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Challenges of Counselling Domestic Violence Survivors in Kibera Slum- Kenya: MSF-B Experience

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Abstract:
Counselling Domestic violence survivors remains a challenge in the modern world with little clear distinction between counseling, advising and confronting clients. This paper was presented in the KAPC 7th Annual conference September 2006 that brought together over one thousand counseling/ psychologist's fraternity from all over the world at Safari Park Hotel in Nairobi Kenya to share practical challenges in counseling field. The paper explored the Counselling challenges faced in dealing domestic violence / HIV/AIDS survivors in Kibera Slum in Kenya during the study period. Welcome and journey with us in this thrilling and painful encounter.
Methodologically, the paper utilized primary data collection based on practical experience of the counselors with the client for a period of over four year's follow-up sessions through clinic appointments. Secondary data was basically drawn from medical records coupled with artistic lenses to conceal the client's identity but remaining focused to bring out her true experience.

Keywords: *Counselling, challenges, domestic violence, Kibera Slum*

1. Introduction

The material for this article comes from our own experiences in working with survivors of domestic violet client on HAART for the past 15 years coupled with the experiences of other counselors detailing the stresses they encountered within this field. The counselors work within the voluntary, public and private sectors. Some with agencies whose sole focus is working with survivors of domestic violence, sexual abuse and HIV/AIDS for example Medicins Sans Frontieres Belgium (MSF-B) in collaboration with Nairobi Women Hospital Sexual Gender Based Violence (SGBV) center during the research period. Not surprisingly, the low resource setting in which the counsellors work, combined with the degree and intensity of contact, have had a direct effect upon the counsellors in either promoting or disintegrating stress.

HIV testing and Counseling is the entry point to HIV-related care and support, including antiretroviral therapy World Health Organization (WHO 2006). This paper explored the challenges faced by counselors working with MSF's Medical interventions for survivors of SGBV/ HIV/AIDS. The paper was based on personal coupled with colleague's experiences with one of the client's encounter that was rated one of the best presentations during the Kenya Association of Professional Counsellors (KAPC) 7th annual conference at Safari park hotel in Nairobi in 2006. While at the same time it was the most difficult client case that posed quite a challenge to Counsellors who journeyed her inner world.

Medecins Sans Frontieres (MSF) is an international, independent, medical humanitarian organization that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from health care and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender, or political affiliation (www.msf.org).

MSF has been continuously working in Kenya since 1987. It was the first organization to provide free antiretroviral (ARV) therapy in public health facilities in Kenya. MSF –B established programs in Nairobi's Kibera slum in 1997 to provide urgent medical care, such as for people living with HIV/AIDS and survivors of Sexual Gender Based Violence (SGBV). The Kibera South and Silanga health centers are run jointly by MSF and the Ministry of Health (MoH) County of Nairobi.

According to United Nations General Assembly (1993) Domestic Violence is defined as *"Any act of gender-based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether accusing in public or private"*.
SGBV continues to be a major social and medical issue of concern in the slums of Nairobi. Each month (during the study period) many went to MSF clinics for treatment in Kibera slum. It is in view of this that the paper sought to highlight and address challenges of counselling survivors of domestic violence who are also co-infected with the HIV virus.

2. Research Methodology
The focus of our presentation was practical based experience of one of the sessions identified as most challenging. The reason being, the client presented with multiple issues which included living with HIV and AIDS and related illnesses such as Kaposis Sacoma Cryptococcus meningitis, losing sight, with a 6 months old baby and facing domestic violence from her husband. It's important to note that majority of survivors of domestic violence are women. The presentation focused on one woman's experience.

2.1. This is Her Story!!!

- "I regret that I am alive because I have lost the zeal for life. I am broken-hearted. I live in a situation which overwhelms me. My wounds get deeper every day. I am constantly mourning. He comes home demanding food that He never provides for. He leaves me with 20 shillings' coins *(equivalent to 0.20076 UDS)* which He splashes on the floor to let me collect knowing very well I don't see because I am blind…. what food can 20 shillings buy? Isn't this the cause of my child's malnutrition? See how the child looks!!!! *"She breaks down with tears streaming down"*.

Narrates a 21-year-old lady on HAART, who went blind four years after she was initiated on ARVs, with swollen face from beatings as she cuddled her 6-month old baby.
Yet, WHO (2006) recommends that *"when replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS), its best that HIV-infected mothers avoid breastfeeding"*. This was and still is an elusive concept to Jane (*not her real name*).

Figure 1: Her Untold Story Continues….
Source: (Field data 2006)

3. Results and Discussion
It's hard to measure the intensity of emotions experienced by the counselors in this session but only to imagine. Burnout due to counter-transference was observed to have been experienced by a colleague counselor, who also had an actual experience with Jane and confided, *"At one point I felt like slapping her, I saw my kid sister in Jane, I longed to beat some sense into her head"*.
Fear for clients' safety, feelings of powerlessness and helplessness for the counselor. At this point, the counselor expressed the feelings of omnipotence ("wanting to safe the client to stop all the abuses and suffering" and "feeling responsible for the clients healing" and importance not being able to offer enough in the face of my clients' needs', with the experience of trying to get it right and feeling like failing most the of time all the while knowing that the client's abuse can never be redeemed) (Kafry and Pines 1980). These feelings increase the demands and challenges of this work according to Corey, (2000).

Edelwich (1980) claims there are no evidence for a cause-effect relationship between facilitative conditions and positive outcome. Blamer, (1992)) on the other hand backs up this argument by pointing out *that "if the counsellor's condition in the relationship is important, then what happens when the counsellor is troubled or does not like the client?"* We however disagree on one hand and agree on the other with these critics on the issue in discussion. In our practical experience, the relationship in any form of communication dictates the results. However, we also wonder if it is the personality of the counsellor rather than the techniques that is important, then why have Counselling training? Conclusively the relationship is probably reviewed as highly complex one in which the offered core conditions can at times hinder or enhance the client's movement.

How do we deal with the hopelessness of a suffering client going back to the source of her suffering? – what effect does this have on a counselor? Where do we draw the line between African culture, ethics, humanity and still maintaining professionalism in the session?

4. Conclusion and Recommendations

The only therapeutic moments seem to be those, where the Counsellor is ready to enter the client's darkness and just be there together with them. To share the suffering and pain for those few minutes of a session, and to allow the client to decide what to do: even if it means, going back to her source of suffering without judging them for being so *'ignorant'* and enduring the violence, without pushing them to get out. Just be there and let them be! For the Lord say *"when the cares of my heart are many, your consolation cheers my soul''* (Psalm 94:19) (Collins, 1994).

On the other hand, Ellis (1984) comments that, the counsellors should ferret out the absolutistic philosophies and perfectionist demands that seem to underlie their difficulties. An additional and connected phenomenon to this theme was demonstrated by Hellman *et al.* (1987) who showed that more rigid counsellors reported greater levels of stress compared to their flexible counterparts.

To combat these pressures, two important strategies for the counsellors recommended were to; adopt the role of personal counselling and supervision which gave them essential and realistic feedback. If counsellors recognized their own wounds and become involved in their own self-healing, the risks to their clients would be minimised.

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