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AIDS PREVENTION COUNSELLING

A GUIDE FOR TRAINING IN THE CARIBBEAN



AIDSCOM

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(Academy for Educational Development)

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INTRODUCTION TO AIDS PREVENTION COUNSELLING TRAINING

Challenges to Counsellors and Educators

AIDS is a devastating disease. As increasing numbers of people are diagnosed with HIV infection and AIDS, more and more professionals, paraprofessionals and volunteers are being called upon to provide AIDS education and training. **Everyone brings specific skills, knowledge and experience to their work as an AIDS educator.** As a new skill and a developing discipline there are still many aspects of AIDS education to explore. For some people the priority will be to develop expertise as a trainer and educator, for others it will be to learn more about the medical, epidemiologic, psychosocial and prevention aspects of AIDS. For everyone there is a constant requirement to expand their understanding and awareness of personal, professional and cultural values and attitudes toward the sensitive issues emphasised by the AIDS epidemic.

The ultimate goal of AIDS prevention counselling training in the Caribbean is to stem the spread of HIV infection by educating the greatest number of people about AIDS and AIDS prevention. In trying to achieve this, counsellors and educators have a number of challenges.

First, they must contend with the large amount of AIDS information which continues to accumulate at a rapid rate. AIDS educators frequently feel overwhelmed in their attempts to keep up with this information, absorb it, and then translate it for others. Inevitably, educators may come to feel that there is too much information to present and too short a time to present it. It is helpful to remember however, that the basic AIDS prevention information has not changed significantly since the beginning of the epidemic.

Second, AIDS educators face the challenge of presenting complex information to others while also helping them to develop AIDS prevention skills and awareness. Many people feel frightened and threatened by the AIDS epidemic. It is important to go beyond the scientific information and address the particular concerns, feelings and reactions of the learners. Until their emotional responses are addressed, their ability to learn new information and skills will be blocked.

Third, AIDS prevention involves talking openly about intimate, sensitive and usually private matters related to sexual behaviour and drug use. Most Caribbean cultures do not approve of open discussion of these topics. Some of the behaviours may be culturally unacceptable or illegal. For AIDS prevention efforts to

succeed it is imperative that culturally acceptable ways are found to discuss these behaviours, so that people are encouraged to talk honestly about their risk for HIV infection. Prevention counsellors can be instrumental in this process by increasing both their own comfort level in discussing sexual and drug use matters and their ability to respond in a non-judgmental manner towards the client.

Fourth, acquiring new knowledge, skills and awareness about sensitive issues demands active participation from learners. Participatory learning may be unfamiliar, personally and culturally, as may be talking about personal attitudes, values and beliefs. As an AIDS educator you will need to assess the relevance, in the cultural context and to the target audience, of specific training activities and techniques. Trainers may need to adapt some of the learning activities described in this section to make them more relevant to the particular audience.

Fifth, a comprehensive AIDS prevention counselling training will comprise a broad range of topics related to basic AIDS information, the cultural context for AIDS prevention, psychosocial issues, and counselling. Fourteen modules covering these general subjects are included in this section, from which trainers can make a selection according to their audience's needs, the time constraints and the availability of outside resources.

How To Use This Guide

This trainer's guide contains all the information you will need to plan and conduct an AIDS Prevention Counselling workshop. The materials have been designed to help you include cognitive and experiential learning into training sessions and to address attitudes and feelings of your colleagues related to AIDS.

This guide does not present just one type or just one suggested outline for a training workshop. Instead the guide helps you review and select different elements for a workshop -- one you can design especially for your particular audiences.

After general introductory remarks in Section I, Section II, "Planning Your Training: Getting Started," focuses on helping you in all aspects of designing and implementing your training. Read this section first, before you go on to the specific content areas of your workshop.

During your workshop you will want to include one or more of the "Training Modules" about AIDS and counselling -- these represent the bulk of the training guides -- and are contained in Section III. Each of these training modules includes a brief introduction, information to cover, sample training activities, and handouts where applicable.

Once you have a good idea of what would be helpful for your audience, you will want to draft a schedule or agenda. Section IV provides sample schedules geared to different amounts of time available.

Section V presents possible responses to difficult counselling situations. These suggestions will help you feel more comfortable coping with the possibility that "whatever can go wrong...will." And you can help your trainees deal with the difficult situations they may encounter.

Section VI provides a sample pre- and post-workshop questionnaire to gauge the level of knowledge and attitudes of your workshop participants related to AIDS and counselling. It also offers a sample evaluation form to give to your trainees to learn from them about the usefulness of the workshop.

Finally, Section VII is a discrete section which outlines a three-day Train-the-Trainer: AIDS Prevention Counselling Workshop. This section is useful for those of you who will be training others to be trainers.

In addition to this guide and the participants' resource materials, you will need several large pads of paper, different colored markers, an overhead projector (if available), a video player and a video about AIDS counselling and risk reduction (if available). If possible, the workshop room should include movable tables and chairs to help move from large group discussions to small group work.

Good luck with your training!

Introduction

This guide contains all the directions and advice you will need to plan, design, and conduct an AIDS Prevention Counselling workshop. The presentations in this guide have been developed, tested, and refined during workshops held during the last two years for health care providers from Caribbean countries. The information provided here will help you -- a health educator, trainer, or counsellor -- to conduct trainings for your colleagues and others who want to become more effective AIDS counsellors.

Each presentation outline, training activity, and discussion topic described in this guide has been used during several counselling workshops in the Caribbean. Health care workers have found these workshop activities helpful in learning more about how to instruct and counsel people worried about HIV infection and AIDS.

AIDS counselling skills and training have been identified as a priority for the National AIDS Control Programmes of countries throughout the Caribbean. CAREC and AIDSCOM sponsored the first regional training workshop on AIDS prevention counselling in July of 1988. Representatives from each of the CAREC member countries attended the workshop. A follow-up training workshop was held four months later. Since that time, several Caribbean countries have conducted national and district counselling workshops. A few countries have taken the next step in developing skills for national counselling programmes by training individuals who can later train others. This train-the-trainer approach is still being developed and refined in the region.

CAREC and AIDSCOM continue to work together to help increase the knowledge and skills of educators, counsellors, and other health care providers in the region by assisting with training workshops and by developing instructional guides like this one. As HIV continues to spread throughout the region and the impact of AIDS increasingly takes its toll on Caribbean populations, the skills that can be learned through prevention counselling workshops become even more important for improving national and regional health and well-being. The sponsors of this training guide hope it will help in this effort.

Acknowledgments

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The experiences of AIDS counsellors in the Caribbean and in North America contributed to the development of the presentations and training activities described in this guide. The information and materials that are part of this guide are intended for use in specific AIDS prevention counselling workshops; they can also be used by individuals who want to improve their counselling skills.

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This Training Guide Is For You If....

The purpose of this manual is to provide health educators with a practical guide to designing, implementing and evaluating AIDS prevention counselling training programs. This manual can be used by individuals conducting intensive AIDS prevention counselling and train-the-trainer workshops as well as brief educational programs. Although it is not designed specifically for those working one-to-one with people at risk for HIV infection or those working directly with people infected with HIV or diagnosed with AIDS, this manual contains relevant information which can be applied to individual or small group work.

So, this training guide is for you if...

- you are a professional, paraprofessional or volunteer who can provide training to other professionals, paraprofessionals, volunteers, students and the community at large.

Specifically, you will find the guide helpful if you work as a:

- physician.
- nurse.
- health educator.
- teacher.
- administrator.
- social worker.
- psychologist.
- psychiatrist.
- substance abuse specialist.
- community leader.
- volunteer AIDS educator.
- pastor.
- trainer.
- school guidance counsellor.
- district health visitor.

PLANNING YOUR TRAINING: GETTING STARTED

The Approach

The approach to AIDS education and training described in the following pages results from combining adult learning theory with extensive practice in AIDS training.

It is equally applicable whether you are conducting intensive AIDS prevention counselling workshops or you have the opportunity to educate individuals or small groups of staff members, educators, community members, students and others.

Effective AIDS educational programmes should incorporate learning which involves acquiring new knowledge, skills and attitudes while taking into account factors which adults need to learn.

Adult Learning

Adults **learn best** when they feel comfortable physically and psychologically, when they are treated as equals, when information is relevant to their experience and when they actively participate in the learning process.

Adults **retain information better** when it is presented in varied forms with opportunities to discover their own insights and practice new skills. Utilising a variety of teaching methods such as lecture, group discussion, experiential exercise, role-plays, case studies, visualisations, multi-media materials and writing will facilitate a positive learning experience.

Adults often approach new learning apprehensively because they feel that the potential for criticism and loss of self-esteem is high. It is your role as trainer to create an atmosphere of safety where people feel willing and able to take risks and explore new ideas, practice new skills and reveal personal biases. This is best accomplished by the trainer's conveying a feeling of openness, modelling behaviour which welcomes diversity and differing viewpoints and setting forth guidelines which can help to ensure a positive learning environment.

In summary, make sure trainees have the opportunity to:

- teach and share their own knowledge and experiences.
- learn in an atmosphere of mutual respect.
- learn through a variety of teaching methods.
- learn in an atmosphere that allows for diversity and differing viewpoints.
- discover their own insights and practice new skills.

Knowledge and Skills

Acquiring new knowledge and skills is an essential part of an AIDS prevention counselling training. In teaching new knowledge, it is important to use what is known about adult learning.

First, adults seek out educational experiences because they have a specific need or use for the information being sought. Although general information can be useful and important, ordinarily adults want to apply new knowledge or skills to their own real-life problems or situations.

Participants need opportunities to:

- utilise previously existing knowledge.
- learn, review, reinforce the relevant scientific information about AIDS/HIV.
- integrate new knowledge.
- apply knowledge to their particular experience.

Second, adults come to the training experience with a wealth of skills and life experiences. Your role as trainer and facilitator is to recognise and build upon the trainee group's collective wisdom, experience and skills as it relates to prevention counselling, and to assist participants to integrate new knowledge into their existing knowledge base.

Third, the understanding and application of new knowledge and skills takes time. **Within the training you should give trainees opportunities to:**

- develop new skills and/or practice existing skills (for example, answering difficult questions, motivating behaviour change).
- practice new skills.
- use current skills and knowledge.
- apply knowledge and skills to their particular experiences.

Attitudes and Feelings

Adults come to a training with well-established values and attitudes. Often AIDS challenges people to reconsider previously-held beliefs or to understand values and attitudes which differ from their own. Learning of this type is often integrated slowly.

As an AIDS prevention counsellor, you will need to feel comfortable about discussing sexuality and sexual behaviours, drug and alcohol abuse, fears of transmission, ethical dilemmas and other difficult subjects. Make sure you create the opportunity for trainees to reflect upon and understand their own reactions, feelings and limitations. The intent is not to challenge people's belief systems but to facilitate a deeper understanding of personal values.

During the training, fears and concerns will surface and these must be addressed. It is inevitable that trainees will have fears about HIV transmission. However irrational, these fears are significant and will not go away just by being countered with facts. It is important for trainers to acknowledge the fears, to allow them to be expressed and shared, and to help people to manage them.

Trainees often express fears and concerns about working with someone with a life-threatening illness or those whose sexual behaviours may differ from their own. To encourage a better understanding of these differences, trainers must provide the opportunity for trainees to learn about the psychological and social experiences of people with AIDS/HIV. This often works best with direct contact.

Dealing directly with HIV-infected people or people with AIDS helps to remove the barriers between "us" and "them" and eases trainees' fears about coming into contact with a life-threatening illness. Putting a human face on the AIDS epidemic gives the trainees the opportunity to understand the psychological and social experiences of people who may have quite different behaviour from their own. This particular approach to learning about AIDS/HIV has been used successfully in several counselling workshops in the Caribbean.

The training programme should enable trainees to:

- discuss their fears and concerns.
- identify and discuss personal feelings, reactions and values raised by AIDS.
- feel more comfortable about people with AIDS/HIV.
- explore viewpoints and values related to these issues.

NOTES ON ADULT LEARNING PRINCIPLES

1. Adults seek out educational experiences because they have a specific need or use for the information or skill being sought.
2. Adults want to apply new knowledge or skills to their own real life problems or situations.
3. Adults come to the training experience with a wealth of skills and life experiences.
4. The integration and application of new knowledge and skill requires time.
5. Adults have well-established values, attitudes and beliefs. Adults bring their various reactions and concerns regarding the topic to the training.
6. Adults need a physically and psychologically comfortable learning environment.
7. Adults learn best when they are treated as equals.
8. Adults learn best when they actively participate in their learning experience.
9. Adults retain information better when it is presented in varied forms, with opportunities for people to discover their own insights and practice new skills.
10. Adults often approach new learning apprehensively and feel that the potential for criticism and loss of self-esteem is high.

IDENTIFYING AND ASSESSING YOUR AUDIENCE

Identifying Your Audience

Before you develop the content and presentation of your AIDS prevention counselling you will need to identify your audience and then assess their learning needs.

This is the first step in designing the training. You may have the chance to choose your audience and in this case, you should decide the group size and establish the criteria for selection.

The ideal size for an intensive AIDS prevention counselling training would be 15 to 25 participants.

The criteria for selecting participants might be based on the following:

- relevant professional and educational experience.
- current employment and job duties.
- training experience and skill.
- AIDS/HIV knowledge and experience.
- interest in working with AIDS and AIDS/HIV prevention.
- comfort level with AIDS/HIV issues.
- mandate or suggestion of sponsoring organisation.

When you are asked to organise a training for a particular group, your audience is already identified. Your challenge will be to adapt or redesign an effective training when you may have little say in the group size, the training environment or the attendees.

Assessing Your Audience

The next step is to assess your audience's learning needs. This will help you to set clear and appropriate objectives, present information relevant to the experience and expertise of your audience, design targeted teaching strategies, and develop an evaluation plan. By conducting a needs assessment you can also enhance the learning process for participants -- you convey the message that learning is a joint effort and participants feel an increased commitment to the training because they have helped in planning it. The trainees will also gain an idea of what to expect from the training through the needs assessment process.

Trainers will need to gather the following information from trainees:

- *Why do they want to be trained?*
- *What are their professional roles/responsibilities?*
- *Who are their clients/audiences?*
- *How much do they know about AIDS/HIV?*
- *How much experience with AIDS/HIV do they have?*
- *How interested are they in dealing with AIDS/HIV?*
- *How relevant is their professional and educational experience?*
- *How comfortable are they in talking about AIDS-related matters?*
- *Do they have special areas of interest within the subject?*
- *Do they have specific AIDS-related fears and concerns?*

Needs assessment for an AIDS training can be done in three ways:

1. Needs Assessment Interview

This interview should be conducted with the person making the initial request for the training. To guide you, use a checklist of questions based on the list above. Write down the answers so that you have a record which can be shared with others.

Whenever possible, consult with others who will be attending the training. Alternatively, ask your contact to poll the trainees about their learning needs. Be clear and specific if you ask people to collect information for you.

2. Self-Assessment Questionnaire

This type of questionnaire is valuable in establishing how trainees estimate their own knowledge and skills in relation to AIDS prevention counselling. Ideally, they will complete it and return it prior to the training. If it is given out as the training begins, it can still be useful by providing you with information for modifying the training as you proceed.

3. On-Site Needs Assessment

Although common themes tend to occur in most AIDS training, it is still important to assess the participants' needs before you begin. A training activity is listed in the "How to Begin a Training" section which follows -- this describes asking the group at the outset to verbalise their expectations and learning needs. These are listed and reviewed with the group, and the trainer can indicate which can, and which cannot, be met by the training. It might also be possible to adjust the training to incorporate the newly-identified needs.

Who Else Should Be Consulted?

When prioritising the learning needs for a particular training, there may be a number of people whose views should be considered, for example, the individuals or institutions sponsoring the training, the Ministry of Health, or the funding agency.

What If You Cannot Meet Participants' Learning Needs?

Time constraints and diverse needs or interests are two typical reasons why every participant's learning needs are not met at a training. Often it is the conditions trainees experience in the work or community setting which provoke a need which is mentioned but cannot be remedied instantly. These frequently include:

- lack of funding.
- inadequate staffing.
- lack of community support.
- inadequate materials.
- lack of administrative support.

Although these are problems which cannot be solved during the training, it is critical that you acknowledge them and their impact on AIDS prevention counselling. In longer trainings attention should be directed towards strategies to resolve them.

There may be learning needs expressed which you, based on your experience as an AIDS educator, decide not to address. This may be because trainees have difficulty clarifying or articulating their needs. There may also be omissions in their assessment which you feel are vital to include.

Alternatively, your audience may have identified the need to learn detailed medical and epidemiological data. You may decide, based on the particular audience and time constraints, to include these topics but to limit the detail. Additionally, because AIDS can be such a volatile and threatening issue, participants may overlook key learning needs because they are masked by fear. When you are not sure how to proceed, use your judgment, previous experience, and the advice of your colleagues.

WRITING GOALS AND OBJECTIVES

How Do You Develop Goals?

Once you know what your audience needs to learn, you can decide what you hope the participants will accomplish. Then write the goals and objectives to reflect these outcomes. These will guide designing appropriate content, training activities and evaluation tools.

There are two steps in establishing your goals:

1. Goals Statement

A goals statement communicates the overall desired outcome of the training. It should be clear, realistic and relevant. A typical one for a training might read, "The goal of this workshop is to promote the integration of AIDS prevention counselling into health care providers' work with their clients."

2. Workshop Goals

These describe in broader terms what participants will accomplish during the training. They outline for the participants the knowledge, attitudes and skills that the training has been designed to help them learn. A typical description might read,

"By the end of this workshop participants will:

- Understand key psychosocial issues for people with HIV and their families. (**Knowledge**).
- Explore feelings and reactions prompted by AIDS work. (**Attitudes**).
- Acquire new counselling skills in response to people with AIDS-related concerns." (**Skills**).

How Do You Develop Objectives?

When you translate your workshop goals into behaviours which you want the trainees to be able to demonstrate by the end of the training, you have arrived at your objectives. Objectives are behaviourally specific and describe the desired outcome of the training in terms of what the participants will have been able to achieve, whether it is knowledge, attitudes or skills.

Think of the word "SMART" as you design your objectives:

S = SPECIFIC
M = MEASURABLE
A = ACHIEVABLE
R = REALISTIC
T = TIME-LIMITED

Ask yourself, "What does the participant need to do in order to demonstrate the desired outcome?" A typical description of objectives might read,

"By the end of the training the participant will be able to:

- List three common psychological problems in individuals who have learned that they are HIV infected. **(Knowledge).**
- Identify five personal values which have a positive or a negative impact on their AIDS prevention counselling work. **(Attitudes).**
- Demonstrate the correct use of a condom." **(Skills).**

DESIGNING THE CONTENT

The first step is to organise your general training plan, outline the basic format and allocate approximate times for each section, including breaks between sessions.

The three sections are known as:

1. Introduction
2. The Body
3. Closing

The Body is the heart of the training and should be developed first, following these steps:

- Identify the general topics to be covered based on your stated objectives.
- Allocate approximate times for each topic.
- Decide on the order of topics.
- Begin with the essential preliminary information -- think of it as the first "building block." Each section should build upon the previous section and set a foundation for the one to follow.
- Begin with topics that are "safe," often the knowledge-based ones, and move on to those that may be more "threatening," attitudinal or skill-based topics.
- Schedule didactic presentations at the outset when participants are alert. Schedule topics which involve more active participation after lunch or at the end of the day, to stimulate the group if energies are running low.
- Remember to include flexibility -- schedules may be altered at the last minute to accommodate speakers, etc.

Next, design each topic in detail, considering each one from a variety of perspectives. **Ask yourself the following questions for each section in the training:**

- *What are the objectives of this session?*
- *What knowledge do participants already have in this area?*
- *What information do I want to convey?*

- *Is my information accurate and complete?*
- *How can I help learners integrate this new knowledge?*
- *How do I give trainees a chance to practice new skills?*
- *How can I help learners apply their knowledge and skills to their own situations?*
- *How do I provide opportunities for trainees to discover their own insights?*
- *What attitudinal barriers might limit participants' integration of the new knowledge and skills?*
- *How do I address these barriers?*

Each topic will be taught using a variety of techniques. **Keep in mind the following recommendations as you design the content:**

- Select the most appropriate training technique(s) for each objective.
- Give enough information on the topic (brainstorming discussion or brief lecture).
- Add impact to material: personal experiences, humor, quotes, audio-visuals.
- Include experiential exercises to give trainees opportunities for practice and application.
- Identify the materials and resources you will need for the training activity.
- Plan the introduction to the activity, including a brief description of its purpose and how it relates to the previous section.
- Outline clear and concise instructions which you will give to trainees for the training activity.
- Check that you are incorporating enough variety into the training in terms of teaching strategies.
- Remember to consider the group's likely energy levels at the time you plan to do the activity.
- Allow sufficient time to discuss the material and the training activity, and answer questions, before moving on to the next section.

- Plan a closing which summarises the key concepts and connects the section to the one that is to follow.
- Finally, keep good notes about your decisions to which you can refer when you are conducting the training.

Creative combinations of training techniques (see next section) will retain the interest of participants. Your choice of the mix will depend on the size of the group, the length of the workshop, your skills as a trainer, the time of day and other variables. Keep in mind that trainees need opportunities to integrate what they are learning. Integration of knowledge, attitudes and skills does not occur by being a passive listener, but through active participation, practice, and application.

TRAINING STRATEGIES

Your choice of training strategies can be made from the following: lecture, brainstorming, small group activities, case studies, and working with guest speakers. These activities are summarised in the following section.

Other strategies which have proved particularly successful for training AIDS prevention counsellors are described in greater detail. They include: role-plays, panel presentations, guidelines and strategy development, and action planning.

The Lecture

The lecture is one way to teach new and complex information. You can avoid its format being dull and predictable by adopting these guidelines:

- Present your information in a way which helps trainees organise the material by separating your lecture into discrete topic headings which you then convey to trainees.
- Illustrate the lecture with slides, overhead transparencies and videos whenever possible.
- Use visual aids: topic headings on flip charts, a handout for trainees to refer to as you lecture.
- Relay the information using frequent anecdotes and personal examples which are relevant to the audience.
- Pace yourself so that trainees can absorb the new knowledge.
- Allow time for question-and-answer and discussion.

NOTE: *The lecture format is the teaching approach most often used throughout the Caribbean. However, experience gained from several workshops conducted during the last few years indicates that audiences appreciate and respond enthusiastically to other approaches, especially those that allow for group interaction.*

Brainstorming

Brainstorming is the unrestrained offering of any and all ideas by members of a group to convey information, identify problems, and

discuss issues and solutions. Brainstorming and discussion can also be used instead of a lecture to convey and clarify information. When used in this way, you can ask participants to brainstorm all the information they have about a particular topic. In the discussion you can clarify misinformation and add to their body of knowledge. It can be conducted in small groups or include all trainees. Participants will share ideas and experience, learn from each other and problem-solve together. Designate one group member as a recorder for the session to write the group's thoughts and responses.

Small Group Activities

These activities enable trainees to learn from one another and apply new knowledge and skills to their experiences. Participants almost certainly find it easier to express themselves with fewer people and when they become more familiar with each other. This can help trainees to address problems and issues as a group and examine difficult ideas or differing viewpoints.

Case Studies

In a case study a hypothetical client situation is discussed in detail by the group. This situation enables trainees to confront something which they may face in the future. According to the outcome you have planned for this activity, you can vary the perspective to apply knowledge, explore feelings and attitudes, practice skills, or convey knowledge.

Guest Speakers

Depth and breadth are added to a training by a guest speaker who can:

- provide expertise, for example, medical or legal knowledge, which trainers may not have.
- model different training styles.
- help maintain participants' interest by adding variety and new perspectives.
- provide a different viewpoint on a controversial subject.
- familiarise people with community resources.

How should you choose a guest speaker?

Ideally, the guest speaker's expertise and presentation style will be known to you. **The right guest speaker for the training will be:**

- knowledgeable about his or her subject.
- effective in his or her presentation style.
- willing to conform with your objectives.
- able to stimulate discussion and active learning.

What are the potential problems with guest speakers?

Typically, two difficulties emerge in working with guest speakers. First, you cannot control the knowledge, attitudes or skills the guest speaker presents. You have a problem if the material presented conflicts with or does not meet your stated objectives for the session.

Second, the guest speaker may overrun his or her allotted time. Interrupting a guest speaker to maintain the schedule could be embarrassing. Both problems can be avoided or minimised by a thorough briefing discussion with the guest speaker well in advance of the training.

What is the best way to arrange for a guest speaker?

Planning is the key to making the best use of a guest speaker. **When communicating with him or her make sure you take these steps:**

- Extend the invitation well in advance to avoid scheduling problems.
- Confirm the date, time and place of the presentation in writing.
- Confirm the content and the length of the presentation.
- Give an overview of the training including the agenda, the audience, the workshop goals and the format of the training activities, especially the experiential participatory learning aspects.

- Explain the objectives for the guest speaker's own section, clarifying what you would like to have covered.
- Be specific about topics or issues you want to have addressed.
- Emphasise how crucial time-keeping is, reiterate his or her allotted time and the necessity of cutting him or her short if the time elapses. You can make it clear that maintaining the schedule is essential if the workshop goals are to be met.
- Clarify payment and expenses for travel and materials, if there are any.
- Discuss whether he or she has any special needs for the presentation, for example, equipment such as a slide projector, materials to be duplicated, or whether the room should be arranged in a particular way.
- Ensure the speaker has your name and telephone number in case of questions or a last minute emergency cancellation.
- If you don't know the speaker well, ask for a brief written biography to be used for his or her introduction.

Written confirmation of all the important points above is vital in many circumstances. Reiterate the date, time and place of the presentation, the topic and objectives to be met, the training schedule and the directions to the training room if necessary.

Role-Plays

Role-playing is a teaching method in which people act out designated roles related to the subject they are learning about. The purpose is to demonstrate particular skills, to practice and assess skills, and to "experience" being in the role. Role-plays use no script or particular dialogue; they are acted out spontaneously. You should give the trainees general guidelines about the type of person they are playing plus any other information relevant to the scenario you want to achieve.

Some trainees may find role-playing risky and threatening. For the trainer it is often a particularly dynamic teaching technique. You should make sure it is structured so that a supportive atmosphere is created for participants. Clarifying the desired outcomes and giving clear instructions to trainees will help.

Trainers can enhance the effectiveness of role-playing by having well considered scenarios, instructions and desired outcomes. You could structure the activity in a number of ways.

Demonstration Role-Plays:

The entire group assembles to observe this role-play which is usually performed by willing participants. This is a non-threatening way to present and model skills, and to discuss the counselling process. It is usually helpful for trainees to see an example before they do a role-play themselves.

Small Group Role-Plays:

For this activity the large group is divided into small groups of two, three or four. When there are two people, one plays the counsellor, the other the client. In groups of three, the role of observer is added. When a fourth person is added he or she plays the role of "angel". **For each role you must assign the following clear guidelines and expectations:**

- The client is given background information for the role.
- The counsellor is given a setting, very basic information about the client, and guidelines about what he or she is to cover in the scenario.
- The observer is instructed to evaluate the content and process of the counsellor's performance.
- The angel role is to support and assist the counsellor by offering advice if he or she needs help.

Feedback follows each role-play and this should include both positive comments and suggestions for improvement from all participants. Keep in mind that role-play and feedback can be time-consuming, with each rotation taking from 5 to 15 minutes, so that you could need an hour to allow each group member his or her turn in each role.

Team Role-Plays:

This takes place with groups of six to twelve trainees. In this structure one person volunteers to play the role of client. The remainder of the group divides into a counsellor team and an observer team.

One member of the counsellor team volunteers to begin the role-play and performs for a specified time of perhaps two or three minutes. He or she then hands over to another team member for their turn, and so on until every team member has performed. At this point, the interaction stops. The observer team gives feedback. Then the teams switch roles and a new volunteer plays the client.

This type of role-play provides trainees with a unique opportunity to observe and learn from each other's differing styles and approaches. It also encourages team work and group learning.

The Trainer's Role:

Ideally, one trainer should be assigned to each small group as an observer and resource person. When this is not possible, you should let participants know that you are available in the room on a "floating" basis. Circulate and observe the groups until such time as your advice is needed.

Some practical tips for role-play organisation are:

- Anticipate problems and address them before the role-play begins.
- Role-plays can be interspersed with other activities through a lengthy training. Begin with short and simple ones and progress, as the trainees gain confidence, to more challenging and complex ones.
- After the role-play session is over allow trainees a few minutes to return from the role. This can be done simply by asking participants to take a moment to refocus their awareness into the room and to the training session.

Panel Presentations

These presentations, by people with AIDS and HIV infection, have been one of the most highly rated elements of AIDS education programmes in the Caribbean. The panel is made up of one to four individuals who are willing to talk to the trainees about the very personal aspects of living with AIDS or HIV infection. For many of the participants this will be their first opportunity to sit in the same room with a person with AIDS.

Many people are profoundly affected by meeting and communicating face to face with people with AIDS and HIV infection; they frequently report increased levels of comfort, awareness and understanding towards people with the disease. As the trainer you will be able to demonstrate interaction with people with AIDS, modelling lack of fear about casual contagion while in close physical proximity and displaying appropriate caring behaviour. This teaching strategy is very effective in dispelling myths, stereotypes and fears about AIDS.

The personal encounter strategy can be used to highlight other key AIDS issues, for example, homosexuality and bisexuality. A panel of homosexual and bisexual men prepared to discuss with trainees their lives and experiences related to their sexual orientation can greatly facilitate understanding. (If these individuals are not available for your training, you might consider using a video that highlights the subject.)

The trainer should allocate time to brief the panelists before the panel session and give them the following information:

- The objectives of the training and for the panel.
- Description of the audience (trainees).
- Description of the other panelists (not names).
- Confidentiality of the session and how it will be maintained, including whether media will be in attendance (use of media should be the choice of the panelists).
- The structure of the panel, for example a 5 to 15 minutes presentation from each panelist, then an open question-and-answer session.
- The content of the panelist's presentation, for example a description of their reactions to their diagnosis and how their lives, relations with family and work have changed.

Some practical tips on organising a panel presentation are:

- Select panelists who represent diverse lifestyles, experiences and viewpoints, for example, a young woman who is HIV positive, a young man with AIDS or a mother whose child died of AIDS.

Guidelines and Strategy Development

- Allow enough time for this activity -- at least one hour.
- Consider the potential anxiety of the panelists, who may be speaking openly about their HIV status for the first time.
- Arrange for all the panelists to meet each other and the chairperson for the session before it begins.
- Brief the chairperson to introduce each panelist to the audience with his or her name, date of diagnosis and a few personal details. (Panelists may prefer use of their first names only.)
- Be sure that water is available to the panelists.
- Inform panelists that they should not answer any question that makes them uncomfortable.
- Support each panelist and his or her viewpoint by ensuring that the presentation does not become a forum for debating their values and lifestyles.
- Leave plenty of time for the question-and-answer session.
- If the audience is hesitant, be prepared to initiate questions which may be personal but which introduce key issues in sensitising the trainees to the realities of HIV infection.

Through the development of guidelines and strategies trainees have an opportunity to synthesise and apply what they have learned. Topics should be based on the areas trainees have identified as critical to AIDS prevention and those which pose obstacles to effective intervention. It is a practical and useful activity for them as they will be focussing on needs they have identified.

Topics which trainees may choose to work on in developing guidelines or strategies might include:

- Safer sex guidelines.
- Overcoming barriers to condom use.
- What women need to know about HIV and pregnancy.
- What parents should tell their children about AIDS.
- Infection control guidelines.

- Client profiles.
- Modification of existing AIDS education materials developed internationally to make them culturally relevant and useful in their own countries.
- Maintaining confidentiality.

Some practical tips for development of guidelines and strategies are:

- Allow from ninety minutes to two and a half hours for this activity, spread out over two planning sessions.
- Give each group specific guidelines to follow and questions to address related to their topic.
- In a training of several days leave this activity until near the end so that trainees benefit from the maximum knowledge acquired during the workshop.
- Ask each group to present a summary of their work verbally.
- Ensure that each group summarises its work and gives copies to all trainees.
- Plan with the group how the guidelines and strategies will be used after the training.

Action Planning

Trainees will gain a sense of how they can use what they have learned through this activity, linking theory with future practice. **The focus for the action planning will be based on the objectives of the training. Assignments might include:**

- To design a six-month training plan for a health centre or health district.
- To design a counselling plan for a specific district.
- To design a system of referrals for your institution.

Some practical tips for organising this activity are:

- Allow from one to three hours.
- Leave this activity until late in the training.

Dividing the Large Group into Small Groups

- Be very specific in your guidelines about what trainees are to achieve and how their efforts will be used.
- Organise a session where each group reports back and distributes copies of their plan to the large group.

Many of these training strategies are carried out in small groups. Over the course of any training it is important to vary the size and composition of the small groups so that participants get to know and work with as many different people as possible. **Some ways to divide people into small groups include:**

- Ask participants to turn to the person(s) next to them and form a pair or group. Since people usually sit next to those they know, this is the least threatening approach and therefore suitable for use at the beginning of a training.
- Ask the trainees to number themselves from one to six (or the six of the group you wish to form). Ask all the number ones, the number twos etc, to form a group.
- Ask participants to form a group with people they have not yet met or worked with during the training.
- Ask the trainees to choose their favorite, color and then form a group with others who chose the same. Any selection criterion can be substituted for a color and this can be a fun and creative interaction. It can also take time and prove cumbersome when the objective is to move people into same-size groups quickly.
- For some activities ask the participants to choose groups according to their interest. You can get a sense of how many trainees share a particular interest by asking for a show of hands before breaking into groups.
- For some activities, divide participants into groups with others from the same country, district, workplace or professional group.

ORGANISING THE TRAINING

Organising a successful training requires good planning and can be time-consuming. **Allow enough time to pay attention to all the logistics which include:**

- selecting the location.
- arranging the room.
- preparing training information packets.
- arranging for audiovisual equipment.
- handling travel arrangements.
- organising refreshments.

The trainer's workload here will depend on the length of the training and the size of the support staff, but some general guidelines in regard to the training environment and the preparation of training packets are given in this section.

The Training Environment

The physical setting of the training needs to be as comfortable as possible for participants. The room should be:

- large enough to accommodate everyone easily in a group and allow several small groups to take place at the same time.
- self-contained and free from interruptions.
- have easily movable chairs and tables.
- arranged so that trainees can see you and each other, either in a U or semi-circle formation at the outset.

The Training Information Packet

At a minimum the packet distributed to all trainees should include:

- The training schedule with title and date of training.
- A statement of objectives for the training.
- A list of trainers, guest speakers, and participants with name, address and phone number.
- An evaluation form.

Depending on availability, budget, size and length of training, you might want to include other materials including:

- Pamphlets and other educational materials, both domestic and international productions.
- Resource list and/or leaflet describing community resources.
- Relevant newspaper and magazine articles.
- Sample products, for example, condoms.
- Handouts.
- Paper and pencil.

IMPLEMENTING THE TRAINING

The Role of the Trainer

The trainer is often also referred to as the "facilitator" because he or she facilitates, i.e., makes easier, the learning process for the trainees. The facilitator's role is to assist participants to actively participate, internalise and master new information, skills and concepts.

As a trainer you will need to carry out three tasks simultaneously:

1. To make sure that specific content is covered and that the group keeps to its task and schedule.
2. To assist the group to assimilate new knowledge and skills.
3. To model skills of presenting information, group facilitation and participatory learning.

The trainer is in charge of the flow and pace of the training and is responsible for the smooth transition from one activity to the next. The key to your success rests in maintaining the delicate balance between the presentation of new material to the trainees, allowing them opportunities to practice and work with it, encouraging discussions of reactions, feelings and experiences -- and the clock.

Setting the Stage

To ensure that the trainer can carry out these three tasks, he or she must first establish a comfortable learning environment and build trust. **This can be accomplished by carrying out the following suggestions:**

- Arrange room so that participants can see facilitators and other participants easily; chairs and tables should be movable to facilitate small group learning activities.
- Introduce trainers and establish credibility as an AIDS educator (name, credentials, expertise and experience in AIDS work and counselling).
- Build trust. Participants want to know why they should listen to you and trust you.
- Be aware of non-verbal messages about your accessibility, ability to maintain control, authoritativeness, responsiveness to participants' needs and flexibility.

