Community Counsellor Training Toolkit

Module 4

HIV Counselling and Testing

Participant Manual

LifeLine/ChildLine Namibia

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Developed by Lisa Fiol Powers, Family Health International (FHI), Namibia, in collaboration with staff from LifeLine/ChildLine, Namibia.

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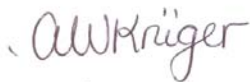
Foreword

In 1988, I started working as a young community liaison officer for a Namibian non-profit organisation. This experience opened my eyes to the tremendous gaps between the values, norms and cultural influences of the country's different ethnic and racial groups and between those living in urban and rural settings. These differences in experience and perspective added to the tension amongst people, leading to a lack of trust and an inability to work together.

Fortunately, Namibians have experienced tremendous social growth since then, as these manuals for training community counsellors demonstrate. They include such sensitive subjects as stigma, coercion and cultural practices detrimental to health. These pioneering learning tools reflect the significant progress made as a result of the great partnerships developed throughout Namibia over the last 18 years. It is heart-warming to witness the openness and trust people from different cultures have achieved by offering counselling to a neighbour, a friend, a stranger.

I am proud to be associated with these manuals. I am proud of every trainer of LifeLine/ChildLine Namibia and every Namibian trainee who contributed. Thanks go to the many partners in faith-based organisations, non-governmental organisations, and the Ministry of Health and Social Services, especially NACOP—Special Programmes Division, which made such important contributions. Ms. Lisa Fiol Powers, a consultant seconded by Family Health International to upgrade and develop these manuals, deserves special thanks. In addition to these dedicated partners, we also want to thank the U.S. President's Emergency Plan for AIDS Relief, which provided funding. We will forever be grateful to you all.



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Acknowledgements

Over the last eight months I have lived, breathed and dreamt about community counselling, training and curricula. Developing the Community Counselling Training Toolkit has been an incredible experience for me. It enabled me to share my passion and concern to provide psychosocial support and counselling to meet the needs of so many around the world, particularly those affected by and infected with HIV. For me, it has been an honour to live and work in Namibia and to share in the lives of so many who are tirelessly working to fight HIV and its effects.

As is true with all curricula development, the entire team creates the finished product. The team I have worked with at Family Health International (FHI) and LifeLine/ChildLine has been especially generous, delightful and supportive.

Let me start by thanking the training team at LifeLine/ChildLine. The training team includes staff trainers Nortin, Frieda, Maggy, Angela and Cornelia, and volunteer trainers Dube, Christine, Hilarie, Emmy, Emelle and Jonas who have been absolutely fabulous to work with. When I rushed to complete drafts of Facilitator Manuals just days before a training workshop, the trainers never lost patience, even though it meant they had limited time to prepare for their sessions. Their enthusiasm and willingness to try new material has never ceased to amaze me. They have welcomed new ideas and significant changes to both the training materials and the methodology. The encouragement and feedback I have received from the trainers has been invaluable! You have been a delightful group of people to work with on this project.

I would also like to thank Amanda Kruger, Hafeni Katamba and Simon Kakuva at LifeLine/ChildLine for recognising the need to make substantial changes in the Community Counsellor Training Toolkit and for their support throughout the process of curricula development, encompassing piloting and testing new material as well as training trainers in process facilitation.

None of this would have been possible without the incredible support from the entire staff at Family Heath International/Namibia. You are all a truly talented, dedicated and fun group of people. I would specifically like to thank Rose de Buysscher for making this whole project possible, not only through the allocation of funds, but also for her support in turning what began as a “harmonisation” into a more extensive project involving significant changes to existing curricula and the design and development of new material. The technical contributions and support for person-centred counselling offered by Dr. Fred van der Veen enabled me to challenge some of the rigid tenets of HIV counselling, and encourage counsellors to focus on their client’s emotional needs rather than adhering to fixed protocols.

Finally, I would like to express my deepest gratitude to Patsy Church for her inspiration and generosity in providing so many resources, for engaging in so many stimulating conversations, for being a cheerleader at times, and for always believing that these materials could make a difference. Patsy tirelessly read through drafts and offered valuable feedback and encouragement. Patsy has not only become a role model, she has become a dear friend.

My hope is that, with this Training Toolkit, community counsellors in Namibia will be better equipped to support their clients emotionally, offering them hope as they wrestle with so many difficult issues such as stigma, loss, coping with their HIV status, death and treatment, as well as financial and emotional uncertainty.

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HIV Counselling and Testing: Participant Manual
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LIST OF BASIC COUNSELLING SKILLS

Below is a list of the basic counselling skills. You will need to continuously remind yourself of these skills as you practise structured types of counselling.

Empathy*

Listening Skills*

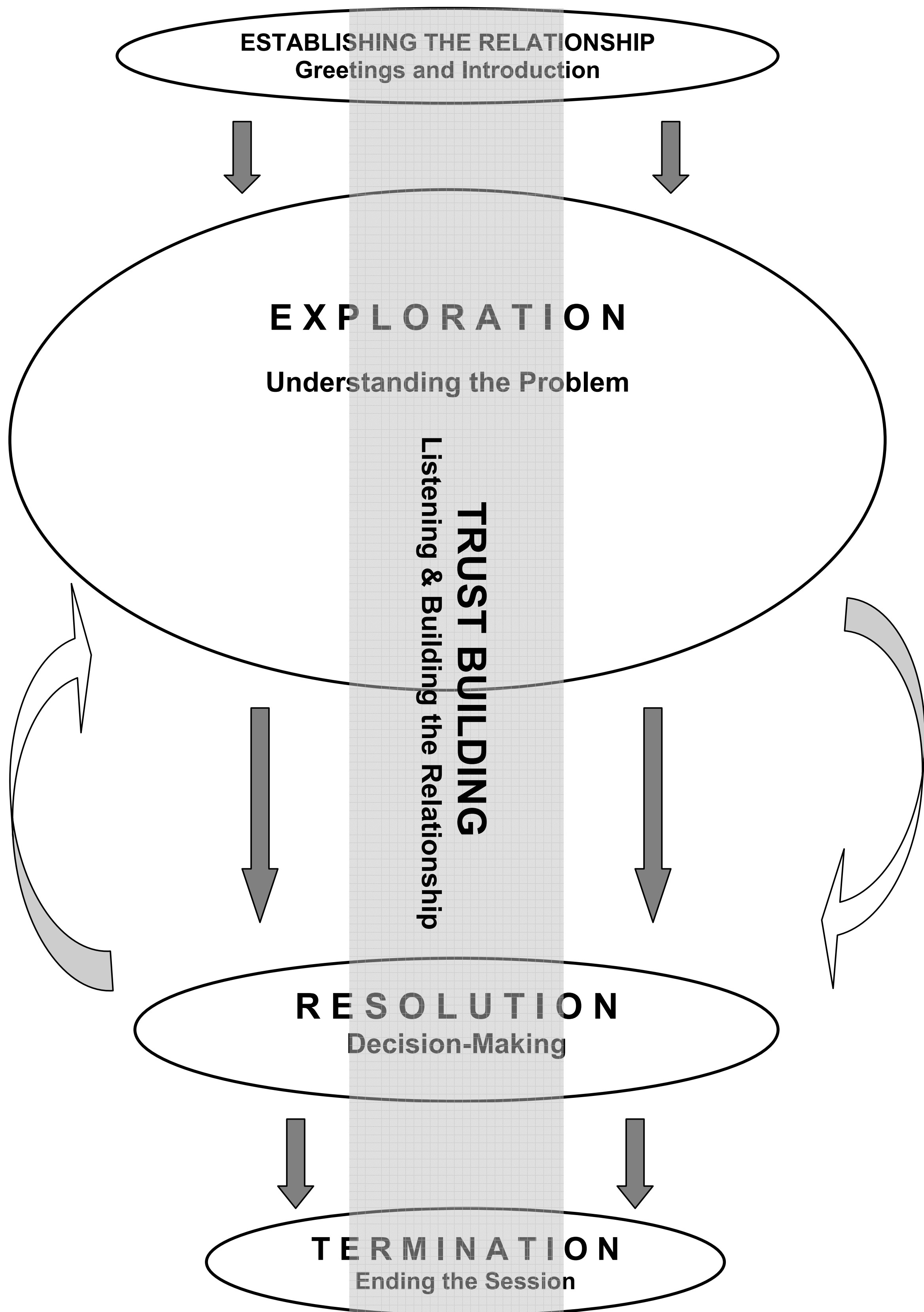
Reflecting Skills:
- **Reflecting Feelings***
- Restating/Reframing
- **Affirmation***
- **Summarising***

Probing/Action Skills:
- **Asking Questions (Clarifying)***
- Interpretation or Making Statements
- Confrontation or Challenging
- Information Sharing and Education

Problem-Solving/Problem Management

* These are the **essential counselling skills**.

Model of a Counselling Session



PERSONAL VALUES AND FEELINGS ABOUT HIV WORKSHEET

Part I

<u>Instructions:</u> Please complete the sentences below. Be as honest as possible. This exercise is to help you think about your own feelings about HIV and AIDS and how those feelings may impact your working with people who have HIV. This assessment is meant to be personal. You will not be asked to show this form to anyone once you are done. You may volunteer to share your responses with others if you wish.

1. When I know that a person with HIV is having unprotected sex, I feel:

2. When a pregnant woman tests positive for HIV, my first thought is…

3. I think my biggest difficulty in working with clients will be…

4. The emotions I am most uncomfortable with are…

5. The most important factors in my own decision to be tested or not to be tested for HIV are…

Part II

Instructions: Read the statements provided below. For each statement, circle the response that most closely reflects your own opinion. Then, in the space below the statement, explain your thoughts and feelings.

SA	A	D	SD
Strongly Agree	Agree	Disagree	Strongly Disagree

1. Health providers and counsellors should recommend HIV testing to all patients with any risk factors in their lives.

   SA **A** **D** **SD**

2. People with HIV have a responsibility to disclose their status to all potential sexual partners.

   SA **A** **D** **SD**

3. Health workers and counsellors who counsel others about HIV should know their own HIV status.

   SA **A** **D** **SD**

4. I am comfortable talking with my clients about their sexual behaviours.

   SA **A** **D** **SD**

5. I have never felt the desire to break the confidentiality of a client's HIV status.

   SA **A** **D** **SD**

SA	A	D	SD
Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**

6. I am equally comfortable working with men and women.

SA **A** **D** **SD**

7. I am comfortable working with homosexual clients.

SA **A** **D** **SD**

8. It is a person's right to end his/her life when his/her pain is unbearable.

SA **A** **D** **SD**

9. There is nothing wrong with extramarital sex as long as the parties involved are adults.

SA **A** **D** **SD**

10. Prostitutes are largely responsible for spreading HIV.

SA **A** **D** **SD**

11. All people with HIV must tell their partners and families their status.

SA **A** **D** **SD**

SA	A	D	SD
Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**

12. Masturbation is an acceptable safer sex strategy.

SA **A** **D** **SD**

13. Women's vulnerability to HIV can be reduced by empowering women through counselling to protect themselves.

SA **A** **D** **SD**

14. It is a woman's duty to have sex when her husband asks for it.

SA **A** **D** **SD**

15. If an adult gets HIV, it is their fault for having many sexual partners.

SA **A** **D** **SD**

Adapted from Ministry of Health & Child Welfare/Zimbabwe. Integrated Counselling for HIV and AIDS Prevention and Care, Primary Care Counsellor Training.

WHAT IS HIV COUNSELLING & TESTING?

HIV Counselling and Testing, also known as VCT:
Voluntary Counselling and Testing

- Testing: Clients find out their HIV status by having a blood test. **Most people who are tested find out that they are not infected with HIV!**

- Voluntary: Clients choose to be tested.

- Counselling: Support for people who want to be tested, and support after they receive their test results.

- Prevention intervention:
    - Personalised way to help people evaluate their own behaviours and explore ways to reduce their risk of infection.

- Starting point for support, care and treatment:
    - Once people know their status, they can make choices and access services in order to have their needs met and to be supported, i.e. if someone is negative, they can make choices to remain negative and reduce their risk of infection. If someone is positive, they can take steps to live positively and to access counselling and treatment services if needed. It is only after someone knows his/her status that he/she can make informed decisions about his/her health.

HIV Counselling & Testing is based on a risk reduction model; it is designed to reduce, not necessarily eliminate, risk.

- Emphasises taking small steps to change behaviour in order to reduce risk of infection.

- VCT is designed to build on successes. When people take small steps to change their behaviour and are successful, they can then continue to take more steps to change other behaviours.

Counselling and Testing has a very simple structure. Each of these counselling sessions has specific topics that should be addressed, but each topic should be personalised to the individual needs and situation of the client.

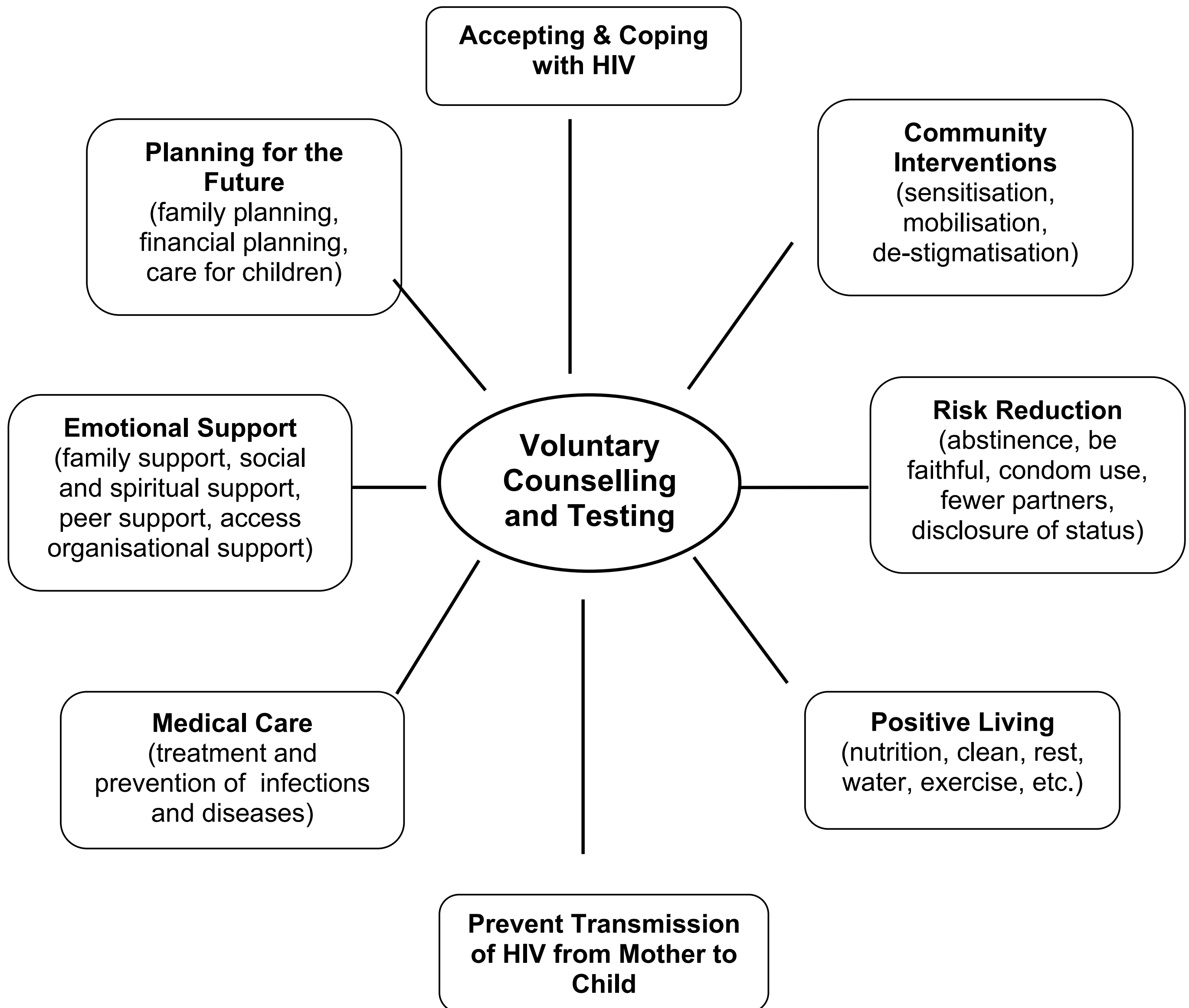
- Pre-Test Counselling: This is a counselling session conducted prior to the client's HIV test.

- HIV test: Depending on the resources and tests available at the testing centre (VCT centre, hospital or clinic), the test involves a finger prick (rapid test) or drawing blood for a test whose results are available in a week or two.

- Post-Test Counselling: In this counselling session, the client is given his/her test result.

- Follow-Up Counselling: This is on-going support for a client as needed.

VCT as an Essential Part of Prevention, Care and Treatment Services



Case scenarios:

Scenario 1: Kandjii does not know his HIV status, but he believes that he and almost everyone he knows is infected with HIV. He has seen many people get sick and die from AIDS. He has had several girlfriends, so he has decided that there is no future. He figures that he too will die from AIDS in the not-too-distant future.

