

HIV/AIDS COUNSELLING

A TRAINING GUIDE FOR TRAINERS

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NATIONAL AIDS
CO-ORDINATION PROGRAMME

G.T.Z
IEC Family Health

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FOREWORD

As the HIV epidemic continues to rise, the related psychosocial and economic impact will continue to overwhelm all persons affected. The ongoing development of HIV Counselling services, with its main objective of reducing infection, its impact and promoting well-being of persons affected, will continue to be a daunting challenge. This is more so in our context where counselling as a component of clinical management only began growing and receiving prominence with the onset of the AIDS epidemic.

The development and growth of HIV Counselling Services in response to an ever increasing demand for these services requires sustained counselling training programmes and curricula that are consistent with the emerging needs of the HIV affected community. As there is the tendency to be flooded with diverse counselling approaches and techniques derived from different scientific orientations, the focus of counselling training should be on the basic skills and techniques. These are often easier to comprehend, practice and monitor, especially in our situation where the bulk of HIV counselling services will continue to be delivered as integrated components of the day to day clinical or other professional duties.

The development of this basic counselling training guide is overdue but most welcome. It sets out the basics of HIV Counselling. It is anticipated that all counselling trainees and practitioners will be familiar with the basic content, skills and techniques of HIV Counselling before being exposed to more advanced approaches and techniques. The launch of this guide sets off the process of systematising and standardising HIV counselling training so essential in monitoring the service and maximising its benefits.

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The preparation of this guide involved many HIV counsellors in the health sector. Through brainstorming over several workshops, they contributed some of the material used in the development of this guide. A list of the people who participated in this exercise is shown in Appendix I. The National AIDS Co-ordination Programme is grateful to all those health workers and many other trainee counsellors for their part in pre-testing this training guide and for their unwavering support and motivation throughout its development.

PREFACE

This Counselling Training guide complements other training programmes. The guide presents the essential and appropriate information for training of HIV/AIDS Counselling trainers at Central, Provincial and District Health Centres in Zimbabwe.

Apart from giving essential information for training, the guide offers step by step training methods for the trainer. The inclusion of this methodology is particularly convenient for counselling trainers who have other duties at workplaces in addition to counselling training. The training methods and activities are designed to facilitate a better learning process.

The guide covers the essential elements of HIV/AIDS counselling in nine chapters in the following sequence:

- Basic facts on HIV/AIDS
- Communication Skills
- Introduction to Counselling
- Basic Counselling Skills
- Stages of Counselling
- Psychosocial Aspects of HIV/AIDS
- HIV/AIDS counselling
- Types of HIV/AIDS Counselling
- Cultural, Ethical and Legal Issues in Counselling

Each chapter has two parts. Part A is the training method which outlines step by step how materials can be presented to trainees. Part B contains content areas and information for learning in the training process. Users of this training guide can use other counselling training materials available to enhance the training sessions. A five day workshop is recommended to satisfactorily complete the training.

INTRODUCTION

As the numbers of infected persons continue to soar in Zimbabwe, the demand for counselling services has far out stretched the available resources. As a result, the need for a crash programme to equip as many people as possible with counselling skills has never been so crucial. Yet at the same time, the cost of training at established institutions such as CONNECT continues to rise. With this state of affairs, NACP has no choice but to utilise the few CONNECT graduates to train other staff at their institutions.

The evaluation of the systemic counselling training programme at CONNECT revealed that most of the graduates feel confident not only to counsel but also to train others provided training materials and time are made available. It is hoped that the availability of this guide to trainers will make it possible for NACP to achieve their initial goal of increasing the number of HIV/AIDS counsellors at all health institutions.

The guide covers the essential information for a training programme in basic counselling. However, trainers are encouraged to look for other relevant sources to enhance training. Moreover, users of the guide should have previous training in basic counselling skills.

The first chapter deals with basic facts about HIV/AIDS, which every counsellor should know. The next chapters cover all issues related to counselling. The concluding chapter gives an overview of cultural, ethical and legal issues in counselling.

CHAPTER ONE

BASIC INFORMATION ON HIV/AIDS

It is recommended that where possible, this chapter be presented by a medical doctor or clinical officer

PART A : TRAINING METHOD

STEP I **10 Minutes**

In plenary session, ask participants to share with others their experiences of HIV illness and HIV related deaths.

STEP II **Group Work** **25 Minutes**

Split participants into groups of 4 or 5 people and ask each group to brainstorm on the following question:

List and discuss the various cultural myths, legends and attitudes commonly held about HIV/AIDS in communities where you come from.

STEP III **Group Presentations** **20 Minutes**

STEP IV **Lecture** **60 Minutes**

Using transparencies and flip charts present the main issues on the basic HIV/AIDS information as outlined in this training guide.

The following materials and any others you have access to can also be used as references to enrich your presentation.

References

1. NACP publications
 2. Facts about AIDS
 3. AIDS Counselling: A Manual for Primary Health Care Workers, Living positively with HIV/AIDS
 4. Blood donation pamphlets
- * These are available from NACP and NBTS

PART B : SUBJECT CONTENT

BASIC INFORMATION ON AIDS

One of the facets of HIV/AIDS Counselling is information giving. A thorough up to date knowledge of facts related to HIV/AIDS is required by the Counsellor to enable clients to make informed decisions and cope with HIV infection.

1.1 What is AIDS?

AIDS stands for Acquired Immunodeficiency Syndrome.

- Acquired - Not hereditary
- Immune - The body's defence system
- Deficiency - Impairment of the immune system
- Syndrome - Constellation/combination of signs and symptoms

1.2 History

AIDS was discovered in the United States in 1981 after many cases of unusual opportunistic infections, most frequently an unusual form of pneumonia called Pneumocystis carinii pneumonia, were reported in previously healthy homosexual men in California and New York. The most common causative agent in Zimbabwe and most countries was isolated from a patient in France in 1983 and given the name HIV - 1 in 1986. Another rarer agent causing AIDS was isolated in West Africa in 1985 and is called HIV - 2. From now onwards HIV-1 will be discussed and referred to as HIV .

Retrospective studies of stored serum specimens have revealed that HIV had been present in parts of Central Africa for two decades prior to the recognition of the clinical syndrome of AIDS. During the 1980s, the HIV epidemic spread widely and became pandemic.

1.3 What is the global HIV/AIDS picture?

Accurate figures for the prevalence of HIV infection do not exist and all figures are estimates. The latest WHO estimates show that there were more than 3.1 million new HIV infections in 1996 and approximately 1.5 million people including 350 000 children died of HIV/AIDS related illnesses. Some 22.6 million people are living with HIV infection or AIDS world-wide. Of these, 1.4 million are in sub-Saharan Africa. Three

distinctive epidemiological patterns of HIV have been identified globally:

Pattern 1 countries (including North America, Western Europe, Australia and New Zealand) had the epidemic starting in the late 1970s and early 1980s among homosexual men and injecting drug users. Heterosexual transmission however occurs and is increasing.

Pattern 2 countries include most sub-Saharan Africa and areas of the Caribbean. Transmission is predominately heterosexual and peri-natal with an additional contribution from unscreened blood transfusions and inadequate injection procedures.

Pattern 3 countries include North Africa, the Middle East, Eastern Europe and most of the countries of Asia and Oceania had HIV introduced late in the global pandemic. However, the situation is changing fast, with increasing numbers of HIV amongst intravenous drug users and prostitutes.

1.4 What is the AIDS situation in Zimbabwe?

The number of AIDS cases in Zimbabwe has been increasing steadily since 1987. The table below shows the number of AIDS cases by year from 1987 to June 1996.

Fig. 1 AIDS cases by year : 1987 - June 1996

Year	Male	Female	Unspecified	Total
1987			119	119
1988			202	202
1989	674	630	7	1311
1990	2405	1917	40	4362
1991	2663	1860	34	4557
1992	4630	3501	49	8180
1993	5225	3888	61	9174
1994	5777	4812	58	10647
1995	7447	5835	74	13356
1996*	1484	1342	10	2836
1996**	1417	1350	7	2774
Cumulative Total	31722	25135	661	57518

* First quarter

** Second quarter

Source : National Public Health Laboratory

As the table below shows, AIDS affects everyone regardless of age and gender.