Presentation and Delivery

1. Make contact with the audience (eye contact, don't always stay behind a table/podium, or sit in a chair.)
 2. Acknowledge the resistance of your audience.
 3. Establish what you and the participants have in common.
 4. Be organised and prepared.
 5. Be human.
- Establish ground rules.
 1. Establish and agree upon ground rules to help create a safe and comfortable learning environment.
 2. Ground rules help clarify the respective roles, responsibilities and expectations of trainer and participant.
 3. The most common ground rules include: confidentiality, managing time, consistent attendance, safety, respecting individual differences.
 - Present overview of training and training objectives.
 1. The overview should include a review of the schedule, content to be covered, scheduled breaks and the overall objectives for the training.
 2. Participants should have a clear sense of what to expect during the training and how the objectives will be met.
 - Group introductions.

The following suggestions for your presentation and delivery style will help you to carry out your tasks as a trainer and facilitator:

- Project energy -- the way you present yourself affects the group's interest and energy level. When you are energetic and enthusiastic, the group often responds similarly.
- Eye contact -- make eye contact with participants.
- Appear accessible -- use non-verbal communications and body language which conveys interest, openness and active participation with the group.

Task Facilitation

- Vary speech -- rate, volume, intensity.
- Appearance -- dress appropriately for the audience, location and context of the training.

Ensuring that the specific content of the training is covered and that the group keeps to the task is one of the trainer's primary tasks. This involves observing the following guidelines during each section of the training:

- Introduce each topic and connect it to the previous one(s). Explain the importance of the new topic, its relevance to participants and how it will be approached.
For example, *"Before lunch we reviewed information about the HIV antibody test and the components of a pre-test counselling session. Now we will have the opportunity to apply this information by role-playing a pre-test counselling session."*
- Explain the purpose and objectives.
For example, *"The purpose of this session is to practice conducting a pre-test counselling session and to observe others in the counselling role. By the end of this session, you will be able to identify the components of a pre-test counselling session, demonstrate effective counselling skills and identify personal areas of difficulty as a counsellor."*
- Give clear, concise directions for the training activity.
For example, *"In one hour, when the role-plays are completed, please return to this room. We will then discuss the activity as a large group."*
- Process activity and stimulate discussion.
For example, *"Which parts of the counselling session were the most difficult for you? -- from the client's perspective or from the counsellor's perspective?"*

- Bring the discussion back to the topic at hand when people get off the track.

For example, *“Your question is important. When we talk about post-test counselling this afternoon, we’ll have an opportunity to address it. Can you save it until then?”*

- Close the activity and the section with a summary and transition statement.

For example, *“During this session, we have practiced a pre-test counselling session. As we continue through the afternoon we will have more opportunities to practice counselling skills when we focus on post-test counselling.”*

Although as trainer your role is to keep the group on task, you must also be flexible and respond to the group’s reactions. Flexibility may require revising the training as you go along. When trainees identify a particular need as a higher priority than you anticipated, you will need to consider redesigning the training content and/or the learning activities. Your co-trainers should be consulted before you change the schedule.

You may also need to demonstrate flexibility in the middle of a particular module or activity. For example, imagine that you are showing a video to the group and after fifteen minutes you sense that the trainees are losing interest. You might decide to stop the video at this point and initiate a discussion about reactions to it so far, in order to refocus the group. Such immediate decisions must be based on intuition, assessing the situation and sensing the group mood. If you are not certain how the group is responding, ask directly. **The trainer’s challenge is that he or she has to keep the group to the immediate task at the same time as considering the larger picture, the group process.**

Process Facilitation

Trainers have three key tasks as facilitators which are:

1. Establishing a comfortable and trusting learning environment.
2. Facilitating group cohesion.
3. Utilising and demonstrating group facilitation skills.

All these three need to be maintained throughout the training, although it is the beginning which will set the tone for the entire session. How to achieve them is described in the following section.

The trainer must establish a learning environment which is:

- comfortable and trusting.
- non-threatening and accepting of diversity.

Participants should feel:

- respected and listened to.
- encouraged to share thoughts, feelings and attitudes.
- safe to expose their lack of knowledge and skill.

Establishing the right atmosphere for the training can be achieved by following these guidelines:

- Set the ground rules and emphasise confidentiality.
- Present yourself as friendly, sincere, enthusiastic, flexible, responsive, fair, supportive -- and firm.
- Acknowledge and encourage the active participation of all group members. For example, "Would anyone else like to comment on the role-playing experience?"
- Convey to the participants that they have been listened to and understood. For example, "I can see why you would have responded that way to the video."
- Respect and protect minority opinion. For example, "I'm glad you raised a different perspective for us to consider."
- Use non-verbal communication which conveys interest, openness and active participation with the group, for example, eye contact; body language: lean forward to the person speaking or if standing, circulate in the room; facial expression; and tone of voice.
- Establish group norms at the outset. For example, "The format for this training will be one which encourages your active participation and involvement."

Facilitating group cohesion is another responsibility of the trainer. These guidelines will help:

- Provide ongoing opportunities for participants to get to know each other, share ideas and experiences.
- Acknowledge the expertise and experience of participants. For example, "Your knowledge and skills in working with clients with other sexually transmitted diseases are so important in working with people at risk for HIV infection..."
- Provide support and feedback when participants contribute to the discussion and participate in activities. For example, "Thank you for being willing to participate in role-plays so fully."
- Expand trainees' sense of connection with each other by pointing out or asking for similarities in their experiences or reactions. For example, "How many of you have experienced a similar situation. Can you say a little more about it?"
- Connect the contributions of one participant to what others have already shared. For example, "Your comment brings me back to the comment that J. raised."
- Encourage all trainees to participate in group discussions. For example, "J., you haven't had an opportunity to comment on this issue. What do you think about it?"
- Discourage individuals from monopolizing discussions. For example, "Thank you for your comments. Would anyone else like to comment on the issue?"
- Respond to criticism, feedback and questions about content and format of training. For example, "I'm glad you raised this issue. Let's spend some time discussing it. How do others feel?"

Trainers must also utilise and demonstrate effective group facilitation skills. The goal of AIDS prevention counselling training is for trainees to return to their worksites, clients and communities confident to teach what they have learned. The facilitation skills you use as a trainer are the ones on which participants will model their own style. The role of facilitator can feel difficult and uncomfortable, particularly when it involves managing time and conflict. Remember, as you gain experience it will begin to feel easier.

Modeling these skills will help:

- Encourage discussion by asking open-ended questions, for example, "How did you feel listening to the panel discussion? How might these feelings affect your work as an AIDS prevention counsellor?"
- Utilise active listening. Paraphrase what you understood the trainee to be saying, both in terms of content and their underlying feelings. This will help to clarify what the individual meant as well as demonstrating that you have listened and comprehended. For example, "Are you saying you would feel uncomfortable requesting a sexual history from a client?"
- Connect what one participant says with what others have discussed previously. Point out similarities among participants' experiences and reactions.
- Listen to and acknowledge everyone's contribution. Even when you disagree with individuals or their comments are inflammatory, you can acknowledge the person's contribution without supporting or agreeing with the statement. For example, "Thank you for your comment. We need to move on to..."
- Be in charge while being flexible and responsive.
- Respond to individuals' feelings and reactions, or to the whole group's response, even if these are not overtly expressed or are hidden in a question about content. Participants may express fear, anger or conflict indirectly. Demonstrate your willingness to elicit hidden emotions when the group is avoiding it. By doing this you show the group are angry about the issue we discussed yesterday. I think it's important to spend some time on this. Would anyone like to start the discussion?"
- Manage time by politely moving the discussion along, bringing it back to the topic at hand and interrupting speakers when it is time to move on in the schedule. For example, "I need to ask you to cut your comments short so that we can go on to the next topic."
- Be yourself.

WORKING WITH CO-TRAINERS

Working with co-trainers can add both depth and breadth to a training because it brings in another person with his or her own areas of expertise, experience, knowledge and skills. Working effectively with a co-trainer, however, requires planning and open discussion. **The following are areas you will want to cover with your co-trainer before you begin conducting your training:**

- Discuss training styles ahead of time.
- When you choose your co-trainer, select someone with a similar training style, or someone whose style complements yours.
- Clarify roles and responsibilities: who is in charge, who makes decisions.
- Assign tasks based upon interest, skill and comfort level.
- Plan for time management: who will keep time, how you will signal each other when it is time to move on, how much warning each person wants before their time is up, etc.
- Discuss what you consider to be support from a co-trainer.
- Plan how to handle your differences of opinion in front of the group.
- Plan how to handle having conflicting factual information in front of the group.
- Discuss your feelings about your co-trainer making comments during a section that you are responsible for.
- Discuss how you like to give and receive feedback to co-trainers after the training.
- Rehearse together.

EVALUATING THE TRAINING

It is important to evaluate the effectiveness of your training. Pre- and post-test questionnaires can be designed to evaluate changes in knowledge and attitudes resulting from the workshop.

Evaluation questionnaires are designed to give feedback about the effectiveness of the training and trainers. For sample questionnaires, see Section VI-1 and Section VIII-45.

TRAINING MODULES

Introduction

In this section you will find training modules which relate to the different elements of AIDS prevention counselling training. The general headings are:

1. *Beginning a Training*
2. *AIDS/HIV Information*

This includes:

- AIDS/HIV update.
- Prevention education.
- Behaviour change.
- Substance use.

3. *Cultural and Psychosocial Issues*

This includes:

- Family life in the Caribbean.
- Sex and sexuality in the Caribbean.
- Psychosocial issues for people with AIDS, and HIV infection, their families.
- Religion and spirituality.

4. *Counselling and Communication Skills*

This includes:

- Counselling and communication skills.
- Risk assessment and risk reduction.
- Pre-test counselling for HIV antibody testing.
- Post-test counselling for HIV antibody testing.
- Grief and bereavement.
- Counselling people with AIDS, HIV infection and their families.

5. *Ending a Training*

Each topic is presented as a training module and includes a brief introduction, information to present (designated by pink paper), a sample training activity (designated by green paper), and handouts (designated by white paper) where applicable. In some modules there is more than one training activity, offering additional approaches and training strategies. The modules are meant to be rearranged, adapted and used by you in different combinations to give you flexibility in designing your specific training.

These training modules will be most relevant once you have identified and assessed your audience's learning needs and established your learning objectives. You can then decide which to incorporate into your training as a result of your audience's needs, time constraints and the availability of outside resources. A comprehensive training over four or five days would probably utilise most of the modules; for a two-hour workshop you would need only one or two, or a combination of sections from several.

BEGINNING A TRAINING

The beginning of the training is the time to set the tone of the workshop, establish a comfortable learning environment and build trust so that participants feel safe, comfortable and willing to reveal themselves within the group.

Participants will be observing and forming initial impressions about the trainer and his or her responsiveness to them. **In this opening session you will need to cover (not always in this order):**

- Introduction of the trainer(s).
- Overview of training and training objectives.
- Ground rules.
- Introduction of participants and “climate” setting.

Introduction of Trainers

Even before the formal beginning of the training, participants are formulating their initial impressions. Subtle, often non-verbal, messages are transmitted to the trainees who will be assessing how prepared, accessible and responsive to their needs the trainer will be. Regrettably, this is just at the moment when you are likely to feel most nervous!

You will need to establish yourself and your credentials in your formal introduction. Trainees will want to have confidence in your credibility as an AIDS educator and to know why they should listen to you and trust you. In addition to your professional background you should mention your experience with AIDS prevention, how many trainings you have conducted and/or HIV clients you have reached.

Beyond the formal introductions, trainees will respond to the fact that you share something in common with them and are familiar with their particular AIDS-related concerns. You can accomplish this by discussing your similar experiences, which may be a common desire to learn about AIDS and stop its spread, professional background, socio-cultural background, or other factors.

Referring to the ambivalent feelings some participants may be having about the training is also helpful. These may be a result of the topic, because of conflicting work commitments or personal matters. In all these instances you will want to convey that you respect the participants and will be responsive to their concerns.

Overview of Training and Training Objectives

During the opening session you should review the agenda for the training with the participants. Remember to include:

- Outlining the overall objectives.
- Informing them of scheduled breaks.
- Explaining the location of materials, display rooms, restrooms, etc.

Participants should have a clear sense of what to expect during the training and how the objectives will be met. This section can be brief, but it is an important step in setting the framework for the training.

Ground Rules

Establishing and agreeing upon ground rules is essential for creating a learning environment with a safe and comfortable atmosphere. **Ground rules clarify the respective roles, responsibilities and expectations of trainer and participant. Commonly-used ground rules include:**

- **Confidentiality** -- Participants agree to respect the confidentiality of other trainees, particularly concerning personal disclosures. This applies to guest speakers.
- **Time** -- Trainers agree to begin and end on time, to be responsible for keeping the group on task and moving through the schedule. At times this will mean interrupting an individual, discussion or session. It is a good idea to have agreement from the trainees for this as you begin the training: *Trainees agree to keep to time.*
- **Attendance** -- Participants agree to attend the whole training and to inform the trainer in advance if this becomes impossible.
- **Safety** -- A participant is entitled to refuse to disclose personal information.
All feedback is given in the spirit of learning and support--not criticism.
- **Diversity** -- Individual differences and opinions will be acknowledged and respected.

Group Introductions

The introduction of trainees is an important moment in the training. It can take the form of brief introductions or it may precede a training activity and be used to obtain information about the trainees' concerns, questions, level of knowledge and expectations.

Brief introductions should be requested from all participants in groups of fewer than forty. **You should ask trainees to give their name and place of work and you may ask them to answer one or more of the following questions, depending on the time available:**

- *What is your professional background?*
- *Describe your AIDS/HIV experience.*
- *What got you involved in AIDS/HIV work?*
- *What one thing do you hope to learn today?*
- *Describe one way AIDS/HIV has affected your life.*
- *Tell the group one little-known fact about yourself.*

Especially in large groups, it is important to ask people to keep their responses brief.

For groups of over forty people when individual introductions are difficult, it is still important to get a sense of the audience and develop a group feeling. This can be achieved by asking for a show of hands on any number of questions, for example:

- *How many of you have worked with people with AIDS/HIV?*
- *How many of you are physicians? nurses? social workers?*
- *How many of you have already attended an AIDS training?*
- *How many of you know someone personally who has been affected by AIDS/HIV?*

When no other "climate setting" activity is practical, it can be helpful to give participants an opportunity to make contact with at least one other person in the group. This can be done simply by asking trainees to turn to the person next to them, introduce themselves and discuss a topic or question designated by the trainer. Talking with another person, particularly in a large audience, helps trainees feel more at ease.

TRAINING ACTIVITY

First Thoughts

Purpose: To share concerns and fears about AIDS, clarify expectations and to get to know other participants.

Objectives - Participants will be able to:

- Identify their fears and concerns about AIDS.
- Clarify the objectives of the training.
- Recognise similarities and differences among group members.

How long does it take?

- Allow thirty minutes.

What do I need?

- Paper.
- Pens.

How do I do it?

- Ask the trainees to write their answers to the following four questions. Write the questions on a flip chart to display them to the group.

1. *What are the three major fears or concerns you have about AIDS?*
2. *What are two difficult questions about AIDS/HIV that you think clients or others will ask and you would like help in answering?*
3. *What are two things you hope to learn at today's training?*
4. *What are ten skills you already have that make you a good educator and/or counsellor?*

- Give trainees time to think about and write down their answers.
- Divide trainees into groups of four to six.
- Ask trainees to discuss what they have answered -- no particular order of questions is necessary.

- Do not circulate so trainees do not feel that they are being monitored in this activity.
- After 15 to 20 minutes, call the small groups together.
- Tell the group that only questions 1, 3 and 4 will be addressed. At the end of the activity you will ask them to hand in their piece of paper, and question 2 will be used for another activity later in the training.
- Begin with question 1, asking trainees to call out what they have written and write their responses on a flip chart. Recognise similarities and differences in what they are saying, point out how they share fears and concerns.
- Go on to question 3 and use trainees' answers to discover what they are expecting to learn. In response, you will be able to clarify the training objectives.
- Finally, number a large sheet of paper 1 - 10 and ask trainees to call out what skills they have written down. The trainees' confidence will be boosted by the realisation that they already have personal and professional skills which allow them to cope with the challenge of AIDS education.

This exercise is useful in several ways. It allows participants to focus on their fears, questions and expectations for the training.

The exercise gives permission for people to:

1. *feel afraid.*
2. *raise questions.*
3. *feel competent.*

It also provides an opportunity for participants within small groups to:

1. *meet each other.*
2. *increase their comfort in the training.*

The exercise can be adapted for different purposes by changing the questions. It is helpful to focus some questions on the emotional impact of AIDS/HIV and others on obtaining information for use later in the training. **Alternate questions to ask might include:**

- *When did you first hear about AIDS and what did you hear?*
- *How has AIDS/HIV affected you personally and professionally?*
- *Which type of client do you anticipate will be the most difficult to work with?*
- *Which issue do you anticipate will be the most difficult to address?*

TRAINING ACTIVITY

Getting To Know You

Purpose: To get to know other participants, acknowledge their expertise, and clarify their counselling needs.

Objectives - Participants will be able to:

- Introduce themselves to other participants.
- Identify three counselling needs for their work setting or region.
- Recognise similarities and diversities among group members.

How long does it take?

- Allow _____ minutes (estimate time based on number of participants.)

How do I do it?

- Display around the room large sheets of paper on which you have written the question topics (listed below) for the participants. Place markers, pens or coloured chalk nearby.
- Assign each participant to a sheet of paper as they enter the meeting room on the first morning and ask them to respond in writing to the questions. Explain that the information will be used in their introduction to other participants later in the training.
- Suggested question/topics are:
 1. *Name*
 2. *City of residence*
 3. *Birthplace*
 4. *Profession and employer*
 5. *Years in health care work*
 6. *Years or months of AIDS experience*
 7. *AIDS-related counselling needs in workplace district, country (identify three)*
 8. *Personal and fun information such as: what are 3 things you like most about yourself?*

On completion of the written responses, invite the participants to take a seat in preparation for the training. If you could be invisible for one hour, what would you do? If you were an animal, what kind would you be?

- When you are ready to begin the training, ask the participants to introduce themselves to the group using the information on the sheets after the pre-workshop test and overview of the training have taken place.
- At the appropriate moment invite the participants to take turns to do this, including mention of their AIDS/HIV work experience and counselling needs.
- To process the exercise you should draw out the common elements of experience and comment on the diversities, emphasising the broad range and number of years of experience represented in the room, and highlighting the AIDS/HIV counselling needs which have emerged.

This is an exercise which works best with a small group. Sharing knowledge about experiences facilitates the process of relaxing in each other's company.

BASIC AIDS INFORMATION: AIDS/HIV UPDATE

Introduction

AIDS educators do not need to be medical experts. They do, however, need to have a basic understanding of the medical and epidemiologic aspects of AIDS, what it is, how HIV damages the immune system, its transmission, the spectrum of HIV infection, signs and symptoms, co-factors, treatment and AIDS prevention and risk reduction. They also need to know the general epidemiology of AIDS/HIV in their countries and in the Caribbean.

Educators often feel anxious about how much there is to know about AIDS, how fast the information changes and how much is still uncertain about HIV infection and AIDS. New information about AIDS is continually being published, but the basic facts on what it is, how HIV damages the immune system, its transmission and how to protect oneself have not changed since they were established five years ago. As trainer, your role is to focus trainees on these essential points, conveying them in a concise and straightforward manner through lecture, discussion, written materials, and training activities. AIDS information can be taught experientially. Be creative.

The medical and technical language you use should be readily understood and acceptable to your audience, taking into account the participants' level of medical knowledge. Statistics are more accessible if presented in graph or bar chart format on slides or video. Handouts which summarise information are useful accompaniments to a lecture.

Basic AIDS information presentations, because of the nature of the AIDS epidemic and people's fears about HIV transmission, inevitably involve addressing people's personal fears and concerns. There may be questions about which participants feel uncomfortable to ask openly. Anonymous written questions resolve this problem. As trainer, make sure you allocate enough time to respond to all questions and concerns. If you are asked something you do not know, offer to provide the answer later when you have had time to research it.

Do not presume that your audience knows all the basics about AIDS/HIV. There are many misconceptions and much uncertainty about AIDS/HIV. Even when people have a firm grasp of the basics, they appreciate a review of the most current information and an opportunity to ask questions about new developments.

Information to Present

What is AIDS?

AIDS is an acronym for Acquired Immune Deficiency Syndrome

- **Acquired:** a condition which develops after conception through specific actions; it is not genetic or hereditary.
- **Immune:** system in the body which fights diseases.
- **Deficiency:** having a lack of; in this case, a weakened immune system.
- **Syndrome:** a disease or condition characterised by a group of signs and symptoms occurring together.

What is HIV?

HIV is an acronym for Human Immunodeficiency Virus, the virus which causes AIDS.

AIDS is a viral disease which attacks the immune system, damaging the body's natural defense against germs and infections. This leaves the person vulnerable to a variety of infections and life-threatening illnesses.

These infections can sometimes be treated, but there is no successful treatment for the underlying immune deficiency caused by HIV. Treatments available for AIDS-related illnesses and infections are not yet available to most people in most Caribbean countries.

What is the history of AIDS/HIV?

- First report of AIDS was in 1981 in the U.S.
- In 1983 and 1984 the virus that caused AIDS was discovered.
- In 1985 the ELISA antibody test was produced to screen blood.
- AZT was first used in 1986.
In 1987 and 1988 vaccine trials began.
- First report of AIDS in your country was in _____.

The virus was known as LAV, HTLV-III and ARV. Now it is known worldwide as HIV.

How Does HIV Damage the Immune System?

HIV infects various cells of the immune system. HIV targets T-cells, a type of white blood cell which acts as the coordinator of the immune system and the "alarm system" for an immune response.

HIV also infects macrophages, which are the scavenger cells of the body which usually engulf invading viruses, break them down, and display the virus to help other cells recognize the invader. With HIV, however, macrophages do not break down or display HIV and therefore do not alert the rest of the immune system. Instead, HIV is hidden in macrophages from other cell that could attack the virus, and can transport HIV throughout the body.

When called by the T-cell, B-cells come to identify a foreign substance like HIV and produce antibodies (a counter-attack) to it. Antibodies usually work to control the invader (antigens). In the case of HIV, B-cells produce a defective antibody which, although they serve as a marker of HIV infection, do not eliminate the infection.

Epidemiology:

Current national statistics for children and adults (i.e., reported number of AIDS cases in your country).

Current international statistics for children and adults (i.e., reported number of AIDS cases in the Caribbean and in the world).

Transmission:

Medical science has established how HIV is transmitted.

HIV can be transmitted by:

- unprotected sexual activity (not using condoms) with a person who is infected with HIV.

- blood.
 - injection with a contaminated needle (intravenous drugs, medication, tattoo, piercing).
 - transfusion with contaminated blood or blood products.
- perinatal -- from a mother who is infected with HIV to her infant during pregnancy and possibly breast feeding. There is a 30% to 50% chance that an HIV infected mother will transmit the virus to her infant.

HIV is not transmitted through casual contact.

HIV is not transmitted by:

- shaking hands.
- mosquitos.
- toilet seats.
- drinking from a water fountain.
- sharing water glasses.
- sharing cigarettes.
- sneezing.
- coughing.

There have been numerous studies of family members living with an adult or child who was infected with HIV or who had AIDS. These family members had more than "casual contact" with the person with HIV/AIDS, including children and adults sharing toothbrushes, food, bathrooms, and having other intimate/non-sexual contact. None of these family members has become infected with HIV as a result of their contact.

Risk to Health Care Workers:

There is a very small risk to health care workers of occupational exposure to HIV through mucous membrane or from needlesticks. The vast majority of health care providers who have been exposed to HIV in the workplace have not become infected.

- To date, 22 health care workers have been reported to have been infected with HIV through needlesticks or splashes with large amounts of infected blood onto open sores.
- The risk of becoming infected through a needlestick is 0.4% or 1/250.
- The risk of health care workers becoming infected with Hepatitis B is 50 times greater than with HIV. In the United States, 200 to 300 health care workers die of Hepatitis B annually.

Almost all risky situations for health care workers can be avoided by implementing universal precautions with blood and body fluids from all patients -- although a patient may exhibit no symptoms he or she could be HIV-infected.

Spectrum of HIV Infection:

The range of possible outcomes for a person infected with HIV is to remain asymptomatic (without illness), become symptomatic, be diagnosed with AIDS, and/or die from AIDS.

When a person first becomes infected with HIV, he or she may have an initial acute reaction.

When a person is infected with HIV, he or she may remain asymptomatic, looking and feeling healthy, for a long period of time. Researchers suggest that the average incubation period -- that is, the time it takes to develop symptoms once a person is infected with HIV -- is from five to eleven years. Some people will develop symptoms much more quickly than in five years. Others may remain symptom-free for much longer. In fact, some people have been infected with HIV for 10 to 12 years and still remain symptom-free. At this point, research suggests that approximately 78% of those infected with HIV will become symptomatic or be diagnosed with AIDS within seven years from the date of first infection.

When a person infected with HIV begins to develop symptoms but does not meet the diagnostic criteria for an AIDS diagnosis, he or she is referred to as symptomatic or as having HIV disease. A person who is symptomatic may exhibit a range of symptoms from mild, such as

chronic lymphadenopathy (swollen glands), to moderate or severe symptoms such as fatigue, fever, night sweats, chronic diarrhea and weight loss which can leave the person unable to work or function in daily life. Some symptomatic people may die from the disease and never be diagnosed with AIDS because they did not meet the diagnostic criteria for an AIDS diagnosis.

A person is diagnosed with AIDS when he or she shows evidence of HIV infection and develops one of a number of opportunistic infections or other life-threatening illnesses. People with AIDS may generally feel well and energetic; others may become sick and die within days or weeks of their actual diagnosis.

The diagnosis of AIDS does not always reflect the degree of health or illness a person is experiencing because some people who are symptomatic may be sicker than some people diagnosed with AIDS. AIDS is now being understood as "HIV disease," a spectrum illness ranging from asymptomatic to symptomatic to life-threatening infections.

Signs and Symptoms:

HIV infection may be indicated by the following symptoms:

- unexplained and prolonged fatigue.
- swollen glands lasting longer than three months.
- unexplained and persistent fevers or night sweats.
- unexplained weight loss greater than ten pounds.
- persistent diarrhea.
- persistent dry cough with breathing difficulties.
- thick white coating of the tongue.
- easy bruising or bleeding.
- unusual red or purple skin spots that do not go away.

HIV Antibody Test

The AIDS (or HIV) antibody test is a screening test that was originally developed to screen the blood supply for HIV. It is now more widely used in a variety of settings to test people for the presence of antibodies to HIV.

The HIV antibody test is not a test for AIDS. It does not tell a person whether or not they have AIDS or will develop AIDS in the future. It does indicate whether a person has been infected with HIV.

If a person tests positive to the HIV antibody test it means that:

- Antibodies to HIV were found in the person's blood sample.
- The person has been infected with HIV.
- The person should assume that he or she is contagious and capable of passing on the virus to others through high-risk activities.

If a person tests negative to the HIV antibody test, it means that:

- The person has not been infected with HIV or
- The person has come into contact with HIV but has not become infected and therefore has not produced antibodies or
- The person has been infected but has not yet developed antibodies.

Research reveals that the majority of people infected with HIV develop antibodies to the virus between two and twelve weeks following infection. Some people, however, will not develop antibodies for up to six months. There have been an extremely small number of people who have not developed antibodies for one to two years after infection. New born infants cannot be accurately tested for antibodies to HIV until 12 to 18 months after birth. Until that time, their antibodies are not distinguishable from maternal antibodies.

The most widely used test is the ELISA, enzyme-linked immunoabsorbent assay. However, results from only one ELISA test are not sufficient to accurately determine a person's antibody status. There are instances where the ELISA test will react to other antibodies which are mistaken for antibodies to HIV, thus leaving the possibility for a "false" positive result. It is recommended that if, after the first ELISA test, the result is positive, that an ELISA test be repeated one to two additional times. If these also indicate a positive result, a

supplemental or confirmatory test should be conducted utilizing either the Western Blot or the IFA, immunofluorescence assay. Both confirmatory tests are more expensive than the ELISA, and therefore are used as supplemental tests to confirm the positive result.

Since the psychological and social ramifications of testing positive for antibodies to HIV can be severe, testing should be accompanied by pre- and post-test counselling and education. Pre- and post-test counselling in general may not be a common practice in many countries. Many health programmes have tried to add this element as much as possible.

Neuropsychiatric Complications:

Neuropsychiatric complications associated with HIV can be caused by direct infection of the brain with HIV and by treatable illnesses related to AIDS.

AIDS Dementia Complex, caused by the direct infection of the brain with HIV is defined as "Clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living; or, loss of behavioural developmental milestones affecting a child, progressing over weeks to months in absence of any other cause..."

Common signs and symptoms of AIDS Dementia Complex include:

- **Forgetfulness:** misplacing objects, forgetting recent events and familiar names, losing track of time.
- **Difficulty concentrating:** easily distracted.
- **Slower mental responses.**
- **Impaired judgement:** impulsive behaviour, poor decision-making.
- **Personality changes:** apathy, withdrawal, irritability.
- **Mood changes:** extreme "highs" and "lows," anxiety, emotional outbursts, rage.
- **Psychotic behaviour:** hallucinations, paranoia, grandiose thoughts.
- **Leg weakness or hand tremor.**
- **Impaired coordination:** clumsiness, deteriorated handwriting.

Some of these symptoms can also result from anxiety and depression, a treatable AIDS-related illness, or medication. Only a complete medical evaluation can rule out the possibility of symptoms being caused by a treatable illness or diagnose other underlying causes of these changes.

Co-Factors:

Researchers suggest that a variety of health factors may increase the likelihood of a person who is infected with HIV developing AIDS. **Although research is not conclusive, the following co-factors have been identified as, possibly, having the effect of progressing the disease:**

- concurrent or previous illnesses such as sexually transmitted diseases or hepatitis B.
- repeated infection with HIV.
- alcohol and drug use.
- stress.
- genetics (heredity factors).
- pregnancy.
- lack of rest and exercise.
- smoking.

Treatments and Vaccine:

At present there is no known cure for AIDS and no vaccine.

Three categories of treatments are currently being developed, tested and utilised:

1. Anti-infectives (used to treat the secondary infections associated with AIDS).
2. Anti-virals (used to prevent further growth or reproduction of HIV); the most widely known antiviral used for HIV treatment is AZT.
3. Immune-modulators (used to simulate and restore the immune system).

Risk Reduction Guidelines:

Safe sex practices:

- Practice protected anal, vaginal or oral intercourse; use a condom.
- Limit numbers of sexual partners. Remember that a person can be infected with HIV and appear healthy.

Needle sharing:

- Do not share needles for any purpose.
- Do not shoot drugs.
- If needles are shared, clean the “works”: flush twice with bleach and with water.

Alcohol and drug use:

- Reduce consumption of alcohol and drugs: alcohol, speed, cocaine can lower resistance to diseases and impair judgement and interfere with safe sex practices.

Personal health:

- Establish a healthy living pattern, eating and exercising regularly, and get plenty of sleep.

TRAINING ACTIVITY

Myths and Facts

This activity should precede a lecture on basic AIDS information or can be used instead of a lecture.

Purpose: To identify myths and clarify factual information about HIV and AIDS.

Objectives - Participants will be able to:

- List three common myths about AIDS.
- Identify who is at risk for HIV.
- Describe the routes of transmission.
- List the possible outcomes of HIV infection.

How long does it take?

- Allow 50 to 60 minutes.

What do I need?

- Large paper.
- Pens, markers or coloured chalk.
- Tape.

How do I do it?

- Ask participants to brainstorm all of the things they have heard about AIDS and HIV from colleagues, family, children, etc., about how it is transmitted, who gets the disease, what happens once you become infected with HIV or have AIDS.
- Limit the brainstorming to facts or myths related to basic AIDS information.
- Rule out the statements that are based on attitudes and beliefs (for example, that AIDS is God's punishment). Explain to trainees that there will be an opportunity to discuss these beliefs later in the training.
- List everything participants contribute on the large sheets of paper, numbering each item.
- If any key myths are not suggested by the audience, prompt them by asking, "Has anyone heard that.....?" and add it to the list if anyone remembers hearing it.

Your final list should contain key myths about AIDS; these might include:

1. Only homosexuals and prostitutes can get AIDS.
 2. You can "catch" AIDS by casual contact.
 3. A positive result from an "AIDS test" means that a person has AIDS.
 4. A negative result from an "AIDS test" means that a person cannot get AIDS in the future.
 5. You can "catch" AIDS by donating blood.
 6. You can "catch" AIDS from mosquitos.
- At the end of the brainstorming (maximum 10 minutes), tape the sheets of paper to the wall so that all trainees can see them.
 - Divide the trainees into small groups of five or six. Ask each group to choose a recorder. Starting with the first item on the list, invite the group to decide whether each statement is fact or myth.
 - The recorder will note the group's decision for each statement.
 - When an item is recorded as a myth the group should then discuss and change the wording to make it into a factual statement. Both this and the explanation of the factual statement should be noted by the recorder.
 - Call the small groups back into a large group after 20 to 30 minutes.

To continue with the activity either:

1. Read each statement and ask the recorders to indicate by a show of hands whether their group considered it fact or myth. If there is disagreement, ask those groups who thought the statement a myth to share the factual statement and explanation they have arrived at.

As trainer, your role is to limit the discussion so that the misinformation is corrected and a true explanation is delivered to the group. Do not let the discussion continue too long.

or:

2. Rotating through the small groups, ask them to give their decision on each of the items in turn. If they identified a myth, ask them to share their factual statement re-wording and the explanation. Ask for the other groups' decisions and if any disagree, facilitate a brief discussion, then clarify and correct the misinformation.

TRAINING ACTIVITY

Pre-Test Questionnaire

This activity includes conducting a pre-test questionnaire and can take the place of the basic AIDS information presentation above, or be used in combination with it.

Purpose: To provide the trainees with the opportunity to review their own understanding of AIDS.

Objectives - Participants will be able to:

- Complete a pre-workshop questionnaire and assess their knowledge about AIDS.
- Work with other trainees to arrive at correct answers for the pre-workshop test, making use of their current AIDS knowledge.
- Ask additional questions about AIDS/HIV.

How long does it take?

- Allow one hour.

How do I do it?

- Give participants a pre-workshop questionnaire and ask them to complete it.
- Divide participants into small groups of five or six. Ask each group to appoint a recorder and give the recorders a blank questionnaire.
- Allow 20 to 25 minutes for the groups to go through the test, one question at a time.
- The group's task is to agree on the correct answer for each question. The recorder will make a note of the decision on the blank questionnaire.
- The participants should not alter their individual answers once the group decision has been reached. The recorder should make a note of the decisions which could not be agreed upon, or were controversial.
- Call the small groups back into a large group. Starting with the first question on the pre-workshop questionnaire, work through each question, inviting the recorders to reveal their group's answer and whether or not agreement was easily arrived at.

- Where there was controversy, ask the recorders to discuss the disagreement. Discuss in more detail those questions that caused difficulty for the participants.
- Answer any other questions about HIV infection and AIDS that arose from the discussion.

In processing the activity, you will be able to determine the trainees' understanding of different aspects of HIV infection and AIDS and modify the training accordingly.

You will also be able to observe and discuss the way in which individuals and groups operated when they experienced difficulty arriving at a consensus.

BASIC AIDS INFORMATION: PREVENTION EDUCATION

Introduction

The prevention of HIV infection is a community-wide, nationwide and worldwide concern. Everyone must work together to stop the spread of this disease.