It is the end of the month, and on Friday he gets paid and goes with his friends to the shebeen. They are drinking and having a good time when Kandjii meets Otilie. She is beautiful and fun to laugh and talk with. They agree to have sex. They never talk about it, but Kandjii thinks that the young woman is most likely infected with HIV, so he chooses not to use a condom.

- Now, imagine if Kandjii is tested and discovers that he is not infected with HIV.
- Knowing that he is not HIV-infected, how might Kandjii feel and act differently? What has changed for him?

Scenario 2: Mbapewa is determined to avoid getting infected with HIV. She finds comfort in reading the billboards throughout the city that say, "By Staying Faithful People Can Avoid HIV/AIDS." She only has sex with her husband. Although she knows many people who have HIV and some who are sick, she does not believe that HIV is a problem for her.

Mbapewa is pregnant, and during her routine visit to the antenatal clinic, the nurse tells her about the availability of testing. Because she believes that people who stay faithful are not at risk of HIV, she sees no reason to be tested.

- Imagine that Mbapewa was tested and discovers that she is HIV-infected.
- Knowing that she is positive, how might Mbapewa think, feel or behave differently?

Benefits of & Concerns about HIV Counselling & Testing

For Individuals

Benefits	Concerns
▪ Empowers the uninfected person to protect him/herself ▪ Assists infected people to protect others and to live positively ▪ Offers the opportunity to access treatment, care and support	▪ Financial difficulties ▪ Fear of stigma

For Couples & Families

Benefits	Concerns
▪ Supports safer relationships (faithfulness, safer sex) ▪ Encourages family planning and treatment to prevent transmission from mother to child ▪ Allows the couple and family to plan for the future	▪ Break-up in relationships ▪ Anger towards the infected person ▪ Possible domestic violence, particularly towards women who are positive

For the Community

Benefits	Concerns
▪ Encourage optimism, as most people test HIV-negative ▪ Positively improves community norms such as testing, risk reduction, discussion of status, safer sex	▪ Fear of changing local culture ▪ Care for those who are infected

BEHAVIOUR CHANGE IN HIV COUNSELLING & TESTING

Key Points for Understanding Behaviour Change
- Change takes time; it is usually a gradual process.
- It takes more than information to change.
- People around us can help us or make it more difficult to change.
- We have setbacks when we try to change.

Stages of Behaviour Change

Stage	Description
1. Pre-contemplation (not aware of or thinking about change)	The person is not thinking about change. Believes there is no problem. Answers questions with "yes, but…" Possible feelings/thinking: ▪ resigned or hopeless (this is just the way things are) ▪ no control ▪ denial (this does not apply to me, there is not a problem) ▪ argumentative; believes consequences are not serious
2. Contemplation (thinking)	Acknowledges that there is a problem Increased awareness and knowledge related to the problem Weighs advantages and disadvantages of behaviour Begins to think about behaviour change
3. Preparation	Develops commitment to change Makes a detailed plan for change Perceives more benefits than barriers to change Experiments with small changes
4. Action	Takes action to change Takes six months before person moves to maintenance
5. Maintenance and Relapse Prevention	Maintains new behaviour over time

**Note: these stages do not happen in a linear pattern. A person usually slips backwards and goes between the stages like a spiral.*

How does behaviour change relate to HIV counselling and testing? *OR* What kinds of behaviours are we encouraging clients to change?

- Change risky behaviours, i.e. reduce the number of sexual partners
- Encourage abstinence, using condoms and being faithful.

> NOTE: When talking about behaviour change in HIV, we usually are talking about changing behaviours related to sex. Sexual behaviours are not easy to change. Simply telling your client that certain behaviours put them at risk for STIs or HIV is not enough to change their behaviour. In order to change practises or behaviour, interventions must address three levels: **knowledge**, **attitude** and **behaviour** (KAB). As counsellors, we must make sure that we not only assess the client's knowledge but understand their attitude and perspective before attempting any behaviour changes.

For example:

1. Knowledge: A person must know which practises can put an individual at risk.

2. Attitude: A person must believe that "people like him or her" can be at risk.

3. Attitude: A person must believe that he or she is at risk (make it personal).

4. Behaviour: Before the person can take action to change his or her own behaviour.

> "Insight is crucial to change. But insight alone is not enough. It takes effort and will."
>
> *~Allen Whelis*

Research has repeatedly identified four characteristics that influence people's ability to change:

1. Self-control: how much a person feels in control of his or her own life (destiny).
2. Assertiveness: the ability to communicate clearly what a person wants or needs.
3. Rationality: the ability to make decisions about one's own life and behaviour in a fully considered way.
4. Social affiliation: how and to what extent a person feels part of a larger group, and how important that connection is.

> **Key Point:** We do not have the power to change other people's behaviour. A person must choose to change his/her own behaviour.

COUNSELLING AND BEHAVIOUR CHANGE

The **role of the counsellor** in the process of behaviour change is to:

- Help a client explore the outcome of his/her current behaviour.
- Help the client identify other options to the current behaviour.
- Provide missing information to the client.
- Explore advantages and disadvantages to current behaviour and desired behaviour.
- Help client to develop skills in order to make any changes he/she is committed to making.
- Encourage and support the client in the change process.
- Behaviour change takes place over the course of many counselling sessions.

Counselling and Behaviour Change

1. **Pre-Contemplative Stage:** The goal in this stage is to encourage the client to begin thinking about change.

   - During this stage, clients may appear argumentative, hopeless or in "denial." They will answer questions with "yes, but…"
   - Some clients spend years in the contemplation stage.
   - The tendency as counsellors is to try to convince clients that they need to change. This usually results in resistance and poorly influences the counsellor/client relationship.
   - The counsellor should shift back to basic counselling skills such as listening, empathy, reflecting feelings and asking gentle questions.
   - The counsellor should gently point out discrepancies between the client's goals and statements.
   - Some example questions to ask:
     - What would have to happen for you to know that this is a problem?
     - What warning signs would let you know that this is a problem?
     - Have you tried to change in the past? What have you tried to do?
     - Yes, it is difficult to change. What difficult things have you done in the past?

2. **Contemplation Stage**: The goal in this stage is to help the client look at benefits and barriers to change.

   - Encourage and support the client in thinking about change.

   - Explore advantages and disadvantages of changing.

   - Help client identify barriers to change.

   - Help client explore options.

   - Some example questions to ask:
     - What is working for you about what you are doing now?
     - What are you doing now that you would like to change?
     - Why do you want to change at this time?
     - What were your reasons for not changing prior to this time?
     - What would keep you from changing right now?
     - What is the hardest (scariest/worst/most difficult) part about changing this behaviour?
     - What might be good about changing?

3. **Preparation**: The goal in this stage is to develop a plan to take action.

   - Begin to identify and develop skills necessary to make the change.

   - The counsellor can provide the client with specific, practical and achievable skills. One method is to conduct reverse role plays, i.e. counsellor plays the client and the client plays the partner.

   - Ask about support for behaviour change.

   - Develop a step-by-step plan to change the behaviour.

   - Start with behaviours that are easier to change in order to build confidence and success.

   - Encourage the client, but also be realistic about the process of change. Expect setbacks and difficulties.
   - Some example questions to ask:
     - What do you expect will be the most difficult part of this for you?
     - How have you handled similar situations in the past?
     - What might help you with the barriers to change?
     - What has helped you change in the past?
     - What will you have to do differently?
     - What do you think would help you at this time?
     - When you do this, what words will you use?

4. **Action**

- Begins with first attempts at changing behaviour. First tries may not always be successful, but simply trying to change is a success.
- The counsellor should encourage and support the client.
- Re-interpret the concept of "failure." Having "unsuccessful" attempts at behaviour change is part of the process, not failure.
- Discuss successes and difficulties with the change.
- Praise the client for his/her successes.
- Problem-solve to overcome difficulties the client encounters.
- Adjust the behaviour change plan as needed; you may move on to the next step of the plan.

5. **Maintenance and Relapse Prevention**

- Continue to encourage and support the client.
- Explore benefits and challenges to the changed behaviour.

<u>Example of Behaviour Change</u>: when people change their sexual behaviour to use condoms to protect themselves from infection, they may pass through the following stages:

1. Pre-Contemplation: have not considered that they are at-risk and need to use condoms.
2. Contemplation: become aware of their risk and the need to use condoms.
3. Preparation: begin to think about using condoms in the next few months. Maybe try to use a condom once.
4. Action: use condoms consistently for a few months.
5. Relapse: have intercourse a few times without using a condom.
6. Action: go back to using condoms; use them consistently for a few months.
7. Maintenance: use condoms consistently for over six months.

Counselling and the Stages of Behaviour Change

Stage	What to do in counselling
1. Pre-contemplation (not aware of or thinking about change)	Explore client's thoughts, feelings and attitudes. Assess client's awareness and understanding. Provide information; raise awareness. Discuss consequences, both positive and negative, of current behaviour.
2. Contemplation (thinking)	Help client weigh options. Explore advantages and disadvantages of current behaviour and changed behaviour. Link information with client's personal behaviour: is the behaviour a problem?
3. Preparation	Help client develop skills that would help to change behaviour. Discuss previous attempts at change. Help client develop a realistic step-by-step plan. Start with easier changes. Support and encourage client to make the change.
4. Action	Discuss removing any barriers to change or ways to support the change. Normalise setbacks or slips. Re-frame "failures" as part of the change process
5. Maintenance and Relapse Prevention	Support and encourage. Reinforce behaviour change.

**Note: these stages do not happen in a linear pattern. A person usually slips backwards and goes between the stages like a spiral.*

Suggestions for Behaviour Change

(for reference)

Changing healthy behaviour is difficult, but changing sexual behaviour is especially challenging. Below are some suggestions:

1. Begin by providing information. Although giving information is rarely enough by itself to produce a change in behaviour, it is a good place to start.
2. Identify change barriers. Identify reasons why individuals are resistant to change and address these barriers.
3. Fear-based messages are limited in their effectiveness in changing behaviour; in fact, they can often hinder behaviour change. It is best to focus on the positive consequences of changing the behaviour. Focus on what the positive results might be if a person changes his/her behaviour.
4. Change behaviour one step at a time. People are more likely to try new behaviours that they feel they are capable of doing. Do not try to change everything all at once; do it in stages.
5. Teach people the skills for engaging in the behaviour change, i.e. how to talk to a partner about using a condom or how to use a condom.
6. Encourage people to substitute a different behaviour rather than just to stop unhealthy behaviour.
7. Provide options. People are more likely to try a new behaviour if they are given a choice of several alternatives.
8. Create environments that encourage change, i.e. Avoid a setting associated with unhealthy behaviours.
9. It is easier to change if there is support from others in the community. If others are changing, especially influential people in the community, then it is easier to change one's own behaviour.
10. Set up realistic expectations. Relapse and setbacks are expected; they are not a sign of failure.

Adapted from Thomas Coates, PhD. "Principles of Behavior Change." Center for AIDS Prevention Studies at the University of California. San Francisco.

Factors that Influence Behaviour Change

These factors can be divided into three different types:

1. Personal Factors
2. Social Factors
3. Environmental Factors

Personal Factors:

- People need information and knowledge.
- People need to believe that the information applies to them and their community; the information needs to be made personal.
- People need communication and skills to be able to change.
- People need to be able to plan and strategise for behaviour change.
- People need self confidence to believe that they can change.
- People need to believe there are more advantages than disadvantages to changing their behaviour.

Social Factors:

- How we behave often depends on how people around us expect us to behave. Different people expect us to behave in different ways depending on the situation, i.e. our children may expect us to behave differently than our colleagues.
- Social support includes reinforcement (reward) for behaving in ways consistent with expectation and material support.

Environmental Factors:

- Access to services.
- Education and job opportunities: sometimes we engage in behaviours we know put us at risk for HIV because we cannot afford not to, i.e. women may feel like they have no other option than to have sex with a husband who has had other partners because they are afraid of being chased from their homes.
- Discrimination.
- Unsafe and safe places: unsafe places in communities might include places where people drink or isolated places like the bush. Safe places include churches or community centres.

COUNSELLING TOPICS IN VCT: RISK REDUCTION

Key Counselling Topics in VCT

- Establish a relationship
- Client's reason for coming for testing/level of concern
- Determining client's knowledge of HIV and transmission
- **Risk Reduction**
  - Risk assessment (Explore the client's risk)
    - Determine risky behaviours
    - Assess costs and benefits of risk behaviour
    - Explore past successes and abilities to change behaviour
  - Explore risk reduction options/strategies
    - Determine options (strategies) for reducing risk
    - Identify barriers to risk reduction strategies
    - Develop ways to overcome these barriers
  - Develop a personalised risk reduction plan
- Partner communication/partner's risky behaviours
- Provide any information the client needs or clarification of incorrect information
- Demonstrate male and female condom (Femidom) use
- Condom negotiation with partner
- Explain the HIV test and meaning of the test results, including the "window period"
- Provide test results
- Assess client's ability to cope
- Disclosure of test results and partner disclosure
- Provide emotional support and referrals as needed

Identifying Behavioural Risk

- Examples of high risk behaviour:
  - A single mother selling sex to support herself and her children
  - A man who has multiple partners: a wife in the village and two girlfriends
  - An older person in a relationship with a young person, i.e. a sugar daddy
  - Young people engaging in sex because of peer pressure
  - Engaging in sex after drinking alcohol

- Examples of lower risk behaviours:
    - Having sex with your husband after agreeing to faithfulness in the relationship
    - Using a condom every time you have sexual intercourse
    - Abstinence (no risk behaviour)

Risk Reduction

- Risk Assessment: explore the client's risk
    - Determine risky behaviours
    - Assess costs and benefits of risk behaviour
    - Explore past successes and abilities to change behaviour

- Explore Risk Reduction Options/Strategies
    - Determine options (strategies) for reducing risk
    - Identify barriers to risk reduction strategies
    - Develop ways to overcome these barriers

- Develop a Personalised Risk-Reduction Plan

Risk Assessment: Explore Client's Risk

1. Determine risky behaviours

- **Patterns of risk**: recurring situations in which the client is more likely to engage in risky behaviour.
  Example: A male client travels for work. He is lonely when he travels, and often stops at a bar for the evening to be with other people. He drinks alcohol at the bar. When he drinks too much, he is more likely to seek out a sexual partner, and because of the alcohol, often does not think to use a condom. As a result, the client often has unsafe sex when he travels for work.

- **Risk circumstances**: the client's circumstances influence patterns of risk. A risk circumstance is a situation in which the client finds him/herself in that may lead to engaging in risky behaviour.
  Example: Lack of money for school fees or food could be a risk circumstance that could lead to exchanging sex for financial support.

- **Risk triggers**: an event that leads the client to engage in risky behaviour.
  Example: Being separated from a spouse could be a risk trigger that could lead to seeking out other sexual partners. OR Going out with friends and drinking alcohol may also be a risk trigger since it lowers inhibition and hinders judgement.

- **Risk vulnerabilities**: emotional or psychological states that lead the client to engage in risky behaviour.
  Example: A person in love might believe that his or her partner could not be infected with HIV.

- Explore the client's feelings or concern about risk behaviour or the client's perception of risk behaviour: is it a problem for him/her?

2. **Assess benefits and costs of these behaviours**: explore the advantages and disadvantages of the risky behaviours.

   - What does the client gain through these behaviours? What kinds of things might someone gain through high risk behaviours?
     Examples:
     - Emotionally: feel "cared for," at least for a short while; do not "rock the boat" in a relationship because it is safer emotionally
     - Physically: physical touch
     - Feed the "ego:" men might feel very manly, women might feel sexy/attractive, etc.

   - What are the negative consequences or costs of these behaviours? What kinds of things might be costs of high risk behaviours?
     Examples:
     - Inconsistency/instability in relationships
     - Do not experience benefits of long-term committed relationships such as stability, love, trust, etc.

> **Key Point:** The benefits and costs of risky behaviours are very personal. They will be different for each individual and his/her unique situation.

3. **Explore past successes and abilities to reduce risk**

   - Previous attempts to change behaviour, i.e. reduce risk such as fewer partners, using a condom, etc.

   - Determine what has worked and what has not worked in order to make future attempts more successful. It is also important to affirm successful attempts at behaviour change in order to build confidence for future changes.

Explore Risk Reduction Options/Strategies

1. **Determine options or strategies for reducing risk**
   Examples of risk reduction strategies:
     - Masturbate
     - Abstinence
     - Get tested for HIV and other STIs
     - Ask your partner to be tested or be tested together
     - Abstain until you know the status of your partner
     - Stop going to high-risk venues, such as bars, clubs or shebeens.
     - Retest and use protection during the three-month window period.
     - Use condoms

- Always have a condom with you
- Communicate with partner about being faithful
- Eliminate a high risk partner
- Stop seeing specific people who might put you at risk for HIV, i.e. commercial sex workers or non-exclusive partners
- Use condoms with specific people, i.e. commercial sex workers or non-exclusive partners
- Ejaculate outside your partner's body
- Reduce, or stop, drinking and/or drug use because alcohol and drugs affect decision-making ability
- Avoid contact with the genital area if genital sores are present
- Get tested and treated for STIs
- Go with a new partner to get tested together
- Get re-tested with your partner
- Be in a monogamous relationship with a tested partner
- Have longer monogamous relationships with fewer partners
- Do not brush your teeth or floss before oral sex. Brushing or flossing may cause gums to bleed, which means there is an opening in the skin for the virus to enter.
- Use a condom when having oral sex
- If performing oral sex on a man, have your partner ejaculate outside the mouth.

