

A close-up photograph of a hand reaching out, with fingers slightly spread. The hand is the central focus, set against a blurred background of warm, golden-yellow light. The overall image has a blue tint, particularly in the lower half where the text is located. The hand appears to be reaching towards the viewer, symbolizing communication, support, and care.

Interpersonal Communication and Counselling Manual

On HIV and AIDS

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Session 1- OPENING SESSION

- 1.1. **Arrival, registration and tagging**
- 1.2. **Pre-workshop questionnaires** are handed to participants as they register. As these questionnaires are filled they are collected and collated by the facilitators. These Questionnaires are then analysed in order to establish participant's entry knowledge, attitude and skills on HIV and AIDS, Peer Education and Training of Peer Educators.
- 1.3. **Welcome Address**
The FHI/Staff or Consultant welcomes everyone to the workshop.
- 1.4. **Who Is Here?**
The following exercise is conducted as a means of helping participants set the climate for the workshop:

Stepping Stones

Specific Objectives:

- To frame introductions in a historical perspective
- To learn where the various participants have come from and to hear what is important to them

Materials: None

Time: Dependent on size of the group

Procedure:

1. Ask participants to work in pairs, interviewing each other. Each should choose 3-4 key important events or "stepping stones" in their lives that are significant in bringing them to this point (and to the workshop).
Stepping stones may be:
 - Name in full
 - Formal training experience
 - Changes in career, job experience
 - Any other key event or stepping stone
2. Start them off by giving an example of your own stepping stones. By mentioning something funny or irrelevant you can show that this is not too serious.
3. Participants can then feed back their chosen stepping stones to the group. This can be done in a number of ways—directly to the group, by paired introductions or visually by displaying the stepping stones for group inspection.
4. Conclude introduction by mentioning preferred workshop name.

1.5 Workshop Expectations, Concerns, Goal and Objectives

Objectives:

To enable participants to discuss what they intend to achieve at the workshop and to identify what might hinder their success

Time: 10 minutes

Materials: Felt pen, flip charts, markers

Process:

- Introduce the session to participants
- Sit participants in semicircle
- Go around the group to mention what individual hopes to achieve during the training
- Skip whoever is not ready during the first round in order to give room for him/her to think it through
- Revisit those who cannot respond
- Jot down responses
- Go the third round in opposite direction from first round and ask participants to state clearly what they think can hinder their ability to function positively during the training
- Jot down responses
- Trainer clarifies issues by addressing the expected fears and, so that hopes are not dashed, tackling them as need arises

1.6 Setting Ground Rules

Objectives:

Participants and facilitators set rules to guide the conduct of the training, especially those rules that will establish a safe space for all participants.

Time: 30 minutes

Materials: Flipchart, markers

Process:

1. Ask participants to name those rules they know will enable the workshop to proceed smoothly and create a safe space for everyone at the workshop.
2. Generate a list based on their comments. Ensure that the following issues are dealt with:
 - a. Confidentiality
 - b. Listening with respect
 - c. Using language with which participants are more comfortable
 - d. Interrupting the process to confront oppression
 - e. Admitting that feelings are O.K, i.e. agreeing to give people the space they need to laugh or cry and to express their feelings
 - f. Agreeing to try on new ideas, feelings, etc
 - g. Accepting that it is okay to pass (trainer could introduce the concept of passing the ribbon now)
 - h. Giving each person the right to self-identity

Session 2- OVERVIEW OF THE FHI/IMPACT PROJECT

Objectives:

To update participants' knowledge of the history of the FHI/IMPACT project in Nigeria, its key stakeholders, project locations and key project strategies

Time: One hour

Material: Flipchart, markers

Process:

- Ask participants to give the full meaning of the following acronyms/ abbreviations and to clarify as appropriate:
 - FHI:** Family Health International
 - USAID:** United States Agency for International Development
 - IMPACT:** Implementing AIDS Prevention and Care
 - NACA:** National Action Committee on AIDS
 - SACA:** State Action Committee on AIDS
 - LACA:** Local Action Committee on AIDS
 - HEAP:** HIV and AIDS Emergency Action Plan (1999-2003)
 - NASCP:** National AIDS and STI Control Program
 - USIPs:** USAID Implementing Partners e.g. CEDPA, JHU/CCP, BASICS, Pathfinder, Engender Health formally AVSC etc.
- Ask large group participants, one after the other, to say what they know of FHI
- Ask participants to name the various states of Nigeria where the IMPACT project is being implemented
- Ask participants to mention the six key strategies of the FHI/IMPACT sub-project

Trainer should complement participants' ideas based on the overview below:

OVERVIEW OF THE FHI/IMPACT PROJECT IN NIGERIA

History of FHI/Nigeria Programs:

The 12+ years of collaborative work by FHI Nigeria was described as belonging to four epochs, as follows:

| | |
|----------------|--|
| 1988 – 1992 | AIDSTECH |
| 1992 – 1997 | AIDSCAP |
| 1997 – 1998 | Bilateral Grant Agreement |
| 1998 – Present | Implementing AIDS Prevention and Care Project (IMPACT) |

The FHI/IMPACT Project is being implemented by 53 NGOs from 12 Nigerian States. The FHI is also working with the National Committee on AIDS Control (NACA), focussing on second generation surveillance, STIs services guidelines, networks for People Living with HIV/AIDS (PLWHAs), World AIDS Campaign, Technical Assistance to the Federal Government on the Interim Action Plan and Integration of HIV/AIDS and STIS into national/state structures and systems, e.g. Armed Forces and Police, Workplace, Unions/Associations and Faith-based Organizations.

Project locations

The FHI/IMPACT Comprehensive Program Sites for HIV/AIDS prevention, care and support, i.e. Lagos, Anambra, Kano and Taraba States

The IMPACT project is also being executed in the Non-comprehensive program sites in Osun, Ondo, Ekiti, Katsina, Abia, Ebonyin, Akwa Ibom and Enugu States.

FHI/IMPACT program strategies

- Behaviour change communication
- Community home-based care and support for PLWHAS & PABAs

- Condom promotion
- Improving quality of Sexually Transmitted Infection (STI) services
- NGO capacity building
- Integration of HIV/AIDS program into the workplace structure

INTERPERSONAL COMMUNICATION AND COUNSELLING (IPCC) ON HIV/AIDS MANUAL

Introduction

The HIV/AIDS scourge has become a global public health crisis with the situation in sub-saharan Africa particularly alarming. As of the end of 2001, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated the number of people infected with HIV across the world at 40 million. The number of new HIV infections in 2001 was 5 million. The total number of deaths from AIDS from the beginning of the epidemic through the end of 2000 is estimated at 21.8 million.

UNAIDS also estimated that by the end of 2001 approximately 14,000 new infections were occurring daily, with over 95 percent of these infections taking place in developing countries. Approximately 70 percent of all people living with HIV/AIDS reside in sub-Saharan Africa and in 1998, an estimated 2.2 million Africans died from AIDS.

Here in Nigeria, the national HIV prevalence rate is put at 5.8 percent according to the 2001 sentinel survey, with approximately 3.47 million Nigerians living with HIV infection. The situation may be worse than this but even with this figure, Nigeria is already in an explosive phase of the epidemic, with potentially grave consequences.

Any effective response to this epidemic would include strategies aimed at mitigating the impact of HIV/AIDS on the infected and affected. Such strategies on care and support have counselling as one of the components. Counselling can help individuals, their families, and in turn the communities in which they live to cope with the consequences of HIV/AIDS. Counselling also provides the support needed to bring about and sustain changes in risk behaviour. However, only a small percentage of those with HIV/AIDS have had access to reliable counselling services because of a shortage of trained counsellors. There is, therefore, a strong need for manuals on HIV/AIDS counselling training that would guide and facilitate the training of many more counsellors to cope with the burden of HIV/AIDS on this country. The materials contained in this training manual were gathered from a variety of HIV/AIDS training and other relevant materials. Though no training manual is exhaustive, this one tries to explore issues on interpersonal communication and counselling on HIV/AIDS. It will be necessary to update the manual with new information periodically, considering the dynamic nature of HIV/AIDS.

This manual is designed to help facilitators run a 10-day workshop for training in communication processes, HIV prevention counselling, counselling skills and strategies for people living with HIV/AIDS, as well as the provision of care and support services for the identified population, including orphans and vulnerable children.

It is divided into eight modules. Preceding the modules are the guidelines on how to use the manual, run the workshop, and set the workshop climate. With practical sessions, the modules will provide a model daily programme to last for 10 working days.

WORKSHOP GOAL AND OBJECTIVES

Goal

To develop the interpersonal communication and counselling skills of the trainees in order to provide effective counselling on HIV/AIDS, thereby providing care and support to people infected and affected by HIV/AIDS and preventing the spread of HIV.

Objectives

By the end of the training, the participants will be able to:

- Discuss the implications of the current/projected epidemiological situations of HIV and AIDS on the communities in Nigeria and the world
- Provide accurate information about STIs and HIV/AIDS
- Demonstrate the ability to counsel PLWHA in different types of situations
- Utilize the principles/practice of counselling to counsel clients effectively on HIV/AIDS
- Demonstrate the ability to train people at various levels to become effective HIV and AIDS counsellors
- Conduct a 15-minute micro-training session using established format
- Collate and submit monthly report of counselling activities promptly
- Explain the processes involved in the provision of care and support to PLWHA
- Describe the anatomy and physiology of reproduction in relation to HIV and STI spread and prevention

How To Use This Manual

The training manual on Interpersonal Communication and Counselling on Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) is organised into eight modules. Each module has sessions ranging from one to four, which build upon each other in terms of information and are sequenced in logical presentation order for a training workshop. The contents are extensive. Therefore, to allow for adequate coverage, practice, and skill development in IPCC on HIV/AIDS, the design is for 10 days of training and a residential workshop is recommended for both participants and facilitators. This will enable further workshop activities outside the scheduled hours for further review, discussions and individual/group exercises.

Before attempting to use the manual, read through the introduction, content page and the section on how to use the manual. Modules/sessions are arranged according to the day of training. According to the tentative schedule, daily sessions begin at 8:00 a.m. and end by 5:00 p.m. Various activities which cover the curriculum for IPC and counselling for HIV/AIDS have been scheduled for each of the training days. Adequate break times for group tea and lunch have been built in. These daily sessions have the following:

1. **Modular Number** – refers to the broad topic(s) to be covered
2. **Title/Topic** – identifies the main topic(s) of the session to be conducted
3. **Session Number** – identifies the sub-topics under the title
4. **Objectives** – describe what the participants will be able to do by the end of the session in order to demonstrate increased knowledge and skills as well as appropriate attitudinal changes
5. **Time** – indicates the approximate amount of time the session will take
6. **Materials** – lists all materials/resources that will be needed to conduct the session
7. There are practical aspects of the workshop to facilitate participatory learning. Facilitators are encouraged to use and/or modify the sessions for maximum results.

Remember the Six “Ps” of Training:

Proper
Preparation
Practice
Prevents
Poor
Performance

Module One



Session 1- VALUES AND VALUES CLARIFICATION

Objectives:

At the end of the session, participants will be able to:

- Clarify values
- Identify at least four sources of value formation

Material: Flipchart, stand, markers, masking tape

Method: Interactive lectures, discussion, group work, brainstorming, exercises

Time: One hour

Process:

1. Share the objectives of the session.
2. Introduce the topic as per trainer's note.

Introduction

Our values are often so ingrained that we are unaware of them until we are confronted with a situation that challenges them. Understanding our own perceptions and values is essential to sensitive counselling. By understanding his/her own perceptions and values, the counsellor is better able to appreciate and respect the various experiences that shape the perception and values of his/her client.

3. Allow the group to know that counsellors are able to counsel effectively if the following points are recognized:
 - i. All clients have individual values and feelings just as counsellors have theirs
 - ii. You should recognize and respect the client's feelings and values
 - iii. You should avoid imposing your values and biases on clients
 - iv. Since values clarification is a skill, you should practice its use in day-to-day communication.

What are values?

4. Encourage the group to brainstorm the meaning of values. Note the points raised and lead the group to define it as follows:

Values are those things we believe in and attach importance to or those things we are against.

What are the sources of value formation?

5. Allow as many participants as are willing to respond to the question. Sources may include:
 - i. Family
 - ii. Religion
 - iii. Society
 - iv. Peer group
 - v. Personality traits
 - vi. Environment
 - vii. Media
 - viii. Education.
6. Lead group discussion to explain how each of these sources contributes to values formation in line with the trainer's note.

Trainer's Note

Family:

The family is the primary agent for socialization. Socialization is the process by which children acquire the social judgment and self-control necessary for them to become responsible adult members of society. Parental discipline and behavioural examples shape social judgement and self-control. Through these, parents transmit to their children the socio-cultural attitudes, traditions and values to which they subscribe. So the family is a major source of value formation.

Religion:

This is one of the major factors that influence the moral beliefs and outlook of the family. Religion influences one's outlook to life and so it is an important source of value formation.

Society:

Society imposes some standards on its members through its norms ("do's" and "don'ts") which spell out permissible and non-permissible behaviour. Through various situations and channels, society affects one's attitude to life, and thus it is an important source of value formation.

Peer Group:

The acceptance of peer group/age mates and conformity are very important to the adolescent and youth. Thus, friends do influence one's outlook on life and are an important source of value formation.

Personality Traits:

These are qualities that are personal to the individual. They contribute to one's value formation.

Environment:

The environment in which individuals live or find themselves also affects the values they hold.

Media:

The media has a great influence on the values an individual holds. This could be through the print, electronics and the Internet.

Education:

This is an important source of value formation. People learn a lot through the formal school system--things that shape their values and overall worldview.

Activities: Values Games

1. Read out some of the statements in the trainer's note – it is not necessary to read all the statements.
2. Ask participants to raise their hands in agreement or cross their arms over their chest in disagreement.
3. Allow 1–2 participants to give reasons for agreeing or disagreeing to the statements.

Trainer's Note

Health/Sexual Activity Survey Statements

1. All females should be virgins when they marry
2. Men are naturally polygamous (have more than one wife)
3. Monogamy for both men and women is the only way to prevent the spread of HIV/AIDS
4. Girls who have sexual experience before marriage are normal
5. It is impossible to be monogamous for your whole life
6. Condoms decrease sexual enjoyment for the man
7. Condoms increase sexual enjoyment for the woman
8. Husbands who have a girlfriend on the side should tell their wives
9. Wives who have a boyfriend on the side should tell their husbands
10. Wives who are not faithful are immoral
11. I would not be at ease working with someone who has HIV/AIDS
12. I would not be at ease inviting a person with HIV/AIDS to my house
13. I would not be comfortable having a person with HIV/AIDS hold my baby
14. I would not be at ease sharing a meal with a person with HIV/AIDS
15. Parents should teach their children how to use condoms
16. People who have HIV/AIDS deserve to have it
17. Only promiscuous people have HIV/AIDS
18. People with HIV/AIDS deserve to die
19. People who have HIV/AIDS should be quarantined
20. If a woman wants to use a condom and her husband or sexual partner does not, she has the right to refuse to have sex with him

21. If one talks to youth about sex, this encourages them to be promiscuous
22. It is okay to have sex only for pleasure
23. It is okay for an HIV-positive person to have sex
24. Everyone should be tested if she/he wants to be and informed that she/he is being tested before the test

1. Process the game by asking:

| |
|--|
| a) Did any of your responses surprise you? Which ones? |
| b) How did people respond to different statements? |
| c) How did you feel about other people's responses? Why? |

2. Possible Responses:

| |
|---------------------------|
| b and c |
| Defensive |
| Judgemental |
| Ambivalent |
| Afraid to express opinion |
| Angry |

Excercise 2 -- Priority Ranking Exercise

Activity

- Display the following values on newsprint:

| | |
|--------------|-------------------------|
| My family | My happiness |
| My country | My husband/wife |
| My tribe | My identity as African |
| My education | My mother-in-law |
| My health | My religion |
| My job | My children's education |
- Instructions:
 - Rank these values from the most important in their opinion (#1) to the least important (#12).
 - No discussion is allowed while the exercise is going on.
- After everyone has finished the exercise, call on 6–8 members to read out what they wrote. Use the frequency tally to record their values.
- Process in similar manner as with the first exercise.

Summarize the key points in the session and encourage group members to use their values clarification skills.

Session 2- Overview of Reproductive and Sexual Health

Objectives:

At the end of the session, participants will be able to:

- Identify the organs/functions of the male and female reproductive systems
- Define reproductive health
- Define sexual health
- Mention at least five components of reproductive health

Introduction

The knowledge of the male and female reproductive organs and their functions is an important prerequisite to a clear understanding of reproductive health as well as STIs/HIV/AIDS, which is the focus in this counselling and communication training. It helps the facilitators/trainees to identify and refer appropriately to the organs and structures involved in the discussions of the key disease conditions. This makes the counselling sessions more meaningful. In addition, it helps in understanding the connections between the reproductive organs and the prevention, detection and treatment of STIs/HIV/AIDS.

ANATOMY OF THE MALE AND FEMALE REPRODUCTIVE ORGANS

External (Outside) Organs of Males and Their Functions

Activities:

1. Ask a participant to read out the objective for the session.
2. Display a labelled diagram of the male reproductive organs
 - a. External organs
 - b. Internal organs.
3. Identify the organs and explain their functions. (Do not use highly technical terms with some groups of participants as this can lead to confusion – see trainer’s note.)
4. Repeat the same process for the female reproductive organs.
5. Present unlabelled diagrams of the male and female reproductive systems (external and internal) one after the other.
6. Ask participants to volunteer to:
 - Label the parts
 - Explain the functions.
7. Summarize the session by informing participants that the expression of human sexuality, especially as it relates to sexual intercourse, is at the heart of the spread of HIV. However, lack of knowledge about human biology further compounds the problem.
8. Distribute copies of labelled diagrams of male and female reproductive systems to each participant.

Trainer’s Note

- **Penis:** The main male sexual organ. It becomes stiff or erect when a man is sexually aroused. A man does not need to have sex just because he has erection. The erect penis is used for sexual intercourse. Sperm and urine pass through the penis, but not at the same time.
- **Scrotum:** It is found behind the penis and contain the two testes. The scrotum protects the testes from damage.

Internal (Inside) Organs of Male And Their Functions

- **Cowper's' Gland:** It secretes a watery fluid that activates sperm, making the sperm capable of fertilizing the female egg(s).
- **Testes:** These are two round organs inside the scrotum that produce and store sperm cells and the male sex hormone (testosterone).
- **Urethra:** the tube that passes through the penis and that carries either urine or sperm
- **Vas Deference:** the long tube through which sperm pass from each testis to the urethra
- **Anus:** opening through which faeces pass

The External Organs (Vulva) of Females and their Functions

- **Clitoris:** small, pointed organ that lies between the labia majora and labia minora and the most sexually sensitive part of a female. It is sometimes removed during circumcision.
- **Hymen:** thin membrane that covers the vaginal opening. It is often used to define virginity although it can be broken during other activities besides sexual intercourse. It may provide some protection from infection to the vagina before it is broken.
- **Labia Majora:** two folds of sensitive skin, one on either side of the pudential cleft and immediately below the pubis or fatty pad. The labia majora cover and protect the labia minora, clitoris, urethra and vaginal opening.
- **Urethra:** small tube and opening below the clitoris for passing urine
- **The vaginal opening:** is seen when a female is viewed externally and is between the clitoris and the anus.
- **Anus:** opening through which faeces pass

The Internal Organs of Females and their Functions

- **Vagina:** the organ/passage through which menstrual blood exits the body, which accepts the penis during sexual intercourse, and which functions as the birth canal during child birth
- **Cervix:** mouth of the uterus through which sperm must pass to fertilize the egg(s) and which opens through muscular contractions when an infant is to be born
- **Fallopian Tubes:** a pair of tubes found on either side of the uterus. These tubes connect the ovaries with the uterus; sperm travel up the tubes toward the ovaries and the egg passes down the tube towards the uterus. Fertilization normally takes place here. The fertilized egg passes through the fallopian tube to the uterus, where it implants to develop into an infant. When no fertilization occurs, the unfertilized egg passes through the fallopian tube into the uterus and is expelled with the uterine lining during menstruation.
- **Ovaries:** two small egg-shaped organs connected, via the fallopian tubes, to the uterus. The ovaries store and protect the female eggs (ova) and produce the female hormones, oestrogen and progesterone.
- **Uterus or Womb:** the organ in which a fertilized egg implants and in which the development of an infant takes place. Its lining is shed during menstruation. It contracts during labour to push out the infant.
- **Vagina:** a canal running from the vaginal opening to the cervix and uterus. The vagina accepts the penis during sexual intercourse; menstrual blood flows through it during menstruation and an infant moves through it during birth.