As AIDS educators and counsellors we communicate messages about AIDS prevention through the language we use (verbal and non-verbal), through our behaviour, communication styles and teaching methods. The messages we convey have a powerful impact on people's perception of AIDS prevention and their subsequent actions. The following prevention messages are important to communicate when counselling an individual or educating a group.

Who is at risk for HIV?

- Everyone is potentially at risk for HIV infection but the activities of some people place them at greater risk.
- It is what you do, not who you are, that puts you at risk for HIV and AIDS.
- AIDS is not a "gay disease," "a white man's disease," or "something prostitutes get."

How is HIV transmitted?

- There are only a very few ways in which HIV can be spread.
- HIV is transmitted by certain high risk activities regardless of a person's sexual orientation, nationality, race or gender.
- A person cannot become infected, or "catch" AIDS merely by being in the same room with, or touching someone who has HIV infection or AIDS.

Can HIV transmission be prevented?

- Transmission of HIV could be stopped today if all individuals took the precautions necessary to protect themselves from becoming infected.
- It takes two to have unsafe sex, only one to prevent it.

What does it mean to be infected with HIV?

- HIV infection is a lifelong infection.
- A person infected with HIV today will remain permanently infected and will be capable of spreading HIV to another person through high risk activities.
- AIDS "victim" is an inappropriate way to refer to a person with HIV or AIDS. It can connote judgement and convey a sense of powerlessness. Referring to a person with AIDS as a person first, who happens to have a particular disease, conveys a message of humanity, hope and the challenge of living with a life-threatening disease.
- People with HIV and AIDS often experience a profound degree of stress, fear and stigmatisation. Support from family, friends, colleagues and the community can ameliorate these feelings.

Prevention messages should be designed as precise, clear and unambiguous. For example, the instruction "Do not share bodily fluids" may confuse people, leaving too much room for interpretation, since it could be unclear what a bodily fluid is, or which particular fluids are relevant. Moreover, the word "share" could be misleading. You should specifically name each bodily fluid with a sufficiently high concentration of HIV to transmit the virus and describe exactly how a person could come into contact with it and risk infection.

Another example of a message which could be interpreted differently by individuals is "Reduce your number of sexual partners." This gives the impression that people become safe from HIV infection if they reduce the number of their partners from ten to six, or from four to two. In fact, since each contact involving unprotected intercourse may spread HIV from one person to another, a more accurate message would state, "Always use a condom whenever you have sex with someone other than a long-term partner in a monogamous relationship of ten years or more."

Information to Present

Transmission:

Scientists know how HIV is transmitted. **The conditions for infection are:**

- The disease-causing organism must find a way into the body.
- The organism must find its way into the right part of the body to cause disease.
- The organism must be present in a large enough dose to cause disease.

The transmission modes for HIV are:

- Unprotected sexual activity with a person who is infected with HIV.
- Blood through injection with a contaminated needle (intravenous drugs, medication, tattoo, piercing) or a transfusion with contaminated blood or blood products.
- Perinatal -- from a mother who is infected with HIV to her infant during pregnancy and possibly, breast feeding. An HIV-infected mother has a 30% to 50% chance of giving birth to an infected infant.

HIV is not transmitted casually by:

- shaking hands.
- mosquitos.
- toilet seats.
- drinking from water fountains.
- sharing water glasses.
- sharing cigarettes.
- sneezing.
- coughing.

HIV can be transmitted through contact with body fluids that contain a sufficiently high concentration of the virus. Those with the highest concentration are:

- blood.
- semen.
- vaginal and cervical secretions.

The body fluids with the next highest viral concentration, although significantly lower than those mentioned above, and capable of transmitting HIV are:

- feces.
- urine.
- breast milk.

HIV has been detected in other body fluids, but in such low concentrations that precautions are not necessary. These include:

- saliva.
- sweat.
- tears.

Alcohol and Drug Use:

Reduce consumption of alcohol and drugs: alcohol, marijuana, speed, coke and poppers can lower resistance to diseases, impair judgement and interfere with safe sex practices.

Avoid injected drugs. If illicit drugs are taken, on no account share needles for any purpose. If needles are shared, clean the "works": flush twice with bleach and water or sterilise in boiling water. This applies for shared needles used for medicinal purposes or tattooing.

Safe Sex:

Safe activities:

- mutual masturbation.
- dry kissing.
- body massage.
- body-to-body rubbing.

Possibly safe activities:

- protected anal, vaginal and oral intercourse using a condom.

Unsafe activities:

- unprotected (without a condom) anal, vaginal and oral intercourse.

With any high-risk sexual activity the risk increases with the number of partners. A person may appear perfectly healthy and yet be HIV-infected.

Effective Condom Use:

DO:

- Put the condom on the penis when it is fully erect.
- Squeeze the air out of the condom tip once in place.
- Use water-based lubrication.
- Hold on to the base of the condom when withdrawing penis from the partner.
- Use a new condom for every act of intercourse.

DON'T:

- Unroll the condom before putting it on.
- Use the same condom more than once.
- Use oil-based lubricants.
- Test condoms by inflating or stretching them.
- Store condoms for a long time in a wallet, pocket or car.

TRAINING ACTIVITY

Barriers To AIDS Prevention

Purpose: To identify common personal, institutional and societal barriers to implementing effective AIDS prevention and counselling campaigns.

Objectives - Participants will be able to:

- List barriers to AIDS prevention.
- List barriers to counselling.

What do I need?

- Large sheets of paper.
- Pens, markers or coloured chalk.
- Tape.

How long will it take?

- Allow 45 minutes.

How do I do it?

- Write on the large sheets of paper the headings:

BARRIERS TO AIDS PREVENTION
BARRIERS TO COUNSELLING

Tape the sheets at the front of the room where all trainees can see them.

- Divide the large group up into small groups of five or six. Invite the groups to choose a recorder.
- Explain that they will be brainstorming responses to the concepts displayed and will be asked to report back to the larger group.

Explain to the trainees that social barriers might include:

- Stigma.
- Illegal status of homosexuality.

Institutional barriers might include:

- Inadequate staffing.
- Lack of infection control policies.
- Limited resources (counsellor or client).
- Bring the small groups back into a large group after 25 minutes. Ask each group in turn to report, through their recorder, a sample of what they discussed. Ask that each recorder add new barriers, not repeat previous contributions. Write the responses on the large sheets of paper.

Close the activity by summarising the barriers the participants identified and draw connections between these barriers and the topics which will be covered during the rest of the training, indicating that strategies to address the barriers will be discussed as the training progresses.

TRAINING ACTIVITY

Safer Sex Guidelines

Purpose: To give the trainees an opportunity to review safer sex guidelines.

Objectives - Participants will be able to:

- List sexual behaviours that are safe.
- List sexual behaviours that are somewhat risky.
- List sexual behaviours that are unsafe.

As AIDS prevention counsellors, one of our primary tasks is to give people information about safer sexual practices and help them change their behaviour. This means that we must be familiar with the full range of safe and unsafe sexual practices, even when certain practices may be unfamiliar or distasteful to us personally. It is especially important that we help people not only to minimise sexual behaviours which are risky but help them to expand their definition and practices to include safe behaviours which may be new or beyond cultural norms -- for both client and counsellor.

How long does it take?

- Allow one hour.

What do I need?

- Large sheets of paper.

How do I do it?

- Write the headings: SAFE, SOMEWHAT RISKY, UNSAFE on large sheets of paper and tape the three sheets on the wall at the front of the room where all the trainees can see them.
- Ask the group to brainstorm sexual practices in each category, beginning with unsafe and ending with safe.
- If necessary, prompt the group so that a comprehensive list is achieved.
- Focus attention on the safe category and encourage creative responses which may be new to participants and challenge cultural norms. Ensure that non-penetrative sex is fully explored.

TRAINING ACTIVITY

Answering Difficult Questions

Sometime before this activity, ask trainees to write down the questions they would find difficult to answer, if asked by a client -- or any questions of their own. As trainer you can select in advance the ones which are most frequently expressed and are relevant to your training programme. Write each question on a separate piece of paper.

Purpose: To practice responding to difficult questions from clients.

Objectives - Participants will be able to:

- Answer a difficult question about AIDS/HIV.
- Discuss various ways to respond to a particular question.
- Utilise the resources of co-workers in answering questions and gathering information.

How long will it take?

- Allow one hour.

What do I need?

- Small cards or pieces of paper.
- Pens.

How do I do it?

- Divide the large group into small groups of five or six.
- Give each group 2 or 3 pieces of paper on which you have written a question.
- Ask group members who have one of the questions to write a possible response to it. Pass the paper to the next person who will write a response. Repeat this until each question has several responses written.
- Ask the group to discuss their responses, and then decide upon the best response to the question, either by selecting one or combining several.
- Move on to the next question until all are completed.
- Call the small groups back into a large group and ask them to call out their answers to each of their questions in turn. If there are areas of doubt or disagreement, as trainer you declare the definitive answer and clarify difficulties if necessary.

In closing the activity, discuss the trainees' approaches to understanding the full meaning of the questions and problem-solving in a group.

An alternative method of conducting the activity is:

- Divide the large group up into small groups of three.
- Give a card with a difficult question on it to each person and instruct them not to share it with other members of the group.
- Ask each group to select one member to play the role of client and one to play counsellor.
- Request that the client "role-play" a short case example within which his or her difficult question is included. Ask the counsellor to role-play his response.
- After five minutes of role-playing ask the groups to discuss the counsellor's response to the question and suggest other ways to answer it. The recorder should note the answer finally chosen.
- Repeat the procedure until all three questions have been discussed.
- Call the small groups back into a large group. Ask the recorders to recount their questions and answers and discuss these with the entire group.

If time restrictions mean that all the questions do not get discussed in depth, make sure that time is allocated later in the training to return to them. Whenever possible, each group's questions and responses should be typed, copied and distributed to the entire group.

THREE CONDITIONS FOR INFECTION

1. The disease causing organism must find a way into your body.
2. The organism must find its way into the right part of your body to cause disease.
3. The organism must be present in a large enough dose to cause disease.

DO'S AND DON'TS OF CONDOM USE

Do put on when penis is erect.

Do squeeze air out of tip.

Do use water-based lubricants.

Do hold onto the base of the condom when pulling out.

Do use a new condom every time

Don't unroll condom before putting it on.

Don't use the same condom more than once.

Don't use petroleum-based lubricants.

Don't test condoms by inflating or stretching them.

UNIVERSAL INFECTION CONTROL PRECAUTIONS

Health care professionals must take precautions with blood and body fluids from all patients to protect themselves from HIV (the AIDS virus). *Remember: any patient can be infected by HIV, even though he or she may show no symptoms.*

1. Wash hands before and after all patient or specimen contact.
2. Handle the blood of all patients as potentially infectious.
3. Wear gloves for potential contact with blood and body fluids.
4. Place used syringes immediately in nearby impermeable container; **DO NOT** recap or manipulate needle in any way.
5. Wear protective eyewear and mask if splatter with blood or body fluids is possible (e.g., bronchoscopy, oral surgery, etc).
6. Wear gowns when splash with blood or body fluids is anticipated (e.g., labor and delivery).
7. Handle all linen soiled with blood and/or body secretions as potentially infectious.
8. Process all laboratory specimens as potentially infectious.
9. Wear mask for TB and other respiratory organisms (HIV is not airborne).
10. Place resuscitation equipment where respiratory arrest is predictable.

MOST FREQUENTLY ASKED QUESTIONS

Q. *What is Acquired Immune Deficiency Syndrome or AIDS?*

A. AIDS is the name of a medical condition that affects the immune system. "Acquired" indicates that it is not inherited or explained by an underlying illness. "Immune Deficiency" is the factor common to all cases: The inability of the body to defend itself against infections. "Syndrome" refers to the variety of diseases which can occur; these are sometimes referred to as opportunistic infections or opportunistic cancers. They take advantage of this loss of natural immunity against disease.

Q. *Are there any symptoms of AIDS?*

A. The symptoms for AIDS are:

- Significant Weight Loss Without Trying
- Persistent Fevers
- Loss of Appetite
- Purple Skin Lesions
- Diarrhea that Lasts 3 to 6 Months
- Swollen Glands
- Chronic Fatigue
- Persistent Night Sweats
- Dry Cough

All of these symptoms can be linked to many other illnesses.

Q. *What causes AIDS?*

A. A virus known as HIV.

Q. *How is the virus transmitted?*

A. There are two major ways of becoming infected with the virus; unprotected sex or sharing I.V. needles. Casual contact, such as that in the office or school, does not spread the virus. The blood supply in the Caribbean countries is now screened for the presence of HIV.

Q. *Who gets AIDS?*

A. Anyone who practices risky behaviours can get AIDS. Risky behaviours include having multiple sex partners, sharing needles or having sex with someone who has multiple sex partners or shares needles.

Q. *What can be done to stop the spread of AIDS?*

A. Most immediately, education in schools and the media to continue teaching people how best to keep from getting AIDS: Having sex with one faithful partner is safest. Correct use of condoms for sex significantly reduces chances of getting AIDS, but it does not guarantee absolute protection from the virus. Drug users should never use a needle someone else has used, unless it has been thoroughly cleaned with bleach or other disinfectant because the virus is transmitted through blood.

The first human testing of a vaccine has begun, but scientists predict it will be eight to ten years, if then, before an AIDS vaccine may emerge as reliable and safe.

AZT, a drug that stops the AIDS virus from duplicating and spreading to new cells, is being used by adult patients and some children. However, it is not a cure and can cause serious side effects. Many other drugs are in development but are not yet approved as treatment. Most are quite expensive and can be very difficult to obtain in some countries.

Q. *Are doctors afraid to treat AIDS patients?*

A. In general, the answer is "no." But since the epidemic began, more than a dozen U.S. health care workers and laboratory technicians have been infected with the AIDS virus through contact with infected blood. Most had accidentally stuck themselves with needles previously used on infected patients. In a few cases, the infected blood got on the health care workers' chapped or broken skin, or in their eyes or mouth. Because hundreds of thousands of health care workers have cared for AIDS patients and other infected patients and only a handful have become infected themselves, the risk of occupational infection is considered slight.

Q. *What about life insurance?*

A. Unlike health insurance, most life insurance is sold as individual policies requiring a physical examination and other tests in advance. Most life insurance companies now require a test for HIV antibodies and reject those testing positive as too great a financial risk.

Q. *What are some of the specific diseases affected AIDS patients.*

A. Many have had one or both of two rare diseases: Kaposi's Sarcoma (KS), a type of cancer, and Pneumocystis Carinii Pneumonia (PCP), a parasitic infection of the lungs. In addition, severe life-threatening bacterial, yeast or viral infections also can occur. In the Caribbean, people ill with AIDS often suffer from severe diarrhea.

Q. *How is AIDS treated?*

A. Since AIDS is the result of a series of conditions, specific infections can be treated. Treatments do exist for some of these conditions, and people with AIDS should be encouraged to seek health care.

Q. *Can children get AIDS?*

A. Yes. HIV can be transmitted if the mother has AIDS or is antibody positive. The disease is passed from mother to child shortly before birth or during the birth process. There is a one-in-two chance of giving birth to a seropositive child if the mother has AIDS or is herself antibody positive. Also, it is possible for infants to get the virus from breast milk.

Q. *How can I tell if I have AIDS?*

A. The best person to answer questions about your personal health is your health care provider. We can refer you to someone who is well informed about AIDS. **REMEMBER, A DIAGNOSIS OF AIDS CANNOT BE MADE OVER THE TELEPHONE!**

Q. *Can I get AIDS from mosquito bites?*

A. You can't get AIDS from mosquitos. There has never been a case of someone getting HIV, the AIDS virus, from mosquitos. While mosquitos can transmit other diseases, such as malaria, they cannot transmit HIV.

Q. *Can I get AIDS from wet kissing?*

A. There is no chance HIV will be transmitted through dry, "social" kissing. Saliva provides a poor medium for HIV, and no study has ever found that saliva can transmit HIV from one person to another by wet kissing.

Q. *Can I get AIDS from oral sex?*

A. HIV is transmitted through a man's semen, a woman's vaginal fluid, and blood. Oral sex presents little risk of transmission unless the one "going down" on the male or female partner has cuts or sores in the mouth into which the virus can enter.

Properly using a latex condom to cover the penis, or a dam over the vagina (a square of plastic wrap will serve the purpose), will prevent any possibility of semen, vaginal fluid or blood from entering the mouth during oral sex.

Q. *Should I stop having sex if I test positive or if I have AIDS?*

A. Sex is an important part of human life and relationships. While some people will choose not have sex after they find out they are infected with HIV or have AIDS, others will still want to express themselves sexually. Both approaches are possible and the choice is up to the individual and his or her partner(s).

Like everyone else who has sex, people who test positive for HIV antibodies -- who are infect with HIV -- or who have AIDS -- should practice the same kind of "safer" sex as those who are uninfected. Using a condom during vaginal or anal intercourse, and a condom to cover the penis or a dam to cover the vagina during oral sex is highly effective in preventing transmission of the virus.

Practicing safer sex reduces the risk of transmission and allows people with HIV disease and their partners to continue to enjoy sexual relations.



Q. *Should a woman who is infected with the HIV delay or end a pregnancy?*

A. There is strong evidence that pregnant women who are infected with HIV will transmit the virus to their unborn child. There is also some evidence that HIV can pass to a nursing baby through an infected mother's breast milk.

A woman considering pregnancy should assess her own risk for infection based on her sexual and drug-using behaviour. If she believes she has been at risk for HIV infection, she should be tested for HIV antibodies to determine whether or not she is infected.

Because she risks transmitting the virus to her child, a woman who tests positive usually is advised not to become pregnant. A pregnant woman who learns she is infected with HIV may or may not choose to terminate her pregnancy, depending on her personal values and her willingness to care for an infected child who may develop AIDS.

Q. *Where did AIDS come from?*

A. Scientists do not know for sure where AIDS came from. We may never know the origin of AIDS, but we do know that today it is present in almost every country in the world.

We also know that no one country or group of people is to blame for AIDS. Like other viruses and diseases, AIDS is a product of nature and not something man-made. We can fight the virus without fighting against those who may have the virus.

Q. *How long can HIV live outside the body?*

A. The AIDS virus is very fragile and cannot live long outside the body. Because it is fragile, HIV can easily be killed by washing an exposed area with soap and water. It also can be killed with one part bleach to ten parts water.

HIV can be transmitted from one person to another only by specific acts -- practicing unprotected sexual intercourse, sharing IV needles and syringes, transferring the virus from an infected mother to her unborn fetus or through breastfeeding.

Properly using a latex condom during vaginal or anal intercourse to cover the penis and a condom to cover the penis or a dam to cover the vagina during oral sex, will effectively prevent sexual transmission of HIV.

HIV is killed in needles and syringes by flushing them with one part household bleach to ten parts water.

Women who are considering pregnancy should assess their risk for HIV infection based on their sexual and drug-using behaviour. If they believe they have been at risk they should be tested for HIV antibodies. If they are positive, they may want to delay pregnancy until more is known about HIV transmission from mother to fetus.

HIV is not transmitted casually -- by hugs, social "dry" kissing, sharing plates, glasses, eating utensils, telephones or showers.

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BEHAVIOUR CHANGE

Introduction

Preventing the spread of HIV requires that all people at risk for HIV infection and those already infected make sustained changes in their sexual and substance use behaviour. Health care professionals who have worked in the areas of sexually transmitted diseases, family planning, substance abuse treatment and other areas know that making changes in these arenas can be a long and difficult task.

We know that information alone has not been enough to motivate people to change health behaviours, and fear has not been the key factor in helping people to sustain long-term change.

People are more likely to achieve behaviour change when they feel hopeful and empowered, able to make the change.

The challenge to AIDS educators is to help individuals to make and sustain behaviour changes. It is therefore a prerequisite that they understand what motivates behaviour change and appreciate the difficulties of sustaining it in the long term.

Information to Present

What factors influence and shape people's health and lifestyle?

The interrelated factors which affect people's health and lifestyle include:

- **Knowledge:** information, facts, awareness, comprehension.
- **Attitudes:** values, beliefs, feelings, judgement.
- **Behaviours:** practices.
- **Environment:** family, peers, cultural values, beliefs and norms and social institutions such as schools, religious, service organisations.

Any one or combination of these elements may be an obstacle to behaviour change or serve as a vehicle to promote behaviour change.

Information alone is rarely enough to motivate or enable people to make or sustain behaviour change because it does not take into account these complex interacting factors which influence people's health behaviours and lifestyles.

What motivates people to change risky health behaviours and sustain these changes?

- **People must first recognise** that the problem or disease is a personal threat to them and that the consequences of their risky behaviours are serious. The negative outcome of these risky behaviours needs to be perceived by the individual as real and likely to occur.
- **People must believe** that they have the capacity to respond to the threat and the ability to make the necessary behavioural changes.
- **People must be motivated** to make behaviour changes and believe that the changes they make will have a positive impact.
- **People are more likely to succeed** in changing their behaviour if it is done incrementally, rather than all at once, and if alternative behaviours are offered as options to replace the behaviour being eliminated.
- **People need support** to change behaviours. Obstacles in the social environment must be minimised.

Many people will not be completely successful in sustaining new behaviour patterns. Support for sustaining new behaviours, even when there are periodic slips, requires continued commitment.

How does this knowledge about health promotion and behaviour change apply to AIDS?

There are step-by-step changes in an individual's belief system that must take place if he or she is to adopt and sustain new behaviours. These changes are:

- **Perceived risk:** AIDS is a threat to me.
- **Response efficacy:** AIDS is avoidable.
- **Personal efficacy:** I have the skills, knowledge and ability to make the changes needed to reduce my risk.
- **Satisfaction:** I can make these changes and still be satisfied.
- **Peer support:** My community of peers supports these new behaviours.

What are the key elements for AIDS prevention and behaviour change intervention?

AIDS prevention interventions must be multifaceted and address the various components which influence an individual's health and lifestyle: knowledge, attitudes, behaviours, environment.

Before a programme of interventions for AIDS prevention is developed the characteristics of the target audience should be studied and aspects which might pose obstacles to AIDS prevention efforts be clearly identified.

Key elements to successful behaviour change programmes may include:

- Community-based programmes with leadership being provided from within the targeted community.
- Advertising and marketing techniques used to select and distribute appropriate messages.
- Programmes designed to both inform and motivate the target audience.
- Emphasis on facilitating social and cultural change, acknowledging that high risk behaviours have an important social dimension, and that changing group norms will have an impact on individual behaviour.
- A programme that does not rely solely upon print-based or broadcast media alone.
- The use of individual health education and counselling and small group interactions.
- Broad-based grass roots participation. Providing opportunities for involvement is important in supporting the individual's commitment to halting the spread of the disease.
- The documentation of high-risk behaviour and behavioural change at baseline (start of the programme).

Several national and district AIDS prevention programmes in the Caribbean already employ one or more of these key elements. The challenge remains to do the planning necessary -- and obtain support and funding -- to include as many of these elements as possible.

TRAINING ACTIVITY

Risky Business

Purpose: To give trainees an opportunity to better understand the process and difficulties with behaviour change.

Objectives - Participants will be able to:

- Assess motivating factors for changing health behaviour.
- Identify obstacles in making these changes.
- Identify the skills needed to make behavioural changes.
- Discuss socio-cultural and environmental factors which influence behaviour change.

How long does it take?

- Allow 40 minutes.

What do I need?

- Pens.
- Paper.

How do I do it?

Ask participants to do the following, writing their answers on a sheet of paper:

- Think of a health behaviour that you have been able to change with some degree of success (for example, giving up smoking, reducing stress, changing diet).
- List the BARRIERS or OBSTACLES that initially hindered you in making the change.
- List the factors that motivated you and helped you start making the change and overcome the obstacles.
- List the factors or influences that have helped you to maintain the change.
- Ask trainees to choose a partner and discuss their responses.
- Summarise the group's findings by brainstorming lists of barriers/obstacles, motivators and maintainers. Discuss each category as it relates to AIDS prevention.

In processing this activity trainees will become aware of the patterns and trends influencing behaviour change and how these could relate to AIDS prevention counselling. Points for consideration include:

- Information alone is not enough to make health-related behavioural changes.
- People need skills to make behavioural changes.
- Environmental factors play a key role in promoting or hindering behavioural change.
- The personal impact: physical, emotional and/or social, of a particular behaviour change affects the ability to make and sustain new behaviour patterns.

HEALTH BELIEF MODELS

Premise: Preventing the spread of AIDS requires that individuals infected and those at risk of becoming infected must alter behaviours which are known to transmit the infection.

Premise: Adopting these beliefs requires step-by-step changes in an individual's belief system.

1. **Perceived Risk**....AIDS is a threat to me.
2. **Response Efficacy**....AIDS is avoidable.
3. **Personal Efficacy**....I have the skills, knowledge and ability to make the changes needed to reduce my risk.
4. **Satisfaction**....I can make these changes and still achieve satisfaction.
5. **Peer Support**....My community of peers supports these new behaviours.

SUBSTANCE ABUSE

Introduction

It is clear that substance abuse plays a key role in most countries in the spread of HIV, although the degree to which it has been directly linked varies widely from country to country.

The risk of transmitting HIV through the sharing of needles and other equipment is extremely high, as is sexual transmission linked to partners of intravenous drug users. Increased sexual activity and/or multiple sexual partners is common in association with some drug use. This, as well as the frequent exchange of sexual favors for drugs, or money to buy drugs, all adds to the risk for substance users and their partners.

Prevention efforts must target not only people who use intravenous drugs, and their sexual partners, but people who abuse other substances, including alcohol. The use of substances for any individual, whether or not considered by themselves to be problematic, must be reviewed in the context of HIV prevention.

The incidence of intravenous drug use is relatively lower in most Caribbean countries in comparison to the problem in the U.S. and Europe. However, the use of cocaine and crack is increasing throughout the region, often leading to problems with prostitution, crime, and -- most likely -- the transmission of HIV and other STDs.

Information to Present

Epidemiology of Substance Use in the Caribbean:

- Consult with specialists in the Ministry of Health or contact the Caribbean Epidemiology Center (CAREC) for information.

AIDS and Substance Use:

- **Direct transmission:** sharing of hypodermic needles, syringes and other equipment.
- **Sexual transmission:** intravenous drug users can transmit HIV to sexual partners.
- **Perinatal transmission:** women who are intravenous drug users or sexual partners of intravenous drug users and are infected with HIV can transmit the virus to the child.

- **Suppression of the immune system:** drug and alcohol use compromise the immune system and increase a person's susceptibility to HIV infection. They may also increase the speed of disease progression once a person is infected with HIV.
- **Impaired judgement:** use of alcohol and drugs reduces some people's inhibitions and decreases the likelihood of a person's practicing safer sex and/or using condoms effectively.

Definition of Substance Abuse:

Substance use becomes problematic when it interferes with a person's physical, psychological or social functioning. This might include:

- Medical problems directly related to substance use.
- Relationship and family problems.
- Depression.
- Inability to hold a job.
- Legal problems.

In general, the use of some substances is sanctioned in all cultures. The standards by which these substances are judged to be problematic usually differ from those used to assess substances which do not receive cultural sanctioning.

Common Myths and Prejudices About Substance Use:

- Substance users are immoral or bad people.
- Substance users cannot change their behaviour.
- There is no point in treating substance abuse for a person with AIDS.

HIV Risk Reduction:

Needle Sharing:

- Avoid injected drugs.
- If drugs are injected, do not share needles for any purpose.

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- If needles are shared, clean the “works”: flush twice with bleach and twice with water or sterilise in boiling water. This applies for sharing needles for tattooing or medicinal purposes as well.

Alcohol and Drug Use:

- Alcohol, marijuana, speed, coke and poppers can lower resistance to diseases.
- Drug and alcohol use can weaken one’s judgement and interfere with safer sex practices.

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TRAINING ACTIVITY

**Substance Abuse:
How do I feel?
What do I believe?**

Purpose: To better understand and discuss personal and cultural beliefs and attitudes about substance abuse.

Objectives - Trainees will be able to:

- List commonly-held beliefs about people who abuse substances.
- Identify personal feelings and beliefs about substance use.

How long does it take?

- Allow 40 minutes.

What do I need?

- Large sheets of paper.
- Pens, markers or coloured chalk.

How do I do it?

- Divide the large group into small groups of six. On three large sheets of paper write the following headings:

ALCOHOL
INTRAVENOUS DRUGS
NON-INTRAVENOUS DRUGS

- Ask the groups to brainstorm all the words they can think of which describe, people who use or abuse alcohol, intravenous drugs or other drugs. The list should include common names or slang terms, beliefs and attitudes. Within each drug category, ask trainees to discuss specific drugs separately.
- After 15 minutes, ask the groups to move on to the following questions:

What does the list suggest about cultural responses to:

1. *alcohol use and abuse?*
2. *intravenous drugs and abuse?*
3. *non-intravenous drugs and abuse?*

What are your personal responses to the above?

In processing the responses trainees should be asked to consider how cultural attitudes and values toward substance use might affect AIDS prevention efforts and how their own personal views might affect their work as a prevention counsellor.

CULTURAL AND PSYCHOSOCIAL ISSUES: FAMILY LIFE

Introduction

AIDS prevention strategies must be considered within the context of family life. Family structure, sex role expectations, economic realities, cultural norms, religion and other factors all influence the state of family life in a given culture.

Initially AIDS prevention efforts target high-risk behaviours and behaviour change. However, since sexual behaviour change takes place within the context of family life, it is also important to focus prevention efforts on those long-term changes in cultural values which will be needed to support long-term sexual behaviour changes. In this way, prevention efforts can target deeply rooted patterns with the goal of strengthening the abilities of young people to maintain stable, intimate relationships and provide ongoing support for sustaining strong community and family commitments.

Family life issues differ from culture to culture. Trainers will need to orient their presentations to the specific culture. In the Caribbean, as elsewhere, there is great concern about the threats to maintaining stable family relationships. A full discussion of the issue may need to address the varieties of unions, the role of women in the family and society, and the problems with incest and child abuse.

Information to Present

Family Unit:

- Typical structure(s).
- Role of women.
- Role of men.
- Economics.
- Role and function of sex.

Gender Differences:

- Status of men and women.
- Role expectations of men and women.
- Differences in subcultures -- race and class.

Cultural Attitudes and Values About Family Life Which Have an Impact on AIDS Prevention:

- Views on: relationships, family, children, love, dating, sex, sexuality, marriage, heterosexuality, homosexuality, bisexuality, sex roles, teenage sexuality, and teenage pregnancy.
- Origin of values and attitudes.
- Ethnic, religious, class differences within a given culture.
- Institutions and other factors which influence and support specific values and attitudes: media, religion, schools, music, arts.

TRAINING ACTIVITY

Family Circle

Purpose: To discuss personal and cultural values and attitudes relating to family life.

Objectives - Participants will be able to:

- Describe their family grouping.
- Identify sex role expectations in the family.
- Identify family values and attitudes.
- Describe how their family life reflects and/or differs from cultural values and attitudes.

How long does it take?

- Allow 35 minutes.

What do I need?

- Large paper.
- Pens, markers or coloured chalk.
- Tape.

How do I do it?

- Give each participant a piece of large paper and a marker or coloured chalk. Ask them to draw a representation of their family, including each member and depicting how each relates to the participant. This could be a family tree, or a simple picture.
- Ask the participants to write the answers to the following questions:
 1. *How would you describe the structure of your family?*
 2. *What are the expected roles of the men and women in your family?*
 3. *What values do your family structure and role expectations reflect?*
 4. *How does your family life reflect and/or differ from cultural values and attitudes?*

- After 15 minutes, ask the participants to tape their papers to the wall where other trainees can see them.
- Invite one or two volunteers to use their representation to describe their family structure, values and role expectations.

In processing the activity, ask for a show of hands which will establish how many trainees felt that their family life reflected cultural norms and how many felt that it differed from them. Ask them to consider the implications for AIDS prevention in respect to their findings.

SEX AND SEXUALITY

Introduction

Most health care professionals and educators have had very little experience discussing sex and sexuality within the context of their professional roles. In fact, most people experience discomfort when openly discussing sex and sexuality within intimate and personal relationships.

AIDS prevention efforts require us to discuss explicit sexual information with individuals and groups in a relevant and non-judgemental manner. In order to succeed in our AIDS prevention counselling efforts we, as educators, must first become aware of our personal attitudes and experiences related to sex and sexuality. Without this self-awareness AIDS prevention efforts will be less than fully effective.

Our values, attitudes and beliefs about sex and sexuality are informed by a variety of environmental factors such as culture, religion, economics, the media, family and peers, and sub-culture values and attitudes. Exploration of sexual attitudes and norms must always be undertaken within a given socio-cultural context and with sensitivity to the audience.

Inevitably, in order to help people become more comfortable dealing with sexual behaviours in a non-judgemental manner, you will challenge cultural norms by initiating direct and open discussions about sexuality and exploring issues which are frequently taboo. You can facilitate the learning process by acknowledging that people do feel uncomfortable discussing sexuality, revealing your awareness of cultural norms and biases, and reassuring the audience that differences in values and beliefs within the group will be respected.

Your decision about how to approach this section of the training will be based on cultural norms and the extent to which participants will engage willingly in activities which involve self-disclosure in varying degrees. The training activities are designed for adaptation to the specific audience.

Information to Present

Definitions Related to Sex and Sexuality:

- **Gender:** the biological sex of a person, male or female.
- **Sex roles:** the proscribed set of behaviours attributed to males and females and considered appropriate and acceptable, based on socio-cultural norms, values and beliefs.
- **Sexual orientation:** the gender towards which a person is sexually/affectionally attracted.
- **Sexuality:** the various cultural and individual components which influence the sexual expression of the individual including gender, sex roles, sexual orientation, and other factors such as body image, self-esteem, self-concept.
- **Sexual behaviour:** the range of an individual's sexual practices.
- **Sexual response:** the physiology of the sexual response cycle for men and women.

Socio-Cultural Influences:

These factors mold and influence group and individual beliefs and values about sex, sexuality and sexual practices:

- culture: norms and taboos.
- religion.
- family.
- economics.
- peers.
- media.

Sexual Orientation:

Although sexual orientation is generally defined by the gender toward which a person is sexually attracted, sexual orientation can be determined by other factors, depending on cultural norms. For example, in some cultures sexual orientation may be identified by the role a person plays in a particular sexual act (active versus passive); this becomes associated with sex role and gender role expectations as assigned to men or women.

The range of sexual orientations include:

- **homosexual:** people attracted to others of the same gender.
- **bisexual:** people attracted to others of both genders.
- **heterosexual:** people attracted to others of the opposite gender.

Every culture maintains norms regarding sexual orientation and same-sex sexual behaviour which vary widely across cultures.

For some people, sexual orientation defines or affects an individual's social and group ties, social status, and individual and group identity. For others, same-sex sexual practices do not reflect a particular sexual orientation or define social and group ties or identity.

Homophobia is a term used to describe hostile and negative reactions towards homosexuals; these are founded on myths, stereotypes or irrational fears. Homophobia can be demonstrated by overt violence, diminished social and legal status, ostracism or benign neglect.

The Impact of AIDS on Sexuality:

AIDS can stir up negative sentiment which may be culturally- and/or individually-based.

AIDS can bring people's private sexual lives into view for public scrutiny.

AIDS can worsen internal conflicts a person may have in regard to his or her sexual practices, sexual conduct or sexual orientation.

By offering a broad range of behaviours which are safe but may lie outside the norm, AIDS prevention efforts can challenge cultural and personal views of what are considered to be "normal" sexual practices. These might include sensual activities, non-penetrative practices, fantasy, etc.

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TRAINING ACTIVITY

Talking About Sex

Purpose: To become more comfortable discussing sexual issues during prevention counselling sessions.

Objectives: The trainees will compile a comprehensive list of words which describe the human body and a variety of sexual activities. They will examine how this language reflects cultural values and norms related to sexuality and sexual behaviour.

Participants will be able to:

- List several ways to describe a variety of sexual behaviours.
- Identify personal reactions to the language being used.
- Discuss the ways in which this language reflects cultural values and norms in regard to sexuality and sexual behaviour.

How long does it take?

- Allow 40 minutes.

What do I need?