2. Identify barriers to risk reduction strategies

- Identify internal and external barriers to the risk reduction options identified by your client.

3. Develop ways to overcome these barriers

> **Key Point:** As with the benefits and costs of risky behaviours, barriers to risk reduction strategies are unique to each person. Each individual's barriers will be unique to his/her situation.

4. Develop a Personalised Risk Reduction Plan

- A personalised risk reduction plan can include some of the risk reduction strategies, but taking into account the barriers and ways to overcome them.

- The plan should begin with small steps. Do not try to change everything all at once.

CASE STUDIES: RISK REDUCTION STRATEGIES

Risk Reduction Steps

- Risk assessment: explore the client's risk
  - Determine risky behaviours
  - Assess costs and benefits of risky behaviour
  - Explore past successes and abilities concerning behaviour change
- Explore risk reduction options and strategies
  - Determine options or strategies for reducing risk
  - Identify barriers to risk reduction strategies
  - Develop ways to overcome these barriers
- Develop a personalised risk reduction plan

In this session, we are going to look at some case studies and explore risk reduction options or strategies for these situations.

For each case, the client is with you in counselling.

Case Study #1: The client is a 28-year-old woman. She is a commercial sex worker who works at a shebeen along a truck route. She has a boyfriend. She has said that her clients do not like to use condoms. She also pays for the condoms, which is expensive for her. She sometimes drinks with her clients.
Case Study #2: The client is a 40-year-old man. He works at a bank in Windhoek. He is married. He also has a girlfriend, whom he believes sees other men. He tried condoms once, but had a negative experience: they made him go soft (lose his erection).
Case Study #3: The client is a 35-year-old woman. She is married, but her husband works in the mines far away from their home in the north. She has a boyfriend in the next town. She believes that both her husband and her boyfriend see other women.
Case Study #4: The client is an 18-year-old girl. She attends high school in the city close to her hometown. She stays with her aunt and uncle. She has a boyfriend who is 28 years old. She thinks he has other girlfriends.

Discuss the following in your groups:

- List possible risk reduction strategies.
- List potential barriers to these strategies.
- List ways to overcome these barriers.

Partner Communication & Negotiation

Important subjects to discuss with a partner:
- Referral for testing
- Disclosing test results to partner
- Negotiating condom use
- Discussing faithfulness/exclusivity
- Family planning

Partner Communication
1. Assess communication
2. Explore barriers
3. Identify strategies
4. Practise skills

Partner Communication

1. **Assess communication**: assess the current communication in the relationship, i.e. what do they talk about, if it is possible to talk about sensitive issues in the relationship, etc.
    - Example questions*:*
        - What do you and your partner typically talk about?
        - Have you ever talked about issues such as sex, condom use or protection against infection, including HIV and STIs?
        - What experience do you have with discussing things like this with your partner?
        - Have you ever brought up sensitive issues with your partner? If so, what was that experience like? If not, why not?
        - Does it seem realistic to talk to your partner about this? Why or why not?

2. **Explore barriers**: If the client expresses difficulty in talking with his/her partner/s about these types of issues, assess what barriers the client perceives.

    - Example questions:*:*
        - What might make it difficult?
        - How do you think your partner might react if you talked to him/her about this?
        - What do you think would be challenging about talking to your partner?
        - What are your fears about discussing this with your partner?

3. **Identify strategies**: Help the client identify strategies that he/she can use to talk to his/her partner.

    - Keep in mind that the most effective strategies come from the client. Only the client is living in her/his particular circumstances and therefore knows what will and will not work.

- Give the client plenty of space to identify potential strategies. Avoid being directive in this discussion.

- Example questions:
  - How do you think you might do this?
  - What do you think will work when talking to your partner?
  - How have you brought up topics like this in the past with your partner?
  - Who might be able to help you? Who could you talk to about this?
  - What have you done in similar situations?
  - What have you thought about doing?
  - Have you ever talked about issues like this before, maybe with a different partner? What worked then?

4. **Practise skills**: Have the client practise skills for talking with his/her partner. Help the client be clear about what he or she wants to say. The communication can be focussed on referral for VCT, disclosure, condom use, etc.

   - The skills can be practised through role plays in the counselling session. The counsellor can play the role of the client or the partner.

   - You can also use an "empty chair technique." To use this technique, you can set up a chair in the counselling room. Have the client pretend that the partner is sitting in that chair and tell the partner what he/she wants the partner to know. Practise putting into words what he/she wants to tell his/her partner.

   - Discuss when and how to talk to the partner:
     - Pick a neutral place to talk.
     - Decide what you want to say.
     - Try not to drink alcohol or use drugs before you talk.
     - Plan to talk some time other than when you are about to have sex.

Suggested Role Play Scenario #1 The client is a 24-year-old woman. She is a university student. She is beginning a new relationship. She has had two sexual relationships in the past, but has not yet been tested. She had unprotected sex in each of those relationships. She wants her new boyfriend to get tested. She knows he sleeps with other women, and she wants to discuss condoms with him and ejaculating outside the body.
Suggested Role Play Scenario #2 The client is a 19-year-old male who drives a taxi. He has a serious girlfriend and another friend he has sex with occasionally. He has had five partners in the past with whom he had unprotected sex. He wants to start using condoms with his friend. He also wants to ask his girlfriend to get tested

MALE AND FEMALE CONDOM (FEMIDOM) DEMONSTRATION

Male Condom Demonstration

1. First, check to see that the condom wrapper is intact. There should not be any holes or tears in the packaging. Do not keep condoms in a hot place such as in your car or in your wallet. They should be stored in a cool, dry place.

2. Then check the expiry date. All condoms have an expiry date. Do not use if it is after the expiry date.

3. Only open the package when you are ready to use it; otherwise the condom will dry out. Push the condom to one side before opening the package so you do not tear or damage the condom when you open the package. If it gets torn, throw it away and open a new package.

4. Condoms come rolled up in a flat circle. Place the rolled-up condom, right side up, on the end of the penis. Hold the tip of the condom between your thumb and first finger to squeeze the air out of the tip. This leaves room for the semen to collect after ejaculation.

5. Keep holding the top of the condom with one hand. With the other hand, unroll the condom all the way down the length of the erect penis to the pubic hair. If the man is uncircumcised, he should first pull back the foreskin before unrolling the condom.

6. Once the condom is correctly on the man's erect penis, he can then put his penis in the woman's vagina.

After sex, it is important that the condom be taken off and disposed of in the correct way.

7. Immediately after the man ejaculates, he should hold onto the condom at the base. This is to make sure that the condom does not slip off.

8. The man must pull out while the penis is still erect.

9. When the penis is completely withdrawn, remove the condom from the penis but pulling at the tip with one hand, while the other hand gently guides the base.

10. Tie the used condom in a knot and throw away in the waste bin. Do not flush it down the toilet.

Another thing to keep in mind when using condoms is lubrication. Condoms with lubrication are less likely to tear during handling and use.

- If a condom is not lubricated enough, you can use a water-based lubricant such as glycerine or K-Y jelly. Even saliva works well for this. It does not hurt you to lick the condom. You can even get flavoured condoms!

- Avoid lubricants made from oil, such as cooking oil, shortening like butter or Rama, mineral or baby oil, petroleum jellies such as Vaseline and most lotions. These can damage the condom. *Rub some Vaseline or baby oil on the blown-up condom to demonstrate this; it should burst.*

Adapted from UNAIDS. "Fast Facts: How do you use a male condom?" www.unaids.org

Ways to introduce a condom demonstration in a counselling session:

- **DO NOT** ask the client if he/she knows how to use a condom! The answer will always be "yes."
- Ask your client to show you how to use a condom; then build on what he/she does correctly, adding missing information and correcting false information.
- Many people think they know how to use a condom correctly, but they have never really been shown how to do it. Let me show you the correct way to use a condom.
- You could also ask the client what he/she thinks are the difficult aspects of using a condom; these are often interpersonal concerns.
- I would like to take a few minutes to focus on what you think and know about using condoms when you have sex.
- Using condoms is an effective way to reduce the risk of HIV infection and other STIs. Generally, people have a lot of different thoughts and beliefs about using condoms.
- As you might know, a condom is very effective against sexually transmitted infections, including HIV. But you must use a new condom the right way each time you have sex to be effective in preventing transmission. This demonstration will allow you to practise proper condom use.

Female Condom (Femidom) Demonstration

1. Open the package carefully; tear at the notch. Do not use scissors or a knife to open it.
2. Look at the condom and make sure that it is lubricated: it should be slippery.
3. Choose a position that is comfortable for insertion: you can squat, raise one leg, sit or lie down.
4. While holding the sheath (condom) at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow. Put it in the form of an eight.
5. With the other hand, separate the outer lips of the vagina.
6. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.
7. Place the index finger on the inside of the condom and push the inner ring up as far as it will go. Be sure that the sheath is not twisted. The outer ring should stay on the outside of the vagina.
8. The female condom is now in place and ready for use with your partner.
9. When you are ready, gently guide your partner's penis into the condom's opening with your hand to make sure that it enters properly. Be sure that the penis is not entering on the side between the condom and the vaginal wall.
10. To remove the condom, twist the outer ring and gently pull the condom out. Try to do this before standing up.
11. Wrap the condom in the package or in tissue and throw it away in the rubbish bin. Do not put it into the toilet.

Additional tips:

- You can insert the Femidom up to 8 hours before intercourse.
- The female condom is made of polyurethane, a soft, thin plastic that is stronger than the latex used to make male condoms.
- It does not require an erect penis to insert the female condom into the vagina.
- The female condom comes pre-lubricated to make it easier to insert. Additional lubricant can be used: either oil-based or water-based are OK because the Femidom is made of polyurethane, not latex.
- Do NOT use the female condom with a male condom, as friction between the plastic and latex rubber can result in either condom failing.
- Practise putting a female condom in and taking it out before using it for the first time during sexual intercourse. Insertion gets easier with practise.

Adapted from UNAIDS. "Fast Facts: How do you use a female condom?" www.unaids.org

Comparison Between Male and Female Condoms

Male Condom	Female Condom (Femidom)
Rolled on the man's penis	Inserted into the woman's vagina
Made from latex; some also from polyurethane	Made from polyurethane
Fits on the penis	Loosely lines the vagina
Lubricant: • Can include a spermicide • Can be water-based only; cannot be oil-based • Located on the outside of the condom	Lubricant: • Can include a spermicide • Can be water-based or oil-based • Located on the inside of the condom
Requires erect penis	Does not require erect penis
Condom must be put on an erect penis	Can be inserted prior to sexual intercourse; not dependent on erect penis
Must be removed immediately after ejaculation	Does not need to be removed immediately after ejaculation
Covers most of the penis and protects the woman's internal genitalia	Covers both the woman's internal and external genitalia and the base of the penis, which provides broader protection
Latex condoms can decay if not stored properly; polyurethane condoms are not susceptible to deterioration from temperature or humidity.	Polyurethane is not susceptible to deterioration from temperature or humidity.
Recommended as one-time use product	Recommended as one-time use product. Reuse research is underway currently.

Adapted from WHO Department of Reproductive Health. 2000. "The Female Condom: A Guide for Planning and Programming."

NEGOTIATING CONDOM USE
Talking about Condoms: Excuses and Possible Responses
(for reference)

If your partner says: **"I do not like using condoms. It does not feel as good."**
You can say: "I will feel more relaxed, and if I am more relaxed, I can make it feel better for you."

"We have never used a condom before."
"I do not want to take any more risks."

"Using condoms is not pleasant."
"Unplanned pregnancy is more unpleasant. Getting HIV is more unpleasant."

"Putting it on interrupts everything."
"Not if I help put it on."

"Do you not trust me?"
"I trust you are telling the truth. But with some STIs, there are no symptoms. Let's be safe and use condoms."

"I know I do not have a STI."
"I want to use them to prevent pregnancy."

"I do not have a condom."
"I do."

"I will pull out in time. I will practice withdrawal."
"Women can still become pregnant or get STIs from pre-ejaculation fluid."

"I thought you said condoms were for casual partners."
"I decided to face facts. I like having sex with you and I want to stay healthy and happy."

"Condoms are not romantic."
"What is more romantic than making love and protecting each other's health at the same time?"

"But I love you."
"Then you will help me protect myself."

"I guess you do not really love me."
"I do, but I do not want to risk my life to prove it."

"We are not using a condom, and that is it."
"OK. Then we can do something else."

"Just this once without it."
"It only takes once to get pregnant. It only takes once to get a sexually transmitted infection. It only takes once to get HIV."

B. Barnett and J. Schueller. 2000. Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents. Family Health International. Research Triangle Park, NC.

SEXUALITY AND GENDER ROLES

Definitions:

Sex: The word "sex" has different meanings. Sex can be used to refer to a person's gender: if they are male or female. Another meaning of sex can refer to sexual intercourse. In this second meaning of the word, sex refers to the body, something that is physical.

Sexuality: Sexuality has a broader meaning than the word "sex." Sexuality relates to our full personhood. It is the total expression of who we are as male and female human beings. It includes the physical, emotional and spiritual parts of us. It encompasses our personality, values, attitudes, gender, race, sexual orientation, etc. Sexuality involves much more than a physical sensation and includes our mental experiences as well.

Sexuality means:

- You are aware of what it means to be male or female.
- You are aware of some of the expectations and gender roles imposed by society and culture.
- You are aware of your own and other people's bodies.
- You feel sexually attracted to other people.
- You are able and have a need to be emotionally close to somebody else.

Gender: Gender is the fact that someone is male or female. There are actions, roles and expectations that we associate with being a man or a woman. We often call these gender roles.

Discussion Questions:

- What do you think are the implications for this exercise and during the process of negotiation with a partner for safer sex?
- How do beliefs about men's or women's sexuality affect how people approach the issue of condom use with a partner?
- What dynamics are different when a person is negotiating with a man rather than a woman?
- How does negotiation for specific sexual behaviour differ from negotiation in other circumstances? What makes it different?
- Can you think of any strategies for addressing the specific concerns of either gender in negotiation situations?
- What factors might hinder communication when negotiating sexual behaviour?

Adapted from AIDSTECH/Family Health International. AIDS/STD Education and Counselling: Training Manual.

PRE-TEST COUNSELLING

Refer to the Pre-Test Counselling Model.

ESTABLISH THE RELATIONSHIP

1. Introduce yourself and describe your role as a counsellor.
2. Explain confidentiality, length of session and give an overview of what will be discussed.
3. Help the client feel comfortable. This leads into Exploration and can be a transition.

EXPLORATION

1. Listen to the client's story.

- Tell me a little bit about yourself. *Find out about family, children; start with easy questions; think of Johari's Window and things that would fall into the Free Self Window.*
    - What brought you here today?
    - Can you tell me a little bit about yourself?

2. Assess HIV knowledge.

- Important HIV-related topics for the client to know about:
    - Transmission
    - Natural course of the disease

- Assessing the client's knowledge
  Example questions:
    - What have you heard about HIV?
    - What do you know about how HIV is passed from one person to another?

3. Risk Assessment

- Determine risk behaviours: recent risk behaviours and patterns of risk behaviour.
  Example questions:
    - How concerned are you about your risk of acquiring HIV?
    - Can you tell me a little about your most recent risk behaviour?
    - Can we look at how often these risk situations happen? *Explore number of partners, type of partners, frequency of new/different partners, condom use, etc.*
    - Can you tell me about what may be going on in your life that could be increasing your risk behaviour? *Explore risk triggers/circumstances*.

- Costs/benefits of risk behaviour: what are the advantages of this behaviour for the client and what are the disadvantages?

Example questions:

- What are the advantages of this behaviour, i.e. having sex without a condom, for you? *Specify the behaviour*.
- What do you gain by doing this behaviour, i.e. having sex without a condom, or having multiple partners?
- What are the disadvantages of this behaviour?
- How do you view your risk behaviour? *Determine the client's view of his/her own risk and if the risk behaviours are a problem for him/her; does the client want to change? At what stage of behaviour change is the client?*

- Past successes and abilities: explore any changes to risk behaviour that the client has made in the past, or the skills and abilities he/she has to make those changes.

  Example questions:
  - Have you ever tried to change these risk behaviours in the past?
  - How did you try and change them? Were you successful?
  - What have you done to try and reduce your risk of acquiring HIV?
  - What has been or what could be the most difficult part of changing your behaviour to reduce your risk?
  - Can you tell me about your experiences using condoms?

4. Risk Reduction Options/Strategies

- Determine options for reducing risk. Explore what options the client has to reduce his/her risk and what falls into the client's circle of influence. *Refer to Decision-Making, Circles of Concern and Influence Session in Personal Growth*.

