Theology in the HIV&AIDS Era Series

Module 9

HIV&AIDS PASTORAL CARE AND COUNSELLING

Accompanying The HIV and AIDS Curriculum for TEE Institutions in Africa

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Theology in the HIV&AIDS Era Series

Theological Education by Extension, Diploma Level

MODULE 9: HIV&AIDS Pastoral Care and Counseling

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Note to Learners, Readers and Users

The overall goal of this module is to contribute towards building an HIV&AIDS competent church and theological institutions. This module is part of a series of ten modules on, *Theology in the HIV&AIDS Era*, which was developed for distance learners. The modules are accompanying *The HIV and AIDS Curriculum for TEE Institutions in Africa*.

The process of production began with an all Africa training of trainers’ workshop on mainstreaming HIV&AIDS in Theological Education by Extension (TEE), held in Limuru Kenya, July 1-7, 2004. The workshop called for the production of a distance learning Curriculum and accompanying ten modules to enable the mainstreaming of HIV&AIDS in TEE programs. Writers were thus identified, trained in writing for distance learners and given their writing assignments. In July 2-13, 2005, twelve writers gathered in the Centre for Continuing Education at the University of Botswana with their first drafts for a peer review and quality control workshop. The result of the process is this series on *Theology in the HIV&AIDS Era* and the accompanying curriculum for TEE institutions. The whole process was kindly sponsored by the Ecumenical Initiative for HIV&AIDS in Africa (EHAIA).

Although the target audience for these modules is the distance learning community, it is hoped that the series will also stimulate new programs, such as diplomas, degrees, masters and doctoral studies in HIV&AIDS theological research and thinking in residential theological institutions. It is also hoped that the series will contribute towards breaking the silence and the stigma by stimulating HIV&AIDS theological reflections and discussions among various groups and occasions, such as Sunday school classes, women’s meetings, youth and men’s fellowship, workshops, conferences and among teachers and preachers of religious faith.

Musa W. Dube, July 28, Gaborone, Botswana
CONTENT OUTLINE

MODULE OVERVIEW

MODULE OBJECTIVES

UNIT 1: DEFINING THE PROBLEM OF HIV & AIDS

- Overview
- Unit Objectives
- The Problem of HIV & AIDS
- Structural dimension
- Community dimension
- HIV & AIDS and Stigma
- HIV & AIDS and discrimination
- Challenges for counselling
- Summary
- Self-Assessment
- Further Reading
- Glossary

UNIT 2: BASIC COUNSELLING AND COUNSELLING SKILLS

- What is counselling?
- Aims of counselling
- Effective counsellor
- Basic counselling skills
- Summary
- Self-Assessment
- Further Reading
- Glossary

UNIT 3: COUNSELLING THEORIES AND PROCESSES

- Theories of counselling
- Counselling in an African Context
- Stages of a counselling process
- Pastoral dimensions and counselling
- Summary
- Self-Assessment
- Further Reading
- Glossary

UNIT 4: HIV&AIDS COUNSELLING
- What is HIV&AIDS counselling?
- Aims of HIV&AIDS counselling
- Being an Effective HIV&AIDS counselling
- VCT and CTC
- Summary
- Self-Assessment
- Further Reading
- Glossary

UNIT 5: HIV&AIDS COUNSELLING
- Pre-test counselling
- Post-test counselling
- Supportive counselling
- Crisis counselling
- Summary
- Self-Assessment
- Further Reading
- Glossary

UNIT 6: HIV&AIDS COUNSELLING AND THE AFFECTED
- Couple counselling
- Counselling the family
MODULE OVERVIEW

Welcome to Module 9 of the HIV&AIDS curriculum for Theological education by extension. This module exposes you to the theory and practice of counseling in the context of HIV&AIDS. The module breaks into ten units which discuss in detail the different aspects of counseling in general and HIV&AIDS counseling in particular. It further discusses the pastoral, cultural, legal, and ethical and policy dimensions of HIV&AIDS counseling. Unit 1 defines the problem of HIV&AIDS and the challenges it poses for counseling. Unit 2 to 3 covers the definition and aims of counseling; the basic skills and qualities for being an effective counselor as well as the theories and stages of counseling. Unit 4 to 7 concentrate on HIV&AIDS counseling as applicable in different contexts. Unit 8 looks at the legal, ethical and policy dimensions of HIV&AIDS. Unit 9 to 10 deals with the role of the church in the context of HIV&AIDS.

It is hoped that after going through this module you will be able to appreciate the theory and practice of counseling in general and that of HIV&AIDS in particular. The information in this module has been presented in a very concise and simplified manner to enable you to read and translate into concrete what you have learned.

MODULE OBJECTIVES

At the end of this module, you should be able to:

- Analyze the problems around HIV&AIDS and challenges they pose for counseling.
- Describe the counseling theories, stages and skills.
- Practice counseling skills in different situations.
- Define HIV&AIDS counseling and apply it in different HIV&AIDS situations.
- Practice the process of HIV&AIDS counseling in different settings
- Critically analyze the mission of the church in general and its role in HIV&AIDS situations in particular.
Activities

This module consists of content, in text activities, self-assessment exercises and further reading. The content is meant to give you information. In text questions are meant to engage you section by section as you read through the module. At the end of every unit there is a self-assessment exercise. This exercise is meant to test your understanding of the main sections of the unit. It also prepares you for the later assessments in the form of assignments, test and examination. Further reading provides you with additional material that could be helpful for the understanding of individual sections of the unit. Apart from the written material, people are also another useful source you can learn from.

Assessment

The module assessment consists of two (2) assignments, one (1) test and a final examination. The first assignment is based on the first six units (Units 1-6) and the second assignment is based on the last four units (Units 7-10). After reading through the first six units please do the first assignment. After reading through unit 7-10, please do the second assignment. The test and the examination cover almost the entire module. After you complete the whole module, please re-read the whole module more carefully for the second time and then write your test and examination.
Unit 1

Defining the Problem of HIV&AIDS

OVERVIEW
Welcome to Unit 1. This Unit 1 introduces you to the problem that HIV&AIDS poses for all of us especially women and girls who are most vulnerable due to a number of factors. We will look at how the different structures of society, such as health, education and food production sectors, are affected by the epidemic. We will also look at how individuals within communities, such as PLWHA, the affected and caregivers, are affected by HIV&AIDS. HIV&AIDS related stigma and discrimination are also discussed. Stigma and discrimination constitute a problem for HIV&AIDS prevention, treatment and care and a challenge to counselling.

OBJECTIVES
At the end of this unit you should be able to:

- Explain the problem around HIV&AIDS.
- Analyse the impact of HIV&AIDS on the different sectors of our society.
- Discuss how individuals within communities are affected by HIV&AIDS.
- Explain HIV&AIDS related stigma and discrimination and its impact on prevention, treatment and care.
- Identify the challenges HIV&AIDS pose for the counselling profession.
TOPICS

- The Problem of HIV&AIDS
  - Statistics
  - Women and Girls
- Structural Dimension
  - Health Sector
    - Education Sector
    - Food Production Sector
- Community Dimension
  - PLWHA
  - The Affected
  - The Caregivers
- HIV&AIDS and Stigma
  - Types of Stigma
  - HIV&AIDS Related Stigma
  - Expressions of HIV&AIDS Related Stigma
  - Effects of HIV&AIDS Related Stigma
- HIV&AIDS and Discrimination
- Challenges for Counselling

Summary
Self-Assessment
Further Reading
Glossary
The Problem of HIV&AIDS

In the words of the United Nations Special Session on HIV&AIDS (2001), HIV&AIDS has spread to every corner of the world since it was reported some 20 years ago. It continues to grow at an alarming rate. And as it does, it affects everything and everybody. It affects the social, economic, cultural and religious spheres of our lives. It infects and affects all people irrespective of status, sex or race. Let us start by looking at the statistics.

The Statistics

The total number of people living with HIV has been rising in every region. Our African continent, too, has felt the devastating effects of the epidemic. While some parts of Africa show some significant declines in HIV prevalence, especially among pregnant women, sub-Saharan Africa remains by far the hardest hit region. At the end of 2004, it is reported that there were 25.4 million PLWHA in Sub-Saharan Africa, with no indications of declining figures. Sub-Saharan Africa, therefore, accounts for one-third of all AIDS deaths globally (UNAIDS 2004:30). These sobering statistics affect the institutions and the people through two main pathways; namely, morbidity (illness) and mortality (death).

Activity 1

1. Find out and write down the number of people in your country who are living with HIV&AIDS.
2. Write down the number of people in your village who are living with HIV&AIDS.
3. List the number of people in your church who are living openly with HIV&AIDS.

Women and Girls

One very notable feature of the HIV&AIDS epidemic is its impact on women and girls. Women and girls make up almost 57% of all people infected with HIV in sub-Saharan
Africa, where a striking 76% of young people (aged 15-24) living with HIV, are female. This indicates that women and girls are most vulnerable to HIV&AIDS than their male counterparts (UNAIDS 2004: 38).

Activity 2

1. Find out the number of women and girls living with HIV&AIDS in your country.
2. List the things that make women and girls more vulnerable to HIV&AIDS than their male counterparts. Take into consideration, biological make up, culture and religion.

In the following sections we will discuss how HIV&AIDS impacts on the structural (institutional) and community dimensions of society.

The Structural Dimension

By structural dimension we mean the different institutions of society, such as family health, educational and food production. HIV&AIDS permeates all these structures of society and renders them dysfunctional. It also works through them to hinder prevention, treatment and care and consequently to fuel the spread of HIV&AIDS. Let us see how HIV&AIDS affects these different structures of society and renders them dysfunctional.

Health Sector

In the health sector, health services are overburdened. A lot of health facilities are not able to deal with increasing numbers of people who need treatment and care. As a result, demand (need) for care and treatment outstrips the personnel and structural resources (supply). In Burkina Faso and Ghana, for example, the ratio is one doctor to 29000 people. In Liberia there are only 40 doctors in the entire country. With the onset of
HIV&AIDS health services are overstretched and the staff is overworked. This is bound to affect the quality of services.

**Activity 3**

1. *Does most of the population in your country live in rural areas or urban areas?*
2. *Name areas that have the high concentration of health services.*
3. *In terms of population, what could be the number of people serviced by the nearest hospital?*
4. *List the number of health professionals (doctors, nurses, counsellors) that work in that hospital.*

**Education Sector**

The education sector is equally affected. A significant number of teachers and education officials is infected (supply). As a result of this, the quality of education is negatively affected and the reduced number of teachers, due to illness or death, is not able to meet the demand for education especially of the vulnerable children and orphans whose needs are special.

**Activity 4**

*Find out the number of teachers and students that have been lost due to HIV&AIDS related illness or death in schools around your area. Discuss how this affects supply and demand.*

**Food Production Sector**

Illness and death resulting from HIV&AIDS affects demand and supply in the food production sector. How? HIV&AIDS increases the demand for food PLWHA and the
affected are not able to provide for themselves. We, also, know that people living with HIV&AIDS have specific nutrition needs. This means that increased capacity for more production of food is needed to meet the increasing demand for food. Yet ironically, HIV&AIDS epidemic reduces people’s capacity to produce food.

| Activity 5 |

Poverty influences choices people make. In your experience in what way does poverty make people vulnerable to HIV&AIDS?

The Community Dimension

In the preceding section we have seen how different institutions or structures of the country are affected by HIV&AIDS in terms of demand and supply. We have seen that HIV&AIDS affects these structures in two main pathways namely, illness (morbidity) and death (mortality). In this section we are going to investigate ways in which individuals in communities are infected and affected by the HIV&AIDS epidemic.

PLWHA

The psychosocial experiences of people living with HIV&AIDS are unique. This is because, as W.J. Smith puts it, in the natural history of medicine, HIV&AIDS are without parallel (1988:17). We, therefore, need to understand the plight and the unique situation of the people living with HIV&AIDS (henceforth, PLWHA).

PLWHA have their unique fears. They fear the gradual loss of their bodily integrity; their beauty and sexual relationships. They also fear the loss of self-worth and self esteem. They have seen their loved ones and their friends, stigmatized, discriminated against and rejected and they are afraid of these experiences turned against them.
They are afraid of death, which is the loss of life, and they are afraid to face what is beyond life and death (fear of the unknown). The feelings of guilt, anger, anxiety that they experience, are so overwhelming that they may lead to suicidal behaviours. The thought of losing a job; the plight of the partner and the children that would have to do without the only bread-winner in the house is very difficult to bear. Coping with the financial demands of having to pay for the anti-retroviral (henceforth, ARVs) therapy are all sources of pressure and frustration.

Activity 6

Stop reading for a moment, recall and write a paragraph on:

The experiences of the closest PLWHA you know at work or at home.

The Affected

Partners, children, relatives and friends of PLWHA are all affected by the plight of their loved one. They have their own fears, frustrations and anxieties to deal with as result of their loved one’s infection or illness. They more or less experience the same psychosocial feelings as do their loved ones. They are constantly living with the fear of being infected (real or imaginary). They are sometimes angry at the infected person for bringing ‘this shame’ upon them. The partner, in particular, has to bear the brand of harassment for having infected the other party. The wives are the ones who normally suffer more than their male counterparts because of their subjugated status and lack of negotiating power (power leverage) in most of our African societies. Women and girls are at the end, the ones who bear the burden of care. This makes them more vulnerable to stigma and discrimination for being associated with PLWHA.

Activity 7
Caregivers

We have seen above that a lot of hospitals and health facilities are not able any more to cope with the growing numbers of people who need treatment and care within a hospital setting. Individual family members are, therefore, forced to take care of their own sick members. This means that there are new demands on the part of children and relatives placed by the sick member of the family. Untrained and with no material resources, the caregivers become helpless and acquire feelings of incompetence which sometimes lead to abandonment of the sick person.

The majority of PLWHA are usually young people in the reproductive stage. This means that they have to be taken care of by parents and grandparents, who also have to take care of the children of PLWHA. In cases where the parents and the grandparents have all died, the children have to head the households. This is a huge responsibility placed on such young people with no life skills.

Dealing with the issues of the magnitude of HIV&AIDS is very stressful, emotionally and physically demanding. Caregivers have to take care of themselves and because of the demands of what they have to deal with; they need care and support from others as well.

Activity 8

1. Discuss the psychosocial problems that confront the HIV&AIDS infected and affected people.
2. List ways in which caregivers are cared for in your own country.
3. In community home-based care, which group is more active? Males or females. Give reasons why this is the case.
HIV&AIDS and Stigma

In this section we are going to look at HIV&AIDS related stigma. It is an ‘epidemic’ that does not only affect people living with HIV&AIDS, but also the affected people. It expresses itself in various forms and has proved to be the number one enemy in effectively fighting the HIV&AIDS epidemic.

Let us now define stigma. The term stigma derives from Greek culture. In Hellenistic Greek the word stigma means a scar, mark or a brand indicating ownership. In the Graeco-Roman world stigma could be used of cattle and people. For people, it meant an actual physical mark, cut or burned into a person’s skin designating a person’s particular defect. This was a distinguishing sign so that the rest of society could recognize the marked person as disgraced and avoid contact with him/her. The reality represented by the term stigma is however not restricted to the Greek context. It is found and expressed in different ways in our societies. In Sesotho (language of Lesotho), we have words such as senyama, sesila, sekhobo. A person who has all these is marked off from others. S/he is to be dreaded or avoided. There are also groups of people that are stigmatised. Terms such as sehole, sebupuoa refer to someone who is physically or psychologically challenged.

We have similar cases of stigma and stigmatisation in the Hebrew Bible. The lepers, for example, were isolated. They were expected to dress in such a way that they would be easily distinguishable so that they could be avoided (Lev.13:1-2, 45-46).

How would we define stigmatization then? According to the Synergy Project, ‘Stigma and HIV/AIDS-A Pervasive Issue’ (2004:1), stigmatization refers to a social phenomenon or process that results in a powerful and discrediting social label that affects the way individuals view themselves and are viewed by others. There are certain qualities or attributes in our own cultural settings that are seen by others as unworthy and therefore discreditable. A person with a stigma has either marked himself/herself or has been marked as being unacceptable as a result of his/her behaviour (being a criminal) or as a
result of the attribute or attributes s/he possesses which are defined by others as discreditable (being blind).

**Activity 9**

We all experience stigma in one form or another in our lives. Have you ever experienced stigmatization? In a paragraph, describe your feelings when you experienced stigmatization.

**Types of Stigma**

Stigma can be internal or external. **Internal stigma** is experienced internally. It is a felt shame associated with a certain condition, and the fear of being discriminated on account of that condition. Certain conditions or attributes are categorized by society as shameful. The knowledge of such categories by society makes the person feel internally stigmatized. **External stigma**, on the other hand, refers to the actual experiences of discrimination. It refers to the treatment that people receive as a result of their condition. Now that we have defined stigma and stigmatization in general terms, let us talk about HIV&AIDS related Stigma. These two types of stigma are often intertwined. They feed each other.

**Activity 10**

1. List things that are categorized by your culture as shameful.
2. Share an experience where you actually discriminated against a person as a result of a stigma you associate him/her with
**HIV&AIDS Related Stigma**

HIV&AIDS related stigma is an attribute used to set affected people aside from normalised social order. They are, as a result of their infection and illness branded as deviants. HIV&AIDS related stigma is a social construct whose specific causes include: pack thinking; ignorance about HIV&AIDS’ transmission, treatment and prevention; traditional and religious beliefs about sickness and death; judgemental attitudes about the lifestyles of those who are affected by HIV&AIDS; fear. For example, HIV&AIDS is associated with stigmatized behaviours such as those of homosexuals, sex workers and drug users.

This perception has triggered very strong responses and reactions from people who thought/think that they are immune from HIV&AIDS infection. PLWHA are said to be receiving punishment for their immoral behaviour. Some images created of HIV&AIDS resemble a horror. These stereotypes not only demonise PLWHA and the affected people, they also create the impression that there are individuals and groups that are destined to be infected.

**How is HIV&AIDS Related Stigma Expressed?**

HIV&AIDS stigma can be expressed in different ways:

- Through laws and policies by governments and non-governmental organisations.
- Through language and media.
- Through people’s attitude and stereotypes seen in the family, workplace, health service centres, in faith organisations and insurance companies.

Let us pick some few examples to show how HIV&AIDS related stigma finds expression in different policies, laws, language and people’s attitudes.

Some countries have adopted policies and/or laws that restrict PLWHA free movement into their countries. In South Africa, AIDS Law Project has documented discriminatory policies and laws around HIV&AIDS especially in the workplace. People are required to do HIV screening and to disclose their HIV status to be employed. Those who are employed loose their jobs. Children living with HIV&AIDS are denied educational
opportunities in day care centres and schools. Nkosi Johnson who died at the age of twelve was not admitted to school for fear that he might infect other children. In a case of Hoffmann vs South African Airways (SAA), the court declared that pre-employment HIV testing was a violation of a worker’s rights to dignity and equality (AIDS LAW Project 2004: 11).

**What are the Effects of HIV&AIDS Related Stigma?**

The effects of HIV&AIDS related stigma are very devastating. They affect, adversely, all efforts aimed at preventive measures in general; mother-to-child transmission; antiretroviral treatment; and care and support for the patient and the family, including children. Health workers, too, are not able to help people living with HIV&AIDS and to assist those affected to cope with the condition. On a personal level, stigma means loneliness, abandonment, ostracism, violence, anger, secrecy, starvation and death.

The impact of stigma is felt more among socially, culturally and economically disadvantaged groups and individuals. Homosexuals, sex workers, injection drug users and women are but some of the marginalized groups that are mostly affected by the stigma. A sad story of Gugu Dlamini, health worker and AIDS activist who was stoned to death by neighbours for speaking openly about her HIV status is but one example of acts of violence and murder meted against PLWHA.

### Activity 11

1. *In half a page discuss the perception of your community about homosexuals.*

2. *Discuss how HIV&AIDS related stigma affect relationships between peoples.*
HIV&AIDS and Discrimination

We have often seen stigma and discrimination used together and sometimes interchangeably. Though closely related, their meaning is not the same. We have seen above that stigma is an attribute or quality. Discrimination, on the other hand, is behaviour. Let us now define discrimination. Discrimination is defined by Manser & Thomson (1999) in Combined Dictionary Thesaurus, as the unjustifiable different treatment given to different people or groups.

HIV&AIDS Related Discrimination

HIV&AIDS related discrimination is much more than the anxiety and the concern that results from how people might react and what they would say. It is the actual experience of being treated differently as a result of HIV&AIDS status. When a kid is denied educational opportunities as a result of his/her HIV status, this is discrimination. When Gugu Dlamini was stoned and beaten to death, she was being discriminated against just because people branded her with a mark of shame and danger (stigma). The experiences of discrimination against PLWHA have led to the feeling of stigmatization of PLWHA and vice-versa.

Activity 12

1. Do people living with HIV&AIDS face discrimination in your community or church?
2. In a paragraph, describe the cases of discrimination that you have heard or experienced in your community or church.

Challenges for Counseling

The massive impact of HIV&AIDS on the entire livelihood constitutes a challenge to the counseling profession in general and pastoral counseling in particular. Below are some of the challenges that HIV&AIDS poses for the counseling profession:
• HIV&AIDS is a life-threatening illness and confronts both PLWHA and the affected with the prospect of their imminence death.

• HIV&AIDS permeates all structures of society and works through them to fuel its spread. It works through unjust structures, discriminatory policies and laws. This evokes advocacy, which is an essential component of counseling, in transforming the disabling structures as we heal the wounds of PLWHA and the affected.

• HIV&AIDS raises emotional and religious issues. It involves restoring hope in the face of hopelessness.

• Counseling PLWHA and the affected involves confronting head-on HIV&AIDS related stigma and discrimination.

• Counselling in HIV&AIDS situations means increasing our capacity to manage stress and burnout that result from having to deal with an incurable disease that causes so much suffering and uncertainty.

**SUMMARY**

Let us now summarize what we have learnt in this Unit. You are all aware that the main focus of this Unit was to define the problem of HIV&AIDS. We set out to achieve this by showing that:

• The HIV&AIDS statistics are on the increase.

• HIV&AIDS permeates the structural and community dimensions of our societies.

• HIV&AIDS related stigma and discrimination are rife and discourage all efforts at prevention, care and counseling of PLWHA and the affected.

• Women and girls, though very vital in care and treatment of PLWHA and the affected, are unfortunately victims of social deprivation and disparate social opportunities, and the most vulnerable to HIV&AIDS infection.

• These issues pose massive challenges for the counseling profession.
SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. Name three ways that makes HIV&AIDS is a problem.
2. Identify some psychosocial problems faced by people living with HIV&AIDS and the affected.
3. In your own words, explain HIV&AIDS related stigma.
4. In what ways is HIV&AIDS related stigma expressed in your own country, church and community.
5. Name some of the effects of HIV&AIDS related stigma and discrimination and how they affect efforts aimed at prevention, care and support in your community.
6. How do you distinguish between stigma and discrimination?
7. What factors in your culture contribute to marginalization and promote the vulnerability of women and girls to HIV&AIDS?
8. Show how the psychosocial conditions of PLWHA and the affected pose a challenge to counseling.

FURTHER READING


**GLOSSARY**

**AIDS**: Acquired Immune Deficiency Syndrome.

**Affected**: Term used for family, friends, neighbors, workmates, churchmates, and other persons closely associated with someone living with HIV&AIDS.

**Caregivers**: term used of people who look after who are terminally ill and orphaned children as a result of HIV&AIDS.

**Discrimination**: An unjustifiable different treatment given to different people or groups.

**Discriminatory policies**: Policies that sanction, directly or indirectly unjustifiable treatment given to different people or groups.

**Epidemic**: A widespread outbreak of an infectious disease where many people are infected. HIV&AIDS has been called an epidemic because it has the attributes of an epidemic.

**External stigma**: It refers to the treatment that people receive as a result of their condition.

**HIV**: The human immunodeficiency virus.

**Infected**: Term used for a person who has the HI virus within his or her body

**Internal stigma**: A felt shame associated with a certain condition and the fear of being discriminated on account of that condition.

**Morbidity**: Number of illnesses in a given period.

**Mortality**: Number of deaths in a given period.

**Epidemic**: An epidemic covering a wide geographical area. HIV&AIDS is an epidemic in that it has the global impact and covers wide geographical areas.