Diagrams

1. Male Reproductive Organs
 - External
 - Internal
2. Female Reproductive Organs
 - External
 - Internal

How Pregnancy Occurs

Process:

How Does Pregnancy Occur?

1. Display the diagram of the four steps of how pregnancy occurs.
2. Ask 1–2 volunteer participants to explain how pregnancy occurs.
3. Commend efforts and complete as in trainer’s note.

Distribute copies of “How pregnancy occurs” to participants.

Trainer’s Note

How Pregnancy Occurs

Step I

Ovulation

Each month, one ripe egg in one of the ovaries leaves the ovary. Ovulation occurs about halfway through the menstrual cycle, or about 14 days before the start of the next menstrual cycle.

Step II

Journey of the Female Ripe Egg

Looking at the picture, you can see how the female ripe egg makes its journey. The ripe egg moves to the egg-carrying tube (fallopian tube) waiting to be fertilized by the male egg (sperm).

Step III

Menstruation

If after one to three days the egg is not fertilized by sperm or if it does not implant, the lining of the uterus is shed during menstruation and the cycle starts over again.

Step IV

Sexual Intercourse

If intercourse takes place, the man at the peak of excitement ejaculates, i.e. he deposits millions of his sperm into the vagina. After ejaculation, the sperm swim up the vagina, through the cervix and uterus to the tubes and may implant.

Step V

Pregnancy

- One of the sperm will try to reach the egg that has been waiting in the tube to join with it.
- If both the male sperm and the female egg join into one, fertilization has occurred.
- The fertilized egg now moves to the womb and implants itself in the lining of the womb. This is the beginning of pregnancy, which will result in the birth of a baby in nine months' time.

Reproductive and Sexual Health

Process:

Exercise 1: What is reproductive health?

1. Read out the objective of this exercise.
2. Ask participants to think about the word “reproductive” and “health”.
3. After 1–2 minutes of thinking time, organise group into pairs.
4. Have each pair share their understanding of reproductive health.
5. Ask two pairs to join their findings and one of them from each group of “four’s” to report to the larger group.
6. After the reporting session, apart from your general comment on the process, you might explain the two words along the lines of:

- **Health**

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

- **Reproductive**

This involves all matters relating to the reproductive system and its functions and processes.

Explain further that reproductive health implies that people are able to have a safe and satisfying sex life and the freedom to decide if, when and how often to have sexual relations.

7. Define reproductive and sexual health as follows:

Definition of Reproductive Health (RH)

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes (WHO). It implies that people are able to have a safe and satisfying sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to have sexual relations. Men and women have the right to be informed and to have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility. They have the right to access to healthcare for safe pregnancy and childbirth.

Sexual Health

Sexual health aims at the enhancement of life and personal relations and does not consist merely of counselling and care related to reproduction and sexually transmitted infections.

Components

1. Safe motherhood
2. Infant welfare services
3. Family planning information and services
4. Nutrition
5. Male involvement in reproductive issues

6. Prevention of harmful practices against women
7. STIs/HIV/AIDS detection and management
8. Adolescent development needs in RH
9. Genital cancer prevention, early detection and management
10. Status of women – gender issues
11. Post abortion care (PAC)
12. Menopause (women) and Andropause (men)

NOTE: Integration of these RH components helps to improve the health status of the populace as well as reduce maternal infant mortality and morbidity.

Session 3- SEXUALLY TRANSMITTED INFECTIONS (STIs)

Objectives:

At the end of the session, participants will be able to:

- Mention three common STIs
- Describe at least four STI syndromes associated with them
- Describe the “four Cs” in the management of STIs
- Explain the relationship between STI and HIV/AIDS
- State preventive measures to the spread of STIs

Materials: Flipchart, stand, marker

Duration: 45 minutes

Introduction

Sexually Transmitted Infections (STIs) are infections that are spread through sexual activity. Common STIs include gonorrhoea, syphilis, herpes, genital warts, chlamydia, trichomoniasis, candidiasis and HIV/AIDS. STIs are spreading at a high rate all over the world. These infections are also increasing among teenagers. Both men and women can have STIs; a man can infect a woman and a woman can infect a man. STIs can be painful and uncomfortable; they can also have tragic consequences including pelvic inflammatory diseases, infertility, blindness and death.

Having unprotected sex with an infected partner spreads STIs. A person’s sexual behaviour may put him/her at risk of acquiring and spreading these infections. High-risk behaviours include having sex with multiple partners or with a partner who has multiple partners and having unprotected sex (without a condom). This session is designed to help trainees acquire the knowledge to educate youth and other community members on the transmission and prevention of STIs, which includes recognising the signs and symptoms as well as the importance of seeking treatment early and adopting safer sex practices.

Main Signs and Symptoms Of STIs

These are now grouped into syndromes:

- Male urethral discharge
- Female vaginal discharge
- Genital ulcers
- Pelvic inflammatory disease (P.I.D.)
- Ophthalmia neonatorum (discharge in the eyes of an infant)
- Others – warts, groin and testicular swellings

NOTE: However, it is very important to know that up to 50 percent of women may not have any symptoms of STIs. STIs facilitate the transmission of HIV and the rate of transmission is higher with STIs that cause ulcers.

Syndromes/Likely Causes

Male urethral discharge

- Gonorrhoea
- Chlamydia

Female vaginal discharge

- Gonorrhoea
- Chlamydia
- Trichomoniasis
- Candidiasis

Genital Ulcers

- Syphilis
- Herpes

- Chancroid
 - Lymphogranuloma Venereum (LGV)
- Female Lower Abdominal Pain
- Gonorrhoea
 - Chlamydia
 - Anaerobic bacteria
- Ophthalmia neonatorum
- Gonorrhoea
 - Chlamydia
- Others
- Genital warts
 - Groin swelling
 - Testicular swelling

Management of STIs

Most STIs can be cured if the person gets the correct treatment from health workers. Recognition of the infection and early treatment are essential to early cure before damages to the reproductive organs and other complications set in. Prescribed medicines for STIs should be taken as directed until the medication is completed, even if the symptoms clear up after only a few days. Notify your partner even though he/she still has no symptoms and get the partner treated to avoid re-infection.

WHO recommends the syndromic management of STIs, which has the following advantages: It

- is cheaper and easier
- can be carried out by all cadres of healthcare providers
- does not require specialised health personnel or a sophisticated laboratory
- involves comprehensive management (which involves partner notification and treatment)
- promotes health education, and the promotion and provision of condoms.

Personal Health

- Wash your underwear daily
- Wear cotton pants only
- Bathe twice daily (morning and evening)
- Do not douche

Management of STIs is not complete without using the four Cs

- **Counselling** to prevent re-infection and to avoid sexual activity throughout the period of treatment
- **Contact treatment**, to break the cycle of transmission and get partner treated
- **Compliance**, to complete the course of drugs in order to complete the cure and prevent drug resistance to infection
- **Condom use**: if he/she must have sex during the period of treatment, a condom has to be worn throughout each sexual exposure, from beginning TO THE END OF ANY AND ALL CONTACT, TO PREVENT NEW INFECTIONS.

Complications of STIs

- Pelvic inflammatory disease
- Infertility
- Pregnancy in the tubes (ectopic)
- Spontaneous abortions
- Heart disease
- Blindness
- Mental illness
- Death

Prevention of STIs

- Avoid sexual intercourse with an infected person
- Avoid sexual intercourse during treatment to prevent infecting the partner or getting re-infected
- Avoid multiple sexual partners
- Use a condom over the penis every time you have sex WITH ANY NEW PARTNER OR ANY PARTNER WHO MIGHT HAVE OTHER PARTNERS
- Be faithful to your one and only partner; otherwise abstain
- Do not use antibiotics without prescription

Activities:

1. Share the specific objectives of this topic among participants.
2. Introduce the topic as in trainer's note.
3. Ask someone to explain what the letters STI stand for and the meaning of each word.
4. Explain that participants may have heard about STDs (sexually transmitted diseases) but the term STI (sexually transmitted infection) is now being used. When we hear the word disease we usually expect to see symptoms but since many STDs are silent (i.e. no symptoms may be seen or felt) we now refer to them as STIs.
5. Explain that the signs and symptoms of STIs are now grouped into syndromes, in line with the WHO recommendation.

Session IV- HIV/AIDS

Objectives:

At the end of the session, participants will be able to:

- Explain the difference between HIV and AIDS
- Discuss the prevalence of HIV/AIDS nationally and globally
- Describe four main routes of HIV transmission
- Explain the role of intravenous drug use in HIV transmission
- Mention at least two major signs and one minor sign of AIDS

Materials: Flipcharts, stand, markers, chalk, board

Time: One hour 30 minutes

Trainer's Note

What is HIV?

HIV is “human immunodeficiency virus”

HIV is the virus that causes AIDS

Human means that it affects only humans and lives only in humans. The virus does not live in toilets, mosquitoes, cups or spoons, on bed sheets or towels that people with HIV might have used.

Immunodeficiency refers to a lack (deficiency) or breakdown of the immune system. The “immune system” is the body’s resistance or the Body’s Defence Force (BDF) for fighting off infections. The virus attacks and eventually overcomes the body’s immune system, the BDF. The immune system is usually able to defend the body against many infections.

A virus is a germ.

What is AIDS?

AIDS means “Acquired Immunodeficiency Syndrome”

To *acquire* means to “get or develop over a period of time”

For “Immune” and “deficiency” see above. The immune system does not break like an egg; it breaks down gradually over time. It gets deficient, or less and less efficient, under the relentless attack by the multiplying numbers of virus in the body.

Syndrome refers to the group or collection of signs and symptoms (or indications) of diseases in a person who has AIDS, such as unusual weight loss (more than 10% of normal body weight), fever (for more than one month – stopping and starting or continuous), a dry cough which hangs on, excessive tiredness, diarrhea for a long time (more than a month), swelling of the lymph nodes, respiratory tract infections including pneumonia and tuberculosis, thrush and night sweats

The difference between HIV & AIDS and the importance of understanding the difference

1. Different things are happening inside the bodies of persons with HIV and AIDS

HIV is the infection stage of the condition; AIDS is the disease phase.

When the virus enters the body, it comes into contact with the front line of the body’s defence system. In the early stages of infection (during the first few days or week) the infected person may feel as though a flu is coming on. HIV overpowers this front line (consisting of white blood cells called macrophages) and makes its way into other body cells, living on them, destroying them and multiplying at a rapid rate.

The body produces antibodies (chemical substances) to the virus. It takes from six weeks to three months to pro-

duce the antibodies and release them into the bloodstream. This period from the point of infection to the end of the six-week to three-month period (shorter or longer depending on the particular body) is called the “Window Period.”

Note: The usual lab tests look for the antibodies; they do not look for the virus itself.

When the level of viruses in the body reaches a high point and the quantity of body cells that are supposed to fight off disease reaches a low point, the body is more open to other infections entering and hanging on. HIV and various diseases then take over the body. This is when the person may be said to have AIDS.

2. The bodies of persons with HIV and AIDS MAY look different on the outside. Persons with HIV look healthy; persons with AIDS MAY look unhealthy.

You can't tell when a person has HIV. A person who is HIV-positive can look and feel as good as a person who does not have the virus. HIV-infected persons can even look better, as many begin taking more care of their health and physical appearance.

When a person is HIV positive, that person can live for several years, looking just like a person who is not HIV positive. There are no signs on the person's body to show that he or she is carrying the virus.

A person who is HIV positive develops AIDS (or can be said to “have” AIDS) when he or she has three or more signs of the syndrome (collection) of diseases listed earlier. A person with AIDS may have such signs such as significant weight loss, thinning hair and skin diseases. Thrush (a white furry coating) on the tongue or the roof of the mouth (and sometimes the vagina) is another sign. Note: No one of these signs by itself means that a person has AIDS.

When a person has AIDS, the person may look sick. He or she certainly feels sick. Diseases take over the body because HIV has broken down the body's defence force or resistance (the immune system). These diseases are caused by “opportunistic infections.” They are called that because when the body's resistance is weak, infections of all types take the “opportunity” to invade and take over the body. Usually a normally healthy person can resist these infections. The body's immune system is designed to fight infections and disease.

There are cures for most of these other infections and diseases, but science has not yet come up with a cure against the HIV.

A person who has AIDS can return to being well when diseases are treated and symptoms disappear.

Persons don't actually die of AIDS. Death usually comes after a series of illnesses and when the body finally succumbs to (that is, is overpowered by) one or more of the diseases which take over in the AIDS stage.

3. Persons with HIV and persons with AIDS lead very different lives. Persons with HIV can get on with their lives as usual, taking extra care of their health; persons with AIDS may be too sick, too often, to be able to carry on normally. They need care and medical treatment.

Persons who are HIV-positive have to make important changes in their sex life.

Persons who are HIV-positive have to be careful not to infect others or to get re-infected with the virus. Every time a person who is HIV-positive is re-infected, the body's resistance is weakened, allowing AIDS to develop sooner.

Persons who are HIV-positive need to be extra careful not to pick up other infections, especially STDs. Every new infection, of whatever type, further weakens the immune system. We all know how easy it is to pick up a “bug” or virus when our resistance is low, and how hard it is to shake it off.

Persons who have AIDS need a lot of care and attention, medical and otherwise.

Although both are infectious, a person who is only HIV-positive is more likely to infect others, for two main rea-

sons: (1) he or she is more likely to continue to attract and desire sexual partners; (2) partners, caregivers and healthcare professionals are more likely to take risks in relation to people who are HIV-positive (because they look good and their status may not be known) than they are with people who have AIDS and are clearly unwell.

The Window Period

The Window Period is that period from the time of infection to the time when the usual lab tests can detect the antibodies to the virus in the HIV-infected person.

The Window Period can last between six weeks to three months. Different bodies take different lengths of time to produce and release the antibodies, sometimes called “clues” to the virus.

During the Window Period, the commonly used tests cannot detect the antibodies to the virus. Therefore, if someone is tested during that period, the test result will be negative even though the person is infected. Some labs describe the findings as “non-reactive.”

Why it is important to know about the Window Period

During the Window Period a person can be carrying the virus and not know it. That person can therefore unknowingly infect another person through sexual contact.

Persons who know about the Window Period will know why one has to be careful about giving and taking blood. People who are careful about remaining HIV-free will know of the importance of donating blood at regular intervals so as to maintain a good supply at the blood bank.

If a person has been exposed to the virus and takes the test soon thereafter, the test results may show up negative. The person who does not know about the Window Period may think that this means that he or she has not been infected. This person may spread the virus to other persons.

Persons who know about the Window Period will know that they must take a second test after about three months to know if they were or were not infected as a result of the suspected exposure to the virus.

Those persons will know that they must abstain from sex, or practice safe sex, during the Window Period.

Someone who produces a lab report in order to get unprotected sex cannot deceive a person who understands the significance of the Window Period because this person will understand that a lab report verifying a negative test result, even if reliable and genuine, only speaks to infection of months ago, not infection (or infections) that may be only nights old or a couple of weeks old.

Those persons will know that if they have unprotected sex while waiting to have their second test, that is, during a period when they are uncertain about whether or not they really are infected, they are once again exposing themselves to the possibility of HIV infection. And of course, if they really were infected in the first case, they will be spreading the infection to another partner or partners.

WHAT ARE THE CONNECTIONS BETWEEN TB, STIs & HIV?

Before the late 1980s, TB was considered to be on the verge of elimination. Then new HIV-related TB cases and multi-drug resistant tuberculosis (MDR-TB) came up.

Many TB patients in high HIV-prevalent countries are HIV-infected

Today, HIV is known to be an important risk factor for TB, contributing to the development of active TB from latent TB infection.

HIV also makes individuals with a recent TB infection more likely to progress rapidly to active TB disease. The increase in TB cases put more pressure on medical resources, thereby reducing the availability of adequate medical facilities. HIV-related stigma may prevent TB patient from seeking medical care.

Twenty important points about STIs & HIV

1. HIV is a sexually transmitted infection.
2. HIV and many STIs are caused by germs during sexual acts.
3. Other STIs (for example, gonorrhea and chlamydia) are caused by bacteria.
4. Some STIs are more infectious at certain stages of the infection.
5. Many STIs can be cured.
6. There is no cure for the STI called HIV. Genital herpes is another STI for which there is no cure.
7. Using home remedies or self-treating with pills can be dangerous. STIs that can be cured but are not treated professionally do not go away. Untreated STIs can lead to serious health problems. Some, like syphilis, can lead to death.
8. Because different bacteria and germs cause different STIs, they need to be treated differently. When a doctor prescribes treatment after an examination, it is important to take the full treatment – even after the signs of the infection seem to have disappeared. Remember that not all STIs can be seen or felt. And some STIs show up sometimes and don't show up at other times. Someone can have an STI and not know it.
9. Overuse and other forms of misuse of antibiotics (black & reds, and others) in treating STIs reduce their effectiveness in fighting infection and damage the body. Over time, the STI that is targeted can become immune to the antibiotic, while the person's general health can be dangerously compromised. Antibiotics are serious medications, to be prescribed for specific purposes, and are not to be taken lightly.
10. Some STIs have no symptoms. That is, a person can have an STI and not know it.
11. Many girls and women with STIs have no symptoms.
12. Mothers can pass some STIs on to their newborn babies; some affect babies' eyes.
13. The condom does not offer complete protection against some STIs. Abstinence and faithfulness are always the best protection.
14. STIs affect not only the sexual organs; they can also infect the area around the mouth and around the rectum (the area inside the opening in the behind).
15. STIs can indicate that a person is careless about his/her general or sexual health.
16. A person who has an STI is at a much higher risk of contracting HIV through sex from an infected person. The sores, blisters, rashes, and soft spots in the skin provide openings for HIV to enter the system.
17. STIs put additional stress on the body's resistance. Persons who are HIV-positive and get (and/or keep) an STI (or more than one STI) are likely to get sick more frequently, and develop AIDS more rapidly. When the body has to keep fighting infections, the body's resistance breaks down over time. When it can no longer resist, infections and diseases take over and the body dies.
18. Persons who are embarrassed or ashamed to examine their sexual organs or have them examined by healthcare professionals can unknowingly have STIs and pass them on to others.
19. Persons who do not pay attention to the sexual organs of their partners risk infection by STIs. You can get a sexually transmitted infection from one partner; you don't have to have many partners to get an STI. A person does not have to have many partners to get an STI. Of course, with each additional partner, the risks increase.
20. STIs can make one's sex life, and life in general, very, very unpleasant.

Activity**How can someone get HIV? or... not get HIV?****Process:**

Share the title and objective of this exercise. Ask someone in the group to say why this exercise is not looking at AIDS. This is an opportunity for the group to be reminded that HIV is an infection that travels or is transmitted. AIDS is not transmitted. AIDS is not passed on. AIDS can't be caught. AIDS is developed.

Ask the participants to form new small groups of two or three.

Ask half of the small groups to come up with three ways a person can get HIV.

Ask the other half of the small groups to come up with three ways a person can't get HIV. Allow a few minutes for discussion. Report as before. Remind the groups to listen carefully to the reports because they will be expected to add points that the other groups did not mention.

After the first set of groups (the "How you can get HIV" groups) has reported, add points as necessary from the notes below. Do the same thing after the second set of groups has reported.

Ask for a few volunteers to say how someone could get HIV from a person who has AIDS.

To those who say "sex," ask them to imagine that they have the virus in their bodies in very high quantities. They are suffering from constant diarrhea, coughing and excessive tiredness. These are only three of the symptoms a person living with HIV and AIDS (PLWHA) might have. Putting aside emotional, psychological, financial and other problems they will be having, they are not feeling good. They are not looking good. Ask them: Would you be wanting sex? Would you be attracting sex partners? What a PLWHA usually wants and needs is care and affection! People who are not living with the virus need to practice showing care and affection in all their relationships, starting now – just in case they are ever put to the test.