  Example questions:
  - Can you think of anything you might be able to do to reduce your risk of being infected with HIV?
  - Tell me what would be easiest for you to change and what would be most difficult for you. Why?
  - What options do you have to reduce your risk of HIV infection?
  - Have you thought about what you might be able to do to reduce your risk of becoming infected with HIV?

- Identify barriers: what are the problems your client might experience with his/her risk reduction options?

  Example questions:
  - What kinds of things might keep these options from working?
  - What might come in the way of making these options work for you in reducing your risk of infection?

- Develop ways or strategies to overcome barriers: problem solve ways so that the client can overcome the identified barriers.

  Example questions:
  - Can you think of any ways to overcome these barriers?

- Is there anything you can do to make these barriers less of a problem?
- Can you think of any strategies to overcome these barriers?

NOTE: Many of the issues related to partner communication may have already been discussed when exploring risk behaviours and discussing risk reduction options and strategies. It is best if partner communication is integrated in the above discussion rather than exploring it separately.

5. **Partner Communication**

- Explore the client's relationship with partner/s.

- Assess communication with partner/s.

- Explore barriers.

- Identify strategies for overcoming barriers.
  Example questions:
  - Tell me about your concerns about your partner's risk. Has your partner had sex with anyone else?
  - What have you and your partner talked about concerning STI and HIV risk?

- Explore partner's willingness to be tested.

- Practise skills. You may even want to role play a conversation with client and his/her partner.

6. **Identify Support**: Find out who the client relies on or who they have talked to in the past. It is important to identify people who have been supportive in the past and could be supportive in the future.
   Example questions:
   - Who have you gone to when you have had problems in the past?
   - Does anyone know that you are here for testing? Is that person someone to whom you would tell your results?
   - Who do you talk to about personal things in your life? Who would you tell if you found out your test results were positive?

RESOLUTION

1. **Develop a personalised risk reduction plan**: the plan does not need to be comprehensive, but at least take into account next steps. Remember that change takes time and does not happen all at the same time.

2. **Explain the HIV Test**. Explain the window period, especially if the client's risky behaviour has occurred within the last 3 months.
   - Explain the test, i.e. if blood will be drawn or if it will be a finger prick. Also explain when the test results will be ready.

3. **HIV test preparation**
   Example questions:
   - How are you feeling about having an HIV test?
   - Have you thought about bringing your partner for a test?
   - What would a positive HIV test result mean to you?
   - How would you understand an HIV-negative test result?
   - What test result are you expecting?
   - Have you thought about how you would deal with each of the possible test results?
   - Do you have any questions before we go for the test?

TERMINATION

1. Set up time for **post-test counselling**, either the same day with rapid testing or schedule a day when test results will be back.

2. Take the client in for the test.

> NOTE: It is important to remember what was discussed during Pre-Test Counselling because you will need to refer to it during Post-Test Counselling. You are encouraged to take notes right after the counselling session so that you can read through your notes before conducting Post-Test Counselling.

> **Key Point:** While there is an outline to follow for the counselling session, the focus is still the client. Listen to what the client says and respond: do not just move on to the next topic on the outline!

Role Plays: Pre-Test Counselling

Role Play Scenario 1: Male Client

James, who is 23 years old, moved to Windhoek from his village about two years ago. He works very hard as a teacher and coordinates a boy's football club after school and on the weekends. Until he met his girlfriend Mary, he and his friends used to have fun, especially at the end of the month. They would go to the shebeens, drink, dance and meet girls. Sometimes he would have sex with these girls, but usually he would wear condoms. A couple of times he had too many beers and forgot to use a condom.

Six months ago, James began dating Mary, who is 21 and also a teacher. He quickly fell in love with Mary and felt the relationship was getting serious. Because he felt in love and committed to Mary, he did not use a condom when they first had sex four months ago. Later, James was worried that he might have exposed Mary to HIV because he had sex with several girls from the shebeens without using a condom. The more he thought about it, he realised that he did not know if Mary had sex with anyone else besides him. They have never talked about HIV, but he has talked with his brother about getting tested and may talk with Mary after he finds out his result.

Role Play Scenario 2: Female Client

Mary is a 21-year-old teacher. She loves working with children and hopes to have a family of her own some day. When Mary was in teacher training, she dated a nice man for over a year. They stayed together often and usually used condoms to prevent pregnancy. She thought he would some day become her husband, but their relationship ended after his father died in an accident and he needed to return to his village to take care of his brothers and sisters.

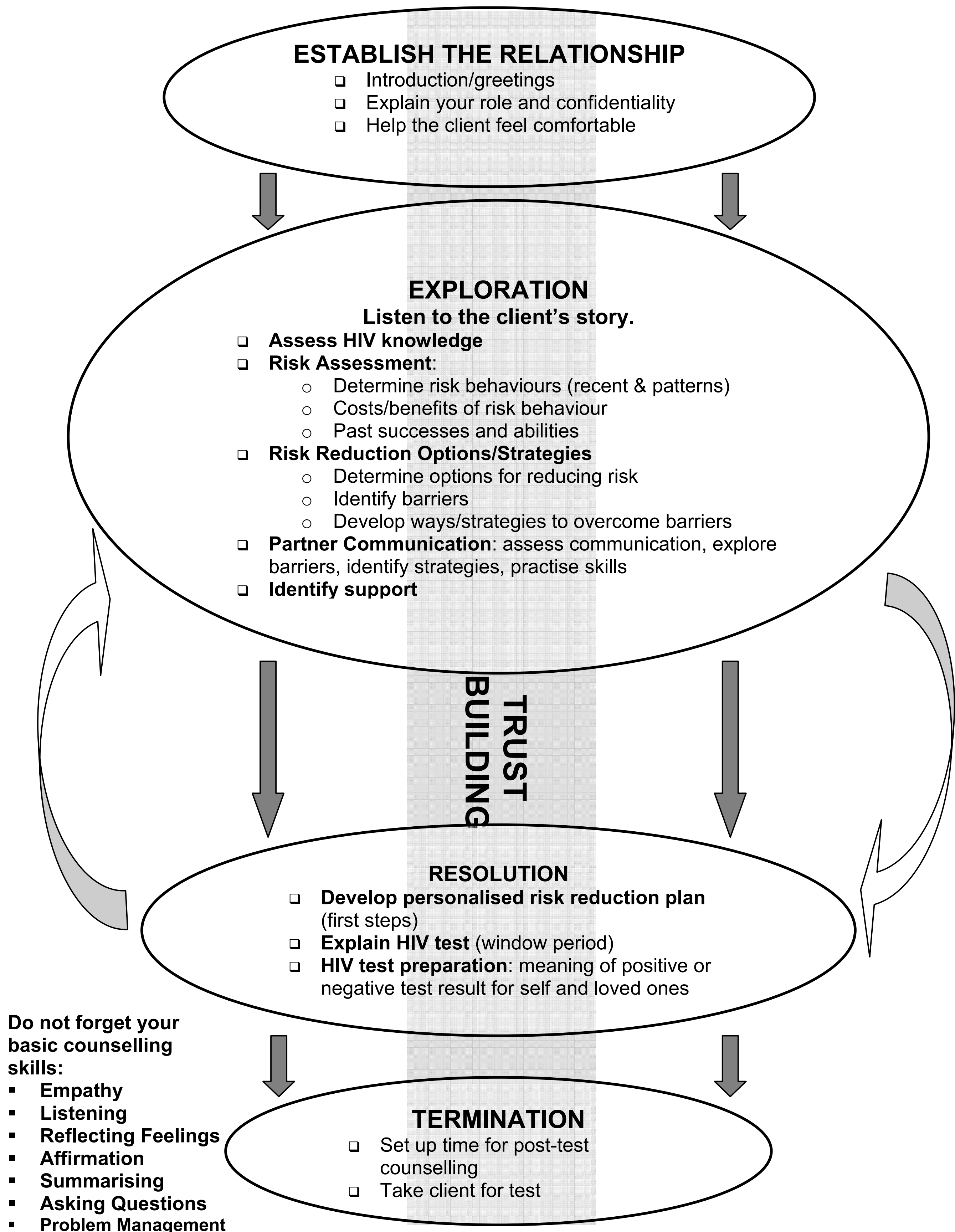
After finishing her training, Mary moved to Windhoek to work. She was lonely, but eventually made some friends and would go out with them. Once she met a man she thought was nice and she dated him a few times. They had sex, but she ended the relationship because he would drink too much. He refused to use a condom when he was drinking and she was worried that she would fall pregnant.

She met a new teacher at school named James. She really liked James and they began dating about four months ago. He has told her that he loves her and is committed to her. They are talking about their future together. When they first had sex, they did not use a condom. Mary thinks this was because it was a way to be really intimate and demonstrate their love for each other. Mary has been thinking about her past and wonders about James' past relationships. They have never talked about their other partners. She wants to get tested for HIV before she asks him to be tested.

Tips for Giving Feedback:

- Ask the client how it felt for him/her.
- Ask the counsellor what he/she did well. You also can ask what he/she needs to improve.
- Observer gives feedback. First, note a specific thing that the counsellor did well or said well. Second, identify a specific thing that the counsellor needs to improve, i.e., a poorly worded question or moving on to a different subject without responding to what the client said. Third, end with a positive comment that can be more general.

VCT: PRE-TEST COUNSELLING



Do not forget your basic counselling skills:

- **Empathy**
- **Listening**
- **Reflecting Feelings**
- **Affirmation**
- **Summarising**
- **Asking Questions**
- **Problem Management**

Post-Test Counselling (Negative Result)

Refer to the Model of Post-Test Counselling with a Negative Result.

ESTABLISH THE RELATIONSHIP

1. The relationship has already been established. The same counsellor should always do pre- and post-test counselling with one client.

2. Affirm and congratulate the client for returning for the result if it is not a rapid test.

3. Ask if the client has any questions before you discuss the results.

EXPLORATION

1. Give the HIV-negative test result.

- State test result clearly and simply.

2. Explore the client's reaction to the test result.

- *Example questions:*
  - What does this test result mean to you?
  - Can you tell me some of what you are thinking and feeling right now?
  - How does it feel?
  - What does this test result mean for your future?

Note: Your client may feel happy, relieved, disbelieving or even worry that the results were wrong. Validate any and all of those feelings; they are all normal reactions to a negative test result.

- If the client's risky behaviour was within the past three months, discuss the window period. Encourage the client to be tested again three months after the risky behaviour.

3. Explore Risk Reduction Options/Strategies

- Discuss any risk patterns that came up during pre-test counselling.
  Example question:
  - What have you done in the past to reduce your risk of becoming infected with HIV?

- Discuss ways of reducing risk of infection in the future.
  Example questions:
  - Do you have ideas for how you will protect yourself from becoming infected in the future?
  - Are there any behaviours you would like to change in order to reduce your risk of becoming infected?
  - Are there any people in your life who can help you change the behaviour you wish to change? *OR* Who can support you?

- Discuss barriers or potential challenges to reducing risk. Refer to what was discussed in pre-test counselling.

- Discuss what might be especially difficult about the different options. Then explore ways to overcome those barriers; be realistic. Refer to pre-test counselling.

4. **Discuss Partner Communication**. Remember that this test result does not indicate whether or not your sex partner is infected with HIV.

   - Discuss disclosure to partner(s) and partner referral for testing. *Example questions:*
     - How would you feel about talking with your partner about your test results?
     - Tell me your thoughts about asking your partner to be tested.

   - Practise skills for disclosure or partner referral. You can use a role play or the empty chair technique.

RESOLUTION

1. **Discuss a Personalised Risk Reduction Plan.**
   Example questions:
   - We have discussed ways to reduce your risk of becoming infected. Now we need to discuss what you will do and how you will do it.
   - We discussed a number of risk reduction options. Can you choose any of these that you think you will be able to do in your life?

2. **Summarise** the risk reduction plan.

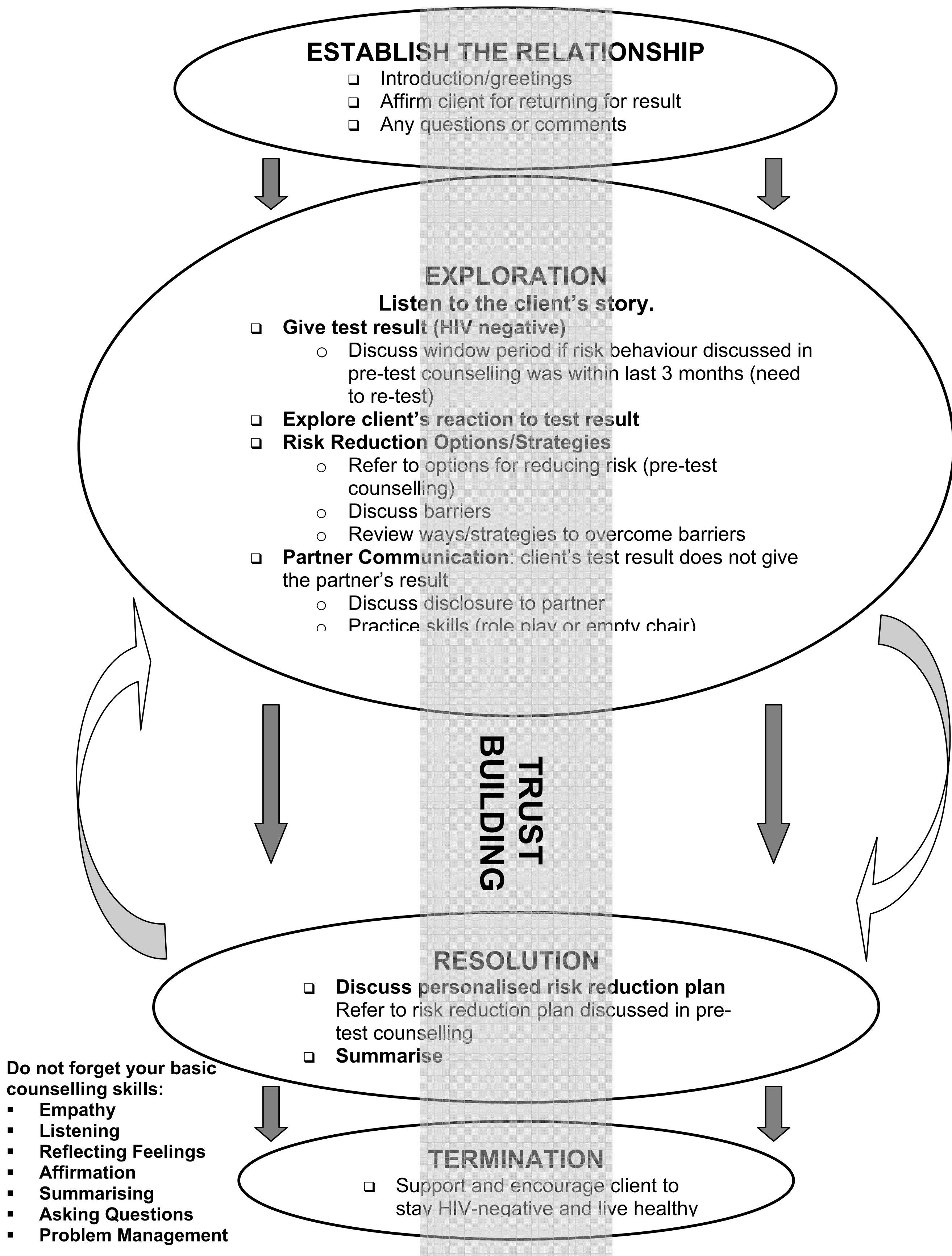
TERMINATION

1. **Support and encourage** the client to stay healthy and HIV-negative.
   - Healthy living
   - Safe sex: use a condom, abstain and/or be faithful
   - Partner disclosure and/or referral for testing

2. Offer ongoing support.

> **Key Point:** While there is an outline to follow for the counselling session, the focus is still the client. Listen to what the client says and respond. Do not forget your reflecting skills!

VCT: POST-TEST COUNSELLING (Negative Result)



Do not forget your basic counselling skills:

- **Empathy**
- **Listening**
- **Reflecting Feelings**
- **Affirmation**
- **Summarising**
- **Asking Questions**
- **Problem Management**

EMOTIONAL REACTIONS TO AN HIV-POSITIVE RESULT

The diagnosis of an HIV infection for a client usually creates a crisis. We have been imagining how we might respond to a positive result and we are going to look more at how the client might react to the crisis. Once again, there is no prescribed way in which a client can, or should, react. Each person's reaction is unique.

Below are some possible reactions to the news of HIV infection:

- **Shock**: this is a normal reaction to life-threatening news. Common shock reactions include:
    - Numbness, stunned silence or disbelief
    - Confusion, distractibility or uncertainty about present and future circumstances
    - Despair: "Oh my God, everything is ruined."
    - Emotional instability: moving quickly and unpredictably from tears to laughter and vice versa
    - Withdrawal: distancing from present issues and circumstances, reluctance to become involved in conversation, activities or plans

- **Denial**: Some people may respond to news of their infection by denying it, i.e. "This cannot be happening to me." Initial denial may be helpful to reduce stress. However, if it continues, denial can prevent appropriate changes in behaviour and adjustments in life necessary to cope with HIV and to prevent transmission.