**PLWHA**: People living with HIV&AIDS.

**Stigma**: A mark imposed on a person designating a person’s particular natural or moral defect.

**Stigmatization**: A phenomenon or process that results in a powerful and discrediting social label that affects the way individuals view themselves and are viewed by others.
Unit 2
Basic Counselling Skills

OVERVIEW
Welcome to Unit 2. In this unit you will be introduced to the concept of counselling. The general components of counselling will be covered. In the same unit, you will learn about the qualities of an effective and good counsellor. Counselling is a skill oriented profession. Hence there is a section that deals with different skills that are at the disposal of a counsellor. These skills are divided into micro and explorative skills. Through examples and illustrations you will be taken through the practice of different counselling skills.

OBJECTIVES
At the end of this Unit you should be able to:
- Define counselling.
- Discuss the aims of counselling.
- Identify the qualities that makes one an effective counsellor.
- Identify the basic skills that one needs to be an effective counsellor.
TOPICS

- What is Counselling?
- Aims of Counselling
- Effective Counsellor
- Basic Counselling Skills
  - Microskills
  - Explorative Skills
    - Listening Skills
    - Reflective Skills
    - Probing Skills

Summary

Self-assessment

Further reading

Glossary
What is Counselling?

Let us start our discussion by looking at what counselling is. Counselling as a profession is a relatively new art although it always occurs in many of our every day interactions, with family members, friends and acquaintances. Many of these interactions may be referred to as informal counselling. We are going to focus more on counselling as a more professional, structured and formal skill.

Counselling has been defined differently by different people depending on different areas of emphasis. Let us outline these different emphases:

- Lawrence Brammer (1979) and G. Egan (2002) put more emphasis on the counsellor and the role s/he plays.
- T. Bond and S. Culley (2004) put emphasis on the process itself which entails the skills and the techniques.

Let us now look into a definition that attempts to balance the different emphases we have seen above:

Counselling is a structured conversation within a relationship of trust, between a counsellor and a counselee aimed at enabling the counselee or client to utilize the resources s/he has for solving or coping better with their problems.

Activity 1

1. Write down your own definition of counselling.
2. Give examples of some professional counsellors in your community.
3. List some of the things done by the counsellors in your community.
4. State the differences between counselling done by ministers of religion and that done by other counsellors.
This definition acknowledges the importance of the role of the counsellor, the client and the importance of the skills that have to be developed for effective counselling to take place.

We will now analyse the above definition by indicating its important components.

**Counselling as a relationship**

The definition tells us that counselling is first and foremost a relationship. A relationship by definition implies two people or more, for instance, the counsellor and the client(s). These two people or more are normally brought together by the need or problem, usually, brought by the client. The problem or the need gives direction to the conversation that follows between the two.

**Counselling as a structured conversation within a relationship of trust**

The counsellor as the more skilled party structures the conversation and gives it direction. It is in this sense that we call this conversation structured, disciplined, focused and goal oriented. The relationship between the counsellor and the client must be that of mutual trust. This helps in shaping and determining the success or failure of the counselling process.

**Counselling helps the counselee to make use of his/her resources.**

Clients often come to counsellors because they are not happy with one or more dimensions of their lives. They go to the counsellor because they have been advised by a friend to do so. Sometimes they volunteer to see the counsellor. Whatever the reasons are for these different clients, at the end of the day, their expectation and their wish is that counselling should help them to cope better with their problems.

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<td><strong>Activity 2</strong></td>
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<td>1. <em>Recall some informal counselling sessions you have had. What pattern or structure did they have?</em></td>
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We can now move on to discuss the aims of counselling.
Aims of Counselling

The definition of counselling given above tells us what counselling involves. For example, we saw that counselling involves a conversation between two parties, the counsellor and the counselee. In this section we shall be looking at the aims of counselling. We need to ask ourselves what counselling seeks to achieve. This helps in determining whether the aims of counselling have been achieved or not. This also helps us to determine whether someone calling himself or herself a counsellor is actually one. We can do that if we know what the aims of counselling are and we are able to relate with the definition. We will first outline the basic aims of counselling and discuss them.

There are four basic aims of counselling given as follows:

a) To enable the client to identify and cope with the impact of his/her problem.

b) To facilitate problem solving through understanding of the problem.

c) To increase or boost the coping abilities towards solving the problem.

d) To empower the client to become more effective self.helpers in the future.

What follows now is the discussion on the aims of counselling. Our understanding of counselling is that it is a joint venture involving both the counsellor and the client. Both the counsellor and the client each have a role to play. The aims of counselling can be achieved only if both play their respective roles. Hence under each aim, the role of the counsellor and the client will be discussed. Let us look at the first basic aim of counselling.

To enable the client to identify and cope with the impact of his/her problem.

The role of the counsellor

The role of the counsellor in any given counselling transaction is to assist, help or enable a client. The first aim suggests that one of the roles of a counsellor is to enable, assist or help the counsellor to identify the problem. When clients decide to consult a counsellor it is, in most cases, because they have tried to resolve their problems and have not succeeded. Sometimes clients are so immersed in their problems that they cannot even
say where the real problem lie. Enabling in this context means collaborating with a client in exploring and eventually identifying the problem and the impact this problem has had on the life of the client. The counsellor’s role is to facilitate disclosure. Disclosure will in turn make it easier for both the counsellor and the client to understand the problem.

The role of the client

It would seem from the above aim that the counsellor is the one running the show. S/he is assisting, helping, enabling. On the contrary, the client is not a passive beneficiary of the service offered by the counsellor. He has to actively participate in the process of identifying the problem by; first, relating the story and by confirming with the counsellor the nature and seriousness of the problem. Because the management of specific problems and coping better with them belongs to the client, it is important that s/he should take ownership of the problems. The second basic aim of counselling is to facilitate problem solving through understanding of the problem.

Role of the counsellor

When the problem has been identified and understood by both the counsellor and the client, the solution to the problem is within reach. The counsellor’s role is to prompt the client to work out and weigh possibilities and alternatives s/he has towards resolving the problem. The counsellor’s role consists mainly in assisting the client to relate the alternatives to the nature of the problem.

Role of the client

The client’s role in this aim is to work out and weigh alternatives s/he has towards solving the problem. If s/he has understood the problem well s/he should be able to work out these possibilities and alternatives.

The third aim of counselling is to increase or boost the coping abilities towards solving the problem. Every individual has coping abilities. These refer to the power that allows a person to cope with the problems as they occur. These abilities are enhanced by
internal or external resources. Internal resources refer to the strength that lies within a person that allows him/her to deal with problems or crises as they occur. External coping resources refer to the family members, friends, colleagues and religious resources. Sometimes the problems are so intense that a person is not able to cope. In this case s/he can resort to the external resources. Sometimes even the external resources are non-existent or not within immediate reach.

**Role of the counsellor**

It belongs to the counsellor to determine the coping levels of the client. A skilled counsellor should be able to do that. For example, if the client is sobbing incessantly and is not able to come to terms with whatever has occurred to him/her could be a sign that his/her coping abilities are low. Again a person may feel that s/he cannot trust anybody anymore. To a skilled counsellor these are indications of the coping levels of the client. These levels will determine the type of help the counsellor should recommend.

**The role of the client**

The client’s ability to talk and ventilate will assist the counsellor in measuring the coping levels. The effort to boost or increase the coping abilities cannot be done without the involvement of the client. His/her active participation in this process is a step in the direction of resolving the problem.

**Activity 3**

Pause for a moment and recall some problems you have encountered in one way or another in your life. In a few lines describe how you dealt with those problems. Did you resolve them on your own or with the assistance of another person? In what ways did the other person assist you?

Let us continue with the last aim. The last aim is to **empower the client to become more effective self helpers in the future.**
Client’s role

R. Nelson-Jones in his book, Essential Counselling and Therapy Skills, has this question to ask: “If we can have skilled counsellors, therapists and helpers, why can’t we have skilled clients too?” (2000: xii). This question shifts focus from just managing the problems, or improving the skills of counselling to improving the poor skills that makes clients vulnerable to future problems. In fact Nelson-Jones is convinced that clients are not passive recipient of the counselling service. Their active participation, so much emphasized, in resolving the problems ensures that they are empowered. When clients are empowered, their ability to think, communicate and act on their own is improved. This active involvement is empowerment and it ensures self-help. This means that at the end, the client should be able to say, ‘I discovered what my problems were and what caused them. I have identified the best way of dealing with my problems. I am responsible for managing these problems now and in the future.’

Counsellor’s role

A number of times clients confront us with a question, ‘what must I do?’ The most tempting response for any counsellor is to give advice. J. Moore argues that giving advice is very unhelpful in a number of ways. First, it cuts short the process of talking about the confusion, the feelings a person has. Second, it robs the client the choice to own up to his/her decisions. Third, by giving advice you are taking responsibility for a choice that is not properly yours. When you give an advice which is supposed to be a solution, if it does not work- who is to blame then? (1992:8).
Effective Counsellor

Let us now turn to the qualities expected from an effective counsellor. We have to admit that there is no blueprint (meaning that there is no standard guideline) for an effective counsellor. In other words, there is no fixed pattern that is universally applicable for effective counselling. However, there are certain qualities that every counsellor needs in order to be effective. An effective counsellor is the one who through his/her informed and skilled interventions, enables a client to grow toward wholeness. Wholeness involves growing in ways that enliven (meaning that which enhances the ability to function as it should) the mind, revitalize the body, renew and enrich our relationships, vitalize our relationship with nature and deepen our relationship with God. Qualities that are required of a counsellor include but are not limited to the following:

- Self awareness and understanding
- Competence
- Warmth and Caring
- Empathy
- Warmth and caring
- Openness
- Trustworthiness

Activity 4

A woman by the name of ‘Mathabo comes to you with some marital problems. She admitted being undecided about separating from her husband. This is her second marriage and she is very much concerned about failing for the second time. She is tied financially to her husband by the joint ownership of the house as well as paying of the tuition to a special school for her two sons. The love between them has died. Moreover, the husband is involved with another woman for over two years now. She has come to you for counselling. In not less than 400 words write down the kind of advice you would give her.
**Self awareness and understanding:** There is strong belief that effectiveness in counselling begins with the self. Counsellors as helpers have to be aware of who they are in terms of their personalities, values, experiences (positive and negative), convictions, be they social, political or religious. However, these personal values and convictions should not necessarily be used as a yardstick for measuring the behaviours and choices of other people. For example, if I conclude on the basis of two instances that a client is very undependable, the question is, ‘How much of this judgement is descriptive of that person and how much of myself and my values and norms is read into that description? Again if I have had a rough experience in dealing with people of a certain gender or ethnic background, that should not influence my future dealings with individuals from that same gender or ethnic group. A counsellor who is genuine and honest about himself/herself knows that s/he is not ‘a know it all’. S/he has to be realistic about their personal strengths and limitations.

**Activity 5**

*Write some of the strong values and convictions you have on sexuality, gender and religion. Explain how far these values and convictions should affect your judgement as a counsellor.*

**Competence** refers to the ability to deal professionally with people and to conduct sessions with the necessary information, knowledge and skills. A professional counsellor is supposed to be someone trained in the skills of counselling. Normally such person is issued with a certificate as a proof of the training s/he has gone through, and the knowledge and skills s/he has acquired. The expectation is that s/he should discharge his/her duties in keeping with the knowledge and skills s/he has acquired.

T. Bond, in his *Standards and Ethics for Counselling in Action*, states that, it is part of the counsellors’ responsibility to ensure that they monitor their level of competence and be willing to be accountable to clients and other counsellors for their practice on a daily...
The minimum standard of competence that you as counsellor should aspire for are to:

- Know why you are doing or saying something to your client
- Be sure you are saying or doing what you intend
- Know the likely effects of what you say
- Adjust your interventions according to the client’s actual needs
- Review your counselling practice regularly to ensure up-to-date and informed delivery
- Assess whether your level of skill is the same or better than that of other counsellors offering counselling on similar terms.

The above principles can act as the foundation of competent counselling practice.

| Activity 6 |

You or the person you know might have been subjected to incompetence. In a paragraph, explain the side effects of incompetent counselling.

**Warmth and caring:** Warmth is an emotional quality of friendliness reflected in the facial expressions, non-verbal attending behaviours. Showing concern and interest are indicators that a person is respected and valued. Caring, though related to warmth, is regarded as showing deep and genuine concern about the welfare of the other person. The modalities of showing this warmth and caring concern have to take into consideration the cultural differences.

**Openness:** One of the principal roles of the counsellor is that of facilitating disclosure (meaning sharing of information) and ventilation (meaning release of painful feelings) from the side of the client. When the client shares information and is able to ventilate, this is a sign that the counsellor has invited openness from the side of the client. How does the counsellor invite openness? The way a counsellor attends to the client
communicates his/her regard for the client. The facial expressions which are congruent with what we say also augur well for inviting openness and self disclosure.

**Trustworthiness:** A counsellor is given the benefit of knowing what is supposed to be confidential information about the client. His/her professionality should remind him/her of the reliability that goes with the task. S/he has to be dependable and honest.

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### Activity 7

1. **List things that evoke trust in the other person.**
2. **Write down things that are positive and negative about your personality and your dealings with other people.** Confirm these with a person who can be honest with you.
3. **List ways in which warmth and care can be shown to different categories of people in your culture.**

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We now turn to the basic counselling skills that any counsellor ought to possess. When used well, these skills can enhance the counselling profession and make it an enjoyable and rewarding experience.

### Basic Counselling Skills

These skills are basic in that they form the basis of more complex skills that could be used in other cases of a more complex nature. Neither the disposition of a counsellor nor the content can alone achieve effective counselling. They have to be articulated through skills. **Disposition** refers to the qualities discussed above that an effective counsellor should possess. **Content** is what both counsellor and client bring to the interaction- their thoughts, feelings, behaviours and experiences. S. Culley and T. Bond, in *Integrative*
Counselling Skills in Action, define content as ‘the what. Skills refer to the how (2004: 14).

What, therefore, are counselling skills? **Counselling skills refer to the basic tools by which you develop in order to effectively conduct a counselling session.** We will see in the next section that there are different stages of a counselling process. Counselling skills help to fulfil the aims of each stage of the counselling process. We are going to group the counselling skills into two main categories namely; microskills or attending skills and explorative skills.

**Microskills/attending Skills:** Attending refers to the art of ‘being with’ the client. Attending skills, therefore, are those skills that help the counsellor to attend fully to the client and to interact with the client in order to build a good working relationship. They help the counsellor to be present to and with the client both physically and psychologically. They are a means by which you communicate ‘non-verbally’ with clients that you are:

- With them
- Interested in them
- Alert to what they want to share with you.

Egan, in *The Skilled Helper*, calls these, skills of visibly tuning in to clients and summarizes them under the acronym SOLER (2002: 68). We prefer to call them microskills, these *microskills* being a collection of body language skills a counsellor adopts during a counselling session. These microskills are as follows:

**S= Squarely:** A posture adopted should be that which implies involvement. It should be a posture that allows both the counsellor and the client to read messages that are communicated through bodily movements and gestures.

**O=Open:** As a counsellor you have to adopt an open posture that communicates non-defensiveness and availability to the client.

**L=Lean:** Leaning towards the client shows some kind of involvement and interest in what s/he is saying.
E=Eye contact: Maintenance of good eye contact conveys the message that you are with the client, you are interested and you want to hear what s/he has to say. Eye contact is important because it allows you to read your client’s body language and to be guided by it. Maintaining eye contact is not staring. Staring is regarded in many cultures as rude and is a sign of confrontation. A=aim has been proposed for blind and visually impaired clients. For them, eye contact has little or no relevance. So instead of E=Eye contact there is A=aim. Aiming your head and body in the direction of the blind and visually impaired client is extremely important.

R=Relaxed: It refers to being natural with the client. Nervousness and distraction are signs of discomfort. It is seen in the manner in which you use your body as a vehicle of personal contact and expression.

These attending skills are not necessarily applicable to the first stage of the counselling transaction (stages are discussed in the next unit), they (attending skills) cut across the entire counselling process.

In adopting the above attending skills, we should do so mindful of the cultural differences. In certain cultures the age and gender of the counsellor count for much of how these attending skills should be employed. How a man should act towards a woman, and how adults and children should behave towards each other for example, determines the way in which the attending skills should be employed.

Activity 8

Write a paragraph on how relevant the micro or attending skills are in your own cultural context. Consider how gender, age and status might interfere.

Explorative Skills: These are the skills that help the counsellor and client explore and understand the problem from the client’s point of view. Explorative skills can further be divided into listening skills, reflective skills and probing skills. Before discussing these
individual skills we will first look at basic empathy as it accompanies the whole process of problem exploration and beyond.

**Empathy:** Empathy means seeing the world the way the client sees it, that is, from their perspective. Put in another way, it is the capacity to participate in another person’s feelings or ideas without, however, losing one’s identity or objectivity. It means that the counselor is involved with the client but at the same time s/he is able to maintain ‘otherness’ (the state of being different). **Empathy** presupposes listening carefully to the client and then communicating back to the client his/her feelings. Let us look at the following example to illustrate empathy:

**Client:** I don’t know what to do now that my girlfriend is HIV positive. My mother wants me to leave her and my father wants me to marry her…. I am not sure what to do.

**Counsellor:** You feel confused and pressurized because your mother and father have each their ideas about whether or not to marry your HIV positive girlfriend and you are not sure what to do.

The words of a counselor above are an example of basic empathy. S/he has picked up the feelings of the client and communicated them back to the client.

Having discussed this very important skill we can now move on to the discussion of the first of the exploratory skills and those are listening skills.

**Listening Skills:** These skills refer to receiving and understanding the messages that clients are sending both by what they say, by what they do, by what they should be saying and they are not saying (omissions), and by what they should be doing and they are not doing (gaps).

We, normally, talk of verbal and non-verbal messages. **Verbal messages** are those messages communicated through a word of mouth. **Non-verbal messages** are communicated through bodily behaviour (posture, body movement, and gestures), facial expressions (smiles, frowns, raised eyebrows, twisted lips), voice-related behaviour (tone, pitch, voice level, intensity), and observable psychological responses (quickened breathing, blushing, paleness).
All these messages verbal or non-verbal have to be captured and interpreted by the counsellor. They have to be captured because they contain the grain of the truth that the client intends to share. Listening goes beyond paying attention to verbal and non-verbal messages it also mean listening to the whole person in the context of his/her social settings. Effective listening brings you in touch with the feelings of a client. In counselling, feelings speak volumes. Indeed the whole point of counselling is to know what the person is feeling and to communicate this with the client.

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**Activity 9**

List ways in which people communicate effectively. Give examples from your own cultural context.

**Reflective Skills** are the skills that enable you to communicate your understanding of the client’s perspective or frame of reference. The reflective skills are closely related to the listening skills. Reflecting follows upon what has been shared by the client consciously or subconsciously and has been understood by the counsellor. We listen, we understand and we mirror that understanding back to the client. We normally mirror back this understanding in three ways, namely restating, paraphrasing and summarizing. These three ways we call the reflective skills. Let us now turn to a detailed discussion of these three reflective skills. We start with restating.

**Restating** means repeating back to clients in a single word or short phrase which they have used. Restating helps to prompting further discussion. Look at the following example:

*Client:* I felt so humiliated.

*Counsellor:* Humiliated! *(Restating)*

*Client:* Yes, I felt really down. I thought I deserved a better treatment than that.

The second reflective skill is paraphrasing. **Paraphrasing** means rephrasing what you have understood to be the substance or the core of the client’s message. Rephrasing
ensures that the counsellor and the client are on the same wavelength. It also ensures that both the counsellor and the client agree on the emerging issues or problems.

**Look at the following example:**

*Client: I have always been a failure. I have not been as successful as my brother and sister in terms of education and work. Everything they have done has turned out so well. What is worse is that now I am HIV positive.*

*Counsellor: You are comparing your achievements with your brother’s and your sister’s and are telling yourself that you are a failure, especially now that you are HIV positive (paraphrasing).*

*Client: Yes! Sort of not quite, you know.*

The third reflective skill is summarizing. **Summarizing** refers to longer paraphrasing that enables you to bring together important aspects of the session in an organized way. Summarizing normally focuses on what the client has said. It achieves the following:

- It clarifies content and feelings
- It reviews the work done so far
- It ends a session
- It begins the next session

**Consider the following example:**

*Counsellor: From what you have said so far, you seem very unhappy about what you have achieved, especially in the light of your being HIV positive. You also compare yourself unfavourably with your brother and sister and see your achievements as inferior to theirs.*

| ? | ? |

**Activity 10**

*Discuss ways in which the above passage can be a summary of the conversation between counselor and client on the above section on paraphrasing.*
**Probing Skills:** This are skills that enables a client to explore more deeply any issue which is, in the judgement of the counsellor, relevant to the issues alluded to by the client. Here the counsellor becomes more directive in his/her manner of digging out information. Though important, these skills should be employed with care as they lead us into areas client might have deliberately avoided. Probing may take the form of statements, questions or requests. **Statements** are used to probe where, in the discretion of the counsellor; questions might be seen as too inquisitorial. For example, ‘I wonder what your parents would say about this’ might be better than ‘What would your parents think about this?’

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**Activity 11**

*Imagine yourself counselling another person in a specific setting.*

1. **What is the client saying to you?**
2. **What are you saying?**
3. **What are you doing?**
4. **How do you respond to feelings shared by the client?**

**SUMMARY**

Remember, in this unit, we have defined counselling as a structured conversation within a relationship of trust, aiming at utilising resources for solving problems. We have also outlined aims of counselling. The unit has also explored the basic qualities required of an effective counsellor. The qualities of self-awareness, understanding of self, competence, empathy, warmth, openness and trustworthiness dispose a counsellor to achieve good results. These qualities accompanied by the development of good counselling skills can ensure that helping service is given to those who need it. These counselling skills include attending skills and explorative skills. Explorative skills can be further divided into listening skills, reflective skills and probing skills.
SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. Define counselling in your own words?

2. Discuss the following statement, “the relationship of mutual trust between counsellor and client determines the success of a counselling process.”

3. A counsellor is more of an enabler than an advisor. Discuss this statement?

4. What does empathy mean?

5. Explain the importance of empathy as a quality for a counsellor.

6. Identify ways in which the attending skills (microskills) discussed above applicable or not applicable in your own cultural context.

7. Explain the difference between verbal and non-verbal messages.

8. Choose a partner. Play the role of a counsellor and ask questions (probe) to seek clarity and concreteness from the client. Observe how the client responds to the questions. Discuss together how those questions were asked and what impact they had and whether or not they achieved their intended purpose.

FURTHER READING


**GLOSSARY**

*Counselee*: A person who is looking for counselling or who is referred to counselling services. The term can be used interchangeably with client and helpee.

*Counselling transaction*: It refers to a counselling encounter between a counsellor and a client.

*Counsellor*: A person trained to provide counselling services. The term can be used interchangeably with therapist and helper.

*Disclosure*: The act of relating one’s story in a counselling transaction.

*Empathy*: It is a conscious attitude of the counsellor by which s/he attempts to perceive events from the perspective of the client or counselee.

*Marital problems*: These are problems associated with a marriage relationship.

*Non-verbal message*: Message communicated through means other than the word, such as bodily behaviour, facial expressions, observable psychological responses.

*Professional counsellor*: Someone who does counselling as a profession and who makes a living out of it.

*Self-help*: It refers to the ability of the clients to live skillfully on their own. The main purpose of counselling is to enable clients to help themselves.

*Verbal message*: Message communicated through a word.

*Ventilation*: It refers to the expression of emotions or feelings.

*Restating*: It is a reflective skill that involves repeating back to the client, a word or a phrase which s/he has used.

*Paraphrasing*: It is a reflective skill of rephrasing what you perceive to be the core message of the client’s communication.

*Summarizing*: It is a reflective skill of bringing together in a brief way, the salient aspects of the message communicated.
Unit 3
Counselling Theories and Processes

OVERVIEW
Welcome to this Unit 3. This Unit serves to introduce you to the theories of counselling. Counselling emerged from given cultural perspective. Logically, theories developed by counsellors and psychologists bear the cultural brand of their authors. These theories have something that can be applicable across cultures, but they also have something particular and specific. It is in this reason that we also discuss counselling in African context to show that the African problems and world view are different and need to be taken into consideration if proper healing is to be given to Africans. The Unit also discusses the three stages of a counselling process. It also explores the pastoral dimension of counselling.