Persons can get HIV in three main ways:

- Unprotected sex (any kind -- vaginal, oral or anal -- where penetration is involved, including sex where there is no ejaculation or "come") with an infected person. Chances of infection increase significantly when STIs are involved.
- Blood transfusion or any blood-to-blood contact, including sharing of needles used to inject drugs.
- Mother-to-child (in the case of an infected mother during pregnancy, during delivery or breastfeeding)

The virus can be found in three main body fluids of the HIV-infected person: semen, vaginal secretions (wetness in the vagina) and blood. Just one drop of any of these three has HIV in very high quantities. Small amounts may be in other body fluids. Urine and saliva that have blood will also have the virus.

Infected persons can become reinfected with every act of unsafe sex. This increases the viral load and can add different virus types to those already in the body.

Where mother-to-child transmission is concerned, it is believed that when babies breastfeed, the nipples become sore; they may bleed and contaminate the HIV-positive mother's milk. Many babies (but not all) who are born to HIV-positive mothers may pick up the virus either in the womb, during the birth process (where blood and vaginal fluids are present) or after birth, through breastfeeding.

Persons can't get HIV, from ...

- Handshakes, touching, swimming or bathing with an infected person, sharing utensils (cup, plate, spoon) with an infected person, toilet seats, mosquitoes, using towels and clothes, sitting next to or sharing a bed with an infected person. (HIV cannot live outside the body. In order to survive, the virus needs the food supply of the cells in body fluids that have cells. This is why HIV will not be found in perspiration; sweat is mainly salts and water.)
- Hugging and kissing (if there are no bleeding gums and broken skin)
- Self-masturbation (when one person rubs and strokes his/her own sex organs) or mutual masturbation (when two persons rub and stroke one another's sex organs). Note: If one or both partners are infected, care must be taken to

ensure that there are no openings on the skin through which the virus could enter.)

- Sex where both partners are not infected and remain faithful to each other
- Avoiding sex with infected persons or persons whose HIV status is not known

Sex with a latex condom, used properly every time, is the only way to reduce risk of HIV and some other sexually transmitted infections.

Just using a condom does not mean “safe sex.” Sex with a latex condom is safer sex, safer than sex without a condom, but the condom must be used correctly and consistently, that is, in the right way —every single time —with all types of sex.

Activity

How HIV Spreads

You may share the general objective of this set, but do not share the specific objective of this exercise, until afterwards.

Prepare slips of paper for each participant. Mark one with a plus sign (+), one with the letter “a” and one with a “c.” Make the markings small so they are not noticeable.

Distribute one to each person, noting the person to whom you gave the one with the plus sign (+). Do not let the group know that there is anything different about the papers.

Tell participants to think of three persons in the group whom they would like to know better. Tell them to walk around the group with their piece of paper and have those three persons punch a hole in it with a pen or pencil.

Tell the person to whom you gave the paper with the plus sign to start the ball rolling. (Don’t let that person think he or she has been selected for any particular reason.)

When that person (think of him/her as a peer group leader) has approached and got the three persons to punch their holes, tell the rest of the peer group that they can now do the same.

When everyone has selected and approached their three persons, tell the group to return to their places.

NOTE TO TRAINER

If someone approaches you, go ahead and play the game. Later on, during your comments, you can explain that although you did not intend to be a player, you went along (as most of us tend to do), taking the risk of exposure to the virus.

Ask the first person to stand and identify the three persons who punched holes in his/her paper.

Ask those persons to stand and take turns in identifying their three persons.

Get those persons who are identified to stand and do the same. Carry on until all those picked point out whom they picked.

Some persons may still be sitting. Ask them to identify the persons they chose.

When the majority of the group is standing, tell them to look at their papers and see whether they have “a” or “c” or “+” marked on it. Tell the persons with the “a” and “c” to step out of the circle and join you.

Tell the group that the person with the plus sign is HIV-positive ... and that in real life, all the persons who had sexual contact with that person — or persons he or she had sexual contact with — could have been infected with the virus. Pause for a while to let this disclosure sink in.

Explain that the “a” stands for “abstinence.” The person with the “a” would have had contact with an infected person, but it would not have been sexual contact. That person would be safe.

Explain that the “c” stands for “correct and consistent condom use.” That person would be safer — not 100 percent safe, but much, much, much safer than persons who took no precautions.

Say: “Put up your hands if you would go ahead and have sex with a condom knowing that the sex partner might be HIV-

infected.” Ask the group what they think about their responses.

Have the group sit. Pass the ribbon and have participants say (1) why they chose the persons they did and (2) what they think and feel about the exercise.

Give your own personal and general comments after everyone has spoken. There are some points below that you can also bring to the attention of the group.

NOTE TO TRAINER

Apart from your personal reflections and comments on participants’ contributions, here are some other observations you may add:

The exercise shows that in a small community, one HIV-infected person can possibly lead to the infection of a great many.

The exercise shows that a relatively small number of infected persons in a big country like Nigeria can start an epidemic, therefore the HIV Sentinel Surveillance figures issued periodically by the National AIDS and STI Control Program, Federal Ministry of Health, Abuja, Nigeria need to be taken very seriously.

Everyone who is sexually active is at risk — not just promiscuous persons. It is not just about whom “I” have sex with; it is also about who “he” or “she” has sex with; and who “they” (the partners of the partner) have sex with.

All of us, including girls and women, girlfriends and wives, need to start taking active responsibility for our sexual health and sex life. Only children and persons who are raped may be considered “innocent” victims.

Too many persons are still engaging in casual, unprotected sex, thereby endangering themselves and others. We can get close physically and emotionally without taking chances with sex.

Activity

High Risk, Low Risk, No Risk

High risk behaviour

Low risk behaviour

No risk behaviour

Don’t know

Write twenty “behaviour cards” with the following statements:

- Having sex after getting “high”
- Having many sexual partners
- Having sex with a “good” person without a condom
- Having sex with a virgin
- Sex with a condom
- Mouth-to-penis sex (oral sex)
- Mouth-to-vagina sex (oral sex)
- Penis-in-the-behind sex (anal sex)
- Using a condom with wife or partner, but not with others
- Using a condom with others, but not with wife or partner
- Kissing
- Using a public latrine
- Exposure to mosquitoes
- Having sex with a commercial sex worker
- Caring for someone who has AIDS
- Drinking from a glass used by someone who is HIV-positive
- Sleeping in the same bed with someone who is HIV-positive, but without having sex

- Getting a tattoo
- Giving blood
- Hugging

Process:

Organise your group into a circle with the four large “Risk” sheets of paper in the middle.

Distribute behaviour cards, one card per person.

Tell participants to take turns placing his or her card on the selected “Risk” sheet and give reasons.

After each person reads out and places his or her card, invite the group to agree, or disagree, giving their reasons.

Ask someone in the group to help out, in the event of any “don’t know” responses.

Correct and/or give additional information where necessary.

Ask the person who received the last card on the list, “How did the language used strike you?”

Use the opportunity for a group discussion on language and behaviours in peer education work.

Tell the group that this exercise was intended to get them thinking, talking and moving around issues of risk-taking and relationships, sex and HIV.

Tell the group that it also helps the educator to learn how much participants already know about how one can and cannot get HIV, and about safe and safer sex and that based on their clients’ response to questions such as those below, the clients can assess their own risk to STIs and HIV:

- Are you sexually active?
- Have you ever contracted an STI?
- Do you currently have an STI?
- Have you treated your STI?
- How many sexual partners do you have?
- Do you use condom consistently?
- Are you practicing mutual fidelity with your partner?
- How many sexual partners does your partner have?
- Do you practice oral sex?

NOTE TO TRAINER

This exercise can be used at the beginning of a workshop, at the beginning of sessions (or modules) which focus on risk or behavioural change, or as a stand-alone activity to reinforce or assess (pre-session or post-session) participants’ knowledge of behavioural risks associated with HIV.

BASIC FACTS ON HIV AND AIDS [EPIDEMIOLOGICAL SITUATION, GLOBAL, NIGERIA

Report on the global HIV/AIDS Epidemic by end of

| | 1997 | 1999 | 2001 |
|--|--------------|--------------|------------|
| People newly infected with HIV | 5.8 Million | 5.6 Million | - |
| No. of people living with HIV/AIDS | 30.6 Million | 33.6 Million | 40 Million |
| AIDS deaths | 2.3 Million | 2.6 Million | 5 Million |
| Total No. of AIDS deaths since the beginning of the epidemic | 11.7 Million | 16.3 Million | - |

REGIONAL HIV/AIDS STATISTICS AND FEATURE 1997/99/01

| | Adults & Children with HIV/AIDS | Prevalence Rate % | Cumulative No. of Orphans & CNIHA | Women's % | Main Mode of Transmission |
|---------------------------------------|---------------------------------|-------------------|-----------------------------------|-----------|---------------------------|
| Sub-Saharan Africa | | | | | |
| '97 | 20.8 ml | 7.4 | 7.8 ml | 55 | Hetero |
| '99 | 23.3 ml | 8.0 | 3.8 ml | 50 | Hetero |
| '01 | 28.1 ml | - | - | - | Hetero |
| North-Africa | | | | | |
| '97 | 210,000 | 0.13 | Orphan 14,000 | 20 | IDU/Hetero |
| '99 | 220,000 | 0.13 | CHINA 19,000 | 20 | IDU/Hetero |
| '01 | 440,000 | - | - | - | - |
| North America | | | | | |
| '97 | 860,000 | 0.6 | Orphan 77,000 | 20 | MSM, IDU, Hetero |
| '99 | 920,000 | 0.56 | CHINA 44,000 | 20 | MSM, IDU, Hetero |
| '01 | 940,000 | - | - | - | - |
| Western Europe | | | | | |
| '97 | 530,000 | 0.3 | 8,700 | 20 | MSM, IDU, Hetero |
| '99 | 520,000 | 0.25 | CHINA 30,000 | 20 | MSM, IDU, Hetero |
| '01 | 560,000 | - | - | - | MSM, IDU, Hetero |
| East Europe & Central Asia | | | | | |
| '97 | 150,000 | 0.07 | 30 | 25 | IDU, MSM |
| '99 | 360,000 | 0.14 | CHINA 95,000 | 20 | IDU, MSM |
| '01 | 1 ml | - | - | - | IDU, MSM |
| South & South East Asia | | | | | |
| '97 | 6.0 ml | 0.6 | 220,000 | 25 | Hetero |
| '99 | 6.0 ml | 0.69 | CHINA 1.3 ml | 15 | Hetero |
| '01 | 6.1 ml | - | - | - | Hetero |
| East Asia & Pacific | | | | | |
| '97 | 440,000 | 0.05 | 1,900 | 11 | IDU, Hetero, MSM |
| '99 | 530,000 | 0.068 | CHINA 120,000 | 15 | IDU, Hetero, MSM |
| '01 | 1 ml | - | - | - | IDU, Hetero, MSM |
| Latin America | | | | | |
| '97 | 1.3 ml | 0.5 | 91,000 | 19 | IDU, Hetero, MSM |
| '99 | 1.3 ml | 0.57 | CHINA 150,000 | 20 | IDU, Hetero, MSM |
| '01 | 1.4 ml | - | - | - | IDU, Hetero, MSM |
| Caribbean | | | | | |
| '97 | 310,000 | 1.9 | 48,000 | 33 | Hetero, MSM |
| '99 | 360,000 | 1.96 | 57,000 | 35 | Hetero, MSM |
| '01 | 420,000 | - | - | - | Hetero, MSM |
| Australia & New Zealand | | | | | |
| '97 | 12,000 | 0.1 | 300 | 5 | MSM, IDU |
| '99 | 12,000 | 0.1 | CHINA 500 | 10 | MSM, IDU |
| '01 | 15,000 | - | - | - | MSM, IDU |

Seventy (70) percent of all people living with HIV/AIDS are from Sub-Saharan Africa. In sixteen countries at least 10 percent of the adult population is infected, while in Botswana and South Africa the figures are an alarming 35.8 percent and 19.9 percent respectively.

NIGERIA AND HIV/AIDS

The HIV/AIDS Nigeria (2001) NACP Report
 60,564 AIDS cases

- 2m estimated actual AIDS cases
- 47m (all ages) HIV infection
- 1m (age 15-49)

MEDIAN HIV PREVALENCE BY ZONE 1999 AND 2001

| | 1999 | 2001 |
|------------|-------|-------|
| N. Central | 7.0% | 5.50% |
| S. South | 5.20% | 7.70% |
| S. East | 5.20% | 5.80% |
| N. East | 4.50% | 5.40% |
| S. West | 3.50% | 4.00% |
| N. West | 3.20% | 3.30% |

HIV PREVALENCE (%) IN 2001

| | |
|----|--|
| SE | - Abia 3.3; Anambra 6.5; Ebonyi 6.2; Enugu 5.2; Imo 4.3 |
| SW | - Ekiti 3.2; Lagos 3.5; Ogun 3.5; Ondo 6.7; Osun 4.3; Oyo 4.2 |
| NW | - Jigawa 1.8; Kaduna 5.6; Kano 3.8; Katsina 3; Kebbi 4; Sokoto 2.8; Zamfara 3.5. |
| NE | - Adamawa 4.5; Bauchi 6.8; Borno 4.5; Gombe 8.2; Yobe 3.5; Taraba 6.2 |
| NC | - Benue 13.5; FCT 5.3; Kogi 5.7; Kwara 4.3; Nasarawa 8.1; Niger 4.5; Plateau 8.5 |
| SS | - Akwa Ibom 10.7; Bayelsa 7.2; Cross River 8; Delta 5.8; Edo 5.7; Rivers 7.7 |

NATIONAL HIV PREVALENCE AMONG SPECIFIC POPULATION GROUP 1996

| | |
|--------------|-------|
| Antenatal | 4.5%; |
| TB Patients | 13.6% |
| STD Patients | 15.1% |
| CSWs | 31.2% |

AIDS DEATH VS ALL DEATHS FOR THE POPULATION 15-49

| | ALL DEATHS | AIDS DEATHS |
|------|---------------|---------------|
| 1990 | Above 200,000 | Below 25,000 |
| 1995 | Above 250,000 | About 50,000 |
| 2000 | Above 400,000 | About 200,000 |
| 2005 | Above 550,000 | Above 300,000 |

PROJECTED NUMBER OF AIDS ORPHANS

| | NUMBER |
|-----------|-----------------|
| 1990-93 | 0 |
| 1994-98 | Over 500,000 |
| 1999-2000 | 1,000,000 |
| By 2010 | About 2,500,000 |

Session 5- HIV TESTING AND DIAGNOSIS

Objectives:

By the end of this session participants will be able to:

- Mention the types of HIV testing
- Explain the meaning and interpretation of HIV test results

Time: One hour

Materials: Flipchart, stand, markers, chalk, board

Process:

1. Share the objectives for the session
2. Introduce the topic in line with Note to Trainer

Introduction

HIV was first isolated in 1983 and identified as the etiologic agent for AIDS. Several methods have been developed to detect the infection. Laboratory diagnosis today is an important tool in the country's National Control Program Strategy for HIV/AIDS. Judicious use of testing combined with patient education (during pre/post test counselling) can help prevent a sero-positive individual from spreading the disease, and preventing sero-negative individuals from acquiring the infection. It is therefore important to evaluate different tests in terms of their appropriateness to available facilities as well as to their cost.

3. What approaches are used for the detection of HIV infections?
4. Encourage participants to respond to this pertinent question and commend their efforts; complement by explaining that:

The definitive diagnosis of HIV infection depends on three approaches:

- a. Detection of HIV antibodies
- ii. Detection of HIV antigen
- iii. Isolation of virus (viral culture)

5. In all the approaches, blood samples of the clients are taken

NOTE TO TRAINER

To avoid confusion, stop the discussion of HIV testing and diagnosis here in situations where participants without a medical background are being trained as HIV/AIDS Counsellors. But ensure that the section on interpretation of test result is for Trainees. Proceed with discussion of types of tests, techniques, advantages and disadvantages of the tests with participants who have a medical background as follows:

Detection of HIV Antibodies

Two types of HIV antibodies test, one for screening and one for confirmation

Screening

This is the presumptive identification of unrecognised disease by the application of a test which can be applied to sort out those who have an infection or disease from those who probably do not.

Techniques involved in HIV antibody testing

- ELISA
- Rapid/Simple test
- ELISA – Enzyme Linked Immunosorbent Assay
- Antigen – Antibody reaction
- Most commonly used screening assay

ELISA:

Advantages

- Cheap
- Efficient
- Can test large number of samples

Disadvantages

- Takes longer time (30 minutes), thus delay in receiving result
- Requires skilled and well-trained staff
- Needs sophisticated equipment

Examples of ELISA test

- Genelavia HIV I/HIV II
- Enzygnost HIV
- Recombigen

RAPID/SIMPLE TEST:

It is also an antigen-antibody reaction

They are EIA (Enzyme Immuno Acid) based on agglutination, chromatography or immuno binding

Advantages

- Whole blood can be used
- Takes less than 30 minutes
- Result read visually
- Sophisticated equipment not required
- Can be done by laboratory staff with minimal skills

Disadvantages

- More expensive than ELISA
- Increase potential of self testing without proper counselling

Examples of RAPID test

- Genie II HIV I/HIV II
- Capillus HIV
- Determine HIV
- Efoora HIV

Types of Confirmatory tests

Immuno blot ((Western blot) – ELISA principle
 Indirect Immuno Flourescent (IFA)
 Radio Immuno Precipitation Assay (RIPA)
 Viral Culture
 PCR – Viral RNA Assay
 The most commonly used is Western blot

Advantages

More specific than ELISA

Disadvantages

Expensive
 Requires highly-trained specialist staff to carry out the test and interpret the result
 Specimen has to be transferred to another lab for confirmation
 Can produce indeterminate results
 Takes much longer time than ELISA

Alternative Confirmatory Strategy for HIV Testing in Nigeria

This was designed to make HIV testing more accessible in the developing world like Nigeria. This strategy is referred to as double ELISA. We are using rapid tests.

Detection of HIV Antigens

The most reliable tests for detection of HIV infection at whatever phase of the disease are tests that can directly detect the virus in serum or plasma. Examples include:

P24 Antigen Assay (Antigen Capture ELISA)
 PCR (Viral HIV RNA Assay)
 Viral Culture

Interpretation of HIV Antibody Testing

(for all cadres of trainees)

- Encourage participants to mention expected results of HIV test and commend their efforts
- Explain that three types of result may be generated in HIV testing, namely:
 1. Negative
 2. Positive
 3. Intermediate or Indeterminate

Knowing the difference between negative, positive and intermediate results can help....

1. People to understand that a negative test result means that HIV antibodies were not detected in the patient's sample

Implications of a negative test result

- The person is either not infected – true negative
- The person is in the Window period – false negative
- Does not mean the person is immune to HIV
- If in the Window period, he could infect others

Other reasons for false negative test results

- Sero Reversion – ONLY HAPPENS CLOSE TO DEATH
- Could be a typical host response
- Technical or clerical error

2. People to understand that a positive test result means:

HIV antibodies were detected in the person's sample. It implies that he has been infected with HIV.

Implications of a positive test result

- He can pass the virus to another person
- It does not necessarily mean he has AIDS
- It could be a false positive result, hence the need for confirmation

Reasons for a false positive result

- Auto-antibodies
- HIV vaccines (there are none in Nigeria at present)
- Factitious HIV infection
- Technical or clerical error
- High sensitivity of test kit
- Poor storage of samples and test kits – belongs in the false negative section

3. People to understand that an intermediate test result means that:

Presence or absence of HIV antibodies could not be confirmed

Implications of Indeterminate test result

- Process of Sero-Conversion
- Cross reactivity due to prior inoculating, e.g. anti viral vaccine
- Prior medical conditions, e.g. auto immune disorders and severe kidney diseases

Summarize the key points and clarify any questions raised. Help participants see how correct interpretation of test results can make counselling effective.

Module Two



Session 1- BASIC PROCESS OF COMMUNICATION

Objectives:

At the end of the session, participants will be able to:

- Define communication
- Mention at least four different types of communication
- Explain the process of communication using the acronym MS-CREF

Materials: Flipchart, markers, overhead projector, transparencies

Duration: One hour 30 minutes

Method: Brainstorming, role playing, interactive lectures

Process:

1. Ask a volunteer participant to read out the objectives

What is communication?