- **Anger**: Some people become outwardly angry because they feel that they are the "unlucky ones" to have gotten the infection. Anger can be expressed as irritability; it can also be expressed as an overreaction triggered by trivial or unimportant events. Anger can also be directed inwards in the form of self-blame for acquiring HIV. These people may engage in destructive behaviour such as harming themselves or others; this can include the use of alcohol, as well as violence, or can result in suicidal thoughts or behaviour.

- **Fear**: These fears can include a fear of death or of dying alone and in pain. Other common fears are fear of desertion, isolation, rejection, leaving children and family uncared for, disability, loss of bodily or mental functioning, and loss of confidentiality or privacy. Fear may be based on the experiences of others and the stigma observed in the community. Fear often can be reduced by discussing it openly.

- **Isolation**: The person with HIV may react by withdrawing from all social contacts. A significant factor is the fear of abandonment. Some may have the anticipatory reaction, i.e. "Everyone is going to abandon me, so I will turn away from them first." Initially, the counsellor should respect the felt need for isolation while continuing a supportive counselling relationship. If isolation continues for a long time, the counsellor will need to look at the causes and encourage a change of perspective.

- **Loss & Grief**: The losses associated with HIV are numerous; they can include loss of one's ambitions, goals, physical appearance/attractiveness, sexual relationships, status in the community, self-confidence, financial stability and independence. As the need for physical care increases, there will also be a loss of privacy and control over one's own life.

- **Guilt**: When HIV infection is diagnosed, there is usually a feeling of guilt about the possibility of having infected others or about the behaviour that may have resulted in the HIV infection. There is also guilt about the sadness, disruption and loss that illness will cause loved ones and family members, especially children.

- **Depression**: Depression may be associated with the realisation that a virus has taken over one's body, the absence of a cure and the feeling of powerlessness. A person may become depressed by the loss of personal control that may be associated with many aspects of the disease.

- **Suicidal thoughts or actions**: People who learn they are HIV-positive have significantly increased risk of suicide, which may be a way of avoiding their own pain or attempts at lessening that of relatives. It could also be a fear of disclosing their status to others and the rejection and stigma that could follow.

- **Anxiety**: The anxiety may be associated with the constant uncertainty associated with the infection. Initial anxiety may revolve around the issues of disclosure, particularly disclosure to a partner. Some of these anxieties include the increased risk of infection with other diseases, a declining ability to function efficiently and the loss of physical and financial independence.

- **Loss of self-concept** (self-esteem): Self-concept is threatened as soon as HIV is diagnosed. Rejection by neighbours, co-workers, acquaintances and loved ones can cause a loss of social status and confidence, leading to feelings of reduced self-worth. The physical impact of HIV-related diseases can make this problem worse.

- **Spiritual concern**: The fear of death may create or increase an individual's interest in spiritual matters. Expressions of sin, guilt, forgiveness, reconciliation and acceptance may begin to appear as a search for religious support.

- **Hypochondria**: A person with HIV may become excessively concerned and preoccupied with his/her own health and even the smallest physical changes

> **Key Point:** The counsellor should encourage the client to express their thoughts and feelings, and normalise whatever the client is expressing. The counselling setting should be a safe place for a client to express their thoughts and feelings without having to worry about how someone else will react.

What the counsellor should do as the client is reacting to his/her result:

- Pay attention to a client's emotional reactions when he/she learns the test result.
- Realise that receiving an HIV-positive test result makes people highly emotionally sensitive.
- Realise that multiple life stresses or multiple crises can further complicate a person's psychological and emotional reactions and functioning.
- Assess any suicidal thoughts or actions.

POST-TEST COUNSELLING (POSITIVE RESULT)

Refer to the Model of VCT: Post-Test Counselling with a Positive Result.

ESTABLISH THE RELATIONSHIP

1. The relationship has already been established. The same counsellor should always do pre and post-test counselling with one client.

2. Affirm and congratulate the client for returning for the result if it is not a rapid test.

3. Ask if the client has any questions before you discuss the results.

EXPLORATION

1. Give the HIV-positive test result.

- State test result clearly and simply.

2. Explore client's reaction to the test result.

Refer to the Crisis & Recovery/Behaviour Change Model and Skills and Techniques for Working with Clients in Crisis in Module 3: Crisis Counselling & HIV.

Example questions:

- What does this test result mean to you? *Make sure the client understands what the test result means.*
- How are you feeling?
- Can you tell me some of what you are thinking and feeling right now?

> **Key Point:** Testing positive for HIV is a crisis for most people. Keep in mind that different people respond to crises in different ways. Allow the client to express his/her emotions.

Crisis Counselling Steps: *Refer to the Crisis Counselling Model.*

Step 1: **Expression**

- Express support and reflect feelings.

- Tell the client that you want to help and you can talk about how he/she is feeling.

- Give permission for the client to express his/her feelings.

- Sit quietly; silence is OK.

- Focus on the client's expression of current feelings and anxieties.

> Use **reflecting skills**: do not be afraid to sit in silence. Reflect the client's non-verbal communication if he/she is not talking.

- Do NOT rush the client through this stage. It can take 10 – 15 minutes.

Step 2: **Control**

- Help the client regain control.

- Assess whether the client has the ability to make decisions or is feeling helpless and out of control.

- Give the client a task to help him/her gain control. For example: give her a glass of water, ask her to drink the water slowly OR take some deep breaths.

Step 3: **Clarify**

- Determine what the crisis is for the client.

- Help the client identify what the most troubling issue is for him/her at this time. For instance, it could be that he/she is worried about dying, he/she is scared to tell his/her partner, or scared that his/her family will reject him/her, etc.

- Validate the fear and feelings and offer information that may support and encourage the client, i.e. "Having HIV does not mean that you have AIDS and will die soon. Most people who have HIV live for many years. There are many things you can do to live a positive and healthy life."

- You can reassure your client with simple information; DO NOT give a lot of information!

Step 4: **Focus/Prioritise**

- Focus on one aspect of the crisis. Pick the aspect that is most troubling to the client or most urgent, i.e. safety.

- Focus on an aspect that is manageable to change.

Step 5: **Identify support**

- Refer to support that was discussed during pre-test counselling.

- Identify strategies for emotional support. This usually involves disclosure.

- Use open-ended questions to help the client identify people and resources that can be supportive. DO NOT tell the client who he/she should disclose to: this is a decision that the client must make for him/herself.

- *Example questions:*
    - Who have you turned to in the past when you have something difficult to deal with? *OR* Who have you talked with in the past?

- Often, people who find out they are HIV-positive find it helpful to share their status with someone in order to get support. Can you think of anyone you could share your status with?
- Does anyone know that you are here?
- Is there anyone that you can share your status with?

RESOLUTION

1. **Plan next steps**.
   - Refer to step 6 in the Crisis Counselling model.
   - Create a next step plan. Try to involve people who can offer emotional support.
     Example questions:
     - What do you plan on doing when you leave the clinic?
     - How will you cope with this news over the next couple of days?

Key Point: DO NOT try to give too much information. SUPPORT the client and leave him/her with a sense of HOPE.

   - Tell the client that you can discuss an overall plan for positive living during the next session.

2. **Summarise** the session, focussing on the client's next step plan.

TERMINATION

1. Support and encourage the client; offer hope.
   - Remind the client that there is so much he/she can do to live a healthy life.
2. Set up another appointment to talk more about positive living.
3. Offer ongoing support.

NOTE: Due to the fact that you are focussing on only the most pressing crisis in this counselling session, you may want to write down the other issues that come up for the client. You can let the client know that you are holding all the other issues for him/her and you will talk about them in future counselling sessions. You may either write down the issues during the session or take notes immediately following the counselling session. Refer to these notes prior to the follow-up counselling session.

Key Point: Remember that giving a positive test result is a crisis for most clients. Focus on letting the client express all of his/her thoughts and feelings.

Review of Suicidal Risks and Counselling with a Suicidal Client

SUICIDE RISK REVIEW		
ARE YOU HAVING THOUGHTS OF SUICIDE?	YES	√
CURRENT FACTORS:		
➢ **Current Suicide Plan**		
How? How Prepared? How soon?	YES	√
➢ **Pain**		
Do you have pain that sometimes feels unbearable?	YES	√
➢ **Resources**		
Do you feel you have few, if any, resources?	YES	√
BACKGROUND FACTORS:		
➢ **Prior Suicidal Behaviour**		
Have you ever attempted suicide before?	YES	√
➢ **Mental Health**		
Are you receiving or have you received mental health care?	YES	√

If a client expresses any thoughts or feelings about hurting him/herself, discuss suicide risk and prevention with the client in counselling.

Model for Suicide Prevention in Counselling

Stage 1: Connect

1. **Explore** "clues."

Note: these clues may come up during post-test counselling with a positive result, or they may come up later during follow-up counselling.

- People who are considering suicide usually display "clues" that they are in pain or wanting their lives to end.
- People who think about suicide are usually ambivalent: part of them wants to live and part of them wants the pain to end.
- Always take suicidal comments very seriously. Do not assume that someone is talking about suicide to get attention: this can be a disastrous error.

2. **Ask** about suicide.

- If suicide comes up, talk openly and matter-of-factly about suicide.
- Talking about suicide will NOT give someone the idea to do it.
- Ask the following questions directly:
  - "Are you having thoughts of suicide?"
  - "How long have you had these thoughts?"

Stage 2: Understand and Assess

3. **Listen** to the client's reasons for living and dying.

 - Listen empathetically.

 - Allow the client talk and express emotions. Practise active listening and reflecting skills.

 - Listen to reasons for dying, to reasons for dying, which may include events, the meaning of events and the client's reactions to those events. For instance, a person with a recent HIV diagnosis may think that he/she is going to die anyway so why not speed up the process, as it may cause less pain to his/her family and that way the family would not have to know of the person's diagnosis

 - Listen to reasons for living, which may include both internal and external things. Internally, they might be feelings, hopes, beliefs, values, attitudes or skills. Externally, they might include resource or support people, hobbies, family, friends, etc.

Suicidal Checklist

A person may be suicidal if he/she:

- ❑ Talks about committing suicide
- ❑ Feels and expresses hopelessness
- ❑ Appears depressed or sad most of the time
- ❑ Has trouble eating or sleeping
- ❑ Withdraws from family and friends and/or social activities
- ❑ Loses interest in work, school, hobbies, etc.
- ❑ Makes out a will and final arrangements
- ❑ Gives away prized possessions
- ❑ Has attempted suicide in the past
- ❑ Takes unnecessary risks
- ❑ Is preoccupied with death and dying (thinks and talks about death and dying a lot)
- ❑ Neglects personal appearance
- ❑ Increases use of alcohol or drugs
- ❑ Recently experienced severe losses, which can include loss of health, job, home, relationship, etc.
- ❑ Recently experienced a perceived "failure" or "humiliating" situation
- ❑ Irritable

Note: a suicidal person may not display all these characteristics, but the list can offer some guidelines of what to look for.

4. **Review** risk.

> **Key Point:** Establish whether a client has a suicide plan, and the details of that plan. A person who has a plan is at much greater risk than someone who simply talks about not wanting to live any longer.

- Explore whether the client has a plan, and the details of that plan.
- **Method?** "Have you thought about how you would kill yourself?" *OR* "Do you have a plan for how you would end your life?"
- **Means?** "Do you have what you need to carry out your plan?" For instance, if the client plans on shooting him/herself, find out if he/she has a gun and bullets, or has a way to get a gun.
- **When?** "Have you thought about when you would do it?" or "Do you have a plan for when you will kill yourself?" It is important to know if the plan is for tonight, next week, or after the holidays, etc.

> **Tips:** Be specific; do not talk in generalities. Be direct; ask the hard questions.

Stage 3: Assist (Help)

5. **Contract** a safety plan. NOTE: This is part of the NEXT STEP PLAN that you develop during crisis counselling.

- After you have explored the client's feelings and reviewed his/her risk: if the client has a plan, you should develop and contract a safety plan. The safety plan should include the following:
- Support People: Involve friends and family of the client. Have the client identify several people to whom he/she can disclose his/her feelings. You can actually call one or two of those people during the session if the client agrees.
- Remove the Means: If the client's plan involves the use of a gun, call the police to remove the gun from the house. If the plan involves taking pills, remove excess medication from the house. You can involve friends and family in this process.
- Plan to Not be Alone: Develop a plan so the client will not be alone if the person is acutely suicidal. Involve a support person or people to stay with the client, or have the client make arrangements to stay with family or friends.

- Develop Alternative Activities: Develop a list of options or actions for when he/she is feeling suicidal. These options should include activities like: calling a friend (list several people so that if one person is unavailable, there are others to contact), going to a family member's house, going for a walk or getting some exercise, writing in a journal or calling a hotline. Make sure to include the client's support people in this plan, i.e. a friend should know if he/she is on a list to be called if your client is suicidal.

- Make a Contract: Actually put a contract in writing. The contract should include the following: a time frame, a plan of action for when feeling acutely suicidal, and involvement of support people. *See the example of a Suicide Prevention Contract.* A contract can also be made verbally, i.e. over the phone; however, if you are with the client it is best to put it in writing.

- **If the client cannot agree to the contract or refuses to sign it, you should call the police.** Remember that harm to oneself, i.e. suicide, is an exception to the confidentiality or privacy pledge.

6. **Follow up** on commitments.

- This would happen in future counselling sessions.

- Did the client uphold the safety plan contract? Talk about how he/she did that, what did and did not work, what the client needs for the future, etc.

- At this stage, you can also talk about triggers: the behaviours, situations or events that increase the intensity of the suicidal thoughts and feelings. For instance, are suicidal thoughts worse when the client is alone, or when they are drinking, etc.

- Identify these triggers and develop ways to avoid them or reduce them.

VCT: POST-TEST COUNSELLING (Positive Result)

ESTABLISH THE RELATIONSHIP

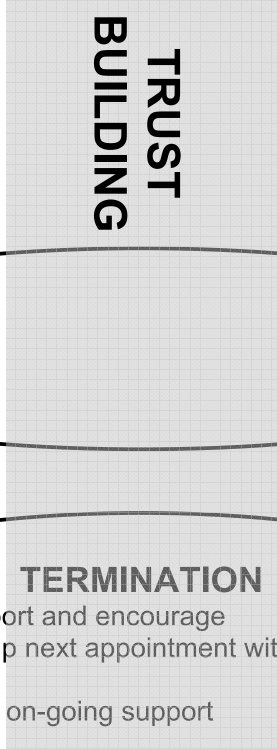
- Relationship already established
- Affirm client for returning for result
- Questions/concerns?

Do not forget your basic counselling skills, especially **listening** & **reflecting feelings**!

CRISIS COUNSELLING STEPS

EXPLORATION

- Give test result (HIV positive)
- Explore client's reaction to the result
- **EXPRESSION**: encourage expression of all feelings
- **CONTROL**: help client gain control; can he/she make decisions?
- **CLARIFY**: determine what the crisis is for him/her
- **FOCUS/PRIORITISE**: focus on most pressing and manageable issue
- **IDENTIFY SUPPORT**: related to disclosure (refer to Pre-Test Counselling session)



TERMINATION

- Support and encourage
- Set up next appointment within a few days
- Offer on-going support

Encourage:

- Return for follow-up counselling
- Offer HOPE for positive living

FOLLOW-UP POST-TEST COUNSELLING

ESTABLISH THE RELATIONSHIP

1. **Relationship has already been established**: starting with pre-test counselling, the same counsellor should always work with a client starting through the whole counselling process if at all possible.

2. **Affirm the client for returning** for follow-up counselling: by returning, the client is already making choices to take care of him/herself.

3. **Ask how the client is doing**: assess how the client is functioning, how he/she has been doing since you last saw him/her, did he/she follow the next step plans, how did it work, etc.

4. **Summarise the previous session**: briefly review what you discussed, what the crisis was for the client and what his/her next step plans were.

EXPLORATION

1. **Assess the client's functioning**: how is he/she doing? Is he/she able to go about his/her normal routine? At what stage is he/she in the Crisis and Recovery Model? For instance, is he/she in denial or shock, resisting the diagnosis, or is he/she depressed?

   - Your assessment should determine how you proceed. If the client is still in denial, then you must focus on his/her status and what that means. Remember to meet the client where he/she is.

   - However, if the client has accepted his/her status and wants to know what he/she can do, you can proceed.

2. **Explore the client's current feelings about his/her HIV status**: explore whether his/her thoughts and feelings have changed from when he/she first found out his/her positive status.

3. **Address the client's main crisis and other issues** mentioned in the previous session. Follow up on the main crisis for the client: how did the next step plan work? Is he/she ready to move on to subsequent steps or to develop a larger plan?

   - If the client is ready, you can begin to look at some of the other issues that came up in the previous session. It is helpful if you have taken notes, either during that session or immediately after it.

   - If the client is still barely coping, focus on the main crisis and look at more options for functioning and getting support.

4. **Assess support**: find out if the client has disclosed his/her status to anyone. Who can he/she go to for support?

- Explore issues of disclosure. Has the client disclosed his/her status to anyone? If so, how was the experience?

