STI/HIV COUNSELLING

in Pacific Island Countries

a training manual

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Introduction

This manual has two main aims: to encourage health workers to use counselling skills as part of their work and to help them learn those counselling skills. The Manual consists of 12 learning sessions, each containing guided discussions and activities on a different aspect of counselling. The appendices contain support material—overhead transparencies, handouts and relevant case studies—to be used during the training sessions. If you are thinking of planning and/or running a training course of this nature, we suggest that you read quickly through the whole Manual, to familiarize yourself with its contents before you start your planning.

Facilitating training in STI counselling involves raising people's awareness of very complex issues in personal communication. Sometimes profound dilemmas arise with regard to human and professional conduct. So it is very important to consider carefully who are the most appropriate participants and what the training should achieve.

WHO IS THIS TRAINING FOR?

The primary purpose of this manual is to train trainers of STI/HIV counsellors. It is also designed to be used by those trainers as they pass on their knowledge and skills to trainee counsellors. Experience suggests that participants most likely to benefit from this training programme include:

- those with practical medical, nursing and/or psychosocial experience in delivery of STI/HIV care;
- managers of STI/HIV programmes;
- those with experience in counselling or psychosocial management;
- those who will be future trainers of counsellors; and
- those for whom counselling has relevance in the conduct of their STI/HIV health work.

WHAT CAN THE TRAINING ACHIEVE?

This training programme represents a beginning in the development or refinement of counselling skills. It should be seen as only a first step in development of STI counselling capacity. In order to sustain the outcomes of this training you should consider follow-up training in managing such specific and complex issues as breaking bad news and helping clients/patients and their loved ones as they adjust to their new situation.

OBJECTIVES

Understanding why counselling is necessary

By the end of their training, participants should have:

- become familiar with basic counselling and communication skills;
- reviewed the process of STI counselling;
- reviewed the major issues affecting the sexual behaviour and health of young people;
- identified cultural and community factors that may affect counselling content; and
- reviewed the content and practice of HIV pre-test and post-test counselling.

Developing counselling skills

By the end of their training, participants should also have:

- developed skills in discussing and exploring sexual behaviour with young people;
- developed skills in discussing safer sex options and how to use condoms—especially for young people;
- rehearsed obtaining a sexual behaviour history, explaining safer sex options and demonstrating the proper way of using a condom;
- rehearsed giving positive and negative test results to clients/ patients;
- experienced leading some aspect of a workshop as a trainer/ facilitator; and
- learned how to organize, facilitate and conduct a participatory workshop.

Planning for counselling in the community

By the end of their training, participants should also have:

- considered the best way of integrating reproductive health counselling into people's daily work—especially that of young people; and
- identified the resources in the local community that may be appropriate for complementary care and support.

Who should facilitate?

In order to facilitate these training sessions a trainer will need good interpersonal skills, experience in running activity-based and role-playing workshops and a sound understanding of the STI counselling process. Ideally, there should be more than one trainer for each workshop and experience and research have shown the importance of including a facilitator or trainer who has lived with HIV or a chronic STI. This helps to reduce stigma and increase understanding of and identification with the physical and psychological problems of living in a state of uncertainty and under the threat of death.

How many participants?

Experience also suggests that this kind of training works best with a group of no more than 20 participants and that the ratio of participants to facilitators should be no more than 6:1. This allows the participants and facilitators to give enough attention to the complex and important issues they are addressing.

How to use this Manual

This training Manual is divided into twelve 'sessions', each covering a different topic and each of a different length. These are:

Session 1:	Introductions, overview of the workshop
Session 2:	Communication skills and counselling
Session 3:	STI/HIV counselling
Session 4:	Culture, sexuality, counselling and young people
Session 5:	Gender and sexual health
Session 6:	Attitudes and values
Session 7:	STI/HIV pre-test counselling
Session 8:	STI/HIV prevention counselling
Session 9:	STI/HIV post-test counselling
Session 10:	Planning training and mobilizing resources
Session 11:	Integrating counselling into the day-to-day work of STI/HIV services
Session 12:	Workshop evaluation

At the back of this manual you will find all the masters for the overhead transparencies mentioned in the session notes; handouts to copy for your participants and some relevant country case studies. There is also support material and additional references which you may wish to use if you decide to adapt or expand one or more of the sessions.

FORMAT

The notes for each session start with a 'what you will need' icon. Here you will find a list of the things you will need in order to run that session.

As you will see, there are several different types of activities. All of them are designed to encourage participation and active learning and they are varied. To help you plan them, we have labelled each one with one or more icons, as follows.

This icon indicates a primarily whole-group or 'plenary' activity in which participants may be asked to brainstorm ideas, share their experiences or report back on small-group activities.

This icon indicates a small-group discussion activity. Participants may work in pairs, threes or fours, gathering or applying ideas, and/or prioritizing or evaluating suggestions.

This icon indicates a role-play or other interpersonal activity.

This icon indicates a brainstorming session, where either the whole group or small groups gather thoughts and ideas freely, without prejudice or evaluation.

This icon indicates a training tip or suggestion, which may be helpful to the trainer who is facilitating the session.

PLANNING YOUR WORKSHOP

Clarifying the context of training

For STI counselling training to have the maximum impact, it is important to find out in advance as much as possible about the contexts in which your participants are working, so that you can tailor the content of the workshop to their needs.

In order to do this, you will need to:

- **find out about the local situation**—identify the local epidemiology, the structures of any local STI services, the ways in which STI care is delivered, and the need for counselling in these areas;
- **review local or regional models of STI counselling**—this will help you to provide options for your participants as they make plans for counselling developments in their local areas;

- **find out about structural issues that affect the provision of counselling**—procedures for STI reporting and partner notification, laws associated with STI management, availability of privacy and time for confidential discussion, and availability of relevant health services to complement STI counselling and management; and
- **collect relevant case material**—gather together any available evidence of the impact and benefits of counselling in STI and HIV/AIDS, and models of care from other countries. There is some information in Appendices 3 and 4 at the back of this Manual, but you can make your training much more relevant by including real information from your own area. A Fiji Ministry of Health Training Trainer's Manual on 'Emergency Contraceptive Pills', prepared by the Reproductive Health Section, will also be useful.

Deciding which sessions to use and/or adapt

If the training is meant only to raise awareness about the complexity of STI counselling and the importance of appropriate training and service planning, then a shorter course, say 5 days, may be appropriate. Alternatively if the training aims to train trainers at the local level or if it aims to teach counselling skills to those who will be managing the medical and psychosocial concerns of patients afterwards, then a 10-day course is appropriate.

You can add or subtract sessions according to their relevance to the culture and country in which you are doing the training. You also need to take into account the time available for training and the level of practical experience in hands-on patient management of the participants. For this reason, the manual contains more sessions than you might normally expect to be included in a ten-day training course of this type.

Overhead 1: Plan of an STI counselling training programmes, shows how you can structure a five-day programme. You should allow about ten days to cover the whole programme in depth.

Getting your materials together

Each session will require the following materials and equipment:

- flipcharts and large sheets of paper (use paper that is cheap and easy to obtain, such as newsprint paper)
- extra paper for the participants to write on
- marker pens, overhead transparency (OHT) pens, pens or pencils for participants;
- sticky tape
- overhead projector and blank overhead transparencies and slides.

You will find a list of any additional materials required at the beginning of each session. It is a good idea to check these as early as possible as it may take a little time to obtain some of them.