2. Encourage the group to think about the word “communication.” Call 2-3 volunteers to define it while the others listen. Lead the group to define it as follows:

Communication is the expression of thoughts and ideas or making known one’s ideas or feelings to another person or group of persons.

Explain further that it should be noted that without it, people cannot relate to one another. It applies to every aspect of people’s lives.

Also it is important to note that in discussing communication and counselling, one needs to understand the supremacy of the spoken language, which is a series of codes to which a group of people attach agreed meanings; on the basis of such agreement, appropriate actions are generated as responses.

What are the different types of communication?

3. Ask participants to brainstorm the different types of communication. Possible responses may be:
 - i. Verbal and
 - ii. Non-verbal communication.
 - iii. Intra-personal
 - iv. Inter-personal
 - v. Mass media

Explain each as indicated in the trainer’s note.

TRAINER’S NOTE

Types of communication

1. Verbal Communication

This is the exchange of ideas through spoken or written expression (word).

2. Non-verbal Communication

This involves the expression of ideas, thoughts or feelings without the spoken or written word. This is generally expressed in the form of body language that includes gestures and facial expressions.

Both verbal and non-verbal form the basis of inter-personal communication, discussed below.

Communication could also be divided into intra-personal, inter-personal and mass media.

3. *Intra-personal Communication*

This is talking within oneself. It is the thought going on within a person. This form of communication takes place before any other form of communication. Before anybody talks to any type of audience or takes any action, he/she must think about it. It follows therefore, that conflict within oneself can negatively influence one's communication with another person or one's perception of another person's messages.

4. *Interpersonal Communication*

Interpersonal communication is the face-to-face verbal and non-verbal exchange of information, ideas or feelings between individuals or groups.

5. *The mass media*

This involves communicating with a large group of people through specialized media such as electronic media (television, radio, etc.) and print media (newspaper, magazines, posters, etc.). Although these media can reach a large audience, they may be inappropriate for counselling, as this does not allow for feedback. Where feedback is possible, as in radio and television phone-in programs, they are costly and not widely accessible.

PROCESS OF COMMUNICATION

What is this process?

By way of definition, a process is a set of steps taken to achieve a task. It is important to understand that communication occurs over time and it is useful to appreciate it as a process that seeks to reduce uncertainty. The communication process will be explained with the use of a shorthand expression/acronym known as MS-CREF.

M - Message

S - Source

C - Channel

R - Receiver

E - Effect

F - Feedback

Explain each step of communication as below:

Message:

This is the content of the information, the idea or thoughts that the sender passes on to another person or group of persons.

Source:

The person who passes on or sends the message is known as the Source. The Source is also called the Sender.

Channel or Medium:

The path chosen for the transmission of the message.

Receiver:

The person who gets the information is the receiver.

Effect:

The impact of the message on the receiver is called the effect. Sometimes the intended effect is not achieved because of the style of presentation. There are times when the communicator has something in his mind (latent content) and ends up saying something else.

Feedback:

What the receiver ends up doing as a result of the message he/she receives is called feedback. It is the assessment of the impact of the message. A feedback can either be positive and/or negative. It is positive if the receiver has the reaction intended by the sender. If he/she does not do what is intended, the feedback is negative. Feedback may be spontaneous (elicited immediately) or delayed.

Explain each of the steps as below:

Skills for effect communication

The source (sender) must:

KISS, i.e.

Keep

It (the language)

Simple and

Sensible.

- Avoid semantic noise, i.e. use of words that is meaningless to the receiver.
Have a good manner of speech in terms of coherence, presentation and use of gestures/expressions that animate the scene.
- Accord respect to the receiver (target audience).
- Avoid changing topics unnecessarily.
- Be lively and confident. By so doing, he/she can establish good rapport.
- Be a good listener as well.
- The message must:
 - Be clear
 - Be brief
 - Be straight to the point.
- The medium must be:
 - Clear. An unclear medium causes distractions (channel noise).
 - Accessible.
- The receiver must be:
Both a good listener and speaker. It is good for her/him not to interrupt a speech for this will make the speaker lose key points.

Able to maintain eye contact.

Summarize the key points and clarify any questions.

Evaluate the session by asking the following questions:

1. What is communication
2. What are the different types of communication?
3. What is the full meaning of the acronym MSCREF?

Session 2-

INTRODUCTION TO INTERPERSONAL COMMUNICATION

Objectives:

At the end of this session, participants will be able to:

- Define interpersonal communication
- Describe the processes of motivation, education and counselling
- Discuss the differences between motivation, education and counselling
- Define HIV/AIDS counselling

Materials: Newsprint, stand, markers, masking tape

Time:

Process:

1. Share the objectives of the session
 2. Review different types of communication as discussed in session 1. Call on volunteer participants to mention a type of communication and explain what it means until all types are reviewed. Make clarifications as necessary
What is interpersonal communication?
 3. Reveal a prepared newsprint with the definition:
Interpersonal communication is an exchange of information or feelings that is face-to-face, verbal and non-verbal between two or more people, including the processes of education, motivation and counselling.
- Draw the attention of trainees to key aspects of the definition of IPC.

What is education?

- Ask the participants to think/write out the meaning of education. Allow 2–4 volunteers to read out their write-up. Commend their efforts.
- Explain that in this context it is defined in relation to HIV/AIDS for which participants are training as counsellors as follows:
“provision of unbiased information and facts about HIV/AIDS to someone motivated to seek education.”
- The process of education may have two effects:
 - i. Creation of awareness
 - ii. Motivation of receiver to adopt a change in behaviour

What happens during education session?

- Greet client
- Introduce yourself and the benefits of learning about HIV/AIDS
- Explain what HIV/AIDS is
- Review how it is transmitted.
- Review also what one can do to prevent or reduce the risk of infection
- Encourage questions
- Correct misinformation
- Provide information on the next steps.

What is motivation?

What happens during motivation session?

- Provide information on the need for the behaviour (such as what AIDS is and the need to protect oneself from infection with HIV).
- Explain how to carry out the desired behaviour (such as how to use the condom)
- Correct misinformation (e.g. condoms are only used by prostitutes and their clients)
- Give information on where to obtain services or commodities (e.g. condom) to support the new behaviour

What is counselling?

- Allow participants to attempt to explain the meaning of the word “counselling”. Note the key points mentioned. Lead the group to define counselling:
“a person-to-person interaction between the counsellor and the client during which the counsellor provides accurate information to enable the client to make an informed choice/decision about the course of action that is best for him/her.”
- Three outcomes of the counselling process are:
 - i. counsellor helps the client define his/her feelings
 - ii. counsellor provides unbiased information
 - iii. client is empowered to make an informed decision/choice
- Looking at the description of the counselling process above, as long as one understands the key points of the process ,i.e.
 - i. Counsellor must be able to provide accurate /current information about the topic being discussed.
 - ii. There should be person-to-person on a one-to-one basis to assure confidentiality
 - iii. Client, not the counsellor, must make the decision.
- Let us now look at the definition below:
“Counselling is the process of assisting clients in making an informed choice/decision regarding how to change his/her behaviour.”
- Conduct medical examination (maybe)
- Take personal history(maybe),
- Counsel client: discuss feelings, attitudes and individual situation.
- Listen and ask questions
- Assist client to identify desired behaviour change/outcome
- Discuss necessary steps to bring about desired behaviour change/outcome.
- Give the client information to learn necessary skills to attain behaviour change, e.g. how to use to condoms.
- Encourage client to identify possible obstacles in attaining desired behaviour change/outcome
- Brainstorm with client on how to overcome obstacles
- Help client develop “plan” for attaining desired behaviour change/outcome.
- Ask client to summarize
- Document
- Schedule follow up visit

EXERCISE:**Motivation, Education, Counselling Game**
“What am I Doing Game”

Time: 15 minutes

Process:

- i. Have the group stand in a circle with their hands free
- ii. Tell them that the game is about to start now and is called “What am I doing?”
- iii. Read out each statement (twice) from the motivation, education, counselling game in Trainer’s note
- iv. After each statement, ask one person in the group to identify the speaker as the motivator, educator or counsellor
- v. Allow discussion in areas of disagreement about the response.

TRAINER’S NOTE**Motivation, Education, Counseling Game “WHAT AM I DOING?”**

I am talking to a village chief about why AIDS education is important to the village.

What am I doing?

I am a satisfied user of the condom, and I am talking to my neighbour about why I like it, where I got it, and how it is free. What am I doing?

I am listening to a woman explain that her husband’s family is opposed to modern methods of family planning, including condoms, and discussing with her some options. What am I doing?

I am explaining a range of contraceptive methods to a woman who wants to prevent pregnancy and infection with HIV. She is trying to decide on a method. What am I doing?

I am talking to a group of women gathered at the village well. I ask them about the health problems that they have. Then I tell them how to prevent getting infected with HIV. What am I doing?

I am asking a woman in an antenatal clinic if she knows that a baby can get HIV in the womb from its infected mother. What am I doing?

I am explaining to an HIV-positive mother in the child health clinic why she should breastfeed her baby. What am I doing?

I am talking to a group of patients with AIDS-like symptoms at a hospital. I am telling them what the HIV blood test is and what the results can indicate. What am I doing?

I am talking to a woman about her concerns that her husband has several “girlfriends.” The woman is worried that he might “bring home” an illness. What am I doing?

What is HIV/AIDS Counseling?

HIV/AIDS counselling is a confidential dialogue between a person and a care provider aimed at enabling the client to cope with the stress and to take personal decisions relating to HIV/AIDS.

Note key elements as follows:

- i. Confidential dialogue
- ii. Provision of accurate information to enable client to:
 - Explore his/her situation and feelings
 - Reach a better understanding of the problems
 - Make choices and take action, e.g.
 - Reduce risk of becoming infected or transmitting the infection to others
 - Adopt new approaches to safer sex and responsible relationship
 - Help those already infected to cope
- iii. Addition of more points as suggested by the group members

Summary: Summarize the key points in the session

Evaluation: Ongoing techniques used

SUMMARY

During a counselling session, person-to-person communication is used to motivate, educate and counsel clients in every area of health, from Family Planning to HIV/AIDS prevention and management.

Counselling should be used in primary healthcare service delivery. A woman with special problems, constraints and fears about getting HIV or AIDS, for example, needs encouragement and empathetic treatment of other STIs in addition to information.

The way in which a healthcare provider interacts with her can have a major effect on whether or not she carries out desirable health practices (such as limiting the number of partners or using condoms).

In HIV/AIDS counselling, the counsellor's objective is to give the power of informed choice to a client, who is then free to choose behaviours that will reduce her/his risk of becoming infected or to manage the illness if she/he already has AIDS.

HIV/AIDS is far more sensitive than other primary healthcare issues. HIV/AIDS counselling may use the same skills as other types of primary healthcare counselling but it requires much more awareness of personal values and preferences, the inviolable nature of client confidence and trust, and the difference between professional guidance and personal persuasion

Interpersonal counselling is used in all areas of healthcare provision. All healthcare staff, whether in the clinic or in the community, rely on person-to-person communication. For this reason, good interpersonal counselling skills can make the difference between success and failure in any healthcare program.

Session 3- PROCESS OF BEHAVIOUR CHANGE

Objective:

- To enable participants to explain the various stages in the process of behaviour change

Time: 30 minutes

Materials: Flipchart, stand, markers, chalk/board

Process:

1. Ask participants to think of any change of behaviour in their lives. They can think of areas such as smoking, religious practice, alcohol or drug use, study or food habits, dress.
2. List the areas they come up with down one side of the flipchart.
3. Ask a few persons to describe step-by-step why and how they changed their behaviours. Ask about various factors: cultural, health, information, partners, peer group, friends, family, etc. List reasons for the change next to each behaviour area.
4. Ask the group to look at the similarities and differences that came up as participants spoke of the reasons for making a behavioural change.
5. Use the heads below to group the reasons:
 - Received additional information
 - Influence from parents
 - Influence from peers
 - Services and/or commodities were available
6. Take one of the examples and chart it along the Behaviour Change Process outlined below. Relate “influences” and “services” noted under #5.

The Process of Behaviour Change

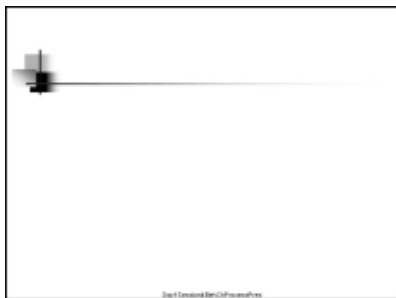
- Unaware
 - Informed
 - Concerned
 - Knowledgeable
 - Motivated to change
 - Ready to change
 - Trial/assessment of new behaviour
 - Sustained behaviour change
7. Ask if anyone is able and willing to share a behaviour change experience connected to STIs or HIV and walk the group through the chart above.
 8. Lead participants in identifying what the Peer Educators response to a client at each of the stages of behaviour change should be.

| Stages Of Behaviour Change | Response Of Peer Educator To A Client At Each Stage |
|--------------------------------------|---|
| 1. Unaware | Provide basic information on situation, e.g. causes and consequences of untreated STIs |
| 2. Informed | Encourage the adoption of positive steps; present them with behaviour change options |
| 3. Concerned | Tell them what to do next in changing their own behaviour, e.g. go to the clinic to receive STI treatment |
| 4. Knowledgeable | Motivate the client to act, e.g. inform them of the benefits of attending clinic |
| 5. Motivated to Change | Point/Direct Client to services and encourage use |
| 6. Ready To Change | Tell client the benefit of using the services |
| 7. Trial/Assessment of New Behaviour | Provide opportunity to practice new skills and reinforce what client will do to continue with new behaviour |
| 8. Sustained Behaviour Changed | Tell client they are doing the right thing Create/encourage environment that promotes new behaviour |

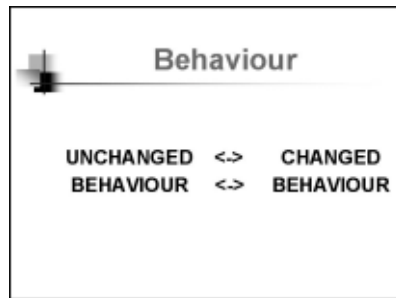
Effects of voluntary changes of behaviour on clients:

- More rewarding to the client
- Leads to better feelings
- Is under client’s control – may choose to make small changes at a time
- Experience success
- Experience good feelings
- Enjoys “internal” reward of change in behaviour as contrasted with punishment
- Internal (self) reward is more durable
- Experience of self reward for small changes encourages client to attempt bigger reward
- The establishment of internal control for longer-term planning are characteristics of maturity – a primary objective of counselling

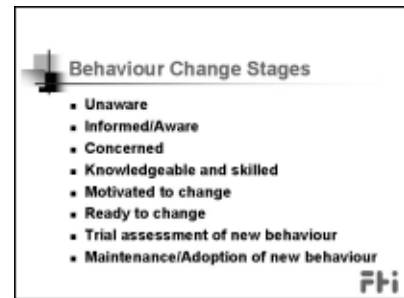
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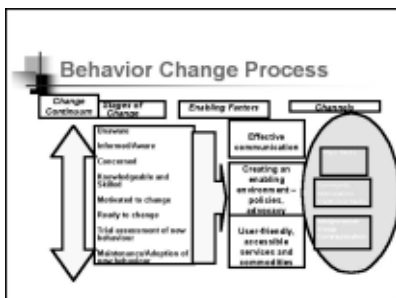
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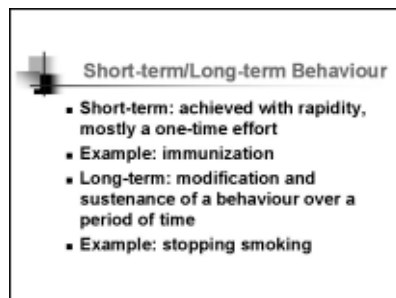
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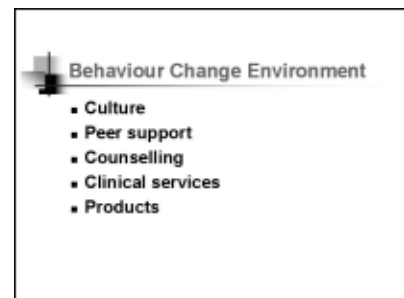
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Slide 6



Module Three



Session 1- PRINCIPLES AND PRACTICE OF COUNSELLING

Objectives:

At the end of this session, participants will be able to:

- Define and explain the concept of counselling
- Discuss the format of counselling session
- Identify the attributes of a good counsellor
- Explain the process of counselling
- Describe the format of initial interview of the clients
- Maintain the general guidelines for effective counselling

Materials: Flipchart, stand, markers, chalk/board

Method: Discussion, role playing, brainstorming

Duration: One hour 30 minutes

TRAINER'S NOTE

- Share the objectives of the session
- Allow each participant to examine the words “principles”, “practice” and review the definition of counselling
- Lead the participants to define the terms as follows:
 - a) Principle – guideline that governs a particular behaviour
 - b) Practice – the process of doing something or performing an act or application of a known knowledge or something
 - c) Counselling – the process of assisting clients in making an informed choice/decision about how to change his/her behaviour

Basic principles of counselling

The most important aspect in the process of counselling is the relationship between counsellor and client.

The relationship must be based on respect for the client as an individual and confidence in the client’s ability to learn to help him/herself.

The counsellor must demonstrate these beliefs in his/her behaviour.

The client must be helped to understand that he or she:

- a) can exercise some control over his/her fate, and to do so
- b) must make decisions, and then
- c) must act on that decision, after which he/she needs to evaluate the result

The counsellor can help clients understand themselves better by helping clients to talk about themselves.

The counsellor can help clients to explore their feelings, and not just facts.

The counsellor can help by saying that feelings are involuntary:

- a) we can (usually) choose how to behave
- b) we are responsible for our behaviour
- c) we can judge our behaviour and others can judge it

Even if we act “badly”, that does not mean that we are “bad.”

The counsellor should accept the client even if the client’s behaviour is not acceptable.

Voluntary changes of behaviour will be rewarding for the client.

Changes in behaviour will lead to better feelings about self.

The counsellor can convince the client to make small changes in behaviour, to:

- a) make the client see that voluntary behaviour is under client's control
- b) enable client to experience success
- c) enable client to experience good feelings resulting from voluntary changes

A reward is more effective than punishment for behaviour change.

Internal ("self") reward is more durable than external reward.

The counsellor must help the client experience an internal reward to achieve self-motivation.

The experience of self-reward for small changes will encourage the client to:

- a) attempt bigger changes
- b) be able to wait longer to experience self-reward

The establishment of internal control over one's own behaviour and the capacity for longer-term planning are characteristics of behavioural maturity, which is a primary objective of counselling

The Initial Interview

A counsellor should note that it is important to:

- Start on time and not to keep the client waiting
- Make the client comfortable
- Introduce yourself
- Ask for the client's name
- Sit face to face on the same kind of chair
- Thank the client for coming
- Begin with the "easy" question
- Help the client to tell why they have come
- Note client's demeanour, whether they are anxious, angry, joking, or flat
- Act to make them relaxed, reduce anxiety.
 - Explore anger; and make it easy to admit it
 - Show that it is acceptable
 - Don't respond to "jokiness" but remain empathetic
 - Try gently to arouse a "Flat" person
- Let the client do the talking, allow silence, but intervene if it goes on for too long
- Notice any change in demeanour and what has caused it
- If the client is not able or willing to talk, suggest another meeting
- If you do not have an answer to an appropriate question, say so and either arrange to find it or arrange a referral, with the client's agreement
- Reassure the client, but don't mislead
- Provide closure at the end of the meeting and arrange for some form of follow-up
- Ask the client how he/she feels before ending the session
- End on time

Attributes of a Good Counselor

A good counsellor is able to:

- Establish rapport by meeting the client at his / her own level
- Express empathy by being in tune with the client's feelings
- Elicit needed information
- Explore client's feelings
- Give accurate information, without being judgemental
- Give practical assistance, such as referral to appropriate services
- Focus on circumstances, facts and feelings, which relate to the client's problem. As a result of the counselling interactions, the client emerges with increased self-confidence and ability to solve his/her problems
- Accept the client as an individual
- Encourage clients to talk freely about themselves
- Help clients explore their feelings
- Demonstrate respect and willingness to listen
- Believe that clients can be helped to help themselves
- Help clients believe that they have some control over their lives, i.e. they can make their own decisions and act on them
- Evaluate the consequences of these decisions and the actions that follow
- Adhere strictly to the concept of confidentiality, which must be made clear and understandable to the clients

Outcome of Effective Counselling

For clients

The clients should:

- Have more control over their lives
- Feel more confident
- Adopt healthy development and behaviour change
- Feel good, which is rewarding in that it will encourage the clients to help themselves
- Plan for the future

Client's Rights

The facilitator should:

- Explain that a good knowledge /respect for the client's rights forms a strong foundation in fostering the relationship between the counsellor and the client
- Demonstrate confidence in the client's ability to learn to help him/herself
- Explain that the client must be helped to understand that they can exercise some control over their fate, make decisions, act on those decisions and evaluate the result.
- Allow clients to know that feelings are involuntary and can change from time to time and as a result we can usually choose how we behave, we are responsible for our behaviour , we can judge our behaviour and can be judged by others
- Write out the acronym "DISCCACCOP", encourage participants to fill in the meaning of each letter and clarify as per trainer's note

TRAINER'S NOTE

D – ignity
I – nformation
S – afety
C – omfort
C – onfidentiality
A – ccess
C – onsent
C – ontinuity
O – pinion
P – rivacy

Activities

- Organise participants into four groups
- Assign topics to each group as below:
 - a) process/format of initial interview
 - b) attributes of a good counsellor
 - c) outcome of effective counselling
 - d) client's rights
- Let group work last for 15 minutes to be followed by five-minute report
- Allow discussion/contribution
- Clarify presentations as per trainer's note

TRAINER'S NOTE

- The initial interview
- Attributes of a good counsellor
- Organise each group to role play the key points raised in each topic assigned for 15 minutes
- Have each group make presentations for three minutes
- Encourage feedback from observers
- Conclude the session by asking participants to practice those key points highlighted in the session.