Fig. 2

Age Group	GENDER			
	Male	Female	Unspecified	Total
0 - 4	4239	3780	51	8070
5 - 14	357	348	0	705
15 - 19	158	889	5	1052
20 - 29	6979	8865	38	15882
30 - 39	10464	6776	45	17285
40 - 49	5322	2424	11	7757
50 - 59	1746	607	5	2358
60 +	791	276	3	1070
Unspecified	1666	1170	503	3339
TOTAL	31722	25135	661	57518

Source : National Public Health Laboratory

HIV sentinel surveillance sites have been established across Zimbabwe to monitor the HIV seroprevalence among various sub-groups. Results are very alarming with seroprevalence results increasing from around 7% in pregnant mothers in 1992 to a range of 20-30% in 1995. Seroprevalence results are even more alarming in STD patients, having risen from around 15% in 1992 to 50 - 70% in 1996.

1.5 How is HIV spread?

The major modes of HIV transmission are: sexual intercourse whether vaginal, anal or oral and breast feeding. HIV is also transmitted through blood, blood products and contaminated needles.

1.6 How does HIV cause AIDS?

Properties of the HIV virus

* is an extremely small organism

- * measures 1/10000 of a mm
- * is only visible through an electron microscope
- * is a circular organism which has a LIPO protein external coating
- * it belongs to a group of viruses called Retroviruses
- * it does not have a DNA which is contained in human cells
- * it contains RNA (Ribo Nucleic Acid) only
- * it is attracted to certain human body cells called the T helper Lymphocytes, monocytes macrophages. These cells have special receptors on their surfaces called CD 4 receptors. The T helper lymphocytes are called CD4 helper cells or CD4 cells and are responsible for the body defence mechanism against diseases when HIV virus enters the body it attracts and destroys the CD cells, thus weakening the body's immune system

The following is the sequence of how the HIV enters the body, attacks and destroys the CD4 cells:

- * HIV enters the body through sexual intercourse or any other modes of transmission
- * virus circulates in the host's blood stream
- * virus attaches itself to and invades a CD4 cell
- * virus releases its RNA into CD4 cell
- * viral DNA is produced by the action of the RNA and an enzyme called "reverse transcriptase" which is part of the virus
- * viral DNA enters the cell nucleus and is incorporated into the DNA of the human cell thus becoming part of the cell's genetic material
- * CD4 cells are depleted until the body's immune system is weakened making it an easy target for foreign organisms normally found around us e.g. bacteria, fungi, parasites viruses to successfully attack the body
- * this results in a person developing opportunistic infections e.g. cancers, kaposi sarcoma
- * opportunistic infections mark the beginning of AIDS. It is these infections that kill individuals
- * HIV has been isolated in tears, urine, semen, cervical secretions, cerebrospinal fluids, and breast milk thus becoming part of the human

genetic material

- * when CD4 cell is activated by infection or other diseases the virus uses the cell to reproduce itself
- * release of virus from the infected cell results in its death and the process is repeated with newly produced viruses attacking the CD4 cells.

This process results in the progressive destruction of CD4 cells which does not only result in the decline of CD4 cells number, but is accompanied by a profound impairment of the functioning of the remaining lymphocytes. The cells and fluids can therefore transmit HIV infection.

1.7 Classification of HIV infection

The clinical manifestations of HIV are classified into 4 stages

- * stage I - Acute
- * stage II - Asymptomatic
- * stage III - Persistent PGL
- * stage IV - other manifestations

1.7.1 stage I - Acute infection

- * transient non specific illness similar to glandular fever
- * fever
- * general malaise
- * muscle pain
- * lymphadenopathy
- * pharyngitis
- * rash

10 - 49% of HIV infected people have been reported to develop the above symptoms. Sero conversion usually takes 2-3 weeks to develop. This is what is called the “window period” during which an HIV test will show negative even if the person is positive.

1.7.2 stage II - This is the asymptomatic phase

- * no symptoms, no signs during physical examination

1.7.3 stage III - Persistent Generalised Lymphadenopathy

Main symptom is generalised lymphadenopathy. Studies reveal that patients with PGL and those without show no difference in the rate of progression to AIDS

1.7.4 stage IV - Other manifestations

Non specific infections occur. These may be intermittent or persistent e.g. fever, night sweats, chronic diarrhoea, weight loss of more than 10% body weight and recurrent bacterial chest infections.

1.8 Natural history of HIV infection

- * most people infected with HIV worldwide are asymptomatic
- * studies of people with known sero-conversion have shown that 50-60% of HIV infected people will develop symptoms within 10 years after infection
- * more than 90% of HIV infected patients show some signs of disease progression
- * initially they have minor symptoms before developing more opportunistic infections.
- * eventually they develop life threatening diseases.

1.9 Other opportunistic infections

These tend to affect the mucous membranes and skin conditions and may include: fungal infection (candidiasis), viral warts that do not respond to treatment, Herpes Zoster, molluscan contagium and bacterial impetigo. Collection of these symptoms and signs are referred to as AIDS related complex (ARC). Severe immuno suppression usually presents with multiple opportunistic infections and conditions such as: Herpes Zoster (recurrent), Mycobacterium tuberculosis infection (pulmonary or extra pulmonary), Candida of the oesophagus, Kaposi Sarcoma, recurrent bacterial pneumonia, toxoplasma encephalitis, cryptococcal meningitis, cancer of the cervix, pneumocystis CARINI pneumonia, chronic ulcerative herpes simplex, lymphomas- brain lymphoma.

1.10 Lab diagnosis of HIV infection

A diagnosis of HIV infection is made by testing for the presence of Anti bodies to the virus. There are two widely used tests:

- a. ELISA
- b. Western Blot

The ELISA is the initial test (first). The Western Blot is a confirmatory test especially if the ELISA is not conclusive. Two ELISA tests are done using tests from different manufacturers.

- Patient is considered HIV positive if both tests are positive
- In case of unclear results the Western Blot test is used to confirm the diagnosis
- Test results may be negative during the window period even though the person is infected
- Children born of HIV positive mothers may test positive for up to 15 - 18 months even if they are not infected as they still carry the antibodies of the mother

1.11 Treatment of HIV/AIDS

- * no cure
- * no vaccine
- * symptomatic treatment
- some anti viral drugs have been developed which can delay the onset of AIDS. These include drugs like: zidovudine (AZT), didanosine (DDI), nevirapine, saquinavir, and ritonavir. These drugs are very expensive and are not affordable for most developing countries including Zimbabwe. For further management guide refer to EDLIZ.

1.12 HIV in children

Diagnosis of HIV in children is usually very difficult because of the presence of the maternal antibodies 15-18 months after child birth. The clinical presentation is difficult as many of the symptoms related to HIV are common in childhood diseases. The common indication for HIV include: recurrent bacterial infections, candida (oral thrush, oesophageal candidiasis or pulmonary candidiasis), wasting syndrome, HIV encephalopathy chronic diarrhoea, pyrexia of unknown origin, pneumocystis carinii pneumonia and lymphocystic interstitial pneumonitis. Most children infected will be symptomatic within 3 years of life.

CHAPTER TWO

COMMUNICATION

PART A : TRAINING METHOD

Step I

5 Minutes

Introduce the lesson by outlining the following objectives. The trainer can use a transparency or flip chart as a teaching tool.

By the end of the Session participants should be able to:

- a. define Communication
- b. describe the process of Communication
- c. list at least 3 qualities of effective communication
- d. list at least 3 barriers of effective Communication

Step II

Group work

15 Minutes

- a. Split Participants into groups of 4 or 5 people
- b. Provide each group with a flip chart and a marker. Each group should choose a rapportaire to present the ideas generated by the group.
- c. Through brainstorming each group should come up with a definition of communication
- d. After 15 minutes of brainstorming, call back participants and all groups to put up their flip charts on the wall .