GETTING THE PEOPLE TOGETHER

Preparing participants

It would be helpful to ask participants to prepare a three-minute summary of their own STI service delivery structure and their experience with counselling (and/or the need for it) within their STI service. At the same time you should ask participants to come prepared to discuss the availability and numbers of personnel providing STI counselling and the types of training these people have received. You will also need to address the sociocultural and ethical issues faced in STI counselling, so any information about these issues which you can obtain will be useful.

You can either ask your participants to send you the STI summary information in written form before the workshop starts (i.e. by posting or faxing it in advance), or you can use these short talks as part of Session 1.

GETTING LOCAL ORGANIZATIONS INVOLVED

If a local adolescent organization exists, it would be helpful if you could invite them to contribute to or (better still) participate, particularly in Session 4. One or more articulate adolescents would greatly help this session.

When you have decided which topics you are going to include in your workshop, read through the notes for those sessions carefully, estimating how long they are likely to take, noting points where you may need to add to or adapt the material to your local situation and also noting what you will need—overheads, handouts, additional materials, teaching/learning aids etc.—to conduct that session.

RUNNING THE WORKSHOP

This training programme is designed to be interactive and encourage **as much participation as possible,** based on the premise that experience is the best teacher. So you will be asking all your participants to take part actively in all exercises, role plays and clinical experiences as participants, actors or observers. Here are some suggestions for encouraging this active learning.

- It is important that your participants feel comfortable about taking an active part. You can encourage **an informal yet disciplined atmosphere** by:
  - making sure the environment is pleasant and inviting. This will help your participants to feel comfortable and encourage them to get to know each other. This includes not only the room you will be using, but also such things as availability of refreshments and toilets as well as staff who can assist with administrative problems such as transport or telephone difficulties or shortage of paper for a session;

- meeting in a room which is big enough to allow your participants to get up and move around as they take part in some of the activities;
- arranging the room to facilitate free and informal exchange of ideas. This is often a circular or U-shaped seating arrangement, preferably without desks or tables in front, as these can form barriers to communication; and
- encouraging equality and avoidance of authority relations (some participants looking up to others). This can be done by just using the first names of all participants.

The participants in your workshops will have been selected because they are skilled in their own fields and it is important to respect this and involve them in the training process. One way of doing this is by keeping them well-informed about the progress of the workshop.

- At the start of the workshop, show the agreed workshop programme to the participants to give them a sense of the structure and content of what will follow. Your programme will probably be an adaptation of the one in Appendix 1, **Overheads 1.1 and 1.2: Plan of an STI counselling training.**
- Each morning, give your participants an opportunity to **review the previous day's activities and key emerging issues** and also to review what will be done that day in order to affirm a sense of continuity and progress.
- Similarly, at the beginning of each session, **explain the logic of that session**, what it will do and why it will be done.
- And at the end of each session, explain why it was done, and use an overhead, flip chart or whiteboard to **summarize the key points** that have emerged.

All these procedures help to reinforce the content and the process of the training. Your participants may subsequently become trainers of their colleagues so try to encourage them to take over as facilitators, introducing sessions, leading plenary discussions, organizing group exercises and role-plays, and summarizing sessions. It is a good idea to do this as early as possible in the programme, so you may need to give your participants some advance notice of this.

Breaking the tension

The nature of some of the material covered in the workshop can be emotionally intense and draining. So it may be appropriate to vary the conduct of sessions, using video presentations of counselling skills, films or field trips. The videotapes or films might deal with medical management or stigma and family issues associated with HIV/AIDS and STI. It would also be useful to make field trips to local facilities so that your participants can see models of STI counselling in action.

You may also wish to gather together some short exercises or activities which you can introduce if you feel a need to break the ice in a discussion, break the tension after an emotional discussion or role-play or allow your participants to relax for a few minutes.

Encouraging participation and active learning

Active learning requires the involvement of participants. If they are actively involved through participation in learning activities, they will be more likely to build their own problem-solving abilities and commitment to the goals of the training workshop. This participatory approach also encourages learners to share and apply the knowledge they have from their own experiences.

There are many ways of encouraging participation. Use your own judgement to decide which of the following might be most effective for your participants:

- whole group, or plenary discussions;
- using brainstorming exercises to facilitate discussion;

> ***Brainstorming*** *is a method of gathering group ideas and views. It involves getting participants to call out their thoughts on issues being discussed. This gives them a chance to share their ideas; it encourages participation, and it promotes problem solving. The facilitator listens to all ideas or responses objectively,* ***without editing or criticizing*** *the ideas and writes the responses down on paper or on an overhead transparency during the discussion. At the end of the discussion, the facilitator summarizes the participants' contributions. A brainstorming session has been successful if there have been many spontaneous responses and a large number of ideas have been raised.*

- carrying out sub-group discussions, using groups of three to four participants;

> *Spend some time thinking about how you will divide your participants into sub-groups or pairs for their role-plays or discussions.*
>
> – *Will you allow them to form their own sub-groups or will you decide?*
>
> – *Will you sometimes take one approach and sometimes the other?*
>
> – *Should they work in the same small groups throughout the workshop or should they move around and work with different people?*
>
> – *What would work best for the particular activity you are doing?*

- using anonymous response cards for participants to answer questions;
- forming pairs of participants to discuss key concepts or questions or to work on tasks;
- encouraging participant pairs to interview one another or to compare their reactions or ideas or to develop questions together;
- having participants present their views as a panel—this may help those who are quiet or shy to express their views and you can rotate the membership of panels to give everyone a chance to participate;

- carrying out active debates;

  *Divide the participants into **two debating teams** and assign each team either the 'pro' or the 'con' position on a controversial issue. Give each team some time to develop arguments for their assigned position and then ask each team in turn to present their views through an identified spokesperson or 'reporter'. Next, give either the spokespersons or all participants the opportunity to ask questions or present counter-arguments to what they have heard. When it seems appropriate, end the debate and convene a group discussion about what the participants have learned and the arguments raised.*

- planning and carrying out active exercises or games which elicit participants' ideas, knowledge or skills;
- using stories, dramas or songs to represent issues and to facilitate group discussion;
- using 'codes,' or 'picture codes';

  ***Picture codes** are codes without words; they are illustrations which can represent situations about which people may have strong feelings. You can use them as a basis for asking a series of questions to stimulate discussion and problem-solving;*

- using 'mindmapping' or concept-mapping to help participants to generate ideas or analyse problems.

  *Give your participants paper and marking pens and ask them to create colourful **visual maps of a problem, issue or concept.** You can suggest that they begin their map by creating a picture or writing out the main idea or topic in the centre of the paper. Then encourage them to draw or write related ideas around the edges of the map.*

In some of the sessions you will find suggestions for alternative ways of conducting training on specific topics, because different approaches work in different cultures. You can choose which way you do these activities, or you can use these examples plus the suggestions above to help you adapt activities as appropriate for your circumstances, audience and available time.

Conducting role-plays

Role-playing is an important technique in counselling and it forms a large part of the active learning in this training manual. It provides a useful method of exploring attitudes and practising skills, including communication and problem-solving skills. For example, a role-play may be a rehearsal of a counselling session. During the role-play, an actual case may be used, in which one participant plays a counsellor, and another plays a person being counselled. A third participant may be designated as an observer. The observer's task is to watch as their colleagues perform the role-play and then to relate the issues raised to the main purpose of the activity.