Module Four



Session 1-

MICRO SKILLS OF COMMUNICATION IN COUNSELLING

Objectives:

At the end of the session participants will be able to:

- List the micro-skills of communication in counselling
- Demonstrate the various skills needed for communication in counselling

Materials: Flipchart, stand, chalk/board, markers

Method: Role playing, demonstrations, brainstorming

Duration: Two hours

LISTENING SKILLS

Introduction:

Often we hear, but we aren't listening to the clients. Studies done on client/counsellor interaction show that counsellors often interrupt the client many times during counselling exchange, cutting off critical information that the counsellor can use in assisting with decision making. This does not show respect for the client and does not allow the client to feel at ease.

Listed below are some of the listening skills needed by counsellors to be active and good listeners: It is very important for counsellors to:

- Be attentive
- Concentrate on the client
- Summarize, reflect
- Avoid interruption
- Give non-verbal feedback (e.g. nod, smile, say "Mmmm", lean forward)
- Ask for clarification

Attending Skills

Body language: A counsellor should be able to read and understand the client's non-verbal body language. He/She should be able to differentiate between angry, happy, frightened or sad postures and looks. He/She should be able to interpret different gestures and facial expressions.

Eye contact: A counsellor should maintain appropriate and comfortable eye contact with the client.

The appropriate one is somewhere between an unwavering gaze (staring) and total aversion of the eyes.

Distance: The distance between the counsellor and the client should be close enough to indicate good rapport and acceptance.

Trunk lean/body movements, synchrony:

The trunk lean and the body movements of both the counsellor and the client should synchronize in such a way as to indicate understanding, closeness, and acceptance.

Quality of utterances:

It is equally important for the counsellor to take note of the quality of the client's utterances, in terms of the speed, the pitch, the volume, the quantity, and whether they are monotonous or varied.

Appearance:

It is also important for the counsellor to note the client's appearance, in terms of style of dressing, tidiness and cleanliness, whether the client looks rough or tidy, whether the clothes are decent or torn.

Encouragers:

These are simple but powerful forms of active listening closely related to body language. They consist of non-verbal signals and utterances given by the counsellor to encourage the client to speak or continue speaking. Such signals and utterances include nodding, Saying huunn, go on, oh, then, I see, okay, etc. These signals and utterances, if used unobtrusively, are indicators to the client that the counsellor is listening, interested and pleased that the client is expressing him/her self.

Reflections of facts, and feelings:

Reflecting back the meaning of what the client has expressed either with regard to facts or feelings is a useful method of encouraging the client to continue talking. Sometimes this may be more effective than asking a direct question. It reinforces the idea that it is up to the client to engage in self-exploration, and that he/she should not depend entirely on the initiative of the counsellor.

EXAMPLES

- 1) Yesterday at work, despite feeling tired, I was asked to work late. The facilitator might respond: So you were asked to work for extra hours in the office yesterday even though you were feeling tired. This is reflection of facts.
- 2) At first I was scared of HIV testing, but after talking to a counsellor I was relieved. The facilitator might say: So after talking with a counsellor you were relieved of your initial fear of HIV testing. This is reflection of feelings

Summarizing

Summarizing is similar to reflection in that it is feeding back what the client has said, but covers more. It is a useful skill to keep the client talking. It is also a useful way to close a topic and change the subject in the least disruptive way.

Summarizing will include both reflections of facts and feelings. It avoids repetition and it is more concise than the client's statement. It must include the important points expressed and emphasized by the client. Summarizing helps to give a clearer expression of the client's experience without moving beyond it into an interpretation.

Verbal following

This involves repeating what the client has said to indicate that the counsellor is paying attention to the client and to ensure that what he /she heard the client say is correct. This skill also allows the client to achieve self-exploration and understanding. It is useful in preventing direct questions from the counsellor.

Some issues that can arise during listening

- When counsellor's response is not relevant to what has been said
- When the counsellor changes the subject
- When there is an incongruous response; when non-verbal messages appear to conflict with verbal messages
- When the speaker is interrupted

Consequences on the clients

- Makes them question whether they were heard
- Causes them to question the worth of what they're saying
- Causes them to lose confidence in the listener

MICROSKILLS OF COMMUNICATION IN COUNSELLING II

- The Art of Asking Questions
- Open Questions, Closed Questions
- Focus and Tense of Counsellor's Statements

1) THE ART OF ASKING QUESTIONS

In counselling, questions are asked for the following reasons:

- To know why the client has come
- To help the client express needs and wants
- To help the client express feelings and attitudes that allow the counsellor to know how the client feels
- To help the client think clearly about choices
- To show the client that the counsellor cares
- To learn the client's knowledge of subject matter
- To learn about situations affecting the client

How to question effectively

- Use a tone that shows interest, concern and friendliness
- Use words that the client understands
- Ask one question at a time and wait with interest for the answer
- Ask questions that encourage clients to express their needs, e.g. "May I ask you about your school and family?"
- Use words such as 'then' "oh". These words encourage clients to continue speaking
- Avoid starting a question with 'why'; this suggests that one is finding fault
- When asking a delicate question, explain why you are asking (e.g. when asking about the numbers of sexual partners to find out about STI/HIV risk)
- Ask the same question in other ways if the client has not understood

Expressive skills

These are verbal expressions that are used to help clients in self-exploration. They could be in the form of questions.

Questions

These are the primary tools that counsellors use to obtain information or seek clarifications from clients.

There are two types of questions: close-ended and open-ended

Close-ended questions

These demand short or one-word answers, e.g. How old are you? What is your name? Do you go to school? Are you married? They are very useful for obtaining demographic data and at the opening stages of the session. When overused they tend to lead to interrogation rather than counselling. Close-ended questions limit counselling sessions and put the counsellor and the client in a difficult position to continue.

Open-ended questions

These demand long explanatory answers. They are the best to use in a session because they allow the client to talk more and also to come up with their own solutions. They facilitate more discussions. Examples are: Can you tell me more about your relationship with your sex partner? Could you explain that? How did that make you feel? How do you spend your leisure? Open-ended questions frequently start with the words What? Could? Would? How?

The difference between the two is the extent of freedom that the person responding has in choosing a response. Open-ended questions allow clients to exercise some control over the direction of the conversation while close-ended questions do not. In an open-ended question, the client can choose how to answer the question from a wide variety of responses.

Circular questions

These questions are used to identify patterns of interaction within the system. The questions also help the family to see how the whole family is involved in the problem and how family members influence and are influenced by the problem behaviour. Circular questions are used to link the past, present and the future in terms of behaviour and interactions. Circular questions are open-ended questions.

Avoid “why” questions.

When we use questions with children be careful about how the questions are phrased, taking into consideration the children’s level of development.

FOCUS AND TENSE OF COUNSELLOR’S STATEMENTS

Focus

The focus of a statement can be divided into five categories indicated by the following pronouns

- ‘You’ – focus on the client
 - ‘I’ – focus on the counsellor
 - ‘We’ – focus on the client and counsellor
 - ‘They’ “Them” – focus on others
 - “It” – focus on the main theme
- “I wonder how you are feeling at the moment” reflects focus on the client
- “I am sorry, I’m afraid, I’d forgotten you told me you had another brother” reflects focus on the counsellor
- “I am glad that we’ve been able to talk together about things that are important to you” reflects focus on the client and the counsellor
- “John, you have told me about your wife and son, is there anything more you’ll like to tell me about them?” reflects focus on others
- “As far as we know, it is common for a boy to stroke his penis for a sexual release, what we call masturbation” reflects focus on the main theme

Tense

This refers to whether the statement made by the counsellor is in the present, past or future tense.

- “How are you feeling now?” reflects present tense
- “How did you react when your boyfriend told you what happened? reflects past tense
- “Have you thought about how you will break the news to your wife/husband?” reflects future tense

The choice of tense reflects the emphasis of the discussion. The past tense is used to help the client explore how she came to have problems. The present tense focuses on what is happening in the counselling session. The future tense is used when the clients are beginning to think ahead as to how they will resolve their problem or difficulty.

It is important to add that focus and tense should be used appropriately by the counsellor to promote effective counselling.

Summary

Micro skills are very important tools for the counsellor in helping the client to achieve self-exploration, self-understanding and decision making and problem solving skills which, together, will increase the client’s self-development. It is crucial that the counsellor acquire these micro skills for effective and successful counselling

Remember

- Your motivation in asking the questions is: what do you need to know/ do you really need to know?
- Is the question necessary or might a reflection be better?
- What will you do with the information?
- How will the client perceive you? As interrogator, magistrate, policeman or helper?

Clarification/Reflections

A counsellor checks his/her understanding of what the client has said by seeking clarification, e.g

“Are you saying that.....?”

“Did I get you right.....?”

“Correct me if I am wrong....”

Never make assumptions in counselling, always seek to clarify. If you are not sure of the meaning, check it out.

Activities

Practice sessions on demonstration of attending skills, encouragers, reflections, summarizing, verbal following, using close- and open-ended questions.

Module Five



Session 1- TYPES OF HIV/AIDS COUNSELLING

Objectives:

At the end of the session participants will be able to:

- Identify the different types of HIV counselling
- Explain the steps in pre-test counselling
- Identify the main counselling issues in post-test counselling
- Demonstrate the skills in pre/post-test counselling

Materials: Flipchart, stand, markers, chalk/board

Method: Interactive lectures, role playing, group work

Duration: Five hours

Process:

1. Share the objectives
2. Review the definition of HIV counselling
HIV COUNSELLING defined as “a confidential dialogue between a person and a care provider aimed at enabling the client to cope with stress and take personal decisions relating to HIV/AIDS”.

Key points:

The process includes: (a) evaluating personal risk of HIV transmission and discussing how to prevent infection (b) describing confidential communication (c) providing basic information.

The goals of HIV/AIDS counselling are to:

- i. Prevent HIV infection and its transmission to other people
 - ii. Provide psychosocial support to those whose lives have been affected by HIV
3. Types of HIV/AIDS Counselling
Lead participants to brainstorm the different types of HIV counselling
Note their responses and then reveal the prepared list as:
 - Pre-test counselling
 - Post-test counselling
 - Crisis counselling
 - Preventive counselling
 - Bereavement counselling

What is pre-test counselling?

Pre-test counselling: dialogue between the client and care provider aimed at discussing the HIV test and the possible implications of knowing one's serostatus

- leads to an informed decision to take or not take the test
- should be offered to all who undergo testing
- should be voluntary (it is against the rights of the individual to be tested without their consent)
- should be devoid of coercion

Focus is on two main topics: (a) the person's personal history of risk behaviours or exposure to HIV (b) assessment of person's understanding of HIV/AIDS (mode of transmission) and how to cope in a crisis situation

Why is pre-test counselling necessary?

- To review the client's risk of infection
- To explain the test and clarify its meaning, to explain the limitations of the test results and caution about potential misuse of results (e.g. a negative result remains negative as long as no exposure to risk occurs) and to discuss pre-

ventive behaviour, risk reduction and condom use

- To help the client think about possible reactions to the test result and who should be informed
- To help the client understand why the test is required and to make a decision about the test

Steps to follow

- Establish a good relationship between you and client
- Identify yourself and clarify your role
- State how much time is available for counselling
- Emphasize confidentiality
- Obtain client's particulars: name, age, sex, address, marital status, etc.
- Establish what prompted the client to come for counselling and/or testing
- Obtain medical history: blood transfusion, history of STI
- Ascertain personal habits: drinking, smoking, condom use
- Assess client's knowledge of HIV/AIDS, misconceptions, misunderstanding, etc.

Assessment of risk based on client's life

HIV/AIDS risk assessment requires discussion of personal sexual lifestyle of the client, with far-reaching implications.

This entails assessment of:

- Current and past sexual behaviour and relationship(s) of self and partner (e.g. one regular partner over many years, serial monogamy or multiple concurrent partners)
 - Use of condoms, practice of safer sex, frequency or unprotected vaginal, oral or anal intercourse
 - Sexual relations with multiple partner or known HIV-infected partners
 - High-risk behaviour, e.g. injecting drug use or commercial sex work (male or female)
 - History of previous blood transfusion or organ transplant
 - Exposure to possibly non-sterile invasive procedures, such as injections, tattooing and scarification
 - Knowledge of the client about the test and its uses. Why the test is being requested.
 - Client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour
 - Particular behaviours or symptoms that are of concern to the client
 - Whether client has considered how he/she will react to the results of the test (positive or negative)
 - If the test result is positive, who could be informed and who could provide emotional support
- Remember that the client may not realize the reasons for the questions and may also be reluctant to answer questions about private matters.

Post assessment

After assessment of personal risk, HIV knowledge and coping ability:

- Correct myths and misinformation about HIV
- Review the test procedure, including issues related to false positive and false negative and also "window period"
- Explain and obtain informed consent
- Discuss potential implications (personal, medical, social, psychological and legal) of a negative or positive result; discuss and demonstrate condom use
- Establish a relationship of trust as a basis for post-test counselling

Activities

Pre-test Activity: Role Playing

Instructions:

- Read the situations below
- Ask the participants to be in groups of four

Each group will identify a counsellor, a client and two observers. The client will choose one of the case studies below as a model.

The counsellor will begin with an open question about the client's concerns, using some or all of the concepts previously learned.

Use the counselling skills that you find appropriate, including open-ended questioning, attending, paraphrasing, reflection of feelings, reframing, verbal following etc.

The observer will verify effective use of both skills and concepts in the counselling session.

After the counselling session, there will be time for feedback; the client will be the first to provide it, followed by the counsellor. The observers will be the last to give feedback to the counsellor.

Once the role playing is completed and both the client and the counsellor have exchanged places, it will be the turn of the observers to play the role of counsellor to each other.

All the participants will have to play the role of counsellors during the exercise.

Case Study One

Female sex worker, aged 32, married.

She has recently been diagnosed with gonorrhoea.

She uses condoms occasionally with clients but never with husband .

Case Study Two

A 25 year-old bisexual male, married.

The wife is unaware of his occasional relationships with men.

He is currently involved with someone who is HIV-positive.

He doesn't feel comfortable talking about his bisexuality.

Case Study Three

A male university student, aged 21.

He occasionally visits a commercial sex worker.

He currently has a girlfriend.

He never uses a condom.

Case Study Four

A divorced woman, aged 31.

She has three children.

She is dating a man who refuses to use condoms.

She occasionally has other sexual partners.

HIV/AIDS Post-test Counselling

What is post-test counselling?

Post-test counselling is aimed at discussing the HIV test result and providing appropriate information, support and referral and at encouraging risk-reduction behaviours.

What is the goal of post-test counselling?

The main goal is to help the client to understand and come to terms with his/her test results and to initiate adaptation to their seropositive or seronegative status.

Who should have post-test counselling?

- All those who have undergone the test, regardless of the test findings

Fears about giving test results

- Giving results (positive) can be difficult and uncomfortable
- Counsellors fear they may not know what to say or do or may have an emotional reaction that may not be helpful to client; some fear that clients may harm themselves or others.
- Counsellors worry that clients may leave the session and not return.

Activity

Write three fears about giving result.

Suggested steps for giving results

- Begin the post-test session by asking how the client has been feeling since he/she had the blood drawn and congratulating client for returning or wanting to hear the test result; review your pre-test counselling discussions.
- Ask if client has any questions, understanding that most clients will want to hear the test result as soon as possible.
- When client is ready, give the test result in a neutral tone of voice, and wait for client to respond before proceeding. For a positive test result, say: “Your test result was positive. That means you are infected with HIV”. For a negative result, say: “Your result was negative. That means we did not detect any antibodies for HIV”.
- It is important to ensure that client has understood the test result and absorbed the information.
- Assess cognitive understanding by asking client to tell you what the test result means, checking for any misperceptions and misinformation.
- Assess emotional understanding by asking client how he/she is feeling at that moment, and allow for expressions of feelings.
- Proceed to behavioural integration only when client is ready to talk about what he/she is planning to do next. Behavioural integration requires that the client make an immediate plan, including partner notification, reducing risk and other behaviour changes, depending on the test result and the client’s situation.

GIVING RESULTS OF HIV TESTING

HIV-negative test result

- It signifies that HIV antibodies were not detected in the person’s serum sample.
- This result implies that the person is either not infected or that the person is still in the window period. Clarify for the client that a negative result does not mean that the person is immune to HIV infection.
- An HIV-negative person is still vulnerable to HIV infection if he/she engages in risk behaviour.
- A person who tests negative but has practiced unsafe behaviour during the window period may be infected with HIV and infectious to others.
- They need to continue to prevent exposure to HIV, maintain positive health behaviours, keep in mind the window period and protect themselves and others.

HIV-positive test result

With a positive result, it is important to inform the client as soon as possible.

- A positive result means that HIV antibodies were detected in the person's serum sample.
- The result means that the infected person can transmit the virus to others.
- It does not necessarily mean that the person has AIDS.

Give the client time to absorb the news. Give a clear, factual explanation of what the result means. This is not the time to discuss progression of the disease or the estimated amount of time left to live.

It is the time to:

- Explain difference between HIV and AIDS
- Discuss positive living
- Demonstrate appropriate condom use
- Convey the need to seek medical health whenever necessary
- Urge client to inform a trusted relation, spouse or friend
- Refer client for follow-up where available, schedule appointment for partner(s) if possible establish relationship for future counselling

HIV-indeterminate test result

Presence or absence of HIV antibodies could not be confirmed.

This can mean that

- The person may be in the process of sero-converting
- The person may have a prior medical condition that is affecting the test , e.g.- arthritis or autoimmune problems

Explain the type of test used, the need for a retest, the need to prevent and avoid exposure to infection by ensuring safer sex practice or abstinence.

Provide psychosocial support during this period of uncertainty or appropriate referral if necessary and available.

Some possible reactions following positive test result

- Shock
- Denial
- Anger
- Suicidal thought or action
- Fear
- Sense of loss
- Grief
- Guilt
- Depression
- Anxiety
- Loss of self-esteem
- Hypochondria
- Spiritual concerns

Determinants of reaction

- How well-prepared the person was for the news
- State of person's physical health
- Type of support the person has in family, friends and community
- How they learnt about the test result
- The pre-test psychological condition of the person
- Cultural and spiritual values attached to AIDS, illness and death.

What counsellors should bear mind in light of possible reactions

- Pay attention to client's emotional reaction when they learn their result, especially if positive.
- Be aware that, most of the time when clients learn that they are HIV-positive they may have these reactions: denial, followed by depression, anger and bargaining, and finally acceptance.
- Recognize that learning to live with an HIV-positive diagnosis makes people highly sensitive.
- Realize that multiple life stresses further complicate the psychological health of an individual.