Step III

Group presentations

15 Minutes

1. Allow participants to discuss each definition taking note of any common themes
2. Using ideas generated, participants formulate a definition of communication
3. Share with participants some of the definitions given in this training guide
4. From all the definitions discussed, participants select a working definition which will be used in all activities that follow

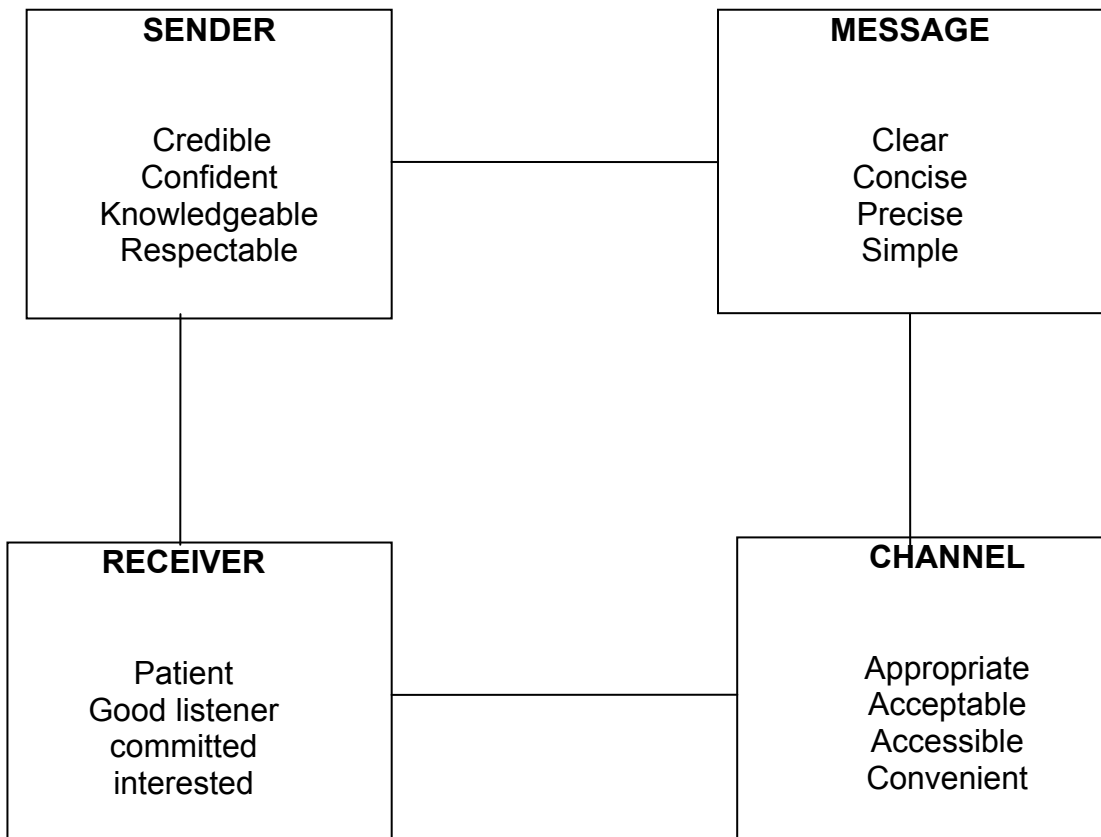
PART B : SUBJECT CONTENT

Definition:

Communication is a process that involves a message, a sender, a receiver and feed back of the message to the sender. It can be verbal or non verbal.

Process of Communication

The diagram below illustrates the communication process:



BARRIERS TO EFFECTIVE COMMUNICATION

Effective communication can be hindered if there is interference or disruption at any part of the communication chain. The following are some of the factors that can cause disruption:

- Language e.g. use of words not understood by the other party
- Environment e.g. disruptive and noisy
- Attitude e.g. uncaring
- Disability e.g. hard of hearing

CHAPTER THREE

INTRODUCTION TO COUNSELLING

PART A : Training method

STEP I

15 Minutes

Introduce the topic by outlining the following objectives of the session. A flip chart or transparency can be used.

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

- a. define counselling
- b. understand and define the different types of counselling
- c. describe the counselling process
- d. define the stages of counselling
- e. list the aims of counselling

STEP II

Brainstorming

60 Minutes

1. Use any of the following statements and questions to trigger discussion
 - a. What do you know about counselling?
 - b. Describe some problems in your community and outline how these have been resolved
2. Write on the flip chart all the responses given
3. Using these ideas together with guidelines presented in this training guide, formulate a working definition of counselling
4. Share with participants some of the definitions outlined in this training guide.
5. Conclude the session by clearly spelling out the differences and similarities between counselling and health education

STEP III

Aims of counselling

45 Minutes

1. Ask the following question: What does counselling aim to achieve?
2. Write all the responses on a flip chart.
3. Discuss each of the listed responses.
4. Summarise the given responses.
5. Present the aims outlined in this training guide.

PART B : SUBJECT CONTENT

What is counselling?

Counselling is a concept and thus has many definitions. However all definitions regardless of their focus have certain common properties. The following definitions demonstrate such similarities and variations:

1. Conversation with a purpose
2. Talking therapy
3. Counselling is a dialogue between client and a care provider aimed at enabling the client to cope with stress and to take personal decisions e.g. decisions relating to HIV/AIDS.
4. Counselling is a one to one relationship between a person (**client**), who asks for help with a problem and a person (**counsellor**) who is trained to provide that help. In this relationship, the counsellor engages the client in a process to explore, understand and solve problems related to the client's daily living (in a relaxed and safe environment)
6. Counselling is a one to one relationship between counsellor and client which focuses on rational planning , problem-solving, decision-making, and situational pressures as they relate to the client's daily living (Brammer & Shostrom, 1982)

Why do people seek counselling ?

Specific goals of counselling are often based on the particular presenting problem or on the needs of the client. Aims of HIV/AIDS counselling include the following:

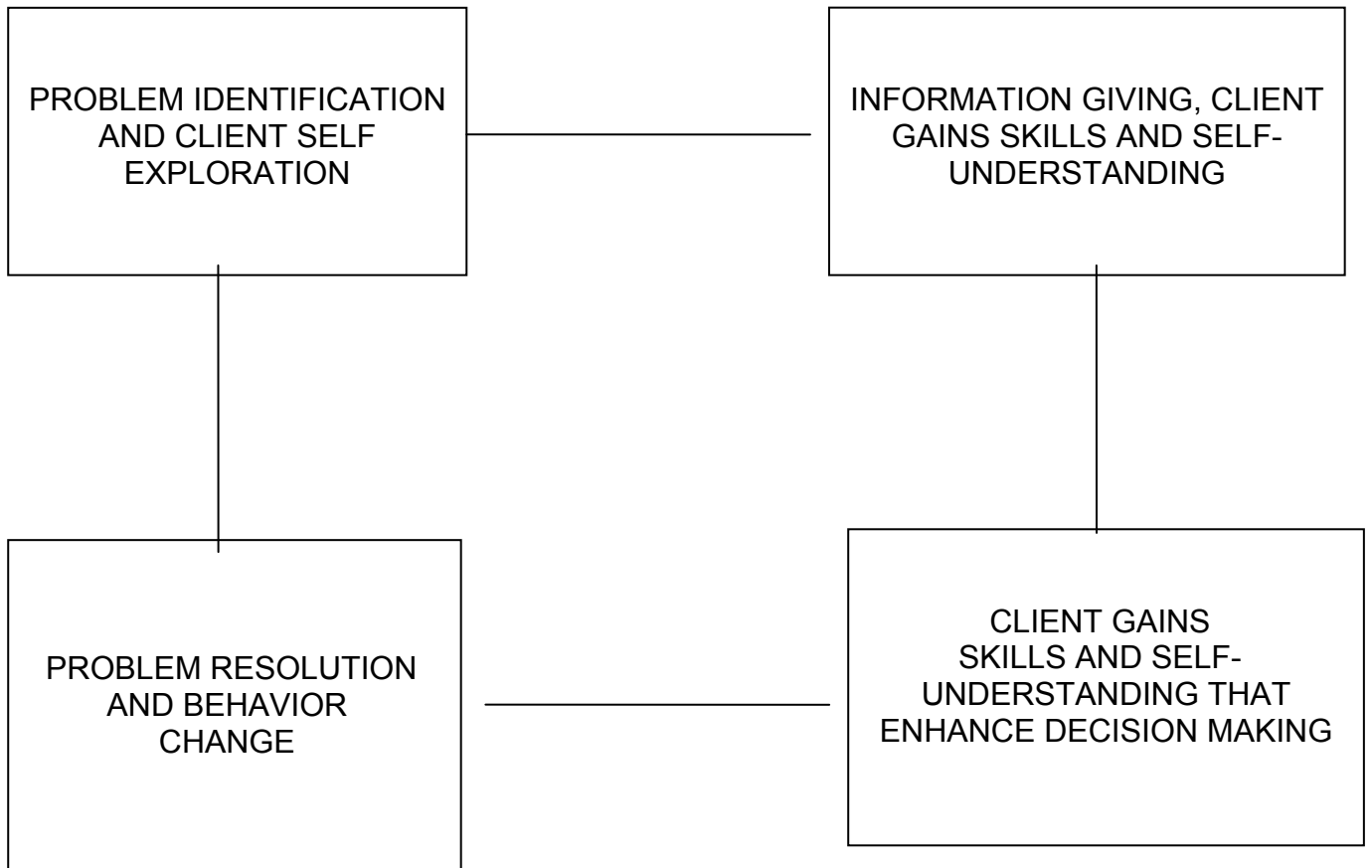
- a. to offer psychological and social support so that people are able to cope with HIV/AIDS related problems
- b. to empower the infected and affected persons to live in a positive manner
- c. to help clients appreciate the need for positive behaviour change

