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RESEARCH ARTICLE

COUNSELING SKILL, KNOWLEDGE, AND SELF-CONFIDENCE OF ADOLESCENT HEALTH COUNSELORS WORKING IN WEST BENGAL, INDIA

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ABSTRACT

INTRODUCTION

The impact of counseling on adolescent health and well-being has been well documented. The task-shifting in India's Adolescent health program, from medical to non-medical cadres, necessitates understanding and capacity building of workers' knowledge and skills.

OBJECTIVE

To assess distribution and determinants of self-rated knowledge, skill and confidence of counseling among adolescent counselors and to explore the demand for learning new skills.

METHODS

This was an observational study of cross-sectional design on adolescent counselors working under the National adolescent health program. Participants completed a self-administered electronic survey form, where they self-rated their knowledge, counseling skill and confidence on a six-point Likert scale. Mean ratings were dichotomized into high (≥4) or low (<4). Nominal regression analysis was performed to identify predictors of high rating. Counselors were also asked to identify areas where they require additional training.

RESULTS

The mean age of counselors was 36.22 years (SD 6.08) and mean service duration was 7.37 years (SD 4.51); 80.2% had completed refresher training. Post-graduation level of education has been achieved by 87.2% of counselors and 86% gave high rating for all domains. High rating was associated with the participant's mother tongue, place of service and education level by univariate analysis but on nominal regression, it was associated with education level only. The need for additional training was expressed by 67.4% of participants, among which the most common was mental health.

CONCLUSION

The rating of knowledge, counseling skill and confidence was high. Recruiting qualified counselors and clearly defined procedures appears to help in smooth task shifting.

KEYWORDS

adolescent health, counselors, health promotion, mental health, national health program.

INTRODUCTION

India is home to 253 million adolescents, comprising more than 20% of the world's adolescent population. In 2014, The Ministry of Health and Family Welfare, Government of India, under the National Health Mission (NHM) launched the Rashtriya Kishor Swasthya Karyakram (RKSK), a comprehensive adolescent health program, to achieve better health outcomes for all adolescents. The key intervention under this program is to provide quality information and counseling opportunities through adolescent-friendly health clinics (AFHC). [1] The impact of counseling on adolescent health and wellbeing has been shown in several studies from India and outside India. [2, 3] In the RKSK program there is task shifting from medical to non-medical staff, so new opportunities and challenges have emerged. The World Health Organization (WHO) recommends task-shifting as a strategy to tide over the shortage of health manpower and rational redistribution of tasks among health workforce teams. [4] While counselors can make healthcare services for adolescents more accessible, the quality of service provided needs to be assured.

LITERATURE REVIEW

A literature review was conducted by searching PUBMED, DOAJ and Google Scholar. Search terms used were adolescent counselor, task shifting, counseling skill, adolescent health program and RKSK program. A study on pre-refresher training evaluation of knowledge among HIV lay counselors in Zambia, reported poor knowledge on standard precautions and post-exposure prophylaxis (PEP).[5] In Uganda, health-workers providing pediatric HIV counseling mentioned challenges of poor counseling skill and difficulty in coping with knowledge demand.[6] A rapid review of RKSK has pointed out a lack of system to measure quality and content of counseling.[7] Self-evaluation of knowledge and skills can help to identify training needs of counselors which may provide useful inputs to capacity building and designing more client-centered programs. This study was therefore planned with the following objectives to -

- assess self-rated knowledge, skill and confidence of counseling on issues included in RKSK modules among adolescent counselors
- explore demographic, academic and service-related determinants for higher self- rating
- find out the training demand for new skills

METHODS

This is an observational study of cross-sectional design that adhered to the STROBE guidelines. RKSK counselors working in the state of West Bengal, India and who had completed induction training were eligible to participate. Data collection was by self-administered online survey forms between October to November 2021.