For this technique to work well, the participants need some support. Before they start you should let them know exactly what is required of them by, for example, presenting the 'case' they are to enact on an overhead or handout. You will also need to give them a short time to prepare their roles and decide what the observer should be looking for.

You can conduct a role-play like this:

- divide participants into equal-sized groups of three or more people;
- explain in detail what the role-play is about and what they will achieve by doing it;
- allow each group to decide who will be the 'counsellor', the 'client/ patient', and the 'observer';
- give the small group time to prepare the role-play;
- ask the participants to perform the role-play:

  Give everyone who has prepared their role an opportunity to participate, and help anyone who is shy or has difficulty (they may find it easier to stop and then try again later after watching the efforts of some of their colleagues).

- after all the role-plays, ask the 'client' to give feedback first, followed by the 'counsellor' and then the 'observer'; and
- after the feedback, invite the whole group to discuss what they have seen.

This is just one way of doing it. Another alternative is to ask one pair to present a role-pay to the whole group in a plenary session. All the others observe and then you can invite them to respond to what they have seen.

When they are feeding their ideas back to the plenary session, it is useful to encourage participants to discuss only the two or three most important points which they have observed. This encourages them to prioritize, which can help them to focus on the main purpose of that activity. It also saves time and helps to avoid unnecessary repetition.

Take care during role-plays that the participants give each other their full attention, especially where role plays are being conducted in front of plenary groups. This means remembering to:

- make sure that the participants can be heard (you may need to remind them in advance to speak up);
- ask your participants to switch off mobile telephones and other electronic equipment;
- keep doors closed so sounds from outside of the classroom do not distract or interrupt;
- make sure that participant observers do not talk among themselves or laugh inappropriately; and
- set a good example: give your full attention to the role-play while it is happening.

There is more information about how to establish these 'ground rules' in the notes for Session 1.

Some of your participants may not find it easy to role-play well. You can encourage them by ending all role-play discussions by listing the positive parts of the counsellor's performance, followed by suggestions for change or improvement. And some role-plays involve controversial or emotional issues. After one of these you must check that the participants are not adversely affected by their experience. You can do this by reminding everyone that the actors have been assuming roles, and that they do not necessarily agree with the values they have acted. If the emotional impact is strong, then you may find it necessary to use a tension-breaking or relaxation activity.

Inevitably, role-plays and discussions can lead in many directions. Keep a particular activity focussed by ending all role-play or discussion sessions with a summary of the points raised plus any other points that have been missed. Appendix 1 contains a number of masters for overhead transparencies which you can use for this and the session notes give details of which overheads are appropriate to each session.

EVALUATION OF THE WORKSHOP

This manual provides you with a sound basis for planning and running workshops to meet your particular needs. However participants—their backgrounds, their needs and their purposes—will differ from workshop to workshop. The more often you run these workshops, the more you will learn about how to improve the next one. An important source of information is your participants so you need to ask them for feedback before they leave. Session 12 allows you to do this. You can ask them to complete the questionnaire which you will find at the end of Appendix 2. You may need to adapt it to your own purposes if you have modified the workshop in any way from the 12 sessions presented here.

An alternative or complementary way of evaluating the workshop would be to present one of the paper case studies at the start of the workshop and ask participants to identify the counselling needs and requirements of the situation. You could then repeat this at the end, and compare the responses to provide a qualitative assessment of the impact of the workshop.

SESSION 1:

Introductions and overview of the workshop

What you need for this session:

***Overheads 1.1 and 1.2**: Plan of an STI counselling training programme*

Aims

- *to introduce group members to each other and identify their different experience with STI counselling and care; and*
- *to explain the plan of the workshop and the uses of plenary discussions and role plays.*

GETTING TO KNOW EACH OTHER

Activity 1.1: Interview and report exercise

This is a warm-up exercise, intended to introduce the participants to the interactive style of the training programme and to help them to learn about each other, and begin to relax in one another's company.

Getting started

Your participants will probably not know each other very well so you can begin by explaining that before they start work, they need to learn a little more about each other. One way of doing this is for them to interview each other in pairs and then for each person to introduce their partner to the group.

They may well be rather shy and hesitant about this to start with, so it may be best to begin this process by using an ice-breaker exercise to help them to get to know each other and begin to establish some mutual trust. One way of doing this is to:

- select pictures from magazines;
- then cut each of the pictures into two separate parts and mix the parts up;

- now give a part of a picture to each participant; and
- ask them to get out of their seats and each find the person with the missing half of the picture.

Once they have become a bit more relaxed in each other's company, you can ask them to divide into pairs. (The people in the pairs should preferably not know each other well.)

Ask each partner in the pair to interview the other one for five minutes in order to find out:

- their name and what they like to be called;
- their place of origin;
- their place of work;
- their professional experience and experience with STI management;
- their experience with counselling in any field;
- their family status (married? children? etc.);
- their pastimes and interests; and
- what they hope to achieve from the workshop.

After each partner has interviewed the other, ask them to use the information to introduce each other to the rest of the group.

Use the information from the introduction of participants to review the special characteristics of the group and emphasize that they can all learn from each other during the training programme.

Tips for trainers

It will help if you ask strangers to interview each other and encourage friendly, informal discussion and presentations of biographies by asking participants to avoid using titles like 'Dr' or 'Professor' which would encourage a sense of hierarchy, especially among colleagues from the same institution or department.

OVERVIEW OF THE WORKSHOP

Tell your participants what they can expect in this workshop. Give them a workshop programme like the one in **Overhead 1.1 and 1.2: Plan of an STI Counselling Training Programme** and outline the organisation of the subject matter and issues which you plan to cover in the course of the training programme over the next few days, ten if you are doing the full programme or less if your requirements are different. It is a good idea to include the comfort breaks designed into each day.

Tips for trainers

Once you have worked out your workshop programme, write out a one-page summary on an overhead or flip chart for the whole group (in addition to the more usual detailed day-by-day plan) and give a copy to each participant. This will help them to get a sense of the structure of the workshop and see the logic of the flow of the course. You should also explain that you will be presenting the content of each day's sessions every morning and that you will also be summarizing the key points emerging from each day the following morning. This will help participants to know what to expect.

This is also a good time to mention house-keeping matters such as:

- the locations of toilets;
- fire regulations;
- no-smoking policy during the workshop;
- location of food and eating facilities
- location of telephones, etc.; and
- identification and introduction of the workshop officer (the person to be approached with any administrative problems eg. flight confirmation, need for telephone calls).

Activity 1.2: Ground rules

You should draw attention to the **interactive** and **participatory** nature of the exercises and role-plays. The participants may be rather uncomfortable with this, so ask them to respect that the content of the workshop and the experiences of participants are:

- confidential to the group;
- without reference to work hierarchy;
- based on an attitude of mutual support; and
- disciplined but informal (using first names only, not professional titles).

At this time you can ask your participants to reach group agreement on any other workshop ground rules which may be appropriate. These will apply to the whole group during the workshop. They encourage efficient use of time, courtesy and respect for other people's views.

One way of doing this is to ask the participants to work in the same pairs as in the introduction activity and to spend a few minutes making a list of rules which they think is appropriate for the workshop. They may wish to include such things as:

- being on time for sessions;
- not leaving sessions early;
- not interrupting others when they are speaking;
- turning off mobile telephones or pagers during the workshop; and
- not making personal remarks about gender, rank or profession.

When they have had some time to think about this, then you can encourage each pair to suggest an idea for a group rule and write the rules on a flip chart or board. Once you have a list of all the suggestions, you can ask the full group how each of these make them feel and what ground rules may suit them.