The counselling process

The counselling process describes what happens in a counselling session. In general the process includes the following:

1. Problem identification and client self-exploration: for any meaningful change to occur in counselling, clients must be willing to talk about and explore their feelings towards the problem.
2. Just talking about a problem does not necessarily lead to behaviour change. Therefore an individual needs to integrate in a meaningful pattern information gained about the self. The increased insight, knowledge and skills help the individual to initiate behaviour change.
3. Behaviour change: the final goal of counselling intervention is behaviour change that leads to positive living.

Illustration of the counselling process :



- a. As a group discuss answers to the following question: If you were to seek counselling, what qualities would you like your counsellor to possess?
- b. Using the list of qualities generated, discuss the importance of each one in a counselling relationship.

PART B : SUBJECT CONTENT

BASIC COUNSELLING SKILLS

Counselling like any other profession calls for special tools for the professionals to effectively deliver the required service. Since counselling is an interpersonal helping procedure which begins with client exploration for the purpose of identifying client's problems, the counsellor uses special techniques to help the client solve his/her problems.

Definition

Counselling skills or techniques refer to the art which the counsellor must develop to effectively conduct a counselling session. It is these skills and techniques derived from behavioural sciences that distinguish counselling from many other communication oriented professions. The skills can be grouped into four broad categories namely: relationship building, information gathering, information giving and specialised skills.

Relationship building skills

Relationship building skills are skills that enable the counsellor to build a positive relationship with the client. The positive relationship is an important pre-condition for the counselling process to be effective

Information gathering skills

Information gathering skills are those that enable the counsellor to explore and understand all the details about the client's problem.

Information giving skills

Information giving skills are those that help the counsellor to give, repeat, reinforce and explain information to the client in simple and clear language. The skills also enable

the counsellor to give client time to process the information and to check whether the client has understood the information

Specialised skills

Specialised skills are those that help the counsellor to deal with a specific client's need e.g. para-suicide, marital problems etc.

The following are examples of some of the techniques and how they are used in a counselling session:

VERBAL TECHNIQUES

1. **Information giving** - this refers to the counsellor's act of sharing timely and meaningfully verbal information for behaviour change and self-improvement of the client.

Example:

Client:

Everything is going wrong at once; I was found HIV positive, and when I told my husband he kicked me out of the house. Furthermore, my son is also very sick. What can I do with all these problems and no money? Is there any help anywhere?

Counsellor:

There are several places that may give free service such as WASN and Social welfare. I will be happy to assist you in getting help from these organisations.

2. Questioning - this is a technique that requires either a closed-ended answer or an open-ended answer. It is one of the most popular and essential counselling techniques and is applicable to a wide variety of counselling situations. Where and when appropriate, the counsellor should use open-ended questions introduced by words such as "how" and "what" for the purpose of getting a generous amount of information while giving the client the flexibility of response.

Example:

Closed-ended question

Counsellor: Are you suspecting that you might be HIV positive?

Client: No

Open-ended question

Counsellor: What happened after you told your wife that you were HIV positive?

Client: She didn't believe me. She thought I just wanted her to leave me so that I could marry another woman that I have been going out with.

3. Reflection - this is the technique wherein the counsellor mirrors what the client is feeling or saying during that moment. This could be reflection of feeling, content, general theme of comments made by client. Reflection allows the counsellor to be a sounding board or reflecting mirror whereby the client can receive feedback in the process of integrating disorganised or incongruent behaviour and gain self-understanding.

Example:

Client: I've literally led a reckless life and now I have nothing to show for it.

Counsellor: I sort of sense that you have a feeling of regret and shame

4. Reassurance - this is a counselling technique that communicates a tone of support, comfort, encouragement, acceptance, and/or reinforcement to the client. It helps the client to relax, reduce anxiety, and assure the client that life

will return to a normal state again.

Example:

Client: I just can't go on in this condition. What is there to live for when I am HIV positive and have just lost one of my children?

Counsellor: You can, being HIV positive does not mean the end of the world. You can live for many years, there are others you must live for and others who are living for you - your other children)

5. **Restatement** - this refers to an actual restating of the meaning or feeling of the client as the client has expressed it. Restatement is a specific form of reflection which uses verbatim language of the client.

Example:

Client: Come what may, I am not going to tell my husband that I am HIV positive.

Counsellor: You are saying, "come what may, I am not going to tell my husband that I am HIV positive".

6. **Clarification** - this is a technique that calls for the client to clarify his/her position by providing additional information or rewording the comment.

Example:

Client: I am stuck

Counsellor: When you say you are stuck, what exactly are you saying?

7. **Probing** - this is the use of a series of questions and/or statements that elicit specific answers.

Example:

Counsellor: How are things now? what does your mother in-law say?

8. **Confrontation** - this is a verbal technique that raises questions or presents feedback in order to bring the client face-to-face with a denied feeling,

resistance, or personal conflict

Counsellor: You say you have two wives and have been engaging in casual sex without condoms on your trips to Johannesburg. Do you realise that you are being selfish and placing yourself and your two wives at risk of HIV infection?

9. **Teaching** - Providing information, understanding and re-education in regard to illogical beliefs; helping the client to re-think and meet his/her needs in realistic and responsible ways
10. **Role reversal** - client is asked to play the role of another person or one that is opposite to that of his/her natural behaviour e.g. Suppose you were the wife, how would you relate to your HIV positive husband?
11. **Summarising** - this technique is used by the counsellor to bring together relevant, fragmented material that has been disclosed by the client during the counselling session to provide feedback to the client in terms of feelings and thoughts. It can be used (a) at the opening of the counselling session to summarise the previous meeting and thus provide continuity between counselling sessions, (b) at any appropriate point in the counselling session in order to put things into perspective and (c) at the end of a counselling session to bring the session to a close.
12. **Paraphrasing** - means restating in your own words what the client has said
13. **Partialisation** - counsellor separates presenting problem into parts to be focused on
14. **Leading** - refers to the extent to which counsellor guides the client
15. **Questioning Skills**
 - tone of voice
 - timing
 - frequency

- types: closed, open, leading

16. Relationship building

Skills such as physical gestures, the welcome, the introductions etc.

17. Acceptance

be non - judgmental

18. Observation Skills (Eye best tool for observation)

NON-VERBAL TECHNIQUES

- 1. Listening** - this is a skill that requires attentive use of sense of hearing along with support of other senses. Listen to what is said, what is hinted and what is not discussed and give the client feedback to let the client know that you are accurately listening to and perceiving the conveyed message.

2. **Para-linguistic cues** - these are non-verbal behaviours that qualify how a word or verbal message is sent or received e.g. tone of voice, spacing of words, emphasis, inflection (pitch/loudness, pauses, and various uttered sounds). The counsellor should pay attention and comment on them to get client to clarify the meaning.
3. **Silence**
4. **Posture or body position**
5. **Facial expressions**

THE COUNSELLING RELATIONSHIP

While counselling techniques enable the counsellor to help the client resolve his/her problems, this is only possible when a good therapeutic relationship has been established. For best therapeutic relationship counsellors should have the following qualities.