Your role is crucial and you need to be supportive and helpful to enable the client to gain a sense of control over their overall health.

Post-test Activity: Role Playing

Instructions

Read the situations below:

- Each group will identify a counsellor, a client, and two observers. The client will choose one of the case studies below as a model. The counsellor will choose to give a negative, positive or indeterminate result.
- The counsellor must have in mind the proper protocols for each result.
- The observers will verify effective use of the protocol and take home points.
- Following the counselling sessions, there will be a brief time for feedback. The counsellor will be the first to express feelings, followed by the client. The observers will give feedback to the counsellor last.
- Once the role playing is completed, the observers will take the place of the client and counsellor and be observed by the other two in the group.
- All the participants should play the role of counsellor as well as give the result that they feel is most appropriate to practice on.

Case Study One

A woman, aged 25, married with four children.

She says her husband refuses to use condoms, since he doesn't do anything outside the relationship. She knows that the husband cheats on her, even with members of her circle of friends.

Case Study Two

A 35 year- old white male, married with no children, since the wife is not ready to have children yet.

He sometimes frequents commercial sex workers.

The wife does not know about his husband's sexual escapades

The man thinks his wife is having an affair.

Case Study Three

A 17 year-old female student with lots of sexual partners.

She uses condoms at the beginning of the relationship, but stops as soon as she "knows and trusts" her partners.

She came here with flat mates who talked her into being "responsible".

She could not sleep for a couple of nights, thinking about the test.

Case Study Four

A 50 year-old male widow.

He never visits commercial sex workers

He has several female friends with whom he has unprotected sex.

He was recently treated for gonorrhoea, but has not told any of his partners.

Other Types of Counselling

Crisis counselling

What is a crisis? It is an individual's response to a sudden change in personal affairs, for example:

- Diagnosis of HIV infection
- Unexpected death in family
- Breakup of a relationship
- Death of another PLWHA
- Emergence of new symptom
- Treatment failure or anything that an individual perceives as a severe life event

Crisis counselling is defined as a confidential dialogue between PLWHA and a counsellor aimed at enabling the client to cope with the crisis which is being experienced.

A crisis occurs whenever a client is:

- Intensely threatened
- Completely surprised and caught unaware by whatever is happening
- Emotionally disturbed as a result of loss of control and/or
- Emotionally paralysed because there seems to be no way to solve the problem

Note: any event that a person perceives and defines as a crisis is a crisis for the person

Characteristics of Crisis

- It is a subjective experience
- What one person perceives as a crisis may not be a crisis to another person
- It may manifest itself as an emotional reaction or disturbed behaviour such as deliberate self-harm
- It is hazardous and has the potential to cause psychosocial deterioration

A crisis situation is a critical situation in which a person is unable to use his/her normal problem solving techniques. The situation overwhelms the person emotionally and cognitively.

Role of the counsellor in a crisis

- Define the problem and restore a sense of control
- "Begin where the client is"
- Be reassuring and supportive as the client discusses the crisis
- Listen carefully; client may sound incoherent
- Comment on the strength of the feelings, the fear, or the client's efforts to deal with the problem
- Remain calm
- Accept the client's fear as genuine

It is the important that the counsellor NOT

- Play down the seriousness, for example by saying "you are over reacting"
- Panic
- Offer false assurance
- Give advice
- Take offense

Elements of crisis

A crisis is made up of:

- The blow—the shock of fearing or realizing that something is wrong, awareness of being at high risk, confirmation of HIV-positive status, death of self or loved one
- The recoil—occurs when person struggles emotionally to come to grips with the full implications of the crisis
- Withdrawal—some want to be alone with their sorrow or anger and to isolate themselves, others suffer depression or acute anxiety
- Acceptance—coming through the crisis without permanent loss of self-esteem and with restored sense of control

Techniques used for crisis counselling

- Use guided (structured) questioning, e.g., “We both need to know what is going on, so I am going to ask you some very direct questions”
- Acceptance, e.g. “You may feel angry at yourself, at me, and everyone else. I accept those feelings”
- Emotional support, e.g. “You may feel very frightened and you may need some extra time to talk. I am here for you.”

In using some of these techniques, counsellor should

- Focus on the client’s expression of current feeling and anxiety and affirm those feelings
- Check whether the client shows decision-making ability, or gives an impression of helplessness and loss of control
- Clarify what the client regards as the crisis and agree on a course of action to resolve or ease the crisis
- Start to work on one aspect of the crisis that can be easily dealt with and build confidence in dealing with future problems
- Repeat some information if the client is in denial or is too distressed to understand what is being said
- Refer the client if there is need to do so

Guidelines in crisis counselling

- Remain calm and show confidence
- Listen actively
- Show acceptance and be non-judgemental
- Show empathy and reflection of feelings
- Provide a relaxing atmosphere/an office
- Allow client to speak freely, with minimal interruption
- Allow ventilation of feelings
- Explore immediate crisis rather than underlying causes
- Assess suicide risk, ask the client about suicidal feelings
- Do not minimize the crisis
- Agree on a plan of action; do not prescribe
- Prioritize; agree on aspects that can easily be dealt with
- Have local resources to help; take all precautions necessary if there is definite risk of suicide

ACTIVITY FOR CRISIS COUNSELLING – ROLE PLAYING

Instructions for Situations Below

Ask four volunteers who will work in pairs for each of the situations below. All others are observers.

Case Study One

18 year-old sewing apprentice diagnosed as HIV-positive six months ago.

Reports at counselling center in a state of shock.

Her friend, also HIV-positive, is now very slim as a result of prolonged diarrhoea.

Case Study Two

A 30 year- old single mother who has just been given a positive HIV result .

HIV prevention counselling

- Prevention counselling is more or less similar to pre-test counselling as it provides an opportunity to the counsellor/client to negotiate and reinforce a plan to reduce or eliminate the risk of HIV transmission

Prevention counselling should:

- Prepare the client to receive and manage his/her test result
- Facilitate an accurate perception of HIV risk for those who are unaware, uninformed, or in denial
- Translate the client's risk perception into risk reduction plan that may be enhanced by knowledge of HIV infection status
- Helps clients initiate and sustain behaviour changes that reduce their risk of acquiring or transmitting HIV

What are the steps to follow?

- Assure the client that test results and other information he/she provides will remain confidential
 - Discuss anonymous testing options
 - Provide client-centered counselling to:
 - Establish and/or improve the client's understanding of his/her HIV risk
 - Assess the clients readiness to adopt safer behaviours by identifying behaviour changes the client has already implemented and
 - Negotiate a realistic and incremental plan for reducing risk
 - Determine the client's understanding of HIV transmission and the meaning of HIV antibody test results
- Remember that these will form the framework for post-test counselling and will strengthen the efforts the client has already taken towards healthier behaviour.

Demonstration of condom use

Objective:

By the end of this session, the participants should be able to demonstrate correctly how to use both male and female condoms.

- Before demonstrating condom use, a counsellor should ensure that it is appropriate to talk about condom use to the client by finding out the client's feelings towards and beliefs about condom use and clarifying any concerns or misconceptions about it. The counsellor must be very sensitive when using the penile model to detect if the client is becoming uncomfortable, especially if the client is of the opposite sex. The counsellor must deal with this situation before continuing with the counselling. For clients who have used condoms before, they should be asked to demonstrate how to use it, using the penile model. Those who demonstrate its use correctly should be commended and those who do not should be corrected. For clients who have never used a condom, the counsellor should perform a demonstration of appropriate condom use and ask the clients to practice, using the penile model, until they are able to use it correctly.

The following are the suggested steps for effective and safe condom use:

- Get condoms from the health center or shop
- Check the expiration date on condom, making sure condoms are in good condition
- Store condoms properly

- Have condoms nearby before sexual act occurs
- Engage in foreplay
- Let the woman become aroused
- Let the penis become erect
- Remove condom from package carefully
- Make sure condom will unroll properly
- Place condom on the tip of the erect penis
- Squeeze air out of the tip of the condom, and hold condom at the tip
- Roll condom down the penis
- Smooth air bubbles
- With condom on, insert penis for intercourse
- After ejaculation, hold on to condom at the base of the penis
- Withdraw while the penis is still erect
- Remove condom from the penis, away from the partner's body
- Tie the condom to prevent spills or leaks
- Dispose the condom in the flush toilet or pit latrine
- Use a different condom each time you have sex

The diagrammatic demonstration of condom use for both male and female is presented below:

Condom Negotiation Skills

Specific Objective:

- To equip participants with condom negotiation skills

Time: Two to three hours

Process:

1. Ask whether there is anyone in the group who uses condoms.
2. Ask whether any of those persons are willing to share with the rest of the group how condom use was negotiated (worked out) in the relationship. That is, how it came up, who proposed it, what happened, how it went, how it is going, and so on.
3. Ask whether any persons in the group tried to bring up the issue of condom use, but failed. Ask them to share their experiences.
4. Organise group into threes. Ask each trio to come up with one situation (being as realistic as possible) where condoms should be used. They should then come up with a strategy for a partner to introduce condom use. The strategy should anticipate possible resistance by the other partner.

5. After about 7 to 10 minutes, ask one person from each trio to describe the situation they were working on, and the strategy they decided on.
6. Here are some tips on condom negotiation you can share:
 - Say no to sex without condoms – clearly and directly
 - State firmly and clearly that your life and health are more important than the sexual relationship
 - Before any sexual activity begins, ensure that (a) partner has condoms and is willing to use them or (b) is willing to use condoms you have
 - Persuade partner that you will make putting on and using a condom very exciting
 - State your reasons for refusing sex without a condom, in a firm manner
 - Tell partner that, in addition to your own concern for your safety, you are concerned about his/her safety
 - Have condoms readily available
 - Propose other ways of having sexual pleasure without penetrative sex
 - Ask someone with influence to intervene
 - Always be conscious of situations you may not be able to handle, and wherever possible, avoid them or have a well-thought-out escape route
7. Ask pairs to demonstrate condom negotiation skills (using some of the tips above) through pair-group role playing of the following situations:
 - Where one partner is “under the influence of alcohol” or “drunk”
 - Where one partner is high on a drug other than alcohol
 - Where one partner is older, in a male same-sex relationship
 - Where one partner is older and male, in a male/female relationship
 - Where one partner is known to be violent
 - Where money or gifts are offered for sex without a condom
 - Where the male partner is being aggressive
 - In a first-time sexual relationship
 - Where a girlfriend introduces it to a long-time boyfriend
 - Where a boyfriend introduces it to a long-time girlfriend
8. Have the group examine each role-playing performance from the point of view of the effectiveness of the communication skills of the person negotiating condom use.
9. Have each participant take turns saying what he or she thought about the exercise and what was learned from the exercise.
10. Have each participant take turns saying how this exercise can be useful in peer education work.

Bereavement counselling

- People always experience grief upon learning that they or their partners or a friend is HIV-positive
- Counsellor needs to understand grief and learn how to help clients through the different phases
- Grief is multidimensional; it can be experienced on all levels of the person — in the heart (feelings and emotions), the mind (thoughts), the spirit (meaning of life), the body (physical manifestations)
- It is a time of transition, beginning with period of diagnosis to death, shock of an anticipated loss, of trying to “prepare”.
- Grief refers to the personal experience of the loss; mourning refers to the process that occurs after the loss
- Grief is a normal response to loss
For example, a couple undergoing divorce may mourn the loss of their relationship. People living with HIV may mourn the loss of good health.

Factors that influence how a person will respond to a loss

- Who the person was and the nature of the attachment
- Mode of death (natural, accidental, homicidal, etc.)
- Where the death occurred (geographically near or far, sudden or expected, etc.)
- Historical antecedents (previous losses and how the person grieved)
- Prior mental history
- Personality variables (age, gender, stress level, etc.)

- Social variables (ethnic and social sub-cultures, religious persuasion and faith)
- Degree of perceived emotional and social support
- The secondary gain the person may find in grieving
- Concurrent stresses, changes following a death

Five stages of mourning

- Denial— It can't be true
- Anger— Why me?
- Bargaining— Maybe if
- Depression— It's all over (past losses)
- Acceptance—a resignation, letting go, but memories still remain. Not always pleasant/happy

The stages are fluid, and an individual may move in and out of them in their unique individual manner and tempo.

Goals of grief counselling

- To increase the reality of the loss
- To help the person deal with spoken and unspoken feelings
- To help the person overcome difficulties of readjustment after the loss
- To encourage the person to say an appropriate goodbye and to feel comfortable reinvesting in life

How can counsellors deal with loss and bereavement?

- Listen actively; your presence and desire to listen without judging or giving advice are critical helping tools
- Be compassionate:
 - give client permission to express feelings without fear of criticism
 - allow them to experience the hurt, sorrow, resentment, anger, fear, anxiety or pain without expectations of what is “right”
- Avoid clichés; words, particularly clichés, can be hurtful to clients
(Cliches are trite comments that can seem to diminish a person's loss by providing simple solutions to difficult realities, e.g. “You are holding up so well”, “Time heals all wounds”, “Think of all you have to be thankful for”, etc.)
- Keep in mind that your client's grief is unique
 - each person is unique and no one will respond to the death of a loved one in exactly the same way
 - there is no right way to grief
 - the process of grief takes a long time and each person has a unique time line for healing

Useful techniques for grief counselling

- Use of symbols, e.g. photo
- Writing and drawing
- Use of ritual
- Role playing and use of imagery
- Memory book/memory box

Potential danger signals in grief reaction

- When someone feels he/she is no longer of value as a person
- Inconsistent behaviour or personality changes
- When client makes threats of self-destruction
- When clients exhibits anti-social behaviour
- Excessive hostility
- Complete withdrawal and unwillingness to interact with other people
- Appearance of fleeing from reality

Module Six



Session 1- SPECIAL COUNSELLING SITUATIONS

Objectives:

At the end of the session, participants will be able to:

- Identify the different types of situations for HIV/AIDS counselling
- Discuss the role of the counsellor in these situations
- Demonstrate the counselling skills used in these populations

PARTNER NOTIFICATION AND COUPLE COUNSELLING

What is partner notification?

- Process whereby the sexual partner(s) of an infected client is notified, informed of their exposure to HIV/STD infection and thereafter offered counselling, testing and referral for support services

Sharing and notifying partner(s) is very important for HIV/STD prevention, particularly in the longer term. It will help in achieving success in limiting the transmission, especially to women.

The aim is to:

- Provide counselling and testing to sexual partner(s) of client
- Provide psychosocial support to the partner(s)
- Provide referral and linkage to other support services, where available
- Observe the principles of confidentiality and trust
- Be non-coercive
- Be sure it is voluntary
- Be gender sensitive (studies reveal that disclosure rates are low and women fear abandonment or abuse if found to be seropositive)

Note: The health worker does not have a right to notify or inform the partner(s) of the client without informed consent. It is ethically wrong to do so. There is a need to observe human rights and respect the dignity of the client. The client should be counselled to understand the need and benefits of notification. Disclosure by health worker to the partner(s) without informed consent from client may lead to unprecedented situations and outcomes beyond the scope of the health worker.

Approaches to partner notification

- Patient referral— client is given the responsibility, after adequate health education and counselling, to inform sexual partner(s) of risk of infections personally
- Accompany partner(s) to come for counselling, testing and provision of psychosocial support and referral

Provider referral

- Client provides information to health worker to contact partner(s) and request them to come for treatment, usually more for STD cases.
- Has a lot of problems associated with it, e.g. wrong names, addresses; it is labour-intensive, too expensive and not a sustainable practice, particularly in resource-constrained settings.

Couple counselling

- Counselling couples is a difficult (either spouse may not want to inform the other about their serostatus and if so, there is a possibility of transmission of infection)
- There is fear of abuse, violence and abandonment.
- Counselling an infected woman should take into consideration how she has learned of her condition.
- Women often discover their infection by accident—usually after the husband/partner or child is already symptomatic with an HIV-infected disorder.
- Counsellor should recognize that the woman will be dealing with at least two crises, that of her husband/partner's or child's illness and her own crisis.
- Women's concerns regarding HIV infection are not only medical but also social and cultural.

- Women are often wrongly accused of having brought HIV infection into their families, even if contradictory evidence exists.
- Counsellor should acknowledge the woman's fear that her family and friends may abandon her because of her actual or perceived past behaviour, and should provide emotional support.
- A woman's infection could be an indication of partner's infidelity (disclosure is usually traumatic, leading to loneliness and isolation, social stigmatisation).

Common emotional reactions are:

- Anger—towards the person who may have infected her
- Grief—loss of health and status, possibility of having to give up having children and of dying and leaving her children alone
- Guilt—from idea that she may have been the cause of illness in her own family, particularly her children

Infected women will be extremely concerned about the welfare of their children and may underestimate their own needs, or may even fear coming to clinics.

COPING AND SOCIAL SUPPORT COUNSELLING AND CONTINUUM OF CARE

Psychological issues and emotional reaction by clients

Diagnosis of HIV is associated with profound psychological distress (this must be addressed at all stages of the infection). There may be an absence of response, which could be an adjustment through denial. It provokes uncertainty about all aspects of one's life, including the length and quality of life, the effect of treatment and the response of society.

All reactions need to be discussed openly and honestly.

- Psychological issues and emotional reaction by clients
 - Shock
 - Denial
 - Anger
 - Suicidal thoughts or action
 - Fear
 - Isolation
 - Loss
 - Grief
 - Guilt
 - Depression
 - Anxiety
 - Loss of self-esteem
 - Hypochondria
 - Spiritual concerns

Factors that may affect severity of the psychosocial state

- The person's physical health at the time
- How well-prepared the person is for the news of HIV infection
- How well-supported the person is in the community and how readily he/she can call on the assistance of friends and family
- The person's prior personality and psychological condition
- The cultural and spiritual values attached to HIV/AIDS, to illness and to death
- Availability of supportive counselling
 - Supportive counselling and psychological support is critical for helping individuals, couple, families and friends affected by HIV to cope with their fears/emotions and has been shown to improve understanding and acceptance of HIV status and facilitate disclosure of that status to significant others or partner(s)
 - It helps to reduce stigma, making people feel less reluctant to seek care and support, as well as having a positive effect on the community

- Network or associations of PLWHA or PABA have been instrumental in providing peer and psychological support in many communities and nations; they are widely seen as valuable but are still limited in some settings and communities.

CONTINUUM OF CARE

Community and Home-Based Care

- Any form of care or set of activities provided to meet the physical, psychological, spiritual, nursing, medical and social needs of infected persons and their families in the home environment
- Increasingly recognized as viable alternative to institutional care
- Can be provided by family members, volunteers, health workers or an NGO/CBo group
- Involves the home management of common symptoms (fever, pain, nausea and vomiting, cough, diarrhoea, skin problems, etc.)
- Training and teaching family members/volunteers how to care for the infected person (there is a low risk of transmission when caring)
- Infection control and on-going hygiene is very important (use of gloves, care of spillage of blood, faeces, vomitus, etc.)
- Nutritional support is important to ensure good health for the infected person and caregiver
- Care of the caregiver is crucial to avoid burn-out and breakdown

Why home care?

For the system

- Decongestion of health facility
- Promotes decentralized capacity building
- Helps to reduce stigma and improve prevention activities

For the family

- Often less expensive than institutional care
- Sometimes only option
- Promotes acceptance within family and community
- Allows family members to attend to other duties

For the individual

- Is in familiar environment with loved ones
- Can still contribute and be part of the family decision making

Challenges of home care

- Limited coverage compared to the number needing care
- Burden of care more on women
- Inadequate training of caregivers
- Insufficient community sensitisation
- Lack of access to nutritional/material/medical support
- Unstable external support— issue of sustainability
- Home care may mean home neglect
- Forming association of PLWHA to counter fear of stigma and recognition of serostatus
- Risk of overburdening caregivers and supervisors

Bereavement and loss

Bereavement is the loss of a beloved dear one. Death, even though well known as an inevitable end, when it occurs after a terminal illness (like AIDS) is usually followed by a deep sense of loss.