OBJECTIVES
When you have completed this unit, you should be able to:

- Describe theory and its function in counselling.
- Critically discuss the role of culture in counselling.
- Explain various stages of a counselling process.
- Discuss the pastoral dimension of counseling.
TOPICS

- Theories of Counselling
- Counselling in an African Context
- Stages of a Counselling Process
  - Current Scenario
  - Preferred Scenario
  - Strategy
- Pastoral Dimension

Summary
Self-assessment
Further reading
Glossary
Theories of Counselling

I am sure you have come across the term theory. You have also probably used the term. The term theory is often used as an opposite of practice. Practice refers to something that has to do with action and so theory has to do with a thought, or a certain way of thinking. It is in this sense that L.M. Heyns and H.J.C. Pietersen in their *Primer in Practical Theology* define theory as a discussion, consideration and planning pertaining to praxis (action) (1990: 24). According to this understanding every action has to be preceded by some kind of thinking and planning. For example, what is actually carved on wood was first planned in mind (theory).

But this is not the only definition of theory. Theory can also refer to an explanation to a phenomenon. Something may happen without necessarily being planned by a human person. An attempt to understand this phenomenon brings about theory. For example, HIV&AIDS is a phenomenon. There are different theories that account for the origin of this phenomenon. For some, the HI virus is a punishment from God. For others, it is the wrath of ancestors for abandoning cultural traditions. Yet for others, the virus crossed the species barrier, from primates to humans. It changed its genetic character and invaded humans.

### Activity 1

1. List some of the theories about the origin of the HI virus that causes AIDS common in your own culture.
2. How do these theories contribute in the prevention or spread of HIV and AIDS?

So, counsellors in dealing with a number of clients will arrive at certain conclusions that account for the behaviour of these and other clients. They also make choices about how
to think about the clients’ behaviour and how they can be treated during counselling sessions. These conclusions, choices or explanations that account for the behaviour of the clients and how they can be treated can be referred to as counselling theories.

The function of theories of counselling is to provide counsellors with concepts/framework which allow them to think systematically about human development and the practice of counselling. Over the years many theories of counselling have been developed. This was in attempt to understand the problems of clients better and to offer appropriate help. Among these theories, we can mention for example, psychoanalytic theory, rational-emotive theory, Rogerian theory and eclectic approach. We will briefly look at what these theories represent.

**Psychoanalytic Theory:** This theory was founded by Sigmund Freud. This theory contends that early childhood memories shape our personalities in a particular way. Understanding these memories helps us to freely choose our future.

**Rational-emotive theory:** This theory was founded by Albert Ellis. Albert contends that all humans have three fundamental goals, namely: to survive, to be relatively free from pain, and to be reasonably satisfied or content. How we think, feel and behave can either contribute to or hinder the attainment of these goals. Ellis is known for his ABC theory of personality.

A= Activating events
B= Beliefs, rational and irrational
C= Consequences, both emotional and behavioural

According to this theory, it is our beliefs that determine how we behave and not the event. For example, as person who is infected with HI virus may be depressed. This depression, which is a consequence, might be a result of his belief that infection with HI virus means death. So the behaviour (C) is determined by belief (B) and not by the event (A).

**Rogerian Theory:** This theory was founded by Carl Rogers. He believes that clients have the potential to resolve their problems without being given directives. His approach is non-directive, client-centred and person-centred.
Eclectic approach: This approach draws from all theories and combines them to come up with an appropriate help in a particular situation.

These theories were developed as a response to problems of people within a Euro-American context. They represent a different world view and they are responding to questions that are not necessarily African questions. It is for this reason that we have a section on counselling in an African context to raise issues that challenge counselling to be contextual.

Activity 2

1. Write down some of the theories in your culture that explain the cause of sickness or disease.
2. In what ways do these theories correspond to your world view?

Counselling in an African Context

It should be clear to you by now that counselling is a service intended for human beings alone. It aims at helping individuals to resolve their own problems. But every human person is a combination of both universal and individual traits. As humans for example, we enjoy, universally, the same gift of intelligence and free will (universal traits). But the exercise of these gifts is determined and limited by socio-cultural factors as well as the way an individual responds to this environment. As individuals, we are unique and distinct and yet we are part of a clan, ethnic group, village, culture and nation.

According to WCC’s document (1990: 18) A Guide to HIV&AIDS Pastoral Counselling, every culture has its own values, traditions and taboos about life, health, sickness, sex and death. A good counsellor would do well to take these issues into consideration in offering counselling to the clients. J. Beuster says, in addition, that to ignore a client’s cultural background not only leads to misunderstanding, it can also be anti-therapeutic and harmful (1997:5).
Before the advent of missionaries and colonisers, Africans have always had their way of helping individuals with their problems; healing the sick and caring for the old, terminally ill and orphans. There were family councils which were largely made up of members (male and female) of the extended family. In some cultures this role was vested upon the elders of the family. Their role was to advice and to mediate whenever there were conflicts in the family and to oversee that things pertaining to that family or clan, as transmitted from one generation to the next, were properly observed.

**Sickness** for the Africans was not only an individual experience and its causes were varied. It was a communal experience including both the living and the living dead. According to Beuster (1997: 6), traditional Africans define abnormal behaviour in terms of disharmony in social relationships. This disharmony is not only recognised between the living but also between the living and the ancestors. The sickness of one member affected all other members of the family, the living and the living dead.

### Activity 3

1. *In half a page explain the concept of sickness from your own cultural context.*
2. *Analyse ways in which you deal with sickness in your cultural context.*

Healing, therefore, involves more than just recovery from bodily symptoms. It extends to social and psychological reintegration of patient and community. It is normally done through the intervention of indigenous healers, diviners (*Mundo mugo, Inyangas, Ingangas, Lingaka*). Theirs was to diagnose, heal people and account for the causes of illness and to prescribe to people as to what to do to be spared or restored to good health. Because of their ability to converse with the Ancestors or Spirits they facilitate harmony between the living and the living dead. When that harmony is restored, the patient is healed together with the whole family, clan or community as there can be no individual healing outside the context of the family, clan or community.
We acknowledge the theories of Freud, Rogers and others. They have indeed made a lot of discoveries in the field of psychology. Their theories emerged from a certain worldview which served as a basis for their discoveries. We should, however, point out that they are experienced within specific cultural contexts. These theories, for example, place more emphasis on the individual client and how s/he responds. This need not be the case in counselling in an African context or any other context different from their own. For an African, an individual is not identifiable outside family, clan or community. The family, clan or community on the other hand is identifiable through its own Ancestors. This is because the person’s being makes sense only within the framework of Ancestor-living relationship.

In Africa there is no single word for counselling instead there are different manifestations or expressions of counselling. In Sesotho (language of Basotho) there is ho eletsa (to advice); ho tselisa (to console); ho tsehetsa (to support); ho tataisa (to guide); ho laola (to divine). All these refer to different ways of doing counselling. And if one were to define counselling, we would define it as: to advice, to console, to support, to guide and to divine. And each of these activities is a response to a specific need situation. Even as we do counselling, its skills and processes, we should do so mindful of the fact that cultural considerations are important in each of these various stages. You may have noticed that we made a lot of generalisations when we talk about Africa. While to a greater extent this is possible, we need to remember that Africa is a big continent with a lot of differences in terms of cultures and cultural expressions.

Activity 4

List values, traditions and taboos about life, health, sickness, sex and death that can contribute either to the spread of HIV&AIDS or to its prevention.

Let us now discuss the stages of a counselling process.
Stages of a Counselling Process

Counselling is a process or a journey that is taken by a counsellor and a client. Culley and Bond (2004: 14) in their book, *Integrative Counselling Skills in Action*, say that the term process refers to the dynamics of a counselling relationship or the *how*; how you and your clients are working together and what is happening between you. To say that counselling is a process implies that it has a beginning, middle and an end. This beginning, middle and end of a counselling process are referred to here-below as stages of a counselling process. The stages of a counselling process help the counsellor to know where s/he is with the client in any given counselling transaction.

There are different stages models of a counselling process. In this module we have adopted “A Three Stage Model” of Gerald Egan. Egan, describes three stages of a helping process namely, current scenario, preferred scenario and strategy (2002: 26-27). We will now look at the content of each of these three stages individually.

**Stage One: Current Scenario**

Current scenario refers to the present state of affairs of the client as it obtains currently. The client has been motivated to consult the counsellor because s/he has a problem. This problem may be seen clearly, obscurely or in a confused manner, by the client. The role of the counsellor is to help the client to see the problem for what it is, to discover and deal with blind spots (that is underlying emotions, distortions and inadequately perceived processes). This stage is sometimes called a problem identifying stage.

The aims of this stage are the following:

- To establish a relationship between a counsellor and a client
- To listen to the client as they tell their stories.
- To help the client to identify and understand the problem or explore missed opportunities.
It is important that the counsellor and the client develop a working relationship which is based on genuineness, respect and trust. This atmosphere of trust and respect depends, for the most part, on how the counsellor uses the attending skills and the listening skills that we talked about in Unit 2. If they are well rendered, the client would be able to tell his/her story and the counsellor would be able to see the problem from the point of view of the client.

Activity 5

A couple have been married for over 10 years and they still cannot have a child. They have gone to a physician for help. He does the fertility test and further recommends that they do an HIV test. The results are that they are both productive he will simply give them medication to sort out their problem. They are also both HIV positive.

Imagine and list some of the problems or anxieties that the couple may face.

Stage Two: Preferred Scenario

When the problem has been identified then solutions to the problem are within reach. Preferred scenario refers to the improved state of affairs or new situation that the client wishes to see himself or herself in. The leading question here is: what do I need or want (preferred scenario) in place of what I have (current scenario).

The aims of this stage are the following:

- To help the client to manage the problem by setting goals.
- To help the client develop a range of options for an improved future.
- To help the client to choose realistic options and turn them into viable goals
- To help the client to commit themselves to a programme of constructive change

Basing himself/herself on how the problem was presented and understood, the counsellor in this stage focuses on helping the client to formulate goals that would ensure that the
preferred scenario is attained. We should remember that clients do not always see their problems as clearly as possible. If this is the case, it is the counsellor’s responsibility to help clients see the problem clearly and for what it is. This s/he can achieve by employing some of the reflective and probing skills that we discussed in Unit 2. The counsellor has to help the client to decide on the goals. The counsellor should ensure that the goals are:

- Clear and specific
- Measurable and verifiable
- Realistic
- In keeping with the client’s values
- Set within a reasonable time frame.

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You have managed to help the couple (see case immediately above) identify the problem or problems they may be facing. Encourage them to tell you what they want. List some of the possible goals that the couple may formulate in order to solve the problem or problems identified above.

Stage Three: Strategy

When the problem has been identified and the goals agreed upon, then the programme to achieve the client’s goal has to be developed. This is where the strategy comes in. Strategy in this context simply means a procedure or a way of achieving a goal. Strategy is a response to the question: how do I get what I want? This stage serves as kind of bridge that unites the current scenario and the preferred scenario. This stage, in the counselling process, seeks to identify ways and means in which the set goals can be achieved.

The aims of this stage are the following:
To help client identify a range of strategies for achieving goals.

To help client choose a set of strategies that are realistic and acceptable to the client.

To help client set an implementation plan with set priorities of what activities need to come before all others.

Once the implementation plan has been finalised, the plan is then implemented. The role of the counsellor at this stage is to encourage, support and guide. S/he should also be prepared to help the client to monitor his/her progress with view to review or improve the strategies.

Activity 7

You have helped the couple formulate goals toward the solution of their problem or problems. You now want to help the couple identify a range of strategies aimed at achieving the goals listed in the preceding stage. List strategy or strategies for every goal listed.

Pastoral Dimension

The term pastoral derives from the term pastor. This word comes from a Latin verb pascere, which means to feed. From the point of view of the bible the term is used interchangeably with the term shepherd. God is the shepherd of his people Israel (Psalm 23). In the New Testament Jesus calls himself the Good Shepherd (John 10:11). When he commanded Peter to feed his sheep, Jesus was entrusting to Peter, and possibly other disciples, the feeding and the tending of his flock (John 21:15f).

Traditionally the term Pastor was reserved especially for church ministers. It was, therefore, easier for people to relate pastoral counselling with counselling that is offered by pastors and priests to their congregations alone. D.W. Waruta in Pastoral Care in African Christianity: Challenging Essays in Pastoral Theology, rightly points out that a
A Guide to HIV & AIDS Pastoral Counselling

Activity 8

1. Discuss the advantages and disadvantages of having pastoral counselling done by the whole church, clergy and the laity especially in the context of HIV & AIDS.
2. Explain how it can be maintained that the church’s mission is to those inside and to those outside.

When the church, through its members, counsels people and restores them to well being it is doing pastoral counselling. This is the pastoral dimension of counselling. This is not to say that a pastor or a lay member of the church cannot specialize in any other type of counselling. This is to say that pastoral counselling is a specialized approach within general counselling which, over and above purely psychological problems, also helps people to grapple with the spiritual and religious dimensions of their problems.

WCC document, A Guide to HIV & AIDS Pastoral Counselling, agrees that people living and dying with AIDS have, over and above emotional and medical needs, spiritual needs. They ask questions related to God, the soul, life and death, condemnation and forgiveness, eternity and transcendence, forgiveness and salvation (1990: 5). As they do that, they are seeking this specialized type of counselling. Good counsellors will not overlook this important dimension of the client’s problems. If they cannot help in responding to such questions they should refer such client’s to pastoral counsellors.
SUMMARY

In this Unit, we have looked at the theories on which counselling as a practice is founded. The development of these theories was a result of the desire on the side of the counsellors, psychologists, and communities to understand the problems of the clients better. We have also looked at the implications of culture for effective counselling. For every client and her/his problems are a product of an environment that encompasses beliefs, values, (religious or social) and world-view. By definition, counselling is a process and as such it ought to have stages. These stages help the counsellor know where s/he is with the client in any given counselling transaction. The pastoral dimension in counselling is also discussed.

SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. Define theory in your own words.
2. Give examples of theories of counselling from your own culture and relate them to the definition given above.
3. Discuss the importance of culture for effective counselling.
4. Counselling is a process. Explain this statement.
5. In what way can the last stage of a counselling process be called a bridge between current scenario and preferred scenario?
6. Discuss the following statement, “every human being is a combination of universal and individual traits.”

7. Explain why it is the mission of the church to do pastoral counselling?

8. Discuss some of the skills that can be employed in the second stage of the counselling process.

FURTHER READING


GLOSSARY

Theory: It is an explanation to a specific phenomenon.

Current scenario: Refers to the present state of affairs as it obtains currently.

Preferred scenario: Refers to the preferred improved state of affairs as compared to the current.

Strategy: A procedure or a way of achieving a goal.
Unit 4

HIV&AIDS Counselling

OVERVIEW
Welcome to Unit 4. This unit deals with HIV&AIDS counselling as a specialized type of counselling. We will look at the definition and aims of HIV&AIDS counselling. Prevention of transmission and psychosocial support as well as reducing stigma as aims of HIV&AIDS counselling will be explored. This unit further discusses the qualities of an effective HIV&AIDS counsellor. Voluntary Counselling and Testing (VCT) and Counselling Testing and Care (CTC) which are the essential components of HIV&AIDS counselling are also discussed.

OBJECTIVES
At the end of this Unit you should be able to:

• Define HIV&AIDS counselling.
• Outline and discuss the aims of HIV&AIDS counselling.
• Compare VCT and CTC as intervention strategies.
• Outline the qualities of an effective counsellor.
TOPICS

- What is HIV&AIDS Counselling?
- Aims of HIV&AIDS Counselling
  - Prevention of Transmission
  - Psychological Support to PLWHA and the Affected
  - Who Needs HIV&AIDS Counselling?
- Being an Effective HIV&AIDS Counsellor
  - Role of an HIV&AIDS Counsellor
- VCT and CTC
  - What is VCT?
    - Goals of VCT
  - What is CTC?
    - Goals of CTC
    - Components of CTC

Summary

Self-Assessment Activity

Further Reading

Glossary
What is HIV&AIDS Counselling?

We have defined the term HIV&AIDS in Unit 1. We have also discussed counselling, its aims and the skills required of a good counsellor in Unit 2 as well as the counselling theories and processes. We now turn to the discussion of HIV&AIDS counselling. Some of the principles and skills of counselling discussed in the first three units will be recalled. HIV&AIDS counselling is as old as the HIV&AIDS epidemic. It evolved with the emergence of the HIV&AIDS epidemic.

It is true that general counselling covers much of the principles and skills that can also be used in HIV&AIDS situations. However, problems associated with HIV&AIDS are such that they require a specialized type of counselling.

So let us start by defining HIV&AIDS counselling.
The World Health Organisation defines HIV&AIDS counselling as an ongoing dialogue and relationship between client and counsellor the aim of which is to prevent the transmission of HIV infection and to provide psychosocial support to those already infected (WHO 1990: 10).

What we learnt from the definition of counselling and its important components in Unit 2 is relevant in understanding the above definition. Normally the dialogue and relationship in the context of HIV&AIDS focuses more on HIV&AIDS and psychosocial issues that go with it. This dialogue and relationship can be between a counsellor and a PLWHA or an affected person. We are aware that the impact of HIV&AIDS in not only felt by those who are infected but also by those who are affected, family members, friends, neighbours, workmates as well as the caregivers.

HIV&AIDS is a very sensitive issue and counselling people in such a context requires a little more than is required in other types of counselling. It involves dealing with the medical aspects, psychological aspects (the thoughts, the feelings), behavioural aspects, and relational aspects such as spouse, family, friends and community. It also involves spiritual and religious aspects such as guilt, forgiveness and condemnation. Hence a need
from the side of counsellors to be informed about such issues or at least they should be ready to refer such cases to people who are better equipped to deal with such issues. This presupposes awareness of HIV&AIDS counselling-related services.

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*List some psychosocial concerns which you think are presented by PLWHA to counsellors.*

**Aims of HIV&AIDS Counselling**

We now move on to the discussion of the aims of HIV&AIDS counselling. According to the definition given above, HIV&AIDS counselling has two main aims, 1) to prevent the transmission of HIV infection and 2) to provide psychosocial support to PLWHA and the affected. We wish to add to this two, the third aim which is not however articulated in the definition given above. This is reducing stigma, both internal and external. This aim will not be discussed here as it is discussed in different Units (1, 6, 7, 8, 9, and 10) of this module. Let us now move on to discuss the individual aims of counselling.

**Prevention of Transmission**

The dictionary meaning of prevention is the act of stopping or securing the non-occurrence of something. In the context of HIV&AIDS what is being prevented is the transmission of the HIV infection from one person to the other. Prevention in HIV&AIDS counselling involves assessing risk of infection, creating insight among those at risk of infection and encouraging appropriate behaviour change and sustenance. Normally prevention of transmission divides into primary and secondary prevention.

**Primary prevention:** In primary prevention, counselling focuses on preventing infection among those who are not infected. Included here are people who are at risk of infection (knowingly or unknowingly). Counselling here aims at 1) discussing behaviour that presents a risk of HIV infection and 2) reviewing ways of managing individual change
This type of counselling can take place in classrooms, youth clubs, sports organisations, church groups and informal gatherings (F. Mc Donnell 2004: 4).

### Activity 2

*Before we proceed with secondary prevention let us do the following exercise:*

1. **Outline the two aims of HIV&AIDS counselling.**
2. **Mention the two types of prevention of Transmission.**
3. **Discuss the focus of counselling in primary prevention.**

### Secondary prevention:

In secondary prevention, counselling is concerned with people who are known or considered likely to be HIV positive. The focus of counselling here is on the implications of being HIV positive and ways of avoiding further transmission of HIV. A. Nwoye sums up the content of secondary prevention thus:

- Getting infected with HIV does not automatically mean that one has already got AIDS.
- One can get infected without developing any symptoms to that effect, and still, can pass on the virus to others.
- Whether one infected with HIV will or will not graduate to full blown AIDS condition is related to the type of life the individual decides to live after getting infected.
- People who are able to get better nourishing diets, can stay in good physical shape especially where a healthy lifestyle is supported with conscientious in take of fresh air, going to bed early at nights and daily participation in some kind of non-strenuous physical exercise (1994: 13).
Activity 3

Theresa has just discovered that she is living with HI virus. She is thinking about what is going to happen to her little son Joe and her job once she gets seriously ill.
Do these questions have to do with primary or secondary prevention? Explain.

Providing Psychosocial Support to PLWHA and the Affected

The psychosocial problems experienced by PLWHA and other HIV related ailments and those who are affected as a result of their HIV infection are such that they require both emotional and material support. HIV infection and AIDS are different from all other life-threatening medical conditions. They evoke severe emotional reactions from both PLWHA and the affected.

The words of a PLWH quoted in Watts’ article ‘Breaking the AIDS taboo’ who said, ‘AIDS is the stuff of all our nightmares, triggering many of our deepest fears’(1988: 28), explains the psychosocial situation of PLWHA and the affected.

It needs to be said that people react differently to an HIV positive result. However, for many clients, a positive HIV test result come as a great shock which is followed by some of the following reactions: fear of rejection and abandonment by family and friends, denial, anxiety, depression, stress and suicidal feelings. Stigma and discrimination experienced by both PLWHA and the affected makes it difficult for them to come to terms with the fact of living with HIV or having to care for someone who living with HIV. (Unit 1 gives a detailed treatment of the plight of both PLWHA and the affected). Because of their unique situation they require a lot of care and support.
Activity 4

Let us say, you have gone for an HIV antibody test. The result has come out positive.

1. How do you feel?
2. What are your worst fears?

Who Needs HIV&AIDS Counselling?

A response to this question requires that we talk about HIV testing first, as HIV&AIDS counselling is done in view of testing. There are a number of reasons why people go for an HIV&AIDS test. But everybody who goes for an HIV test is encouraged to do Pre-test and Post-test counselling (A pre-test counselling is counselling done before HIV test and post-test counselling is counselling done after HIV test and these are discussed in more details in Unit 5). So, everybody who goes for an HIV test, mandatory or willingly, needs HIV&AIDS counselling. Let us see reasons why people go for an HIV test. It can be for:

- Insurance purposes
- Because of exposure to risky practices or activities (behavioural or not)
- People who have HIV&AIDS unfounded phobias
- Clients who are infected with HIV or other HIV related ailments
- Marriage plans
- To know your status so that you avoid self-exposure

Regardless of the reason for the HIV test may be, any of the above persons qualifies for HIV&AIDS counselling. HIV&AIDS counselling may also be offered to people who though not infected are family members of a PLWHA.

Read the following story and answer the questions that follow.
John was in taxi. He came back home panicking that one person, a well known HIV activist, had sneezed in the taxi and has therefore infected everybody else including him.

1. Is John’s fear founded?
2. Take a pen and a paper and say how you would help John with his fears.

Being an Effective HIV&AIDS Counsellor

HIV&AIDS Counselling is a specialized type of counselling. It requires special training and preparation. A good professional counsellor is, therefore, not necessarily a good HIV&AIDS counsellor. Over and above the qualities and skills that are expected of a professional counsellor, an effective HIV&AIDS counsellor needs to have:

- Basic knowledge of facts around HIV&AIDS: Origin, myths, modes of transmission, symptoms and diseases associated with it, diagnosis of HIV infection and AIDS, management of HIV infection, care and support services.
- Right attitude: An HIV&AIDS counsellor must be impartial and non-judgemental, genuine, open minded, ability to maintain confidentiality, empathetic, awareness of strengths and limitations and the right motivation for helping others.
- The desire to learn by doing more: Like any other type of counselling, HIV&AIDS counselling is best acquired through practice. Though every individual who comes for HIV&AIDS counselling is unique, every encounter provides an opportunity for learning more about the skills of counselling.

Ask your friend to say what your attitudes are with respect to being or not being judgemental, being open-minded, ability to maintain confidentiality and the motivation for helping others.
Role of HIV&AIDS Counsellor

In any HIV&AIDS counselling transaction the role of the counsellor is to:

- Create and non-judgemental atmosphere of trust and confidentiality
- Listen fully and actively
- Provide accurate and consistent information in clear and simple terms
- Clarify misconceptions
- Provide options and leave choices open to client
- Explore and identify together with the client barriers to using risk reduction behaviour
- Develop together with a client a plan to connect with needed resources.