The study protocol was approved by the institutional ethics committee of the Medical College Kolkata with ref no.MC/KOL/IEC/NON-SPON/1202/10/21. Informed consent to participate was provided by all participants. The survey form auto-generated the raw data sheet which did not include any personal identifier.

RKSK PROGRAM AND TRAINING

Adolescent counselors were posted at the AFHCs and were trained to deliver services as per RKSK modules, which include - nutrition, sexual and reproductive health, addiction and substance misuse, violence and injury including gender-based violence, non-communicable diseases (NCD) prevention and mental health. Counselors initially received a six-day induction training which has been followed up with refresher training after a gap of at-least two years. The content, duration and methodology of both training were same. Training sessions were participatory. Pre- and post-training knowledge improvement was checked by a standard questionnaire which was included with the facilitator's module.

STUDY DESIGN

By checking training schedules, it was found that there were 440 trained counselors. The study target was to recruit 20% of the counselors or around 90 participants. Considering generally high non-response rates for online surveys, participant recruitment target was kept at 30% or higher. [8] Participants were recruited by stratified sampling, where strata were the post-test training scores. Eligible counselors were categorized into tertiles according to their post-test score of last training. From each of highest, middle and lowest tertiles 40 counselors were randomly invited to participate in this study. All the invitees were sent a link to the survey form at their mail ids. The survey form was developed from training elements of the RKSK module and content was validated by three experts in public health and sociology.

Variables included for data collection were demographic variables like age, sex, education and mother tongue;

service-related variables like duration of service, level of institution and area of service; and finally the primary outcome of interest was self-rating of knowledge, skill and confidence of counseling. Rating was done on a six-point Likert scale, one being poorest and six being best. Participants were also asked to identify adolescent health issues on which they need more training.

STATISTICS

Statistical Package for Social Sciences (SPSS) IBM Corp. Released 2010 (IBM SPSS Statistics for Windows, Version 19.0. Armonk, NY: IBM Corp. United States of America) was used for statistical analyses. Distribution of variables is shown by frequencies, percentages for categorical and mean (SD) for continuous data. Mean rating for knowledge, skill and confidence was separately calculated. Participants, whose mean rating was ≥4 for all three domains, were considered to have high self-rating. The alternate category was low self-rating. Nominal regression analysis was done to predict factors for differential self-rating.

RESULTS

Results were analyzed for 86 completed questionnaires (response rate 71.6%). The mean age of counselors was 36.22 years (SD 6.08) and mean service duration was 7.37 years (SD 4.51). The majority of the respondents (60.5%) were above or equal to thirty-five years of age and female (80.2%). More than half of the respondents (55.8%) had service experience of more than and equal to five years and received both induction and refresher training (80.2%). Most counselors (84.9%) worked in rural areas; hence, most had no experience working in a tertiary care setup. Most of them acquired post-graduation qualifications in humanities. (Table 1)

Knowledge and counseling skills were assessed based on the different areas of their training module. Table 2 describes the mean and standard deviation of self-rated knowledge and counseling skill of RKSK counselors on adolescent health issues. Though in almost all the domains they had higher knowledge and skill (>=4), the highest knowledge and skill was acquired in menstrual hygiene followed by Body Mass Index (BMI) calculation and the lowest knowledge was in internet use and cyber safety related issues (<4) as per the working definition of the study.

In all the domains their confidence in handling the clients was high as per the study definition. (Table. 3) Participants expressed that they felt maximum confidence in maintaining privacy and confidentiality (mean score 5.19 and SD 1.17), which is crucial for handling delicate clients like adolescents. Whereas their confidence was minimum in handling clients of third gender (mean score 4.05 and SD 1.31). A high rating in all three domains, namely knowledge, counseling skill and confidence was given by 74 (86%) respondents.

Finally, the predictors of high rating among the counselors by nominal regression analysis were assessed. Participant's mother tongue, service area, as well as education level, were associated with the rating pattern. Education level alone came as the strongest predictor during multiple regression analysis. (Table 4).