The process of bereavement can be categorized as follows:

- *Feelings*, which can be expressed in the form of shock, anger, guilt and self-reproach, loneliness, helplessness, hopelessness and depression, etc.
- *Physical symptoms* such as tightness in throat and chest, excessive sensitivity to noise, irritability, weakness, loss of appetite, insomnia, etc.
- *Behaviour*, which can be manifested in the form of confusion, hallucination (seeing or hearing the deceased person), absentmindedness, obsession to belongings of deceased person, relief, irrational behaviour

As counsellors you are dealing with probably the most severe crisis in human existence. A great deal of caution and empathy is required on the part of the counsellor. It is important to allow bereaved persons to grieve and ventilate their feelings.

Communication is key to coping and adjusting to the new change as a family goes through grief. It is important to allow them to talk, cry, vent their rage or even sit in silence or grieve privately, depending on how they feel. Remember that no two people will react the same way under similar situations and the counsellor must give room for such differences and work with the client to deal and develop personal strategies for coping with the situation.

Linkages, referral and networking

Referral can be made to appropriate services where and if available.

- Creating linkages, networking and referral is essential to ensure effective care across a continuum
- Available resources within the community must be identified and linkage established with them for referral services
- No single organization can meet all the identified needs of people living with HIV/AIDS and those affected by the disease (family members and orphans)
- Resources available within the community could be formal or informal, e.g. government or NGOs/CBOs, social welfare systems, income generating schemes, women/youth groups, peer support groups of PLWHA

Conclusion

Coping and living with HIV/AIDS exerts a huge burden on the infected, the affected and the healthcare providers. Increased awareness and understanding of the disease by community members will help reduce the stigma and improve support for people infected and affected by the disease. Community involvement and participation in social support, home-based care for infected persons and care of orphans will help ensure long-term sustainability of the services. Finally, the role of health workers as educators, care providers and role models is crucial in the success of prevention and care interventions. A lot of patience and empathy from all is required in the process.

Counselling Women

Given obvious economic, social and biological differences between men and women, there are some issues related to HIV/AIDS that need special attention when providing HIV counselling and testing to women.

Depending on the individual situations of female clients, the counsellor will have the challenge of responding to a multitude of problems and issues specific to each woman.

It is impossible to list all the problems and issues that women may present within a counselling situation. Some aspects requiring special attention for women receiving HIV counselling and testing are presented below.

Because of the vulnerable position of women in society and their role in the family, they usually experience severe emotional distress when faced with HIV/AIDS-related problems. The counsellor must recognise this.

Each woman requires different psychological and social support at each phase of the counselling process, i.e. the pre-test counselling phase, the post-test counselling phase and other supportive counselling sessions.

When women feel powerless or have low self-esteem, the counsellor should reassure her and help her build her self-confidence by pointing out her strength and capabilities.

When a woman is distressed or depressed, the counsellor should acknowledge her fears, provide emotional support as much as possible and help maintain or reestablish familiar social sources of support as well as identify other sources of support for the woman.

The counsellor should assure confidentiality.

In the face of worries, the counsellor should alleviate the psychological distress by refocusing on the woman's needs and identify specific problems related to children.

SUPPORT IN NEGOTIATING RISK REDUCTION

Since the most common route of HIV transmission is sexual, it is important to ensure that women will be able to facilitate and obtain behaviour change from their partners. A woman may have a good risk reduction plan (e.g. abstinence and use of condom) but not be in a position to enforce the plan with the sexual partner. The counsellor should help the woman by providing information on negotiation skills that will help her to negotiate behaviour change from the partner without conflict.

Ask how confident she is about being able to carry out the plan and identify and discuss potential barriers.

Encourage women to discuss risk reduction with partner.

Proceed very carefully, especially with couples where there is a history of violence, STDs or infidelity. Referral may be required.

Contraception decision making

Contraception is a very sensitive issue to discuss, particularly in cultural settings where the value of a married couple, especially that of the woman, is determined by the number of children they have.

The counsellor should provide the appropriate information and assist each woman to make an informed decision about whether or not to become pregnant. Referral may be required.

Pregnancy decision making

Women of childbearing age present particular challenges to the counsellor, depending on her condition upon coming to the counselling centre. Many women may not establish any connection between pregnancy and HIV infection. Some may be aware and be struggling with the idea of whether or not to become pregnant; others may already be pregnant and trying to decide if they will keep or interrupt the pregnancy, or be wondering what will happen to their newborn.

The risk of mother-to-child transmission: There is a 70 percent chance of not infecting the infant, so only one-third of the babies may become infected.

Clients are to make their own decisions.

Women who are not yet pregnant: discuss the possibility of avoiding or delaying pregnancy until appropriate care is secured. Referrals may be necessary for antenatal care and anti-retroviral management.

The husband/partners of HIV-infected pregnant women should be involved as much as possible in the counselling sessions and in the various decisions to be made. This will facilitate the medical, psychological and social support required by the HIV-infected pregnant women.

Breastfeeding decision making

HIV can be transmitted from an infected mother to her baby through breastfeeding. It is estimated that mother-to-child transmission of HIV accounts for about 15 percent of prenatal HIV transmission. The risk of transmission seems to be higher among mothers who are recently infected, mothers with advanced disease, and mothers with nipple cracks. Prolonged breastfeeding also seems to increase the risk of mother-to-child transmission of HIV.

On the other hand, breast milk is normally the food for babies. It provides high quality nutrients that are easily digested and protects babies against diarrhoea and other infections. Breastfeeding is also important for the development of the emotional relationship between the mother and her baby.

Counsellor's information to client

In some settings, the babies are more at risk of dying of other infectious diseases and malnutrition than of the risk involved in being breastfed. The situation should be critically assessed and the clients should make the decision.

Discuss the available options to reduce the risk of HIV transmission through breastfeeding, taking into account each woman's individual situation.

Issues in counselling adolescent with family

Adolescence is a period of transition from childhood to adulthood and from external to internal control and maturation.

COUNSELLOR'S ROLE

- *Determine who chose to come for help. Was it the adolescent? Someone else?*
- Ask them to explain how and why they made the decision to come for counselling.
- Ask them to explain how and why they made the decision.
- Observe how they seat themselves.
- *Explain that counsellor's role is to help to clarify the situation and to help them take action to improve the situation.*

You may feel it necessary to see the adolescent and adults separately at first.

- Learn from each whether they think there is a problem and what they believe it to be.
- Observe how they seat themselves
- *Explain that the counsellor's role is to help clarify the situation and to help them take action to improve the situation.*
- If you feel it necessary, see the adolescent and adults separately at first.
- Learn from each whether they think there is a problem and what they believe it to be.
- Bring them together and don't separate them again.
- Describe briefly and neutrally the points of view they have expressed to you.
- Enable each to listen to the other.
- Observe what is hurtful, what arouses anger, what is comforting.
- Comment on what you observe by reflecting facts and feelings so that each will
 - see that you understand
 - correct you if you don't
 - help each to listen to what the others have said.
 - help each to listen to what the others have said on others.
- Comment on what you observe by reflecting facts and feelings so that each will
- Don't take sides but ensure that each person is able to express their feelings.
- Remember that the roles of parent and adolescent are different.
 - parent has more responsibility and authority
 - but*
 - the relationship changes as the adolescent matures.
- Help them to negotiate a new arrangement recognizing this.
- Adolescents are very sensitive to "justice". If an agreement is reached that seems fair to them, they are likely to abide by it.
- If father is present, he may feel that the counsellor is usurping his authority. Be sure not to do that.
- Remember that you are helping them to make their own decisions.

- Thank father for coming. Compliment him on his willingness to help the family by talking things over with an outsider.
- Explain that families naturally fall into habits of communicating that sometimes make it difficult to see changes.
- Reassure him that your main job is to help clarify the situation so that they may decide what to do.
- If arguments within the family occur during the session, allow them to continue for a little while and reflect on what has occurred.
- To end the initial session, summarise key points in a balanced way and highlight positive aspects of the family relationship and achievements in the session.

Difficult moments in counselling

Objectives:

By the end of this session the participants should be able to:

- Define difficult moments in counselling
- List at least eight difficult moments that can appear in counselling sessions
- Explain how to deal with the difficult moments

Materials: Flipcharts, stand, markers

Notes:

Psychosocial reactions to news of HIV test results and infection can create some moments that are particularly difficult for the counsellors and healthcare providers to handle. The psychological reactions to such news may include shock, denial, anger, suicidal thoughts, fear, feelings of loss, feelings of uncertainty, grief, guilt, depression, anxiety, loss of self-esteem and dignity. In such situations the counsellor must be equipped with basic knowledge about such possibilities and strategies for dealing with them.

What are difficult moments in counselling?

Difficult moments in counselling are such moments when reactions or responses from the clients suggest discomfort of any type or when the counsellor finds him/herself in a fix as to what to do to continue with a counselling session. Below are some identified typical difficult moments in counselling and how to deal with them.

When the clients are silent

- The clients are unwilling or unable to speak for some time. This may be common in clients who are anxious or angry because of the uncertainty associated with their condition. They may feel that they are the unlucky ones and they blame themselves. If this happens at the beginning of a session, it is best for the counsellor to wait for a little while and then gently call attention to it by saying: “I can see that it is a bit difficult to talk. It is often that way when people first come to see me, or when one is feeling a bit anxious.” On the other hand if the silence seems to be an angry one (e.g the client is looking away from the counsellor), the counsellor might say: “You know, sometimes, when someone is angry with himself/herself or his/her situation, such a person may not be able to say anything. Is that how you are feeling now?”
- Sometimes silence will occur in the middle of a session. In such a case the counsellor should find out why it has occurred and wait for the client to express his/her feelings or thoughts and encourage such expression.

When the clients cry

- A client who starts to cry or who becomes hysterical will make a counsellor uncomfortable. If this happens, the counsellor should wait for a while for the client to become composed. This type of client reaction is a helpful way to release pent-up emotion. The counsellor can show support by saying: “It is all right to cry; it is a natural reaction when one is feeling sad and unhappy.” The crying will usually cease after a little while. While it may be appropriate to touch a client to comfort, the counsellor should be cautious when dealing with clients of the opposite sex. In all cases of counselling, a professional relationship should be strictly established and enforced; it is not a social or personal one.

When the clients threaten suicide

- This is perhaps the most anxiety-provoking situation for a counsellor. People who learn that they are HIV-infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding their own pain or of lessening that of their relatives.
- It is appropriate to say that while no one can stop a person from taking his/her own life, you would feel terribly sad if that were to happen. You are just getting to know each other and you see much in the client that you like and admire. The lifeline that the counsellor throws to the client is that he/she does care and this may give sufficient hope to the client to carry on. So the most valuable approach is a comment indicating positive feelings about the client, not comments about the threat.

When the counsellor makes a mistake

- There are many ways in which a counsellor can make a mistake. The counsellor may provide some incorrect information or may become inappropriately embarrassed or angry at something the client said. In such a case the counsellor should admit to his/her mistake and apologise if wrong. The counsellor might say: "I am sorry I forgot that you told me you had a younger brother".
- If you get angry with a provocative client you might say: " You know, a moment ago when you said that you did not see how I can help anyone in your situation, because I can never imagine how it feels to be in your situation, I was angry for a moment and maybe you noticed that. It is a natural way to react, but it was not fair to you. I may not feel the way you are feeling right now, but I can appreciate how you feel. Would you like to talk to me about your feelings right now?" The more openly you can deal with your feelings when it is appropriate, the better example you will be providing for the client to follow.

When clients refuse help

- This may happen if the client did not come voluntarily. The counsellor should probe gently by saying: "Well, I can understand how you feel, and I am not sure if I can help, but maybe we could take a few minutes to see what you think and together we can decide whether it might be worthwhile talking a bit more about it." If the client completely refuses to talk, stress the positive by thanking him/her for coming and say that he/she is free to come back if he/she reconsiders.
- A client may have HIV infection, but after counselling does not want to be tested or does not want to know his/her status. A counsellor must remember that HIV testing is not the aim of counselling. The counsellor should always accept the client's decision and never put pressure on him/her to have the test. The discussion could focus on the ways in which a person can live his/her life without knowing whether he/she is infected with HIV. Safer sex should be advised whether or not a person is infected with HIV.

When HIV-positive clients are referred for counselling, but do not know that their blood has been tested

- HIV testing without counselling and consent is an abuse of a person's right. This practice should be discouraged. However in some workplaces and hospitals people are tested in this way, and those who test HIV-positive are often referred for counselling.
- If the people do not know that they are HIV- positive, it may be possible to start the process again. The counsellor can give proper pre-test counselling. If the clients decide not to have the test or not to be told the test results, then their wishes should be respected.
- If they already know or suspect that they have been tested, counsellors should avoid using only one session to tell the clients that they are HIV –positive. Instead, the counsellor could begin by explaining the test and its implications and why their blood has been tested. The discussion could center on whether the clients want to know the results, giving them enough time to mentally prepare themselves to learn that their suspicions are correct.

When clients are anxious about telling their sexual partners that they are HIV- positive

- Not telling a partner poses practical and ethical problems. The couple will not be able to fully discuss whether to have children or how to cope with possible illness and death. Unprotected sex may result in the partner becoming infected. Keeping silent makes adopting safer sex more difficult. Alternatively, the partner may already be infected and may want counselling.

- If the clients are in stable sexual relationships, the counsellor should try to introduce the idea of shared confidentiality right from the beginning. People who come for pre-test counselling alone can be invited to come back with their partners so that the decision about testing can be made together.
- If the clients feel unable to disclose the news, the counsellor can suggest that they have counselling and testing again, but this time with their partners, and that they behave as if the first test had not been done.
- Clients may not be ready to tell anyone very soon after the test or if they are still feeling healthy. The counsellor can offer more counselling sessions and suggest that they meet other people who are HIV-positive.
- If clients do not see the need to protect others from infection, the counsellor should emphasize the need to use condoms to protect the clients themselves, as this will help keep them healthy by reducing the risk of STIs, which can be more severe in people who are HIV-infected and re-infected with HIV.

When clients are reluctant to tell close family members that they are HIV-positive

- Deciding not to tell anyone can result in loneliness and depression, and can make it difficult to get help and support. Some people overestimate the likelihood of rejection and counselling can help them to assess the situation more realistically.
- The counsellor can encourage clients to think of others they could trust, such as members of self-help groups for HIV-positive people or their doctors. The counsellor can suggest that they ask close family members or friends to share a session with them, if this will help them to disclose the news.

When clients appear not to understand what it means to be HIV-positive or deny the test results

- A counsellor needs to find out the best way to explain the issues to the clients. If the client has severe physical or mental health problems or is very upset, counselling about HIV/AIDS may not be possible.
- The family should not be told that the client has HIV without the client's permission, but if the client is confused or very ill and nearing death, the counsellor may consider telling the key family members.
- Denial may be linked with feelings of extreme anxiety and helplessness, and fears that life is finished. Over time and with continued counselling, this may change. The counsellor can help the clients to view HIV infection as something that can be managed, and develop a positive attitude about their lives with HIV. Denial may make it impossible for the clients to explore what they feel. The counsellor can try to discuss being HIV-positive as an imaginary situation by saying "Let us pretend that it is true and look at what it would mean for your life."

When clients are uncomfortable with the counsellor's gender

- This difficulty may be made explicit if the client says "I don't think I can talk to a woman (or man) about this" or "I was expecting a woman, (or man)." In the absence of an overt comment, the counsellor may notice the discomfort. In this case it will be best for the counsellor to raise the issue by saying "I wonder if you were expecting to see a man (or woman)?" Once this issue is in the open, the counsellor can go on to say "Some people at first are more comfortable with people of the same (or opposite) sex, but this usually become less important once they get to know each other. Why don't we try to continue and see how we get along?"
- At this point it is very important for the counsellor to be attentive, respects the client and be non-judgemental. The counsellor should use encouragers and reflections to assure the client that the counsellor is listening and that what the client is saying is acceptable. However, if the client is adamant, the counsellor may need to refer the client to a counsellor of the preferred gender.

When the counsellor and the client know each other socially

- This may be common in small communities, where the client knows the counsellor and the counsellor knows the client. If the relationship between the two is casual, it may be possible to serve as a counsellor, but it must be made clear very early that confidentiality will be totally respected, and the way you will relate to your client is quite different from the way you would relate to a friend or an acquaintance. If, however, both the counsellor and the client know each other well, it will not be possible to serve as a counsellor. It will be necessary to explain this to the client and arrange for another counsellor to help.

When the client asks a personal question of the counsellor

A counsellor/client relationship is a professional one, and not a social one. This allows the counsellor to react in ways different from those of other people in the client's life. As such, the counsellor can help the client to learn about more constructive and rewarding ways of relating to people. The counsellor should not respond to personal questions from the client for the following reasons:

- It takes attention away from the client
- It may lead to a series of questions that border on very private matters that the counsellor is not ready to answer. This may give a confusing message to the client about what is possibly wrong.
- It is far better for the counsellor to respond to a personal question by saying "It is not helpful to you if I talk about myself, that is why I make it a rule not to." The client will accept this rule. This approach is far better than leaving some questions unanswered or evading the issue, both of which may destroy the honesty of the relationship between counsellor and client.

Activity**Practice Sessions**

Volunteers and facilitators should model at least two difficult moments. In addition participants should practice in triads, using various difficult moments.

Evaluation of Counseling**Objective:**

By the end of this session the participants should be able to:

- List and explain the criteria for the evaluation of counselling

Materials: Flipcharts, stand, markers

Notes:

To evaluate the effectiveness of counselling sessions it will be necessary to ask: what should determine whether counselling has been successful? Below are some of the criteria and the corresponding questions that address them.

Self-exploration and self-understanding

One of the purposes of counselling is to help clients learn more about themselves by talking about their feelings, thoughts and experiences with the help of the counsellor. The evaluative question here is: To what extent has this been achieved?

Termination of counselling

It is important in counselling practice that counselling sessions be terminated by mutual agreement between the counsellor and the client.

Therefore the evaluative questions are: Did the counselling sessions come to an end by mutual agreement between the two parties or was one party more eager to end than the other? If so what is the reason for this?

Action by client

Evidence of behaviour change is one way to determine the effectiveness of counselling sessions. So the evaluative questions are:

- Did the client make some changes in behaviour or circumstances as a result of better understanding of him/herself, his/her situation and key relationships with in his/her life?
- Was the action taken appropriate and constructive?
- Will it lead to other steps that will be helpful to the client?
- Was the decision to take action reached by the client in a more mature way than would have been done before counselling?

Changes in relationships

The evaluative questions here are:

- Does the client see him/herself differently now?
- Have there been changes in relationships with other people?
- Are these changes likely to endure?
- Has the way the client relates to the counsellor become more mature?

Client satisfaction

The pertinent questions here are:

- Is the client satisfied with the outcome of counselling?
- Has the issue that brought the client for help been resolved in a satisfactory way?

Satisfaction of the referrer

If the client was not self-referred, the evaluative question here is:

To what extent are those who referred the client satisfied with the outcome?

Future state

The evaluative questions here are:

- Is it likely that the client will be able to avoid similar problems in the future or deal with them in a healthy way, should the need arise?
- Has the client left with positive feelings towards the counsellor, making future contact likely, if needed?

TERMINATION OF COUNSELLING

Objective:

By the end of this session the participants should be able to:

- Describe the steps to be taken for appropriate termination of counselling sessions.

Materials: Flipcharts, stand, markers

Notes:

The pertinent questions to be addressed regarding termination of counselling sessions are:

When is it appropriate to terminate counselling?

How should such a decision be reached?

The appropriate way to terminate counselling is by mutual agreement between the counsellor and the client. Counselling should not end abruptly. It is more helpful if this is discussed in advance. Some counsellors find it useful to agree on the number of sessions at the beginning of counselling and might say during the seventh session, (if the agreement was for eight), "Next week will be our eighth session together; you remember we agreed to stop after eight sessions. How do you feel about this now?" If the two parties feel that more sessions are needed, the reasons for the extension should be reviewed.

If a client terminates counselling by just not returning, an effort should be made to contact the client without violating confidentiality. The counsellor should indicate to the client that when a client decides to stop counselling, it is usually best to have a session in which the matter is discussed and then possibly terminate the counselling appropriately. The counsellor should let the client know that the counselling need not continue if he/she does not want it to, but that it has to be terminated properly. The counsellor can then suggest an appointment, to be confirmed by the client, so that the counselling sessions can be brought to an appropriate end.