1. **Self-confidence** - this needs no explanation, it is simply a function of ones knowledge and skills of the process as well as a sense of "together". This attribute comes with training and practice.
2. **Empathy** - this can be defined as the counsellor's ability to assume in as far as is possible, the internal world of the client i.e. to perceive the world as the client sees it and to perceive the client as he/she perceives himself/herself. This must not be confused with sympathy which means that one person identifies with and shares the feelings of another.
3. **Acceptance** - this means that there are no reservations, conditions, evaluations and judgements of the client's feelings, but rather a total positive regard for the client as a person of value. N.B. Acceptance does not imply approval of specific behaviours.
4. **Genuineness** - being at one with oneself. It is synonymous with realness, honesty or authenticity i.e. a genuine counsellor employs no facades. Counsellors are not "salespersons" portraying a front of friendliness in order to

sell their goods.

5. **Trustworthiness** - trust is the first step toward establishing an effective relationship. When clients believe in and trust the counsellor, the client shares more and gets more involved in the counselling relationship.
6. **Confidentiality** - this is the **cornerstone** of any counselling relationship. No genuine therapy can occur unless clients trust the privacy of their revelations to their counsellors. **Counsellor's should however define the degree of confidentiality that can be promised, as there are times when confidential information can be divulged.**
7. **Competence** - training and education in counselling principles and skills influences the client's perceptions of the counsellor. Research shows that counsellors perceived as experts in their field (counselling) are viewed as more competent and more effective than those perceived as non experts.

When these qualities are perceived in the counsellor, then the client feels secure and trusts the counsellor enough to engage in self exploration.

CHAPTER FIVE

STAGES OF COUNSELLING

Part A : TRAINING METHOD

Step I Role play 40 Minutes

1. Restate the working definition of counselling formulated in the previous session.
2. Split the participants into 3 or 4 groups and ask the groups to role play the counselling process involving the given case outlined below.
3. Non acting participants should note observations on the process and issues involved in each counselling session

CASE STUDY

Tim who was single then developed herpes about 8 years ago which was treated and cleared. Tim now married with a nine month old baby has again developed herpes. Tim does not understand what is happening and is worried about his wife and child. He has not told his wife that he has herpes. He has not had sex with his wife for the last three months always giving excuses that he is not feeling well. Because of this state of affairs, Tim has started coming home late in a drunken state and his wife thinks he is seeing someone. Tim's wife has come to you for counselling.

Instructions:

Read this case study and role play the counselling session you would have with Tim's wife.

Step II: Group reports and discussion 40 minutes

- a. Use observations made to trigger discussion about the stages of counselling.
- b. Using Table 1 given at the end of this chapter, list the main stages of counselling and skills appropriate for each stage.
- c. Conclude the session by presenting a summary of the stages and appropriate

skills for each stage as described in Table 2 at the end of this chapter.

PART B : SUBJECT CONTENT

STAGES OF COUNSELLING

The counselling process can be divided into three stages as outlined below. However, there is no fixed time or number of sessions required to complete each stage.

Beginning stage or relationship building stage

This is the stage/condition that influences the course of the counselling process. The initial interview is the first time the client and counsellor are meeting, it is also the session that will influence the client's decision whether or not to come back for the next counselling session. The counsellor should take the opportunity to assure the client of confidentiality and trust. Counselling then proceeds with history taking and exploration of client's problem and how the client feels about it. With the information obtained, the counsellor starts to work with the client to prepare a plan of action. Preparing an action plan includes:

- * finding out how the client would like the problem to be solved
- * determining what the client thinks should be done to manage the problem
- * clarifying what the client expects from counselling
- * describing the help that the counsellor can offer, giving realistic hope for change or assistance, and discussing the reasons for any limits on help
- * establishing long-term and short-term plans
- * stating the counsellor's commitment to working with the client

Effective counselling techniques

Active listening, attending, observing, reflection, empathising, respecting, recognising, encouraging, reassuring, questioning.

Middle stage or information gathering stage

When the client is sure that the counsellor can be trusted, and will provide information, guidance and support, the counselling enters the middle stage where the plan of action is put into practice. During this stage of information gathering the counsellor should:

- * support the continuing expression and discussion of feelings
- * refer to available formal and informal resources
- * monitor progress and modify plans as necessary
- * promote the continuation of changes in behaviour
- * help the person to move towards acceptance and control

Effective counselling techniques

The same skills as used in the beginning stage including encouraging, information giving, connecting, challenging, repeating, motivating, summarising, probing, teaching, role play, role reversal, questioning, structuring, clarifying, paraphrasing, emphasising, re-framing, coping reframe, commenting on the process.

End stage

After the client has shown willingness to participate in formulating and carrying through plans, counselling enters the end stage. The counsellor should help the client to summarise the presenting problem or the day's session and provide the client with some framework to work on before the next session. The counsellor should end the relationship only when it is clear that the client:

- * can cope with and adequately plan for day-to-day functioning
- * has a support system such as family, friends and support groups to help them carry through their plan of action

Terminal interview

Even though there is no time schedule for counselling, at some point, counselling has to end. This is often very difficult for clients who have built a close relationship with their counsellor. The thought of ending the counselling relationship may be painful for both client and counsellor. For this reason the ending should be carefully and gradually planned in order to

- * prepare the end of the counselling relationship
- * ensure maintenance of coping skills
- * assure client of continuing help with handling future problems in the family or work place associated with the client's condition
- * review plans for the management of illness and care of survivors
- * make sure that all needed and available resources have been identified and are

being used.

Effective counselling techniques

Summarising, clarifying, homework, teaching, referring, information giving.

Step II Table 1:

FUNCTION	APPROPRIATE STAGE	APPROPRIATE SKILLS
RELATIONSHIP BUILDING		
INFORMATION GATHERING		
INFORMATION GIVING		

Table 2: Summary of the stages of counselling and the counselling skills that are appropriate at each stage.

FUNCTION	EXAMPLES	STAGE WHERE APPROPRIATE
Relationship building skills (Beginning stage)	Trustworthy, empathy, genuine, acceptance, confidence, confidentiality, reassurance, non judgmental, warmth	First stage
Information gathering (Middle stage)	questioning, clarification restatement, probing, summarising, confrontation, para-linguistic cues, posture and body position, silence, active listening	Middle stage
Information giving and formulation of action plan (End stage)	silence, summarising, repeating emphasising, reframe, clarifying, teaching, paraphrasing, role play	End stage

CHAPTER SIX

PSYCHO SOCIAL ASPECTS OF HIV/AIDS

Part A : TRAINING METHOD

Step I Introduce the topic and outline the objectives below 15 Minutes

OBJECTIVES

By the end of the session participants should be able to

- * identify the major psycho social reactions that HIV positive individuals may go through.
- * help participants understand how to deal with the various reactions in the counselling process.

Step II Brainstorming 15 Minutes

- a. Split participants into three groups.
- b. Ask each group to brainstorm on feelings and reactions that an individual may go through on being diagnosed HIV positive.

Step III Group presentations 60 Minutes

- a. At the end of the brainstorming session, ask each group to present their findings
- b. Summarise the reactions and feelings identified.

Step IV Plenary discussion 60 Minutes

- a. Discuss each of the reactions and feelings as outlined in the subject content of this training guide
- b. Brainstorm how counsellors can handle these reactions in a counselling session.

PART B : SUBJECT CONTENT

Introduction

As the HIV infection is fatal, being diagnosed HIV positive can create varying psychological reactions in the individual. Counsellors should therefore be aware of these reactions and be able to identify and handle them. The central goal of HIV/AIDS counselling is to help the clients work through these psychological reactions till they accept their condition. It is only after clients accept their HIV status that they will be able to handle it in a more positive manner. The following are some of the possible reactions:

SHOCK

Shock is usually characterised by

- * silence, numbness, disbelief
- * despair and withdrawal

ANXIETY

Anxiety is an uncomfortable feeling of tension or fear occurring as a reaction to perceived threat to one's body, integrity, self concept etc. Anxiety can manifest itself in physical as well as behavioural symptoms.

Physical symptoms: elevated blood pressure, muscle tension, upset stomach, changes in appetite, urinary frequency, tension headaches etc.

Behavioural symptoms: Decreased productivity, inability to concentrate, increased use of alcohol, drugs and smoking, loss of interest in usual activities, lethargy, absenteeism from work etc.