SESSION 2:

Communication skills and counselling

What you need for this session:

Overheads: *2.1-2.2, 3.1-3.2, 4, 5.1-5.3, 6.1-6.2, 7.1-7.2, 8.1-8.3.*

Handouts: *1, 2.1-2.4, 3, 4.1-4.2.*

You can photocopy them for the participants as ice-breaking activities.

Aims

- *to understand what counselling is;*
- *to begin to develop basic counselling skills;*
- *to clarify some of the non-verbal aspects of communication;*
- *to discuss and understand the client-centred model in basic counselling skills; and*
- *to understand the importance of values and ethics in counselling.*

Tips for trainers: How to organize groups

One of the most effective ways of teaching basic counselling skills is to have the participants sit in a circle without desks/tables in front of them. This facilitates participation and belonging. Also, it is best not to have any barriers as this helps to promote the interactions which the session is designed to encourage.

Think about how you are going to divide the participants into groups and refer back to the section on encouraging participation and active learning in the Introduction for ideas if needed.

Remember the ground rules that the participants set for themselves in Session 1. Do they need to be reminded of them? If so, then write them on paper and post them around the room. Are your participants relaxed in each other's company? Do you need to do another ice-breaking exercise to warm them up before they start the session?

Make sure there are sufficient breaks between the activities. Some activities flow naturally from the previous one, but be ready to take a break when you feel the group needs one. In this session you will be asking the participants to work in pairs, threes, fours and bigger groups. Have some icebreakers ready to help get people moving around.

Provide as much feedback as possible. All feedback is useful!

WHAT IS COUNSELLING?

This session begins with a brainstorming session on what counselling means and what skills are required by a counsellor.

Activity 2.1: Counselling is ...

Ask the participants to form into groups of three to four people. Ask them to choose a group recorder to take notes on what is said and a spokesperson or reporter to present the groups findings to the rest of the participants. Provide some paper for participants to write their answers on.

- Ask all the groups to spend 10 minutes brainstorming their understanding of what counselling is.
- When they have done this, ask the group to take another sheet of paper and to spend a further five minutes brainstorming their ideas on the types of skills counsellors need.

Then call the groups together for a feedback session in which the reporters will present their group's findings to the larger group.

It will become clear that some common helping skills will emerge. Your role, as facilitator, is to bring the answers of the groups together and to point out what counselling is and what it is not. You will need to highlight the commonalties and show that in some roles, counselling skills can be used to enhance other roles, such as nursing or administration.

To reinforce these important definitions place the groups' notes around the room so that others can read them. You can also show **Overheads 2.1 and 2.2: Counselling and counselling skills** and distribute **Handout 1: Counselling and counselling skills.**

The key lesson from this activity is…

Counselling means many different things to different people. People get their ideas of what counselling is from personal experience, what they have read in the newspaper or seen in a movie or on TV, books about counselling and the beliefs of friends and family. If the participants use counselling skills in conjunction with their other professional skills, then they will find that they enhance their relationships with their clients/patients.

COUNSELLING SKILLS

The following activities require participants to begin to develop basic counselling skills. These are:

- active listening;
- understanding and using non-verbal communication;
- using open and closed questions;
- reflecting content and feeling; and
- paraphrasing and clarification.

The basic counselling skills that your participants will learn in the following activities are culture free. This means that they can be used in any culture. What will be different in different cultures will be the way people display non-verbal behaviours and the meanings associated with them.

LISTENING SKILLS

Begin this activity by emphasizing that a very important skill in counselling is being an **active listener.** The following activities will help to demonstrate this.

Activity 2.2: Non-verbal communication only

Ask the group to form into pairs for a mirroring exercise. Explain that this is a non-verbal exercise where one partner should try to match the other's movements as if they were looking in a mirror. No talking!

- One person in each pair should act as the leader and the other person should follow their movements without any verbal communication.
- Each person should start in a basic position facing their partner with hands held up towards the face, palms outwards.
- The leader should then make movements with his/her hands, legs, head or trunk of body.
- The follower should try to follow the leader's exact movements.
- After two minutes, the partners should swap roles.
- The activity should run for a total of four minutes. two minutes for each person.

Then ask each participant:

How did you know your partner was paying attention to you?

Some possible responses:

I knew because their eyes were following mine.

I knew because of the way he/she moved his/her head when I moved mine.

Use this to elaborate on how we obtain information from another person. We do this by **active listening.** We listen with our eyes as well as our **ears** to give us the information we need. We all, whatever our culture, use cues from non-verbal behaviour to tell us more about the person we are talking to. Different cultures use different 'body language' as it is sometimes called, but we all use it. After a while the listener's body language usually begins to mirror that of the other person. This is an unconscious behaviour which shows that the listener is paying attention and actively listening to the speaker, in this case, the client/patient.

Activity 2.3: Verbal communication only

Ask the group to stay in their pairs and to sit back-to-back. They must remain in this position throughout the entire activity.

This time one person in the pair should listen while the other talks for three minutes on 'the things I don't like in a person'. After three minutes they should change roles, for another three minutes.

What are the thoughts and feelings of each participant? You can ask:

How did you feel when you were talking?

What were your thoughts?

Some possible responses:

I felt uncomfortable, as I did not know whether she was listening to me.

I liked it.

If a person says they liked it, mention that they might need to think about how they would sit when they are talking to a client/patient during a counselling session. This person may prefer to sit at a side angle so that they are not looking directly at the client/patient, and they will need to think about why they preferred this format.

Activity 2.4: Verbal and non-verbal communication

The same pairs should work together again and this time they should sit face to face. Again each should take three minutes to speak and three minutes to listen. This time the topic is 'the things I like about myself are…'

After both persons in the pairs have spoken for three minutes each, ask:

How did you feel when you were talking face to face?

What were your thoughts?

How did you know the person was listening to you?

Some possible responses:

Much better. I preferred it this way because I knew he was listening to me.

Because, although he wasn't responding to me using words, he was nodding his head and smiling.

Although I didn't like the topic, I felt comfortable, as I knew she was listening to me.

The topics in this activity are designed to encourage your participants to think about:

- their biases towards the things they do not like about other people. This will be useful in Session 6 when you explore values and how they influence the counselling relationship; and
- the things they like about themselves—something many people have not thought about before.

Some of the lessons from this topic are:

How can we help another person if we do not know ourselves?

How can we appreciate unconditionally another person if we do not like/love things about ourselves?

EXPRESSING FEELINGS

In any helping relationship, people are going to express their feelings, sometimes very strongly. Our general reaction to the expression of feelings will depend upon our values and beliefs about emotions. We will have learned these values and beliefs from past personal experiences and from the views passed down from our own upbringing and culture.

In the helping relationship we can express and react to feelings or emotions by:

Witnessing someone express his or her feelings strongly i.e. the person may cry or shout in front of us.

Listening to someone talking about their feelings i.e. they may tell us how angry they are at their partner for not telling them that he/she is HIV positive.

Thinking or talking about our own feelings i.e. being reminded of how sad we were when someone close to us has died.

Expressing our own feelings i.e. feeling sad and crying on our own account, perhaps remembering some loss we have suffered.

Activity 2.5: Exploring emotions

Ask the participants to form groups of about four people. Give each group an emotion to mime, but do not let the other groups know what it is. These emotions might be:

- love
- hate
- anger
- frustration
- depression
- fear
- numbness

Give the groups three to five minutes to prepare their mime. Ask them to think of a story, preferably one which is based on the theme of STI/HIV/AIDS, that illustrates an emotion.