5. **Explore partner disclosure and referral for testing**: has the client disclosed to his/her partner(s)? How would the client feel about disclosing his/her status to his/her partner(s)?

   - You may want to address discordant results, i.e. that the client's positive result does not mean that her/his partner's result will be the same.

   - You may even want to role play disclosure to the partner in the counselling session.

   - Provide referral for the partner(s) to be tested.

6. **Explore risk reduction**: Refer to pre-test counselling. What can the client do to reduce his/her risk of infecting others and to protect him/herself from re-infection?

   - Discuss risk reduction options, barriers to those options and strategies to overcome the barriers.

7. **Positive living**: Ideally, these topics will come up during other exploration and assessment.

   - If the client asks about positive living, it is much easier to address the idea in the natural course of counselling.

   - However, if the client is not ready to make a plan, hope can be offered by taking about positive living in general.

   - Health education topics can be addressed by asking about the client's knowledge or answering his/her questions:
     - Understanding transmission of HIV
     - Positive living, including:
       - nutrition
       - avoid smoking, alcohol and drugs
       - hygiene
       - safe drinking water
       - getting plenty of rest
       - taking light exercise, such as walking
       - family planning
       - safer sex

RESOLUTION

1. **Develop positive living plan OR next steps plan** if the client is still coping with his/her status and not able to think beyond the next few days or a week.

2. **Summarise** the counselling session, including key points discussed and the agreed plan, either next steps or a longer-term plan.

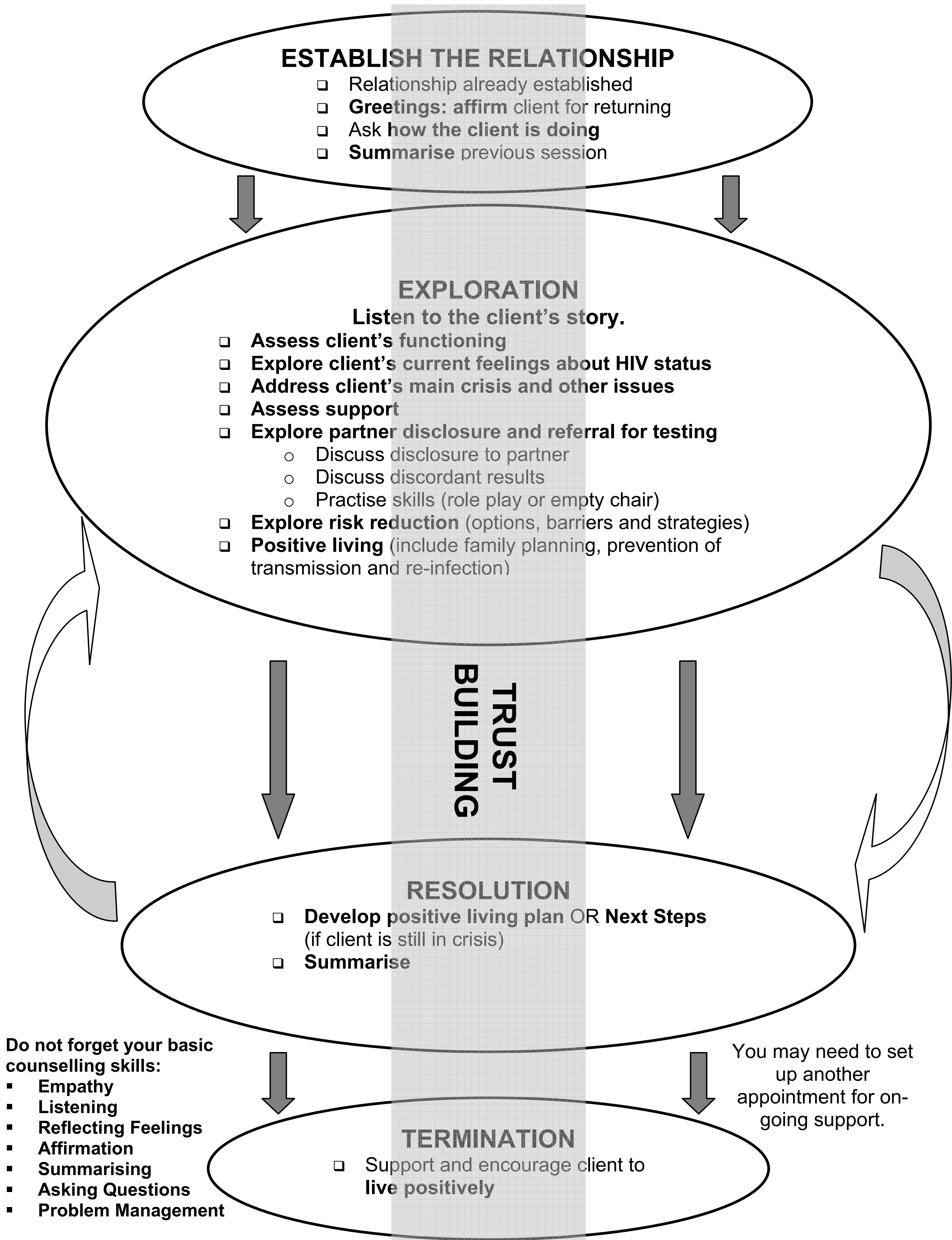
TERMINATION

1. **Support and encourage client to live positively.**

2. **Offer on-going support**: set up another appointment if needed. The next counselling session can either be to discuss more issues or related to follow-up and support.

> **Key Point:** It is important to assess how the client is doing. Is he/she still in crisis, or can he/she address larger issues?

VCT: FOLLOW-UP COUNSELLING



CLIENT-CENTRED COUNSELLING DISCUSSION

Client-Centred Counselling Worksheet

Rate the following statements on a scale of 1-5, with 1 meaning you agree completely and 5 meaning you totally disagree.

Statement	Rating
1. Client-centred counselling is education. You are telling the client what he/she needs to know.	1 2 3 4 5
2. Counselling involves giving good advice and guidance.	1 2 3 4 5
3. Client-centred counselling is not letting the client talk about anything he/she wants. Rather, it is keeping the client focussed on the agenda for the counselling session.	1 2 3 4 5
4. If a client says he/she knows about HIV/AIDS and condoms, there is no need to discuss these topics further.	1 2 3 4 5
5. A counsellor should use technical language to demonstrate that he/she is knowledgeable about the subject.	1 2 3 4 5
6. It is important to ask questions that can be answered with “yes” and “no” because they are easier for the client to answer.	1 2 3 4 5
7. Confidentiality and privacy are ideal, but not necessary, for good counselling to occur.	1 2 3 4 5

Review of Client-Centred Counselling Worksheet

1. **Client-centred counselling is education. You are telling the client what he/she needs to know.**
   Client-centred counselling is different from education. In client-centred counselling, you are exploring with the client what his/her specific situation is and then possibly providing specific information. You provide information so that the client can make informed choices.

2. **Counselling involves giving good advice and guidance.**
   Giving advice does not help the client. In client-centred counselling, the counsellor avoids telling the client which action is the best. Instead, the counsellor uses his/her skills to enable the client to reach a better understanding of the problem, deal with feelings, and take responsibility for looking at the options and making a decision.

3. **Client-centred counselling is not letting the client talk about anything he/she wants. Rather, it is keeping the client focussed on the agenda for the counselling session.**
   While the client is free to talk about whatever is troubling him/her, it is helpful for the counsellor to gently guide the client in order to avoid becoming overwhelmed and unable to focus.

4. **If a client says he/she knows about HIV/AIDS and condoms, there is no need to discuss these topics further.**
   The counsellor must explore and assess the client's knowledge and understanding further. While the client may say he/she knows about these topics, his/her information may be incorrect or incomplete. It is best to ask probing, open questions to find out what the client knows and understands.

5. **A counsellor should use technical language to demonstrate that he/she is knowledgeable about the subject.**
   It is very important that the client understand what the counsellor says, so the counsellor must use language and words that the client understands. It is best not to use technical language when talking with clients.

6. **It is important to ask questions that can be answered with "yes" and "no" because they are easier for the client to answer.**
   By asking questions that can be answered with a "yes" or "no," you are limiting the information you are getting from the client. You are also limiting the relationship you can develop with your client. Open-ended questions are better for encouraging the client to share and to create a dialogue or conversation between the client and the counsellor.

7. **Confidentiality and privacy are ideal, but not necessary, for good counselling to occur.**
   Confidentiality is essential for counselling in order to allow the client to feel safe and free to share sensitive issues. This is especially true for HIV-related issues, since they are often emotionally charged and a person's positive HIV status can make them vulnerable to stigmatisation and discrimination.

GENDER AND COUNSELLING

Discussion Questions

- Do you think that working with women is any different from working with men in counselling? If so, what do you think the differences might be?
- In your cultures, what might it be like for a man to counsel a woman? Will establishing the relationship be the same or different? If it is different, what do you think the differences might be?
- What about the other way around: if a woman counsels a man? How might establishing the relationship be different?
- What about counselling someone of the same gender?
- How might the expectations of men and women in counselling be different?

Working with Men in Counselling

Counsellors who work with men in counselling often want more training on how to talk to men in counselling sessions. Many are aware that there may be a difference between how to talk with men and how to work with women, especially in counselling that is related to sexuality. While it is impossible to generalise communication approaches that work best for all men, an understanding of men's needs and roles might help counsellors engage and establish relationships with men for effective and productive counselling sessions, particularly when they involve sexuality and sexual health.

NOTE: Keep in mind that these tips may not apply to all men. They are NOT hard and fast rules, but suggestions for working with men in counselling.

1. Men are usually decision-makers. They are socialised to act decisively and be in control. This can cause conflict when a man goes to a health facility, especially when urged to go by his partner.

    - Be careful to allow men to make as many decisions as possible, just as it is important to let all our clients make their own decisions. Start by affirming his decision to come into counselling and then ask probing questions to find out what decisions he is considering.

> **Scenario:** A man has come to your health facility because he had unprotected sex. He is concerned about HIV infection or other STIs.
>
> *What might not work:* the provider might simply tell the man that unprotected sex puts him at risk for STIs, show him how to use a condom, give him condoms, and then tell him that he needs to use one every time he has sex.
>
> *What might work:* The provider might say: "You made a really good decision to come here today for help. You have told me that there are times you have successfully used condoms in the past. What do you think worked for you when you used condoms? How might you make sure you use condoms every time you have sex in the future?"

2. Men may not want to appear ignorant (as if they do not know something). Men are often socialised to know all about sex. Admitting that they do not know something, especially something related to sex, creates anxiety for men. In a counselling session, this may be a problem if the counsellor is expecting a man to ask questions or ask for clarification when he does not understand something. Men are not likely to ask questions or to admit that they do not understand.

    - One technique counsellors can use is to make it OK for men not to know. Instead of asking men to acknowledge what they do not know, providers can take the burden off a man by proactively giving information without making it appear like he does not know something.

Scenario: A counsellor is about to do a condom demonstration for a man.

What might not work: The counsellor might ask the man if he knows how to correctly use a condom. The man might say "yes," and the counsellor would not do the demonstration. Or the counsellor might do a condom demonstration and then ask, "Do you have questions?"

What might work: The counsellor might say, "I am sure you already know how to use a condom correctly, but I will just review a few important points about what some men struggle with…"

3. Men may be more comfortable with thoughts and action than with feelings. In general, women tend to be more comfortable discussing feelings than men. In a counselling session, the counsellor might focus on thoughts, options and decision-making steps rather than on a discussion of emotions. If you ask a man how he felt when he found out that his partner was pregnant, he might not be quick to describe his feelings, but if you ask him what thoughts were going through his mind, he may be more likely to talk about those.

Scenario: A man comes to the health facility to be tested for HIV. The man is there because he just found out that his girlfriend has tested positively for HIV.

What might not work: The counsellor might ask the man, "Your girlfriend just told you that she tested positive for HIV. How are you feeling about that?"

What might work: The counsellor might say, "I really appreciate the fact that you came in for counselling and testing given the difficult news you have received. That was not an easy thing to do, but it was a good idea to come here and talk about it. It sounds as if you have been doing a lot of thinking. What sorts of things have you been thinking about?"

4. Men like to know that other men share their fears and concerns. A man may be more comfortable discussing his feelings if the counsellor validates that his fears or concerns are normal and that other men have similar feelings.
    - If the counsellor suspects that the client has a concern he is not communicating, the counsellor can talk about that issue in terms of what other men like him have shared in the past.

Adapted from EngenderHealth. 2003. Comprehensive Counselling for Reproductive Health: An Integrated Curriculum, Trainers' Manual and Participants' Manual.

Helpful Phrases to Use When Working with Men in Counselling

Need or Role	Sample Phrase
Men are decision-makers and want to solve their own problems.	▪ You made a good decision to come here today. ▪ You made a good decision to use a condom that time. ▪ How do you plan to talk to your partner about this?
Men are supposed to know it all when it comes to sex.	▪ You may already know this, but… ▪ You have probably heard this before, but I have to tell all my clients that… ▪ I am sure you already know how to put on a condom correctly, but why don't we just review a few important points about…
Men might not ask questions about sex.	▪ You seem to understand in general how to use condoms, but are there any points you would like to know a little more about? ▪ As long as you are here today, are there any things you would like to ask or tell me about? ▪ Even when we have dealt with a problem we sometimes have a few doubts afterwards. Is there anything more you would like to discuss with me?
Men want to know that they are "normal" and as good as, or better than, other men.	▪ Many men are concerned about the same thing. ▪ Many men have asked that question before. ▪ A lot of men wonder about that.
Men may need validation for asking questions about sex.	▪ That is a really good question. ▪ I am glad you asked about that. ▪ You are really brave to ask that question. ▪ If is great that you came here to be tested and to ask the questions you did.

Adapted from EngenderHealth. 2003. Comprehensive Counselling for Reproductive Health: An Integrated Curriculum, Trainers' Manual and Participants' Manual.

Self-Assessment and Improvement Worksheet

Strengths:
My strengths as a counsellor or the basic counselling skills I am good at:
Example: I am good at establishing the relationship and making the client feel comfortable in counselling.

How will I use this to build on my skills as a counsellor?
Example: I will expand my ability to make an initial connection with a client to build trust and allow the client to explore very personal things that are often hard to talk about, such as sexual behaviour.

Areas for Improvement:
The areas where I need to improve as a counsellor or the skills I struggle with:
Example: I am uncomfortable when my client is emotional. I try to make her feel better by reassuring her, and then I usually give advice instead of helping the client explore her feelings and options.

How will I work on improving these skills?
Example: I will write in my journal every day about my own feelings to get comfortable with my own emotions. I will role play with my counselling colleagues, focussing on simply validating the feelings and not giving advice.

Couple Counselling

Discordant & Concordant Couples

Concordant: both partners have the same HIV status: either both members of the couple are positive or both are negative.

Discordant: when the members of a couple have a different HIV status: one is HIV-positive and the other is HIV-negative.

Discordance is very common with couples, ranging from 10 – 18%.

Common beliefs related to concordance or discordance:

- Discordance is not possible; both partners will always either be HIV-positive or HIV-negative.
- When tested alone, many people assume that their partner's HIV status is the same as their own.
- Many believe that discordance is a sure sign of infidelity.

Some Facts about Discordance

- A negative partner in a discordant couple is not protected by remaining faithful. The couple needs to take precautions, such as using condoms to prevent transmission from positive to negative partner.
- When discordant, the infection may have occurred before the couple was together. The other possibility is that the HIV-infected partner had other partners outside the relationship.
- The risk of HIV transmission is extremely high in steady discordant relationships.

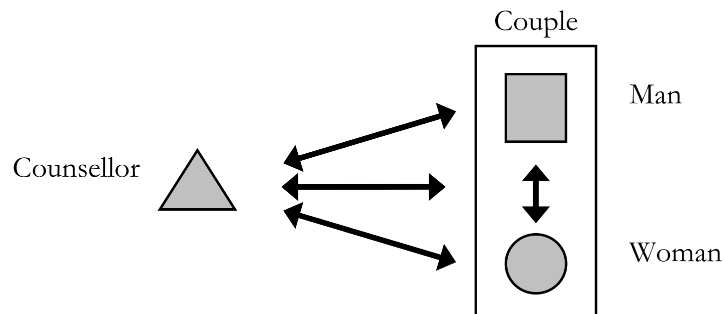
Why couple counselling is important for HIV counselling and testing:

- Prevention and care are best achieved with support from and in cooperation with partners, and testing can be the first step.
- Safe environment to discuss risk concerns and prevention
- Receive the same information and hear information together
- Reduce blame by having a counsellor to ease the tension
- No concern about disclosing results to the partner since the partners are together
- Facilitate communication between partners and cooperation for risk reduction
- Discuss treatment and care decisions
- Make decisions for the future together

Principles of Couple Counselling

In individual counselling, there is only one relationship to focus on: the relationship between the counsellor and the client. However, in couple counselling there are actually four relationships that the counsellor must be aware of:

1. The relationship between the counsellor and the man
2. The relationship between the counsellor and the woman
3. The relationship between the man and the woman
4. The relationship between the counsellor and the couple (man and woman together)



Key point:
When you establish the relationship in the beginning of the counselling session, you must establish all four of these relationships. You must establish and begin to build a relationship with both the man and the woman. In addition, you must establish the relationship with the couple and begin to understand and assess the relationship between the man and woman as a couple.