- Large sheets of paper.
- Pens, markers or coloured chalk.
- Tape.

How do I do it?

- Divide the large group up into small groups of five or six.
- On the large sheets of paper write the following headings:

VAGINAL INTERCOURSE

ANAL INTERCOURSE

FELLATIO (ORAL SEX ON A MALE)

CUNNILINGUS (ORAL SEX ON A FEMALE)

MASTURBATION

PENIS

VAGINA

- Repeat the headings until there are enough to give each group a selection of two.
- Ask the group to elect a recorder. Hand the two sheets of paper to each group and ask them to brainstorm all the terms they have ever heard referring to the particular sexual behaviour described by the heading. The recorder should list the terms as they are suggested.
- After ten minutes, ask the recorders to tape the lists to the wall where all the trainees can see them and then to read out the lists in turn. Any further terms contributed by the other trainees should be added to the lists.

In processing the activity trainees should be asked:

- How they felt using these words to describe sexual behaviours.
- Whether there were words they had never heard before.
- In what ways the language used reflects cultural, racial and class values, attitudes and biases.
- Which words they found negative and derogatory and what this reveals about attitudes towards the group of people they refer to.
- To imagine how they might feel helping a client assess their AIDS risk and using their language to describe particular sexual behaviours.

NOTE: *You as a trainer might feel a little awkward or embarrassed to introduce this activity. Be assured that this training activity has been used among Caribbean health care workers on a number of occasions and has been well-received.*

TRAINING ACTIVITY

Where do You Stand? (A Values Clarification Exercise)

Purpose: To give the participants an opportunity to clarify and examine their own values related to sex, sexuality and AIDS.

Objectives - Participants will be able to:

- Identify values and biases related to sex and sexuality.
- Share beliefs and values with group members.
- Recognise similarities and differences among group members.

How long does it take?

- Allow 40 minutes

What do I need?

- Large sheets of paper or card.
- Pen, marker or coloured chalk.

How do I do it?

- On four large sheets of paper, write the following headings:

AGREE
PARTLY AGREE
PARTLY DISAGREE
DISAGREE

- Tape one of the papers in each of the four corners of the room.
- Explain to trainees that you will be reading out a series of statements about sex, sexuality and AIDS prevention. As each statement is read, ask the participants to decide which heading corresponds to their response. They should move to that corner. Designate the middle of the room for those who are undecided, but encourage people not to use this option.

- **Emphasise that the purpose of this activity is not to debate each statement, but rather to give participants an opportunity to identify their own values and attitudes, and see the similarities and differences among the group members. You will be moving on to the next statement as soon as they have assembled in the corners in response to the previous one.**

Read out loud some or all of the following statements one at a time, allowing time for the trainees to move to the area of their choice:

- A child should be taught about sex primarily by parents.
- Parents should not allow their daughters as much sexual freedom as their sons.
- I would hesitate to marry someone with whom I had not had sexual intercourse.
- Easy availability of sex education and birth control tends to encourage sexual activity, especially among young people.
- Men are more likely to enjoy sex without love than are women.
- It is more important for the man to be sexually experienced at the time of marriage or union than for the woman.
- Parents should wait until their children ask questions about AIDS before discussing it with them.
- The average woman wants sexual activity less frequently than the average man.
- It is acceptable for men to have sex with other men.
- People who are HIV positive should not be sexually active.
- Anal sex is a normal sexual activity among heterosexuals.
- It is acceptable for a man not to disclose his sexual activities outside the relationship to his female partner.
- It is acceptable for a woman not to disclose her sexual activities outside the relationship to her male partner.

- HIV-positive women should not have children.
- It is more important for the man to be sexually satisfied than for the woman.
- I feel comfortable asking a client if they engage in anal intercourse.

When there appear to be clearly divergent views on a statement, add an additional exercise. Ask each trainee to find a partner in their corner and explain to them in one minute why he or she responded in the way he or she did. Next, ask every trainee to find another partner from a different corner of the room and repeat the exercise. When this additional activity is completed, move on to the next statement.

Ask everyone to return to their seats.

In processing the activity, emphasise that it is designed to identify personal choices, not to provide a forum for debating them. Ask the trainees to consider the following questions:

- *Did any of your responses surprise you?*
- *Was it more difficult to decide your response to the statement or share it with others?*
- *What shapes our values and attitudes towards sexuality?*
- *How did you feel as you responded to the statements?*
- *Which statements did you feel most uncomfortable responding to?*
- *How might your values and attitudes affect your work as an AIDS prevention counsellor?*

PSYCHOSOCIAL ISSUES FOR PEOPLE WITH AIDS, HIV INFECTION AND THEIR FAMILIES

Introduction

People with AIDS and their families face a complex set of psychosocial issues as they confront the impact of a diagnosis on their lives. They share with others who know their lives are threatened by incurable disease many of the psychological responses to, and the coping mechanisms for dealing with, the disease. However, the socio-cultural aspects of the AIDS epidemic and the fact that HIV is transmissible complicate the adaptation process of living with this life-threatening illness.

The fact that HIV affects disenfranchised populations and evokes strong cultural taboos about homosexuality, sex, death and drugs accounts for the degree of stigma attached to the illness. The complexity of the psychosocial responses to the diagnosis is increased by the young age of most people with AIDS.

AIDS prevention counsellors and educators must have a keen awareness of the psychosocial experiences of people with AIDS and their families. It is through this understanding that AIDS prevention counsellors and educators will be more effective in their efforts to support people with HIV or AIDS and their families while promoting the adoption of low risk behaviours.

Information to Present

How do people with HIV and AIDS adapt psychologically to their diagnosis?

People with HIV infection or AIDS typically experience a range of emotional responses and grief reactions which would be associated with adapting to any diagnosis of a life-threatening illness.

The ability of a person with HIV infection or AIDS to cope with the diagnosis is largely determined by his or her level of functioning prior to diagnosis including:

- access to resources.
- coping skills.
- personality style.
- family history.
- substance use.
- self-esteem.
- social support.

Adapting to a diagnosis of HIV infection or AIDS involves adapting to a series of physiological and psychological crises. Inevitably, the first crisis is that of the diagnosis. **Once the individual has adapted to this, new crises emerge at different stages of the illness. These might include:**

- rejection by a family member or a friend.
- losing financial security.
- onset of new symptoms or infections.
- becoming bed-bound and physically dependent on others.

This crisis-adaptation process continues throughout the course of the illness.

How does AIDS complicate this adaptation process?

The socio-cultural and medical factors unique to the AIDS epidemic pose an additional burden for people with HIV infection and AIDS, making adaptation more difficult. These include:

Stigma, which manifests itself by:

- rejection by family.
- rejection by community and peers.
- loss of employment.
- loss of housing.
- loss of insurance.
- discrimination.
- withdrawal of social support system.

Fear others have of "catching" AIDS, which manifests itself by:

- withdrawal from and/or rejection of the person with HIV infection or AIDS.
- irrational fears creating discriminatory or violent situations.

Discomfort others feel with the taboo issues raised by the epidemic which include:

- sex.
- homosexuality.
- death.
- drugs.

The necessity for, and difficulty of, adapting low risk behaviours at a time of physical and psychological crisis.

What are typical emotional and psychological reactions experienced by people with HIV infection or AIDS?

Strong emotional reactions to living with a life-threatening illness are appropriate and expected. These can include:

- anger.
- helplessness.
- guilt.
- sadness.
- hopelessness.
- suicidal thoughts.
- fear.

Individuals typically experience depression and/or anxiety at different points throughout the illness. Depression and anxiety can also be caused by medical conditions associated with AIDS, by medications or by neurologic manifestations of the disease. If and when the depression or anxiety becomes severe and incapacitating, and/or when the cause is unclear, appropriate interventions should be made.

People with HIV infection and AIDS experience ongoing grief related both to anticipated losses, such as death, and current losses, for example, inability to work. Frequently, the individual may have just begun to accept one loss when another one occurs.

These psychosocial issues affect an individual's abilities to make and sustain behavioural changes. Support and assistance in developing coping skills to adapt to a diagnosis and the necessary behavioural changes increases the likelihood of people with HIV infection and AIDS being able to sustain new behaviour patterns. Exposure to stigma and rejection will make adopting new behaviour patterns even more difficult for those with poor psychological coping.

TRAINING ACTIVITY

Panel Discussion: People with HIV Infection, AIDS and Their Families

Purpose: To meet people with HIV infection and AIDS and their families; to dispel myths and stereotypes about people with the disease; to increase their comfort level in interacting with HIV-infected people, and people with AIDS.

Objectives - Participants will be able to:

- Identify three psychosocial concerns for people with HIV infection and AIDS.
- Discuss one myth or stereotype that has been challenged or changed.

NOTE: *If a panel is not available, you may be able to substitute a video presentation that features people with AIDS/HIV infection talking about their lives.*

How long does it take?

- Allow one and one-half hours.

How do I do it?

- Have the trainees assemble into a large group and seat the panelists facing them. Introduce each panelist briefly by name, diagnosis, date of diagnosis and anything else they may wish to have said of them, for example:
 1. *Profession.*
 2. *Work status.*
 3. *Family status.*
- Ask each panelist to speak about their physical and emotional experiences since being diagnosed, what their lives (work, social and family life) were like before AIDS and how that has changed. Allocate 5 to 15 minutes each, depending on the number of panelists and their comfort level at speaking in public.
- After the panelists have finished, ask for questions to them from the audience. Tell the panelists that they do not have to answer any question they find uncomfortable or too personal.

- If the trainees show reluctance in asking questions of a private and personal nature, ask some questions yourself that seem personal yet are key in sensitising the audience to the true experience of people with HIV infection and AIDS.
- After the panel session is completed and the panelists have been thanked and left the workshop, leave ample time for participants to express their feelings and reactions, either in several small groups or the large group.

In processing the activity the trainees should be asked to consider the following questions:

- *What did you learn about people with HIV infection and AIDS after listening to the panel?*
- *Did you learn anything new about yourself? If so, what?*
- *What key psychosocial concerns for people with HIV infection and AIDS were identified by the panel members?*
- *Did the panel discussion encourage you to reconsider any myths or stereotypes? If so, which ones?*
- *Do you feel better prepared by the panel to work as an AIDS prevention counsellor? If so, in what way?*

NOTE: *Remind the trainees that they should not discuss or reveal the identities of the panel members once they leave the workshop.*

Alternative Training Activity

When panelists for this activity cannot be located, an alternative which can be offered is a showing of videos depicting the lives of one or more people with HIV infection or AIDS. Conduct the process question session in the same way as above.

RELIGION AND SPIRITUALITY

Introduction

Religion and spirituality can provide enormous help and solace to a person with AIDS, and his or her family, in coping with the life-threatening illness and during times of grief.

Religion also influences people's values and attitudes about family, sex roles, sexuality and sexual orientation. As such, organised religion, the clergy and congregations of all churches can contribute in a powerful and widespread way to the AIDS prevention effort.

Information to Present

1. Religious organisations and activities in the Caribbean.
2. Cultural feelings about religion and spirituality in region.
3. The role of religion and spirituality in helping individuals through difficult times.
4. The role of the churches and congregations in responding to AIDS:
 - Religious doctrine.
 - Clergy.
 - Church members.

TRAINING ACTIVITY

Religion and Spirituality in My Life

Purpose: To consider the personal meaning and significance of religion and spirituality.

Objectives - Participants will be able to:

- Determine a personal definition of religion and spirituality.
- Explain the significance of religion and spirituality in their lives.
- Discuss the ways that religion and spirituality might be helpful and/or difficult for people with AIDS and their families.

How long does it take?

- Allow 30 minutes.

What do I need?

- Large and small sheets of paper.
- Pens, markers or coloured chalk.

How do I do it?

- Write one of the incomplete sentences on each of six sheets of paper:

RELIGION IS...

SPIRITUALITY IS...

RELIGION IS IMPORTANT IN MY LIFE BECAUSE...

RELIGION IS NOT IMPORTANT IN MY LIFE BECAUSE...

SPIRITUALITY IS IMPORTANT IN MY LIFE BECAUSE...

SPIRITUALITY IS NOT IMPORTANT IN MY LIFE BECAUSE...

- Tape these sheets at the front of the room and hand the trainees a small sheet of paper and a pen each.
- Ask the trainees to complete four of the six sentences above on their sheets of paper. They should choose one each of the alternative sets. Allow them 5 to 7 minutes to complete the writing.

- Read out each of the statements in turn and ask the trainees to volunteer to share their definitions with the group. Write down their statements and continue to ask for contributions until you have a considerable list on the large sheets. Summarise the common themes.

In processing the activity, questions which the trainees should consider include:

- *What role might organised religion play in the lives of people with AIDS and their families?*
- *What role might spirituality play in the lives of people with AIDS and their families?*
- *What role might organised religion, clergy and church members take in AIDS prevention efforts?*

COUNSELLING AND COMMUNICATION SKILLS

Introduction

AIDS prevention counselling may be the only practical means for promoting the adoption of long-term low risk behaviours. Counselling programs should identify and promote low risk behaviours and provide emotional and psychological support to people with HIV infection, their families and friends.

Counselling is the process of face-to-face exchange and support through which people can question, share and come to terms with alternative prevention behaviours. Counselling helps people understand the threat of HIV infection in personal and tangible ways. It helps people select specific behaviours suited to their lifestyle and then provides support to maintain those changes.

Counselling gives people the opportunity to ask questions, to vent anger and share frustration. It helps to ensure that they do not unduly fear the disease or those who have it. Counselling can help people decide whether to be tested for HIV infection and how to cope with the results if they choose to be tested. It can reinforce condom promotion and behaviour change strategies by allowing people to explore these ideas confidentially.

For those individuals who need personal support for making and sustaining behaviour changes, and practice with new behaviours such as using condoms properly, counselling is particularly helpful. It can also be valuable for those individuals who are unlikely to attend public meetings, for people who would need to hear information that is very sensitive and personal in a private setting, and for individuals with negative attitudes towards the new behaviour, or who have habits, such as intravenous drug use, that prevent them from easily adopting a given behaviour.

Counselling can take many forms. It can:

- occur individually or with groups.
- rely on professionals or on peers.
- focus on crisis or long-term problem-solving.
- be useful to those at risk as well as those already infected.

Counselling is a primary prevention tool because it is the only one, of all the means to educate, which allows sustained interaction, exchange, and dialogue about specific prevention behaviours.

Information to Present

Counselling is a special form of interpersonal communication in which feelings, thoughts and attitudes are expressed, explored and clarified. It is a process which can help people to feel less anxious, to make decisions and to take action. Often, but not always, counselling implies helping another person to make a decision about a future course of action. Counsellors utilise a set of skills to "enable" the client to reach a better understanding of his or her problem or situation, deal with the related feelings and concerns, examine the options and choose alternatives that seem best.

Characteristics of Effective Counselling:

1. *Confidential*

Counselling is a non-threatening interaction in which clients can feel safe to identify and discuss their thoughts, feelings and attitudes because the content of the discussion remains confidential between the counsellor and the client. To ensure and protect a trusting relationship between the counsellor and the client, the limits of confidentiality (when they exist) must be disclosed to the client at the outset.

2. *Non-Judgemental*

The counselling process depends upon the establishment of a trusting relationship between the counsellor and the client. Clients must feel comfortable disclosing personal and private information to a relative stranger. To facilitate the process, counsellors must take a non-judgemental stance towards the client and his or her lifestyle.

This means that the counsellor keeps his or her values, attitudes and opinions out of the counselling process. It means that counsellors accept and respect the client, even if his or her lifestyle is different from the counsellor's. It does not mean that the counsellor must agree with the client, adopt the client's lifestyle or refrain from challenging the client about behaviours, thoughts or emotional patterns which may be self-destructive.

3. *Non-Directive*

The counselling process is non-directive. The counsellor maintains a non-directive stance by facilitating the client's process of coming to a better understanding of his or her problem and solutions rather than giving opinions or advice. This is not to say that the counsellor acts in a passive role. On the contrary, the counsellor's role is quite active in that he or she presents information and guides the client.

4. *Process-Oriented*

Counselling focuses on the client's process of coming to a better understanding of his or her situation. This process will involve many developments and changes as the client works toward understanding and solving the particular problem. The counsellor listens for and comments on the problem and what the client says about it as well as what the client does not say. The counsellor remarks upon the feelings and attitudes which may be expressed verbally or non-directly.

Prerequisites to Essential Counselling Skills and Responses:

1. *Establishing Rapport*

The first step towards developing trust between counsellor and client involves establishing rapport with the client. The opening phase of the counselling session is the time to create a non-threatening environment by establishing an accepting and compassionate relationship. This is accomplished through the counsellor's initial interactions with the client such as greeting, introductions, non-verbal communication, framing the counselling session, conveying a non-judgemental atmosphere, addressing concerns about confidentiality, etc.

2. *Demonstrating Empathy*

The most basic and significant counselling skill is the ability to demonstrate empathy with the client. Empathy is

the ability to understand and relate to another person's feelings and experiences. This entails being sensitive and responsive to him or her without making assumptions about the client based upon what the counsellor thinks he or she would feel. A counsellor demonstrates empathy by listening attentively to what the client says, what the client does not say and what feelings the client expresses verbally or non-verbally.

The counsellor then communicates to the client understanding of these feelings, thoughts and attitudes regarding a particular problem. To demonstrate empathy counsellors must be acutely aware of their own feelings and responses so as to be sensitive to the client. They must be able to use their own emotional responses as clues to understanding the client while also being able to separate their emotions from their clients'.

3. *Genuineness*

Establishing rapport, building trust and demonstrating empathy all rely on the ability of the counsellor to be genuine. When the counsellor interacts with the client as a real and sincere person, rather than acting out a role, a genuine relationship can develop.

4. *Non-Verbal Communication*

Non-verbal communication is an important element in letting clients know that they are being attended to, heard and understood. Counsellors convey this to clients through:

- *body language, for example, leaning forward.*
- *frequent eye contact.*
- *mirroring client's energy or emotional level.*
- *encouraging conversational cues, for example, nodding.*
- *calm body posture, no fidgeting.*

Essential Counselling Skills and Responses:

1. Active Listening

Active listening demands extremely concentrated listening on the part of the counsellor, who must pay acute attention to the client's verbal disclosures, non-verbal cues and feelings that are indirectly expressed. Counsellors maintain and communicate their active involvement with the client while listening through non-verbal communication such as eye contact, nodding the head, etc.

2. Paraphrasing

Counsellors can paraphrase or restate in his or her own words what the client said in order to let the client know that he or she has been heard. Counsellors can paraphrase both content and underlying feelings. This can help to clarify what the client has expressed.

Example:

"So, what you are saying is that you can't imagine how you could have been exposed to HIV."

3. Asking Effective Questions

Counsellors use questions to obtain specific information, to help the client communicate clearly, to encourage exploration and clarification of thoughts, feelings and attitudes. Open-ended questions, those which require more than a yes or no answer, encourage this type of discussion and communication because they allow for any response. Closed questions, by contrast, only allow for a yes or no answer and discourage discussion or exploration.

Example:

"Would you tell me more about how you are feeling?"

"Can you tell me more about that?"

"What was that like for you?"

4. Identifying and Reflecting Feelings

Counsellors can help clients identify and clarify their feelings and reactions by listening for the feelings being described and then reflecting them back to the client. Reflecting gives the counsellor the opportunity to interpret, and then compare with the client, what the client has expressed.

Examples:

“You seem to feel very angry with your husband for becoming infected with HIV, and very worried about him at the same time. Can you tell me more about your feelings toward your husband?”

Additional Counselling Skills and Responses:

1. Problem-Solving

Counsellors often help clients in solving a problem. This is most effectively done by allowing the client to state the problem and then helping the client to clarify and define it. The counsellor may suggest possible solutions and then facilitate the client's exploration of the potential solutions and their consequences, as well as the process of decision-making and carrying out of the solutions. Counsellors should not make assumptions about what is problematic to the particular client, nor should they attempt to solve the problem for them.

2. Assuring and Reassuring

Counsellors assure and reassure clients verbally and non-verbally. For example, a client who receives a positive test may feel afraid of being rejected and “untouchable”. The counsellor can reassure the client that he or she does not fear the client and will not back away by maintaining an open body posture, leaning forward, or reaching out and touching the client's hand.

3. *Universalising and Normalising*

When clients are expressing emotional responses that are typical, and often universal, it is helpful to them to be told that. Counsellors can universalise and normalise the client's responses by explaining to them what is a typical or usual response to a similar situation.

Example:

"Your reaction is completely normal. Most people react very much like you have, and feel frightened when they find out they tested positive for HIV."

4. *Acknowledging and Validating*

Counsellors can let clients know that they are aware of their feelings and understand how and why they might be feeling that way by validating the response.

Example:

"I can understand why you would feel so sad about testing positive about HIV, and the losses you may face."

5. *Confirming Realities*

Counsellors need to confirm the truth and facts of what clients are facing and experiencing, even when they may want to protect them or cushion them from reality.

Example:

"Yes, it's true that the majority of people who test positive will develop symptoms over time."

6. Probing

Counsellors probe the client through questioning in order to fully explore and investigate the client's situation.

Example:

"In what other ways might difficulties be created in your life if you do not change your sexual behaviour?"

7. Confronting

Confronting the client may be an effective response when an issue is being denied or has not come out into the open.

Example:

"I know that it is difficult to understand how you can feel healthy, but have this virus inside of you that you are capable of transmitting to others. But if you do not adopt safer sex practices your wife could become infected."

8. Focussing

It is easy for the client to become sidetracked in the counselling session because it causes so many thoughts and feelings to emerge. The counsellor needs to help the client focus on the most important issues at hand.

Example:

"Let us come back to the issue of safer sex practices."

9. Appropriate Use of Silence

Silence in a counselling session is important at times. It gives the client an opportunity to reflect, integrate feelings, think through an idea or absorb new information. It is not always comfort-

able to allow the silence to continue, but counsellors should not interrupt it prematurely because of their own discomfort. There can be no specific guidelines as to when silence is helpful but counsellors should consider whether they are motivated to break it because of their own discomfort, or as a positive intervention with the client.

10. *Supporting and Modelling Behaviours*

Counsellors can support and reinforce specific behaviours by modelling them for and with the client. For example, if a goal of the counselling session is for the client to improve communication skills, the counsellor can model clear and direct communication when he or she interacts with the client. When the client responds with clear and direct communication, the counsellor can comment on and support this type of dialogue.

11. *Providing Information*

Providing information during a counselling session requires skill and awareness. Counsellors should present information in a clear and understandable manner, in an amount which is sufficient but not an overload, and during a point in the session in which it is appropriate and helpful.

12. *Summarising*

Summarising is a useful technique at the end of a session, or in the middle; a time to pause, reflect on what has been discussed so far and to propose a similar or new direction.

Example:

“So far we have discussed safer sex practices and how you feel about making these changes. Do you feel that we have discussed this topic enough for now?”

TRAINING ACTIVITY

Without Words

Purpose: To improve active listening skills.

Objectives - Participants will be able to:

- Demonstrate empathy non-verbally.
- Practice attentive listening.

How long does it take?

- Allow 25 minutes.

How do I do it?

- Ask participants to choose a partner.
- Ask each participant to think of a current personal problem or concern that they are willing to discuss. Explain that each partner will have five minutes to talk about his or her problem, during which the other person will listen attentively and communicate empathy and understanding non-verbally. The listener should not speak at all. After five minutes, the pair should switch roles.
- After they have each spoken for five minutes, ask the pair to discuss their experience for three or four minutes.
- Call the pairs back into the large group.

In discussing the activity ask the trainees to consider the following questions:

1. *How did you feel about talking for five minutes without interruption?*
2. *How did you feel, listening but not speaking?*
3. *Did the silence make you uncomfortable? If so, why?*
4. *Did you feel that your partner was (or was not) listening attentively? What non-verbal cues communicated this?*
5. *Did you feel that your partner understood your problem? How could you tell?*

TRAINING ACTIVITY

What Did You Say?

Purpose: To practice the counselling skill of paraphrasing.

Objectives - Participants will be able to:

- Listen to a partner describe his or her reaction to a controversial statement.
- Accurately, and in his or her own words, restate what the partner said.

How long does it take?

- Allow 20 minutes.

What do I need:

- List of controversial statements, xeroxed for all participants.

How do I do it?

- Demonstrate, with your co-trainer, the skill of paraphrasing in front of the large group. Choose a controversial topic that may or may not be AIDS-related. Prior to the demonstration, decide which one of you will take a stand for or against the statement. Explain to the group that you will be demonstrating the skill of paraphrasing, and that you have each chosen an opposing opinion that may or may not reflect your actual feeling on the subject.
- Tell the group the topic of statement. Ask your co-trainer to state his or her opinion. Paraphrase what was said. Tell your co-trainer whether he or she accurately paraphrased what you said. Next you state your opinion, and your co-trainer paraphrases what you said. Tell your co-trainer whether or not you were paraphrased accurately. Repeat this a second time, each of you stating an additional reason why you agree or disagree with the topic or statement. For the purposes of a demonstration, one of you may decide to paraphrase what your partner stated incorrectly. When you are finished with the demonstration, ask participants if they have any questions about paraphrasing. Emphasise the difficulty of paraphrasing, without giving your opinion, when your belief is different from the person you are listening to.

- Next, hand out the sheet of paper with controversial statements. Ask each person to write their responses to each statement. When this is completed, ask each person to select a partner.
- For the next ten minutes, ask each pair to select as many statements as they have time to discuss. Ask the first person to explain his or her response to the statement. The partner is to paraphrase what was said. The first person is then to acknowledge whether he or she was accurately paraphrased. The partners then switch roles while discussing the same topic.

After ten minutes, call the large group back together again. In processing the activity, ask the participants to consider:

- *Was there anything you found difficult about paraphrasing?*
- *How would paraphrasing be useful in the context of AIDS prevention counselling.*

In the blanks, fill in an (A) for agree and (D) for disagree.

1. _____ People who get an STD deserve it.
2. _____ Parents should not allow their daughters as much sexual freedom as they allow their sons.
3. _____ I would hesitate to marry someone with whom I had not had sexual intercourse.
4. _____ Masturbation is a healthy sexual expression for people of all ages.
5. _____ Men are more likely to enjoy sex without love than are women.
6. _____ Sex improves with age.
7. _____ Children should be taught about STD's and AIDS at school.
8. _____ The average woman wants sexual experience less often than the average man.
9. _____ It is acceptable for men to have sex with other men.
10. _____ People who are HIV positive should not be sexually active.
11. _____ Anal sex is a normal sexual activity among heterosexuals.
12. _____ People who are at high risk for contracting HIV should be required to take an HIV antibody test.
13. _____ I feel comfortable talking with a person about his or her homosexual feelings and behaviour.
14. _____ HIV positive women should not have children.
15. _____ It is more important for the man to be sexually satisfied than for the woman.
16. _____ I feel comfortable asking a client if they engage in anal intercourse.

TRAINING ACTIVITY

Asking Effective Questions

Purpose: To practice asking open-ended questions.

Objectives - Participants will be able to:

- Ask open-ended questions.
- Identify the impact of being asked open-ended questions as the client.
- Discuss the role of asking closed questions.
- Discuss the benefits of asking open-ended questions in a counselling session.

How long does it take?

- Allow 35 minutes.

How do I do it?

- Divide the large group into groups of three. Divide the group so that participants are working with new partners.
- Ask group members to choose roles for themselves: client, counsellor and observer. Each member of the group will play each role.
- Ask the client to think of a current personal problem or concern that they are willing to discuss. Explain that each person will have five minutes to talk about his or her problem. The counsellor is to respond only with questions. The observer is to write down the questions the counsellor asks, noting whether they are open-ended or closed questions.
- After five minutes, the triad is to discuss, for two minutes, what type of questions were used in the role play and whether or not they were effective from each person's perspective.
- Have the triad switch roles and repeat this process two more times.
- Call the triads back into the large group.

In discussing the activity, ask the trainees to discuss the following questions:

- As the client, what was it like to be asked closed and open-ended questions?
- As the counsellor, what was it like to ask closed and open-ended questions?
- In what instances were closed questions most helpful?
- In what ways are open-ended questions effective in a counselling session?

TRAINING ACTIVITY

What Are You Feeling?

Purpose: To become more familiar with identifying and communicating feelings.

Objectives - Participants will be able to:

- List a variety of feelings.
- Demonstrate feelings non-verbally.
- Recognise feelings from non-verbal cues.

How long does it take?

- Allow 25 minutes.

What do I need?

- Large sheet of paper.
- Pen, marker or coloured chalk.

How do I do it?

- Ask the large group to brainstorm feelings or emotions, calling them out by name. Write each suggestion on the large sheet of paper.
- Divide the large group into small groups of six to eight. Ask each participant to choose an emotion from the list you have just written and, taking turns, act it out for the others without using any words. The other group members should guess which emotion is being portrayed. Depending on time, the group may go around a second time acting out their feelings.

Call the small groups back into a large group. In processing the activity ask the participants to consider:

- *Which non-verbal cues were most helpful in communicating the emotion?*
- *Were some feelings easier to guess than others? Why was this?*
- *Which non-verbal cues were misinterpreted or missed when the wrong emotion was guessed?*
- *What helps to identify clients' feelings when they may not be acting them out so visibly?*

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TRAINING ACTIVITY

Identifying and Reflecting Feelings

Purpose: To practice identifying and reflecting clients' feelings.

Objectives - Participants will be able to:

- Identify feelings accurately.
- Interpret the reason for the feeling.
- Reflect back to the client his or her feeling.

How long does it take?

- Allow 45 minutes.

How do I do it?

- Ask participants to choose a partner. Explain to the pairs that, in this role-playing activity, each person will play both the counsellor and the client roles.
- In the client role, ask the trainee to discuss one of the following concerns:
 - fears or concerns about talking with a person at risk for AIDS.
 - fears or concerns about talking with a person with AIDS.
 - fears or concerns about being an AIDS prevention counsellor.

In the counsellor role the trainees will respond to what the client tells them, but use only statements which describe the emotion being expressed, as for example "You feel sad, angry, afraid, etc."

- Explain that this limited response in the counsellor role may feel awkward but that its sole purpose is to practice accurately identifying the feelings of the client. Other ways of responding to clients and identifying their feelings can be discussed after the exercise.
- Each partner will have five minutes to talk about his or her problem and will then exchange roles to play the counsellor.
- After ten minutes inform the pairs that the role-play continues. The client continues to describe his or her personal problem from the point where they left off. The counsellor continues to identify feelings for the client but

this time, adds an interpretation of the feeling, as for example, "You feel angry about working with a person with AIDS. You already have too much to do at work."

- Allow each partner five minutes and then instruct the pairs to spend three or four minutes discussing the activity.

Call the pairs back into a large group and process the activity by asking the trainees to consider the following questions:

- *As counsellors, how did you feel making the statements "You feel..." and "You feel....because..." ?*
- *As clients, what was it like to have your feelings identified, interpreted and reflected? What did you feel or do as the client if the counsellor did not accurately identify or interpret your feeling?*
- *What other ways can you phrase statements or questions to identify and interpret feelings for clients?*

COUNSELLING: STAGES OF A SESSION

STAGE	PURPOSE	SKILL
INITIATING	<ul style="list-style-type: none"> • Relationship building. • Acceptance of the individual's need to share the nature of the dilemma shows RESPECT. • Appreciating the personal significance of the dilemma conveys EMPATHY. • Authenticity in dealing with the individual shows GENUINENESS. 	<ul style="list-style-type: none"> • Listening • Attending • Observing • Asking Open Questions
EXPLORATION	<ul style="list-style-type: none"> • Understanding the implication and effects of the difficulties experienced. • To enable the individual to gain a greater understanding of the dilemma. 	<ul style="list-style-type: none"> • Reflecting • Paraphrasing • Focussing
UNDERSTANDING	<ul style="list-style-type: none"> • To encourage the individual to begin to move toward a consideration of possible options. • To begin the process of assessing the various options and considering the pressure for and against them. 	<ul style="list-style-type: none"> • Defining • Confronting • Focussing on Immediate Needs
ACTION	<ul style="list-style-type: none"> • To help move toward change. • To create a climate of choice. • To enable the individual to take charge. 	<ul style="list-style-type: none"> • Making Action Agreements with Client • Action Planning • Goal Setting • Homework
CLOSURE		<ul style="list-style-type: none"> • Completing Session

COUNSELLING SKILLS SHEET

Counselling is a special form of interpersonal communication in which feelings, thoughts and attitudes are expressed, discussed and clarified. It is a process which can help people to feel less anxious or depressed, to make decisions, and to take action. Often, but not always, counselling implies helping another person to make a decision about a future course of action. Counsellors utilise a set of skills and responses to "enable" the client to reach a better understanding of his or her problem or situation, deal with the related feelings and concerns, examine the options and choose alternatives that seem best.

Characteristics of Effective Counselling:

1. Confidential.
2. Non-judgemental.
3. Non-directive.
4. Process-oriented.

Prerequisites to Essential Counselling Skills and Responses:

1. Establishing rapport.
2. Demonstrating empathy.
3. Genuineness.
4. Non-Verbal communication.

Essential Counselling Skills and Responses:

1. Active listening.
2. Paraphrasing.
3. Asking effective questions.
4. Identifying and reflecting feelings.

Additional Counselling Skills and Responses:

1. Problem-solving.
2. Assuring and reassuring.
3. Universalising and normalising.
4. Acknowledging and validating.
5. Confirming realities.
6. Probing.
7. Confronting.
8. Focussing.
9. Appropriate use of silence.
10. Supporting and modelling behaviours.
11. Providing information.
12. Summarising.

COUNSELLING IN HIV INFECTION AND AIDS

**E.O. Thomas, et. al.
Comprehensive STD and Health Clinic
Kingston, Jamaica**

Our countries are desperately short of resources to deal with the AIDS crisis, but despite this, we can rely on one fundamental resource -- solidarity.

We must be able to recognise a common goal and work together to achieve that goal.

AIDS CAN BE PREVENTED, but it is very important that we note the following five features of HIV infection and AIDS:

- Infection with the virus is lifelong.
- An infected person may not show any symptoms for years.
- People with the infection can continue to be fully functional.
- HIV infection can be prevented even without a vaccine.
- The AIDS epidemic has provoked fear and misunderstanding about what HIV infection and AIDS mean for social relationships and society. We have all been influenced by this fear and misunderstanding.

THE ROLE OF COUNSELLING

COUNSELLING AS A PROCESS can:

- help people understand better.
- deal with their problems.
- communicate better.
- improve and reinforce motivation to change behaviour.
- deal with fear and anxiety.
- solve problems arising with self, families and others.
- ensure correct information.
- assess expectations, willingness and capacity to change behaviour.
- help individuals considering HIV antibody testing to be well-informed and appreciate the technical, social, ethical and legal implications.

COUNSELLING AS A SERVICE SHOULD ENSURE:

- continuing access to counsellor.
- consistent support from health and social system.
- adequate time for discussion and problem-solving.
- respect for the individual regardless of sexual preference, socio-economic background, state of health, nationality, religious or ethnic origin.
- protection from discrimination against the infected.
- ensure their continued integration in society.

WHO SHOULD RECEIVE COUNSELLING?

- Individuals considering HIV antibody testing (pre-test counselling).
- Individuals whose HIV antibody test results are negative (post-test counselling).
- Individuals whose HIV antibody test results are positive (post-test counselling).
- Individuals practicing high-risk behaviours.
- Individuals infected with HIV (asymptomatic or symptomatic).
- Individuals with AIDS.
- Individuals with AIDS facing imminent death.
- Families, lovers, friends and employers of people infected with HIV.

THE COUNSELLOR SHOULD BE ABLE TO:

- communicate information accurately, consistently and objectively.
- gain trust from people with psychological and social difficulties.
- listen sympathetically.
- understand people's feelings.
- accept feelings and expressions without criticism or censure.
- respond to people so that they will feel free to talk.
- help people understand their problems and those of others in their lives.
- help people reduce or solve their problems.
- avail themselves of further training and courses designed to upgrade their knowledge and skills.