DENIAL

Denial is failure to acknowledge the occurrence of some life threatening illness such as HIV infection. Clients diagnosed of HIV infection may say "this cannot happen to me" (as a sign of denial). Other signs of denial may be :

- * shopping around syndrome
- * ignoring early signs of illness
- * ignoring positive blood test results

ANGER

Anger is a strong feeling of displeasure over an event, usually expressed after the initial shock of receiving HIV positive blood test results. It may be directed at a sexual partner or oneself for having indulged in high-risk behaviours. The following behaviours could be manifestations of anger:

- * deliberate effort to spread the virus to others
- * abusive language
- * abuse of alcohol or drugs
- * cursing God, friends or family members

GUILT

The fact that HIV is related to lifestyles, it causes self-examination of one's past lifestyle evoking feelings of guilt. Client can see HIV infection as punishment from God.

DEPRESSION

The realisation that one is infected with the HIV virus can invoke feelings of powerlessness, loss of personal control, loss of one's physical and cognitive functioning. All these feelings can result in depression which may manifest itself in any of the following:

fatigue, decreased energy levels, loss of memory, weight loss, decreased social interaction, decreased libido, feelings of worthlessness, diminished ability to concentrate, insomnia etc.

HYPOCHONDRIA

Hypochondria is an exaggerated concern over one's health

BARGAINING

Bargaining is a realisation that death due to the HIV infection is imminent. Such realisation may lead an individual to make efforts to prolong life through:

- * prayer and appealing for magical power
- * seeking any form of healing such as traditional healing or faith healing
- * performing cultural rituals to appease the spirits

ACCEPTANCE

Acceptance is the realisation that

- * one's condition is inevitable.
- * there is no cure.
- * the infection is permanent and the individual has to live with it. Acceptance relieves pressure and anxiety and enables the individual to find ways of coping with the infection in a more positive manner.

CHAPTER SEVEN

HIV/AIDS COUNSELLING

PART A : Training methods

PART ONE Pre-test counselling

Step I **Outline the objectives of this session** **15 minutes**

Objectives

By the end of the training participants should be able to:

- * define Pre-test counselling
- * list the aims of Pre-test Counselling
- * state when Pre-test Counselling is offered
- * tabulate the information to be covered in a pre-test counselling session
- * demonstrate Pre-test Counselling through role plays

Step II **Brainstorming** **60 Minutes**

1. Begin by asking the following questions:
 - (a) What is pre-test counselling?
 - (b) What issues should be covered in pre-test counselling?
2. Write all the responses to each question on a flip chart.
3. Discuss each response.
4. Conclude the discussion by
 - a. formulating the definition of pre-test counselling .
 - b. summarising the issues that need to be discussed with a client in a pre-test counselling session.

Step III **Role plays** **60 Minutes**

1. Ask for volunteers to role play a pre-test counselling session while the rest of the participants observe.
2. At the end of the role play, ask the counsellor and client how they felt.
3. Ask other participants for their comments and observations of the counselling process
4. Repeat role plays with different sets of volunteers to give as many people as

possible a chance to practice counselling

PART TWO Post - test counselling

Step I **Objectives** **15 minutes**

By the end of the session participants should be able

1. to define Post Test Counselling
2. to demonstrate how to give results
3. to list at least 6 Psychological reactions that may be experienced following a positive result
4. to deliver post-test Counselling to both HIV positive and HIV negative individuals
5. give information related to test results and HIV/AIDS

Step II **Brainstorming** **60 Minutes**

1. Begin by asking the following questions:
 - (a) What is post-test counselling?
 - (b) What issues should be covered in post-test counselling?
2. Write all the responses to each question on flip chart.
3. Discuss each response.
4. Conclude the discussion by
 - a. formulating the definition of pre-test counselling
 - b. summarising issues to be discussed with the client in post test counselling.

Step III **Role plays** **60 Minutes**

1. Ask for volunteers to role play a post-test counselling session while the rest of the participants observe.
2. At the end of the role play, ask the model counsellor and client how they felt.
3. Ask other participants for their comments and observations of the counselling process.
4. Repeat role play with different sets of volunteers to give as many people as possible a chance to practice counselling

PART THREE SUPPORTIVE COUNSELLING

Training method

Step I Objectives 15 minutes

By the end of the lesson participants should be able to

- * define Supportive Counselling
- * identify cases that might need supportive Counselling

Step II Group work 40 minutes

1. Split participants into groups of 4 or 5 people.
2. Ask each group to list as many situations as possible that might require supportive counselling.
3. Ask each group to formulate a case study around any one of the situations.

Step III

Role plays

60 Minutes

1. After about 40 minutes call participants back to plenary.
2. Collect each group's case study and put these cases in a basket.
3. Ask one member from each group to pick one case from the basket.
4. Call the groups one at a time to role play the case picked from the basket while the rest of the participants observe.
5. At the end of each role play, discuss all the observations made.
6. Conclude the session by summarising all the possible situations likely to require supportive counselling and list them on flip chart.

PART B: SUBJECT CONTENT

PRETEST COUNSELLING

Pre - test counselling is counselling offered to clients before taking an HIV test. This involves setting a supportive, non judgmental and caring environment in which the client will feel free to talk about HIV testing. The following areas should be covered in a pre-test counselling session:

- a. Previous client's history of HIV counselling and testing.
- b. Why the test is being requested
- c. HIV transmission and prevention
- d. Risk assessment
 - * History of STDs
 - * history of drug use
 - * has client received blood in the past
 - * exposure to invasive procedures
- e. Description of the test
 - * Elisa and Western blot tests
 - * window period
- f. Possible implications of either positive or negative results
- g. Disclosure of results to partner and significant others
- h. History of handling crisis situations
- i. Available resources for support
- j. Does the client still want to be tested
- k. emphasis on safer sexual practice
- l. assure easy access to further counselling whenever needed
- m. provision of relevant reading material on HIV/AIDS

POST-TEST COUNSELLING

Post - test counselling is counselling given to clients coming to receive their test results. The client should receive test results in person. The following areas should be addressed during post-test counselling

- a. ascertain before providing the results if the client is ready to receive the results

- b. Reassure the client of the confidentiality of the results.
- c. disclose the results and check if the client has understood the results
- d. allow for emotional expression
- e. discuss personal, family, and social implications of the results
- f. discuss disclosure of results to partner(s) and significant others
- g. discuss what the client is going to do now and whom they are going to tell, why and when?
- h. give information on available community support resources e.g. support groups
- i. assure easy access to further counselling sessions
- j. give practical information for people living with HIV and emphasise
 - use of condoms
 - client should not donate blood or body organs
 - infection control at home
 - diet and nutrition
 - importance of seeking medical attention promptly when not feeling well.
 - that treatments for some of the infections are available, therefore it is important for HIV positive clients to keep contact with the medical care system

Be prepared to deal with the client's emotions which may include: disbelief, anxiety, anger, guilt, depression, apathy, fear of death

Sero negative

Explain and discuss

- a. the meaning of negative results
- b. the window period and the need for a retest
- c. possibility of infection after negative results
- d. risk reduction
- e. provide literature on HIV transmission and prevention.
- f. assure accessibility for further counselling if client wants.

Sero positive

If the client is distressed:

- * stay with the client and respond to the situation and listen to the client's

concerns and help sort out the issues

- * help identify coping mechanisms used in other crisis situations
- * if necessary, call for assistance from a mental health professional
- * provide telephone number for 24 hour crisis hot-lines such as the "Samaritans"
- * discuss the client's feelings about the test results and how the client hopes to handle the information during the next 48 hours and thereafter
- * remind the client about supports identified in the pre-test session. Ask who the client can talk to about the test result, such as a family member, friend, mental health professional or a member of the clergy. If the client identifies someone discuss how the patient might tell that person and what the reaction might be
- * Provide the client with referrals for emotional support e.g. support groups

Discuss the meaning of positive test results emphasising the following points:

- * a positive result does not mean that the client has AIDS
- * Laboratory tests can tell how the immune system is functioning and show if HIV related infections are present
- * Treatments are available that may slow down the progression of the infection and prevent some infections
- * a positive result may mean that partners and children could be infected with HIV. Encourage client to refer partners and children for HIV testing and medical evaluations and counselling referrals for partners and children
- * if client is pregnant, it does not mean that the baby is infected with HIV (research shows that 30 - 50 % of babies born to infected mothers are themselves infected.
- * Women who are considering future pregnancies should consult their doctor who will be able to review reproductive options
- * Although the client may not have any signs or symptoms of HIV infection, the client has the virus and can transmit infection to others.
- * Refrain from risky behaviours
- * Advise clients on their rights
- * Let clients talk about how they feel

CHAPTER EIGHT

TYPES OF COUNSELLING IN HIV/AIDS

PART A : Training Method

Step I **Introduction and objectives** **10 Minutes**

Present on flip chart or transparency the objectives of this session as outlined below.