As a couples' counsellor, you must pay attention to the communication of the couple: notice the verbal and non-verbal communication between the man and the woman. For instance, you could ask, "How did the two of you decide to come here today?" Then notice how they answer the question, i.e. who talks first, do they consult each other before answering, does the partner disagree with the one who is speaking, does one partner pay attention while the other speaks, etc.

Counselling Skills and Qualities Required for Couple Counselling:

1. Counsellor self-awareness. This is related to Personal Growth, but in couple counselling it is especially related to awareness in relationships.
2. Capacity to tolerate (allow or put up with) intensity. The counsellor must be able to tolerate strong emotions and feelings, since these are often intensified by the couple relationship.
3. Ability to both validate and challenge. The counsellor must be able to validate the feelings and perceptions of the individuals in the couple, as well

as to challenge them when they need to address a different reality, such as the reality of HIV.

4. Recognise that relationships are full of contradictions. For instance, members of a couple may want to protect their partner from transmission of HIV, but may struggle to accept the required behaviour change such as faithfulness or consistent condom use.

5. Understand relationships in the context of cultural norms and values. These norms and values include culture, gender, religion and economic status.

Skills for Couple Counselling

- Neutrality and non-biased concern for both members of the couple
- Convey respect for the relationship
- Balanced participation of both partners
- Model appropriate listening and communication skills
- Facilitate dialogue between the couple: help them talk to each other
- Not afraid of raising difficult issues that the couple needs to address
- Ease tension and diffuse blame; encourage each partner to take responsibility for his/her own behaviour

Mediation Skills:

These skills reduce tension and diffuse blame, and can assist to reduce blaming between the partners.

1. Normalise feelings, reactions and experiences. It is normal for partners to have disagreements and differences of opinion. It is normal for there to be some tension when couples go for counselling and testing.

2. Use silence while being supportive and calm. Allow the couple time to collect their thoughts before responding. You may need to ask one member of the couple to wait quietly as the other collects his/her thoughts before responding.

3. Express confidence in the couple's ability to deal with problems that arise, especially HIV-related issues. You may do this by reflecting on the couple's strengths and their history together. For instance, ask how they have dealt with challenges or problems in the past. Highlight what they did well: this reflects on their ability to handle problems in the future.

4. Admire the couple's willingness to deal with the challenges of HIV in their lives, i.e. their willingness to come to counselling together. This demonstrates their willingness and commitment to the relationship.

5. Redirect and reframe questions and discussions that are blaming and hostile. Identify underlying, non-hostile feelings. Fear, anxiety, hurt and

uncertainty can be expressed as anger, aggression or hostility. For instance, anger might hide hurt or pain underneath. Help clients identify their underlying emotions.

6. Calmly and gently name and acknowledge the behaviour being observed. When couples are discussing difficult topics, it can be helpful to simply acknowledge behaviour in order to find a way to address it. For instance, "I understand that you are feeling disappointed and upset. Can you help me figure out how we can talk about this in a way that might be helpful to you?"

Solution-Focussed Couple Counselling

1. Build on strengths rather than weaknesses, i.e. the ability to adapt, flexibility and resilience (ability to survive and excel).
2. Focus on solutions, NOT problems. It is important to hear both partners' perspectives on the problem prior to exploring solutions, but focus on the solutions rather than the problems. Make sure that partners do not use a lot of blame when discussing the problem.
3. Use strengths to address HIV-related issues, such as behaviour change.
4. Validate feelings, but focus on positive actions.
5. Small behaviour change can lead to larger changes. Start with small changes before trying to tackle large changes

Differences between Individual and Couple Counselling:

- More topics to cover in the introduction and explanation of counselling and testing.
- Couple issues are more important than individual issues. The "client" is the "couple" or the relationship, not either of the individuals.
- Communication must be even clearer than in individual counselling, i.e. you must make sure that you hear from both partners when you ask a question and you must try and get them to communicate to each other.

Personal issues that might influence a counsellor in couple counselling:

- Experience, values and feelings related to couple relationships, which can include gender roles and expectations
- Dreams and desires related to the counsellor's relationships with family and future
- Relationship with own partner
- Own experiences with counselling and testing, especially couple counselling and testing
- Counsellors' feelings about disclosure of HIV test to partner and the partner's response and impact on the relationship

Ground Rules for Couple counselling and Testing:
There are some very specific ground rules that you must review at the beginning of a pre-test counselling session with couples. These rules include the following:

- Partners must agree to discuss HIV risk and concerns together. They must agree to be honest with each other.
- Partners must be willing to receive their HIV results together.
- They must commit to shared confidentiality. What is shared in the counselling room will be kept confidential among the three people present. They will not talk about it with any other people.
- Disclosure decisions, i.e. with whom to disclose their status, must be made together.

Roles and Responsibilities of the Couple:

- Participate equally
- Listen carefully and respond to each other
- Treat each other with respect and dignity
- Be open and honest with each other
- Provide understanding and support to each other

Information in this session adapted from Centers for Disease Control and Prevention (CDC). Draft March 2006. Couple HIV Counseling and Testing. Trainer and Participant Manuals.

UNDERSTANDING CHILDREN (OPTIONAL)

There are 5 basic needs of children:

1. Physical: to do with their bodies
2. Emotional: to do with their feelings
3. Social: to do with people around them
4. Mental: to do with their minds, including knowledge and education
5. Spiritual: to do with their beliefs

> NOTE: Children's needs are different from adults' needs; children need security, love and emotional support. They need a lot of reassurance and stability. They need guidance as they grow and mature emotionally, spiritually, physically and mentally.

Resilience: the human capacity or ability to face, overcome and be strengthened, transformed or changed by the difficulties of life. Resilience makes you stronger and better able to face the future.

"Resilient children say: "I can!," "I have!" and "I am." For example: "I can solve this problem;" "I have solved problems in the past," and "I am a smart person."

What children need to become resilient:

- Have the ability to understand a difficult situation or event, such as explaining the death of a parent.
- Believe that they can cope with a crisis because they know that they have some control over what happens.
- Can give a deeper meaning to a difficult event, i.e. a spiritual meaning or inner acceptance.

Inner Resources
Some examples of inner resources to build resilience:

- Minds: intelligence or cleverness
- Emotions: feelings that inform
- Spiritual beliefs
- Attitude
- Ability to look at things from different perspectives
- Physical: health, strength of bodies

External Resources
Some examples of external resources to build resilience:

- Living in a secure environment without abuse
- Maintaining a close relationship with a caregiver
- Keeping close relationships with other family members

- Having friends and playing with them
- Having enough basic food, shelter, clothing and medical services
- Having access to education and attending school regularly
- Having financial stability
- Keeping close links with the child's cultural community, church, etc.

As adults, but especially as community counsellors, how do we help children in our communities develop resilience? We can think of these things as "gifts" that we can give.

- Love, acceptance and guidance
- Providing children with a sense of belonging
- Appreciating the accomplishments of children
- Listening to and encouraging children
- Finding opportunities to spend time together
- Giving children a voice in their families and communities
- Providing opportunities for the child to express feelings

Developmental Stages of Children: Six Stages

1. Infants: 0 – 2 years
2. Pre-schoolers: 3 – 5 years
3. Children: 6 – 9 years
4. Children: 10 – 12 years
5. Children: 13 -15 years
6. Adolescents: 16 – 18 years

Key Themes for Normal Stages of Child Development:

- 0 – 2 years: Safety and security; stimulate the senses
- 3 – 5 years: Curiosity; try out new behaviours
- 6 – 9 years: Learning
- 10 – 12 years: Peer acceptance, changing bodies
- 13 – 15 years: A time of change; more independence
- 16 – 18 years: Making decisions

Group Discussion Questions:

- Pick five words (adjectives) to describe this age group.
- What do children learn during this developmental stage?
- What factors in the child's environment may affect what the child learns?
- What do children need during this developmental stage?
- What could happen if these needs are not met?
- What could happen if the child experiences a big loss, such as a severe illness or death of a parent?

Development in Children

	Physical (body/health)	Cognitive (thinking/learning)	Emotional/Social (feelings & friends)	Gender/Sex (gender identity)
0 – 2 years	• Crawl, learn to walk • NEED: holding, cuddling, stimulation, affection	• Understand language, respond to gestures, grabs wanted things	• Expresses emotion • Pleasant emotions influence better adjustment later in life	• Idea of boy and girl as different
2 – 7 years	• Muscle coordination • Feed and dress themselves • Run, hop, skip, jump & dance	• Speak and understand • Solving skills begin (puzzles, hidden objects) • Literal and concrete thinking • Learn through play • Short attention span • Learn to read, seek instant gratification	• Experience most emotions intensely • Seek attention from primary caregiver • Learn to form relationships • Seek peer and adult approval • Stability and routine important	• Recognise physical differences between boys and girls • Explore body parts, seek information, discuss sex with peers
7 – 9 years	• Less rapid growth • Lots of energy, can be reckless • Likes structured games	• Larger attention spans • Reading to learn • Likes discovering things on their own	• Form longer-lasting friendships • Influenced by peer group • Tend to be self-conscious • Need adult encouragement	• Greater self-awareness about sex • Recognise sexual differences • Increased curiosity about sexual activity
10 – 13 years	• Rapid physical growth • Hormonal changes • Puberty sets in, girls start menstruation • Body changes (girls and boys)	• Abstract thinking skills develop • Plan ahead, organise tasks independently • Opinions about social issues	• Strong need to conform to peer group • Form close friendships • Need loving supportive adult influence	• Interest in the opposite sex • Self-conscious about bodies and looks
14 – 19 years	• Complete growth spurt, gain weight, body maturity • Peak motor skills and coordination	• Full cognitive development	• Establish personal identity • Strong and changing emotions • Question authority, break rules • Need support at home & school	• Painfully self-conscious • Relationships with opposite sex very important • Attention to details about one's body

Information adapted from: I-TECH, by Dr. Lucy Steinitz. Draft April 2006. *Training on the Use of the Namibian Guidelines for Paediatric HIV Care, Unit 6: Psychosocial Issues in Paediatric HIV Care*. Windhoek, Namibia.

Family Health International (FHI), by Dr. Jonathan Brakarsh. Draft February 2006. *Guidelines for Counselling Children Affected by HIV/AIDS*. India Country Office.

Southern Africa AIDS Training Programme. January 2003. *Guidelines for Counselling Children who are Infected with HIV or Affected by HIV and AIDS*. Harare, Zimbabwe.

COUNSELLING WITH CHILDREN *(OPTIONAL)*

Communicating with Children: As counsellors, we need to meet children where they are and on their level. Communicating with children on their level includes literally being on their level: eye to eye (crouching down to be their height or sitting on the floor with them) and using language that they understand. This also means finding creative and non-threatening ways to explore sensitive issues and help children express their feelings.

Ways to Communicate with Children in Counselling

1. Drawing: Drawing allows children to communicate their feelings without having to put it into words.

   How to use drawing in counselling with children:
   - Give the child different materials to use, such as pens, pencils, markers, crayons, paints, etc.
   - Ask the child to draw something related to what you would like to explore, i.e. "draw something that makes you angry" or "draw a picture of your family having fun."
   - Gently follow up by asking the child to describe what is happening in his/her drawing.
   - Ask open questions to encourage the child to talk more about what he/she has drawn and why. For example, "How do the people in your drawing feel about what is happening right now?"

2. Storytelling: Children tend not to like direct questions or long lectures, but listening to a story about someone who is in a similar position can be very comforting. A story can also be a useful tool for problem-solving around a child's own situation.

   How to use storytelling in counselling with children:
   - Use a familiar story, fable or folktale that has a message for the child. You can have animals represent people.
   - Avoid using real names or events.
   - At the end of the story, encourage the child to talk about what happened. Ask the child about the message of the story to make sure that he/she has understood.
   - Sometimes it is helpful to have the child tell his/her own story based on a topic you give, i.e. "Tell a story about a girl who was really sad."
   - Sometimes either you or the child can tell a story and then you can make up different endings as a way to problem-solve solutions.

3. Drama: Drama or role play is an excellent way to raise issues with a child or with the whole family.

How to use drama in counselling with children:

- Give the child a topic to perform, such as "A day in the life…," that relates to the issues you want to explore.
- After the performance, encourage the child to discuss what happened in the drama and what issues came up. For example, "What was the happiest/saddest part of the day?"

4. Play: Play is an important way that children explore their feelings about events and make sense of their world. Through play, we can begin to understand what type of emotions children are experiencing.

   How to use play in counselling with children:

   - Give the child a variety of play materials, including simple everyday objects such as boxes, string, and sticks. It is also helpful if you have some dolls or stuffed animals that can be characters in the play.
   - Ask the child to show you parts of their life using the play materials. For example, "Show me what you like to do with your family." While the child is showing you, you can ask him/her to tell you about what is happening.
   - Follow and observe what the child is doing; do not take over the play. If you want to check that you understand what is going on, you can make comments such as, "I see the mommy doll is so sick that she cannot get out of bed," and see if the child agrees.
   - If the child gets stuck in the play, ask him/her questions, i.e. "What is going to happen next?" or "Tell me about this person (pointing to a character)".

Helpful Materials for Counselling with Children

- Paper, in different colours if possible
- Crayons, markers or coloured pencils. Make sure you have a variety of colours.
- Dolls and/or stuffed animals. It is best if you can have dolls of different ages and gender, i.e. adults and children, mother and father.
- Ball
- Magazines, ideally for different ages and topics such as sports, fashion, movie stars, especially for teenagers
- Some children's books
- Games, i.e. board games, cards or puzzles

Establishing a Relationship:

1. For children 5 years and below:
   - Physically: get down on their level, i.e. if they are on the floor, get down on the floor with them.
   - Comment positively on their appearance.
   - Show them some toys or objects that look interesting.
   - Find a simple game to play together, i.e. rolling a ball, clapping hands, etc.

2. For children 6 – 12 years old:
   - Physically: get down to their level.
   - Find out what activities or sports they like to play.
   - Find out about their hobbies or other interests.
   - Look through an interesting magazine together.
   - Children of this age like to show adults what they can do. Ask them if they can do mildly challenging tasks, such as balancing on one foot for a period of time, touching their nose and hopping, etc.

3. For children 13 – 18 years old:
   - Comment positively on their appearance, i.e. the clothes they are wearing or their hair.
   - Share an object of interest and discuss it, i.e. a beautiful rock or an object from another country.
   - Look through a magazine or newspaper together. Discuss their likes and dislikes on general issues like fashion, strength of the men, which sports figures they would like to be, etc.

Tips for creating a child-friendly environment

- Create boundaries of safety. Let the child know what he/she can and cannot do in the room.
- Let the child know how long the session will last. If the child is under 7, you may want to explain the length using a television program or some other things that has a set duration. Young children do not know lengths of time such as an hour yet.
- If parents or guardians are not in the room, tell the child where they are and will remain during the session, i.e. where they are sitting.
- Let the child know that he/she can say whatever he/she wants and that the counsellor will not discuss anything the child says with the parent or guardian without permission. The exception to this rule is if the child tells the counsellor about wanting to hurt him/herself or someone else, or if the child is doing something to harm him/herself.
- Focus on the child. Show an interest in his/her life and daily activities. Be curious and appreciate who the child is.
- Have toys and objects that the child likes and that are age-appropriate.
- Use age-appropriate language.
- Be calm and unhurried. Follow the child's lead.
- Continually acknowledge and validate what children feel and say about their situations. Do not make assumptions or wait to hear what adults have to say.

HIV Counselling and Testing with Children

Advantages:

- Access information and services to prolong life, i.e. improving diet and taking exercise
- Gain the support of others in a similar situation, i.e. join a support group of peers
- Be helped to understand how to avoid infecting others
- Become a role model by showing that you can live positively with HIV
- Experience the relief of knowing the truth rather than being worried and stressed about the unknown

Disadvantages:

- Might not fully understand the situation and only experience the negative effects of being HIV-positive while unaware that they can live positively.
- Disclose their status without being aware of the possible consequences such as stigma and discrimination
- Feel angry and resentful or depressed and hopeless

When you should test a child for HIV:

- Ideally, the child decides with his/her parents or guardians to be tested for HIV.
- If the parents have HIV and their child is very young, i.e. an infant
- If the child is sexually active or if there is strong evidence of sexual abuse
- If the child has been at-risk due to unsafe blood or unsterilised needles
- If an HIV diagnosis would influence medical care for the child

Criteria to help counsellor, parents and child decide about HIV testing:

- Does the child have any symptoms of HIV-related illness?
- Will the test results help the child to receive medical treatment, i.e. HIV treatment?
- Will the test results reduce the child's anxiety about his/her health?

If you have answered "yes" to at least two of these questions, then the HIV test may be in the best interests of the child.

Should a child be informed about being tested for HIV?

- Children have the right to express their own opinions about issues that affect their lives.

- Even if they are very young, children have the right to be given information and support to help them understand their situation and be involved in making decisions about what is best for them.