Mr. E.O. Thomas is the Chief Contact Investigator at the Comprehensive STD and Health Clinic in Kingston, Jamaica. 1989.

RISK ASSESSMENT AND RISK REDUCTION COUNSELLING

Introduction

AIDS educators and counsellors play a key role in helping individuals to assess their risk for HIV and implement risk reduction behavioural changes. This can take place during pre- and post-test counselling sessions, as well as in a variety of other counselling situations in which antibody testing may not be involved.

Risk assessment and risk reduction counselling is an interactive process between counsellors and clients in which counsellors provide clear and simple information, clarify misinformation, and assist in decision-making and implementation of behavioural changes. Due to the intimate, and often taboo, nature of risk behaviours, counsellors need opportunities to practice asking explicit questions about sexual and drug use matters while noting their own reactions, values and attitudes.

The process of risk assessment involves helping an individual to personalise his or her risk for HIV: that is, to bring a person to the understanding that HIV poses a personal threat as a result of his or her behaviours. Education and counselling can help people break through their denial and come to terms with their potential risk.

The counsellor assists the individual to recognise that, although HIV is a personal threat, it can be avoided by adopting safer behaviours. Once this message is internalised, the counsellor helps the client decide which behavioural changes to make and how to implement them.

AIDS educators face considerable challenges in helping people to assess their risk and reach decisions about the changes they are willing to make to reduce it. Changing sexual and drug use practices, even in the face of danger, is no easy task. Many sexual practices do not fall into the categories of completely safe or completely unsafe. Thus people can be asked to embrace changes in their sexual behaviours which do not always guarantee absolute safety. Confusion, denial and difficulty in personalising the risk for the client can result.

Information to Present

Risk Assessment Counselling:

The goals of a risk assessment counselling session are to help the client:

- Personalise his or her risk for HIV by recognising that it is a personal threat.
- Assess his or her current and past risk for HIV infection.

There are several areas which are important to discuss as you begin the session:

- Explain the purpose of HIV risk assessment.
- Assess the client's knowledge of how HIV is transmitted and clarify any misinformation.
- Ask the client to assess his or her current and past high risk behaviours.
- Ask the client to assess his or her risk for HIV. Discuss any concerns and clarify misconceptions.
- Summarise the discussion about the client's HIV risk, leading to a discussion about risk reduction.

The crucial messages which should be conveyed at an early stage of the session are:

- Discuss the importance of assessing HIV risk so that the disease can be prevented. Explain that in order to do this, you must discuss explicit sexual behaviour and substance use, including subjects which may be culturally taboo. Explain that the purpose is not to make assumptions about or judge a person's behaviour but rather to prevent the person from becoming sick or transmitting HIV to others.
- Explain the necessity of reviewing all forms of risky behaviour with each individual, even if the behaviour is familiar to the client.
- Acknowledge the discomfort and embarrassment the client may feel in discussing explicit sexual behaviour and substance use openly. Reassure them that these are normal reactions.

- Explain that you will be asking the client to reveal very personal and explicit information that is not normally discussed with others.
- Explain that you will initially be using formal terms to describe specific sexual behaviours. If the client is not familiar with the formal expression, use a colloquial expression to describe the behaviour or ask the client how he or she refers to the behaviour. Use the term with which the client is most familiar.

Risk Reduction Counselling:

The goals of a risk reduction counselling session are to help the client to:

- Recognise that HIV transmission is avoidable.
- Identify behaviour changes that will reduce the client's level of risk of contracting or transmitting HIV.
- Plan behaviour changes.
- Develop strategies to overcome potential obstacles to implementing and sustaining new behaviours.

The general sequence which a session should follow is:

- Explain the purpose of HIV risk reduction counselling.
- Ask the client to summarise his or her risk for HIV.
- Ask the client to describe his or her understanding of risk reduction.
- Ask the client to identify new or infrequent behaviours that he or she might adopt to decrease HIV risks.
- Ask the client to discuss how he or she intends to make these behavioural changes. Explore and identify obstacles to implementing and sustaining these behaviours, for example, lack of skills or knowledge to implement change, anticipated resistance from partner/spouse, concern that the behaviour will not be satisfying. Counsellors can help the client problem-solve, strategise, role-play and finalise a behavioural change plan. This

planning process should end with the client's deciding upon an attainable first step for implementing these changes.

- Summarise the client's HIV risk reduction plan.

These are the important messages to convey at the outset of the session:

- HIV is avoidable.
- Transmission of HIV to others is avoidable.
- Changing sexual and drug use behaviours is difficult: these are step-by-step changes which take time, effort and commitment.

TRAINING ACTIVITY

HIV Risk Assessment

Purpose: To become familiar with the information that needs to be gathered in HIV risk assessment and to understand the client's experience when asked the very personal questions that are part of an HIV risk assessment.

Objectives - Participants will be able to:

- Identify general areas of behavioural assessment for HIV risk.
- Describe personal reactions to responding to these questions.
- Evaluate the experience of risk assessment.

How long does it take?

- Allow 30 minutes.

What do I need?

- HIV Risk Assessment forms for each participant.

How do I do it?

- Ask participants to fill out the HIV risk assessment form. Explain that these risk assessment forms will remain in the hands of the participant. They will not be asked to share their responses with anyone else.
- Remind participants that the purpose of the activity is not to evaluate the risk assessment form. The form is only a guideline to the kind of information to be gathered in session, not a recommended tool for using with clients.

After five minutes, divide up the large group into small groups of four. Ask them to discuss these questions:

- *How did you feel as you completed the form?*
- *Were there questions you were unwilling to answer or wanted to answer untruthfully? Why?*
- *What did you learn from this experience that may help you when you are conducting risk assessment interviews with clients?*

Bring the small groups back to a large group and discuss the activity with the following questions:

- *Why might it be difficult for clients to be honest in disclosing information about their high-risk behaviours?*
- *As a counsellor, what can you do to help clients feel more comfortable in talking honestly about their HIV risk?*
- *What methods of assessing risk might be most helpful for the client?*

Points to consider in discussing the activity include the reasons that **people will not disclose honest information about their HIV risk. These include:**

- Fear of recognising one's risk.
- Denial of risk.
- Reluctance to disclose participation in culturally taboo behaviours.
- Fear of stigma and discrimination.
- Discomfort in discussing sexual behaviours and substance use openly.
- Discomfort in discussing personal matters with a stranger.

NOTE TO TRAINER: *This activity works most effectively as an introductory and sensitising activity.*

TRAINING ACTIVITY

Risk Assessment Counselling

Purpose: To practice conducting a risk assessment counselling session.

Objectives - Participants will be able to:

- Demonstrate the steps involved in a risk assessment counselling session.
- Demonstrate effective counselling skills.
- Discuss positive reactions as counsellors and clients.

How long does it take?

- Allow 50 minutes.

What do I need?

- Case examples.

How do I do it?

- Review the steps involved in a conducting a risk assessment counselling session.
- Ask each participant to choose a partner. Explain that each person will take a turn playing the role of counsellor and client.
- Ask each person to take a moment to think of someone they know personally who might be at risk for HIV. Instruct the client to answer the questions as if they were this person. Instruct the counsellor to go through the steps of the risk assessment counselling session and help the client to assess his or her current and past high risk behaviours. (You may use the Risk Assessment Form as a guideline for the kind of information you will want to assess.)

Allot ten minutes for the role-play and five minutes for discussion. After the first is completed, ask partners to switch roles. **Then ask the group as a whole these questions:**

- *What helped the client to personalise his or her risk?*
- *What were the difficulties in this process?*

- ***What part of the risk assessment counselling session felt most comfortable?***
- ***What was most difficult about the counselling session? From the client's perspective? From the counsellor's perspective?***

Ask for questions about information, content or the counselling process. Answer and discuss.

TRAINING ACTIVITY

Risk Reduction Counselling

Purpose: To practice conducting a risk reduction counselling session.

Objectives - Participants will be able to:

- Demonstrate the steps involved in a risk reduction counselling session.
- Demonstrate effective skills in helping a client plan behaviour changes.
- Identify strategies which can help clients overcome potential obstacles to implementing and sustaining new behaviours.

How long does it take?

- Allow 50 minutes.

What do I need?

- AIDS safe sex cards.

How do I do it?

- Review the steps involved in conducting a risk reduction counselling session.
- Have the groups return to their partner. Instruct the client to continue in the role they played in the risk assessment role-play. Instruct the counsellor to conduct a risk reduction counselling session using the risk reduction counselling checklist as a guide to the steps, and an AIDS safe sex card to help the client identify new or infrequent behaviours he or she may be willing to adopt.

Allot fifteen minutes for the role-play and five minutes for feedback. After 20 minutes, ask partners to switch roles. **Then discuss the answers to the following questions with the whole group:**

- *What was most helpful to the client in developing a risk reduction plan? What were the difficulties in this process?*

- ***What was most difficult about the counselling session? From the client's perspective? From the counsellor's perspective?***
- ***What skills, tools or techniques were most helpful to the counsellor in facilitating this counselling session?***

Ask for questions about information, content or the counselling process. Answer and discuss.

TRAINING ACTIVITY

Risk Reduction Strategies: Overcoming Obstacles

Purpose: To identify obstacles to risk reduction and strategies to overcome them.

Objectives - Participants will be able to:

- List five common obstacles to risk reduction
- List five strategies to overcome these obstacles.

How long does it take?

- Allow 45 minutes.

What do I need?

- Large sheets of paper.
- Markers or coloured chalk.
- Masking tape.

How do I do it?

- Divide the large group into small groups of four to six. Ask the groups to choose a recorder.
- Assign each group one of the following topics:
 1. Condom use.
 2. Safe sex practices (non-condom related practices).
 3. Safe needle use practices.
- Give the recorders a sheet of paper and ask them to write their group's topic at the top of it and divide the page into two columns. One column should be headed "Obstacles" and the other "Strategies".
- Ask the groups to brainstorm for ten minutes all the obstacles and objections they can think of for their topic. These should be as specific as possible. Ask the groups working with the safe sex practices to brainstorm separate obstacles lists for different sexual behaviours.
- For the next twenty minutes, ask the groups to brainstorm at least one response or strategy for each obstacle they identified.

Ask the recorders to tape their sheets to the wall and invite participants to spend seven minutes walking around to read them. Call the small groups back into a large group. Inform them that the responses will be copied and circulated later, if this is possible. **Discuss the activity with the following questions:**

- *What did you discover that is new about obstacles to or strategies for HIV risk reduction?*
- *How might you use this information effectively about obstacles and strategies in a risk reduction counselling session?*

HIV RISK ASSESSMENT

Sexual History

1. **Since 1978, have you had sexual intercourse (anal, vaginal or oral) with:**

- anyone infected with HIV? ___yes ___no ___don't know
- anyone who has used intravenous drugs?
___yes ___no ___don't know
- anyone who has shared unsterile needles?
___yes ___no ___don't know
- anyone who has received blood transfusions or other blood products (including hemophilia or other coagulation disorders) before _____?
___yes ___no ___don't know
- any man who had sex with other men?
___yes ___no ___don't know
- any man or woman who has had sex with anyone in the above categories? ___yes ___no ___don't know

2. **With these partners, I have engaged most frequently in the following sexual practices:**

- _____ vaginal and/or anal intercourse without a condom.
- _____ vaginal and/or anal intercourse with a condom.
- _____ oral intercourse (fellatio, cunnilingus) without a barrier.
- _____ oral intercourse with a barrier.
- _____ masturbation, body rubbing, dry kissing.

3. **If you used a condom for anal, vaginal or oral intercourse, did you use it:**

- _____ all the time?
- _____ sometimes?
- _____ once in a while?

4. **How many sexual partners, with whom you have not practiced safer sex, have you had in:**

- the past 10 years? _____
- the past 3 years? _____
- the past year? _____

**Substance Use and/or
Needle Sharing**

5. *Have you ever used drugs intravenously?* ___yes ___no
*If yes, have you ever shared needles or other
paraphernalia?* ___yes ___no
6. *Have you ever shared unsterilised needles for other
purposes such as medications, tattoos, acupuncture?*
___yes ___no
7. *Do you drink alcohol or use non-IV drugs?* ___yes ___no
*If yes, have you ever had difficulty remembering what
happened while you were using drugs or alcohol?*
___yes ___no

**Blood Transfusion
and/or Blood Products**

8. *Have you received any blood transfusions or blood products
(including for hemophilia or other coagulation disorder)?*
___yes ___no *If yes, in what year?* _____

RISK ASSESSMENT COUNSELLING CHECKLIST

1. Explain the purpose of HIV risk assessment. _____
2. Assess client's knowledge about modes of HIV transmission.
Clarify any misinformation. _____
3. Ask the client to assess his or her current and past high-risk behaviours. _____
4. Ask the client to summarise his or her risk for HIV.
Discuss any concerns and clarify misconceptions. _____
5. Summarise the discussion about the client's HIV risk, leading into a discussion about risk reduction. _____

RISK REDUCTION COUNSELLING CHECKLIST

1. Explain the purpose of HIV risk reduction counselling. _____
2. Ask the client to summarise his or her risk for HIV. _____
3. Ask the client to describe his or her understanding of risk reduction. _____
4. Ask the client to identify new or infrequent behaviours that he or she might adopt to decrease HIV risks. _____
5. Discuss plans for making these behavioural changes.
 - a. identify obstacles. _____
 - b. identify strategies to overcome obstacles. _____
 - c. identify an attainable first step. _____
6. Finalise a behavioural change plan. _____
7. Summarise the client's HIV risk reduction plan. _____

PRE-TEST COUNSELLING

Introduction

The HIV antibody test is widely used, both to screen the blood supply and to diagnose HIV infection. A comprehensive understanding of the test, the meaning of the results, and of HIV infection in general is crucial information for those conducting it. Counsellors and educators need to be prepared to give this information both to the general public and to clients seeking the test.

Since the psychological and social impact of testing positive for antibodies to HIV can be severe, testing should be accompanied by pre- and post-test counselling and education.

Pre-test counselling should include:

- introductory information about the antibody test.
- information about AIDS and HIV infection.
- exploration of motivations for being tested.
- exploration of the potential psychosocial ramifications of testing positive.
- discussion about confidentiality and testing procedures.
- education about AIDS prevention, risk reduction and coping strategies.
- consent to be tested.

Information to Present

The HIV Antibody Test:

The AIDS (or HIV) antibody test is a screening test that was originally developed to screen the blood supply for HIV. The antibody test is now more widely utilised in a variety of settings to test for the presence of antibodies to HIV.

The test does not tell a person whether he or she has AIDS or will develop AIDS in the future. It does indicate whether an individual has been infected with HIV.

A Positive Result:

If a person tests positive to the HIV antibody test it means that:

- antibodies to HIV were found in the person's blood sample.
- the person has been infected with HIV.
- the person should assume that he or she is contagious and capable of passing the virus to others through high risk activities.

A Negative Result:

If a person tests negative to the HIV antibody test it means:

- the person has not been infected with HIV or
- the person has come into contact with HIV but has not become infected and has not produced antibodies or
- the person has been infected but has not yet developed antibodies.

HIV Infection:

HIV is a virus which suppresses the immune system, leaving the infected person unable to fight certain infections and diseases.

HIV can be transmitted through:

- unprotected sexual practices.
- blood: sharing of needles, transfusion with contaminated blood or blood products.
- perinatal transmission, from mother to child.

The majority of people infected with HIV develop antibodies to the virus from 2 to 12 weeks following infection. Some will not develop antibodies for up to six months. The time between initial infection and the development of antibodies, often referred to as the "window period," is when a person can test negative on the antibody test although they have been infected.

The most widely used antibody test is the ELISA. It is recommended that each blood sample testing positive on the first ELISA be tested one or two more times and then verified using either the Western Blot or IFA antibody tests. The HIV antibody test is extremely accurate. It is more than 99.9% accurate, after the "window period," when a positive test is verified and confirmed by a Western Blot or IFA test.

The antibody test does not predict whether an individual will develop AIDS in the future. Research indicates, however, that the majority of people (78%) infected with HIV will develop AIDS or HIV-related symptoms within seven years from the time of initial infection.

Motivation for taking the HIV Antibody Test:

Among the reasons why people choose to take the test are:

- It is recommended by their health care provider.
- They know they are at high risk for HIV infection.
- They suspect they have been exposed to HIV.

- They are afraid of AIDS and fear that they have been exposed to HIV, even though they are at extremely low risk of infection.

Research has been inconclusive as to whether knowing one's antibody status motivates behaviour change and the adoption of low risk behaviours. Some people do not take the antibody test yet adjust their behaviour to avoid becoming infected or infecting others. For others, knowing one's antibody status helps them make the necessary behaviour change and helps in future planning.

Psychosocial Implications of a Positive Test Result:

Testing positive for HIV has significant psychosocial implications for the individual. The impact on a person's psychological and emotional response, social support network and activities of daily living must be taken into account as part of pre- and post-test counselling.

Confidentiality:

The limits of confidentiality should be determined for each testing site. **For the counsellor and the client it is important to know:**

- Who has access to the test results.
- How the results will be documented.
- Who has access to the files.
- How confidentiality of the client will be protected.
- Procedure for reporting test results to local authorities.
- Who has access to this information.

Process of Testing:

Testing procedure may vary slightly from one place to another but the steps taken include:

- A small amount of blood is drawn from the arm.
- This blood sample is tested.

- The time lapse between drawing the blood, testing and having results available varies.
- Results are disclosed at a follow-up appointment.

AIDS Prevention and Risk Reduction:

Safer sex guidelines: use a condom for every act of vaginal, anal, and oral intercourse.

Needle use: do not share needles; clean needles with bleach water after every use.

Strategies for Coping:

The ways a client has coped with stressful situations in the past as well as his or her current sources of emotional support should be assessed and maximised. This knowledge is important both for handling the delay between the time blood is drawn and the time test results are available, as well as preparing for a potential positive test result.

Review of Pre-Test Counselling Checklist:

On reviewing the checklist, ask for any questions on the information to be covered in this session.

Discuss the best way to give certain information and to ask questions of the client.

TRAINING ACTIVITY

Imagine If...

Purpose: To better understand the experience of making a decision about taking the HIV antibody test.

Objectives - Participants will be able to:

- Identify feelings, thoughts and reactions associated with being at risk for HIV infection.
- Consider reasons for and against HIV antibody testing.

How long does it take?

- Allow 30 minutes.

How do I do it?

- Ask participants to close their eyes and sit comfortably with their feet flat on the floor.
- Explain that you will be asking them to imagine a situation and that you want them to have a clear picture in their minds, paying attention to their thoughts, feelings and reactions.

Read out the following description, pausing after each image:

"Think about your current or a previous sexual partner in the recent past. Establish a clear picture of him or her in your mind. Imagine yourselves together, notice your surroundings. Imagine that your partner says, 'I want to discuss something important with you.' You sit down to talk and your partner tells you that he or she has been hearing more about AIDS and has begun to worry about previous sexual encounters, from several years ago.

"Your partner thought you should know that during your relationship, he or she was also sexually involved with several other people, whose sexual histories are unknown. This comes as a surprise to you.

"Your partner is pretty sure that most or all of them were sexually involved with others during the time they were involved. Your partner is very worried about AIDS, has not been feeling well lately and is considering taking the HIV antibody test.

"Your partner thought you should know and thinks you should take the antibody test as well. He or she feels terrible you could have been infected with HIV as a result of his or her fooling around but several years ago he or she did not know anything about AIDS.

"You do not know how to respond but you say you need to be alone to think. Your partner then leaves. Notice what you are thinking and feeling about your potential exposure to HIV and as you consider the antibody test."

After a few minutes ask participants to open their eyes and take a moment to get reoriented to the room.

Ask each person to find a partner close to them and spend 5-10 minutes discussing the following questions:

- *How did you feel when you realised you may have been exposed to HIV?*
- *How did you feel when you found out that your partner had been sexually involved with others during your relationship?*
- *How did you feel knowing that your partner may be infected with HIV?*
- *How did you react when your partner said you should take the antibody test?*
- *What would you consider are the reasons for and against taking the test?*
- *Ultimately, will you decide to be tested? Why or why not?*

Call the group back together. Ask for a show of hands to indicate those who would and those who would not decide to be tested. **Discuss the activity with the following questions:**

- *What are the reasons for your decision?*
- *What were the key feelings you identified in this exercise?*

- ***How can you apply what you may have learned about yourself from this exercise to pre-test counselling?***
- ***What information would you want presented in the pre-test counselling session?***
- ***What might you want from the counsellor in this session?***

TRAINING ACTIVITY

Pre-Test Counselling Role-Plays

Purpose: To become more familiar with pre-test counselling.

Objectives - Participants will practice conducting a pre-test counselling session and be able to:

- Practice conducting a pre-test counselling session.
- Demonstrate effective counselling skills.
- Identify areas of difficulty as a counsellor.

How long does it take?

- Allow 90 minutes.

What do I need?

- Pre-test counselling checklists.

How do I do it?

- Review the pre-test counselling checklist to make sure trainees are clear about the information to be discussed in the counselling session. Review each section, asking for questions on content or process. Anticipate problems and address them prior to the role-play, for example, discussing different and optimal ways to ask a client about his or her motivation for taking the test.
- Divide the large group into small groups of four. Ask each group to assign members a role: client, counsellor, observer and "angel." Each member of the group will have the opportunity to play each role. Each role-play will last for ten minutes, with five minutes for feedback and discussion after each session.
- Hand out a different role-play scenario to each participant in the small groups of four. (You will need to use a minimum of four role-play scenarios.) They will use this when it is their turn to play the client. Instruct them not to divulge the information to the others and to hold on to it, as they will be continuing with the role in future role-plays.

Give out the following instructions:

The **client** should read the role he or she is to play and share with the counsellor the information which is written above the line. The information below the line is background information. It can be adapted or changed but should not be shared with the counsellor.

The **counsellor** should use the pre-test counselling checklist to conduct a pre-test counselling session. The client will give you some general identifying information about the role he or she is playing.

The **observer** should use the pre-test counselling checklist as a reference to observe the role-play in terms of content and information covered. The counselling skills sheet should be consulted as a reference for feedback on the counselling process and suggestions for improvement noted.

The **angel** should support and assist the counsellor by offering suggestions when the counsellor seems to need help. The angel is also the timekeeper for the group.

When the role-play is finished, feedback should focus on the positive aspects and suggestions for improvement. The observer speaks first, giving his or her feedback to the counsellor. Then the counsellor and the client have a chance to discuss feelings and reactions in the role. The angel then gives his or her feedback.

After each person in the small group has played each role, bring the participants back to the large group. Ask the trainees to take a moment to re-orient themselves. **In processing the activity ask them to consider the following:**

- *What difficulties did they identify in presenting information to the client?*
- *What part of the counselling session felt most comfortable?*
- *Which parts of the counselling session felt most difficult? Consider from the client's and the counsellor's perspective.*
- *Which counselling skills were most effective and helpful?*

NOTE: *These suggested role-plays were developed by participants at regional AIDS Prevention Counselling Workshops conducted by AIDSCOM and CAREC. As the trainer you should choose the ones which correspond most closely to the characteristics of your trainees' future work situations in terms of:*

- risk factor.
- cultural background.
- class background.
- psychosocial factors.

HIV ANTIBODY TEST: PRE-TEST COUNSELLING CHECK LIST

During the pre-test counselling session, the counsellor should discuss, and the client should understand the following:

1. HIV Antibody Test Information.

- a. What the test is and is not.
- b. What a positive result means.
- c. What a negative result means.
- d. Predictive value of test.

2. Information about AIDS and HIV.

- a. How HIV affects the immune system.
- b. Difference between AIDS and HIV.
- c. Transmission.

3. Reasons for Considering Testing.

4. Psychosocial Implications of Testing Positive.

- a. Psychosocial reactions.
- b. Social support response.
- c. Daily living considerations (housing, employment, etc.)

5. The Limits of Confidentiality.

6. The Process of the Testing Procedure.

7. AIDS Prevention and Risk Reduction.

- a. Safer sex practices.
- b. Perinatal issues.
- c. Safe needle and syringe use.

8. Strategies for Coping.

- a. Previous coping strategies.
- b. Coping with the waiting period (before getting the test results.)
- c. Social support system.
- d. Resources and referrals.

9. Client's Informed Consent/Agreement to be Tested and Obtained.

Role-Play One

Identifying Information:

A woman of African descent in her late twenties, neatly dressed, appears healthy.

Background:

You are a single woman with two children, aged 3 and 12. You are from a middle-class background, currently unemployed. In the last 15 years you have had two boyfriends. The first was the father of your two children. When your relationship with him ended, you had a brief interlude, purely sexual in nature, over three months with a man whose circumstances when away from you were unknown to you. Seven months ago you began a serious relationship.

Motivation for Taking the Test:

You recently learned more about AIDS and the risk for women. You became concerned about your brief casual relationship.

Concerns:

You have not considered yourself to be at high risk for HIV before now because:

- Compared to most people you know you have had few sexual partners. No past partner has become ill.
- Your current relationship is with a man who has a similar background and risk history; you are confident of his fidelity. You do not practice safe sex with him.

Hidden Concerns:

You are not sure what to do after you receive the antibody test results. You expect to test negative but do not wish to consider future use of condoms with this partner and do not believe he would be willing to use them. He does not know you are taking the test.

You are taking the test because it seems a sensible, positive step although, if the result is negative, it will have no effect on your sexual practices.

Role-Play Two

Identifying Information:

Male of African descent in mid-thirties, well-dressed with a polite manner; appears healthy.

Background:

You divorced your wife four years ago. There are two children from the marriage, aged 8 and 10. You are Roman Catholic, from a middle-class background and employed as a civil servant. You are the youngest of four children. Over the past fifteen years you have had multiple sexual partners, both male and female. For the past two years you have been in a relationship with a man.

Motivation for Taking the Test:

Attending an STD clinic for gonorrhea recently, your physician recommended you be tested for HIV. You have taken several weeks to decide whether to take the test.

Concerns:

You had not given AIDS much thought up to now, but you decided you might as well take the doctor's advice.

Hidden Concerns:

You have been feeling tired and ill for the past year. Only very recently did you connect this with the possibility of AIDS and now you are having difficulty concentrating and working.

Role-Play Three

Identifying Information:

East Indian woman in mid-thirties, six or seven months pregnant, appears quiet and withdrawn.

Background:

This pregnancy is your fourth with your husband of 12 years. He is 40 years old and recently took the HIV antibody test, receiving a positive result. You learned of this one month ago. At the same time your husband told you that he had sexual relations with several women and a few men from time to time throughout the marriage.

Motivation for Taking the Test:

Your husband and your doctor have urged you to take the test and it has taken you the whole month to develop the courage to do so.

Concerns:

You are feeling overwhelmed and frightened, anxious that you are HIV-infected and could pass the virus to your baby. You are very angry at your husband for his sexual activities, for becoming infected and for the risk in which he has placed you, and the baby and the other children.

Hidden Concerns:

Whether you test positive or not, your trust in your husband is destroyed. You cannot imagine staying in the marriage but have no independent financial resources. You are apprehensive about the reaction of your family if you were to leave your husband.

Role-Play Four

Identifying Information:

Male of African descent in early thirties, appears neat and well-groomed, seems very nervous.

Background:

You are married and have three children, aged 8, 5 and 3. For the past ten years you have travelled to work in the United States. When at home you have been faithful to your wife. You recently learned about AIDS.

Motivation for Taking the Test:

It is required for work.

Concerns:

You are certain you will test negative, but you feel anxious to get the result so that you can continue working to support your family.

Hidden Concerns:

You fear that you could have a positive result as you have had casual sex and used drugs occasionally. You find it hard to imagine that you are infected because none of your co-workers who have behaved the same way has become ill.

Role-Play Five

Identifying Information:

Female of African descent in mid-twenties, neatly dressed although clothes are worn and old, appears drawn and unhealthy.

Background:

You are in the first trimester of pregnancy. You have had a common law husband for two years and this is your second child. For the past two years you have been addicted to cocaine. You support your child and pay for your drug habit by having sex for money.

Motivation for Taking the Test:

You were referred for testing by the doctor you saw at your recent prenatal clinic visit.

Concerns:

You do not understand clearly why you need a test. You have heard something about AIDS but never thought it had any relevance to you.

Hidden Concerns:

The doctor suggested you use condoms, but you know that your customers would find that unacceptable.

Role-Play Six

Identifying Information:

Male of African descent in early thirties, neatly dressed, appears friendly and polite.

Background:

You are homosexual, single, and work as a lab technician. You had a steady relationship with a man for six years, but that ended some years ago. Since then you have had multiple sexual contacts both at home and abroad in the U.S. and Europe on vacation. You drink heavily from time to time; but currently, you seem to have it under control.

Motivation for Taking the Test:

Through a friend in the U.S. you have been receiving a lot of written information about AIDS. The same friend has urged you repeatedly to be tested. You have become convinced he is right and have made the appointment.

Concerns:

You expect a negative result because most of your activity is lower-risk oral sex. You are unlikely to engage in high risk activity as it has never appealed to you.

Hidden Concerns:

There were a number of times, possibly many, during the heavy drinking periods when you found yourself with someone in the morning and had no idea of how you got there or what kind of sexual contact had been made.

Role-Play Seven

Identifying Information:

Male of East Indian descent in early forties, neatly dressed with a quiet manner, appears nervous.

Background:

You have been married for eighteen years and have two children, aged 13 and 15. You have a job you enjoy a great deal as an engineer. During your marriage you have had sporadic sexual contact with men; your wife does not know this.

Motivation for Taking the Test:

One of your colleagues died recently of AIDS and you became very worried about yourself.

Concerns:

You are extremely nervous that you could have been exposed to HIV. You were not aware to what extent your contacts with men were putting you at risk. You do not want your wife to discover your previous sexual activities with men.

Hidden Concerns:

You are desperately anxious to prevent your family from learning about your sexual encounters with men.

Role-Play Eight

Identifying Information:

Male of African descent in mid-twenties, appears calm and easy-going but there is a detectable edge of anxiety and irritability.

Background:

You are a single heterosexual man who has worked for the last six years as a construction worker. You live at home with your family and two siblings. You have an extensive history of sexually transmitted diseases, including herpes. On occasions, you have used needles with friends "just to see what it is like." Recently, you started seeing a woman you like very much and with whom you believe there may be potential for a committed relationship.

Motivation for Taking the Test:

A friend has just been diagnosed with AIDS. Many years ago you once shared a needle with him. This has made you worry and you decided to take the test.

Concerns:

Although you have been hearing about AIDS for some time you never thought of yourself as at risk because you are not homosexual. Now your friend's diagnosis has scared you but you still sense very little danger of a positive test.

Hidden Concerns:

A positive result will mean that you have to tell your new woman friend about your past and you fear it will jeopardise the relationship and prevent you from continuing your sexual practices.

Role-Play Nine

Identifying Information:

Female of African descent in mid-twenties, appears well-groomed, pleasant and friendly.

Background:

You have been in a visiting relationship for the past two years. For nearly ten years you have worked as a prostitute. To protect yourself from STDs your medical check-ups have been regular but, on rare occasions, you have been treated for gonorrhea.

Motivation for Taking the Test:

At a recent clinic visit you read more about AIDS and wanted to make sure you were healthy.

Concerns:

You have come to realise that condoms are now essential equipment for all acts of intercourse. You are worried that if you insist on this with customers you will lose business.

Hidden Concerns:

The doctor has told you that you must use a condom with your boyfriend as well as with your customers. You know you may lose business from customers. You also know that you are not even prepared to suggest condom use to your boyfriend.

THE HIV ANTIBODY TEST

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ASSESSMENT

Assess why the client wants the test. Low-risk clients may have misconceptions about the test and may need to be triaged to other services. If the exposure occurred less than six weeks previously, sufficient time for seroconversion has not elapsed. Questions that can help in their assessment include:

- "Why do you want to take this test?"
- "When were you exposed to someone who might be infected?"
- "When were you last tested? Why? Where? What was the result?"

(If client was tested less than three months ago, tell the client that the test results may not be valid.)

EDUCATION

Describe the Testing Procedure:

- What will happen if the client decides to take the test? (i.e., blood taken from the arm; results available on a certain day.)
- Efforts to preserve confidentiality (or anonymity).
- Results only given in person.

Provide the client with information about AIDS and the HIV antibody test:

- Test Purpose -- The test is for antibodies to HIV -- it does not diagnose AIDS or tell whether the individual will get AIDS.
- AIDS Prognosis -- 20% to 40% of people who test positive do not develop AIDS within seven years of infection.
- Meaning of Test Results -- There are three possible outcomes: negative, positive and uncertain (equivocal).

Negative Result: A negative test usually means that an individual is free of the virus. However, anyone who has had "unsafe sex" or shared needles with infected persons in the last three months may be infected and later develop a positive test. Anyone at increased risk of acquiring HIV who is currently negative should take control and reduce those risks. This effort includes suggesting that any sex partners be tested for the virus.

Positive Result: A positive test indicates infection with HIV and the ability to transmit it to others by sexual contact, sharing of needles or from mother to unborn child. A positive test by itself does not diagnose AIDS; it detects antibody to HIV.

Indeterminate Result: Occasionally, the test result is uncertain. The laboratory cannot definitely tell whether the test is negative or positive. It is recommended that the client submit another blood specimens for testing when this occurs.

Test Value: Some people don't take the test, yet adjust their behaviour to avoid catching or passing the virus. Other people find the test helpful in making meaningful plans. If you're negative, you'll know what you must do to help avoid infection. If you're positive, you'll know what you must do to protect others and to help you avoid illness or developing AIDS.

COUNSELLING

Find out if the client intends to take the test. "What other questions do you have about the test?" "What is your decision about taking the test?" (If yes, proceed. If no, give the prevention recommendations, omit partner notification.)

Assess the impact of test results on the client's lifestyle. Any HIV antibody test result can have a significant psychological impact on both the individual tested and those who are close to him or her. The following questions can help with this assessment:

- "What are your expectations about the test results?"
- "What would a positive test mean for you?"
- "What changes will you make in the life if you're positive?"
- "What would a negative test mean for you?"
- "What changes will you make in the life if you're negative?"

Assess how the client plans to handle the waiting time until the test results are received and give reasons for not getting unduly upset. The following questions can help with this assessment:

- "How do you plan to cope while you are waiting for test results?"
- "Have you made plans to tell anyone that you had the test done?"

Emphasise that a person who takes the test should plan to return; even if they have second thoughts about learning their results and whether they're infected, they should still return to discuss their situation and available support services for making changes to reduce risk.

THE TEST RESULTS

Give the results in a clear, direct manner. Provide positive feedback to the client by using the following information. (It is important throughout the session that the counsellor assess if the client understands the messages before proceeding.)

- **NATURAL HISTORY OF INFECTION** -- Your positive result does not mean you have AIDS or that you will get it. At least within the first seven years, 20% to 40% of people with a positive test result do not develop AIDS.
- **CONTROL** -- How healthy you decide to live may be a factor in determining whether or not you develop AIDS.
- **IMMUNE SYSTEM** -- AIDS occurs IF the virus multiplies enough to overwhelm the body's defense system. Laboratory evidence suggests that the virus multiplies faster when the body's defense system becomes active, for example, when the body fights an infection or tries to counter the effects of poor eating, lack of sleep or lack of exercise.
- **PROTECT YOUR HEALTH** -- By avoiding infections (such as sexually transmitted diseases) that might cause the immune system to become active, you may be able to delay the onset of AIDS.
- **CONSIDER SUPPORT** -- There may be support groups to assist HIV-infected people understand and cope with their infections.

Dr. Braithwaite is a Senior Health Officer; Ministry of Health; Kingston, Jamaica. 1989.

1986

POST-TEST COUNSELLING

Introduction

A positive result to the HIV antibody test has a severe impact with psychological and social ramifications for the individual. Testing should be accompanied by counselling both before and after. The post-test counselling session offers significant opportunities to promote the adoption of long-term low risk behaviours while providing emotional and psychological support to HIV-infected people.

Ideally, this post-test session allows the client to:

- Clarify information.
- Express feelings and reactions.
- Integrate the test result information.
- Identify coping strategies.
- Begin to come to terms with alternative prevention behaviours.