Additional training need was expressed by 58 out of 86 (67.4%) of participants. The major requirements of training were mental health (40.7%), cyber-security and internet usage (29.1%), life skills (18.6%), addiction (16.3%), sexuality and gender roles (11.6%), injury and violence (10.5%) and learning problems (9.3%)

TABLE 1. DISTRIBUTION OF COUNSELORS ACCORDING TO THEIR DEMOGRAPHIC, ACADEMIC AND SERVICE-RELATED PROFILES (N=86)

Variables	Frequency (%)
Age	
<35years	34(39.5)
≥ 35 years	52(60.5)
Sex	
Male	17 (19.8)
Female	69 (80.2)
Mother tongue	
Bengali	83 (96.5)
Others	3 (3.5)

Duration of service	
<5years	38 (44.2)
≥ 5 years	48 (55.8)
Training received	
Induction	17 (19.8)
Refresher	69 (80.2)
Service area	
Rural	73 (84.9)
Urban	8 (9.3)
Both	5 (5.8)
Whether working at tertiary level	
Yes	20 (23.3)
No	66 (76.7)
Education level	
Graduation	11 (12.8)
Post-graduation	75 (87.2)
Branch of study	
Science	11 (12.8)
Humanities	75 (87.0)

TABLE 2. MEAN SELF-RATED KNOWLEDGE AND COUNSELLING SKILL OF ADOLESCENT HEALTH COUNSELORS ON ADOLESCENT HEALTH ISSUES (N=86)

Items	Knowledge mean (SD)	Counselling Skill mean (SD)
Adolescent growth & puberty	4.90 (1.05)	4.92(1.04)
Menstrual hygiene	5.21 (1.04)	5.22(1.03)
Contraceptive choice	4.86 (1.13)	4.88(1.10)
Adolescent pregnancy	4.83 (1.17)	4.94 (1.09)
Safe abortion	4.34 (1.00)	4.44 (1.02)
Prevention of RTI/STI	4.86 (1.15)	4.93 (1.18)
NCD risk factors	4.71 (1.23)	4.72 (1.24)
BMI calculation	5.16 (1.09)	5.10 (1.09)
Balanced diet	4.94 (1.10)	4.84 (1.16)
Harmful use of substances	4.90 (1.12)	4.79 (1.07)
Violence and injury	4.47 (1.03)	4.28 (0.98)
Gender roles	4.63 (1.13)	4.56 (1.21)
Internet use & Cyber safety	3.86 (1.05)	3.83 (1.15)
Mental health issues	4.38 (1.09)	4.22(0.99)
Severity categorization of mental health problems	4.15 (1.08)	4.12 (1.02)
Health promotion	4.36 (1.03)	4.35 (1.00)

TABLE 3. MEAN SELF-RATING OF COUNSELING CONFIDENCE OF ADOLESCENT HEALTH COUNSELORS (N=86)

Confidence in conducting counseling sessions in given situations	Mean (SD)
Clients of the opposite gender	4.70 (1.21)
Clients of the third gender	4.05 (1.31)
Counseling parents	4.50 (1.24)
Discussing sensitive issues in school-based counseling	4.92 (1.14)
Maintaining privacy and confidentiality	5.19 (1.17)
Overcoming language barrier	4.73 (1.13)
Retaining clients	4.64 (1.05)

TABLE 4. PREDICTORS OF HIGH RATING AMONG THE COUNSELORS BY NOMINAL REGRESSION ANALYSIS (N=86)