Then ask one of the small groups to role-play their emotion to the whole group, and ask one of the other groups to explain the story. When they have done this, ask how that group knew which emotion was being expressed in the mime. Repeat this until each of the groups has role-played their emotion.

Follow this up with some discussion on how people recognized the emotion being expressed. You can encourage the discussion by asking questions of the performing group. For example:

> *Did the other group describe your story correctly?*
>
> *Why were you (pointing to one of the actors) throwing your hands around in the air?*
>
> *When you smiled was it because you were happy or because you were trying to hide something?*
>
> *And so on.*

Try to use this discussion to elaborate the importance of being aware of the ways in which humans express emotions verbally and non-verbally. Also try to emphasize and explore the influences of culture on how emotions are expressed and the contexts in which they are expressed. The role-plays should also help you to reiterate the importance of using eyes and ears when listening actively. Remind participants that when they are in doubt they should ask for clarification from the client/patient. For example, 'You are telling me this very sad story and smiling at the same time. What does that mean?' They may find this difficult at first, and they may need to be reassured that this approach will greatly strengthen their helping abilities.

Tip for trainers

Handouts 2.1-2.4 will be useful here The accompanying overheads are Overheads 3.1-3.2: Active listening, Overhead 4: Projection–be aware of hidden feelings, Overheads 5.1-5.35: Open and closed questions, Overheads 6.1-6.2: Reflection of content and feelings and Overheads 7.1-7.2: Paraphrasing and clarification.

The key lessons from this activity are…

We **listen** with our **ears** and **eyes**. There are cultural reasons why people behave in particular ways and we need to be aware of the ways in which people communicate non-verbally. We use non-verbal behaviour to show that we are listening and what we are feeling.

You can elicit responses from the group on specific non-verbal cues from their own cultures, for example, hand gestures, nodding of head, smiling, laughing, facial expressions, tone of voice and body posture while sitting. You might draw up a list of these for the participants to take away with them. They need to understand that when humans are communicating, we use our bodies to convey our message as well as words.

The activities in this session should also have shown that there are barriers to communication. Ask the group to suggest barriers which appeared in these activities and list them on a flip chart. Examples might be too much noise from outside, not looking at the person when talking to him/her, staring, sitting too close, shouting, soft voice, listener feeling tired or hungry, hot weather and listener preoccupied with their own thinking.

Help the participants to become aware that there are many barriers to communication, and that as a listener/helper they will need to be aware of their own barriers as well as those of the client/patient. They can help someone by:

- listening sensitively and accurately to him or her (this means being sensitive to their whole person);
- being aware of their own emotional blind spots;
- being aware of how people express their feelings cross-culturally; and
- developing empathic skills.

Now explore emotional responses a little further. Projection and projective identification are important psychological concepts that illustrate the power of the unconscious mind. The next activity is designed to explore the participants' own barriers and emotional blind spots.

Activity 2.6: Projecting your feelings onto other people

This activity requires the participants to begin to think about their own values and beliefs about STI/HIV/AIDS and for them to reflect on how their feelings about someone or something else can have a negative effect on the way they help a person.

Begin by reading a case study about a person who has HIV. You can use **Handout 3: Cema** here or a case study of your own. Then ask the group to choose one character from the story and explore their feelings towards that character.

Then ask each participant why he or she has chosen the character.

> *Did you find yourself identifying with that character? Why?*
>
> *What are your feelings towards that character?*
>
> *How would they affect your dealings with another of the characters in the case?*

This is how we project our own feelings onto others. In counselling this is known as **projection**.

For example, suppose that a nurse who works in an STI clinic has had a fight with her husband and comes to work feeling very angry with him. She displays a very uncaring attitude (telling them off, shouting etc) at work that day. In other words she is projecting her anger onto the patients. Suppose now that in the afternoon a patient yells back at her for treating him rudely. An argument erupts. The patient has identified with the nurse's anger and is responding to it. This is known as **projective identification.**

Ask the participants if any of them would like to share a similar experience with the group.

The key lessons from this activity are…

Self-awareness of one's values and prejudices are important because they can creep into a helping session. (Reiterate lessons learned from activities 2.5 and 2.6.)

Be very careful **not to project** your feelings onto a client/patient.

Be very careful **not to identify** with the client's or patient's emotions, as that will not be helpful to the client or patient.

ASKING OPEN AND CLOSED QUESTIONS

Activity 2.7: Open and closed questions

Start by giving an example of an open and a closed question. For example:

> *Sina can you tell me what you did last Friday evening? (Open question)*
>
> *Peni did you have breakfast this morning? (Closed question)*

A closed question only gets a one word response (yes or no, usually) while open questions allow for more elaboration. Open questions use words like who? what? why? when? where? how? Which are more useful to a counsellor? Which should be avoided? Ask the participants to try them out as follows.

Ask the participants to work in pairs again, to ask each other a series of questions and to answer them. Give them a few moments so that each one can prepare a set of closed questions and another set of open questions. Then allow three minutes for one member of the pair to ask their questions and the other to respond to them. Then they should swap roles for a further three minutes.

When they have done this, bring the group together and ask each participant:

> *How did you feel or what did you notice about using closed questions?*
>
> *How did you feel or what did you notice about using open questions?*

Make use of these responses to elaborate on the appropriateness of using open questions. Draw the attention of participants to the difficulties of using 'why' questions. Questions that begin with 'why' tend to have a judgmental feel to them, which can harm communication in the relationship. For this reason counsellors should try to limit the use of questions beginning with 'why'. You can demonstrate this by asking participants some of the questions below and then asking them for feedback on how they felt when you asked questions beginning with 'why'.

Some examples of closed questions

> *Did you have unprotected sex last night?*
>
> *Does your family know you're having sex outside marriage?*
>
> *Do you have children?*
>
> *Have you been taking your medication?*

Some examples of open questions

Tell me how did it feel...

Can you explain further...?

What forms of contraceptive have you tried before?

Can you tell me where have you been getting information about sexual health from previously?

The key lessons from this activity are…

- Try not to ask too many closed questions.
- Open questions facilitate trust and warmth in the helping relationship.
- Open questions enhance the breadth and depth of communication.
- Avoid questioning situations that may sound intrusive or judgmental. For example, 'Why did you do it?' Replace with, 'Can you please tell me why you…?'

Tip for trainers

In the next activities your participants will be role-playing aspects of the counsellor/client relationship. They may find this easier if you first brainstorm with them a few appropriate situations to provide a context. List these on a flip chart, so that your groups can choose from them as they prepare their role-plays.

DEMONSTRATING ACTIVE LISTENING

It is not enough just to listen actively. A good counsellor also lets their client know they are doing so.

Activity 2.8: Reflection of content and feeling

Reflection involves reflecting the content and feeling of the other person's responses back to them. The purpose of reflection is to send a message to the client/patient that you are listening carefully to what they are saying and that you are trying to understand. The key to reflection is to reflect (like a mirror) back to the client/patient their feelings and content of what they are saying. Activity 2.8 is a role-play which will demonstrate this.

Ask the participants to form into groups of three people. One person will role-play the listener, another the client and the third person will play the observer who will provide non-judgmental feedback to the listener, or 'counsellor'. Each person will play their role for about five minutes before the roles are rotated around the group.