This can be accomplished when the counsellor, by utilising a variety of counselling skills and basic human concern, establishes a safe and caring environment which is both non-judgemental and confidential.

Information to Present

Goals for the Post-Test Counselling Session:

This session is designed to help the client:

- Cope with the immediate reactions to the test result.
- Integrate the meaning of the test result cognitively, emotionally, behaviourally and interpersonally.
- Develop a health plan.
- Maximise coping skills and strategies.

Procedure for Disclosing Negative Antibody Test Results:

1. Establish rapport with the client.
2. Disclose test result.

3. Assess:

- the need for a retest by identifying potential risk factors in previous six months.
- the client's commitment to remaining negative.
- the client's alcohol and drug use (needle sharing or use of substances which could impair judgement and/or lessen commitment to safer sex practices).

4. Provide information on risk reduction, including safer sex guidelines, proper condom use and needle cleaning.

5. Develop a health plan for risk reduction, setting specific and realistic goals.

6. Provide resources and referrals as needed.

Common Psychological Responses to Receiving Antibody Test Results:

Most people returning to find out the result of their test initially exhibit a high degree of anxiety. Many will be confused about the meaning of their result because they have a poor recall of the pre-test counselling information.

Relief and joy are invariably the reactions to a **negative** result. There is the danger however, that some people will feel that they have been granted future immunity by this result. The counsellor needs to challenge this false sense of security and reinforce information about risk reduction.

When a person hears that their test result is **positive**, he or she is likely to be in a state of shock. This may last a few moments or the entire counselling session and will mean that the person appears numb and will be unable to absorb any more information. Written back-up information and the scheduling of follow-up sessions are recommended in case shock prevents the individual from registering anything further at this point.

Following this state of shock some people feel emotionally overwhelmed and will experience a feeling of loss of control with a rapid outpouring of emotions, thoughts and questions. Frequently underlying this response is a feeling of urgency about the meaning of the test result and the fear that death is imminent. The counsellor's role is to help contain the anxiety by acknowledging the client's feelings and providing reassurance that there will be time to address his or her feelings, concerns and decisions.

Other reactions which may be expressed at this point are:

- depression.
- helplessness and hopelessness.
- guilt.
- self-blame and anger.
- suicidal thinking.

Clients may feel and appear anxious; they may explain that they are sleeping badly, are suffering from intrusive thoughts and have become preoccupied with symptoms and/or changes in the body.

Denial of the test result or its meaning is a common reaction. The counsellor must determine whether the denial is helpful or destructive to the client. Constructive denial helps to cushion the impact of the devastating news, saying for example, "I am going to be the first one to beat this disease." Destructive denial puts the client at a disadvantage in some way. For example, it could cause him or her to discount physical or psychological symptoms or to nurture a belief that he or she, due to feeling so well, is unable to transmit HIV.

The behavioural changes which people need to make can seem overwhelming. The counsellor's role is to reassure the client that these changes will not occur overnight and to help the client set realistic goals.

Most people fear being rejected. Some fears are founded on a realistic assessment of how others will respond to the news of a positive test result. Other fears are irrational and will be proved false. The counsellor's role is to help the client distinguish between the two.

Whether their fears are realistic or not, some people will choose to isolate themselves. It is not uncommon for people to feel contaminated and withdraw from those they need most. Sometimes this is based on the irrational fear of infecting loved ones through casual contact. These reactions are compounded by the negative public and societal messages the person internalises about the disease and the behaviours associated with it.

Sexual dysfunction may result from receiving a positive test result. It is not uncommon for people to experience a variety of difficulties in their intimate and sexual relationship(s) because sex becomes associated with death, as well as feelings of contamination and fear of transmission to others.

While the initial responses to receiving a positive test result are inevitably a crisis for the individual, it is one that usually passes after a period of time. The most helpful reaction to their clients by counsellors is to reassure them that the feelings and responses associated with this crisis are normal. Introducing the seropositive individual to others living well with HIV infection is a useful way of demonstrating how the initial crisis will pass and that a positive approach to coping with the disease can be adopted.

Procedure for Disclosing Positive Antibody Test Results:

Disclosing results:

1. Establish rapport with the client.
2. Ask if there are any questions.
3. Follow the lead of the client as to when to disclose the results.
4. Give the test results in a direct, neutral tone.
5. Wait for client's response before answering.

Integration of Result

Cognitive Integration - "What does the test really mean?"

1. Explore the client's understanding of the meaning of the test result.
2. Clarify the meaning of the test result.
3. Answer questions simply and clearly.

Emotional Integration - "How could this be happening to me?"

1. Provide a non-threatening environment to allow for the expression of feelings.
2. Normalise responses: make clients aware that their responses are normal.
3. Acknowledge and validate fears, grief and other feelings, saying for example, "I know this is frightening."
4. Be realistically hopeful.
5. Remind the client that this is initial crisis and difficult adjustment period to the test result is limited in time and will change.
6. Explore any guilt regarding HIV infection
7. Assess depression and suicidal thinking.

Behavioural Integration - "What should I do now?"

1. Clarify what safer sex means.
2. Discuss what correct condom use involves.
3. Discuss the implications for pregnancy and childbirth.
4. Discuss other health issues: re-exposure to HIV, STDs, alcohol and drug use, stress level, coping styles.
5. Probe possible denial responses by the client.
6. Schedule a medical follow-up.
7. Develop a health plan, setting specific and realistic goals.

Interpersonal Integration - "Who should I tell? How, when and what should I tell them?"

1. Discuss the impact of informing others: sexual partner(s), family and friends, and employers. Help the client make decisions about disclosure.
2. Encourage varied ways of maintaining intimacy.
3. Encourage staying involved in the community and the development of a supportive social network.
4. Develop a plan regarding disclosure of the result to increase support and minimise potential negative consequences.

Maintaining Hope

1. Encourage and support positive coping strategies: religion and spirituality, stress management, maximising social support.
2. Be realistically hopeful: acknowledge the client's feelings and focus on quality of life issues.
3. Encourage client's active participation in coping with a positive result and his or her own health care plan.
4. Encourage the client to make use of available resources.
5. Be available for additional counselling sessions or telephone contact when possible.

Resources and Referrals

1. Identify additional resources for client:
 - information resources.
 - medical services.
 - social services and counselling.
 - substance abuse services.
 - legal services.
 - social support and other services which can assist in maintaining his or her health plan.
2. Provide written information about HIV and AIDS.
3. Schedule a follow-up appointment when possible.

GRIEF AND BEREAVEMENT

Loss and grief are universal experiences, yet most of us have seldom worked closely with someone who is facing death. As AIDS prevention counsellors and educators we are constantly made very conscious of our thoughts, feelings and attitudes about death, appropriate grieving, religion and spirituality, and existential concerns.

Often the pre-eminent feeling, when in contact with someone who is facing death or has recently lost a loved one, is one of helplessness. For this reason, it is valuable to explore and discuss our personal experiences and reactions to death, dying and grief. By understanding our own beliefs, experiences and biases, we can become more effective as AIDS counsellors.

What is the typical experience of a person who has lost a loved one through death?

People typically experience psychological, physiologic and/or behavioural reactions in response to the death of a loved one. The grief process involves a wide variety of feelings and associated behaviours which change over time.

There is a tremendous variation in individual responses to a loss; these are determined by:

- ethnicity.
- culture.
- personality.
- religion and/or spirituality.
- cultural perceptions and attitudes towards illness.
- nature of illness.
- nature of relationship.
- previous physical and psychological health.

Grief reactions are characterised by changes in the following areas. Depending on cultural and religious norms, reactions may appear more or less frequently in a specific area.

Emotions and thought process:

- shock and disbelief.
- sadness and despair.
- anger and irritability.
- anxiety.
- mood swings.
- intense yearning and longing.

Behavioural changes:

- slowed-down.
- agitated and restless.
- crying.
- lack of interest.
- increased use of cigarettes and/or alcohol and drugs.

Interpersonal and social changes:

- shifts in social status.
- reactions from others.

Physical complaints:

- disturbed sleep patterns.
- poor appetite.
- pain.
- gastrointestinal problems.

The grief process has frequently been described in terms of phases or stages. Observers have identified five stages of grief which evolve through:

- shock.
- anger.
- bargaining.
- depression.
- acceptance.

These emotional states are experienced by many people as they grieve although they do not occur in a linear fashion. Every individual's experience of these states, and the degree to which they are experienced, is different.

For many people there is an intense initial period of grieving which manifests itself in depression and distress. Others do not share this experience. There is no one way to experience normal grieving. **There are, however, four tasks of grieving which individuals must complete in order to resolve their grief. These include:**

1. Accepting the reality of the loss.
2. Experiencing the pain of the loss.
3. Adjusting to life without the person.
4. Reinvesting in life.

The loss is considered to be resolved when the person completes the phase of acute grieving, even though the pain of loss may remain for a lifetime. The resolution is characterised by a return to the previous level of functioning where the individual feels hopeful, becomes reinvested in his or her life, and adapts to a new role.

TRAINING ACTIVITY

Cultural Views of Illness and Death

Purpose: To explore cultural norms and attitudes about illness and death.

Objectives - Participants will be better able to:

- List cultural views of and attitudes to illness.
- List cultural views of and rituals related to death.

How long does it take?

- Allow one hour.

What do I need?

- Large sheets of paper.
- Pens, markers or coloured chalk.
- Tape.

How do I do it?

- Divide the large group into groups of six or seven. Ask each group to choose a recorder. Hand out two large sheets of paper and a pen, marker or piece of chalk to each group.
- Ask the groups to brainstorm under the two following headings for 20 to 25 minutes:

Cultural beliefs about illness:

1. causes
2. appropriate actions
3. emotional responses

Cultural beliefs and practices related to death:

1. causes
2. responses from others
3. mourning rituals

These beliefs should be general cultural beliefs and practices, not specifically AIDS-related.

- Bring the small groups back into a large group. Invite the recorders to read their group's list under the first heading. When the other groups follow in turn ask them only to read out new beliefs, not to repeat.
- Repeat the procedure for the second heading.

In processing the activity, ask the trainees to consider the following questions:

- *Given the cultural beliefs about illness, what are the implications for AIDS prevention counselling and caring for people with AIDS and their families?*
- *Given the cultural beliefs and practices related to death, what are the implications for counselling people with AIDS and their families?*

TRAINING ACTIVITY

Guided Imagery

Purpose: To explore coping and counselling strategies for managing loss.

Objectives - Participants will be able to:

- Recall a personal experience of loss and the factors which helped them to cope with the loss.
- Discuss responses which might be helpful to someone who is facing death or has lost a loved one.
- Identify personal strengths and weaknesses in helping others to cope with loss and grief.

How long does it take?

- Allow one hour.

How do I do it?

1. Explain to participants that the guided imagery activity will involve them in recalling in detail a significant loss in their life. **This loss could be:**

- the death of a person close to them.
- a separation or divorce.
- loss of health.
- change of employment.

If the most significant loss is too recent or too painful, suggest that the participant recall another loss. Those trainees who find the entire activity too stressful should be allowed to pass on it. Participants should feel free to reveal only that which they feel comfortable discussing.

Tell participants that they can imagine a loss if they cannot think of one. If they find constructing mental images is difficult, suggest that they recall the situation in whatever way they wish.

2. In a calm tone of voice relay the following instructions to the participants: *"Make sure you are sitting comfortably with your feet flat on the floor. You may want to close your eyes to help you focus and relax."*

"As I guide you through this exercise pay attention to your thoughts and feelings as you become aware of images and memories. Think of a significant loss you have experienced in your life. It may be the death of a loved one. If this is too recent and painful, think of the loss of someone else. If you have not experienced the death of someone close to you, recall a loss associated with separation or divorce, loss of health, change of employment or any other loss that caused you grief. Picture this person or event in your mind. Notice what you are feeling and thinking.

"Now think back to the events surrounding the loss and what led up to it. Fix in your mind an image of how you first learned of this potential loss. If there was no forewarning, concentrate on an image of when you first learned of the loss.

- *What was your initial response?*
- *What were you experiencing?*
- *How did others respond to you?*
- *What helped you most at this point?*
- *What helped you least?*

"Now make a mental image of yourself after this initial shock but before the death or change. If there was no time between the two, imagine this period. Notice your feelings and thoughts.

- *What was this period like for you?*
- *How did you interact with others?*
- *What emotional and behavioural changes occurred?*
- *What helped you survive this period?*
- *What made it difficult?*

"Now imagine the actual death or loss and the two weeks following it. Make a picture of that time in your mind.

- *What are you feeling and thinking?*
- *Who is around you?*
- *What is most helpful about what they are saying or doing? If they are not helpful, what would you like them to do differently?*
- *What helps you most at this moment?*

"Now imagine yourself in six months.

- *Where are you? What are you doing?*
- *What are you feeling and thinking?*
- *Do you notice any physical or behavioural changes?*
- *What has changed in your life?*
- *What has helped you get through the last six months?*

"Now make a picture of yourself today. Notice what you look like, what you are wearing. Notice how you feel. Imagine the other participants in the room. Make a picture of where you are sitting in the room. Picture the person next to you. Think back to an earlier session and recall what you were thinking then.

"Bring your attention back to yourself, sitting in this room. Notice your breathing. Feel your feet on the ground. When you feel ready, open your eyes. Take a moment to readjust to the room. If you are feeling emotional, take a moment to recompose yourself. When you feel ready, find a partner and spend 5-10 minutes discussing what you are feeling as a result of this guided imagery. Begin to think about and discuss what you learned about yourself and your experience with loss."

3. Invite the pairs to join another pair, making groups of four people. Give each group several large sheets of paper and a pen or marker. Ask the groups to choose a recorder.

4. Ask the groups to discuss the following questions for the next 20 minutes, recording their responses on the large sheets of paper:

- *What did you learn about yourself and your experience with loss?*
- *How did your personal values, attitudes and beliefs about death and dying affect your experience of loss?*

- ***What helped you most:***
 1. *When you first learned about the potential death or loss?*
 2. *During the period between first learning of the potential loss and the actual death or loss?*
 3. *At the time of the death or loss?*
 4. *During the two weeks after the death or loss?*
 5. *Up to six months after the loss?*
 - ***What helped you least during each of these periods?***
 - ***What does this tell you about helping people with HIV infection and AIDS, and their families, to live with a life threatening illness and/or cope with an actual death?***
 - ***What are your personal strengths and weaknesses in helping others to cope with loss and grief?***
5. Call the groups back into a large group and ask them to tape their sheets of paper to the wall. Discuss the responses in the large group.

COUNSELLING PEOPLE WITH HIV, AIDS AND THEIR FAMILIES

Introduction

Throughout their illness there will be times when people with HIV infection and AIDS, given the psychosocial complications associated with it, will be in special need of support and assistance in managing their daily lives. Counsellors and visiting nurses may be some of the only people who can provide this resource.

Counselling people with HIV and AIDS and their families requires skill, knowledge, self-awareness and experience. The counselling and communication skills described in the previous section provide the foundation for working effectively as a counsellor. In addition, in the following section there are some specific interventions which counsellors can use to help people manage their illness.

Information to Present

Assessment:

Information about the way the individual with HIV infection or AIDS functioned in his or her daily life before their diagnosis gives the counsellor an indication of their ability to cope with the illness. **The areas you will need to cover with him or her are outlined below:**

Current problem of difficulty: inevitably, the diagnosis of HIV or AIDS will be the broad problem. You will want to be more specific.

What are the primary problems related to the diagnosis?

Current level of functioning:

How well is the client coping with the illness?

Is he or she able to continue working and maintain social contact?

Does he or she appear extremely depressed or anxious?

Previous level of functioning:

How well did he or she function before diagnosis: occupationally, socially, coping abilities, personality, style?

Social support:

How much social support does this person have?

Is it adequate?

Who are the key people in this person's life?

Coping skills:

What has helped this person cope with previous crises?

Substance use:

Does this person use alcohol or drugs (intravenous or non-intravenous)? If yes, how frequently and what kind?

Stage of illness:

At what stage in the diagnosis are you seeing this person?

What is his or her current degree of health or illness?

What types of treatment or medications is the person taking?

AIDS knowledge:

How much does the person know about HIV and AIDS?

How much does he or she know about risk reduction?

What is the client's perception of his or her illness?

Risk for suicide or homicide:

Does he or she exhibit any of the signs of potential risk for suicide or homicide? These include:

- Self-disclosure of inability to cope.
- Despondency, feelings of hopelessness and/or suicidal ideation.
- Extreme rage and/or homicidal ideation.
- Social isolation.
- If the client is having suicidal or homicidal thoughts, does he or she have a specific plan for carrying it out?
- Does he or she have the means to carry it out?
- Does he or she have a history of past suicidal or homicidal behaviour?
- Has the client recently experienced losses or other traumatic events?

Access to resources:

What financial resources does the client have?

What other resources does the client have (housing, medical, social services)?

Counselling Interventions with People with HIV and AIDS:

The goal of counselling interventions is to help the person with HIV or AIDS live with the illness in the best way possible. **Among interventions which could be helpful are:**

• **Education:**

Information about the illness itself, risk reduction, normal emotional responses to the diagnosis, etc.

• **Individual counselling:**

Adopting a non-judgemental stance, empathising, normalising/universalising responses, active listening, supporting coping skills.

• **Provision of support:**

Emotional support, support and reinforcement for risk reduction and behaviour change.

• **Assistance with disclosure of diagnosis:**

Offering, when possible, to help the client disclose his/her diagnosis to spouse/partner and/or family members.

• **Grief counselling:**

Talking directly about reactions to the losses the client has already experienced or anticipates, talking directly about death and dying, helping the client take care of practical matters (provision for children, legal matters, finances, etc.), assisting the client in addressing unresolved emotional and relationship issues.

• **Crisis intervention:**

Identifying and validating client's ability to cope with past life crises, assisting with concrete problem solving, encouraging client's active and positive participation in current situation,

increasing awareness of options, encouraging expression of feelings within counselling session, mobilising support network, providing client with appropriate referrals.

- **Substance abuse treatment:**

Providing referral for substance abuse treatment if client is experiencing negative consequences from his or her use of alcohol and/or drugs.

- **Reinforcement of hope:**

Support spiritual and religious beliefs, help identify sources of hope, positive aspects of life.

- **Encouragement of client's active participation to increase sense of empowerment:**

Learning more about the illness, changing health behaviours, helping others, increasing involvement with spiritual and religious practice.

- **Skills training:**

Problem solving, coping skills, stress management.

- **Mobilise social support:**

Facilitating contact with other people.

- **Advocacy:**

On behalf of client unable to do so on his or her own, for example, financial assistance, basic living concerns, medical and treatment issues.

Family Interventions:

The goal of counselling interventions for the family is to help them come to terms with the impact of the HIV or AIDS diagnosis on their lives. **Among interventions which could be helpful are:**

- **Education:**

About the disease, transmission, what to expect in terms of the course of the illness and emotional responses.

- **Assistance to family:**
Clarifying conflicting feelings about the disease, stigma, reactions to disclosure of the diagnosis and risk factor(s), fears of contagion, reactions to anticipated death of the family member and other losses, shame, impulse to reject; giving everyone opportunity to share their viewpoint.
- **Conflict mediation:**
Alliance with supportive family member; establishing common ground; mediating conflicts.
- **Modelling positive interaction:**
Diffusing fear about contagion by acting as a role model for family members when interacting with the person with AIDS.
- **Mobilising family support:**
Helping maximise support for family members within the family and from friends and community members where possible.
- **Encouraging family members to take action:**
Finding out more about the disease, helping others.
- **Supporting the spouse/partner:**
Validating their concern about their own risk for HIV, reinforcement for behaviour change, exploration of satisfying and safe forms of sexual contact and intimacy.
- **Grief counselling:**
Talking directly about reactions to the losses already experienced and/or anticipated, talking directly about death and dying, helping the family take care of practical matters (provision for children, legal matters, finances), assisting the family in addressing unresolved emotional and relationship issues.

Group Interventions:

Any intervention which facilitates interactions among people with HIV or AIDS, or among family members, will help to decrease isolation and stigma while providing education, social support and

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role models for coping with the illness. Peer groups can be generally focussed or targeted to a specific audience such as people with AIDS, couples, parents, gay and bisexual men, women, etc. Group interventions are extremely helpful, but often difficult to assemble. **Ways to promote interaction among people with similar experiences of HIV and AIDS include:**

- **Peer groups:**
Education, social support, emotional support, problem-solving.
- **One-to-one peer contact:**
In person or by telephone. Anonymity and confidentiality can be more easily protected.
- **Formal or informal groups:**
Groups of people affected by AIDS who work towards public education and advocacy.

Management of Dementia:

When a person with AIDS is suffering from AIDS-related dementia, environmental interventions can be useful in minimising some of the disorientation, confusion and memory loss that he or she may be experiencing.

TRAINING ACTIVITY

Case Studies

Purpose: To practice assessment skills, to identify relevant individual and family interventions for different client situations and to explore personal values and attitudes which would have an effect on their work.

Objectives - Participants will be able to:

- Identify three key concerns for this client.
- Identify three intervention strategies.
- Discuss personal values or attitudes that would affect their work with this client.

How long does it take?

- Allow 50 minutes.

What do I need?

- Large sheets of paper.
- Markers or coloured chalk.
- Masking tape.
- Vignettes.

How do I do it?

- Distribute a case study to each participant.
- Divide the large group into small groups of five or six. Give each group three large sheets of paper and a marker or chalk.
- Ask the trainees to read their case studies and consider the following questions which should be written on a large sheet of paper and taped where they can all see them.

1. *What are the key concerns for this client and his or her family?*
2. *What intervention strategies should be used to work with this client?*
3. *How would your personal values and attitudes affect your work with this client, both positively and negatively?*

- Ask the trainees to work individually for five minutes, noting their responses to the questions.
- Ask the groups to elect a recorder and spend twenty minutes discussing their responses. The recorder should write these down, putting all responses to question one on the first piece of paper, question two on the second, and so on.
- After twenty minutes ask the recorders to tape their sheets to the wall. Invite the trainees to look at the other group's responses.

Call the large group together again and discuss the responses, exploring in more detail the key concerns and intervention strategies.

Discuss the activity with the following questions:

- *Which of your attitudes and values would affect your work with this client? How would they do so?*
- *What would be the area of greatest difficulty for you in working with this client? What would help in overcoming this difficulty?*
- *Was it helpful to work with colleagues on this case study?*
- *How did you resolve disagreements?*

A sample case study can be found as a handout this in module and can be used for this activity. Case studies can also be developed based on the role-plays found in the pre-rest counselling section or on the trainers' and/or trainees' experiences.

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CASE EXAMPLE

Patrick: Part One

Patrick is a thirty-nine-year-old store manager who has been referred by a doctor at the health clinic for individual counselling after he had complained about stress-related problems. He had been forgetting things and experiencing difficulty concentrating at work and said, "I just don't seem to be thinking very clearly." He asked the doctor to give him something to help him to sleep. The doctor gave him a prescription and recommended that Patrick talk to a counsellor to help him deal with the stress he was feeling.

Patrick has been married for six years and has two children. Two months ago he noticed his irritability at work and home, for which there was no apparent cause. The combination of his memory loss and concentration problem was causing him to make mistakes in his managing his store.

During several sessions with the counsellor Patrick explored his anxiety. He told the counsellor of his happy marriage and his love for his family. Recently though, his wife had questioned his fidelity, accusing him of an involvement with another woman. He had emphatically denied it. In discussing this he was patently uncomfortable.

Eventually Patrick revealed the truth: during most of his married life he had been having sexual contact with men. He had hidden this from his wife as he felt guilty and ashamed about it. The counsellor led the discussion towards Patrick's risk, through his multiple partners, for HIV infection and AIDS. Patrick responded that he has never thought of himself as at risk for AIDS since he is not gay. He expressed extreme anxiety on hearing that he was at risk.

Patrick: Part Two

After several sessions with the counsellor, Patrick decided that he would take the antibody test and have a check-up. The counsellor suggested a doctor knowledgeable about AIDS because Patrick did not want to consult his own doctor.

Next time he sees the counsellor he announced that he had a positive result to his test. He also says that his doctor is referring him for some neuropsychological testing because his symptoms could be related to HIV infection. "I don't know how this could happen to me," he keeps repeating. Patrick tells the counsellor that he has not told anyone about the test results.

ENDING A TRAINING

At the end of an AIDS training session participants may be feeling excited, interested and emotionally affected. They may, however, be feeling overwhelmed, tired or restless. In either instance it is important to allow time for some type of closing activity which can help participants re-establish group contact and bridge the gap between the training and their work lives.

The end of a training is a time to:

- summarise the significant concepts covered during the training.
- answer remaining questions.
- acknowledge the issues that you were not able to address during the training.
- acknowledge the hard work and participation of the trainees.
- express thanks to organisers and trainers.
- encourage participants to continue the discussion of the issues with each other and in their workplace.
- close the workshop on a positive note.

You will want to end the training with closing comments and a brief activity. One such activity would be simply to ask trainees to take a turn in answering a question such as:

- *What is the most important thing you have learned in this training?*
- *What is the most important skill you will be bringing to your work as an AIDS prevention counsellor and educator? What skill would you still like to develop?*
- *What have you learned that has most surprised you?*
- *Describe a change in your workplace that you would like to make regarding AIDS prevention.*
- *What emotion best describes how you are feeling now?*
- *Suggest two ways in which you have found the training useful.*

This is an activity which could be extended, time permitting, either by full group or one-on-one discussion in greater detail of these and other questions. It will serve to focus trainees on what they have learned, how they are feeling, skills they are confident about, planning for action and areas for continued learning.

HOW TO SCHEDULE YOUR TRAINING WORKSHOP

What Should I Include In My Training If I Have Different Amounts of Time?

What you include in your training will depend on:

- your objectives.
- your audience.
- the amount of time you have available.

There are some general rules to follow. In every training you will want to include:

- an introductory exercise (even if it is very brief.)
- AIDS information and risk reduction guidelines.

If you have half a day or a full day you will also want to include:

- a pre- and post-test.
- skills development.
- examination and exploration of feelings, reactions, values and attitudes.

A half-day workshop might look like the schedule that follows.

**Half-Day
Sample Training**

This is a sample of a half-day training workshop:

- | | |
|---------------|--|
| 8:30 - 8:45 | Overview of training
Pre-Workshop Questionnaire
Introductions |
| 8:45 - 9:30 | Introductory activity |
| 9:30 - 10:30 | Basic AIDS information <ul style="list-style-type: none">● History and Cause● Transmission● Spectrum of HIV Infection● Risk Reduction● HIV Antibody Test |
| 10:30 - 10:50 | Break |
| 10:50 - 11:30 | ● Training Activity:
Answering Difficult Questions |
| 11:30 - 12:15 | Speaker(s): Persons with AIDS, HIV infection
and/or family member or video. |
| 12:15 - 12:30 | Post-Workshop Questionnaire, evaluation |

**What Should I Include
In a Full,
Comprehensive
Workshop?**

When you have four to five days for a comprehensive AIDS prevention counselling workshop, your workshop goals might include the following:

- To increase knowledge about the medical, epidemiologic and psychosocial aspects of HIV infection and AIDS.
- To develop skills in AIDS prevention counselling.
- To examine feelings, reactions, attitudes and values stimulated by AIDS.
- To dispel fears and myths related to high risk behaviours and populations.

**Five-Day
Sample Training**

A five-day AIDS prevention counselling workshop which would achieve these goals might look like the following:

DAY ONE

8:00 - 8:30	Registration & Administrative Matters
8:30 - 9:00	Welcome Opening Address
9:00 - 10:30	Pre-Test Questionnaire Overview of Training and Training Objectives Group Introductions • Training Activity: First Thoughts
10:30 - 10:50	Break
10:50 - 12:15	AIDS Update: Medical, Neuropsychiatric and Treatment Aspects
12:15 - 1:30	Lunch
1:30 - 2:00	Global, Regional, Local Perspectives on HIV
2:00 - 2:45	Family Life in the Caribbean: Socio-Cultural Issues Which Affect AIDS Prevention Strategies
2:45 - 3:10	• Training Activity: Barriers to AIDS Prevention
3:10 - 3:30	Break
3:30 - 4:10	Barriers to AIDS Prevention (continued)
4:10 - 4:40	Introduction to Counselling: What Is Counselling? Role of AIDS Prevention Counsellors
4:40 - 4:45	Wrap-Up

DAY TWO

- | | |
|---------------|---|
| 8:30 - 8:45 | Review of Day 1
Overview of Day 2 |
| 8:45 - 9:45 | Behaviour Change <ul style="list-style-type: none">• Training Activity: Risky Business |
| 9:45 - 10:30 | Introduction To Counselling Skills and Responses <ul style="list-style-type: none">• Training Activity: Without Words |
| 10:30 - 10:50 | Break |
| 10:50 - 12:15 | Counselling Skills and Responses (continued) <ul style="list-style-type: none">• Training Activity: Counselling Role-Plays |
| 12:15 - 1:30 | Lunch |
| 1:30 - 2:30 | Panel Presentation and Discussion: People With AIDS, HIV Infection and their Families |
| 2:30 - 3:10 | Group Discussion |
| 3:10 - 3:30 | Break |
| 3:30 - 4:40 | Sex and Sexuality <ul style="list-style-type: none">• Training Activity: Where Do You Stand? |
| 4:40 - 4:45 | Wrap-Up |
| 6:30 - 8:00 | Video Presentation - optional |

DAY THREE

8:30 - 8:45	Review of Day 2 Overview of Day 3
8:45 - 9:30	Psychosocial Issues
9:30 - 10:30	Safer Sex and Risk Reduction
10:30 - 10:50	Break
10:50 - 11:30	• Training Activity: Teaching Effective Condom Use
11:30 - 12:15	Counselling Skills • Training Activity: Identifying and Reflecting Feelings
12:15 - 1:30	Lunch
1:30 - 2:30	Panel Presentation: Homosexuality and Bisexuality in the Caribbean
2:30 - 3:10	Small Group Discussion Following Panel
3:10 - 3:30	Break
3:30 - 4:40	Development of Guidelines and Strategies (small groups)
4:40 - 4:45	Wrap-Up

DAY FOUR

8:30 - 8:45	Review of Day 3 Overview of Day 4
8:45 - 10:10	HIV Antibody Testing: Lecture, Video and Discussion • Training Activity: Imagine If...
10:10 - 10:30	Pre-Test Counselling Session Protocol
10:30 - 10:50	Break
10:50 - 12:15	• Training Activity: Pre-Test Counselling Session Role-Plays
12:15 - 1:30	Lunch
1:30 - 3:10	Post-Test Counselling Session: Result Reporting Protocol • Training Activity: Post-Test Counselling Session Role-Plays (positive and negative results)
3:10 - 3:30	Break
3:30 - 4:40	Development of Guidelines and Strategies (small groups)
4:40 - 4:45	Wrap-Up

DAY FIVE

8:30 - 8:45	Review of Day 4 Overview of Day 5
8:45 - 9:30	Socio-Cultural View of Illness and Death in the Caribbean
9:30 - 10:30	Counselling People with AIDS and Their Families • Training Activity: Answering Difficult Questions
10:30 - 10:50	Break
10:50 - 11:15	Discussion: Difficult Counselling Situations (cont'd.)
11:15 - 12:15	Reports from Groups on Guidelines and Strategies
12:15 - 1:30	Lunch
1:30 - 2:15	Where Do We Go From Here?
2:15 - 2:30	Closing Comments
2:30 - 3:15	Post-Workshop Questionnaire Evaluation
Closing	

DIFFICULT COUNSELLING SITUATIONS

Health Care Worker with a Needle Stick

You may be asked to provide counselling and education in response to a crisis. In this section, some of these situations are described with suggestions for how to respond to them.

Several days ago a nurse at the public hospital which serves a large number of AIDS patients was stuck with a needle while trying to recap it. The needle had been used to draw blood from a patient who is likely to have AIDS, but who, as yet, has not been diagnosed.

This incident has triggered the fears of all the staff on the unit. They have demanded that from now on they be informed of the HIV status of all patients who are admitted to the hospital.

At the training or workshop you organise in response to their concerns your tasks will be to:

- Anticipate the staff's questions and fears.
- Begin by acknowledging their shared personal experiences and realistic fears.
- Let them know that you will leave plenty of time to answer their questions.
- Acknowledge the situation that brought you there -- the nurse who was stuck with a needle.
- Provide updated AIDS information:
Review modes of transmission and conditions for infection. Do not assume that all staff have an accurate understanding of AIDS. On the other hand, do not talk down to staff, assuming ignorance on their part.
- Discuss risk of HIV infection for health care workers:
Present current statistics and discuss the specifics of health care workers who have been infected through their work. Most of them involved unusual circumstances or accidents or situations in which infection control precautions were not being adhered to.
- Emphasise the very small but possible risk for health care workers.
- Review universal infection control precautions. Make sure that everyone understands all procedures. Emphasise that needles should not be recapped.

- Discuss problems in implementing and adhering to universal precautions, for example, lack of supplies, lack of knowledge, habit, staff not seeing the necessity. Spend some time problem-solving solutions to these obstacles.
- Discuss staff's demand to know all patients' HIV status on admission to hospital. Spend some time discussing this proposition with them, but ultimately, refer the issue to the hospital administration. **Emphasise your understanding of the position they have taken, but point out too, some of its problems:**
 1. The cost of testing and providing counselling to everyone tested.
 2. Emergency cases could not usually be tested before treatment takes place.
 3. Some HIV-positive people would test negative on the have HIV antibody test results because of the "window period."
 4. Staff would have the illusion of safety except when they were working with a known HIV-positive patient and would neglect infection control procedures with the unknown HIV-positive patient for other infectious diseases that are spread more easily than HIV.
- Listen for other sources of fear that staff may not be expressing overtly, such as prejudice towards people with AIDS, workload, difficulty living with uncertainty, etc. Acknowledge and work with these issues as they emerge.

Schoolchildren With HIV

An eight-year-old child at a local school has AIDS and the parents of other children have just learned about it. Many of them are extremely upset because they do not want their children to have contact with a child with AIDS. Some have already kept their children away from school. They are demanding that the child with AIDS be withdrawn from the school. The principal of the school has called you for help.

Over the telephone you should assess the situation:

- *Does the school or district have any established policies about children with AIDS attending school?*
- *What policies about confidentiality are in place?*
- *What do the parents and child want to do?*
- *How well or sick is the child?*
- *How well is the family able to cope with the controversy?*
- *What are the general feelings among staff at the school?*
- *What AIDS information has been provided to staff? to parents? to children?*
- *What does the administrator need from you? information? educational materials? education for staff and parents?*

Among the short-term interventions you may wish to make are to:

- Work with the immediate crisis.
- Meet with the school administrator(s) and other significant district personnel to develop a plan.
- Meet with the family to discuss their desires and the best ways to handle the situation.
- Provide educational sessions for staff.
- Provide educational forums for teachers.
- Provide educational forums for students.

Among the long-term interventions you may wish to make are to:

- Work with policy makers to develop policies about confidentiality related to children with AIDS attending schools.
- Develop plans for ongoing AIDS education programmes for staff, parents and students.

Suicidal Client

Three months ago a female client was diagnosed with AIDS. At that time she was seven months pregnant. Last month she gave birth to a baby boy. He has been very sick and probably has AIDS as well. The client has been extremely depressed. On several occasions she has missed appointments with her doctor. At the last appointment which she did make, she told the doctor that she feels she cannot go on. The doctor referred her to you as he is concerned she might attempt suicide.