Activity 7

1. List some of the common misconceptions regarding the origin, transmission and cure of HIV&AIDS in your context.
2. Critically analyse the reliability of these misconceptions.

VCT and CTC

What is VCT?

VCT is a common abbreviation in HIV&AIDS counselling. It stands for Voluntary Counselling and Testing. It combines two important activities, namely counselling and testing. We know from the preceding units what counselling is. Testing refers to an accurate scientific test done on a person’s blood, to see if a person has been infected with HIV.

It is clear from the preceding units that counselling is an important element in the response to HIV&AIDS epidemic. Through counselling, PLWHA and those affected by
HIV are given information, advice and support in coping with their situation. Testing as a process requires counselling, as people need to be prepared emotionally for the outcome.

These two activities are qualified by the term voluntary. Voluntary means that a person decides on their own whether or not to have a test. VCT can, therefore, be defined as an intervention initiated and entered into freely by the client with a view to explore and understand his/her HIV risks and to learn about his/her HIV status.

Voluntary Counselling and Testing has emerged as a proven HIV prevention and care strategy in a number of countries especially in Africa.

Activity 8

“Voluntary counselling and testing has been named a proven strategy and an integral part of HIV prevention.”

Give a critical analysis of this statement.

Goals of VCT

- It helps people to know their current HIV status.
- It helps in the prevention of HIV transmission and acquisition in the following:
  - from HIV positive tested people to untested or HIV negative partners
  - from HIV positive mother to child
  - acquisition by HIV negative tested person from HIV positive or untested person
- It facilitates early and appropriate access to services, such as medical, psychosocial and others.

What is CTC?

CTC is a recent abbreviation that emerged in the Zambian context. It stands for Counselling Testing and Care. It represents a new vision that responds to the signs of the
21st century. According to the Ministry of Health of Zambia (2003: 116) what CTC has added to the concept of VCT is greater emphasis on care and defining priorities with renewed resolve and affirmative action.

CTC requires that counselling be given as a matter of routine for all chronic illnesses as well as other social and psychosocial concerns. Testing too should not be restricted to HIV&AIDS. It should extend to other opportunistic infections. The care component ensures that those who are directly or indirectly affected by HIV&AIDS and other chronic illnesses are supported and cared for. The emphasis in CTC is not so much on testing out of free will. It is rather on taking affirmative action which is clearly manifested in self-disclosure, partner notification, preventing further transmission and greater involvement in HIV&AIDS activities. The above actions are, in a way, proactive modalities of providing care and support. How can you say you care if you do not disclose, notify partner or engage in HIV&AIDS activities aimed at prevention, education and support?

**Goals of CTC**

Counselling, Testing and Care aims at achieving the following:

- Provision of factual information on HIV&AIDS
- Provision of counselling routinely for all chronic illnesses
- Provision of testing facilities for all chronic illnesses
- Provision of quality preventive and support care services.

**Components of CTC**

- Information, education and communication (IEC) component: It aims at mobilising communities to participate in CTC services, to create awareness about HIV&AIDS and promoting risk-reduction behaviours.
- The pre-test and post-test counselling component: Pre-test done before the test ensures that reasons for test are established and that implications of the test are
explored. Post-test, done after the test ensures that implications of a result for self, family and community are explored.

- The testing component: involves the testing strategies and the type of tests.
- The supportive care component: refers to the physical, emotional, social and spiritual support due to PLWHA and those affected by HIV&AIDS.

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**Activity 9**

1. *Compare and contrast VCT and CTC as explained above.*
2. *In what ways can you say CTC is an improvement on VCT?*

**SUMMARY**

In this unit we have learnt the following:

- HIV & Counselling is a specialized type of counselling which emerged with the advent of HIV&AIDS epidemic
- The aims of HIV&AIDS counselling are to prevent transmission and to provide psychosocial support to those affected
- Over and above the counselling skills and techniques required of an effective counsellor, an HIV&AIDS counsellor needs to have:
  - Basic knowledge about on HIV&AIDS
  - Right attitude
  - Desire to learn by doing more
- VCT is an entry point for HIV&AIDS prevention treatment and care.
- Over and above the advantages of VCT, CTC emphasizes a care component beyond testing; it also emphasizes that counselling should be given as a matter of routine and that testing should not be restricted to HIV&AIDS alone but should extend to other conditions.
SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. Define HIV&AIDS counselling in your own words.
2. Outline and discuss the aims of HIV&AIDS counselling.
3. In what way can primary prevention take place in classrooms, youth clubs, sports organizations, church groups and informal gatherings?
4. Discuss the content of secondary prevention according to Nwoye.
5. Outline and discuss qualities and skills required of an effective counsellor.
6. According to your experience, what form of emotional and material support do PLWHA and the affected need?
7. If you were to choose a strategy would you go for VCT or CTC? Give reasons for your answer

FURTHER READING


**GLOSSARY**

**HIV&AIDS Counselling**: It is an ongoing dialogue and relationship between client or patient and counsellor, with the aims of preventing transmission of HIV infection and providing psychosocial support to those already affected.

**Transmission**: The spread of the disease-causing organism from one person to another.

**Primary prevention**: Refers to a type of counselling that focuses on people who are at risk of HIV infection but are not known to be infected.

**Secondary prevention**: Refers to a type of counselling that focuses on people known or considered likely to be HIV infected.

**PLWHA**: Stands for people living with HIV&AIDS.

**VCT**: *(Voluntary counselling and Testing)*. A proven strategy for HIV prevention and care.

**CTC**: *(Counselling Testing and Care)* It represents a recent strategy originating in the Zambian context which lays greater emphasis on care, and defining priorities with renewed resolve and affirmative action. This strategy also requires that counselling be given as a matter of routine for all chronic illnesses as well as other social and psychosocial concerns.

**Voluntary**: Done out of free will without any external coercion

**HIV sero-status**: The status of the person’s blood with respect to the presence of antibodies which are indicative of the HIV in the person’ body.

**HIV sero-positive**: Describes a person whose blood shows the presence of antibodies to the infection. It is commonly referred to as HIV-positive.

**HIV sero-negative**: Describes a person whose blood shows no infection with HIV. It is commonly referred to as HIV-negative.
Unit 5

Process of HIV&AIDS counselling

OVERVIEW
Welcome to Unit 5. In unit 4, we defined HIV&AIDS counselling and discussed its aims. We also examined VCT and CTC as strategies for HIV&AIDS prevention, treatment, care and support. In this unit we are going to look at the process of HIV&AIDS counselling. This process involves pre-test counselling and post-test counselling which can be called procedures for both VCT and CTC. Supportive counselling and crisis counselling which, logically and in terms of sequence, follow a post-test counselling are also discussed.

OBJECTIVES
At the end of this Unit you should be able to:

- Define pre-and post-test counselling.
- Identify the steps of pre-, post-test counselling and counselling.
- Describe supportive counselling.
- Analyse the concept of crisis.
- Outline and discuss the steps in dealing with a crisis situation.
TOPICS

- Pre-test Counselling
- Aims of Pre-test Counselling
  - Conducting a Pre-test Counselling
    - Step 1: Establishing a Relationship
    - Step 2: Risk Assessment
    - Step 3: Decision Making
- Post-test Counselling
- Aims of Post-test Counselling
  - Conducting a Post-test Counselling
    - Step 1: Sharing the News with the Client
    - Step 2: Risk-reduction Plan
    - Step 3: Partner Notification
    - Step 4: Supportive Care
- Supportive Counselling
- Crisis Counselling
  - Components of a Crisis
  - Types of Crisis
  - Definition of Crisis Counselling
  - Dealing with a Crisis Situation

Summary
Self-assessment
Further reading
Glossary
Pre-test Counselling

We will start by defining the term pre-test counselling. We will also discuss the aims and the points that should be covered in a pre-test counselling. You have probably heard of pre-test counselling before. The word is self explanatory. It is made up of three words which explain its meaning. There is pre- which means before. We should be familiar with the meaning of test from Unit 4; we also know from Unit 2 what counselling is.

So pre-test counselling would be a counselling process that is undertaken before the test. It is normally done before an antibody test. A client is strongly encouraged to go for pre-test counselling before doing an HIV antibody test. We should, however, remember that the decision to test and to go for counselling lies with the client.

Aims of Pre-test Counselling

The aims of pre-test counselling are:

- To provide information on the technical aspect of testing.
- To ensure that any decision to test is fully informed and based on the understanding of the personal, medical, legal and social implications of both positive and negative results
- To provide necessary preparation to those who might be traumatized by a positive result
- To discuss the test as a helpful act linked to changes in risk-behaviour

Activity 1

Make a list of fears and misconceptions that you or other people have about pre-test counselling. After going through the definition and aims of pre-test counselling do you
Conducting a Pre-test Counselling

We now turn to how a pre-test counselling should be conducted and what points should be covered. The pre-test counselling unfolds in three steps.

**Step I: Establishing a Relationship**

This first step in a pre-test counselling is to establish a relationship. Like all other types of counselling, pre-test counselling should build on a good, trusting and professional relationship. Clients who come for counselling, especially in view of HIV testing, do so with a high degree of anxiety and nervousness. A good relationship is therefore important in reducing the anxiety. We will do well to recall the attending skills discussed in Unit 2, which go a long way in facilitating a relationship of trust between a counsellor and a client. Over and above these attending skills, the counsellor should be neutral, respectful, genuine, and empathic toward the client.

A good counsellor would make sure that the following are covered in the first step:

- Introducing oneself: it involves greeting, in a culturally appropriate manner and saying who you are and what you do. This is where a client should also be allowed to introduce him/herself.
- Establishing set of rules: these include a contract that needs to be signed, confidentiality, time available, and boundaries.
- Socializing: it refers to a social conversation around non-threatening issues like weather etc. This should be done if the emotional state of the client allows it.
• Invitation to talk: this is where the counsellor invites the client, in a relatively neutral manner, to relate his/her story by asking one of the following questions or similar ones:  How can I help you Mrs or Mr………. (Mention the name)?
  Mr. or Mrs…what would you like to talk about?
  What brings you here?

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**Activity 2**

You have learnt that establishing a relationship with a client is an important step toward fruitful counselling. Drawing from your own experience, briefly write down ways in which this step can be enhanced.

**Step 2: Risk Assessment**

In this step a counsellor helps the client to make sense of his/her concerns. S/he should make sure that the following issues are covered:

• Assessment of the client’s level of risk (exposure to unprotected sex, drug related behaviour).
• Checking the client’s understanding and knowledge of HIV&AIDS and its transmission
• Clarification of misconceptions and myths around HIV&AIDS.
• Advantages and disadvantages of doing a test.
• Explaining the HIV test (the process, meaning of test results and their implications)
• Help people to prepare for problems they may face in the future and to provide support, for them and their families.

As we go through this process together with the client, we should remember to display an empathic understanding and a non-judgemental attitude. We should avoid asking too many questions that would give the impression that a client is being interrogated. Mc Donnell (2004: 6) rightly observes that when dealing with HIV&AIDS a balance should
be maintained between giving information and finding out how much the client knows about being infected and its consequences.

| Activity 3 |

Get a partner and role play step 1 and 2 of a pre-test session. Exchange roles and remark on how each felt during the conversation.

Step 3: Decision Making

When the client’s understanding of the meaning and implications of an HIV test have been explored, the counsellor should allow the client the liberty to decide. The client after weighing advantages and disadvantages may decide to go or may decide not to go for a test. Alternatively, a client may choose to postpone the test and return later for testing. They may want to discuss the matter with their partners, relatives and friends. Remember that it is their right to choose what they think is best. The best the counsellor can do at this stage is to support the client through this decision making process. If the client is prepared for a test, help him/her with a test and inform him/her how long the results will take. You can then arrange for the follow up session.

| Activity 4 |

Paul (not real name) is 20 years old he was pressured by peers to have girlfriends. He engaged on more than two occasions in an unprotected sex with some of these girlfriends. He has come to you for a pre-test counselling. You have taken him through step 1 & 2. After them (2 steps), he decides, he is not ready to go for a test. What do you say or do to him? Why?
Post-test Counselling

Post-test counselling can be defined as a *counselling process that is undertaken after the test*. A post-test counselling follows upon a pre-test counselling. A well done pre-test counselling lays a foundation of a good post-test counselling. It is therefore advisable that a pre-test and post-test counselling be done by the same person. This is for obvious reasons that:

- A relationship will have been established and this provides a sense of continuity
- Knowledge of a client and what to expect in this second encounter can be anticipated.

Every test counselling encounter is unique. No two clients would come to the counselling session in exactly the same emotional state. The counsellor, too, needs to work, on a constant basis, on his/her feelings.

Aims of Post-test Counselling

The aims of post-test counselling are:

- To communicate the HIV test results
- To help clients understand the meaning of and come to terms with their result
- To help clients express their feelings about the result
- To help clients to make plans for the future
- To help clients to decide on partner notification and other
- To help clients to reduce their risk of infection and infecting others
- To help clients access medical, psychological and spiritual support they need

Activity 5

Imagine you are pre-test counselling a client. Make simple notes on how you would start the session, what points you would cover and how you would end the session. This will help you determine whether you have grasped the main points of the pre-test counselling.
Conducting a Post-test Counselling

Post-test counselling unfolds in four steps, namely: sharing the news, risk-reduction plan, partner notification and supportive care.

Step 1: Sharing the News with the Client

When clients have presented themselves for the results, they are greeted warmly and made to sit down. It is important to check with the client that s/he has come for the results. A counsellor may also ask a client if s/he has anything to ask or talk about before results are given. If a client has issues to raise, s/he should be given a chance to do so. Positive as well as negative can be communicated in different ways. It can be by giving the results to the client to read for him/herself. This has the advantage of helping the client to own up to the result. It can also be done verbally. When the latter method is followed, the news should be given by the counsellor, in clear and simple terms. It may be necessary to find out from the client how they would prefer to have the results.

When giving positive results verbally you may say, for example, “your results are out and they test show that you are HIV positive.” The positive results are often received with shock and distress. A counsellor should allow time for the result to sink in. No two clients would react in the same way to the positive result. Some may be violently angry, hysterical or just petrified. The role of the counsellor at this stage is to be there for the client and to allow him/her to express their feelings in their own way. S/he must be prepared to discuss the meaning or implications of the positive result for the client.

When giving negative results

You may say, for example, “your results are out and they show that you are HIV negative.” A client is often relieved to receive a negative test result. The client must be given the chance to experience the pleasure of not being infected. The counsellor should help explore the feelings of the client and what this negative result may mean for the client. It is necessary to discuss the ‘window period’ and the need to repeat the test after three months to ensure that the client is indeed not infected.
When giving an indeterminate results

There are times when the results of the test do not tell whether the test is positive or negative. This result is called indeterminate or inconclusive. This occurs rarely. When it does, a person should have a repeat test. The counsellor should explain to the client what this result mean and what its implications are. Waiting for results in itself is very distressing. Having to redo the test can be very stressful. A counsellor has to be very supportive to the client throughout this period and should be encouraged to practice safe sex.

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<th>Activity 6</th>
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<td>Imagine that you are a counsellor and you have just communicated a positive result to your client. She breaks down crying. What do you do? What do you say?</td>
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Step 2: Risk-reduction Plan

The risk reduction plan will depend on the nature of the result. In cases where a result is positive, the counsellor should make sure that s/he:

- Asks the client about his/her intensions upon leaving the counselling session
- Assess the client’s social support
- Helps the client to establish a clear plan for medical, physical, dietary and psychological support
- Helps client identify possible actions that may help resolve their problems
- Identify tasks clients may be able to accomplish with the counsellor support.

The risks for transmitting HIV infection to others and the possibility of re-infection should be discussed and planned for. Whatever plan is made it should be within the ability and means of the client. The client should identify with it as his/her own otherwise s/he would not be able to live by it.

A risk reduction plan is equally important even in cases where the result is negative. The client should be helped to make plans to protect themselves. This important goal has to be
accompanied by discussion on clear strategies and skills needed to achieve this risk-reduction plan.

### Activity 7

*Discuss the meaning of risk reduction plan for an HIV positive result, HIV negative result and an indeterminate result. Take your own local experiences into consideration.*

### Step 3: Partner Notification

It may be necessary to inform a spouse or sexual partner whether the client’s HIV test results are positive or negative. The situation will differ depending on the nature of the result and on how the client got infected. A positive result is often more difficult to deal with than a negative result.

In cases where the client’s HIV test results are positive, especially, the decision to disclose becomes difficult. It has consequences for the person living with HIV and people around him/her. It is therefore important that the decision to disclose be planned for and thought through very carefully. The practical way of doing it is to discuss the matter as a ‘what if’. In other words, the counsellor does not tell the client that s/he has to tell the partner but rather to explore ‘What if s/he knows that you are HIV positive? What will be the result?’

The counsellor’s role is to help the client deal with his/her concerns. The counsellor should not, in any way, put pressure on the client to disclose. The counsellor together with the client can play around with or imagine possible reactions in telling others. In that way a counsellor is helping the client to explore his/her feelings and deal with them. Sometimes it may even be necessary for the client to role play telling different people about his/her status. Disclosure is done for a purpose. It is true it has its negative consequences but it has its own advantages. It helps people to:
• Accept their status and reduce stress of coping on their own
• Access medical services, care and support
• Protect themselves and others (for women especially it helps them to negotiate for protected sex).
• Protect their children from HIV infection
• Reduce stigma, discrimination and denial.
• Take responsibility and plan for the future

Take a pause and answer the following questions:

Activity 8

Let us imagine you have gone for an HIV test without informing your partner. The result has come out positive. Would you tell your partner? If not why? If yes how would you put it?

Step 4: Supportive Care

Partner notification or disclosure is a giant step out of isolation and secrecy. The latter are barriers for prevention, treatment, care and support. Partner notification is itself a way of caring for self and others. It is critically important that a client who has had the courage to disclose be given as much support as possible; from partner, spouse, family and friends. The counsellor comes in to help a client identify where, when and how to access support and how best to deal with his/her HIV positive status. Professional support (counsellors, health workers’) becomes easier if support from partner, spouse, family and friends is secure.

Let us take a brief pause and do the following exercise:
Activity 9

_Critically discuss how partner notification enhances prevention, treatment, care and support in HIV&AIDS situations._

Supportive Counselling

Supportive counselling in the context of HIV&AIDS is a _process aimed at empowering HIV positive clients and those affected by it to live positively_. Living positively means living as normal as possible and looking after one’s physical, psychological and spiritual health and well being. People living with HIV&AIDS face a lot of psychosocial, spiritual and financial problems. They therefore need a lot of support. This support can come from counsellors, health workers, family members and the wider community. It only depends on the nature of problems being presented by the client. While support may be given by a lot of people, supportive counselling as a specialized form of support can only be given by people who are trained in it. The aims of supportive counselling are to:

- Empower clients to manage their own problems
- Help clients realize and mobilize resources for their benefit
- Help clients identify and appreciate strong and positive aspects of their lives that they might otherwise overlook
- Empower clients to take control over their lives
- Empower clients to develop skills for problem solving and decision making.

Activity 10

_Find out how many support groups there are in your own community and what kind of support they offer. Basing yourself on the HIV&AIDS related problems in your_
Crisis Counselling

You have always heard people say that they are in crisis. You may have said so of yourself. We experience a catastrophe like the tsunami and we say it is a crisis. We see a terrible accident we say it is a crisis. What exactly do we mean? Do we mean the accident itself or what happens as a result of an external catastrophic event, is a crisis? How can we define crisis?

Crisis can be generally defined as a difficult situation, a life-threatening event or an emergency situation that requires an immediate attention. Technically, however, a crisis is an individual’s internal reaction to an external hazardous event. Though our definition speaks of crisis in relation to an individual, we must not forget that a crisis may also happen to a family or a community. It is clear from this definition that a crisis takes place inside a person. But it is however triggered by something that happens outside.

Components of a Crisis

According to H.W. Stone, a crisis as an event consists of four major elements, namely: 1) precipitating event or stimulus 2) appraisal 3) resources and coping methods and 4) crisis (1993: 12). Let us now look at these individual components of a crisis.

A precipitating event is an external hazard such as loss of a job, death, divorce or being HIV positive. Divorce or death is not a crisis it can trigger a crisis. The way in which a person is going to perceive an event will render it a threat or a non-threat. If the event is perceived as a threat to their well-being, then this perception of an event by an individual is what we call appraisal. It refers to the individual’s perception of the external event as a threat or a non-threat. When an event has been perceived as a threat, then the individual’s coping abilities and resources are mobilized to deal with the perceived
threat. If the person’s coping resources are able to deal with the threat, a crisis will be forestalled. If one’s coping resources are not able to deal with the threat then a crisis will occur. So a crisis should not be confused with an external hazardous event. Stone (1993: 13) rightly observes that a crisis happens within people or families as a response to that external hazardous event.

Types of Crisis

There are two basic types of crisis, namely: developmental crisis and situational crisis. Developmental crisis refers to the normal, predictable experiences that one goes through in his/her growth process. Menstruation often times pose problems for young girls who reach the age of puberty. This would be an example of a developmental crisis. Situational crisis are unpredictable and they have an element of upheaval that poses a threat to an individual’s coping resources. Death, divorce, being HIV positive may be unpredictable and threatening to an individual’s coping abilities. We should however remember that people are unique and as such they may perceive an event in different ways depending on their experiences, coping resources and the manner in which the event took place.

Activity 11

Recall a crisis that you or somebody you know had to go through. What was the precipitating event? If it happened to you, explain in a paragraph what the feeling was like. If it was somebody how did you get to know?

Definition of Crisis Counselling

Crisis counselling refers to a strategy or method of helping individuals and systems to cope with emotionally decisive and life-threatening events in their lives. The fact that HIV&AIDS is an incurable medical condition, threatens people from many fronts. As such it has the capacity of knocking someone off balance. Learning that one is HIV
positive can evoke feelings of anger and intense fear. These can be expressed in different ways depending on the individual’s internal and external coping resources.

**Dealing with a Crisis Situation**

From the preceding discussion on crisis and crisis counselling, it becomes very clear that people respond to situations of crisis in different ways. It would be quite easy for counsellors to deal with situations of crisis if 1) external hazardous events were the same 2) people’s reaction to that hazardous event were the same and 3) clients’ internal and external coping resources were the same. But this is not the case and as such it becomes difficult to propose a ready made answer for all situations. We can only suggest some guidelines of how a counsellor should react given a situation of crisis. The rest would be left to the personal and individual spontaneity and imagination of a counsellor.

People’s reactions to the news that they are HIV positive, vary considerably and they can be very unpredictable. In some cases even the pre-test counselling does not help to give a clue of what to expect. An HIV&AIDS counsellor needs to be prepared for this. The immediate concern of the counsellor in a crisis situation is to normalize the situation and the underlying causes later. The counsellor has to remain calm. S/he should remember to allow the client to speak freely and ventilate his/her feelings.

When the situation has been normalized, then the counsellor first task would be to identify the kind and the deeper causes of the crisis. Secondly, the counsellor has to help the client understand the nature and cause/s of the problem (which they do not understand in most cases). This will help in bringing the situation under control for the time being. Lastly, the counsellor has to help the client to look for a program aimed at bringing long term stability. This may include medical, psychological, spiritual and social interventions.

**SUMMARY**

This unit has exposed you to four HIV&AIDS counselling interventions, namely: pre-test, post-test, supportive and crisis counselling. Each of these interventions has a specific role to play in the process of helping a PLWHA cope with his/her emerging new
situation. The meaning, the aims and the steps of pre- and post-test counselling have been explored. We have also learnt how to counsel in cases of HIV positive, HIV negative and HIV indeterminate results. Supportive and crisis counselling are particularly helpful during and after the communication of HIV test results.

SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. Discuss the difference between pre-test and post-test counselling.
2. Outline the three steps of pre-test counselling and explain the third step.
3. In what way/s does a well done pre-test counselling lay a foundation for a good post-test counselling?
4. Put down in writing, how you would prepare for the sharing of an HIV test result. Explain how you would communicate it and why that way?
5. ‘Partner notification is a giant step out of isolation and secrecy.’ Discuss this statement.
6. What are the aims of supportive counselling?
7. Outline and discuss the components of a crisis.
8. Would you classify HIV infection as a developmental crisis or a situational crisis? Give reasons for your answer.

FURTHER READING

89


**GLOSSARY**

Pre-test counselling: A counselling conversation that is undertaken before the HIV test.