By the end of this session participants should be able to

- * define crisis , preventive, supportive and family counselling
- * identify cases requiring crisis and preventive Counselling
- * demonstrate crisis and preventive Counselling

STEP II **BRAINSTORMING** **60 Minutes**

1. Ask participants why people go for counselling or under what situations do individuals seek counselling?
2. Write all the given suggestions on the flip board.
3. Use the suggestions given to identify the different types of counselling
4. Summarise and list the various types of counselling as outlined in the training manual.

Step III **BRAINSTORMING** **30 Minutes**

1. Ask the following questions:
 - a. When is a situation regarded as a " crisis?"
 - b. Who needs preventive counselling ?
2. List all the suggestions on the flip board

1. Split participants into small groups.
2. Using the suggested responses, ask half of the groups to design an HIV/AIDS related case for crisis counselling and the other half a preventive counselling case.
3. After about 30 minutes, call all groups back.
4. Ask each group to role play their case while the rest of the participants observe.
5. At the end of all the role plays, list all the important aspects of crisis and preventive counselling.
6. Conclude the session by summarising the important issues as outlined in the training manual.

PART B : SUBJECT CONTENT

Crisis Counselling

Crisis counselling focuses on the client's feelings and accepts the client's own definitions. The counsellor should not play down its seriousness. Regardless of the nature of the crisis, the counsellor needs to accept the situation, remain calm and maintain self-assurance. This type of confidence can help reduce the anxiety on the part of the client. Crisis counselling is most often used because of the threat that HIV/AIDS poses to survival and the social stigma involved. An emotional crisis exists when a person feels:

- * intense fear
- * completely surprised and caught unawares by whatever is happening
- * emotionally disturbed as a result of loss of control
- * because there does not seem to be any solution to the problem, all efforts to resolve the crisis seem hopeless

Basic guidelines for intervention

- * Remain calm and stable
- * If possible, remove the client from the crisis situation and provide a place for her/him to relax and compose her/himself.
- * Allow client full opportunity to speak freely and to ventilate their feelings.
- * Avoid interrupting the client while she/he is talking.
- * Deal with the immediate situation rather than its underlying unconscious causes that may be left for later.
- * Check whether the client shows decision-making ability, or gives an impression of feelings of helplessness, hopelessness and loss of control
- * Encourage the client to relax tell what is bothering her/him
- * Help the client to see their crisis as temporary rather than chronic.
- * clarify what the client regards as the crisis and agree on a course of action to resolve or ease the crisis
- * start to work on one aspect of the crisis, preferably one that can be more easily dealt with. This fosters confidence to deal with more difficult aspects of the problem
- * As much as possible, obtain information from others who may be aware of your client's situation and who may supply information that may be helpful in intervention
- * Have readily available local resources to assist you(the counsellor) e.g. community, medical, legal

DONT'S

- * Don't try to "cheer up" the client, to tell him/her that his/her problems are not as bad as they seem
- * Don't ask the suicidal client to abandon her/his plans.
- * Don't attempt to solve the total personality adjustment difficulty.
- * Don't argue with the client

Preventive counselling

Preventive counselling is counselling aimed at preventing being infected with HIV and preventing its transmission to other people. Preventive counselling is often divided into primary and secondary depending on the stage and status of the infection.

1. Primary prevention

Primary prevention is specifically for clients who are at risk and not known to be infected. They may not know that they are at risk. Commercial sex workers and STD patients are groups of clients relevant for primary preventive counselling.

2. Secondary prevention

Secondary prevention is considered likely for clients known to be HIV infected or likely to be HIV infected. The emphasis is on behaviour change that will prevent transmission of HIV to others. The focus is on the need for infected clients to recognise their responsibility for the health and welfare of those they have sexual contact with. The following are the main areas to be explored in preventive counselling:

- * client's knowledge of basic facts on HIV/AIDS and how they personally affect the client's behaviour
- * determine whether the behaviour of an individual or group of individuals involves a high risk of HIV infection
- * work with the people concerned to help them understand and acknowledge the risks associated with their behaviour
- * define with them how their life-style and self-image are linked to this behaviour
- * help individuals define their potential for changing behaviour
- * work with individuals to introduce and sustain the modified behaviour.

Supportive counselling

People with HIV face many problems. They constantly need emotional and practical support. They may experience anxiety, financial problems, loss of relationships, loss of housing, etc. Supportive counselling will focus on a number of issues, depending on the problems being presented by an HIV client viz:

- a. help client plan on how best to manage their problems
- b. help client realise and mobilise resources for their benefit.
- c. help client appreciate aspects of their lives or strengths they might otherwise overlook.
- e. help them resume authority over their lives.
- f. help clients react positively when problems arise.
- g. help them develop skills for problem solving and decision making.

Supportive counselling is actively a process of empowering HIV positive clients and those affected to live positively with HIV/AIDS.

Family counselling

Since the family is the primary group from which each of us derives meaning and is the context in which most of us live (Becvar and Becvar,1988), the family becomes a very important source of support for the individual who comes for counselling. Many people come to counselling as individuals, however, counsellors should consider the individual as part of a family system which can provide some of the solutions to the client's problem. Therefore family counselling often requires the participation of other members of the family in the counselling session. Skills such as widening the system, circular linking questions, re-framing, use of the genogram together with all the usual counselling skills do enable the counsellor to explore with the client, sources of support within the family system.

CHAPTER NINE

CULTURAL AND ETHICAL ISSUES IN COUNSELLING

PART A : Training Method

Step I

5 Minutes

By the end of the session participants should be able to

- a. appreciate that different people hold different values
- b. understand that their clients can come from different cultures, race, religion etc.
- c. appreciate that as counsellors they should respect clients regardless of their culture, race, religion etc.

Step II

30 Minutes

1. Designate three areas of the room to be called: STRONGLY AGREE, AGREE, STRONGLY DISAGREE, DISAGREE.
2. Explain to the group that you will read out a list of statements one at a time. Each person must listen carefully and decide how they feel about each statement and then move to the appropriate area of the room.
3. Read the statements (**see appendix III**) . Once the group has moved to their chosen place, ask volunteers from each area to share their feelings on why they chose the area where they are.
4. Repeat this procedure for as many statements as time permits.
5. At the end of the exercise, explain why it is important for counsellors to be clear about their own values and that other people may have different values. (for further details refer to training guide).

Step III

GROUP WORK

30 Minutes

1. Split participants into 3 groups.
2. Present each group with case studies that follow.
3. After about 30 minutes, call the groups back to plenary.

Step IV **GROUP PRESENTATIONS AND DISCUSSION** **60 Minutes**

1. Ask each group to present its conclusions.
2. End the session by summarising and listing the major ethical and cultural issues raised in each case.

Step V **PLENARY SESSION** **30 Minutes**

Discuss the legal issues regarding HIV/AIDS in Zimbabwe

CASE STUDIES

CASE STUDY ONE

Consider the issues in the following case and discuss the questions that follow:

You are doing an interview with a male client who tells you that he is bisexual. He was referred to you because he is experiencing a crisis after receiving test results indicating he is HIV positive, although he has no symptoms of AIDS. He lets you know that his wife is unaware of his occasional relationships with male friends, and under no circumstances does he intend to bring up this subject with her. He also has no intention of disclosing his HIV status to her. He tells you that if she is going to be infected, the damage has already been done. What's the point of letting her know about the test results? It would only cause her extreme agony.

At the same time, I don't know how she is going to handle knowing that I have had sexual relations with men over the past few years. It would mean the end of our marriage and the break up of our whole family. I can't handle all that stress now on top of what I just found out about my HIV status.