In your initial assessment you will want to determine:

- *What are her primary concerns about her illness and her baby's illness?*
- *How well or ill is she? What types of treatment or medication is she taking, if any?*
- *How well is she coping with the illness?*
- *Is she able to continue working and maintaining social contacts?*
- *How well did she cope prior to her diagnosis? What was her life like before diagnosis?*
- *What are her financial and other resources?*
- *How much social support does she have?*
- *Does she use alcohol and drugs? If yes, how frequently and what kind?*
- *What has helped her cope with previous crises?*
- *How much does she know about HIV and AIDS?*
- *Does she appear to be depressed or anxious? Has she expressed her inability to cope? Is she feeling despondent? Is she feeling hopeless? Is she isolated?*
- *Has she been thinking about suicide? If yes, does she have a specific plan for carrying it out? Does she have the ability and the means to carry it out? Does she have a history of depression, suicidal thinking, or attempts?*

Subsequently, you will be able to provide counselling which:

- Identifies, examines and validates her ability to cope with past life crises.
- Assists her with concrete problem-solving.
- Encourages her to express feelings within the counselling session.
- Encourages her to actively participate in her current situation by helping her to redirect her behaviour and to increase awareness of her options.
- Encourages and mobilises her support system.
- Makes appropriate referrals, should a suicide attempt be likely.
- Gives her referrals to relevant community resources.

Families in Crisis

A young man was diagnosed with AIDS several months ago. Although he told his girlfriend about the diagnosis immediately, he told his family -- including his mother, father, sisters and grandmother -- only this past week. When they wanted to know how he could have got AIDS, he told them that he has had sexual involvement with several men in addition to his girlfriend.

The entire family was extremely upset and distraught, but his father was enraged and threw him out of the house against the wishes of the other family members. He is now staying with some friends. He wants you to help him reconcile with his family.

One of the first things to do is to let the young man know that you understand his concern and worry -- about his family and about his diagnosis. Then express your willingness to work with him to find solutions.

- *You will need to help the client calm down enough to discuss the next steps to be taken. If he is too upset for that right now, focus on the most immediate needs (e.g., temporary housing, friends to talk with, etc.) and reassure him that the family problems do not have to be resolved immediately and that, in fact, it will probably take some time for this to happen.*
- *Ask the young man if he wants to focus on what steps to take with his family now or to take care of his immediate needs and come back in a day or so to talk about the family. Be sure that he knows you are willing to proceed with either option.*
- *When you do focus on the family problem with him, discuss the different family relationships with him. How do each of his relatives relate to him individually? How do the family members treat each other? Who is he closest to? Who does he have the most difficulty with?*
- *Identify with the client which family members he might stay in contact with so that he doesn't break all family ties.*
- *Assist, as needed, with what the client will tell or talk about with this family member. A role-play might be helpful.*

- *Help the client develop a few different options to match different outcomes for his family relationships; for example, if he has to stay away from the family house for one month, what will he do? if he cannot return to the house for a longer period of time, what can he do? If he can only maintain a relationship with a few of his family members, how will he cope with that?*
- *Discuss with the client several options for how he might cope with his father's anger? Have there been circumstances in the past that help him to know how to respond now? Consider with him whether he should directly contact his father, whether he could get a message to him through someone else, or whether he should not risk any further anger until some more time passes.*
- *Discuss what would be the possible benefits or risks if you were to speak with the young man's family. If you did so, what would he like to have happen during that meeting?*
- *Be sure to discuss with the young man the level of emotional and social support he might have from other sources. Consider with him what others should be told; for example, should he reveal his HIV status with anyone else?*
- *Develop a short-term plan of action with the client that will guide him over the next few days and weeks.*
- *Schedule a time when you will see him again; let him know how available you are if an additional crisis should occur (do not make offers that will be difficult or impossible for you to meet later on).*
- *Reassure the young man that he can rely on you, that he can trust you to keep his case confidential, and that you are willing to help him.*

**Married Man Who
Tests Positive;
Doesn't Want to
Use Condoms**

A man in his 40s comes to the clinic and asks to speak with you privately. He says a friend suggested he see you because you were someone "who could be trusted."

Then he explains that two months ago he went to a neighboring country to get tested for HIV; last week he returned to get the results and discovered that he had tested positive. He makes it clear that he knows quite a bit about HIV and AIDS and he knows what it means to be positive.

He continues to explain that he already uses condoms with his outside female partners, but that he has not used them with his spouse. He doesn't want to begin using condoms with her and he doesn't want to tell her about his HIV status. He asks you, "Am I doing the right thing? Do I have to stop seeing my other partners?"

The client has presented a complex situation to you, and you wonder how comfortable he is with his decisions and how much he really does know about HIV transmission. You are also personally upset that he may have already infected his spouse with HIV by refusing to use condoms.

You could begin by assuring him that you will live up to his friend's recommendation of you: that is, you will protect his confidentiality. **Then you can ask for more information, such as:**

- *Ask him to describe the nature of his relationship with his wife: how close are they? how much do they usually discuss personal issues or problems? how understanding are they of each other?*
- *Ask him whether he and his wife want to have children or more children; if not, what precautions do they take to avoid pregnancy? If they want to avoid pregnancy, could he suggest they use condoms to do so (and thus reduce risk of HIV transmission as well?)*
- *Whether he has had intercourse with his wife or other partners since he learned of his HIV status? If not, ask why he has not: fear of infecting them, depression about his HIV status, etc. If he has, did he use condoms with those partners and/or with his spouse? Why or why not?*

- *Determine how well the client understands the risk he is presenting to his spouse if they have intercourse without using a condom. Clarify any misconceptions or inaccuracies.*
- *The client is obviously facing a difficult situation; help him weigh the different outcomes of his actions: telling his wife of his status, suggesting using condoms, not telling and not using condoms. What are the outcomes of each? How does he /will he feel about each of the possible outcomes?*
- *The client clearly may not be ready to make any decision on what to do at this point. Try to get him to agree to avoid intercourse for a short period of time -- until he decides or until he speaks with you again.*

There is no easy answer about how to proceed with this client other than to encourage serious consideration of the outcome of his actions, to help him determine his feelings about them, and to present the options as clearly as possible. There are ethical dilemmas about any course of action: notifying the spouse yourself or maintaining the promised confidentiality with your client.

You will want to ask a colleague or superior whether the Ministry of Health or your institution has a policy regarding informing the sexual partners of HIV-infected individuals.

For your own sake you will need to recognise that there are limits on how much a counsellor can do in these situations.

PRE-TEST QUESTIONNAIRE

PART 1: Answer the following questions by circling "True" or "False."

1. You can usually tell just by looking at someone whether he or she is infected with HIV.
TRUE **FALSE**
2. A person who has tested antibody positive will develop AIDS within three years.
TRUE **FALSE**
3. When a mother is infected with HIV, she will almost always transmit the virus to her infant.
TRUE **FALSE**
4. It is possible for someone infected with HIV to test negative on an HIV antibody test.
TRUE **FALSE**
5. Accurate antibody testing of newborn infants can take place at birth.
TRUE **FALSE**
6. Telling a person his or her antibody test result without providing further information or services always motivates people to change their high-risk behaviour.
TRUE **FALSE**
7. If you don't associate with homosexuals, intravenous drug users or prostitutes, you won't get AIDS.
TRUE **FALSE**
8. Sexual partners who are both infected with the HIV do not need to follow safer sex guidelines.
TRUE **FALSE**

9. HIV is devastating because it destroys T-4 cells, which direct the immune response.

TRUE

FALSE

10. Following an initial mononucleosis-like response to infection to HIV, a person can have no observable symptoms for many years.

TRUE

FALSE

PART 2: *Circle the best answer. If two or more answers are equally correct, circle all that apply.*

11. **Of the following body fluids, which have been shown to contain enough virus for HIV transmission to occur?**

- a. Blood.
- b. Vaginal secretions.
- c. Semen.
- d. Saliva.

12. **A person who tests HIV antibody positive:**

- a. Will definitely be diagnosed with AIDS within eight to ten years.
- b. Is likely to become ill with symptoms over the next eight to ten years.
- c. The HIV antibody test has no predictive value.

13. **A negative HIV test result means that an individual:**

- a. Has not been infected with HIV.
- b. Might have recently been infected but has not developed antibodies to HIV.
- c. Has developed an immunity to HIV.

14. **If a condom breaks (bursts) during intercourse, it might mean:**

- a. The condom was put on "inside out."
- b. The sexual activity was too strenuous or "rough."
- c. An oil-based lubricant was used and this weakened the condom.
- d. No room ("space at the tip") was allowed for when putting the condom on.
- e. The condom itself was poorly made.

PART 3: For each of the following statements, check (✓) how strongly you agree or disagree:

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1. People with AIDS should not have sex.						
2. If I had a choice, I would not work with AIDS patients.						
3. Women who don't care about themselves are the ones who get AIDS.						
4. I would feel more comfortable caring for an AIDS patient who got the illness from a transfusion than a homosexual AIDS patient.						
5. I would not want my child to go to school with a child with AIDS.						
6. Life is hopeless and not worth living if you have AIDS.						

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POST-TEST QUESTIONNAIRE

PART 1: *Answer the following questions by circling "True" or "False."*

1. You can usually tell just by looking at someone whether he or she is infected with HIV.
TRUE **FALSE**

2. A person who has tested antibody positive will to develop AIDS within three years.
TRUE **FALSE**

3. When a mother is infected with HIV, she will almost always transmit the virus to her infant.
TRUE **FALSE**

4. It is possible for someone infected with HIV to test negative on an HIV antibody test.
TRUE **FALSE**

5. Accurate antibody testing of newborn infants can take place at birth.
TRUE **FALSE**

6. Telling a person his or her antibody test result without providing further information or services always motivates people to change their high-risk behaviour.
TRUE **FALSE**

7. If you don't associate with homosexuals, intravenous drug users or prostitutes, you won't get AIDS.
TRUE **FALSE**

8. Sexual partners who are both infected with the HIV do not need to follow safer sex guidelines.
TRUE **FALSE**

9. The "AIDS virus" is devastating because it destroys T-4 cells, which direct the immune response.

TRUE

FALSE

10. Following an initial mononucleosis-like response to infection with HIV, a person can have no observable symptoms for many years.

TRUE

FALSE

PART 2: *Circle the best answer. If two or more answers are equally correct, circle all that apply.*

11. **Of the following body fluids, which have been shown to contain enough virus for HIV transmission to occur?**

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5. I would not want my child to go to school with a child with AIDS.						
6. Life is hopeless and not worth living if you have AIDS.						

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Answer Key for Sample Pre- and Post-Test Questionnaire

1. False
2. False
3. False
4. True
5. False
6. False
7. False
8. False
9. True
10. True
11. a,b,c
12. b
13. a,b
14. a,b,c,d,e

5. I feel that I am now more able to talk with people at risk for AIDS/HIV without letting my personal feelings about their risk behaviours get in the way of my counselling them:

_____ strongly agree

_____ disagree

_____ agree

_____ strongly disagree

6. During the workshop there were opportunities for learning new skills through role-play exercises. I feel that I learned a lot from these exercises:

_____ strongly agree

_____ disagree

_____ agree

_____ strongly disagree

7. What did you like best about the workshop?

Why? _____

8. What did you like least about the workshop?

Why? _____

9. What would you change about the workshop to improve it?

Thank you for your active participation throughout the workshop.



TRAINING TRAINERS FOR AIDS PREVENTION COUNSELLING: A MODEL

Introduction

The ultimate goal of AIDS prevention counselling training is to stem the spread of HIV by educating the greatest number of people about AIDS and AIDS prevention with limited resources. Train the trainer programmes are an effective model toward reaching this goal. The "AIDS Prevention Counselling Train the Trainer" programme described in this section is a two- to three-step model in which providers are first trained as AIDS prevention counsellors and secondly as trainers.

The AIDS prevention counselling workshop teaches people about AIDS, AIDS prevention and counselling by providing opportunities to integrate new knowledge, practice new skills, and examine personal values and attitudes that occur as a result of the AIDS epidemic. Following this workshop, participants are asked to return to their workplace and share with others what they have learned as well as gain some practice as AIDS prevention counsellors.

The "Train the Trainer Workshop," a two-and-one-half- to three-day workshop, is the second step in this model. With two to three months separating the first and second workshops, trainers will have had time to integrate more knowledge, practice counselling and education skills, and initiate counsellor and/or educational programmes. By the time this workshop begins, participants will have a better awareness of their strengths and weaknesses as educators, gaps in their knowledge, and pitfalls in planning and implementing AIDS counselling education programmes. With the experiences as a foundation, the "Train the Trainer" workshop focusses specifically on the various aspects of planning and implementing AIDS training and educational programmes.

This section details the "Train the Trainer" curriculum. The participants in this workshop should be selected based on the following criteria: 1) previous participation in an intensive AIDS Prevention Counselling Workshop, 2) availability and interest in conducting educational programmes as a part of their work schedule, 3) good interpersonal skills, and 4) good group skills, teaching abilities and public speaking.

The goal of the "Train the Trainer Workshop" is to increase skills in training others about AIDS prevention counselling. By the end of the workshop, participants should be able to design training objectives and training activities, apply principles of adult learning environment, present AIDS information, facilitate group discussion and

activities, and develop strategies for dealing with difficult training situations and difficult learners.

In order to accomplish these objectives, the workshop should include didactic information about adult learning principles, designing a training, teaching strategies, implementing a training and evaluating a training.

It is helpful to devote some time at the beginning of the workshop for participants to discuss their recent experiences as AIDS prevention counsellors and educators, as well as identify their strengths and weaknesses as trainers.

The greater part of the training should allow for participants to go through the steps of designing and implementing a training programme. This includes writing training objectives, designing the training in terms of content and presentation, choosing appropriate teaching strategies and implementing the training.

Allotting time for participants to discuss strategies for handling difficult learning situations and difficult learners is an important step in refining training skills. Finally, time needs to be allotted for action planning.

The third step in this model includes a follow-up workshop in which participants can further refine their skills as trainers, update their AIDS knowledge, consult with colleagues, and problem-solve difficult situations and dilemmas that have emerged during the course of their work as counsellors and educators. This workshop should take place three to six months after the "Train the Trainers Workshop".

TRAIN THE TRAINER WORKSHOP: AIDS PREVENTION COUNSELLING

Objectives

By the end of the workshop, participants w'll be able to:

1. Design training objectives.
2. Design training activities.
3. Establish an effective learning environment.
4. Present accurate information related to the medical, epidemiologic and psychosocial aspects of AIDS and AIDS prevention.
5. Facilitate group discussion of sensitive issues related to AIDS prevention.
6. Facilitate learning activities.
7. Develop strategies for dealing with difficult training situations and difficult learners.

TRAIN THE TRAINER WORKSHOP: AIDS PREVENTION COUNSELLING

DAY ONE

8:00 - 8:30	Registration and Administrative Matters
8:30 - 8:45	Welcome
8:45 - 9:30	Overview and Philosophy of Training Introductions Pre-Test Questionnaire Introductory Exercise: "A Scavenger Hunt"
9:30 - 10:15	Self-Assessment Questionnaire Discussion of AIDS Training Experiences
10:15 - 10:30	Coffee Break
10:30 - 11:45	AIDS Update
11:45 - 12:00	• Training Activity: "What Makes A Good Trainer"
12:00 - 1:00	Lunch
1:00 - 3:00	Introduction to Adult Learning Principles Designing and Implementing a Training
3:00 - 5:00	• Training Activity: "Design Your Own Training"

DAY TWO

8:00 - 9:30	Time available to work with co-trainers or individually
9:30 - 9:45	Coffee available
9:45 - 10:15	Small groups convene Instructions for giving feedback
10:15 - 11:15	Group 1: Presentation
11:15 - 12:00	Group 1: Feedback and Discussion
12:00 - 1:00	Lunch
1:00 - 2:00	Group 2: Presentation
2:00 - 2:45	Group 2: Feedback and Discussion
2:45 - 3:00	Coffee Break
3:00 - 4:00	Group 3: Presentation
4:00 - 4:45	Group 3: Feedback and Discussion
4:45 - 5:00	Closing

DAY THREE

8:00 - 8:15	Convene in small groups
8:15 - 9:15	Group 4: Presentation
9:15 - 10:00	Group 4: Feedback and Discussion
10:00 - 10:30	Closing with Small Group and Discussion of Experience
10:30 - 10:45	Coffee Break
10:45 - 11:15	Reconvene as Full Group
11:15 - 12:00	• Training Activity: "Strategies for Handling Difficult Training Situations"
12:00 - 1:00	Lunch
1:00 - 2:00	Action Planning
2:00 - 2:45	Closing Post-Test Questionnaire Evaluation

PRE-TEST QUESTIONNAIRE

Circle the best answer. If two or more answers are equally accurate, circle all correct answers.

1. Adults learn best when:

- a. the information is relevant to their personal and professional experiences.
- b. they are told by a supervisor to attend the training.
- c. the learning environment is comfortable.
- d. they have an opportunity to practice the new material.

2. Good training objectives are: (complete the word)

- a. S _____.
- b. M _____.
- c. A _____.
- d. R _____.
- e. T _____.

3. When a participant challenges a statement made by the trainer, the trainer should:

- a. tell the person he is wrong.
- b. ignore the comment.
- c. acknowledge the trainees' opinion.
- d. invite the group to explore the issue in more depth.

4. The goal of training activities is:

- a. to facilitate participatory learning.
- b. to fill gaps in the day.
- c. to carry out training objectives.
- d. to emphasise only factual information.

Based on adult learning principles, examples of the most effective training activities are:

- a. brainstorming.
- b. a structured small group activity.
- c. role-playing.
- d. case discussion.
- e. lecture.

6. When a group of health care workers is repeatedly anxious about their risk of contracting AIDS from patients, a good trainer should:

- a. drop the entire training plan to lecture about modes of transmission.
- b. dismiss the fear as ridiculous.
- c. acknowledge legitimate concerns and review modes of transmission.
- d. suggest they test all their patients for HIV.
- e. suggest that the best way to reduce risk of occupational exposure to HIV is to refuse to care for people with AIDS.

7. A good public speaker is one who:

- a. makes eye contact with the audience.
- b. varies the rhythm and volume of speech.
- c. reads from notes.
- d. uses body language that conveys interest, openness and active participation with the group.

TRAINING ACTIVITY

Scavenger Hunt

Purpose: To become reacquainted or meet each other.

Objectives - Participants will be able to:

- Meet other participants.
- Briefly discuss personal experiences as AIDS counsellors and educators.

How long will it take?

- Allow 15 minutes.

What do I need?

- Scavenger Hunt form.

How do I do it?

1. Each participant is given a Scavenger Hunt form and asked to obtain signatures from other participants who can answer "yes" to the statement made on the sheet. More than one signature can be obtained for each statement. The object is to obtain a signature for each statement.
2. Give participants five minutes to complete their forms. Have them return to their seats.
3. Ask participants "Who was able to fill the entire sheet? Were there any surprises about someone they thought they knew well? About themselves?"

Comment:

This activity is short and fun. It gets the energy moving in the room. The statements can be changed for different audiences to include different questions.

SCAVENGER HUNT FORM

Instructions: Below are statements of characteristics, roles, experiences and behaviours of people. Some are related to experiences you may have had as an AIDS educator, some are not. Your job is to interview other participants and find someone who fits into each of these different categories. Once you find a person who agrees with the statement, ask them to sign their name in the blank provided. The object is to fill in as many blanks as possible, with one signature for each.

1. Know someone with AIDS/HIV _____
2. Explained AIDS/HIV to a group _____
3. Became so nervous during a presentation that I forgot my material _____
4. Discussed AIDS with my child _____
5. Had a positive experience as an AIDS trainer _____
6. Became angry or upset during an AIDS training I was conducting _____
7. Discussed AIDS with a friend _____
8. Knows someone who has taken the HIV antibody test _____
9. Discussed safer sex with my spouse/partner _____
10. Taught someone how to use a condom _____

TRAINING ACTIVITY

Self-Assessment for Trainers

Purpose: To assess participants' level of comfort and skill as AIDS trainers.

Objectives - Participants will be able to:

- Identify areas of comfort and discomfort as a trainer.
- Identify strengths and weaknesses as a trainer.
- State learning objective for the training.

How long will it take?

- Allow 15 minutes.

What do I need?

- Self-Assessment for Trainers form.

How do I do it?

1. Hand out the Self-Assessment for Trainers form to all participants. Ask participants to fill out the form. Collect the forms.
2. Ask trainees to discuss:
 - the areas they feel most comfortable as a trainer.
 - the areas they feel least comfortable as a trainer.
 - the one thing they hope to get out of the workshop.
3. Write their responses on large paper in front of the room.
4. Collect the questionnaires at the end of the discussion.

Comments:

This assessment tool is useful in two ways: First, it helps participants assess their skills, comfort level, strengths and weaknesses as an AIDS counselling trainer and educator. Second, it gives you information about the participants and can help you revise the workshop according to the learning needs of the group.

SELF-ASSESSMENT FOR TRAINERS

Part I.

The following scale will help you to assess your level of comfort with various roles and skills of AIDS prevention counselling trainers. Your answers will also help us in designing activities that will most closely address those areas that need work.

Rate your knowledge, skill and comfort level according to the following statement scale. Enter the appropriate letter for each statement.

- A. Strongly Agree.
- B. Partly Agree.
- C. Partly Disagree.
- D. Strongly Disagree.

- _____ 1. I have a comprehensive grasp of AIDS information.
- _____ 2. I have a comprehensive grasp of the psychosocial aspects of AIDS.
- _____ 3. I have a comprehensive grasp of counselling skills and their application to AIDS prevention.
- _____ 4. I am comfortable working with varied attitudes toward sex and sexuality in a non-judgemental manner.
- _____ 5. I am comfortable in the role of trainer.
- _____ 6. I know how to design clear training objectives.
- _____ 7. I know how to design the content of a training.
- _____ 8. I know how to conceptualise and plan training activities.
- _____ 9. I am knowledgeable about effective teaching strategies.
- _____ 10. I am comfortable observing role-plays and delivering constructive, supportive feedback.

- _____ 11. I have a good understanding of how to organise material for a presentation
- _____ 12. I understand the role of a group facilitator.
- _____ 13. I am comfortable in the role of group facilitator.
- _____ 14. I know how to establish a comfortable learning environment.
- _____ 15. I can create a safe atmosphere where differences can be acknowledged and appreciated.
- _____ 16. I am adept at dealing with oppositional, resistant or hostile trainees.
- _____ 17. I can communicate information easily to a large group.
- _____ 18. I have an effective presentation and delivery style.
- _____ 19. I am skilled at eliciting audience participation throughout a training.
- _____ 20. I know how to set limits while remaining flexible when the situation requires it.

Part II.

Please briefly answer the following:

1. List five strengths you have as a trainer.

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

2. List three areas where you feel you need improvement as a trainer.

- a. _____
- b. _____
- c. _____

3. If I were to get only one thing from this training, I would like it to be:

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TRAINING ACTIVITY

Discussion of AIDS Training Experiences

Purpose: To stimulate discussion about personal experiences in providing AIDS training.

Objectives - Participants will be able to:

- Describe their AIDS training experiences to date.
- Discuss successes and difficulties as AIDS educators.

How long will it take?

- Allow 20 to 60 minutes.

What do I need?

- Large paper.
- Markers.

How do I do it?

1. Ask participants for a show of hands to the following questions: *Who has...*
 - *provided some type of AIDS training for a group of people?*
 - *used experiential learning strategies in their AIDS training?*
 - *conducted a training of over an hour?*
 - *found it easy to answer people's questions and concerns about AIDS?*
 - *found it difficult to be an AIDS trainer?*
2. Ask several participants to describe in detail the training(s) they have conducted including: type, content, audience, teaching strategies, successes and difficulties.
3. Begin writing two lists of "successes" and "difficulties" on large paper in front of the room.
4. Ask the rest of the group to fill in the successes and difficulties lists and continue the discussion about trainees' personal experiences and AIDS trainers.

TRAINING ACTIVITY

What Makes a Good Trainer

Note: This activity should precede any presentation on planning and implementing a training.

Purpose: To discuss characteristics of a good trainer.

Objectives - Participants will be able to:

- Reflect on previous educational experiences.
- List qualities of a good trainer.

How long will it take?

- Allow 15 minutes.

What do I need?

- Large paper.
- Markers.

How do I do it?

- Ask participants to recall a positive educational experience they have had in which they were the learner.
- Brainstorm a list of skills and characteristics which made the trainer effective in his or her role.

This brainstorming session should lead into the information you will cover on designing and implementing a training.

DESIGNING AND IMPLEMENTING A TRAINING

Before you review information related to designing and implementing a training, give participants an overview of the "Designing Your Own Training" activity.

Information on designing and implementing a training can be found in Section II of this manual entitled "Planning Your Training: Getting Started." **Since there is limited time in this training of trainers workshop to cover so much information, the following sections are those you will want to be sure to highlight:**

- Adult learning principles.
- Writing goals and objectives.
- Designing the content and presentation.
- Training strategies.
- Implementing the training.

Suggestions for methods of reviewing this material are found below.

Adult Learning Principles

Ask the group to recall their formal education. Brainstorm a list of characteristics of "traditional" learning. Next, brainstorm characteristics that trainees feel contribute to adult learning. Based on these lists, review the information found in Section II on "The Approach: Adult Learning Principles."

Writing Goals and Objectives

Review the information found in Section II on "Writing Goals and Objectives." Discuss the differences between workshop goals and objectives. As a group, discuss possible objectives that would relate to the topics participants will be working on in "Designing Your Own Training" activity.

Designing the Content

Review the information found in Section II on "Designing the Content." Use specific examples from the topics participants will be working on in the activity to discuss key issues in this section.

Training Strategies

Brainstorm a broad list of training strategies. Add any strategies discussed in Section II, "Training Strategies," that were not listed during the brainstorm. Discuss creative training strategies for several sample topics such as HIV transmission.

Implementing the Training

Review the role of the trainer found in Section II, "Implementing the Training." Explain the tasks of the trainer. Discuss this section by reviewing the trainer competencies list found on the next page. Have these competencies written on large paper and posted at the front of the room. Explain that these are the areas of knowledge, skills, and attitudes. We will be giving feedback on when participants conduct their training module. Discuss each section briefly and expand as needed. (See Facilitation Activity, VIII-22 for a learning activity to follow discussion on process facilitation.)

TRAINER COMPETENCIES

The following sets of knowledge, skills and attitudes are critical in designing and implementing effective AIDS prevention trainings. These are to be exhibited by the trainer and observed by participants/learners. They have been stated in general terms to facilitate your planning, training, observing and feedback.

KNOWLEDGE

- AIDS/HIV.
- HIV transmission and prevention.
- Safer sex and condom use.
- HIV antibody test.

SKILLS

Setting the Stage:

- Establishes a comfortable setting for learning by helping participants. Participants feel interested, motivated and supported.
- Presents a clear overview of the module and training objectives.

Task Facilitation:

- Makes sure that specific content is covered and that the group stays on task.
- Introduces and frames topic and learning activities.
- Gives clear and concise directions for learning activities.
- Processes activity and stimulates discussion.
- Closes with a summary.

Content:

- Presents accurate information.
- Presents information in an easily understood manner.
- Organises material in an effective manner.

Presentation and Delivery:

- Projects energy.
- Makes eye contact.
- Appears accessible.
- Varies speech -- rate, volume, intensity.

Process Facilitation:

- Facilitates group cohesion.
- Acknowledges the knowledge and expertise of participants.
- Encourages and acknowledges the active participation of all group members.
- Encourages the sharing of diverse opinions and experiences.
- Protects minority opinion.
- Conveys to participants that they have been listened to and understood.
- Responds to feelings and reactions of individuals and the group as a whole by acknowledging feeling which may be hidden or covertly expressed.
- Demonstrates flexibility by responding to group needs.
- Discourages individuals from monopolizing discussions.
- Manages time effectively.

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Effective Training Team Member:

- Is prepared.
- Provides support and feedback to co-trainer.
- Makes smooth transitions with co-trainer.
- Demonstrates respect for co-trainer.

ATTITUDES

- Models sensitivity and non-judgmental stance.
- Demonstrates sensitivity to participant needs and pace of learning.
- Demonstrates respect toward participants' thoughts and feelings.
- Appropriately reveals personal feelings, thoughts, values, and observations.

(Adapted from The Center for AIDS and Substance Abuse Training).

TRAINING ACTIVITY

Facilitation

Purpose: To practice facilitation skills while participating in a values clarification exercise.

Objectives - Participants will be able to:

- Identify personal values as they relate to the AIDS epidemic.
- Practice group decision-making skills.
- Observe group process and facilitation skills.

How long will it take?

- Allow one hour.

What do I need?

- Facilitation activity handouts.
- Slips of paper with the following roles written on them: facilitator (1), observer (1), the rest participants (you will need this configuration of roles for each small group.)

How do I do it?

1. Review the Trainer competencies and skills, highlighting process facilitation skills.
2. Divide the group into small groups of seven to nine people. Explain that in this activity, one person will be the facilitator. He or she is to make sure the group stays on task, attend to group process and facilitate the completion of the activity. The facilitator is not involved directly in the decision-making process of the group. The observer is to sit outside of the group and observe the process facilitation skills utilised by the facilitator and group process. As a guide, he or she should use the list of trainer competencies. The rest of the group will be participants in this values clarification exercise.
3. Explain the activity. Each group will be discussing a scenario. Explain the scenario (written on the top of the facilitation activity handout) but do not read the rest of the information. If participants are unfamiliar with AZT, explain that it is a treatment which has been effective in

increasing the life expectancy of people with AIDS and HIV. AZT is most effective for people who are infected with HIV but are asymptomatic. The groups' task is to come to agreement about who should be given the AZT.

4. Give each participant the handout. Next, ask each person to select a slip of paper that will designate his or her role within the group. Make sure trainees understand their roles.
5. Give small groups 20 minutes to reach consensus. After 20 minutes (or when the group comes to consensus), ask the observer to share his or her insights about facilitation and group process, and briefly discuss as a group their experience in this exercise. Trainers should act as observers for each group.
6. Bring participants back to the large group. In processing this activity, focus your discussion on the process rather than the content and people's decisions. Discuss the facilitation skills that were utilised and highlight those that were most effective.

FACILITATION ACTIVITY HANDOUT

Scenario

A sufficient quantity of AZT, the only treatment for AIDS and people with HIV, has just become available to treat *ONE* person. It is impossible to divide this treatment among two or more persons.

The following individuals are eligible to receive the AZT but only one will ultimately get it based upon your groups consensus decision:

- A three-year-old child with AIDS who contracted the infection from its infected mother. The child is extremely ill.
- A 35-year-old male physician who has won many awards for research. He is antibody positive, homosexual, and became HIV positive through male sexual contact. He is currently healthy with no symptoms.
- A 22-year-old woman using the oral contraceptive pill. She is studying to become a nurse and lives with her boyfriend who is in the military and is away a lot. However, they are very committed and are planning on getting married. She became infected at the first intercourse with him. It is unknown how he became infected. She has mild symptoms.
- A 70-year-old minister who became HIV positive as a result of a blood transfusion. He has no symptoms.
- A 30-year-old pregnant married woman with two uninfected children ages five and seven. She is three-months pregnant and was just diagnosed with AIDS. Her husband has had multiple sex partners (male and female) during their marriage.

TRAINING ACTIVITY

Design Your Own Training

Purpose: To design and implement an AIDS training module with co-trainers.

Objectives - Participants will be able to:

- Write training objectives.
- Apply adult learning principles to the planning and implementation of an AIDS prevention education module.
- Design a one-hour training module on an assigned topic including didactic and experiential learning activities.
- Practice teaching AIDS information.
- Demonstrate group facilitation skills.
- Increase repertoire of teaching strategies and techniques.
- Provide constructive feedback to other presenters.

How long does it take?

- Allow 10 to 12 hours.

What do I need?

- Trainer Competencies handout.
- Peer Feedback form -- you will need enough copies for every trainee to fill one out for each person in his or her small group (8 to 12 per trainee).
- Trainer Feedback form -- you will need enough for each trainer to fill out for every trainee in his or her group (8 to 12 per trainer).
- Large paper.
- Magic markers.
- Paper.
- Pens.

Be sure to have two to three separate rooms that can each accommodate 14 people. In addition, make sure that there is enough room for co-trainers to spread out and work quietly.

Part I

How do I do it?

Note: Before this activity you will want to assign participants to a group. You will be dividing the group into two smaller groups with a trainer assigned to each. Try to get a good mix of people in each group based upon gender, ethnic background, professional role, training skills and other factors you feel are important.

1. Explain that the group will be divided into two pre-assigned groups and will stay with this group until Day Three. Within each group, participants will choose from four topics the training module they would like to design. Two to three co-trainers will design a module and then present it to the rest of the group. Specific instructions for designing and implementing the training module and for feedback sessions will be discussed after breaking into two groups.
2. Tell people which group they have been assigned to and have them move to the room they will be working in.
3. From this point on, each trainer will be giving the following instructions to his or her group.
4. Explain that the remainder of today, all day tomorrow and the next morning will be devoted to the designing and presenting of trainings in order to give participants an opportunity to design a training, present material as well as give others feedback about their effectiveness as trainers. Review the purpose and objectives of this activity.
5. Explain that everyone will have a chance to select their topic from the following choices and will hopefully be able to work on their first or second choice. Ask participants to be thinking about which training module they would like to work on. Let them know that after you explain the activity in more detail you will be asking them to select a module. (Each topic includes specific questions to cover.)

- Basic AIDS information.
 - What is the difference between HIV and AIDS?
 - How does HIV affect the body?
 - What are the stages of HIV infection?
 - What are the symptoms during each stage?

- HIV transmission and prevention.
 - How is HIV transmitted?
 - How is HIV not transmitted?
 - How can HIV transmission be prevented?

- HIV antibody test.
 - What the antibody test is and is not.
 - What does a positive test result mean?
 - What does a negative test result mean?
 - What are potential social and emotional consequences of taking the antibody test?

- Safer sex and condom use.
 - What are safe, possibly safe, and unsafe sexual activities?
 - What does one need to know about condoms.?

(Change the topics and /or the intended audience if you think it will be more relevant to participants.)

6. Explain that each group will be designing a one-hour training on their topic. Today's planning time will involve the following steps in order to plan and conduct the training module.
- Write objectives.
 - Design the training: content and presentation.
 - Select teaching strategies.
 - Plan the implementation of the training.
 - Conduct the training.

*Due to time constraints, this activity does not include:
1) needs assessment, 2) organising the training and
3) evaluation.*

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7. Explain that the modules can be designed in any format and should be one hour long. Each group will decide how to divide the work among co-trainers.
8. Explain that they will have the rest of the day and some time in the morning to plan their module. (If they need extra time, they may want to work with co-trainers, or separately, tonight or early tomorrow morning.) Tomorrow each group will teach their module to the rest of the group.
9. Ask participants to select their module. Have the four choices written on a blackboard or large paper. Beginning with the first one, ask who would be interested in working on this topic. Write down their names. Repeat this for each topic. You will want two to three trainers for each group. If too many people want to work on one topic, ask if someone is willing to work on a different topic. Topic selection will have to be negotiated until there are the right number of people in each group.
10. Give the following reminders:
 - Keep adult learning principles in mind as you design your module.
 - Be creative in your design. You can set the stage in whatever way you chose.
 - You are in charge of keeping to time. You may want to assign one group member to be the time-keeper or devise a different system.
 - Acknowledge that some people may feel uneasy about this activity and that it is difficult to expose oneself in this way among peers. Remind participants about the ground rules and that this activity is to be carried out in an atmosphere of trust, support and mutual respect.
11. Ask for questions and clarification.
12. Explain that the trainers will be available to assist the groups in any aspect of designing the training. The trainers will also be available for coaching any individual or teaching team.

13. Before breaking into groups with co-trainers, review the schedule for tomorrow. Remind participants that each group will present their module during an assigned hour with a 45-minute feedback session immediately following. Looking at the training schedule, assign each group to a specific time slot for their presentation. Remind participants about the time you will want to reconvene tomorrow morning and begin the presentations.

Comments:

This activity is designed for a maximum total group size of 24 people with two trainers. In this design, participants divide into two groups of 8 to 12 people each and then divide again into co-training groups of 2 to 3 people. **If your total group size is larger than 24 people, you will need to adapt this activity in one of the following ways:**

- If you have more than two trainers, you can divide the entire group into as many smaller groups as you have trainers.
- If time allows, you can add one or more training modules and training teams within each small group.
- If time does not allow for this, you can shorten each training module presentation and feedback session to accommodate an additional training team group.