Post-test counselling: A counselling conversation that is undertaken after the HIV test.

HIV antibody test: A laboratory test made on a small sample of blood to detect whether the body has reacted to the presence of HIV.

Partner notification: Process where a person informs his/her spouse or partner about the outcome of the HIV test. It is used interchangeably with disclosure.

Indeterminate results: This is when an HIV test does not tell whether the test is positive or negative. It sometimes called inconclusive test result.

Supportive counselling: A process aimed at empowering HIV positive clients and those affected by it to live positively.

Crisis: An individual’s internal reaction to an external hazardous event.

Developmental crisis: A normal, predictable experience that one goes through his/her growth process.

Situational crisis: Unpredictable event that poses a threat to an individual’s coping resources.

Crisis counselling: Process of helping individuals and systems to cope with emotionally decisive and life-threatening events in their lives.
Unit 6

HIV&AIDS Counselling and the Affected

OVERVIEW
Welcome to Unit 6. HIV&AIDS counselling is useful not only to people living with HIV&AIDS. It is also useful to people who are in one way or the other related to and therefore have to care for PLWHA such as couple, family and caregivers. We call such people the affected. The role they play in caring for their loved ones often times makes them vulnerable to stress and burnout. It is for this reason that we have a section within this Unit on stress and burnout, their causes and management.

OBJECTIVES
Upon completion of this Unit you should be able to:

- Define couple counselling.
- Discuss how families in the context of HIV&AIDS can be placed where people can be formed, transformed or deformed.
- Outline and discuss different types of caregivers.
- Make a brief comparison between stress and burnout.
- Describe how caregivers are vulnerable to stress and burnout.
- Identify ways of managing stress and burnout.
TOPICS

- Couple Counselling
  - Aim of Couple Counselling
  - Couple Counselling and HIV&AIDS
  - Counselling Challenges
- Counselling the Family
  - Family Counselling and HIV&AIDS
- Counselling the Caregivers
- Stress and burnout
  - Causes of Stress and Burnout
  - Symptoms of Stress and Burnout
  - Stress and Burnout Management

Summary

Self-Assessment

Further reading

Glossary
Couple Counselling

In Unit 5 we have touched briefly on the issue of partner notification as a step in post-test counselling. Here we want to move beyond partner notification to couple counselling. Let us start by defining what a couple is. A couple may be defined as two people living together with a common commitment of love to each other such as that of marriage. Couple counselling would, therefore, refer to a helping relationship that involves a counsellor and a couple aimed at enabling them (couple) to utilize the resources they have to solve or cope better with their problems.

Aim of Couple Counselling

The aim of couple counselling is to provide information on strategies that could be adopted by persons that are married or co-habiting in living more effectively and coping with their problems.

Activity 1

List some of the issues that make couples seek counselling. Take your own local situation into consideration.

Couple Counselling and HIV&AIDS

Couple counselling has been identified as an optimal entry point for HIV prevention, treatment, care and support among persons who are married or co-habiting. For a couple that have gone for a test, a result can be positive or negative for both or it can be discordant. A result is discordant if one partner has tested positive and the other negative.

Where a result is negative, the role of the counsellor is to alert the couple to the question of window period. This refers to a period between exposure to HIV and the development of detectable HIV antibodies. The couple should be informed that the test done during this period may not be a true reflection of their status. Hence it would be
important that the couple be allowed to discuss and decide on the issue of safer-sex practices and to try another test after 3 months.

In cases of an HIV positive result for both couples, the role of the counsellor would be to discuss the risk of re-infection, pregnancy and breastfeeding and the use of condoms properly and consistently.

**For a discordant couple**, the counsellor should focus on helping the couple to work on a plan to reduce chances of infection of the HIV negative partner. The issue of window period is equally valid. It, therefore, has to be raised with the couple. The issue of child bearing in marriage ranks high in Africa. Its implications for the couple, their health as well as that of a child, should be thoroughly explored. This will make it easier for the couple to make an informed decision.

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*Thomas and Grace couple is discordant but they would love to have a child. They have approached you for counselling. Explain 3 issues you explore with them and what would be your role as a counsellor.*

A question may be asked if a couple should be encouraged to come together for counselling. If a couple decides to come together for counselling this is indeed useful in a number of ways.

- It ensures that both receive pre-test counselling together, which prepares them emotionally and psychologically to conduct the test
- It creates an atmosphere of trust between the couple
- It promotes commitment to remain negative
- It enhances adoption of risk reduction behaviour
- It encourages support and commitment to positive living in cases where both partners are HIV positive or discordant.
Ideally, couples must be encouraged to counsel, test and receive results together. In cases where one partner receives results alone, s/he must be encouraged to notify the other partner. If a partner is not ready to disclose the HIV result to their partner, s/he should not be coerced rather s/he should be allowed time for reflection.

Activity 3

In half a page discuss whether it is better for a counsellor to counsel the couple together or separately. Take your own local context into consideration.

Counselling Challenges

Couple counselling has its own specific needs and it also presents counsellors with a lot of challenges. Let us give some few examples of such needs and challenges. Not all couples prefer to come for counselling together. A partner who knows that s/he has been exposed to risky behavioural patterns, would not want to go through counselling, test and receive results in the presence of a spouse. Others, who for want of a valid reason to refuse the idea of joining the spouse for a test, would go, and on testing positive would resort to violent behaviour against the spouse. This is the case for the majority of women who are seen as culprits for the infection of their husbands or partners.

But when an individual prefers to do counselling alone, then the counsellor should avail him/herself to help, for the counsellor’s role is to help each individual to cope with his/her emotional reactions to the test results. Even those who chose to come together are not without their problems. One counsellor in UNAIDS, Knowledge is power, shares an experience thus:

“Some of our most challenging cases are couples who arrive seemingly healthy and discover they are discordant…If the husband is positive, sometimes he will say: “I have been with my wife for a long time and she has not been infected yet. Why should we start using condoms now?” He
will take the free condoms we offer and the wife will return later and tell us he is refusing to use them” (1999: 31).

UNAIDS, further observes that:

- Overall clients who come for counselling as couples have much lower rates of infection than those who come as individuals.
- Among couples already married, 18% are discordant and 15% are both infected
- It is difficult to share discordant results to couples who practice unprotected sex.
- It is difficult to explain negative results to couples engaging in high-risk behaviour (1999: 31-32).

The counsellor’s role would be to help the client to think through the reasons for opting for the test.

In couple counselling, the counsellor should:

- Avoid taking sides (this is called the skill of neutrality).
- Avoid getting involved in any blaming
- Avoid telling the couple what to do
- Avoid talking on behalf of one partner
- Facilitate informed decisions and choices
- Allow both partners equal time to talk
- Encourage shared responsibility
- Encourage joint planning and consensus
- Support the couple emotionally (Ministry of Health:Zambia 2003: 136).
Activity 4

Imagine that your friend has tested HIV positive and his/her partner has tested negative and yet they have been practicing unprotected sex. How do you label such a couple? Explain what make it difficult for a counsellor to share such results?

Counselling the Family

H. Clinebell (1984: 244) contends that the family is the garden of human personality – the primary place where persons are formed, deformed, and (hopefully) transformed. As such the family becomes the very important source of support for every individual that comes for counselling.

Activity 5

Give your own understanding of family. In half a page discuss ways in which families resolve their own problems in your culture.

The family here is understood as group of people that interact closely with each other because of biological and other ties (A. Haworth 2001: 50). The family, therefore, has a life of its own consisting of interdependent individuals or subsystems. As such, whatever affects one part (individual) of the family automatically affects all others. This is what is referred to as systems approach to counselling. This approach corresponds to the way an African sees the world around him/her, where everything is interconnected. In most African countries the concept of community is entrenched in our societal structures. An individual can only be defined in relation to the family or community. M.W. Dube articulates this well in her module on a Theology of Compassion (Unit 4). Every
individual, therefore, has the moral obligation to contribute positively toward the good name of the community which includes both the living and the living dead.

Let us look at how this approach (systems approach) is important in addressing the problems of an individual living with HIV&AIDS and the affected family?

- It makes reference to the family and community lives in resolving problems
- It takes into account the total environment of the individual
- It looks at the context of the individual’s problem, be it at community, family, peer group or organisation
- It focuses on mobilizing the natural supportive resources available

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<td>Community and family life is a common feature of most cultures in Africa. List some of the values of community or family life that can be used to enhance care and support for people living with HIV&amp;AIDS.</td>
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**Family Counselling and HIV&AIDS**

According to family systems approach whenever a member of the family is living with HIV&AIDS, the rest of the members are directly affected by that individual’s infection. This new situation or challenge forces the family to adapt. Our experiences are that families adapt differently to a situation of a member living with HIV&AIDS. Some families choose to isolate, reject or stigmatise such a member. Others provide support and care to a person living with HIV&AIDS. In either case such a member influences the behaviour of the system (family) and the system (family) influences the member living with HIV&AIDS. Any counselling done under these circumstances focuses not on the individual member living with HIV&AIDS, but on the relational process between both the member and the family. By counselling the family, we are preparing a place for all
members of the family (infected and affected) to be formed and transformed on a continual basis. Counselling the individual without rehabilitating the place where s/he lives is counterproductive and anti-therapeutic. This does not only perpetuate the illness of the individual it also perpetuates the illness of the family for an injury to one member is an injury to the whole family.

The **Systems Approach**, which is useful in counselling families, does not detract much from the counselling principles that apply to individual counselling. The only difference is that the family, rather than the individual, becomes the client. In such a situation the counsellor focuses on:

- Helping the family to identify their problems, concerns and issues about the virus in the system/family (current scenario)
- Helping the family to say what they want or need within limits imposed by the virus (preferred scenario).
- Helping the family identify what they need to do (strategies)
- Helping the family to implement strategies with view to living more effectively with problems created by the virus (action).

## Activity 7

*Imagine yourself counselling a family affected by HIV&AIDS. Write down your conversation with the family and as you do that remember to include:*

1. **What the family is saying to you?**
2. **What you are saying to them?**
3. **What you are doing?**
4. **How do you respond to the feelings shared by the members of the family?**
Counselling the Caregivers

In the context of HIV&AIDS, the caregivers are the people who in one way or the other look after the welfare of people living with HIV&AIDS or their survivors. According to the study done by UNAIDS (2000: 13-24), in South Africa and Uganda caregivers for PLWHA are made up of different groups and individuals. These typically include:

**Carers in family:** With the epidemic gaining momentum each day, the demand for carers far outstrips the capacity of the health services and workers. As a result the role of caring is borne non-professional carers within families. UNAIDS (2000: 60) calls these people, and rightly so, a precious resource. At the family level, the burden of care is predominantly borne by women and children. While men are also increasingly rising to the challenge of caring for the sick, children are forced by circumstances to care for their ailing parents who have nobody to look after them. We need to mention from the outset that care-giving in an African context is a way of life. It is emanates from the African understanding of being human. To say, ‘*Motho ke motho ka batho*’ (a person is a person through others) imposes upon us as members of the community to do to others what we would expect them to do to us when we are in their situation. To care for others is giving back what was entrusted temporarily to my care.

**Volunteers:** At the community level one least acknowledged resource are volunteers. These are the people who, for one reason or the other, dedicate their time and energy to giving service to the community. Volunteers may be informal or formal. **Informal volunteers** are friends, neighbours and church members who care for the sick out of love or duty. **Formal volunteers** are mostly people recruited, trained and supervised by organisations responsible for AIDS care programmes.

**Health care professionals:** This group is mostly made up of nurses, counsellors and social workers. They work directly with clients or families themselves. Their responsibility is, mainly, to train and support volunteer carers in the community.

**Indigenous healers:** These are among the most widely consulted practitioners in Africa. However the role they play in the treatment and care of people living with HIV&AIDS is
yet to be recognized in other countries. Some of the concoctions they prescribe to their patients (such as African potato) have been found to be useful. It is just that they need to work together with western trained doctors who could help with proper regulation of dose and identify ones that could not be taken together with ARVs. In Lesotho, for example, some western trained doctors encourage people living with HIV&AIDS who consult traditional healers to bring along some medicine they got from them.

Activity 8

We have said above that responsibility of care at the family level is borne mostly by women. Why do you think this is the case? Explain and illustrate your answers through examples. Suggest and put down in writing ways in which other groups at family level can be encouraged to help in providing care to people living with HIV&AIDS.

Stress and Burnout

Stress and burnout are used together so often that it would appear they mean one and the same thing. It is true that the two terms are closely related but technically they are different. Burnout is a stress experience that results from being over involved in interpersonal relationships with clients. Stress on the other hand does not have to be a burnout experience. It is not necessarily related to over involvement with clients. A person who is not able to cope emotionally with the demands of work for example is likely to experience stress. It is in this sense that Haworth defines stress as an emotional imbalance between demand and ability to cope with a situation (2001: 88). The nature of the work that caregivers do renders them most vulnerable to stress and burnout.
Activity 9

Write about the experience of stress or burnout you or the person you know have gone through as a result of HIV&AIDS. How did you or s/he feel? What were the causes of these stress or burnout experiences?

Causes of Stress and Burnout

We now focus our attention on the main causes of stress and burnout. HIV&AIDS is an incurable condition responsible for the death of millions of people. It causes a lot of suffering and is heavily stigmatized; it affects relationships and families; it forces people to care for others, with inadequate training, skills and preparation for the work. Having to work under such conditions can be very challenging.

UNAIDS (2000: 39) lists the causes of stress and burnout among care professionals and volunteers working with HIV&AIDS care programmes as financial hardships, stigma associated with HIV&AIDS, oppressive workloads, over-involvement with PLWHA and their families and fear if infection.

Financial hardship: The words of a training officer in Uganda, “The messages about living positively, eating well, looking after your health, can seem cruel when people are struggling to bring food to the home” and those of a volunteer caregiver in KwaZulu-Natal, South Africa “We go to see hungry people and we are hungry too” are a reflection of financial hardships that caregivers have to go through (UNAIDS, 2000: 28).

Stigma associated with HIV&AIDS: HIV&AIDS related stigma has a negative impact on both the PLWHA and the caregivers. Caregivers are avoided by families and friends and the society for working with PLWHA. This adds the burden on the already overwhelmed caregivers.

Oppressive workloads: There is always pressure to achieve from inside and from outside. Often times HIV&AIDS programmes are funded by donors who have specific targets and deadlines failing which there is always a fear of losing support. There is also
pressure from inside- from individuals failing to recognize what is do-able in the face of overwhelming need. This forces caregivers to push themselves beyond their own limits.

**Over-involvement with people with AIDS and their families:** In countries where almost every family is affected by HIV&AIDS, becoming over-involved is not a matter of choice. At work one is involved with HIV&AIDS as a duty and at home one is involved as a matter of must. As a result the risks of stress and burnout are very high.

**Fear of infection:** With or without information and education caregivers are living with a danger of exposure to infection. This is especially true in cases where the demand for service far outnumbers the resources of an individual facility.

There are many other causes of stress and burnout which we can only mention without any discussion for lack of space such as:

- The fact of AIDS being incurable
- Inadequate support and supervision
- Lack of clarity about what caregivers are expected to do
- Lack of recognition for work done by volunteers
- Lack of medication and health care materials.

**Symptoms of Stress and Burnout**

Stress and burnout, though technically different have more or less the same symptoms. These symptoms manifest themselves in a variety of ways ranging from mild, moderate to severe. The most common signs and symptoms include:

- Loss of interest in and commitment to work
- Failure to observe punctuality and neglect of duties
- Feelings of inadequacy, helplessness and guilt
- Loss of sensitivity in dealing with clients
- Loss of quality in performance
- Irritability
- Sleeplessness
Caregivers are an extremely important resource in the care and support of PLWHA and the affected. No family or society, therefore, can afford to lose its caregivers to stress and burnout. There is therefore a need for helping caregivers with skills for taking care of themselves. This is the matter for the next section.

### Activity 10

You have related the experience of stress or burnout you or somebody you know experienced in the previous activity. Say what symptoms you or s/he experienced and in what ways they affected your or his/her work, relationship and health. Did anybody help you or him/her to manage? If somebody helped in what ways did s/he help? If you or s/he managed without external assistance, how did it happen?

### Stress and Burnout Management

Stress and burnout can be attributed to physical, psychological and spiritual causes. Helping people especially in the context of HIV&AIDS requires a lot of physical involvement (washing clothes, cooking, feeding, and turning the sick). It affects people mentally and emotionally (thinking about what should/could be done). It further involves religious or spiritual issues (what have I done to God to deserve this?) A comprehensive approach to its management has to take into consideration all these aspects. The following approaches and skills can help caregivers in working with people living with HIV&AIDS:

**Realistic expectations and performance goals:** Every caregiver should know their strengths and their limitations. Their expectations and goals have to be set and achieved within their own limits and strengths.

**Care for self:** There is no better medicine for stress and burnout than taking care of oneself. This means eating a balanced diet, taking enough rest and keeping one’s body healthy by regular exercising. The observation of Anne Finnegan, the director of a Life
Line branch in South Africa is equally valid for caregivers. She says, “We impress upon our counsellors the importance of looking after themselves, pointing out that if they allow themselves to get sick or burnt out they will be unable to help anyone” (UNAIDS, 2000: 46).

**Using support system:** Support, both at a personal and organisational level is a must for caregivers who are working with PLWHA. At a **personal level** they should talk to and use their spouses or partners as their support systems. At the **organisational level**, caregivers should be encouraged to form their own social and spiritual support groups or clubs if none are in existence. They should also avail themselves of counselling opportunities as they are very useful in remedying stress-related problems. **Team work:** working as a team ensures equitable distribution of labour to spread the burden of care among all members.

**SUMMARY**

In this Unit you have learnt mainly about HIV&AIDS counselling with respect to the couple, the family and the caregivers. I hope you have noted the importance of couple counselling especially in the context of HIV&AIDS. The family is ideally a place and a context of personality formation. Unfortunately this is not always the case, especially in the context of HIV&AIDS. Sometimes a member living with HIV&AIDS is not accepted sometimes s/he is accepted. Whatever the case, the whole family has to be afforded counselling. I have also indicated that caregivers in their different forms are an important resource in situations of HIV&AIDS. Their greatest enemy is stress and burnout. They (caregivers) or indeed other people involved in the work with PLWHA are likely to experience stress and burnout. It is therefore important that they should be exposed to ways of managing stress and burnout such as setting realistic goals, caring for self, using available support system and working as a team.
SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. Define couple counselling in your own words.
2. Discuss the role of a counsellor in situations where a couple is discordant.
3. What are the advantages and disadvantages of having a couple go together for counselling?
4. In your cultural context, who are most likely to go willingly for counselling especially counselling for HIV&AIDS, men or women? Give reasons for your answer.
5. Discuss the principles that should guide a counsellor in counselling a couple.
6. Explain why it is important to counsel the family of a PLWHA.
7. Describe systems approach and its importance in counselling families.
8. Care-giving in an African context is a way of life. Discuss this statement.
9. What are the common causes of stress and burnout in HIV&AIDS situations?
10. Discuss ways in which HIV&AIDS related stress and burnout can be managed.

FURTHER READING


**GLOSSARY**

**ARVs**: Antiretroviral drugs. These are the drugs that are given to people whose CD4 count is below 200 to help boost their immune system.

**Couple**: Two people living together with a common commitment of love to each other such as that of marriage or co-habitation.

**Couple counselling**: Is a helping relationship that involves a counsellor and a couple the aim of which is to enable them (couple) to utilize the resources they have to solve or cope better with their problems.

**Discordant couple**: Used often in HIV situations when one partner has tested HIV positive and the other HIV negative.

**Caregiver**: This is the term used of people, professional and non-professional who care for people who are sick as a result of AIDS.

**Volunteers**: These are the type of caregivers. They are the people who, for one reason or the other, dedicate their time and energy to giving service to the community without expecting payment in return.

**Formal volunteers**: They are volunteers recruited, trained and supervised by organisations responsible for AIDS care programmes.

**Informal volunteers**: They are volunteers such as friends, neighbours and church members who care for the sick out of love or duty.

**Stress**: Is an emotional imbalance between demand and ability to cope with a situation.

**Burnout**: Is an individual stress experience that results from being over involved with clients.
Unit 7

HIV&AIDS Counselling and Special Cases

OVERVIEW

Welcome to this Unit 7 of our module. This Unit deals with the application of HIV&AIDS counselling to abused clients, pregnant women, orphans and the terminally ill. We have referred to these as special cases for want of a better term that could encompass these experiences. Abuse in itself is a traumatic experience. It becomes even more traumatic when a survivor of abuse becomes HIV, positive as a result of abuse. Pregnancy has its emotional turmoil. That, coupled with abuse as well as social injustices and power leverages that often favour men, makes it a unique experience. The experiences of orphans have lasting physical and psychological effects on them and these present counsellors and indeed the whole human race with immense challenges. We will also look at the specific counselling needs of terminally ill people. Lastly, we will deal with grief and grief counselling.

OBJECTIVES

By the end of this unit you should be able to:

- Define abuse and its different forms.
- Describe signs of abuse in abused clients.
- Identify the unique experience of pregnant women in HIV&AIDS contexts.
- Discuss the experience of orphans in situations of HIV&AIDS.
- Describe the specific needs of the terminally ill.
- Discuss grief, grief counselling and stages of grief process.
TOPICS

• Counselling Abused Clients
  ➢ Forms of Abuse
  ➢ Women, Girls and Abuse

• Counselling Pregnant Women

• Counselling the Orphans
  ➢ Impact of HIV&AIDS on Children

• Counselling the Terminally ill
  ➢ Specific Needs of Terminally ill People
  ➢ What do Terminally ill People Require from a Counsellor

• Grief Counselling
  ➢ Definition of Grief Counselling
  ➢ Grief Counselling and African Culture

Summary
Self-Assessment Activity
Further Readings
Glossary
Activity 1

1. In one sentence define abuse in your own words
2. Name two of the most common forms of abuse in your locality
3. Who are mostly the perpetrators and who are the victims of these two common forms of abuse?

Counselling Abused Clients

We have certainly heard people use the word abuse. We have probably used it as well. What is abuse? How can we define it? The Brainy Encyclopaedia defines abuse as a general term for the misuse of a person or thing, causing harm to the person or thing (www.brainyencyclopedia.com). Though from the definition above, a thing or a person can be an object of abuse, our concern is on abuse that is directed at human beings. Someone who is abused is someone who is treated badly or misused or harmed. Abuse can affect anyone: women, children and men, though, generally, women and girls are the ones who suffer mostly from abuse. T.M. Hinga asserts that women, from a very tender age, are vulnerable to sexual abuse by the so called ‘child molesters’ (2000: 138).

Forms of Abuse

Abuse takes place, mostly, in families but it is also found in the workplace, schools, public domain and in religious institutions. Abuse can take different forms. It can be physical, sexual, emotional, or it can be a combination of any or all of the above forms. Physical abuse is where a person inflicts physical violence or pain on another. It involves actions that cause physical injury or physical pain to the other party. It includes hitting, kicking, whipping, beating and throwing things at someone. Sexual abuse is an improper use of another person for sexual purposes without their consent or under physical or psychological pressure. Sexual abuse includes inflicting pain during sex or not allowing the partner to use protection against STI/HIV. Emotional abuse is where a person uses emotional or psychological manipulation to compel another to do something they do not want or that is not in their best interest. It is sometimes called psychological abuse.
All these forms of abuse may be entrenched in and fuelled by culture or religion. Wife beating has become a norm in some societies. In religious institutions or churches some abusive behaviour is justified on biblical grounds. For example, some people would say that wives are expected to submit to their husbands failing which they need to be disciplined. It needs to be said that these are selective and erroneous interpretations of the Bible and have to be condemned.

Activity 2

1. Take a pen and a paper and write an experience of physical abuse done on you or someone you know. What are your feelings as you look back on it?
2. In a paragraph, write down the form of abuse that men and/or women are likely to experience. Give reasons and examples for your answer.