Variable	Percentage of high rating	Likelihood ratio test		Exp (B)	Sig
		Chi-square	Sig		
Age					
<35years	94	0.25	0.62	0.60	0.62
≥ 35 years#	81				
Sex					
Female	86	1.06	0.30	0.32	0.29
Male #	88				
Mother tongue					
Bengali	86	5.54	0.02*	2.936E8	--
Others#	100				
Duration of service					
<5years	92	3.60	0.06	0.10	0.09
≥ 5 years#	81				
Training received					
Induction	82	1.49	0.22	3.09	0.21
Refresher#	87				
Service area					
Both	100	14.19	0.001†	2.66E-17	0.99
Rural	86			2.721E-9	0.99
Urban#	75				
Whether working at tertiary level					
No	83	12.87	<0.001†	3.827E8	0.99
Yes#	95				
Education level					
Graduation	81	5.74	0.02*	52.80	0.04*
Post-graduation#	87				
Branch of study					
Humanities	84	3.36	0.07	1.246E7	0.99
Science	100				

Reference category; *p<0.05, † p<0.01

DISCUSSION

As opposed to community or school-based projects for adolescent health promotion, RKSK is a country wide national program with much larger coverage and impact. Rewarding cost effectiveness is expected with investment in adolescent health.[9] This study is probably the first to explore the perception of prime driver to adolescent health care delivery in India-RKSK counselors. Since its inception seven years ago, RKSK program is still in a stage of evolution. An intervention study conducted on adolescent health services in six states of India, reported availability of trained counselors in only 27% of adolescent friendly health clinics at baseline which improved to 54% post intervention. [10] After an extensive literature search in PubMed, Embase, DOAJ and Google Scholar using an advanced search strategy, no yield was obtained which specifically assessed counseling skill and knowledge of adolescent counselors. The mean age and service duration of present study participants agreed with a study done on Ugandan HIV providers. [11] Mean age also agreed with a study on adolescent HIV providers of Kenya, however participants of our study had higher education levels and service experience as only 27.5% of respondents in the Kenyan study started a degree program and had median service experience of four years. [12] In the Kenyan study the median competence score was high, and it was statistically significant for training and years of experience in adolescent HIV care. Our study too reported high rating but it did not vary with type of training or years of service experience and education level emerged as the most important predictor in our study. Differences in results can be accounted by higher education level and homogenous group of counselors against a heterogeneous group of health workers in the Kenyan study. [12] In the Ugandan study perceived self-efficacy was high (mean 7.6 on a ten-point response scale), which compares favorably with current study. In both studies higher self-confidence rating was for items that had clearly defined procedures like maintaining confidentiality in current study and counseling people living with HIV (PLHIV) to start ART early, in the comparator study. [11] Almost two-third of respondents in the present study expressed need for further training which compares well with the Kenyan study where 55% respondents who had training in adolescent HIV care expressed need for refresher training. [12] Higher training need was reported for relatively poorly rated skills like mental health and cyber safety. It is estimated that 10% of children and young people suffer from mental health problems. [13] Cyber victimization is a new phenomenon without any agreed upon definition. However, studies around the world report high prevalence of this emerging phenomenon and its association with adverse mental health outcome among adolescents. [14-16] Relatively poor knowledge and skill of counselors to address this issue is of concern.

LIMITATIONS

This study adds new information which can be successfully used in planning adolescent health care; however, some limitations of this study are high non-response and unknown self-selection pattern of online responses, reliance on self-reported data and newly developed measures.

CONCLUSION

From the study results it can be concluded, qualified counselors will help in smooth task shifting, while clearly defined procedures may improve counseling quality. It is both reassuring and of concern that most counselors identified specific areas for further training, especially in adolescent mental health issues and cyber safety which are critical areas gaining momentum in the lives of present-day adolescents.

Given the future impact of adolescent health counseling, it is recommended that counselors with post-graduate qualifications are to be recruited. Along with present induction and refresher training, focused training is required on mental health and cyber-safety issues.

SIGNIFICANCE OF THE STUDY

This is possibly the only study conducted in India to understand the capacity and training needs of adolescent counselors. Findings of this study will likely improve the reach and depth of RKSK program and in turn the nation's health.

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The authors declare that the research was conducted in the absence of any commercial or financial relationships.

CONFLICTS OF INTEREST

There are no conflicts of interest.

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