsellor who would wish to participate willingly in my study based on your training and experience as (***a counselling service provider,*** *policy maker, programme manager)**.***

We shall use an open/ongoing consent.

Please read this key-informant interview guide and feel free to ask me for any clarification(s) or elaboration or ask me to read it for you. I shall leave a copy of this interview guide with you for your keeping. You are free to ask me for any further information or clarification (face to face, telephone or through email).

You are freely agreeing to participate in my pilot study and you may terminate from the study at any time.

Bases for this pilot-study

The task-shifting model of care delivery is a common occurrence and especially in HIV & AIDS care and has been strengthened in Kenya as in many other sub-Saharan countries in order to cope with the severe shortages of staff and care givers

Procedure

If you agree to take part in the study, I shall personally interview you for an agreed period of time depending on your availability.

I will ask you to share your counselling experience and knowledge on task-shifting. I shall tape record the interview so as to make sure that the information is not lost, and to allow you and I further clarification, questions, or additions. After the interview, I shall store the tape(s) safely in a computer data-base after ensuring that I have removed all the identifiable data replacing it with coded numbers so that only I shall be able to avail it for transcription and analysis from the computer so that answers can never be traced back to you. Only I (or my supervisor) will have access to these transcripts.

There are no foreseeable risks to you for participating in this pilot study. Although you will not receive immediate benefit from participating in this pilot study, you will be contributing to further clarifications on the interview guide for the main study that I shall undertake in task-shifting after my proposal has been approved by University of Manchester Ethics committees (from July 2011) and which I hope shall contribute to a home-grown knowledge base in identifying the counsellor-administrators task-shifting lived experiences in HIV & AIDS arena in Kenya.

Withdrawing participation

You are free to refuse to participate in this study interview(s) and to withdraw at any time. You are equally free to refrain from answering any specific questions and such refusal will not affect you in anyway.

If you have additional questions or any complaints about the study please raise them with me:

Anastasia C. W. Ndiritu

Counselling Doctorate Student

University of Manchester

Po Box 16091 00 100

NAIROBI, Kenya

Cellphone +254 722 493 459

Appendix 3: Copy - Ethical Approval Email

From: Anastasia Ndiritu <wagithinji2006@yahoo.com>
Subject: Re: Ethics Approval Application - CONFIRMATION for Low Risk
To: "Ethics Education" <ethics.education@manchester.ac.uk>
Cc: "William West" <william.west@manchester.ac.uk>, FRJFAY@aol.com
Date: Thursday, January 5, 2012, 9:48 PM

Dear Gail,
Thanks very much for this good news! I shall keep my supervisors informed.
Kind regards for the new year.
Anastasia

--- On **Thu, 1/5/12, Ethics Education *<ethics.education@manchester.ac.uk>*** wrote:

From: Ethics Education <ethics.education@manchester.ac.uk>
Subject: Ethics Approval Application - CONFIRMATION for Low Risk
To: "Wagithinji2006@yahoo.com" <Wagithinji2006@yahoo.com>
Cc: "William West" <william.west@manchester.ac.uk>
Date: Thursday, January 5, 2012, 5:42 AM

Dear Anastasia,
Ref: PGR-7418750-A1
Apologies for the delay in getting this confirmation to you,
Your ethics application has been confirmed as Low Risk by your supervisor and the School Research Integrity Committee (RIC) against a pre-approved UREC template.
Please accept this email as confirmation that you are now able to carry out your research. If anything untoward happens during your research then please ensure you make your supervisor aware who can then raise it with the School Research Integrity Committee on your behalf.
Regards
Gail Divall
PGT & Quality Assurance Administrator
School of Education
Tel: +44(0)161 275 3390
Working Week: Tues - Fri
http://www.education.manchester.ac.uk
http://www.education.manchester.ac.uk/intranet/

Appendix 4: Interview Guide

Student Anastasia C. W. Ndiritu DJK/DCouns (Kenya) / 7418750

Study Title Exploration into the Influence of Task Shifting on HIV-AIDS Agencies (units/ centers/ facilities) in Kenya "The Experiences of Counsellor-Administrator-Managers"

1. Let us begin by you telling me about yourself that is; your designated work-title, your educational background and your professional training.

2. How would you describe the counselling environment here at this facility?

3. Who is responsible for ensuring quality counselling services here and how is this done?

4. What are your views regarding supervisory support under task-shifting environment?

5. How would you define Task-Shifting within the HIV & AIDS counselling and how does the task-shifting approach influence your role as an administrator or manager within this counselling center or unit?