Women, Girls and Abuse

We have noted that generally, women and girls are more vulnerable to abuse than their male counterparts. In South Africa, studies show high rates of HIV infection in women who were physically abused, sexually assaulted or dominated by their male partners (www.powa.co.za/display.asp). Given the fact that abusive men are more likely than non-abusers to be HIV positive, the vulnerability of women and girls to HIV infection is very high. This, together with women’s marginal status in most African societies; power imbalance which renders them incapable of negotiating safer sex practices; violence that goes with the disclosure of their status increase women’s and girl’s vulnerability to sexual exploitation, abuse and HIV&AIDS. The following story will help us have a feel of the unique experience of women in HIV&AIDS situations:

“A high schools teacher shot himself dead, his wife and mother-in-law and critically wounded his father-in-law before killing himself…..a note written on a brown paper which read: ‘HIV positive AIDS’ was found on top of
Mpho’s (wife) body – According to a relative, the couple went for an HIV test some two weeks ago – She (the relative) suspected that Motloung (husband) had blamed his wife for contracting the virus” (The Sowetan, 23 August 2000).

This story echoes the experiences of the majority of women (to give it a human face – Our mothers, wives, sisters, children) who suffer in silence and die and are not able to tell their stories.

Activity 3

Describe three things that you would do to champion the campaign against the abuse of women and girls in your community.

We now turn to the discussion of the common features in the experiences of the abused clients. For most abused people, abuse was or is not an isolated incident. It tends to characterise a major part of their lives. The following are some of the signs of abuse:

- Abuse evokes in survivors feelings of shame and stigma
- Abused clients tend to isolate themselves as a result of being abused
- Abused clients tend to have a negative perception of themselves
- Abused clients develop a feeling of being betrayed and they tend to mistrust anybody
- Abused clients tend to harbour suicidal feelings.

These experiences make the counselling process of an abused client very special. The three stages of a counselling process discussed earlier should be recalled. It should, however, be remembered that these stages and the features common to them, are not intended as hard and fast rules that cannot be discarded when such a need arises. They should be understood simply as guidelines. We will outline the three stages and simply
refer to them as initial stage, middle stage, and final stage. Let us now identify the common features in each of the three stages.

**Initial stage**

**Trust:** It should be remembered that for abused clients the decision to seek help is not an easy one. It is done amidst threats, feelings of denial and shame. In the first contact, the counsellor should remember that s/he represents both the potential healer and the feared abusive person. The gender of a counsellor plays an important role here. A male counsellor would not be the best choice for a woman or girl that has been abused. The predominant reaction of women or girls abused by their male partners or fathers is that of mistrust for all males. These feelings, therefore, have to be met with assurance that the reason to trust that was denied by the abuser can be reclaimed in the counsellor.

**Setting boundaries:** This refers to agreeing with the client on the frequency and duration of the session. This helps make the session predictable and safer. Walker (1992: 146) warns us to remember that neither caring nor predictable behaviour has been part of the abused client’s experience.

**Controlling the process:** Though, how the session proceeds lies mainly with the counsellor, the client should be assured that they are not mere passengers or spectators but they can take charge of the use, progress and content of the time agreed upon. The counsellor should remember that an abused client should not only be taken seriously but s/he should also feel that s/he is taken seriously.

**Middle stage**

**Facing the abuse:** Once trust has developed, then the client is ready to relate the story. A counsellor needs to be patient as the client may have only vague memories of the experience or s/he may have repressed these memories for some time. Having to bring them back may be a very painful scenario. The counsellor has to be prepared for an outburst of painful feelings, expressed in crying or anger directed at the counsellor.

**Dependency:** The development of trust in the counsellor can also evoke in the client what was denied them by the abusive relationship. They therefore tend to
develop some kind of dependency on the newly found carer. This is not necessarily something negative. It is common to people who have a feeling of having been betrayed. The counsellor should build on their strengths and guide them towards more independency.

Empowering the client: The counsellor has no choice but to believe the story of the client. S/he should listen attentively, empathise and avoid making judgements. A client’s feelings have to be validated. This is because abused clients tend to have mixed feelings about the abuser. They may be angry, afraid, sad, loving, guilty, hoping. They should therefore be allowed time to vent these feelings. They must be assured that these are normal.

Facing abusers: The decision to face the abusers rests entirely with the client. The role of the counsellor is to assist the client through the process, by first looking at the ways of carrying it out and their implications.

Final stage

Termination: It depends on both the counsellor and the client. They have to agree. Some client may on their own say that they are ready, others are unable on their own and therefore need some help to decide. Whatever the case, the decision to terminate has to involve both the counsellor and the client. Whenever done, it should take into account, the client’s level of self-esteem. It should also be done when the losses have been sufficiently mourned and feelings of anger been dealt with. Counsellor should remember that a complete healing may have to wait for another year. Termination does not have to depend on it but on the reasonable and sufficient progress.

Reviewing: This is where the counsellor and the client review the journey they have had together. Clients have to be taken back that road to discover what they have achieved, overcome and missed. Disappointments have to be accepted as part of the journey and successes celebrated. This feature is important as it makes the client own up to the whole process as his/her achievement.

Let illustrate the stages and what happens in each stage through the following diagram:
<table>
<thead>
<tr>
<th>Initial stage</th>
<th>Middle stage</th>
<th>Final stage</th>
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<tbody>
<tr>
<td>Trust</td>
<td>Facing the abuse</td>
<td>Termination</td>
</tr>
<tr>
<td>Setting boundaries</td>
<td>Dependency</td>
<td>Reviewing</td>
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<tr>
<td>Controlling the process</td>
<td>Empowering the client</td>
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<tr>
<td></td>
<td></td>
<td>Facing the abusers</td>
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</tbody>
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**Activity 4**

*Imagine that a young woman girl of 18 years has come to you for counselling. She claims to have been raped repeatedly by her father. She has had to conceal this for years, but she feels she cannot take it anymore. In the middle of narrating her story, she suddenly starts crying and insulting her father, you and all men who are responsible for her suffering. What do you do as a counsellor? What do you say to her?*

**Counselling Pregnant Women**

The situation of women is not confined only to issues of abuse. Most, women as we have shown above have very little say if any at all on issues of sexual relationships in general and safer sex practices in particular. The use of a condom as a protection against infection or as a contraceptive is often a unilateral decision by a husband or male partner. Women, therefore, become pregnant as a result of a forced sexual relationship. In most of these relationships, a husband who has HIV infects the wife who gives birth to an infected child as well.

As a result of their situation, pregnant women often battle with the multiple trauma caused by constantly forced sexual intercourse; pregnancy as a result of that forced sexual relationship; guilty conscience for having to carry the child that is likely to be infected; fear of stigma and discrimination as a result of not breastfeeding the child (this is always associated with the fact that the woman is HIV positive); possibility of terminating pregnancy; lack of support and care from partner.
A counsellor who has to work with pregnant women has to take into consideration all these issues and deal sensitively with them by:

- Empathising with their situation
- Avoiding making judgements
- Refraining from blaming her for the situation
- Listening carefully to her story and her fears in order to identify issues that hurt her most.
- Offering appropriate help and adequate information about HIV&AIDS and the implication for mother-to-child transmission.

Activity 5

Pick up a partner. Imagine that s/he is a pregnant woman and you are a counsellor. She has been suspicious that her husband is sleeping around. She has had to go to the clinic for STD treatment. She reported that to her husband who blames the wife for it. She now fears that she might be infected. Role play the conversation and write it down on a paper as it occurred.

Counselling the Orphans

The number of orphaned children as a result of AIDS is growing at an alarming rate. In Africa alone, there are millions of orphans. Sub-Saharan Africa is the worst affected with 12 million children having lost one or both parents to AIDS. It is further projected that by 2010, this number will have risen to more than 18 million (UNAIDS 2004: 61).

But before we start talking about the unique situation of orphaned children and the challenge that it raise for counsellors, we need to define who the orphan is. UNAIDS defines an orphan as a child under the age of 18 who has had at least one parent die (2004: 62). It further distinguishes between a maternal orphan (a child whose mother
has died); a **paternal orphan** (a child whose father has died); and a **double orphan** (a child who has lost both parents). We are however aware that different countries have different age limits for defining a child.

### Activity 6

1. Find out the number of orphaned children in your community.
2. Make a list of interventions that have been made to help the situation.
3. Are they being successful or not? Give reasons for your answer.

### Impact of HIV&AIDS on Children

The impact of HIV&AIDS is most discernible among children whose parents succumb to illness and eventually die. When parents become seriously ill children have to take care of them. This implies that they withdraw from school or they do not attend school regularly. They have no access to adequate food, shelter and health-care services. We have shown above that care giving has its own demands. It is emotionally and physically strenuous. Apart from this, children who care for their infected parents run the risk of being infected with HIV. In Africa, the arrangement extended family is under tremendous strain because of HIV&AIDS. They (extended families) turn away orphaned children for fear of the consequences of caring for them. It has become quite common for orphans to be cared for by grandparents or great grandparents. They too die while the child is still young. Many children, therefore, experience a string of multiple caregivers before they finally reach the age of independence. This has lasting psychological and physical repercussions on the child. How?

- Having to loose both parents often in quick succession is bound to affect orphaned children economically and psychologically.
- Having to be separated from his/her siblings causes a lot of emotional and psychological suffering.
Having to head households with no life skills, orphaned children are often exposed to discrimination, child labour, sexual exploitation and harsh street life conditions.

If an orphan by definition is a child under the age of 18, then any other issue that affects children has to affect them. Childhood is a stage in life that is distinct from other life stages in terms of the meaning of life, its expectations and goals. This, therefore, makes counselling for orphaned children both general and particular. General in that whatever principles are valid to counselling for children they will also be valid for counselling orphans. Counselling for orphaned children is particular in that, orphans are children who lack economic, psychological and material privileges that all other children have. So, we can say that counselling for orphaned children is a specialized form of counselling for children.

In the light of this we have to stress that in counselling children in general and orphaned children in particular counsellors need to understand and appreciate processes that govern the child’s physical, social, emotional and intellectual growth. Counsellors also need to remember that the life of orphaned children is often characterised by the following psychological and emotional imbalances:

- Bitterness and hostility
- Unhappiness within family setting
- Poor performance at school
- More disruptive in community
- Antisocial and disruptive behaviours
- Emotional stress that may lead to suicide
- Trauma

Cape Times of 17th April 2001 reports a story that vividly paints the sad experience of Slindelo, a 16 year old orphaned boy who also has to care for his 4 year old sister who is sick and his 8 year old brother: “We have nothing. Some people chase us away when we ask for food or for little jobs to get some money. They say we are a nuisance.”
Indeed, S. Lucas (2004: 29) is right in saying that children need more than education and food, especially children who have experienced the trauma of losing one or both parents and have taken on early responsibilities for caring for sick adults, and often, the responsibility for younger siblings. What they need is psychosocial support.

Activity 7

Pause for a while and think about the plight of Slindelo and his younger brother and sister. Write a paragraph about the kind of psychosocial support would you give to Slindelo, his brother and sister.

Counselling the Terminally ill

In the preceding units we have emphasized the need to distinguish between being HIV positive and having AIDS. These are two different medical conditions. We have described AIDS as a syndrome (collection of symptoms that occur in the body as a result of the weakening of its immune system). When the body’s immune system has been completely paralysed by the HI virus the infected person becomes prone to different types of opportunistic infections. In Africa the most common opportunistic infection associated with AIDS is tuberculosis (TB). Because the body is not capable anymore to fight the opportunistic infections, a person becomes terminally ill. It is in this sense that AIDS is called a terminal illness. Let us now turn to the specific needs of terminally ill people.

Specific Needs of Terminally ill People

Smith observes that becoming dependent upon others, is a common experience of most persons who are seriously ill (1988: 105). However dependent upon others terminally ill people may be, their need to have control over their lives has to be respected. It is expressed in the person’s desire to be left alone. While this is often times interpreted,
albeit wrongly, as ingratitude or rejection, it should be seen as a normal psychological strategy to take control of one’s life even at this most difficult moment. In cases where a person has gone through experiences of rejection and abandonment, it is highly likely that such an experience will intensify as s/he becomes seriously ill. This is true even in cases where a person is being supported by family members, friends.

Activity 8

Recall an experience in which either you, your close relative or friend was seriously ill. What did you spend time talking about? What kind of feelings flooded your/their mind when they/you were alone? What kind of care did you/they like most?

What do Terminally ill People Require from a Counsellor?

An effective counsellor to terminally ill people as a result of AIDS needs to arm themselves with the knowledge of the needs of such people. So, what do people living with AIDS want in a counsellor? Over and above the qualities required of a good counsellor discussed in Unit 2, counselling the terminally ill person requires:

- **Being supportive**: Counsellors and indeed everybody who is called to participate in the care of terminally ill people should be able to provide practical and emotional support.
- **Understanding**: The unique experience of stigma and discrimination of PLWHA, needs to be met with a caring attitude as opposed to a judgemental and holier-than-thou attitude.

A. Van Dyk, in *HIV&AIDS: Care and Counselling*, quotes the advice that Palermino, a person living with AIDS, gave to all health care professionals who care for terminally ill people with AIDS:

> As in life, people facing death have a right to do it their own way. Do not pry or force patients to feel feelings or ‘face’ death. It’s a disservice to force patients to give up their denial or to give cheery false hopes.
Sometimes I just want someone to listen. Sometimes I do not want to talk about my medical treatments. Sometimes I do not want to talk at all. If you stay in the moment, contribute what you can, and permit the patient to do the same, you cannot fail (2001: 399).

This advice summarises well what the terminally ill person requires from the counsellor.

**Activity 9**

In one page, discuss the differences between the following terms: death, bereavement, grief, mourning and funeral. Discuss what we can learn from the way Jesus, in the New Testament, dealt with these situations.

**Grief Counselling**

Grief and bereavement have always been identified with death. Our conviction is that this need not be the case as we shall discuss here below. We include this topic here because grief and bereavement are experiences some people with terminal illness have to go through. The counsellor needs to know how to respond to such challenges. But first let us discuss what grief and bereavement are.

*Grief is defined as an emotional response experienced after the loss of a significant attachment.* Grief is closely related and often confused with bereavement. The former refers to a person’s internal experience, thoughts and feelings related to the experience of loss. *Bereavement would normally refer to a state of being deprived of somebody or something.* The following example serves the purpose of clarifying the distinction between the two: ‘I am bereaved of my beloved friend through death and I grieve this loss.’ Though commonly used of the death of people, bereavement also covers losses that are not related to death. *Loss can be defined as being deprived of someone or something of attachment, through accident, misfortune, or natural occurrence (real or perceived).* But both grief and bereavement are related to loss as cause to effect. They have been and they continue to be an integral part of our existence.
Grief may be anticipatory or actual. The moment we perceive the impending loss, physical or psychological, we begin to experience **anticipatory grief**. But experiencing **actual loss**, physical or psychological, evokes feelings of grief. WCC, *A Guide to HIV&AIDS Pastoral Counseling*, observes that grief begins as soon as the person becomes aware of the possibility of being HIV-positive. S/he begins to mourn the forthcoming loss of life and all the other physical, mental, social, economic and spiritual losses (1990: 37).

**Definition of Grief Counseling**

How would we define grief counseling then? *Grief counseling is an intervention aimed at helping a person to cope with emotional feelings of loss*. Grief counseling as an intervention is complicated by the fact that every individual reacts differently to the experience of loss. Here below is the chart that outlines the stages, commonly referred to as stages of a grieving process, the features common to each stage as well as the suggested counseling responses (WCC 1990: 38).

<table>
<thead>
<tr>
<th>Stages of Grief</th>
<th>Features common to each stage</th>
<th>Counseling responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shock and Denial</td>
<td>Numbness, Feeling of betrayal, Not accepting the reality of impending or actual loss</td>
<td>Help client regain composure and accept the loss</td>
</tr>
<tr>
<td>2. Anger</td>
<td>Agitation, Negative emotions directed against: Self, Others, God</td>
<td>Explore and identify sources of anger and help client to cope</td>
</tr>
<tr>
<td>3. Guilt</td>
<td>Blaming oneself for: Infections the other, Wishing the other dead, Not resolving issues before death</td>
<td>Help client accept inevitability of death and appreciate the negative effects of self blame etc.</td>
</tr>
<tr>
<td>4. Depression</td>
<td>Inability to sleep, Feelings of inadequacy, Hopelessness, Sadness and crying</td>
<td>Help client reflect and reorganize him/herself and to cope with situation</td>
</tr>
<tr>
<td>5. Acceptance</td>
<td>Sleep returns to normal, Pain gradually lessens</td>
<td>Encourage and support client</td>
</tr>
</tbody>
</table>
Grief Counseling and African Culture

Every people have their own way of acknowledging loss, grieving and mourning that loss. The Africans too have their different ways of acknowledging loss, grieving and mourning. Hence the chart above should not be taken to be a universally valid grieving code for every body. No loss is given much attention than loss through death of a human person in Africa. In many African cultures death is explained in terms of a passage or a journey into the land of the ancestors. The funerary rites are performed to redress the situation of death. They have a two-fold purpose: 1) To accompany the dead into the land of the ancestors 2) to help those affected to cope with the loss. It is in this sense that we can call African therapy social therapy. Through the rituals, both society and the affected individual (patient) are healed. By identifying the cause of death, by being present at the home of the deceased, the affected are healed (therapy by identification and presence). By telling and re-telling their story to those who visit, the affected members are taken through the process of healing (therapy by exhortation). Through observing the rituals, members do not only give the deceased member a proper sent off, they also appease the ancestors, who will in turn give peace and comfort to those who remain behind (therapy by ritual observation).

Activity 10

Describe ways in which people in your culture understand:
  1. Loss through death
  2. How they mourn their dead through funerary rites
  3. What healing purpose these rites serve.

SUMMARY

In this Unit 7 we have discussed issues that a counsellor needs to take into consideration in helping abused clients, pregnant women, orphans, the terminally ill as a result of AIDS and those who grief as result of AIDS. We have called these special cases because while counselling skills and stages seen in the preceding units are, for the most part, applicable
to these cases, they require a specialized attention. We have also discussed grief and grief counselling and its implications and meaning in an African context.

SELF-ASSESSMENT ACTIVITY

Answer All Questions
1. How would you define sexual abuse?
2. Give examples of abuse that takes place in the family, at school, in the workplace and in the religious institutions.
3. In what way are women and girls vulnerable to sexual exploitation, abuse and HIV&AIDS infection?
5. List psychosocial issues that pregnant women usually have to deal with in the context HIV&AIDS.
6. Discuss three specific needs of terminally ill people.
7. Outline the stages of a grieving process and counselling responses proper to each. Compare and contrast them to what you have in your own culture.

FURTHER READING


**GLOSSARY**

**Abuse**: A general term for the misuse of a person or thing, causing harm to the person or thing.

**Abuser**: A person who misuses, treats others badly or abuse others.

**Physical abuse**: Is where a person inflicts physical violence or pain on another. It involves actions that cause physical injury or physical pain to the other party. It includes hitting, kicking, whipping, beating and throwing things at someone.

**Sexual abuse**: Is an improper use of another person for sexual purposes without their consent or under physical or psychological pressure. Sexual abuse includes inflicting pain during sex or not allowing the partner to use protection against STI/HIV.

**Emotional abuse**: It is an abuse where a person uses emotional or psychological manipulation to compel another to do something they do not want or that is not in their best interest. It is sometimes called psychological abuse.

**STI**: Sexually transmitted infection.

**Orphan**: A child under the age of 18 who has had at least one parent die.

**Maternal orphan**: A child whose mother has died.

**Paternal orphan**: A child whose father has died.

**Double orphan**: A child who has lost both parents.

**Grief**: An emotional response experienced after the loss of a significant attachment

**Bereavement**: State of being deprived of somebody or something.

**Grief counselling**: An intervention aimed at helping a person cope with emotional feelings of loss.
Unit 8
Legal, Ethical and Policy Dimensions of HIV&AIDS

OVERVIEW
Welcome to Unit 8. It has been said elsewhere that HIV&AIDS is a multidimensional epidemic. In this Unit we will discuss the impact of HIV&AIDS on the legal, ethical and policy frameworks of our different countries and institutions. The rights and duties of PLWHA as enshrined in internationally recognized charters; issues of privacy and confidentiality and informed consent will be discussed.

OBJECTIVES
By the end of this unit you should be able to:

- Explain how the rights of people living with HIV&AIDS are recognised in law.
- Analyse the legal dimension of HIV&AIDS.
- Identify some ethical principles and apply them to concrete cases of HIV&AIDS.
- Explain the importance of policy on HIV&AIDS in the workplace.
TOPICS

- Legal Dimension of HIV&AIDS
- Ethical Dimension of HIV&AIDS
- Management and Policy issues
  - Definition of Policy
  - HIV&AIDS Policy
  - Importance of HIV&AIDS Policy
  - Policies against HIV&AIDS Related Stigma and Discrimination

Summary

Self-assessment Activity

Further reading

Glossary
Activity 1

1. *List clauses in the constitution of your country, or any other legal document in your country that protect the rights of people living with HIV&AIDS.*
2. *Explain how each of these clauses protects the rights of people living with HIV&AIDS.*

Legal Dimension of HIV&AIDS

Many of our countries are signatories to the international charter of Basic Human Rights. They have, therefore, committed themselves to upholding and respecting the rights and duties of all their citizens in accordance with this charter. The Basic human rights are founded on a principle that recognizes equal worth and dignity of all human beings (WCC Study Document 1997: 70). These basic human rights are enshrined into most of our countries’ constitutions to protect the rights and duties of all citizens. They have, therefore, a force of law.

The United Nations Commission on Human Rights in its 63rd meeting of 1993 noted with concern the discriminatory laws denying people with HIV infection or AIDS, their families and associates enjoyment of their fundamental rights and freedoms. It further called upon states to ensure that their laws, policies and practices introduced in the context of AIDS respect human rights standards.

People living with HIV&AIDS should enjoy the same basic rights and responsibilities as any other citizen. But then what does this have to do with counselling in an HIV&AIDS context? Counsellors are supposed to be professional agents. As such they are expected to discharge responsibilities associated with their work within national and international systems of law. A counsellor, especially an HIV&AIDS counsellor needs to be well informed as regards the law in order to protect the rights of his/her clients. Relevant to the situation of HIV&AIDS are the following rights which have legal implications:
The right to privacy
The right to non-discrimination, equal protection and equality before the law
The right to marry and found a family
The right to highest attainable standard of physical and mental health
The right to informed consent before a medical procedure is carried out
The right to information for making choices about one’s health and well being

Counsellors in HIV&AIDS situations would do well to remember that they are liable to their clients in relation to counselling in general and HIV&AIDS counselling in particular. Counselling in HIV&AIDS situations has legal implications. This means that violation of any of the above rights in respect of PLWHA person and indeed any other person who has come for a professional service, is punishable by law.

Activity 2
1. Do health care professionals in your country have any code of ethics?
2. What does it say about the rights of clients or patients?
3. Do counsellors in your country have an association?
4. Are they governed by any code of ethics?

Ethical Dimension of HIV&AIDS

What do we mean by ethics? Ethics is generally defined as a branch of philosophy that concerns itself with human conduct and moral decision making. It seeks to discover the principles that guide people in deciding what is right and what is wrong. A counsellor is a professional and his/her dealings with clients have to be governed by certain principles or guidelines. These principles or guidelines are normally referred to as professional code of Ethics. They set boundaries and limits within which counsellors practice their profession. Failure to act within these boundaries means that as a professional you have acted unethically or wrongly.
Some of the ethical principles that should guide counsellors in dealing with clients in situations of HIV&AIDS are autonomy, beneficence, confidentiality and privacy, shared confidentiality and informed consent.

**Autonomy:** It simply means that people living with HIV&AIDS enjoy the same right of autonomy as any other person. They enjoy the right to make their own decisions on matters affecting them. This principle has its own limitations. A person’s right to make decisions may be limited by immaturity, lack of relevant information or physical or mental constraints such as physical or mental impairment.

<table>
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<th>Activity 3</th>
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Robby is a forty-five year old male. He was hospitalised and operated the following day without any prior information. The operation was successful. Upon leaving the hospital, he charged the hospital and the doctor who did an operation on him.

1. Name the ethical principle/s that the doctor violated.
2. How possible is it for Robby to take this matter with the courts of law? Explain.

**Beneficence:** This principle refers to a moral duty on the side of professionals to do good and not harm to those entrusted to their care. Discrimination against people living with HIV&AIDS, which is unfortunately occurring in our communities, is a violation of this principle. How? According to A WCC Study Document, discrimination violates this principle in two ways:

- It is an obstacle to effective means against further spread of the epidemic
- It renders the whole community — both those who discriminate and those discriminated against — more vulnerable to the spread of HIV (1997: 58).