First, demonstrate reflection of content and feelings. For example:

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, you sound confused and afraid (*reflected feeling*) about what people will say when they find out about your relationship with Viliame, especially your father (*reflected content*).

As the groups do this, walk around them providing feedback.

Then bring the whole group together for a feedback session. Ask participants:

How did you feel as you used content reflection?

How did you feel as you used feeling reflection?

What do you think you have gained from the activity?

The key lessons from this activity are…

- Reflection is part of active listening.
- Reflecting content and feelings shows the client/patient that you are paying attention to them.
- The ability to give good reflections without sounding like a 'parrot' is a matter of practice.
- Reflection is a basic counselling skill that communicates empathy, a core condition discussed later on.

Activity 2.9: Paraphrasing and clarification

Paraphrasing and clarification are another part of active listening. When used together they become a powerful method of communicating your care and attention to the person you are trying to help.

Paraphrasing is summarizing in a few words what the speaker is saying. Although in some circumstances it may be best to use the client's/patient's own words, it is much more than just parroting their words.

The example in Activity 2.8 also includes paraphrasing:

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, you sound confused and afraid (*reflected feeling*) of what people will say when they find out about your relationship with Viliame, especially your father (*reflected content*).

Clarification is not quite obvious as it sounds. It means seeking clarification of your own understanding of the client's world. Clarification helps the client/patient to come to understand themselves better as a consequence of having to explain something in more detail, or in a different way. Doing this can help your client/patient to feel that you are trying really hard to understand.

Ask the participants to form into groups of three people again: one to role-play the listener, another the client and the third person to play the observer who will provide non-judgmental feedback to the 'counsellor'. Each person should play their role within five minutes before the roles are rotated around the group.

Start by demonstrating clarification, for example:

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, I'm sorry I'm not quite clear about what you meant by that. Could you please tell me a bit more? (*Clarification*).

Again ask the groups to role-play a situation where the client shares some aspect of his/her situation and the 'listener' uses the basic counselling skills learnt in the previous activities. These must now also include paraphrasing and clarification skills.

As they do this, move from group to group providing feedback as required.

When the role-play is finished, bring the whole group together for a feedback session. Ask the participants:

How did you feel about using paraphrasing and clarification?

What have you gained from the activity?

The key lessons from this activity are…

- Paraphrasing is not repeating back the client's words exactly. It is about showing that you understand.
- Clarification allows the listener/helper to get a more accurate understanding of the client's/patient's world.
- By asking for clarification for yourself, you can help the client/patient clarify his or her own thoughts and feelings.
- Paraphrasing and clarification demonstrate empathy and active listening.

A CLIENT-CENTRED APPROACH

All these skills, active listening, awareness of non-verbal communication, asking open questions, reflecting content and feelings and paraphrasing and clarifying are part of a client-centred approach. The client-centred approach to counselling makes the client the centre of the helping process in the sense that helping is seen as providing for a self-healing process. This helping process makes use of the self-healing skills which the client already has, by providing important helping conditions. These core helping conditions are:

- empathy;
- congruence; and
- making the client feel good about him/herself.

Empathy is trying to see things through your client's eyes. Congruence is being as open and honest as you expect your client to be. Making your clients feel good about themselves involves **unconditional positive regard**. Unconditional positive regard is showing respect for your client.

In order to provide these conditions there must be a complete absence of threat to the client. The next activities are designed to help the participants practise their new skills to demonstrate empathy congruence and unconditional positive regard.

Activity 2.10: Developing a client-centred approach

Start by discussing with participants **Overheads 8.1, 8.2 and 8.3: The client-centred approach** and distributing **Handouts 4.1-4.2: The client-centred approach.**

Then ask the group to form themselves once more into groups of three people, one to role-play the listener, another the client and the third person to play the observer who will provide non-judgmental feedback to the 'counsellor'. Each person should play their role within five minutes before the roles are rotated around the group.

They will begin by practising **empathy**. As the 'client' explains their situation, the 'listener' should use the basic counselling skills learnt in the previous activities to demonstrate empathy, particularly through *reflection, paraphrasing and clarification* skills. During the role-play you should walk around the groups providing feedback.

At the end of this activity, ask the following questions:

How did you feel using all the basic counselling skills?

How did you know someone was being empathic?

What have you gained from the activity?

The second part of the activity is to practice **congruence.** This fishbowl exercise requires people to be honest in their feelings and expressions.

Split the participants into two groups of equal size. One group will form an inner circle, facing outwards and the other group will form an outer circle, facing inwards. Each person in the outer circle will in a sentence or two tell the person opposite them in the inner circle how they 'honestly' feel about them. Then the outer group will move in an anti-clockwise direction around the inner group, speaking to each person in the same way until all the people in the outer circle have spoken to all the people in the inner circle.

Now ask the participants:

How did you feel giving congruent statements? and

How did you feel receiving congruent statements?

When you have received all the comments from the group, summarize them on the flipchart.

Tip for trainers

You may feel you need a tension-breaking or relaxation exercise here if this exercise has become intense.

The third part of the activity is to practice **unconditional positive regard**.

Divide the participants into groups of four and ask them to spend about eight-10 minutes discussing the following situation and how it could be handled.

> *What would happen if you were supposed to be helping someone whom you didn't like because you knew they were a sex worker?*
>
> *Should you be judgmental and say that you don't like them or should you be non-judgmental and be falsely warm and accepting towards them? What would you do?*

While the groups are discussing this, move around providing feedback to them as required. When they have finished, bring the whole group together and ask the participants:

> *How did you feel about being non-judgmental?*
>
> *What are some of the more positive ways of dealing with such a situation?*

When you have received all the comments from the group, summarize them on the flipchart.

The key lessons from this activity are…

- It is useful to have the three core conditions (empathy, congruence and making the client feel good about him/herself) integrated into your basic counselling skills to help people.
- Empathy is listening sensitively, understanding the other person, checking to see if you got the message right and suspending judgement. It is trying to understand the client's/patient's world, their meanings, and seeing their life through their eyes.
- An empathic helper uses active listening. Basic skills like active listening, reflection, paraphrasing and clarification are used to display empathy in a helping relationship.
- Congruence is displaying honesty and genuineness. As a helper you should not first deny or avoid your own feelings but be aware of them and then not be afraid of expressing them if it becomes appropriate.
- Unconditional positive regard is the absence of judgement. As a helper you must accept the person you are trying to help as a worthwhile human being.

SUMMARY

In this session participants should have learned that counselling skills can be used alongside other professional skills, such as health care or administration, to great benefit. They should also have had the opportunity to practise some of the key counselling skills.

Active listening is a key skill used in any helping relationship. Active listening is the use of verbal and non-verbal communication. It is about what we pay attention to in the person we are helping.

Some aspects of non-verbal behaviour are culturally defined and as helpers we must first be aware of our own ways of expressing ourselves non-verbal expression before we can understand another person.

Open questions facilitate and enhance communication. Open questions facilitate trust and warmth in the helping relationship.

Basic counselling skills that facilitate trust in a helping way are the reflection of content and feelings, paraphrasing, and clarification.

Self-awareness of our own values and prejudices is important. As counsellors we must be very careful not to project our own feelings onto our clients/patients. We must be very careful not to identify with our client's/patient's emotions because this will not be helpful to them.

The three core conditions, empathy, congruence and unconditional positive regard, are qualities that enhance the helping relationship. They are qualities of being with and helping people. The basic counselling skills of active listening, reflection, paraphrasing and clarification contain the three core conditions, which facilitate a warm and trusting helping relationship.