If the counsellor feels that counselling should end, but the client does not, something may be wrong. It may be that the client has become overly dependent on the counsellor and efforts should be made to deal with this issue before the counselling sessions are terminated.

Module Seven



Session 1- STIGMA AND DISCRIMINATION

Objectives:

At the end of the session the participants will be able to:

- Define stigma
- Mention settings where stigma is manifested
- List five manifestations of stigma in each of the identified settings
- Mention four strategies to address stigma at all levels

Materials: Flipchart, stand, markers

Time: One hour

Process:

1. Share the objectives of this session with the group
2. Write out the words “STIGMA” and “DISCRIMINATION”
3. Organise participants into groups of four and encourage them to explain the meaning of the two words
4. Commend participants’ output
5. Explain the meaning as below

Stigma

Any form of behaviour towards or by a person living with HIV/AIDS leaves the individual feeling unwanted or dejected. It can occur in different settings – healthcare setting, home, office, church or community

Discrimination

Attitudinal differentiation, e.g. I do not want to have anything to do with particular person or persons.

6. Have participants give examples of manifestations of stigma in:
 - a) Healthcare settings
 - b) The home
 - c) The office
 - d) The church or community
 - e) Self-stigma
7. Commend participants for output
8. Explain the manifestations of stigma as per trainer’s note

TRAINER’S NOTE

Manifestations of stigma in healthcare setting

- Denial of appropriate level of care
- Inability to break news
- Selective use of universal precautionary measures
- Immediate discharge after laboratory result
- Withholding results until discharge
- Overlooking/covering up of AIDS diagnosis
- Labeling
- Segregation/Isolation

Results of stigma in healthcare setting

- Conspiracy of silence (Fear)
- Missed opportunities: barriers to available prevention and care and support intervention
- Healthcare workers who suspect they are infected deny and hide in order to avoid repercussions

Manifestations of stigma in the home

- Rejection of infected person by family members
- Denial
- Fear of contracting the virus
- Sadness
- Family may not want to invest in the future of the infected person
- Family members see infected person as a disappointment
- Lack of willingness to share food, room or talk with infected person
- Excessive demonstrations of love
- Providing separate items for person
- Pity

Manifestation of stigma in the office

- Sack/loss of job
- Denial of promotion, employment
- Colleagues may not come near—isolation
- Deprived of official rights/protocol
- Gossip
- Lack of consideration of health needs in the design of workload
- Denial of medical care payment

Manifestations of stigma in church or community

- People will not deal with the person
- People point fingers
- Unkind gestures directed at the known infected person
- Treating the infected as an outcast
- Keeping distance from infected person
- Regarding infected person as a sinner
- Treating person as a disappointment
- Community members reject infected person

Manifestations of self-stigma

- Loss of interest/withdrawal
- Dejection
- Suspicion of others
- Loss of self-esteem
- Suicidal tendencies
- Guilt
- Isolation
- Non-disclosure of status
- Hostility

Strategies to address stigma at all levels

- Policy makers and community leaders to plan and formulate comprehensive HIV prevention and care activities
- Advocacy/sensitisation
- Community mobilisation
- Inclusion of HIV/AIDS into various curricula
- Adoption of policies aimed at reducing stigma; protect rights of PLWHA
- Promoting voluntary counselling and testing
- Improving access to medical care and support
- Role of PLWHA activists—speaking out and giving the virus a human face
- Promoting the establishment of autonomous self-help groups

Activity:**Stigma and Discrimination Role Playing**

Case Study 1

21 year-old male student, in a family of six.

Has lots of sex partners, never uses condoms and already tested HIV-positive.

He is stigmatised at home and at school.

He comes for counselling at the health centre.

Case Study 2

35 year-old mother of three children with signs and symptoms of AIDS.

Her husband sends her packing out of home.

Upon her refusal, her husband deserted the home.

All three children refuse to have anything to do with her in the home.

Instructions

- Ask participants to form groups of three
- Each group will identify a counsellor, a client and an observer
- Ask the trio groups to play roles for case study #1, using all the counselling skills that they find appropriate
- Observers will verify effective use of skills and concepts in counselling session
- Following the counselling session, there will be time for feedback with client first, counsellor second and observer last.
- Switch roles among the trio until all participants have played the role of the counsellor, client and observer
- Repeat the activity for case study #2.
- Ask participants to return to the large group
- Encourage participants to respond to the question “How did you feel while playing the role of client, of counsellor, of observer?”
- Conclude that HIV-positive and AIDS clients experience all feelings, hence the need to provide necessary care and support.

What strategies are needed to address stigma at all levels?

Explain these strategies as per note to trainers

Module Eight



Session 1-

OVERVIEW OF CARE AND SUPPORT IN HIV/AIDS

Objectives:

At the end of the session, the participants will be able to:

- List the main needs in care and support
- Identify at least five different interventions required in providing care and support

Materials: Newsprint, markers

Process:

1. Share the objectives of the session
2. Ask participants what they know about the topic
3. Complement participants' ideas based on the overview below.

In developed countries, approximately eight to ten years elapse from HIV infection to the development of clinical AIDS, after which people survive approximately one to five years without anti-retroviral treatment. Survival times are believed to be shorter in developing countries due to malnutrition, co-infections with other diseases and more limited access to healthcare.

People living with HIV/AIDS (PLWHA) need access to a broad continuum of care throughout the course of the illness. Early counselling helps people to cope better with the diagnosis and future illnesses as well as prevent transmission. Medical care addressing the problems of opportunistic infections can help PLWHA live more comfortable, productive lives and ease the burden on their families.

Care and support for people living with HIV/AIDS (PLWHA), their families and their communities were, until recently, neglected components of most HIV/AIDS programmes in developing countries. Experience has shown that community-based projects that are linked with medical and social support services helped to remove the stigma of HIV, reinforced AIDS-prevention strategies by encouraging people to come forward for voluntary counselling and testing (VCT), and allowed early management and prevention of tuberculosis (TB) and sexually transmitted infections (STIs) in HIV-positive and HIV-negative people.

Therefore, universal access to cost-effective drugs that relieve common symptoms and control opportunistic infections should be a top priority for HIV/AIDS programmes.

From these services much was learned about the needs of PLWHA.

4. Ask the participants what the main needs of PLWHA are, based on information provided in the overview.

Needs of PLWHA

The needs of PLWHA and often of their families have been identified in four interrelated areas:

- Medical needs
- Psychological needs
- Socioeconomic needs
- Human rights and legal needs

As HIV infection progresses, the type of services needed also changes. It is this provision of comprehensive care across a continuum from home and community to institutional services and back that will ensure that the needs of clients and their families are met.

5. Utilize note to trainer to clarify needs of PLWHA
Different interventions required to provide care and support

6. Organise the large group into two small groups. Give each group 10 minutes to think of 10 different ways in which the care and support of PLWHA can be made
7. Allow each group to report in three minutes
8. Outline the interventions as below:

- Medical and nursing care

Such as:

- Appropriate diagnosis
- Treatment and prevention of TB and other OIs and HIV-related illnesses
- Provision of anti-retroviral therapy
- Clinical monitoring and palliative therapies

This will reduce HIV morbidity and mortality. The choice of interventions and the quality of care will depend on the capacity of the health systems and the human and financial resources available.

- Access to appropriate diagnosis

These include:

- Detection of HIV infection
- Levels of immune responses
- Detection of opportunistic infections
- Anti-retroviral drugs in therapy and prevention
- Reduce morbidity and mortality
- Their use is limited in developing countries because of their high cost
- Some countries in the developing world are implementing various anti-retroviral (ARV) regimens to prevent mother-to-child transmission of HIV and for post-exposure prophylaxis.

- Psychological support

- critical for helping individuals, couples, families and friends affected by HIV to cope with their fears and emotions
- socioeconomic support to families, orphans and vulnerable children (OVC)

Due to the economic impact of HIV/AIDS on the individual, the family and the community, PLWHA are confronted with other challenges such as:

- medical expenses
- loss of income
- needs of orphaned children for feeding, clothing and education.

However, community safety nets and building economic resources can alleviate the negative consequences of HIV/AIDS.

- Human rights and legal support

PLWHA face:

- stigma
- discrimination
- other violations of their human rights

Protection of these rights and provision of legal services to them are important in care and support.

- Community involvement

Community responses are useful in care and support and should be recognised, strengthened and supported.

- Care for carers

Caregivers need support in order to perform their job well. It is therefore necessary to provide an environment where work is appreciated. They should have ongoing training opportunities and social events to overcome stress and fatigue.

9. Ask a few volunteers to identify the barriers to care and support.
10. Correct and /or give additional barriers where necessary. Barriers may include:
 - Sociocultural
 - Economic
 - Stigma
 - Lack of commitment by policy makers
 - Slow response by policy makers
 - Inadequate resources including personnel
11. Summarize the key points of the session.
12. Evaluate, using the following questions:
 - List four needs in care and support of PLWHA
 - Mention five interventions required in providing care and support

Session 2- ORPHANS AND VULNERABLE CHILDREN (OVC)

Objectives:

At the end of this session, participants will be able to:

- Define HIV/AIDS orphans and vulnerable children
- Discuss the impact of HIV/AIDS on OVC
- Describe appropriate strategies for the care and support of OVC

Materials: Newsprint, stand, markers

Time:

Process:

1. Request a volunteer participant to read out the objectives.
2. Ask individual participants to fill in the full meaning of O.V.C.
3. Commend efforts as necessary.
4. Give two minutes to the participants to think of the words “orphans” and “vulnerable children”; ask each one to write out the meaning of the words.
5. Call on 2–4 volunteers to read out the write-up.
6. Clarify as per note to trainer.

NOTE TO TRAINER

- Orphans – Either father or mother or both parents are dead
- Vulnerable Children – One or both parents may be alive but too ill to support their children and so these children go out to beg or become street children who are exposed to all forms of danger and assault
or
Such children may be sent to live with relatives who subject them to harsh handling and different child labours, e.g. hawking, doing household work, etc
or
The child is HIV-positive (may or may not be very ill)

7. Explain the estimates of OVC globally and nationally as below:

Estimates of the number of orphans, children affected by HIV/AIDS and other children made vulnerable by the HIV pandemic are high. Globally, by the end of the year 2000, the number of orphans in 34 countries was estimated at 34.7 million (children under 15 who have lost their mother, father or both parents). The projection by 2010 is 44 million orphans. Without AIDS the total number of orphans would have declined to less than 15 million.

In Nigeria, about 2.6 million children have lost one or both parents or 5.2 percent of children under 15 are orphans. It is projected that by 2010 there will 33.7 percent maternal and double orphans as a result of AIDS.

Impact of Aids on orphans/problems of vulnerable children

- Organise the large group into two small groups
- Assign topics to each group to discuss as follows:
Group I – Children orphaned by AIDS (Impact of AIDS)
Group II – Problems of vulnerable children
- Group work to last 10 minutes
- Presentation – 3 minutes per group
- Encourage additional contributions and the following points may be included

The impact of HIV/AIDS on children orphaned by AIDS include:

- Loss of family, identity and destiny
- Psychosocial distress

- Increased demand for labour
- Reduced opportunities for schooling
- Increased malnutrition
- Loss of healthcare
- More vulnerability to HIV infection
- Loss of inheritance
- Forced migration
- Homelessness
- Increased responsibilities (households headed by child)
- Risk of abuse and neglect

Problems of vulnerable children

Similar to those mentioned earlier

Strategies For Care Of OVC

8. Encourage each participant to mention a strategy or steps to take in the care of OVC
9. Wrap up the discussion with the following:
 - a) Strengthen the capacity of the families to cope with their problems
 - b) Mobilize and strengthen community-based responses, e.g. religious –affiliated organizations, youth and women groups, NGOs
 - c) Increase the capacity of children and young people to meet their own needs through access to quality education, protection from exploitation and excessive labour, and building the capacity to care for themselves
 - d) Create an enabling environment for children and families through such activities as ensuring basic legal protection through laws and policies to protect women and children, decreasing stigma and behaviour change interventions
 - e) Ensure that governments protect the most vulnerable and provide essential services
10. Summarize the highlights of the session
11. Evaluate by asking each participant to mention one key learning point/issue learned during the session. Tell them to listen attentively to others' points in order to avoid repetitions.

Session 3-

VOLUNTARY COUNSELLING AND TESTING (VCT)

Objective:

By the end of the session, the participants will be able to promote VCT through provision of accurate information on HIV/AIDS.

Materials:

Time:

Process:

1. Give out the objective of the session.
2. Ask 2–3 volunteers to explain what VCT stands for. Commend volunteers for output.
3. Explain the VCT process as below:

Voluntary HIV counselling and testing is the process whereby an individual or couple undergoes counselling to make possible an informed choice about being tested for HIV. The decision must be entirely the choice of the person(s) and they must be assured that the process will be confidential.

VCT is a vital entry point to other HIV/AIDS services, including prevention and clinical management of HIV-related illnesses, TB control, psychosocial and legal support, and prevention of mother-to-child transmission of HIV.

4. Have the group mention the possible components of VCT
5. Explain that VCT has four main components
 - Pre-test counselling
 - Laboratory testing
 - Post-test counselling
 - Ongoing counselling
6. Review the issues in each component in line with the points highlighted below:

Components of VCT

Pre-test counselling

The issues to be addressed during this session are:

- Reason for attending
- Knowledge about HIV and the modes of transmission
- Correcting misconceptions
- Assessment of risk profile
- Information concerning the test
- Discussion of meaning of HIV-positive and HIV-negative test results and possible implications
- Capacity to cope with HIV-positive result
- Discussion of potential needs and available support
- Discussion of a personal risk reduction plan
- Informed consent/dissent given freely
- Follow-up arrangements discussed
- Adequate time for questions and clarifications
 - Laboratory testing (see module on testing)
 - Post-test counselling

The issues to be addressed during this session are:

- Giving the result simply and clearly
- Giving time for the result to sink in
- Checking for understanding
- Discussing the meaning of the result to the client

- Discussing the personal, family and social implications, including to whom, if anyone, to tell the results
- Discussing a personal risk reduction plan
- Dealing with immediate emotional reactions
- Checking availability of adequate immediate support
- Discussing follow-up care and support
- Identifying options and resources
- Discussing follow-up plans and referrals, when necessary

Explain that there are five main models of VCT

Models of VCT

- Stand-alone* (also known as direct sites or free-standing sites).
Stand-alone sites are not associated with an existing medical institution and usually have staff fully devoted to VCT.
 - Integrated model*: Integrated sites are ones in which VCT is an integral part of other ongoing, usually public sector, healthcare services such as hospitals, STI clinics, TB clinics, family planning clinics or antenatal settings. The antenatal setting has received special attention since it is integral to preventing mother-to-child transmission (MTCT).
 - NGO model*: In this model the NGO either integrates VCT into its other established activities or provides VCT services as its only activity.
 - Private sector model*
 - Mobile/Outreach model*: There is limited information on this model. Where it has been done, it has been through a mobile van unit or caravan offering services at designated places and dates. It is useful for hard to reach and migrant populations
7. Summarize the highlights of the session
 8. Evaluate session by requesting participants to answer the following:
 - What is VCT?
 - How many components does VCT have? Explain issues in each one.
 - Mention the five models of VCT.

Session 4- STRESS AND BURNOUT

Objectives:

At the end of the session, participants will be able to:

- Identify the signs of stress in themselves and others
- Describe three strategies for reducing stress

Materials: Flipchart, stand, markers

Duration:

Process:

1. Ask a volunteer to read out the session's objectives
2. Explain that stress occurs when people adapt to demands and changes in their lives. Stress becomes burnout when you have lost energy, enthusiasm and interest in life.
3. Signs of stress

Exercise 1

- Distribute pieces of paper to each participant; tell them to write out a minimum of 10 and a maximum of 15 signs of stress.
- Display four blank pieces of newsprint around training wall, provide masking tape and ask each participant to fix his/her write-up on any of the blank newsprints.
- Ask all participants to move around and read the displayed pieces of paper, taking note of the similarities and differences.
- Commend participants for the output.
- Make clarifications, as needed, using the list below:

These signs of stress may be emotional, physical or changes in thinking pattern.

Emotional signs

- Crying more than usual
- Feeling irritated or angry all the time
- Losing interest in things you liked
- Feeling hopeless or helpless
- Dreading to go to work
- Disliking your co-workers or your clients
- Disliking change

Physical changes

- Headaches
- Feeling anxious and restless
- Feeling tired and sick all the time
- Unexplained aches and pains
- Problems with sleep
- Loss of appetite
- Losing interest in sex

Changes in thinking

- Lack of concentration
- Problem remembering things
- Inability to think clearly

4. Sources of stress

Exercise II

- Organise participants into four small groups
- Ask the groups to take down one of the blank newsprints on which pieces of paper have been pasted and ask them to summarize the sources in 10 minutes
- Request a reporter from each group to present the summary in two minutes

Sources of stress could be from:

- a) Work, e.g. too many clients, inadequate support and lack of resources
- b) Family situation, e.g. marital problems, too much responsibility
- c) Living situation, e.g. housing, transportation, water and light problems
- d) Money, e.g. no salary, debts, school fees
- e) Health, e.g. medical or sex problems, pregnancy

5. How can stress be reduced?

6. Encourage as many participants as possible to respond to this question. Commend the efforts in the contribution.

7. Make clarifications in line with the following:

How stress can be reduced

- Pay attention to your emotions, physical health and thinking patterns
- When you notice changes in your emotions, physical health or thinking pattern, find out whether these are signs of stress
- Write down a list of all sources of stress in your life
- Some sources of stress can be changed and some problems can be solved. Take some time and solve these problems. The extra effort it has taken you will pay off later.
- Some sources of stress cannot be changed and some problems cannot be solved. For those problems that cannot be solved, figure out how to reduce the emotional impact they have on you.

Some ways of reducing the emotional impact of problems that cannot be solved:

- Give yourself small breaks
- Find other activities to take your mind off the problem
- Talk to other counsellors or to someone who is understanding
- Exercise, sing, listen to music
- Pray, tell a joke, watch TV
- Play with your children
- Count your blessings

Group work on stress

- Use instructions/case study in trainer's guide

TRAINER'S GUIDE

Divide the participants into two groups and assign a case to each group for discussion. A member of each group will summarize the main points of the discussion to present during plenary.

Group 1

Case study

A matron who also is a leader of a church group that teaches other women how to keep their homes united is having marital problems because her husband is seeing another woman and often stays with her. He hardly gives her money for the upkeep of the house but she is feeling embarrassed to discuss her problem with anyone. She has been assigned by the state Ministry of Health to supervise two maternal and child health clinics and her colleagues are not cooperating with her.

Group 2

Case study

A doctor had seen over 30 patients and at closing he still had over 10 patients waiting, all complaining that they were very ill and had been waiting all day. He was already tired and wanted to leave, but could not. He manages many AIDS patients and is worried that he might get infected. His wife does not relate closely with him because she says he will bring AIDS to their home. His friends are stigmatizing him because of these "AIDS people" with whom he is associating.

Process the group exercise by asking the following questions:

How is the counsellor feeling?

What problems is the counsellor facing?

Can the problems be solved or not?

What can the counsellor do to reduce stress?

Summarize the key points and encourage the use of knowledge they acquired themselves as well as any that they may come across from counselors who are either experiencing stress or burnout.

LIST OF ACRONYMS AND REFERENCES

| | |
|---------------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| FHI | Family Health International |
| HIV | Human Immunodeficiency Virus |
| USAID | United States Agency for International Development |
| IMPACT | Implementing AIDS Prevention and Care |
| NACA | National Action Committee on AIDS |
| SACA | States Action Committee on AIDS |
| LACA | Local Action Committee on AIDS |
| HEAP | HIV/AIDS Emergency Action Plan |
| NASCP | National AIDS Control Programme |
| USIPs | United States Implementing Infections |
| STI | Sexually Transmitted Infections |
| UNAIDS | United Nations Action on AIDS |
| PABA | People Affected by AIDS |
| PLWHA | People Living With HIV/AIDS |
| IPCC | Interpersonal Communication and Counselling |
| VCT | Voluntary Counselling and Testing |
| OVC | Orphans and Vulnerable Children |
| MTCT | Mother to Child Transmission |
| NGO | Non-Governmental Organisation |

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4. Counselling Guidelines for Service Providers by Association for Reproductive and Family Health, Ibadan
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