- However, exactly what a child should be told depends on his/her individual development and maturity.

- Counsellors have the challenge of finding a balance between listening to the child's concerns, respecting the parents' wishes and ensuring the child's overall welfare. Keep the following in mind when trying to achieve this balance:
  - Know the laws about age of consent for HIV testing in Namibia (16).
  - Discuss with the parents what information they have given to the child so that you can reinforce this or correct any information that is wrong.
  - Enable the child to feel in control and listened to; this can be done through drawing or play.
  - Recognise that an HIV test may raise different issues for children of different ages, i.e. young children may be most scared of the pain of having their blood taken, while older children may be most afraid of what their friends will think and how they will be treated.
  - Give honest answers to the child and do not hide information, even if it is difficult to say.

Pre-Test Counselling with Children:

- Meet with the parents/guardians first to discuss the reasons for wishing to test the child. Refer to the criteria for testing children above.

- Discuss with the parents/guardians how they wish to involve their child in the testing procedure, etc. If the parent requests that their child not be informed, explore why.

- Find out how much the parent knows about HIV and how much their child knows, and correct any misconceptions.

- Discuss the implications of a positive or negative test result.

- Prepare the parents for discussing the HIV test with the child.

- After discussing the above issues, invite the child into the room and encourage the parents to tell the child about the test. Encourage a dialogue between the parents and child.

  - Counsellor with child:
    You can either meet with the child alone or with the parents present. Do not meet with the child alone if he/she shows any discomfort with this.

- Establish a relationship with the child; see previous information for ideas on how to do this.
- Explore the child's feelings about being in the session and address any fears the child might have.
- Find out what the child knows about HIV and what else the child might want to know.
- Answer the child's questions openly and honestly, keeping in mind that information must be age-appropriate and understandable to the child.
- Explain the testing procedure. Explore and address any worries or fears the child might have about the process. Do not lie to try to protect them, such as promising that the blood test will not hurt!
- Ask the child how he/she feels about having this kind of test.

The following items can be addressed with the child and parents/guardians together, especially if the child is young. If the child is a teenager, you may first want to discuss ways of receiving the results and then bring the parents in to explain how the child wants the results to be given.

- Explain the possible test results and what each might mean for the child.
- Discuss who will receive the test result, how they will be given and who will provide support. Identify a support person or people.
- If the parents or guardians are not present, ask the child for permission to discuss his/her feelings with the parents/guardian.
- If the child does not seem ready for a test or asks for more time, offer the child another pre-test counselling session.

- Obtain consent for the test from child and parents.

Termination:

- Summarise what you have talked about.
- Review the plan of action.
- Discuss what you will talk about the next time you meet.
- Ask the child how he/she felt about the session.
- Ask if he/she has any questions.
- Set a date for the next counselling session

Post-Test Counselling with Children

A child should not be rushed into receiving his/her test result. One or more sessions should be offered to a child to cope with the result, especially if it is positive.

- Gain the child's confidence and trust; try to create a friendly and private environment.
- Check that the person who was previously identified to provide support is present. Then follow the plan for giving test results that was discussed during the pre-test counselling session, i.e. if the result should be given to the whole family or to the child first and then shared with the parents/guardians.
- If the child is younger than 11 years old, it is best to first give the result to the parent or guardian. Discuss how to prepare the child and finally how to tell the child: this could be a process that takes weeks or months, depending on the child's age. Invite the child to join the session and ideally, have the parent or guardian tell the child the result.
- Briefly check how much information given in the pre-test counselling session is understood, specifically related to the meaning of the result.
- Assess if the child is ready for his/her result. Check any fears or concerns.
- If the child is not ready, ask when he/she thinks he/she will be ready and make a plan for that.
- If the child is ready, give the result. Remember to do so in an age-appropriate way so the child will understand.
- Allow the child to react whether the test is positive or negative. The reaction can be through play, drawing or verbally.
- Answer the child's questions.
- Make sure that the child and parents/guardians understand the result. Ask them to repeat the result and explain what it means.
- Ask the child for his/her immediate plans and how he/she will get support from others.
- Be aware of the child's level of energy and concentration. If he/she is ready for more information, continue. If not, schedule another appointment for follow-up support.
- If you have done the post-test counselling session alone with an older child, make sure that you bring in the parents/guardians to also give them the result. Discuss with the child alone how he/she would like the result to be shared with his/her parent/guardian. Encourage the child to share the result if possible. If not, check with the child when he/she is ready and give the result to the parent/guardian yourself with the child present.

Guidelines for Counsellors Working with Children

- Plan for more than one post-test counselling session, especially if the child has been diagnosed with HIV.
- Give the result only if the child and parent/guardian seem ready to receive it.
- Allow parents/guardian and the child, if appropriate, enough time to deal with a positive result before discussing plans, referrals, etc. Remember, a positive result is a crisis.
- Encourage the parents/guardian and/or the child to speak about their feelings, concerns and needs.
- Help parents/guardian/children deal with feelings of shame and guilt associated with testing positive for HIV.
- Assess need for and access to appropriate referral services for the child and the family. These could include counselling, medical services, support groups, abuse and domestic violence services, drug and substance abuse services, legal and financial services, and spiritual support.
- Identify an adult who can be a consistent support person.
- Explore issues around disclosure, i.e. to whom, how much, under what circumstances, and when.
- Plan for risk reduction and care as appropriate. This could include HIV treatment, nutrition, home-based care and other medical treatment.
- In the case of a negative result, help parents/guardians and child remain negative.
- Plan for ongoing support including, but not limited to, counselling.

Small Group Activity: Case Scenarios

1. Frieda is a 4-year-old child. She has come to the health facility with her grandmother, whom she lives with, along with her 9-year-old brother and 13-year-old cousin. The grandmother has brought her to counselling at the request of Frieda's doctor. Frieda has been in and out of the hospital for the last 4 months.

2. Demas is 14 years old. He has come to the health facility with his mother. His mother wants him tested for HIV because he has been sexually active. Demas is angry about coming to the health facility because he does not know why he is there.

3. Silvia, who is 10 years old, has been brought to the health facility by her grandmother. The grandmother is worried about Silvia's HIV status because she was sexually abused by her mother's boyfriend.

4. Ndapandula has been brought to the health facility by her mother. She is 13 years old. Her mother says that Ndapandula has an older boyfriend who buys her new clothes and nice things. She is worried about Ndapandula's HIV status but does not know how to talk to her daughter about it.

5. Jonas is a 6-year-old boy. He has been brought to the health facility by his grandmother, whom he lives with. His mother died of HIV several years earlier. Jonas is HIV-positive and has been sick off and on for most of his life. He has been on HIV treatment for the last year. It has only been recently that he has been asking a lot of questions about his medicine and why he is taking medicines twice a day. He has become difficult and does not want to take his medicines when his grandmother tries to give them to him. The grandmother wants to know what she should tell her grandson about the medicines and his HIV status.

Small Group Discussion Questions:

- What are the primary issues to be dealt with in counselling?
- How would you address these issues with the parent/guardian? How would you address these issues with the child?
- Develop an outline for how you would proceed with counselling. The outline should include whom you will talk with first and second, as well as how many counselling sessions you think you might need. Also mention the topics to be discussed during each counselling session.
- How would you establish a relationship with the child? What would you do with the child to develop trust and make the child feel comfortable?

Glossary

Abrupt stopping of breastfeeding/abrupt weaning: Completely stopping breastfeeding with a switch to replacement feeding. Mixed feeding should be avoided during this time.

Adherence: The extent to which a person's behaviour (taking medication, following a treatment regimen, making lifestyle choices, etc.) corresponds with recommendations made by the health-care team. ART adherence is taking the correct dose at the correct time and in the correct way.

AIDS (Acquired Immune Deficiency Syndrome): late-stage HIV infection.

> **Acquired**: obtained or contracted; not inherited.
>
> **Immune**: the body's defence system that provides protection from most diseases.
>
> **Deficiency**: a defect, weakness or inability to respond; when linked with the immune system, this refers to the inability of that system to perform its functions and combat antigens or germs.
>
> **Syndrome**: a group of symptoms and diseases that indicate a specific condition; it is not by itself a disease.

ANC: Antenatal clinic or antenatal care.

Antenatal care: Care of a pregnant woman and her unborn child or foetus.

Antibody: the substance that the body makes to fight an antigen (foreign substance in the body such as a germ). Its purpose is to protect the body from disease by countering or identifying the antigen to be destroyed.

Antigen: any foreign substance that gets into the body and causes the immune system to respond. Antigens include bacteria and viruses such as HIV.

Antiretroviral drugs (ARV): drugs that slow the growth and replication of HIV and the progression of HIV disease.

Antiretroviral prophylaxis (HIV prophylaxis): use of antiretroviral drugs to reduce the likelihood (or possibility) of HIV transmission, for example, the use of single-dose Nevirapine for prevention of HIV transmission from mother to child.

Antiretroviral treatment (ART): Use of antiretroviral drugs to treat HIV infection or AIDS.

Asymptomatic: without symptoms of illness or disease. People who are infected but asymptomatic may transmit HIV or other STIs (sexually transmitted infections).

CD4 cell: The white blood cell within the immune system that is targeted and destroyed by HIV.

CD4 count: The number of CD4 cells in the blood, which reflects the state of the immune system. A normal count in a healthy adult is 500-1,200 cells/mL3. When the CD4 count falls below 200 cells/mL3, there is a high risk of opportunistic and serious infection.

Complementary food: Any food used as in addition to breast milk or to a breast milk substitute when feeding an infant.

Cup feeding: Feeding an infant from an open cut without a lid.

Diarrhoea: illness characterised by loose, watery bowel movements more than three times a day, every day.

Disclosure: sharing personal information, thoughts or feelings with others. In the context of HIV, disclosure is usually used to refer to sharing one's HIV status with others.

Discrimination: treating one particular group in society in an unfair way.

Embryo: fertilised egg (egg & sperm) until 2 months of development.

Exclusive breastfeeding: an infant receives only breast milk and NO other liquids or solids, not even water. The only exceptions are drops or syrups that contain vitamins or minerals, or any medicine prescribed by a doctor.

Foetal (also spelled fetal): connected with a foetus, i.e. foetal blood is the blood of the foetus.

Foetus (also spelled fetus): a baby before birth, while the baby is still in the mother's uterus/womb; from 2 months to birth.

Gender: our maleness or femaleness, often including our social roles.

HIV (Human Immuno-deficiency Virus): the virus that causes AIDS.

> **Human** means that it affects only humans and lives only in humans.
> **Immuno-deficiency** means a deficiency or a breakdown of the immune system; a decrease in the body's ability to fight disease.
> **Virus**: A virus is a germ that invades the body and causes diseases. A virus is a type of antigen.

Health care worker (Health care provider): A doctor, nurse or midwife who work with patients in a health care facility, i.e. hospital or clinic.

Immune system: the body's resistance or the body's defence mechanism for fighting off infections. The immune system defends the body against infections; it includes the white blood cells, which include CD4 cells, T cells and B cells.

Infant: a person from birth to 12 months of age; a baby.

Infant formula: a breast milk substitute that contains the nutrients an infant needs. It is a powder sold in tins.

Intercourse: sex that involves one partner entering another's body. Intercourse may refer to oral, anal and vaginal sex.

Intervention: Specific action or strategy to address a particular problem or issue and to accomplish a specific action or outcome.

Maternal: of the mother, or related to being a mother, i.e. maternal blood is mother's blood.

Mixed feeding: feeding both breast milk and other foods or liquids, including water. Mixed feeding increases the risk of transmission of HIV from a positive mother to her child.

Mother-to-child transmission (MTCT): transmission of HIV to a child from an HIV-infected woman during pregnancy, delivery, or breastfeeding.

Nutrients: substances that come from food and are needed by the body, i.e. carbohydrates, proteins, fats, vitamins and minerals.

Opportunistic infection: infections that occur in the presence of immune deficiency (weakened immune system), or HIV-related diseases. Any disease that occurs more frequently in people with HIV.

Oral thrush: a fungal infection of the mouth that looks like white patches or curdled milk.

PCP (Pneumocystic carinii pneumonia): a severe, life-threatening lung infection that causes fever, dry cough and difficulty breathing. It is an opportunistic infection.

PCR (polymerase chain reaction) test: This test detects HIV in the blood and can be done at 6 weeks following possible exposure; it is also may be used to test infants.

PEP (post-exposure prophylaxis): medicine given after someone has been exposed to a virus or disease, such as HIV, in order to prevent infection.

Placenta: organ in the womb that filters the mother's blood and allows oxygen and nutrients to pass through the umbilical cord to nourish the growing foetus.

Postnatal care: care given to mother and baby after the child is born. It includes medical treatment, services on breastfeeding, immunisations, maternal nutrition and support for the mother and her family.

Prevention of mother-to-child transmission (PMTCT): prevention of mother-to-child transmission of HIV.

Replacement feeding: feeding infants who are receiving no breast milk with a diet that provides all the nutrients they need until they can eat family foods. During the first six months of life, replacement feeding should be with a breast milk substitute such as infant formula or modified cow's or goat's milk.

Replicate: to duplicate or make more copies of something.

Resistance (viral resistance): changes in the genetic makeup of HIV that decrease the effectiveness of antiretroviral drugs (ARVs).

Safer sex: Ways to have sex that reduce the danger of acquiring or transmitting HIV or other sexually transmitted infections (STIs).

Sex: sexual activity or behaviour; sexual intercourse.

Sexual orientation: determined by whom a person is physically and emotional attracted to; common divisions are **heterosexual** (attracted to people of the opposite gender), **bisexual** (attracted to people of either gender) or **homosexual** (attracted to people of the same gender).

Sexuality: the experience of being sexual; this is shaped by behavioural, psychological, emotional, social and orientation factors.

Sexually Transmitted Infection (STI): infection that is spread from one person to another through sex or sexual activity. The unprotected sex may include vaginal, oral and anal sex.

Side effect: unintended action or effect of a medication or treatment.

Stigma: mark of shame or discredit; the strong feeling in a society that a type of behaviour is shameful. An attribute of a person that is considered unacceptable.

Symptomatic HIV infection: the stage of HIV infection when a person experiences symptoms. Common symptoms include fever, weight loss and swollen lymph glands.

Transmit (transmitted): to pass on, as in a disease. To transmit HIV is to pass on the virus to another person.

Tuberculosis (TB): A highly contagious (easy to get) bacterial infection that attacks the lungs and other parts of the body.

Umbilical cord: connects the foetus (unborn baby) to the placenta. The umbilical cord carries oxygen and nutrients from the mother to the unborn baby. The umbilical cord is cut after the baby is born and forms the belly button.

Unprotected sex: sexual intercourse without a condom or other barrier to prevent contact with the partner's body fluids. This can be vaginal, anal or oral sex.

Vaginal fluids: liquids produced by the female reproductive system that provide moistness and wetness in the vagina and serve as lubrication during intercourse.

Viral load: The amount of HIV in the blood as measured by a blood test (usually the HIV RNA polymerase chain reaction test, or PCR).

Viral replication: the process by which a virus makes copies of itself, using genetic material in human cells.

Virus: a type of germ that causes infection.

Wasting (syndrome): condition characterised by loss of more that 10% of body weight, and either unexplained chronic diarrhoea lasting more than a month or chronic weakness and unexplained fever lasting more than a month.

Window period: the time between infection with HIV and a definitive positive result on an antibody test. For HIV, the window period is usually about 3 months.

REFERENCES: HIV COUNSELLING & TESTING

Barnett, B. and J. Schueller. 2000. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. Family Health International, Research Triangle Park, NC.

Department of Health & Human Services, Centers for Disease Control and Prevention. October 2004. *Voluntary Counseling and Testing (VCT), Training Course*. Facilitator's and Participant's Manuals. USA.

EngenderHealth. 2003. *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*. Trainers' Manual and Participants' Manual.

Family Health International (FHI), by Dr. Jonathan Brakarsh. Draft February 2006. *Guidelines for Counselling Children Affected by HIV/AIDS*. India Country Office.

Family Health International. VCT Toolkit. January 2004. *HIV Voluntary Counseling and Testing: A Reference Guide for Counselors and Trainers*.

Family Health International. VCT Toolkit. January 2005. *HIV Voluntary Counseling and Testing: Skills Training Curriculum.* Facilitator's Guide.

I-TECH, by Dr. Lucy Steinitz. Draft April 2006. *Training on the Use of the Namibian Guidelines for Paediatric HIV Care, Unit 6: Psychosocial Issues in Paediatric HIV Care*. Windhoek, Namibia.

Southern Africa AIDS Training Programme. January 2003. *Guidelines for Counselling Children who are Infected with HIV or Affected by HIV and AIDS*. Harare, Zimbabwe.

UNAIDS. "Fast Facts: How do you use a female condom?" www.unaids.org.

UNAIDS. "Fast Facts: How do you use a male condom?" www.unaids.org.

United Nations Development Programme (UNDP). *HIV and Development Program activity: Wildfire. Available from:* www.undp.org/hiv/publications/toolkit/sample10.html.

WHO, Department of Reproductive Health. 2000. *The Female Condom: A Guide for Planning and Programming.*