SESSION 3:

STI/HIV counselling

What you need for this session:

Overheads: *9, 10, 11 and 12.*

Aims

- *to identify some of the positive characteristics of an STI counsellor;*
- *to identify the essential features of an STI counselling session;*
- *to find out how to structure a counselling session; and*
- *to examine the process of an STI counselling session.*

Activity 3.1: Characteristics of an STI counsellor

This activity will require the participants to identify the positive qualities of an STI counsellor.

Begin with a brief opening discussion on the variety of health workers providing STI counselling and what their background qualifications are or should be. Note these down on a flipchart so that participants can refer to them later if they need to.

Ask the group to divide themselves into pairs who will work together to identify some positive qualities of an STI counsellor. Provide each pair with paper to write their answers on and give them about 10 minutes to do this activity.

Bring the whole group together and ask each pair to present their findings. Then work with the group to draw out all the characteristics that are common and so make up a list of them.

Then ask the participants:

Why are these characteristics positive?

This should start a discussion on the reasons. Add these to the list so that it can be posted on the wall for later reference. Also, encourage the participants to keep a record of the discussion for their own reference.

Activity 3.2: The essential features of an STI counselling session

This activity requires the participants to identify the essential features of an STI counselling session.

Use the same process as in **Activity 3.1** but this time the topic for discussion is:

What are the essential features of an STI counselling session?

Use the same process for feedback and discussion and for recording and sharing the information.

At the end of these two activities, elaborate on the positive characteristics of an STI counsellor and the essential features of a counselling session. You should make specific reference to the importance of confidentiality, accessibility, respect, privacy, honesty and time. Try to make it very clear to the participants that if these qualities are not present, then it will be very difficult for trust to develop in the helping relationship and without trust, appropriate support for the prevention of these illnesses will not emerge.

Here are some examples of personal characteristics and essential features that may emerge in the discussion (see **Overheads 9.1-9.2: Essential features of a good counselling session).**

A good counsellor is …	*A good counselling session takes account of …*
Warm	Time - the value placed on time in the cultural context
Trusting	Ethics - professional ethics
Knowledgeable	the use of basic counselling skills in an appropriate, understanding and helpful way.
Respectful	the client's need for a competent and responsible helper
Practices confidentiality	the client's need for confidentiality.
Smiles a lot	the requirement to do the most good and the least harm when there is a dilemma
Consistent	the requirement to act within the law of the land
Treats people fairly	location - easy to access
Supportive	
Friendly	
Sensitive to issues of:	
Gender	
Culture/ethnicity	

Time is a very important issue in any counselling session. This means both keeping time (especially if the client has an appointment) and maintaining time (keeping to the agreed length of the counselling session). It has been recommended that a session should last no longer than 55 minutes to one hour, on the grounds that spending longer does not help your client or yourself. Some organisations have a set length of time for a counselling session. The group should discuss what they think is an appropriate length of time for a counselling session and how counselling sessions can be timed.

THE STRUCTURE AND PROCESS OF A COUNSELLING SESSION

The next activity will assist the participants in structuring a session and it will also help them to examine the process of such a session. Begin by leading a group discussion on how a counselling session is structured. Use **Overheads 10.1,10.2 and 10.3: The structure of a counselling session** and **Handouts 5.1 and 5.2** which accompany them. Also use the notes which follow as a guide, and write any additional points on a flip-chart for all to see.

Notes for the facilitator

Every session must have a beginning, a middle and an end.

- The beginning is where the helper/counsellor introduces himself/herself—who he/she is and what he/she is there for. In some sessions it may be appropriate at this point to mention the ethical values of respect and confidentiality to the client to reassure them.
- The middle part of the session is where the helping relationship develops. Here the counsellor uses basic counselling skills, displays the three core conditions and provides preventative messages.
- The end of the session can be an end of the relationship or it can be the beginning of a long-term relationship. This depends partly on the skills and understanding of the counsellor, but also on the circumstances.

An STI counsellor can use the skills and core conditions learned in Session 2 to help the client/patient solve their own problems. Introduce the LEPERS model of problem solving to the group.

***LEPERS** means:*
***L**istening*
***E**xplaining*
***P**roviding information*
***E**xamining*
***R**educing anxiety/providing appropriate reassurance*
***S**uggesting strategies*

An STI counsellor can use this model to structure a counselling session. Within the basic structure of a beginning, a middle and an end, the STI counsellor uses basic counselling skills (active listening, reflection and paraphrasing and clarification) and displays the three core conditions (empathy, congruence and unconditional positive regard). He/she will explain and provide reproductive information, examine options for the client, reduce anxiety and provide appropriate reassurance and may also suggest strategies for coping.

Activity 3.3: Practising the beginning and the ending

These role plays build on the range of basic counselling skills and the listener must remember these and the core conditions learned in Session 2. This may require some revision of the basic skills learnt in the previous session.

Ask the group to form into groups of three people: one person to role-play the listener, another the client and the third person will play the observer who will provide non-judgmental feedback to the 'counsellor'. Each person should play their role within five minutes before the roles are rotated around the group.

Give the groups a few minutes to prepare. Then demonstrate an 'introduction' and an 'ending', using **Overheads 11.1-11.3: Introductions and endings**

An example of an introduction:

> *Hello (or can use local greeting) Avinesh (or substitute with local name). My name is Mere. I work here at the Clinic. I will do my best to help. I would like to tell you that whatever you say here today will be held confidential. Can you tell me what is concerning you?*

- You can change it to suit a standard introduction that all the workers in the Clinic use.
- You can change it to suit the cultural context you are working in.
- The introduction can be peppered with local words or the use of vernacular.

An example of an ending:

> *Avinesh, can you tell me if you have received the information you came here for?*
>
> *OK! Remember you can always come back and see me again if you have any questions or need someone to talk to. If you can make an appointment that will guarantee you will see me again.*
>
> *Yes you can take all the pamphlets, they are free.*
>
> *Take care/bye/see you again (this depends on what you prefer and the person you are helping).*

Now ask the groups to role-play a beginning and an ending of their own.

While these role-plays are taking place, walk around the groups providing feedback as appropriate. Then bring the whole group together for a feedback session. Ask the participants:

> *How did you feel about using an Introduction and an Ending?*
>
> *Was it helpful?*

Would you use the same Introduction all the time or would you change it? Ask for some explanation of the answer to this.

What have you gained from the activity?

Some discussion on introductions and endings might follow, depending on the group. Issues raised might include the following, which are also provided in **Overheads 11.1-11.3.**

Some important points to keep in mind …

- For many people issues of a sexual or reproductive nature can be embarrassing for them to discuss. To seek assistance is a big step and a person can come with many expectations about the session or the preventative messages that will be provided. Be mindful of this.
- Language is an important issue to think about when you are counselling in a helping way. The use of vernacular or slang may assist open communication. Be flexible.
- Be mindful of cultural beliefs and expectations and how they influence the thoughts, feelings and behaviour of human beings. Be aware of your own cultural beliefs and expectations.
- Discussing sensitive topics (e.g. reproductive health, sex contraception) can be uncomfortable for both the client and the counsellor. These tips for putting adolescents at ease and inviting them to talk with you apply to clients of all ages:

    - Make adolescents feel welcome
    - Ensure privacy and confidentiality
    - Treat adolescents with respect and do not judge them
    - Use a sense of humour

Ask the group whether they can think of anything else to add to this list.