Discrimination against people living with HIV&AIDS violates the principle of beneficence in that it does harm and not good to both the perpetrator and the survivor.
Activity 4

John is 28 years old. He is HIV positive. He is deeply in love with a girl, 4 years younger than he is whom he intends to marry. He is faced with a dilemma. He informed his previous girlfriends about his status and they all deserted him. He has decided not to mention this to any of his girlfriends anymore for fear of losing them. John has come to you as a counsellor.

1. Write in one page how you would response to John.

2. List the ethical principle/s that is involved here.

Confidentiality and privacy: This principle is about keeping to oneself and not revealing information received from the client who expects that the information should not be shared with others. From the side of the counsellor it is a promise or contract to reveal nothing about the client without the express consent of the client. This principle stems from and is closely related to the client’s right to privacy.

The right to privacy implies that every person has a right to determine what to keep to him/herself as confidential information. People living with HIV&AIDS have the right to confidentiality about their health and status. A counsellor should under no circumstances put pressure on the client to disclose information that s/he is not prepared to share. Counsellors are bound in conscience to respect this right.

Let us pause for a while and answer the following questions.

Activity 5

1. Are there cases where confidential information can be shared with the third party?
2. If so, under what circumstances can it be shared?
3. What do counsellors need to take into consideration when doing so?

We continue with our discussion on confidentiality and privacy. Professionals, such as counsellors or medical doctors are sometimes faced with a dilemma in having to choose between two conflicting principles. For example, take a case of a counsellor who is in possession of confidential information of a husband who is HIV positive and a wife who is at the risk of infection by her partner. In such a case, there is a principle of beneficence which upholds the right of the wife’s life to be protected. There is on the other hand the right to privacy. The answer to this dilemma is partly covered in the next sub-topic, shared confidentiality.

**Shared confidentiality**: This is when information about the client is shared with another person who is directly involved in the care of the client. But this has to be done with the client’s consent. This can only be done when:

- It is necessary
- When it benefits the client more than the counsellor

When confidential information is shared the following should be considered:

- The client must be given time to make up his/her mind on sharing confidential information.
- Ideally it is the client who should share the confidential information and not the counsellor
- The role of the counsellor is to assist and to support.
Activity 6

Martha is 15 years old. She is a student doing standard 5. She has been in and out of hospital. Her parents out of concern have advised that she goes for an HIV test. You are a counsellor in a hospital and Martha has approached you for counselling and testing.

1. What would be your initial reaction?
2. Write a letter to Martha counselling her and include a counselling plan.

Informed Consent: This principle, in the context of HIV&AIDS, means that a person has been informed and that s/he understands the implications of any medical diagnosis, test or treatment that is done on him/her. A person should be given necessary information in order to make an informed decision.

We will recall also that to every right there is a corresponding duty. We have emphasized the rights of PLWHA which ought to be given to them by others. But on the other side, people living with HIV&AIDS also, have the moral responsibility and duty to respect the rights of others and to ensure that their health integrity is fully respected. This, in the concrete, means that they have the moral obligations to protect others from infection. They also have the obligation to protect themselves from re-infection.

Before we move on into the next topic let us do the following exercise.

Activity 7

1. Take a pen and a paper and list some of the policies by governments or organisations which discriminate against people living with HIV&AIDS.
2. Give reasons why you think insurances should or should not grant policies to people before they do an HIV test.

Having discussed these principles, we need to reiterate what we mentioned in Units 3 and 6 that our world view influences for the most part how we think, understand and explain
things. It is on the basis of this different world views that there is bound to be a tension between the principles discussed above and our own understanding of how we should relate among ourselves. We have, for example, learned how the life of an individual is intertwined with that of the community and how an individual’s being is realized in community. So to talk about privacy, confidentiality and autonomy seems to contradict what the ethic of *ubuntu* (being human) stands for. This tension raises an important question: To what extent can we maintain confidentiality and privacy when the community is there to account for who I am?

**Management, Policy Issues and HIV&AIDS**

The United Nations Commission on Human Rights sounded an alarm on the emergence of discriminatory policies and practices denying people with HIV infection or AIDS their fundamental rights and freedoms. Governments and States are, as a result, called upon to introduce policies that respect rights of people living with HIV&AIDS. Before we discuss the importance of policy in creating an enabling environment for prevention, care and support, let us define what a policy is.

**Definition of Policy**

*A policy is a guideline that defines the organisation’s stance and practice in relation to its employees and its clientele.* If an organisation sets a policy, all employees and stakeholders should follow and are bound by that policy. Though policies are not laws, a legal case can be made against an organisation that has violated a policy in respect of a client or employee.

**HIV&AIDS Policy**

In the context of HIV&AIDS organisations have had to enact policies that guide dealings between both management and employees or clientele of such organisations who are HIV positive. The purpose of an HIV&AIDS policy would be to:
Define the organisation’s position and practices for preventing the transmission of HIV and for handling cases of HIV infection or AIDS among employees

Guide workplace behaviour and activities designed to prevent and treat HIV&AIDS among managers, labour leaders and employees

Importance of HIV&AIDS Policy

These policies are important in protecting individuals against stigmatization and discrimination by fellow workers. Let us look at some examples of stigmatization and discrimination in the workplace due to lack of policy or commitment to implementing a policy:

- Co-workers may refuse to work with an infected individual
- Co-workers may harass the person
- The individual may be isolated during meal or break times
- The individual may be asked to use separate restroom or other facilities

The following story, of an HIV positive man, aged 27, is an example of workplace discrimination by fellow co-workers:

Nobody will come near me, eat with me in the canteen, nobody will want to work with me, I am an outcast here”(www.avert.org/aidsstigma.htm).

The lack of an HIV&AIDS policy in the workplace or implementation thereof, may also be seen in the following examples:

- They may be fired
- They may be passed up for a promotion or denied salary increment
- Unfair job restrictions may be placed upon them
- Organization may refuse to make reasonable accommodations for their condition
- They may be denied health insurances or other benefits.
Let us look at the following quote, from a Head of Human Resource Development in India. It is an example of discriminatory attitudes by managers in the workplace:

*Though we do not have a policy so far, I can say that if at the time of recruitment there is a person with HIV, I will not take him. I’ll certainly not buy a problem for the company*” (www.avert.org/aidsstigma.htm).

### Activity 8

1. **Recall and write down discriminating policies or attitudes against people living with HIV&AIDS in your church.**
2. **Discuss whether or not there can be any justification for discrimination in the Bible.**

### Policies against HIV&AIDS Related Stigma and Discrimination

You will recall that in Unit 1 we argued that HIV&AIDS related Stigma and discrimination can be expressed through laws and policies by governments and non-governmental organisations. In fact, in many countries, laws, policies and regulations around HIV&AIDS have been formulated. These efforts, good as they are, have been frustrated by lack of political will and commitment and weak enforcement mechanism in a number of countries and organisations.

We are, however, encouraged by efforts in other countries which have set up bodies that monitor and follow through, the implementation of laws and policies around HIV&AIDS issues, within organisations and institutions. In South Africa, for example, professional associations and bodies such as Treatment Action Campaign, AIDS Law Project, Health Professions Council of South Africa, South African Human Rights Commission, have made it their duty to advocate for, educate on and implement the laws and policies that protect the rights of people living with HIV&AIDS (see AIDS Law Project, *HIV&AIDS: Current Law + Policy: Testing for HIV – Know your rights*, Centre for Applied Legal Studies, University of the Witwatersrand (2004:12).
Activity 9

1. Engage your friend, a group, your congregation on whether or not the church and the government are doing enough in terms of working out policies or advocating for policies that promote the cause of people living with HIV&AIDS.
2. Make a summary of emerging issues.

SUMMARY

In this Unit we have learnt that HIV&AIDS epidemic has legal, ethical and policy dimensions. HIV&AIDS is a human rights issue. And as such it calls for the commitment of all countries that upholds the rights of every individual as contained in the Universal Declaration of Human Rights and in the Declaration and Charter on HIV&AIDS. These rights and duties have to be adhered to as a matter of law. HIV&AIDS also has ethical implications. It confronts all of us with many difficult ethical questions. The whole human society — in both its secular and religious dimension — has to give both spiritual and moral guidance to the entire society in the face of these concrete challenges posed by HIV&AIDS. Policies that promote or frustrate the welfare of people living with HIV&AIDS have been made. It is the duty of every person, individually and collectively to work towards HIV&AIDS policies that enhance the worth and dignity of very person.

SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. In what way does the policy/ies in your country protect people living with HIV&AIDS?
2. Why is it important for a counsellor to know about the basic rights and
responsibilities of people living with HIV&AIDS?

3. Discuss critically the relevance of the right to marry and start a family in the context of HIV&AIDS.

4. What is the code of ethics and what is its importance in the context of HIV&AIDS?

5. Describe the principle of beneficence and the principle of confidentiality and privacy.

6. In what way does the principle of beneficence conflict with the principle of autonomy?

FURTHER READING


GLOSSARY

Confidentiality: Refers to non-disclosure of shared with the counsellor or health provider without the client’s consent.

Discriminatory laws: Laws that directly or indirectly sanction discrimination of people by another or others.

Duty: In legal and ethical terms a duty is something of moral goodness that I owe to others.

Ethics: A branch of philosophy that concerns itself human conduct and moral decision-making. It seeks to discover principles that guide people in deciding what is right and what is wrong.

Guideline: An optional point of reference used to help people to arrive at their goals.

Informed consent: It is the agreement to an action based on knowledge of what the action involves and its likely consequences.

Policy: A guideline that defines the organisations stance and practice in relation to its employees or clientele.

Principle: A norm or rule that is accepted as true and that can be used as a basis for reasoning or conduct.

Principle of autonomy: Refers to a right people have to make their own decisions on matters affecting them.

Principle of beneficence: Refers to a moral duty to do good and not harm to others.

Right: In legal and ethical terms a right is something of moral goodness that is owed to us.

Shared confidentiality: It is when information about the client is disclosed to another person directly involved in the care of the client, with the client’s consent.
Unit 9

HIV&AIDS Counselling and the Church

OVERVIEW
Welcome to Unit 9. This Unit defines the mission of the church in general terms. Questions such as who is the church? What is it sent to do? Are asked and a response to them is given. It also discusses the ways in which the church can be present to PLWHA, the terminally ill and those who are grieving as a result of AIDS. With regards to grief counselling the church has traditionally been present through conducting funerary rituals and being available to individuals who grief. This Unit argues that the church can do more to enhance its ministry in these areas.

OBJECTIVES
Upon completion of this unit you should be able to:

- Define in general terms the mission of the Church.
- Discuss the role of the church in HIV&AIDS situations.
- Identify ways in which the church can be present to PLWHA.
- Describe ways in which the church can be present to the terminally ill.
- Analyse the role of the church in grief counselling, through funerary rites and individual counselling.
TOPICS

- The Church’s Call in HIV&AIDS Situations
  - But who is the Church?
  - The Church’s Call is to be Sent
  - The Church Sent to do what?
  - The Church Called to Minister
- The Church and PLWHA
  - Concerns of PLWHA
  - Ways in which the Church can be Present to PLWHA
- The Church and the Terminally ill
  - Concerns of the Terminally ill as a result of AIDS
- The Church and Grief Counselling
  - What the Church can do
- Funerary Rituals
- Ministers and Funerary Rituals
- Ministers and Individual Grief Counselling
The Church’s Call in HIV&AIDS Situations

In an interview with Contact Rev Dr. Samuel Kobia, the WCC General Secretary, says that the fight against HIV&AIDS is an essential part of the Church’s mission (No. 177/178 Winter/Spring 2004: 5). This conviction is reiterated by Rev. Vitillo in the same Contact magazine, in these words, “Christians do not have a choice on whether or not they could respond to HIV&AIDS, the gospel of Jesus mandates them to do so (no.177/178 Winter/Spring 2004: 34).

But who is the Church?

The church is all Christians who, through baptism, share in different ways, in the royal, priestly and prophetic ministry of Jesus. Indeed within the church there are a variety of gifts, there are different ways of serving, but it is always the same Lord working in each one of us (1 Cor.12: 4-11). The church, therefore, in its ministerial and lay aspect has been called to bring God’s love to all humanity.

The Church’s Call is to be Sent

Indeed the call of the church to minister or to be sent belongs to its nature. The church is missionary by its very nature. Without this essential missionary component the church ceases to be the church. The church’s missionary activity takes place in the world where it is called to be the sign of God’s encounter with his people.

The Church Sent to do what?

The content of the church’s missionary activity is God’s love to all humanity. This love has to permeate the entire ministry of the church as received from the Lord, who said, ‘Love one another as I have loved you’ (John 13:34). When Jesus launched his mission, he chose the twelve to be with him; to be sent to proclaim the message and to heal (Mark. 3:13-14; 6:13). Being with Jesus (communion with Jesus), therefore, was absolutely essential to the success of the mission of the twelve.

142
The Church Called to Minister

Today, at the top of the agenda of the church’s missionary activity is the HIV&AIDS epidemic. It constitutes, in Dube’s words, a historic moment of crisis (2003: 46). The church is challenged to recommit itself to the mandate that Jesus gave to her by ministering to the people in this historic moment of crisis. We have identified three stages in which the church can be present to the people in the context of HIV&AIDS. They are: the stage of HIV infection, stage of being terminally ill and the stage of grieving. Under every stage we will discuss the concerns of the affected and ways in which the church can be present to them.

The Church and PLWHA

We are making a distinction between people who are infected with HI virus but who are not sick and people who have developed AIDS. We need to be constantly reminded that these are two different medical conditions, with different needs requiring different caring needs. Here we are going to look at the special pastoral concerns of people who are
infected with HI virus but who have not yet developed AIDS and how the church can be present to such people.

**Concerns of PLWHA**

The psychosocial concerns of HIV PLWHA are summarized in the story of an HIV positive person quoted in Van Dyk, *HIV&AIDS Care & Counselling*.

"My mind was racing. I could not concentrate on anything for more than a few seconds. Ninety percent of my thoughts were death-related or reflections on what life choices I had made. Mistakes, broken dreams... What would my funeral be like? My obituaries? What infection would finally kill me? Suffering and grief were what I felt. On top of that you feel you have no future, you will not feel the wind against your skin... And you will not love or be loved. I had crossed the line. The line between the living and the dead. I feared to be alone and yet needed to be alone. In my 20s I grew to believe in God, or my higher power, as I prefer to call him. Had he betrayed me? I felt ripped off (2001: 254)."

The concerns and needs of HIV infected person are of a psychosocial, spiritual and material nature. They fear discovery as a result of stigma and discrimination. They feel guilty; they feel hopeless and helpless; they doubt the existence of God; they question the legitimacy of suffering; they lose trust in people.

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**Activity 3**

1. *Explain the difference between HIV and AIDS?*
2. *Is this distinction clear in the way people who are HIV positive and people who have AIDS are treated?*
3. According to your experience, what are the psychosocial concerns of PLWHA?

4. How has the church contributed in stigmatising people who are HIV positive?

Ways in which the Church can be Present to PLWHA

We need to emphasize that despite incidences of silence and indifference, on issues of HIV&AIDS, from the side of the Church, the majority of people still regard the churches as places of refuge and solace. As the church we can learn from Jesus who, confronted with a similar situation (Mark 1:40-45) did the least expected. He touched the leper as a gesture of acceptance, support and solidarity with the afflicted. By his action driven by compassion Jesus restored the leper to his rightful place in society. The church in its members, ministers and the laity, is called to feel pity and offer healing to those who, because of their HIV status, are separated from the church and society. This, in the concrete, means mixing freely with HIV PLWHA, supporting them, caring for them. How can the church do that?

• At the level of ministers
  - There is a need for more collaboration among ministers of different churches.
  - Sharing of resources and networking beyond denominational limits and boundaries, especially in Africa where there are very few professional counsellors, is necessary. Sue Parry in *Responses of Faith-Based Organisations to HIV&AIDS in Sub Saharan Africa*, observes that, in general, churches in West Africa and central Africa are ill equipped to confront the epidemic (2002: 11). Among the problems faced by the clergy concerning HIV&AIDS are lack of knowledge on:
    > preventative measures
    > counselling
    > advocacy
    > community mobilization and networking
- cultural taboos about open discussions on sexual issues.
  - Educating people and thus de-stigmatising PLWHA
  - Community mobilization in necessary

- **At the level of the laity**
  - There is a need for more empowerment and mobilization at the village level.
  - Therapy by presence and exhortation has always been at the heart of the African community features. This is where the church lives its daily struggles and fights its real battles.
  - They need to form support groups or clubs to take care of various needs of PLWHA.

- **At the level of the institutions**
  - The church boasts some of the best infrastructure that reaches even the remotest of areas: schools, clinics, places of worship, and hospitals. Through such infrastructure, the church should be exemplary in striving for support and concern that is imbued with the spirit of compassion and selflessness.
  - The church needs to source funds for sustaining holistic pastoral care attending to physical, moral and spiritual dimensions of human caring.

### Activity 4

1. Take a pen and a paper and list some of the human and material resources that the church has that can help in improving the lives of people living with HIV&AIDS.

2. Explain whether or not the church has to do anything more to maximize the use of these resources.
The lack of knowledge on the side of the clergy should not, however, make us overlook the success stories that can be replicated as models for other African churches. In a number of African countries, different denominations and ecumenical bodies have shown commitment in building capacity within churches and the local communities. To cite just a few examples:

In **Mozambique** different churches have collaborated to bring about an interdenominational AIDS organisation ‘Kubatsirana’ (meaning helping one another) to address HIV&AIDS.

In **Namibia**, Catholic AIDS Action is using 90 parishes, 300 Christian communities, hospitals, clinics, schools and hostels as a basis for spreading the message of prevention and care on the basis of Christian values of spiritual and physical care for others.

In **Botswana**, collaborative efforts between different Christian denominations have led to the establishment of one of the best counselling service and network, through BOCAIP.

The church in **Uganda** showed commitment by working alongside government to preach ‘Love Faithfully’ as opposed to ‘Love Carefully’ by Government campaign.

In **Senegal** interfaith efforts have led to UNAIDS calling this collaboration ‘Best Practices’ ([www.fhi.org/NR](http://www.fhi.org/NR)).

**The Church and the Terminally ill**

We now turn to the concerns of terminally ill people as result of AIDS and how the church can be present to such people. The New Testament is replete with incidences where Jesus is seized with restoring people to health, both bodily and spiritual. This portrait of Jesus is well represented in the Gospels. He further commissioned his disciples to preach, teach and heal the sick. The church, the disciples of Jesus in the modern world, continues to offer healing, in different ways, to the sick in keeping with the mandate of Jesus. Before we start talking about how the Church can be present to the terminally ill as a result of AIDS we need to look at their concerns and needs.
Activity 5

1. Identify and discuss some two incidences in the New Testament where Jesus restored people to health, bodily, social and/or spiritual.

2. In what way is your church called to continue this healing ministry of Jesus in the context of HIV&AIDS?

Concerns of the Terminally ill as a Result of AIDS

We have seen in Unit 7 what the specific needs of terminally ill people are. We have also discussed the type of care and support they require from a counsellor. The Church through its members, pastors or laity need to recall these issues as they are required of every counsellor including pastoral counsellors. However, there are specific issues that can best be addressed by specially trained personnel within Churches, such as pastoral counsellors and other health professionals because they are spiritual or religious in nature:

- The fear of death and uncertainty
- Search for the meaning of death
- Feelings of guilt
- Feelings of hopelessness
- Making peace with the past
- Unresolved issues with the Church

Activity 6

1. Explain how death can be a religious issue.

2. How are terminally ill people taken care of and supported in your
Most pastors, as well as the laity especially in recent years, are well placed to deal with religious and spiritual issues such as death, guilt, hope, reconciliation and forgiveness that confront terminally ill people as a result of AIDS. Their training equips them to handle such issues comfortably. However, this is not automatic. It further requires a minister or pastor or a trained lay person’s awareness of one’s attitude toward:

- People with AIDS
- Disease
- Caring for terminally ill people

A church minister is such situations needs to remember that compassion, love and sensitivity are the key in ministering to terminally ill people. We are aware that different denominations lay emphasis on different aspects when it comes to pastoral care of the sick. Some are inclined to scriptures while others rely heavily on sacraments as sources of solace and comfort. Whatever the case may be, Christians (pastors and laity) need to be careful to assess the person’s needs first. The following two examples will illustrate how much harm can be done by Bible wielding or Sacraments administering that does not take the terminally ill person’s needs into consideration:

David was admitted in a hospital. He was hospitalized for recurrent pneumonic infection. David was visited by a Catholic priest. Baptised and raised in the Roman Catholic faith, David had been a non-practicing nominal Catholic since he entered college. Because David had noted on his admission record his religious affiliation as “Catholic” and since his medical condition was grave, he was automatically visited by the Catholic chaplain. Upon entering his room, the chaplain was attired in his habit and
wore a purple stole around his neck. He was friendly and jovial. After a few opening remarks, he announced: “Well, David, let’s get a few things straight with the Lord. I’ll hear your confession and then give you the sacrament of the sick. Now how long has it been since your last confession, son?” David was clearly stunned and agitated by the priest’s approach to him, but he was not strong enough physically to confront him. He simply said, “Father, could we do this some other time?” The priest said: “No brother, son. Just make a good act of contrition and I’ll give you absolution.” With that he raced through some scarcely audible prayers while anointing David’s forehead and hands. As he concluded, the priest smiled and made some light comment and departed waving a farewell blessing (Smith 1988: 90).

In the other example:

A pastor visited a sick person in hospital. On arrival he opened his Bible and started preaching to the sick person. Incidentally the sick person had soiled himself and had been left as such for the whole day and nobody took trouble to listen to what he had to say. After preaching the pastor said the prayers and left (story of one of the participants from Swaziland in a TOT workshop in Kempton Park, South Africa in 2000).

These two stories are examples of how pastoral care to the sick can be mismanaged by people who are inattentive and negligent to the needs of sick people. Smith has this advice to give to pastoral carers:

Take time to establish a relationship with a sick person. The “Who are you/” and “What do you need?” questions are indispensable. The formation of an accepting and understanding relationship makes it possible for pastoral carers to begin assessing the person’s psychosocial resources and needs (1988: 91).
Activity 7

1. How does your church empower lay members to take part in the healing ministry of the church?
2. Recall and describe an incidence in which a member of your family or a friend was a victim to the negligence of a pastor when s/he was terminally ill.

The Church and Grief Counselling

Grief is an integral component of all human relationships. Whenever we love and care for others, we invest and commit our physical, emotional, spiritual and material resources in those we love and care for. When such relationships are interrupted or broken we feel the loss. Loss through death is something that is bound to happen to all of us but over which we do not have control. According to C.V. Gerkin in *Crises Experience in Modern Life*, our living in time is our living toward death (1979:74). Loss of an object loved necessarily leads into grief.

We see the Church in action, in its very early stages, when Jesus presented himself at the grieved family of Mary and Martha, the sisters of Lazarus (John 11). Jesus’ presence to this family at this trying moment, gives a portrait of Jesus who was always there for the people to give hope and encouragement.

Activity 8

Pause for a moment and recall a loss that you experienced.

1. Explain how you grieved this loss. Did you rely on your coping abilities or also on some external help?
2. In what way did the church play a role in helping through the loss?
What the Church can do?

There are a number of things that Churches can do in the face of loss and grief. The two that comes to mind immediately are: 1) funerary rituals which are, in most cases if not all, communitarian in nature, and 2) individual counselling.

**Funerary Rituals**

Churches have rituals that recognise loss. Such rituals help us acknowledge and celebrate what would, otherwise, be difficult life transitions. A minister of the Church who works in and for the Church exercises a pivotal role in performing these rituals. In the face of death his/her ministry is not meant only for the dead but also for the grieved members. It is to this end that funerary rituals and grief counselling are done. These services, done for and on behalf of the dead and the grieved, from the Christian perspective, are underpinned by the central belief in the resurrection of the dead, well articulated by apostle Paul: ‘If there is no resurrection of the dead, then Christ cannot have been raised either, and if Christ has not been raised, then our preaching is without substance, and so is your faith’ (1 Cor.15:12-28).