Part II

Presentations and Feedback Sessions:

1. Begin the morning by reviewing the procedure for the day. Review the schedule and remind participants that their presentation should be one-hour long. Acknowledge participants' nervousness.
2. Explain that a 45-minute period is scheduled after each presentation for feedback and evaluation. Remind participants that this is not a formal evaluation, but an opportunity to learn about our strengths and weaknesses as trainers in a supportive and constructive atmosphere by giving and receiving positive feedback and constructive suggestions for improvement. Review guidelines for giving and receiving feedback. ("Giving and Receiving Feedback" handout VIII-33.)
3. As a large group, discuss some examples of the type of feedback you are looking for using the Trainer Competencies List as a guide for behaviour. For example, ask the group how it might impact their learning if you gave clear and concise directions for a learning activity. Would it be positive or negative? How would it facilitate their learning? Use several more examples from the Trainer Competencies List until the group is clear about giving feedback, observable behaviours and the impact it had on their learning.
4. Review the feedback procedure. During each presentation the trainer is to fill out a Trainer Feedback form for each person on the training team. Participants/learners are to fill out a Peer Feedback form for each member of the training team. Remind participants to use the Trainer Competencies List as a guide for observing behaviours.
5. The feedback session should begin by having one of the participants/learners share two observable behaviours, one positive and one negative, and their impact on delivery for one of the training team members. Go around the room until all participants/learners have given feedback

then give his or her feedback to the training team member. Repeat this process until feedback has been given to each training team member.

6. When all of the feedback has been given, ask each member of the training team to respond to the feedback by asking for clarification, repeating what was heard in order to clarify, and responding to the feedback and the experience in general.
7. Everyone should hand their feedback forms to the person for whom it was given.
8. Answer any questions, clarify information and respond to any concerns about this activity. Begin!

Part III

Closing:

1. Ask participants to discuss their reactions to the experience of the last day and one half, including positive and negative reactions and key learnings.
2. When participants reconvene into the large group, you will want to spend a little time discussing the small group experiences as a large group. This will give trainees time to transition from the intensive small group experience and reconnect with other participants from whom they have been separated for most of the workshop. This can be an open or more structured discussion and can include sharing of reactions, key learnings and particularly interesting and noteworthy experiences.

GIVING AND RECEIVING FEEDBACK

Giving Feedback

Feedback can focus on knowledge, skills and attitudes and can help an individual by correcting misinformation, modifying and enhancing skills and attending to unsupportive attitudes. Feedback is given so that the receiver can choose to modify his or her behaviour.

Feedback given to an individual is most helpful when it:

- Describes a behaviour(s) and its context (when and where it happened).
- Describes how it affected your learning (positively or negatively).

For example:

- *John gave clear and simple instructions for the role-plays. This helped me understand what I was to do and lowered my anxiety. (positive impact)*
- *John spoke too quickly when he described how to use a condom correctly. I missed some of the information. (negative impact)*

Feedback should not include:

- Judgements about the person.
- Your interpretation of why they did something.
- Something the person cannot change.

Receiving Feedback

Receiving feedback can feel threatening. However, when it is given in specific and behavioural terms, without judgement, it can provide useful information to the receiver who can then choose to modify his or her behaviour.

The best way to receive feedback is to:

- Listen openly without trying to defend yourself.
- Repeat what you heard the person say to confirm what you heard and clarify the feedback.
- Respond to the feedback by explaining what you intend to do about it such as think about it, use it to modify your behaviour or reject it.

PEER FEEDBACK FORM

Topic: _____

Presenter: _____

Use this form to record your feedback on the knowledge, skills and attitudes of the training team member designated above. Use the Trainer Competencies list to guide you in your observations.

OBSERVABLE BEHAVIOURS

IMPACT ON DELIVERY

+ = contributed to; - = detracted from.

Explain in what way.

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

6. _____

6. _____

(Adapted from The Center for AIDS and Substance Abuse Training.)

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PEER FEEDBACK FORM

Topic: _____

Presenter: _____

Use this form to record your feedback on the knowledge, skills and attitudes of the training team member designated above. Use the Trainer Competencies list to guide you in your observations.

OBSERVABLE BEHAVIOURS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

IMPACT ON DELIVERY

+ = contributed to; - = detracted from.

Explain in what way.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

(Adapted from The Center for AIDS and Substance Abuse Training.)

PEER FEEDBACK FORM

Topic: _____

Presenter: _____

Use this form to record your feedback on the knowledge, skills and attitudes of the training team member designated above. Use the Trainer Competencies list to guide you in your observations.

OBSERVABLE BEHAVIOURS

IMPACT ON DELIVERY

+ = contributed to; - = detracted from.

Explain in what way.

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

6. _____

6. _____

(Adapted from The Center for AIDS and Substance Abuse Training.)

TRAINER FEEDBACK FORM

Use this form to rate the training team member's knowledge, skills, and attitudes as demonstrated by his or her presentation. Note observable behaviours and use a (+) or (-) to signify whether it had a positive or negative impact on learning. Use the Trainer Competencies List to guide your feedback.

KNOWLEDGE

SKILLS

ATTITUDES

(Adapted from The Center for AIDS and Substance Abuse Training.)

TRAINING ACTIVITY

Strategies For Handling Difficult Training Situations and Difficult Learners

Purpose: To increase participants' knowledge and confidence about their role as trainers.

Objectives - Participants will be able to:

- Identify strategies for handling difficult training situations and difficult learners.
- Share ideas and expertise with colleagues.

How long does it take?

- Allow 45 to 60 minutes.

What do I need?

- "Difficult Training Situations" handout.
- Large paper.
- Markers.
- Tape.

How do I do it?

1. Prior to this activity, write the difficult situations at the top of separate pieces of large paper. The following are suggestions for difficult situations or learners. (You can also ask participants to suggest difficult situations they would like to discuss either at the beginning of this activity or prior to it starting.)
 - Group energy is low.
 - Participants consistently arrive and return from breaks late.
 - Work with co-trainers.
 - Participant states "factual" information that is inaccurate.
 - Quiet and isolated participants.
 - Several people talking among themselves and not paying attention.
 - Hostile and disruptive participant.
 - Strong differences of opinion between participants.
 - Asking questions that are off the subject.

2. As a group, brainstorm strategies and responses to the difficult learning situations and difficult learners. Trainers should be prepared to add strategies to the list and discuss the effectiveness of certain interventions during the course of the brainstorming activity.
3. When the brainstorming is completed, pass out the handout "Difficult Training Situations" and ask trainees to fill in other ideas in each scenario.

DIFFICULT TRAINING SITUATIONS

Certain situations will challenge you as the trainer. Some typical problem situations are outlined with some suggestions for how to respond to them.

1. Group energy is low:

- Take a break for people to stretch and move around the room.
- Ask the group, "Do you need a short break before we continue?"
- Switch to an activity which actively involves the group. Use the element of surprise to shift the energy.
- If possible, make the environment more comfortable by opening windows, changing seat arrangements, etc.
- Ask the group, "Are you feeling tired or is this topic not meeting your needs?"
- _____
- _____
- _____

2. Participants arrive and return from breaks consistently late:

- Remind people before the break or end of day that the next session will be starting on time.
- Remind people of the ground rules and the commitments on the part of trainer and participants to begin and end on time.
- Start on time and do not wait for latecomers.
- Ask the group if there is a problem with the time schedule or logistics that is making it difficult for them to be on time, for example, transportation, parking, etc. If a problem is identified, find a solution with the group.
- _____
- _____
- _____

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3. Collaboration with co-trainers:

- Discuss any differences in training styles ahead of time. Assign tasks based upon interest, skill and comfort level.
- Plan for time management: who will keep time? How will you signal each other when it is time to move on? How much warning does each person want before their time is up?
- Discuss how to handle differences of opinion in front of the group.
- Plan how to handle differences you may have in factual information in front of the group.
- Discuss how you feel about a co-trainer's contributing comments during a section which you are conducting.
- _____
- _____
- _____

4. Participant states "factual" information that is inaccurate. Correct misinformation, expressing your viewpoint in one of the following ways:

- "It is my understanding that..."
- "Researchers have differing opinions about that, but most seem to agree that..."
- "In fact, what has been found to be true is..."
- "This is the first time I've heard that information, and I would be very interested in seeing that article."
- _____
- _____
- _____

5. Quiet and isolated participants. Involve them to the best of your ability by:

- Spending time at the beginning of the training giving people a chance to get to know each other.
- Structuring the training so that participants can interact in pairs and small groups.
- Structuring other activities in which everyone has to participate in some way.
- _____
- _____
- _____

6. Several people talking among themselves and not paying attention. Deal with this behaviour by:

- Ignoring them if it is not excessive or disruptive.
- Recalling their attention to the large group by saying, "Excuse me, I need everyone's attention."
- Switch to an activity where everyone is actively involved.
- Rearrange the seating by asking everyone to move at the break.
- _____
- _____
- _____

7. Person who monopolises conversation:

- Remind group of ground rules -- trainer will keep group to time and ensure participation of all group members.
- Break in when the person pauses or takes a breath.
- Say, "Thank you for your comments. We need to move on now."

- Ask, "Would anyone else like to comment on this subject?"
- Say, "I'm going to have to cut you short so that we have time for others to respond as well."
- Suggest, "I would be happy to speak with you about this in the break. What you are saying is important but unfortunately we don't have time to talk about it now."

- _____
- _____
- _____

8. Hostile and disruptive participant:

- Avoid a power struggle with the individual.
- Acknowledge the participant's contribution without supporting their particular view and move on.
- Say, "I'm glad you raised this issue. Let's spend some time discussing it. How do others of you feel?"
- Let group members intervene rather than your doing so as the trainer.

- _____
- _____
- _____

9. Strong differences of opinion between participants:

- Remind participants that when discussing a feeling, reaction, value or attitude, there is no right or wrong.
- Confirm that there does not need to be total agreement on different issues; suggest, "The greater variety of views we hear the better."

- Structure an activity which allows a safer way for participants to express different opinions. For example, the training activity "Where do you stand?", or small group discussions about the issues or an organised debate.
- Shift the focus of the discussion from the issues at hand and discuss effective ways for people to resolve differences.
- Ask the group to agree to disagree and move on.
- _____
- _____
- _____

10. Asking questions that are off the subject. Respond to these with:

- "Your question is a good one. Can we save it until we finish this topic?"
- "We will be covering that subject later on this afternoon. Is it okay to address it then?"
- "Let me give you a quick answer now and we will spend more time discussing it later."
- On a large sheet of paper taped to the wall write down all the questions which are out of the scope of the section you are dealing with. Make sure that time is allocated before the training finishes to deal with them.
- _____
- _____
- _____

TRAINING ACTIVITY

Action Planning

Purpose: To develop training plans.

Objectives - Participants will be able to:

- Meet with their planning teams.
- Develop a detailed training plan for their region, district or workplace.

How long does it take?

- Allow 1 to 1.5 hours.

What do I need?

- Paper.
- Pens.

How do I do it?

1. Ask the appropriate person to give an overview of the goals for training and education in the National AIDS Control Programmes Plan. Describe the intended follow-up objectives to this "Training the Trainers" workshop including the number of educational programmes to be planned within a given time frame and the number of people to be reached. Discuss the mechanisms of implementation, coordination and monitoring of the training plans.
2. Divide the group into appropriate work groups. This may be by region, district, workplace or any other grouping appropriate for planning.
3. Ask each planning group to develop, at the minimum, a six-month training plan including:
 - number of programmes.
 - number of participants.
 - target audience.
 - objectives and general content of trainings.
 - timeline.
 - implementation plan (who will conduct the training, how it will be organised, publicised, etc.)

4. Bring the large group together again and ask each planning group to present a brief summary of their training plan to the large group.

5. End with a summary of what will be expected of the trainers in their follow-up activities and review the mechanisms for coordinating and monitoring the education and training programmes.

POST-TEST QUESTIONNAIRE

Circle the best answer. If two or more answers are equally accurate, circle all correct answers.

1. Adults learn best when:

- a. the information is relevant to their personal and professional experiences.
- b. they are told by a supervisor to attend the training.
- c. the learning environment is comfortable.
- d. they have an opportunity to practice the new material.

2. Good training objectives are: (complete the word)

- a. S_____.
- b. M_____.
- c. A_____.
- d. R_____.
- e. T_____.

3. When a participant challenges a statement made by the trainer, the trainer should:

- a. tell the person he is wrong.
- b. ignore the comment.
- c. acknowledge the trainees' opinion.
- d. invite the group to explore the issue in more depth.

4. The goal of training activities is:

- a. to facilitate participatory learning.
- b. to fill gaps in the day.
- c. to carry out training objectives.
- d. to emphasise only factual information.

5. Based on adult learning principles, examples of the most effective training activities are:

- a. brainstorming.
- b. a structured small group activity.
- c. role-playing.
- d. case discussion.
- e. lecture.

6. When a group of health care workers is repeatedly anxious about their risk of contracting AIDS from patients, a good trainer should:

- a. drop the entire training plan to lecture about modes of transmission.
- b. dismiss the fear as ridiculous.
- c. acknowledge legitimate concerns and review modes of transmission.
- d. suggest they test all their patients for HIV.
- e. suggest that the best way to reduce risk of occupational exposure to HIV is to refuse to care for people with AIDS.

7. A good public speaker is one who:

- a. makes eye contact with the audience.
- b. varies the rhythm and volume of speech.
- c. reads from notes.
- d. uses body language that conveys interest, openness and active participation with the group.

Key to TOT Pre- and Post-Test Questionnaires

1. a,c,d
2. Specific
Measurable
Achievable
Realistic
Time-Limited
3. c,d
4. a,c
5. a,b,c,d
6. c
7. a,b,d

EVALUATION TRAIN-THE-TRAINER WORKSHOP: AIDS PREVENTION COUNSELLING

To Workshop Participants:

Please complete the following brief evaluation of the just-completed workshop. Please answer all of the questions and give any additional comments that you feel would be helpful to improve future workshops.

Date: _____

District or Facility: _____

1. **This workshop provided me with new and useful information about how to educate others about AIDS prevention counselling:**

_____ disagree

_____ strongly agree

_____ strongly disagree

_____ agree

2. **I now feel more comfortable about providing accurate AIDS information to groups including medical and psycho-social aspects coping with AIDS and HIV infection and the behaviour changes necessary to stop the spread of AIDS:**

_____ disagree

_____ strongly agree

_____ strongly disagree

_____ agree

3. **During this workshop I learned and practiced new skills for designing training objectives and activities.**

_____ disagree

_____ strongly agree

_____ strongly disagree

_____ agree

8. What did you like best about the workshop?

Why? _____

9. What did you like least about the workshop?

Why? _____

Thank you for your active participation throughout the workshop.

THE IMPORTANCE OF TRACKING PROGRESS

Once your programme is under way, you may not be able to anticipate all contingencies that may arise, but you can plan ways to identify potential problems. You should build a monitoring system into your programme to help you identify any problems, flaws or oversights regarding materials, implementation strategies or channel selection *before* they become major impediments to success.

Often, problems are quickly correctable if you can identify them but can cause harm if you don't. For example, if you ask the public to call for more information, you should provide a mechanism (e.g., a simple response form) for telephone operators to record questions asked and answers given. A frequent review of responses will identify whether incorrect or inadequate information is being given, any new information required to respond and inquiry patterns.

Frequently, programme implementation takes longer than you might expect -- materials may be delayed at the printer, a major news story may preempt your publicity or a new priority may delay community participation. A periodic review of planned tasks and time schedule will help you alter any plans that might be affected by unexpected events or delays. There is nothing wrong with altering your plans to fit the situation -- keeping in mind what you are trying to achieve. In fact, you may risk damaging your programme if you aren't willing to be flexible and alter specific activities when needed.

Process Evaluation

Tracking how and how well your programme is working can provide tangible evidence of programme progress, often useful to provide encouragement and reward to participants and evidence of success to your own agency. It can also assure that the programme is working the way in which you planned -- a vital assurance prior to undertaking any more formal outcome evaluation.

Review and Revise Programme Components:

Whether or not you continue to expand and involve more media outlets or organisations in your programme, you should periodically assess whether:

- Activities are "on track" and on time.
- The target audience is being reached.
- Some strategies appear to be more successful than others.

- Some aspects of the programme need more attention, alteration or elimination.
- Time schedules are being met.
- Resource expenditures are acceptable.

The process evaluation and other tracking measures you established should permit this assessment. You should establish specific intervals to review progress. Preparing progress reports -- with successes, modified plans and schedules -- can help you keep all your agency and programme "players" information and synchronised.

How Well Did The Programme Work?

Process measures are designed to monitor the programme in progress. Tracking the number of materials distributed, meetings attended or articles printed will tell you how the programme is operating and may well tell you whether the target audience learned, acted or made a change as a result. Therefore, it is important to evaluate the results of your programme -- its effect or outcome.

Most outcome measures are designed to tell you *what* effect was achieved, but not how or why -- these are the subjects of formative research and process measures. The effect or outcome is paramount, but you also need to know what happened, how and why which elements worked, and to analyse what should be changed in future programmes. Therefore, plans for outcome measures are combined with other evaluation strategies during planning.

Outcome Evaluation

Outcome evaluation methodologies usually consist of a comparison between the target audience awareness, attitudes and/or behaviour before and after the programme. Unlike the pre-testing methods ("formative evaluation"), these are quantitative measures, necessary to draw conclusions about the programme effect. Going a step beyond process measures, outcome evaluation should provide more information about value than quantity of activity. The measures may be self-reported (e.g., interviews with the target audience) or observational (e.g., changes in clinic visits or disease morbidity). Comparisons between a control group (one that did not receive the programme but is similar in other respects to the target audience) and the target audience receiving the programme are desirable.

Determine What Evaluation to Do

Limited resources may force you to choose between process evaluation or outcome evaluation. Neither, independently, will provide you with a complete picture of what happened. Some experts will tell you that if you must choose, you should choose *outcome evaluation*: the only way to certify that you accomplish your objectives. However, *process evaluation* can help you understand *why* you did or did not accomplish your objectives. Therefore, others will advise that process measures are more important -- to allow you to manage your programme well.

Every programme planner faces constraints to undertaking evaluation tasks, just as there are constraints to designing other aspects of a communication programme. **These constraints may include:**

- Limited funds.
- Limited staff time and capabilities.
- Length of time allotted to the programme.
- Limited access to computer facilities.
- Agency restrictions to hiring consultants or contractors.
- Policies limiting the ability to gather information from the public.
- Management of perceptions regarding the value of evaluation.
- Levels of management support for well-designed evaluation activities.
- Difficulties in designing appropriate measures for communication programmes.
- Difficulties in separating the effects of programme influences from other influences on the target audience in "real world" situations.

These constraints make it necessary to accommodate existing limitations as well as the requirements of a specific programme. However, it is *not* true that "something is better than nothing." ***If an evaluation design, data collection or analysis must be compromised to fit limitations, the programme must make a decision regarding whether:***

- The required compromises will make the evaluation results invalid.
- An evaluation strategy is essential for the particular situation, compared with other compelling uses for existing resources.

These are some of the questions you should consider before deciding what kind of evaluation will be best for your programme:

- How long will your programme last? Will the implementation phase be long enough to permit measurement of significant effects and periodic adjustment?
- Do you want to repeat or continue your programme?
- Are your objectives measurable in the foreseeable future?
- Which programme components are most important to you?
- Is there management support or public demand for programme accountability?
- What aspects of the programme fit best with your agency's priorities?
- Will an evaluation report help communication efforts compete with other agency priorities for future funding?

There are a number of sources for you to find help when you design an evaluation. If there is not a planning and evaluation staff in your agency, you may find help at a nearby university. Also, you may contact an appropriate clearinghouse or government agency and ask for evaluation reports that may have been prepared (but generally are not published) on similar programmes.

Important Notes: *This planning should be part of your initial programme planning, although it is discussed here, where it actually occurs.*

ELEMENTS OF AN EVALUATION DESIGN

Every formal design, whether formative, process, outcome, impact or a combination, must contain certain basic elements. These include:

1. ***A Statement of Communication Objectives.***
Unless there is an adequate definition of desired achievements, evaluation cannot measure them. Evaluators need clear and definite objectives in order to measure programme effects.
2. ***Definition of Data to be Collected.***
This is the determination of what is to be measured in relation to the objectives.
3. ***Methodology.***
A study design is formulated to permit measurement in a valid and reliable manner.
4. ***Instrumentation.***
Data collection instruments are designed and pre-tested. These instruments range from simple tally sheets for counting public inquiries to complex survey and interview forms.
5. ***Data Collection.***
The actual process of gathering data.
6. ***Data Processing.***
Putting the data into usable form for analysis.
7. ***Data Analysis.***
The application of statistical techniques to the data to discover significant relationships.

8. ***Reporting.***

Compiling and recording evaluation results. These results rarely pronounce a programme a complete success or failure. To some extent, all programmes have good elements and bad. It is important to appreciate that lessons can be learned from both if results are properly analysed. These lessons should be applied to altering the existing programme or as a guide to planning new efforts.

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USE FEEDBACK TO REFINE PROGRAMME

Apply What You Have Learned

The ideal way to apply evaluation findings is to improve your ongoing programme. **You also may use what you learn from process or outcome evaluation measures to:**

- Justify your programme with management.
- Provide evidence of need for additional funds or other resources.
- Increase institutional understanding of and support for health communication activities.
- Encourage ongoing cooperative ventures with other organisations.

Revise Programme

If your programme is continuing or you have an opportunity to advise others who may plan similar programmes, take the time to apply what you have learned. **For example:**

- **Reassess goals and objectives:**
 - *Has anything changed (e.g., with the target audience, the community, or your agency's mission) to require revisions in the original goals and objectives?*
 - *Is there new information about the health issue that should be incorporated into the programme messages or design?*
- **Determine areas where additional effort is needed:**
 - *Are there objectives that are not being met? Why?*
 - *Are there strategies or activities that did not succeed? Are more resources required? Do you need to review why they didn't work, and what can be done to correct any problems?*
- **Identify effective activities or strategies:**
 - *Have some objectives been met as a result of successful activities?*
 - *Should these be continued and strengthened because they appear to work well?*

- *Or should they be considered successful and completed?*
- *Can they be expanded to apply to other audiences or situations?*
- **Compare costs and results of different activities:**
 - *What were the relative costs (including staff time) and results of different aspects of your programme?*
 - *Are there some activities that appear to work as well but cost less than others?*
- **Reaffirm support for the programme:**
 - *Have you shared the results of your activities with the leadership of your agency?*
 - *Did you remember to share this information with the individuals and organisations outside your agency who contributed?*
 - *Do you have evidence of programme effectiveness and continued need to convince your agency to continue your programme?*
 - *Do you have new or continuing activities that suggest the involvement of additional organisations?*
- **Determine to end a programme that did not work.**

Share What You Have Learned

It is frequently difficult to find the time to analyse and report on what you have learned and share it with others. You may find that other responsibilities leave you little time to prepare formal documentation of your programme or to submit findings for publication. Nevertheless, what you learn from implementing a communication programme might be invaluable to someone who is faced with a similar responsibility. You may not have to prepare a formal report or article to let others know what you have learned.

Consider:

- Letters about your findings to appropriate medical, public health or health education journals.
- A poster presentation at a relevant professional meeting.

Write an Evaluation Report

- A programme description and sample materials sent to a related clearinghouse.
- Local professional newsletters.
- Letters, telephone calls, brief reports or meetings with your peers in similar organisations.

Letting others know about your programme may prompt them to tell you about similar experiences, lessons, new ideas or potential resources.

Taking the time to write a report about a pre-test or other evaluation task that you have conducted is useful for several reasons. **The report can provide:**

- The discipline to help you critically analyse the results of the evaluation and think about any changes you should make as a result.
- A tangible product for your agency.
- Evidence that your programme or materials have been carefully developed -- to be used as a "sales" tool with gatekeepers (e.g., television station public service directors.)
- A record of your activities for use in planning for future programmes.
- Assistance to others who may be interested in developing similar programmes or materials.
- A foundation for evaluation activities in the future (e.g., it is easier to design a new questionnaire based on one you have previously used than to start anew.)

Careful Analysis

Most frequently evaluation tasks are added on to other responsibilities that already represent full time commitments. Therefore, there is seldom sufficient time to think about the meaning of evaluation findings. If you are conducting or observing a pre-test or another evaluation task, it may be easy to develop conclusions about the effectiveness of your materials or programme during the time the tasks are being conducted. You may want to avoid this temptation and take the time to review all of the findings before you conclude how well

your materials or programmes work, or what changes should be made.

It is important to consider the subtleties or absences demonstrated in the evaluation (e.g., an absence of discussion or a lukewarm vote of support), as well as what may have been directly stated. Writing a report can provide the opportunity to consider everything that happened in the course of the evaluation, how these events relate to the purpose of the evaluation, and any recommendations for modification to improve your materials or programme.

A Tangible Product

Pre-testing and other evaluation tasks require a considerable investment of scarce programme time and funds. Presenting your agency with a product may be particularly useful if there is a lack of support for evaluation. It can help others not only to see that something was received for their investment, but also to understand why the evaluation was valuable.

Evidence of Effectiveness

If you want intermediaries (e.g., a television station, clinic, school, organisation or employer) to use your materials or programme, you may have to convince them of its value. An evaluation report offers proof that the materials and programme were carefully developed. This evidence can help you explain why your materials or programme may be better than others.

A Formal Record

What you learned in conducting an evaluation, both the process and the results, may be applicable to future programmes to be planned by you or others. Staff may change and your memory may fade; an evaluation report is assurance that lessons learned are available for future application.

Help Others

Sharing your evaluation report with peers who may be considering the development of similar programmes may help them to design their programmes more effectively, convince them to use (or modify) your programme instead and establish your reputation for good programme design.

A Foundation for Future Evaluation Efforts

Report Outline

It is much easier to design an evaluation based on former experience than to start "from scratch." A report outlining what you did, why, as well as what worked and what should be altered in the future provides a solid base from which to plan a new pre-test or evaluation. Be sure to include any questionnaire or other instruments you used in your report so that you can find and review them later.

Consider including these sections in your report:

- **Background:** purpose and objectives of the programme.
- **Description:** what was evaluated.
- **Purpose:** why the evaluation was conducted.
- **Methodology:** how it was conducted (with whom, when, how many instruments used).
- **Obstacles:** problems in designing or conducting the evaluation.
- **Results:** what you found out and what application it has to the programme (programme recommendations).

Although the report should provide a clear record of what you did, it should not be any longer or more formal than needed. Keep it short and easy to read. Attach any questionnaires, tally sheets or other instruments you used as appendices instead of describing them in narrative form. Don't make it any harder a task than necessary!

Finally, make sure to share it with whomever might find it useful, as well as programme implementors who provided feedback. The best report is of no value if it is filed unread.

FOCUS: A GUIDE TO AIDS RESEARCH AND COUNSELLING EVALUATING AIDS PREVENTION PROGRAMMES

Deborah Rugg, Ph.D.

U.S. Federal AIDS prevention activities have shifted from reacting to the urgent needs to "do something," to questioning the efficacy of what is being done. In response, AIDS prevention programmes are being asked to demonstrate that they are having an effect on HIV transmission. This situation presents a tremendous challenge to administrators and researchers who must now evaluate their programmes and present accurate evidence that their interventions work. This is particularly difficult in an area like AIDS prevention where standards for success are only now being developed, and where grassroots organisations, often without sophisticated evaluation processes, dominate the field.

As U.S. agencies face the question of efficacy of their intervention programmes, several issues have become clear:

- "Evaluation" had very different meanings to different people.
- Extensive evaluations of AIDS interventions are rare.
- "Ideal" evaluation is often impossible, and it is necessary to be creative in confronting methodological barriers.
- Many groups lack evaluation expertise and resources.
- Objective evaluation is difficult in the politically and emotionally charged environment framing most AIDS interventions.
- Interventions vary throughout the country and are evolving.
- Determining efficacy is going to take time.

This article seeks to elucidate evaluation in this context. It first discusses the ideal evaluation process and then explores some of the methodological, ethical, and financial constraints that complicate evaluation.

Definitions

Evaluation refers to the process of determining the value of a programme through a careful examination of its design and objectives, quality of implementation, and short- and long-term outcomes. *Programme evaluation* methods are not designed to produce scientific data or generalizable results. *Evaluation research*, on the other hand, considers scientific criteria, such as adequate and representative sample sizes, subject selection criteria, and the use of appropriate control or comparison of groups. Ideally, research and development of the procedures to be used to evaluate a programme, including demonstration projects, should precede actual programme development, implementation, and evaluation activities. The urgency for prevention programmes as a public health response to the HIV epidemic, however, has often precluded this process.

Process evaluation refers to how well a programme is designed and implemented. *Outcome evaluation* refers to how well the programme has achieved its immediate or short-term objectives. *Impact evaluation* refers to how well the programme has achieved its long-term goals. *Goals* reflect the general purposes of a programme. *Objectives* are the specific, time-phased, measurable elements of the goal. *Success indicators* are the specific measures of programme success. **Both process and outcome indicators are necessary.**

For example, an HIV prevention programme may have as its goal to reduce HIV transmission and as its objectives to intervene with 100 high-risk men in the next month and to attain reported condom use by at least 50 percent of the men by the end of the year. Its process success indicators might include a count of the number of people reached; its outcome success indicators might include clients' self-reports of condom use, or a more concrete measure, such as reduction in the number of sexually transmitted diseases (STD). The actual methods used to achieve the objectives should be determined on the basis of past programme experiences and, ideally, applied theory and research.

The Ideal Evaluation

AIDS prevention programme goals and objectives are often not conceptualised or specified clearly, and basic intervention research, applied demonstration projects, and programme development and implementation occur simultaneously without translating the results of one step to the next step. In this context, it may be no surprise that "textbook" evaluations, specifically those that include all the appropriate components in the right sequence, are rare. Ideally, an evaluation plan is developed as the intervention programme is conceived and is implemented as the programme begins. This facilitates both process and outcome evaluations by providing useful baseline information, which may be used later as comparison data for programme outcomes. Evaluation is made easier if, after describing the goals and objectives, evaluators define discrete programme elements that may be translated into obtainable outcome measures. Evaluators should next begin periodic process evaluations to ensure the quality of programme implementation.

Evaluators perform outcome assessments when they believe the intervention has had some measurable effect. Ideally, outcome evaluation uses baseline information and proceeds to examine *immediate outcomes*, such as changes in knowledge and attitudes. These factors may be reassessed at specified intervals if this is deemed useful. *Short-term outcomes*, such as reported behaviour changes, are then measured. Finally, an overall impact evaluation is conducted to determine if the project has met its *longer-term goals*. In general, service programmes do not need to do scientific research to produce useful evaluation data and are often unable to perform scientific evaluations because of the methodological, ethical, and financial constraints discussed below.

Process Evaluation: The Always Feasible First Steps

The first questions to ask in a process evaluation are:

- *What are the stated goals and objectives of the programme?*
- *What exactly is the expected change?*

- *What is the target population(s)?*
- *Are there important sub-groupings of this population -- for example, English speakers and non-English speakers -- that require different versions of the intervention and different evaluation methodologies?*
- *What activities are involved in the intervention?*
- *How is the quality of programme implementation monitored?*
- *How are programme outcomes to be measured?*

The answers to these basic questions can be found in three ways: by interviewing programme administrators and staff; by observing the intervention; and by reviewing written materials regarding the programme protocol. Evaluators should attempt to reconcile contradictory or missing information obtained from these sources before proceeding with the evaluation.

If these basic programme structure and content questions can be answered adequately, the evaluation can progress to more in-depth analysis of programme quality and immediate outcomes. **For example, some of the first process questions might be:**

- *What is the size and nature of the programme?*
- *Who delivers the intervention?*
- *Are they implementing the intervention protocol correctly?*
- *Do intervention workers, evaluators, administrators, and clients agree in their descriptions of the intervention?*
- *Are there barriers to peak performance among intervention workers, such as lack of support, training, or sufficient staff, or stress and burn-out?*
- *What are the effects of the programme on clients?*
- *How do clients feel about the programme?*
- *Do "would be" clients identify barriers to obtaining service?*

Although this is a partial listing of questions, answers to these would move the evaluation forward in significant ways.

Outcome Evaluation

Outcome evaluation, that is, the process of determining whether or not a programme "works," is considerably more complex than process evaluation. At a minimum, the evaluator endeavors to document the effects of a programme. The challenge comes in proving that the effects observed were due to the intervention and not due to other influences. This is difficult with most AIDS prevention programmes since these interventions operate in a sea of other influences, including: other AIDS prevention interventions, like mass media campaigns; and other factors, like peer pressure, poverty, homelessness, drug addiction, social ostracism, and trends in sexual and drug-using behaviour. Proving that a programme is effective may be as challenging as developing the programme itself.

The classic method to determine whether an intervention works is to randomly assign subjects either to an intervention group or to a non-intervention (control) group and then to observe outcomes for all subjects. This method is useful in laboratory or specific field settings but is not possible in many applied settings where it is unethical to randomly assign people to a control group. To deal with this ethical constraint, researchers have developed quasi-experimental and field research designs.¹ Such designs often rely on pre- and post-test assessments and the selection of some comparison group, such as people on the waiting list for the programme, clients receiving some other clinic service, or people in a different school or neighborhood.

Without random assignment to control groups, however, there are considerable threats to the validity of any single prevention study. Quasi-experimental designs and field research require careful examination for consistency of both programme results and results of similar interventions reported in the literature. The validity of this approach increases with repeated outcome evaluations.

Methodological Issues

Several methodological issues conspire with ethical constraints to threaten the feasibility and validity of evaluation efforts. Below is a brief discussion of these issues. An in-depth discussion is available elsewhere.^{2,3}

Sample Size. Research samples must be large enough to draw valid conclusions and to perform appropriate statistical analyses. If sufficient numbers are not available in one programme, evaluators might consider combining data with other programmes. This strategy requires an experienced evaluator and sufficient resources to conduct a multi-site analysis. If these are not available, the programme will need to reduce its expectations of what the evaluation will “prove.”

Selection Bias. Evaluators should attempt to determine differences between those who join the programme and study and those who do not. Among the variables that should be researched are the sociodemographic, knowledge, attitude, belief and behavioural characteristics of these individuals. This will enable the programme to know who it is serving and to whom the evaluation results can be generalised. However, since a “volunteer” or “readiness-to-change” bias will always be present, researchers must be prepared to restrict the applicability of conclusions to those who participate in such programmes and studies.

Change in Behaviour in the General Population. There is a chance that the true effect of an intervention in a sample may be masked by the overall decline in risk behaviour in the general population. Under such circumstances, there may be no detectable difference between the behaviour of control group members, the general population, and intervention group members. This problem, of course, can only be identified over time and with input from large behavioural and HIV seroprevalence surveys; small programmes should simply be aware of this potential problem.

Changes in the Intervention. In order to remain attuned to the dynamic nature of many HIV prevention interventions, it is important that researchers incorporate well-defined, in-depth programme monitoring in their protocols and fully document when interventions change. Documenting changes serves two purposes; it ensures an accurate description of the nature of the intervention and it helps programme staff and evaluators to decide when changes are significant enough to require modifying the evaluation design.

Appropriate Outcome Measures. Since HIV seroincidence rates are so small in many settings, it is generally agreed² that reported behaviour change, though not perfect, is the primary outcome measure of choice in HIV prevention programmes. This may be supplemented and corroborated by measures of interval STD incidence. HIV seroincidence is best used as a success indicator in determining long-term programme impact.

Conclusion

Programme administrators should design programmes and conduct process evaluations so that outcome evaluations could be conducted if sufficient resources were available. Experience teaches that the act of designing and preparing an objective outcome evaluation helps tremendously in improving the design, implementation, and probable effectiveness of the programme.

Carefully planning evaluations also increases the quality of applications for federal and state grants, increasing the likelihood of receiving such funding. Although the evaluation of an AIDS prevention programme presents challenges, this process is necessary to ensure continued public support for such programmes and to assure clients that programmes are offering effective interventions.

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