QUESTIONS FOR DISCUSSION

1. Does this man present danger to his wife?
2. Do you have a duty to warn and protect the wife?
3. Would you be inclined to push him to inform his wife, even though he is very opposed to this idea?
4. Would you tell him that you have a duty to break confidentiality because he

poses a danger to others, especially to his wife?

5. Would the fact that a warning might be too late to be effective, influence your interventions?
6. What do you see as being the central ethical and cultural issues in this case?

CASE STUDY TWO

A 15 year old girl from a nearby high school came to you in confidence for counselling two weeks ago. In the last session the girl requested for an HIV test, the results of which you just received today. The test is positive and the girl is scheduled to see you tomorrow. Before taking the test, she told you in no uncertain terms that if her test results turn out to be positive, she would kill herself. Are you obliged to reveal this information to her guardians. What are you going to tell your client? What are the legal and ethical issues involved here? How are you going to handle the whole case?

CASE STUDY THREE

You are working in a community health care centre that provides testing and counselling services for those at risk of being infected with HIV. What legal and ethical issues should your counsellors consider? Must counsellors violate confidentiality and force a client known to be HIV infected and believed to be sexually active with multiple partners to notify all partners involved?

PART B : SUBJECT CONTENT

CULTURAL ISSUES

Introduction

Counsellors like any other health professionals, are expected to provide service to all people irrespective of their race, culture, religion, or any other grouping. As such, counsellors need to be sensitive to the client's world (culture).

Counselling Vs conformity

Counselling is NOT pushing people to conform to certain "acceptable" standards to live by. Instead counselling is a process whereby clients are challenged to honestly evaluate their own values and then decide for themselves in what ways they will modify these values and their behaviour. Effective counselling must therefore take into account the impact of culture on client's perception of the world.

Culture Vs special groupings

Culture is simply, the values and behaviour shared by a group of individuals. Therefore, culture does not refer just to an ethnic or racial group but can also be determined by age, gender, life style or socio-economic status. Thus, counsellors should avoid being culturally "encapsulated" i.e. wrapped up in their own culture and clinging to their own beliefs and failing to recognise the client's world.

Culturally encapsulated counsellors

Such counsellors tend to:

- rely on stereotypes in making decisions about people

- ignore cultural differences among clients

- define reality according to their own set of cultural assumptions. Counsellors working with clients who are culturally different from them must develop a basic respect for these clients' experiential world. In short, counsellors should be culture sensitive if they are to effectively deliver their services. **Counsellors who truly respect their clients will show a willingness to learn from them.**

Ethical issues

By definition ethics refer to morals and rules of conduct regarding practice in any profession. In general ethical practices benefit the client while unethical practices are done for the counsellor's self interest at the expense of the client's health or safety. In general, in the practice of counselling the following are considered unethical practices:

- * breech of confidentiality i.e. disclosure of information shared in the counselling session to third parties who are not involved in the management of the client's case without client's consent.
- * infringing rights of clients e.g. forcing clients to take an HIV test.
- * use of tapes and counselling research without consent of client
- * discriminating clients on grounds of race, ethnic grouping, religion etc.
- * imposing own agenda, needs and values on the client
- * engaging in inappropriate relationship with the client.

All the above are regarded as unethical practices and may invoke legal action against counsellors by clients.

APPENDIX I

1.	Eve	Budala	21.	Salphina	Mashavakura
2.	R.D.	Chieza	22.	Daniel	Mukova
3.	Diana	Chigudu	23.	Linda	Musiyiwa
4.	J.	Chinguwa	24.	Chiratidzo	Mushayi
5.	E.	Dambanemweya	25.	Grace	Muzwuru
6.	Jane	Dadzie	26.	Amon	Mpofu
7.	Simukai	Dube	27.	F.S.	Mpala
8.	Sithembiso	Dube	28.	Rebecca	Mzite
9.	Jubilee D.	Gwatidzo	29.	Chipo	Ngwenya
10.	Eugene	Govere	30.	Victoria	Ndlovu
11.	Sam	Khosa	31.	Janet	Phiri
12.	Lawrence	Kupara	32.	Sithabisiwe	Sibanda
13.	Plaxcedes	Mahoboyo	33.	A.R.	Sibanda
14.	R.	Machipisa	34.	Miriam	Siziba
15.	Regis	Makoni	35.	T.S.	Tlou
16.	R.	Mashozhera	36.	Emma	Tshuma
17.	Dorothy	Mhlanga	37.	Phyllis	Wadi
18.	G.	Mutambanengwe	38.	Sinokutemba	Xaba
19.	Otilia	Mlingo	39.	Peter	Vhoko
20.	L. S.	Makanyire	40.	Ellen	Vengere

APPENDIX II

Has communication taken place in each of the following situations?

Write YES, NO, OR I DON'T KNOW, AT THE END OF EACH STATEMENT.

1. A PROSTITUTE ASKS AN HIV OUTREACH WORKER FOR CONDOMS AND THE WORKER GIVES HER SOME
2. A PROSTITUTE ASKS FOR AN HIV TEST AND THE RECEPTIONIST CONTINUES FILLING OUT HER FORMS WITHOUT TAKING ANY NOTICE OF HIM
3. AN HIV OUTREACH WORKER ADVERTISES THE AVAILABILITY OF HIV TESTING FOR IV-DRUG USERS AND THE CLINIC RECEIVES REQUESTS FOR MANY APPOINTMENTS FROM HEALTH CARE WORKERS
4. SOMEONE WATCHES A TRAFFIC LIGHT CHANGE FROM RED TO GREEN AND DECIDES TO CROSS THE ROAD
5. SOMEONE IS TOLD THAT THE HIV TEST IS POSITIVE
6. A COUNSELLOR TELLS A CLIENT THAT HE MUST USE CONDOMS AT EVERY SEXUAL ENCOUNTER
7. A DOG GROWLS AT ANOTHER AND THE OTHER DOG RUNS AWAY
8. AN HIV-INFECTED CLIENT EXTENDS HER HAND TO A PHYSICIAN, THE PHYSICIAN DOES NOT OFFER HIS HAND
9. A VILLAGER LOOKS AT A POSTER WITH A SKELETAL FACE WHICH SAYS "AIDS KILLS" AND HE FROWNS.
10. A DOCTOR TELLS HIS PATIENT THAT HE WOULDN'T HAVE CONTRACTED AIDS IF HE HADN'T BEEN SO PROMISCUOUS

11. AN AIDS EDUCATOR EXPLAINS ON A RADIO PROGRAM THE IMPORTANCE OF GETTING TESTED EARLY FOR HIV, AND A CALLER PHONES TO ASK THE LOCATION OF THE NEAREST TESTING SITE

12. MIMI TELLS HER HUSBAND WHO IS WATCHING THE AFRICA CUP SOCCER FINAL ON TV, THAT SHE AND HER BABY HAVE BOTH BEEN DIAGNOSED HIV POSITIVE AND THE HUSBAND REPLIES, “ THAT’S NICE DEAR”.

APPENDIX III

SOME VALUE - LOADED STATEMENTS

1. IT IS MY RIGHT TO DIE WHEN THE PAIN IS UNBEARABLE.
2. THERE IS NOTHING WRONG WITH EXTRA-MARITAL SEX AS LONG AS THE PARTIES INVOLVED ARE ADULTS.
- 3 DRUGS ARE A GOOD WAY OF RELAXING.
4. BEATING ONE'S SPOUSE IS AN ACCEPTABLE FORM OF DISCIPLINE.
5. THE CHOICE TO ABORT SHOULD BE LEFT TO THE WOMAN.
- 6 PROSTITUTES ARE RESPONSIBLE FOR SPREADING AIDS.
7. HIV POSITIVE BABIES SHOULD BE LEFT TO DIE SINCE THEY ARE GOING TO DIE ANYWAY.
8. TO ERADICATE HIV INFECTION, ALL HIV POSITIVE PEOPLE MUST BE QUARANTINED.
10. ALL HIV POSITIVE PEOPLE MUST NOTIFY THEIR PARTNERS AND FAMILIES.

N.B. The above statements are only a guide, the trainer is free to come up with more statements specific to particular needs of the trainees.

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