You may have noticed that different denominations, informed by this central premise, have celebrated the death of their members in a variety of ways. For some, funerals include a mass, for others a prayer service which, normally, include reading and expounding from scriptures. All these are done with the intention of bidding farewell to the deceased and consoling the rest of the members of the family who are grieving the loss of their member. In Africa more than anywhere else, people attach special importance to this critical stage in the life of the believing community.

**Ministers and Funerary Rituals**

- Ministers, as far as it is possible, should journey with terminally ill people towards their death. In that way, they understand better the adaptive processes that the terminally ill person and the family have to go through.
- If a minister has been effective in helping a terminally ill person who has now died, it is reasonable, therefore, that s/he avail him/herself as far as possible to support the surviving members.
• Work towards founding interfaith collaborative ministry drawing on clerics and lay people who would bring healing to those who suffer and those who grieve.

• Ecumenical networking among ministers working in a given locality, given the fact that in Africa death and funerary rituals are everybody’s business, should be encouraged.

• Ministers too should make it their business to be present in funerary rituals irrespective of the deceased’s denomination and officiate or co-officiate if possible.

• Produce an ecumenical prayer book which incorporates the traditional funerary rituals, especially ancestor veneration, which seems to permeate most African rites of passage.

• Through their preaching, people should see God’s compassion and acceptance for those who have died, and love and comfort for those who mourn.

• Organize religious services to support persons living with AIDS and their care-providers, to remember those who have died of AIDS, can be helpful.

Activity 9

Churches have their different ways of conducting funeral services.
Traditional African people have their own ways too. Explain whether or not it is necessary to merge these different ways of celebrating the death of our beloved ones?

Ministers and Individual Grief Counselling

• Should be available for individual grief counselling of their members as group counselling offered by funerary rituals may be inadequate or superficial in some cases

• Because ministers are an important resource for people who are hurting, they should be there to listen. Smith emphasizes the importance of listening by citing an old saying: “When in doubt, listen” (1988: 180).
• Foster knowledge and appreciate the traditions of the people, on death rites, as they are important for effective individual counselling.

SUMMARY
In this unit, we have discussed the following points:

• The mission of the church in general
• The call of the church in three specific HIV&AIDS areas: PLWH, the terminally ill people as a result of AIDS, and grieved people as result of HIV&AIDS
• The prominent concerns of people in these HIV&AIDS situations
• The church can be present to these people in a number of ways which include: counselling, availing infrastructure, being compassionate, conducting funerary rituals, preaching and organising religious services for PLWHA, their caregivers and also to remember people who have died as a result of AIDS.

SELF-ASSESSMENT ACTIVITY

Answer All Questions
1. In what way could we say Christ and even the Church is HIV positive?
2. Briefly describe how you would explain the relationship between mission and the church.
3. Discuss the content of the church’s mission.
4. Critically discuss in what two ways your church can improve in caring and counselling the terminally ill.
5. Identify ways in which the church can enhance its ministry towards the grieved?
FURTHER READING


www.fhi.org/NR
GLOSSARY

Clergy: normally used as a collective term that refers to a group of ministers ordained to perform religious tasks.

Community mobilization: Is a process of bringing together the community to demand and work for a particular development programme.

Compassion: A deep, religious awareness of and sympathy for another’s suffering.

De-stigmatise: The process of reversing or removing stigma.

Funerary rituals: A series of rites done for and on behalf of the dead.

Grief counselling: Counselling given to those experiencing periods of grief or loss.

Individual counselling: Counselling done by a counsellor to a client on a one-to-one basis.

Kubatsirana: A term which literally translates ‘helping one another’ is used to refer to an interdenominational AIDS organisation in Mozambique.

Pastor: An ordained minister charged with the spiritual care of a local community. This term is loosely used to refer to a minister in charge of a congregation.

Therapy by presence: Therapy or healing that is achieved by the presence of the people to the person who is going through a difficult time.

Therapy by exhortation: Therapy or healing that is achieved by the power of the words directed to the person who is going through a difficult time.
Unit 10
Church, Advocacy in HIV&AIDS
Context

OVERVIEW
Welcome to Unit 10 of our module. In Unit 9 we have seen what the call of the Church is in different situations that obtain as a result of HIV&AIDS. The connection between the preceding nine units and this unit is that any effort aimed at prevention, treatment and care, in situations of HIV&AIDS is incomplete without attacking the root cause through advocacy. By showing the connection between prophecy and advocacy we have underlined the connection between the Church’s ministry of healing and the eradication of the causes of sickness.

OBJECTIVES
By the end of this unit, you should be able to:

- Define advocacy and identify its essential components.
- Link the Church’s prophetic call and advocacy.
- Identify the focus of HIV&AIDS related advocacy.
- Discuss the prophetic call of the church in HIV&AIDS situations.
TOPICS

- What is Advocacy?
  - Essential Components of Advocacy
  - Expressions and Forms of Advocacy
- The Church and Advocacy
- The Church and HIV&AIDS Related Advocacy
  - What does the Church have to do with HIV&AIDS Advocacy?
- Areas for HIV&AIDS Advocacy
  - Human Rights
    - What can the Church do?
  - Gender Inequality
    - What can the Church do?
  - Involving People with HIV&AIDS
    - What can the Church do?
  - HIV Testing
    - What can the Church do?
  - Children and Youth
    - What can the Church do?

Summary
Self-assessment
Further reading
Glossary
Activity 1

1. Write down your own definition of advocacy.
2. Give some examples of actions of advocacy done in your community and say what the issue was, who the targets of advocacy were, and who were to benefit from it, and how it was implemented.

What is Advocacy?

We will start our discussion by defining the key word in this Unit and that is advocacy. Advocacy has been defined in various ways, by different people, depending on the context within which it is defined. Let us look at some of these definitions.

- Advocacy is the act or process of supporting a cause or issue (J. Hamand 2001: 304).
- Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions (International HIV/AIDS Alliance: Advocacy Skills-building workshop for HIV/AIDS, Zimbabwe, July 2001).
- Advocacy is speaking up, drawing a community’s attention to an important issue, and directing decision-makers toward a solution (Cucuzza, and Moch, 2000: 312).

Essential Components of Advocacy

In the face of these different definitions we can only identify what appear to be essential components that would distinguish advocacy from other related concepts.

- It is a process focusing on an issue
- It is aimed at change/transformation/influencing policies, laws and practices
- It targets decision-makers, leaders, policy makers and people in positions of influence
- The beneficiaries are people affected by the issue

These components distinguish advocacy from other related concepts such as information, education and communication (IEC) and community mobilization. Advocacy essentially
implies the development of the capacity to intercede for, speak publicly and promote a cause of group interest (www.ippfwhr.org).

Activity 2

List words that are associated with Advocacy in your own context.

Expressions and Forms of Advocacy

Advocacy can be expressed in different ways. It can be expressed through writing, song, speech or dramatized. Advocacy can take different forms depending on how it is initiated. It can either be reactive or proactive. It is reactive when the problem or issue is there and forces people to act and solve the problem. It is proactive when it is used to prevent a problem before it happens.

Activity 3

1. List ways in which the church in your locality has assumed a prophetic/advocacy role.
2. Has it been successful or not?
3. To what can you attribute its success or failure?

The Church and Advocacy

The leading questions here would be: What has the church to do with advocacy? Advocacy is central to Christian life and witness. The notion of advocacy as applied to the Church tallies with the prophetic call of the Church. How? A prophet is generally someone who speaks on behalf of God; the mouthpiece of God. Though a prophet is one who speaks on behalf of God, it is not God but people on behalf of whom prophecy is
done, who stand to benefit from that prophecy. A prophet’s mission is summed up in the narrative of the call of Jeremiah. He has been set over nations and kingdoms ‘to root up and to tear down, to destroy and to demolish, to build and to plant’ (Jer. 1:10). This antithesis brings out the twofold nature of the prophet’s call: to demolish what serves no purpose and to restore or deepen what was misrepresented.

Jesus, by coming for the rise and fall of many in Israel, became a prophetic sign, in the mould of Jeremiah, that will be contradicted (Luke 2:25-35). He was anointed to bring good news to the poor; to proclaim release to captives and recovery of sight to the blind; to let the oppressed go free (Luke 4:16-19). In her article, “The Prophetic Method in the New Testament” Dube says, ‘not only did Jesus read from the book of prophet Isaiah, he also identified himself with Isaiah and took up Isaiah prophetic agenda’ (2003: 49). By so doing Jesus became the advocate of the marginalized, the disadvantaged and the voiceless. He spoke on behalf of God for the benefit of the needy. It is on the basis of Jesus’ prophecy and advocacy that the Christian church must fully embrace the advocacy and prophetic role. To whom is this prophetic ministry or advocacy directed? J.W. De Gruchy in his book Theology and Ministry in Context and Crisis: A South African Perspective, has this answer, “The prophetic task in the life of the congregation, and the prophetic ministry to society, are in the end, however structured, the ministry of Jesus through the same Spirit speaking both to the church and to the world” (1987: 79) (Italics mine).

What would be the content of the Church’s prophetic role or advocacy? The Church is called to actualize God’s kingdom of justice and peace. This involves challenging social injustice, hypocritical religiosity, corrupt and uncommitted leadership and announcing hope (Dube 2003: 48).

The Church and HIV & AIDS Related Advocacy
What is HIV&AIDS advocacy and what does the Church have to do with it? HIV&AIDS advocacy is a process that focuses on:

- Creating awareness of the magnitude and seriousness of the HIV&AIDS problem
- Diminishing HIV&AIDS related discriminatory practices
- Removing policy and other barriers to HIV&AIDS prevention and care activities
- Campaigning for the availability of affordable ARVs, effective and sustainable action.

HIV&AIDS-related Advocacy targets, especially but not exclusively, the highest authorities in the church and/or the country to provide leadership, political support, and commitment.

**What does the Church have to do with HIV&AIDS Advocacy?**

Dube defines HIV&AIDS as a historical moment of crisis that requires an all out prophetic commitment from the side of the Christian church (2003: 46-48). She goes on to show how HIV&AIDS is a crisis moment. It has the potential to infect all of us; it affects all of us; it works through social injustice and attacks mostly the marginalized and disadvantaged populations. We will recall that the focus of Jesus’ ministry were the marginalized and disadvantaged groups. The gospel of Luke, especially, depicts Jesus as the friend and saviour of sinners, women, the sick, rich and poor, the persecuted and the disadvantaged (Luke 5:29-32; 8:1-3; 5:31-32; 12:33-34; 21:12-19; 10:29-36). The church, taking cue from Jesus, is called to do the same. In this moment of crisis, the church should raise a prophetic voice on behalf of the voiceless and challenge those who are sustaining the structures which create and perpetuate social and religious injustices.

### Activity 4

1. In the area of HIV&AIDS in what ways has your own church done advocacy?
2. If you were called to do HIV&AIDS advocacy in your area, what issue would you address? Give reasons.
Areas for HIV&AIDS Advocacy

We have seen in Unit 1 and elsewhere in this module that HIV&AIDS is a problem that pervades the social, economic, cultural and religious spheres of our lives. It works through social injustice. Where there is gross violation of human rights, gender inequalities, child abuse, gender-based discrimination, abject poverty, economic imbalances HIV&AIDS finds its home. We are going to look at the individual areas through which HIV&AIDS thrives and see how they can be addressed through advocacy.

Human Rights

A number of people have become survivors of human rights abuse, in society and in churches, as a result of their HIV status. As seen in Unit 7 and 8, HIV&AIDS are fuelled by violation of human rights. Many people who are infected with HIV are denied, directly or indirectly right to treatment and services; they have been denied the right to work; the right to attend school; the right to inherit money and property; the right to marry simply because they are HIV positive.

What can the Church do?

A WCC Study Document: *Facing AIDS: The Challenge, the Churches’ Response*, outlines some of the things churches can do in the face of human rights’ violation. These are:

- To safeguard the rights of persons affected by HIV&AIDS and to study, develop and promote the human rights of people living with HIV&AIDS through mechanisms at national and international levels.
- To promote sharing of accurate information about HIV&AIDS, to promote climate of open discussion and to work against the spread of misinformation and fear.
- To advocate increased spending by governments and medical facilities to find solutions to the problems-both medical and social-raised by the epidemic (1997: 93-95).
**Activity 5**

*Read Luke 17:11-19 and list things that we can learn from Jesus actions and words about advocacy, in the area of Human rights violations.*

**Gender Inequality**

HIV&AIDS uses gender inequality as well as poverty and culture, as argued elsewhere in this module, to attack individuals, families, children and communities. A lot of our African cultures sanction and support the subordination of women. As a result they are subjected to forced sexual intercourse; they have no power leverage to negotiate safe sex practices; they have no access to information as a result of disparity in educational opportunities; they have no right to inheritance or possession of land. In most cases in the event of the husband dying they become so poor and desperate as to turn to sex work. This makes them more vulnerable.

**What can the Church do?**

In the situation of gender inequality and its consequences, the church is called to:

- Work with women as they seek to attain the full measure of their dignity and express the full range of their gifts
- Focus on situations that increase vulnerability to HIV&AIDS such as migrant labour, mass refugee movements and commercial sex activity
- Recognize the linkage between HIV&AIDS and poverty and to advocate measures to promote just and sustainable development.
- Promote advocacy initiatives that target young boys who are valuable in enhancing more gender-equitable relationships between men and women.
- Advocate elimination of all forms of violence against women and campaign for change of laws where appropriate.
- Advocate empowerment of women and give them more negotiating skills as a tool for combating HIV&AIDS.
• Advocate improvement of women’s access to education and economic resources.

Activity 6

What does the story of a woman caught in adultery (John 8:1-11) teach us in the area of gender inequality and on how we should advocate for gender equity?

Involving People with HIV&AIDS

Non involvement of people with HIV&AIDS in issues that affect them directly is a reflection of stigmatization and discrimination. It is a case of ‘talking about them without them ’, something which creates a chasm between them and those who claim they are not infected.

What can the Church do?

In response to the situation, the church is better placed to:

• Provide a climate of love, acceptance and support for those who are vulnerable to, or affected by, HIV&AIDS by providing space for these concerns to be raised within regular worship events, through support groups and by visits to those affected by HIV&AIDS

• Advance theological Unity: the church needs to identify with PLWHA by underlining that if one part is hurt, all the parts share its pain and if one part is honoured, all the parts share its joy (I Cor. 12: 26).

• Work for better care of persons affected by HIV&AIDS

• Advocate involvement of those affected by HIV&AIDS in designing and carrying out strategies for prevention and care

• Advocate for employment and empowerment of people living with HIV&AIDS
• Support and empower PLWHAs to articulate their concerns

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*Identify a lesson/s that the story of the Good Samaritan (Luke 10:25-37) teach us on advocacy in the area of caring for people living with HIV&AIDS.*

**HIV Testing**

There have been concerns regarding HIV testing, in terms of its accessibility, quality and policies governing it. Facilities and equipment are still scarce in a number of countries for Voluntary Counselling and Testing. In places where it is accessible it is the quality that renders efforts to test reluctant. In other places, policies that govern cases of HIV&AIDS are discriminatory.

**What can the Church do?**

The church through its influence, infrastructure and involvement with the people even at the remotest of areas is better placed to:

• Advocate for good quality and accessible counselling and testing services
• Encourage voluntary counselling and testing
• Advocate for elimination or change of discriminatory policies around HIV&AIDS
• Discourage mandatory testing even within its circles
• Insist and advocate for confidentiality of services
• Participate in the discussion in society on ethical issues posed by HIV&AIDS and support and guide their members who face difficult ethical choices in the area of prevention, treatment and care
Activity 8

1. Analyse Voluntary Counselling and Testing in your locality in terms of accessibility, quality and policies governing it.
2. How can the church help to improve on or intensify the quality of service?

Children and Youth

Children and youth are among the most HIV&AIDS vulnerable groups. In a number of developing countries close to 60% of new infections are among 15-24 year olds. Biologically and socially young women are more vulnerable to infection than their male counterparts. The increase in the rate of infection among women means the increase in HIV-infected babies born to them (www.ippfwhr.org). A lot of other young people are rendered vulnerable because they are denied access to HIV education, information, health care and means of prevention.

What can the Church do?

The Church can assume its prophetic role by:

- Improving access to information, health care and means of prevention by young people
- Advocating for social change, which would go a long way in correcting popular myth such as the idea that having sex with a virgin will cure a man of AIDS, which fuel intergenerational sex and rape of the girl-child.
- Speaking strongly against harmful practices which contribute to HIV infection, such as female genital cutting, sexual exploitation and abuse/rape
- Involving young people in development of HIV&AIDS prevention programs.
Activity 9

1. Take a pen and a paper and write down the factors that contribute toward the vulnerability of children and young people to HIV&AIDS in your area.
2. In what ways can the church help to reverse or change the situation?

We affirm with the WCC study Document that,

“The church as the body of Christ is to be the place where God’s healing love is experienced and shown forth. As the body of Christ the church is bound to enter into suffering of others, to stand with them against all rejection and despair. Because it is the body of Christ – who dies for all and who enters into the suffering of all humanity – the church cannot exclude anyone who needs Christ. As the church enters into solidarity with those affected by HIV&AIDS, our hope in God’s promises comes alive and becomes visible to the world” (1997: 102).

SUMMARY

Unit 10 has exposed us to different definitions of advocacy. Despite the differences in emphasis between those definitions, we have identified essential components that distinguish advocacy from other related concepts. The church’s role towards advocacy is understood along side its prophetic role after the example of Christ who was a prophet par excellence. HIV&AIDS as a moment of crisis remains in the agenda of the church’s prophetic mission to challenge social injustices through which HIV&AIDS thrive. The unit has also outlined areas of HIV&AIDS advocacy and a corresponding series of activities that can motivate the church to more HIV&AIDS advocacy-oriented responses.
SELF-ASSESSMENT ACTIVITY

Answer All Questions

1. What are the essential components of Advocacy?
2. Mention any two ways through which advocacy can best be expressed in your own local context.
3. In your opinion, does the church have anything to do with advocacy? Give reasons for your answer.
4. Give scriptural basis for the church to act in the area of advocacy.
5. In the context of HIV&AIDS, what is the prophetic task of the church, to itself and to society?

FURTHER READING


www.cedpa.org/publications/faithcommunities
www.ippfwhr.org

GLOSSARY

Advocacy: the act of supporting a cause or issue.
Child abuse: Any form of cruelty to a child’s physical, moral or mental well-being.
Crisis: It is a crucial time and a turning point.
Gender inequality: Giving men and women different opportunities because of their gender.
Proactive advocacy: It is when people act to prevent a problem before it happens.
Prophet: Someone who speaks on behalf of God or the mouthpiece of God.
Reactive advocacy: It is when people are forced to act and solve the problem that is there.
Sex-based discrimination: Is discrimination done on the basis of one’s sex or gender.
Social injustice: concept relating to perceived unfairness of society in its distribution of rewards and burdens.
ASSIGNMENT I

Answer 4 questions only

QUESTION 1
a) List any three sectors of society.
b) Discuss how HIV&AIDS affects each one of them in terms of supply and demand.
c) Explain briefly how stigma and discrimination hinder prevention, treatment and care in HIV&AIDS situations.

QUESTION 2
a) State the four components of the definition of counselling
b) Discuss in detail, in your own words any of these components.
c) Show how important attending skills are for counselling.

QUESTION 3
a) Every person is a combination of both universal and individual traits. Explain this statement.
b) Discuss the importance of the concept of community in providing healing in an African context.
c) State and briefly describe the three stages of a helping process according to Egan.

QUESTIONS 4
a) Give the four aims of pre-test counselling.
b) Give three steps of pre-test counselling and discuss briefly each one of them.
c) Discuss the role of an HIV&AIDS counsellor in any HIV&AIDS counselling transaction.

QUESTION 5
a) What is the meaning of discordant couple?
b) Discuss what the focus of the counsellor should be in counselling discordant couple.
c) Systems approach to counselling corresponds to the way an African sees the world
around him/her. Discuss this statement.

ASSIGNMENT II
Answer 5 questions only

QUESTION 1
a) List forms of abuse most common in the workplace.
b) List ways in which abuse can be present in schools
c) What are the most common forms of abuse in the religious institutions.

QUESTION 2
a) Why do you think the issue of gender is so important in counselling abused clients?
b) How should the counsellor deal with the issue of dependency from an abused client?
c) Is it a good thing to encourage an encounter between an abused client and an abuser? Give reasons for your answer.

QUESTION 3
a) Orphanhood is not a new phenomenon. Discuss ways in which people in your culture dealt with it.
b) Find out in your locality some of the common psychological and emotional imbalances found in orphaned children.
c) Discuss three specific needs of terminally ill people.

QUESTION 4
a) Funerary rites are performed to redress the situation of death. Discuss ways in which funerary rites help people cope with loss through death in your culture.
b) How do stages of grief given in unit 7 compare with stages of grief in your own culture?
QUESTION 5
a) Discuss the relationship between the right to privacy and the right to confidentiality.
b) Briefly discuss the tension that could exist between anyone ethical principle discussed in unit 8 and its application in your culture.
c) In what ways can policies that protect the rights of PLWHA be introduced or improved or effectively implemented?

QUESTION 6
a) “The fight against HIV&AIDS is an essential part of the church’s mission.” Discuss in detail the implications of this statement.
b) List and discuss two ways in which the church can be present to PLWHA.

QUESTION 7
a) Discuss the difference between reactive and proactive advocacy.
b) In what two ways can the church be an advocate on issues of gender inequality?

TEST
Answer 4 questions only

QUESTION 1
a) Discuss ways in which HIV&AIDS pose a challenge to counselling.
b) Explain briefly the qualities required of an effective counsellor.
c) Discuss the difference between the attending skills and the exploratory skills.

QUESTION 2
a) Compare and contrast VCT and CTC as HIV&AIDS intervention strategies.
b) Discuss the importance of both supportive and crisis counselling in relation to post-test counselling.
c) Outline and discuss the components of a crisis.
QUESTION 3
a) State the challenges faced by caregivers in HIV&AIDS situations.
b) Discuss the distinction between stress and burnout.
c) Suggest three ways through which stress and burnout can be managed.

QUESTION 4
a) The experience of abused clients makes their counselling process very special. Argue for or against this statement.
b) Outline and discuss very briefly the common features of the initial stage in counselling abused clients.
c) What makes counselling pregnant a special intervention or case.

QUESTION 5
a) What do legal issues have to do with HIV&AIDS?
b) Discuss briefly the call/mission of the church in situations of HIV&AIDS in terms of:
   i) Source of its call/mission.
   ii) Beneficiaries of its call/mission.
   iii) Content of its call/mission.
c) Discuss the notion of advocacy and how it relates to the mission of the church.

EXAMINATION
Questions 1 and 7 are compulsory. Answer any other three questions of your choice.

QUESTION 1
a) HIV&AIDS related stigma is a social construct. Argue for or against this statement.
b) Define and explain the essential components of the definition of counselling.
c) Discuss anyone aim of counselling.

QUESTION 2
a) What does the skill of listening entail?
b) There are different theories regarding the origin of HIV & AIDS. State three of them and argue for or against their validity.

c) State and discuss the second stage of a counselling process according to Egan.
QUESTION 3

a) Describe in writing how you would prepare for and conduct a pre-test counselling.
b) Very briefly discuss the pastoral dimension of counselling.
c) Discuss the importance of couple counselling in HIV&AIDS situations.

QUESTION 4

a) According to the study done in Uganda and South Africa by UNAIDS, caregivers for people with HIV infection and AIDS are made up of different groups of people. Mention and discuss two of these groups.
b) Name and discuss three forms of abuse.
c) What is it that makes women and girls more vulnerable to abuse? Taken your own local situation into consideration.

QUESTION 5

a) Define an orphan and discuss three types of orphans.
b) Discuss the impact of HIV&AIDS on children.
c) Discuss the specific needs of terminally ill people and show what terminally ill people as a result of AIDS require from a counsellor

QUESTION 6

a) Define the following three terms and show how they are related:
   i) Grief
   ii) Bereavement
   iii) Loss
b) Mention and discuss any three ethical principles that should guide counsellors in dealing with clients in HIV&AIDS situations.
c) What is a HIV&AIDS policy and what is its importance in the workplace?

QUESTION 7

a) Discuss ways through which the church can be present to PLWHA?
b) What can the church do in the face of grief and loss?

c) What can the church do in the area of Human rights Advocacy within the context of HIV&AIDS?

SELECTED BIBLIOGRAPHY