Activity 3.4: Preventive messages

Ask the group to form into groups of four people, and ask each group to identify a recorder and a reporter. Provide paper for them to write on.

Now ask the participants to work together in their groups to identify **some of the preventive messages** that can be included in a counselling session. Ask them to make a list and give them about 10 minutes to do this.

Then bring the whole group back together and ask each group to present their list. Work with the whole group to draw out all the preventative messages that are common to all groups and make up an inclusive list.

Use this list to ask the participants **why these messages are important.** This should start a discussion on the reasons. Add these to the list so that it can be posted on the wall for later reference. Also, encourage the participants to keep a record of the discussion for their own reference.

The list should include:

- abstaining from sex;
- remaining mutually faithful; and,
- using condoms regularly.

You could also refer to **Overhead 12: The ABC of preventing STI's.**

Activity 3.5: Skill practice and reflections

This activity is intended to allow the participants to practise the whole range of basic counselling skills and to display the three core conditions that facilitate a helping relationship as well as to reflect on the use of counselling skills in a helping way.

Ask the participants to form into groups of three people: one person to role-play the listener, another the client and the third person will play the observer who will provide non-judgmental feedback to the 'counsellor'. Each person will play their role within 10 minutes before the roles are rotated around the group.

Again, give the groups a few minutes to think about what they are going to say. The aims of this activity are for the participants:

- to practice the range of basic counselling skills and conditions;
- to practice an introduction and an ending;
- to practice providing preventative messages;
- to use the range of basic counselling skills; and
- to display the core conditions learned in Session 2.

While the groups are discussing this, move around providing feedback to them as required. When they have finished, bring the whole group together and ask the participants:

> *How did you feel about using the range of skills you have learned?*
>
> *How do you feel about maintaining the three core conditions?*
>
> *How do you feel overall about your level of the skills you have learned?*
>
> *What have you gained from the activity?*
>
> *Are there any further questions from Sessions 2 and 3?*

Depending on the group, there could be some discussion on any of these questions.

SUMMARY

You may wish to end this session by summing up and providing any further information that is required by the group.

SESSION 4:

Culture, sexuality, counselling and young people

What you will need for this session:

Copies of the Country Case Studies *(see Appendix 3)*

If you have available any research reports on young people and sexuality, you might find them useful for the second part of this session.

Try to invite an articulate adolescent who is willing and able to address the workshop on 'what sex means to us' or try to find a short video on adolescent sexuality and problems.

This session falls into two parts:

- *Culture, sexuality and counselling*
- *Adolescent/youth sub-culture and sexuality*

CULTURE, SEXUALITY AND COUNSELLING

Aims

- *to discuss the issue of sex and sexuality in a cultural context;*
- *to explore the relationship between cultural practices relating to sex and STI transmission; and*
- *to attempt to understand the roles of culture and religion in communicating about sex and sexuality.*

Activity 4.1: Brainstorm on culture, sex and sexuality

Start by leading a brainstorming session on the meaning and important aspects of culture and religion. You can ask each participant to write down what he/she understands about the words culture and religion, then write all these meanings on a flip chart to display any differences. These definitions should inform the discussion which follows.

Activity 4.2: Culture, religion, sex and STI

Taking the definitions from **Activity 4.1** as a starting point, try to encourage this discussion by eliciting from participants aspects of their community's cultural and religious understanding of sex and its practices and how some of these can contribute to the spread or prevention of STI. These practices should include gender roles in sexual relations, expectations, responsibilities and multiple sexual partnership.

Ask the participants to write down their knowledge of particular sexual practices within their own culture and religion that can contribute to STI transmission or to its prevention. Examples might include: adult-youth mandatory sex, sex as an initiation requirement, single partnership, abstinence, group sex among teenagers, adult and young adolescent female marriages and sexual abuse.

It may be difficult to get participants to speak about these things, especially in countries where there is a 'culture of silence' on sex and sexual relations and practices. Yet it is very important that these things are elicited and discussed. A useful approach may be to try to elicit the reasons for the silence and how this silence relates to STI infection and known cultural practices of STI prevention. Try also to encourage discussion of the role of religion to sexual taboos or practices and write the responses to these on the flip chart.

Activity 4.3: Discussion of culture and talking about sex

Following the previous two discussion activities, try to elicit from participants how communication is organized within their cultures. Focus especially on cross gender and age-differential communication about sex, illness and treatment. What are some of the acceptable forms of interpersonal communication? For example what are the acceptable ways of showing respect in communication, discussing bad news, offering advice? And how would the culture of silence about sex impact on STI/HIV counselling?

Again write the group's findings on the flip chart before they divide into small groups for the following discussion.

Activity 4.4: Specific aspects of sexual practice and communication

Begin by asking the participants to refer to the Vanuatu Case Study (Appendix 3). Then ask them to divide into small groups, each spending 15 minutes discussing an aspect of sexual practice and communication such as those given below. Remind them to keep the emphasis on how culture influences sexual encounters, partnership(s) and consequences. The discussion should raise the issues of culture/role conflicts of men and women, and especially adolescents. Here are some suggested topics for this discussion (you may think of others).

- known traditional sexual practices;
- male-female communication about sex and gender responsibilities;

- cultural practices relating to sex, and STI infections among teenagers and adults;
- expectations of men and women in negotiating sex and maintaining socio-cultural expectations (emphasis should be put on community and family expectations especially on cross-cousin sexuality or other kin-related
sexuality); or
- 'forced marriages' of adolescent females.

After the 15 minutes, ask a spokesperson from each group to present issues raised in their discussion.

Tips for trainers

This discussion can be difficult for some. You should be very observant while you are introducing the topic and if you notice difficulties and silence at this point then try dividing the participants into small groups. Think carefully about group gender membership with respect to the cultural situation of the country.

If there is silence, then you should also acknowledge that and have the groups discuss it and its role in their societies.

Try also to get some information on a known cultural practice of sex which has implications for STI/HIV transmission. You can then use this as a basis for discussion or include a description of it in a handout.

YOUNG PEOPLE AND SEXUALITY

If you have available any research reports on this subject, these might be useful here.

Aims

- *to explore adolescent sub-culture and its characteristics that relate to sex and sexuality;*
- *to attempt an understanding of the meaning of and myths about sex, and sexual activity among adolescents;*
- *to identify reasons for the lack of knowledge among adolescents of consequences of sexual behaviour and sexuality;*
- *to demonstrate an ability to obtain information on sex and sexuality from adolescents in a manner which respects diversity, is culturally sensitive and appropriate and which generates rapport and trust;*
- *to emphasize some of the positive, risk-free behaviour of adolescents and to understand the factors that encourage it.*

Activity 4.5: The subculture of adolescents and youths

Introduce and encourage a group discussion on the subculture of adolescents and youths and its major characteristics in relation to risk behaviour generally.

In this discussion give emphasis to adolescent behaviour with regard to cigarette smoking, drug and alcohol use and sex. Encourage the participants to discuss why these are part of the sub-culture and how society at large contributes to these aspects of the sub-culture.

The discussion should examine, with examples where necessary, marital cultures which subordinate adolescents' sexuality to adult sexual behaviour e.g. forced or arranged marriages between older men and young girls.

The discussion should also highlight positive, adolescent behaviour and risk-free and healthy lives. Questions to be addressed here could be, for example:

- Why do some adolescents/youths stay away from risk behaviour?
- What strategies do they have for coping with their sexuality and growing up?
- What are the source of these strategies?
- Why are those strategies unavailable to other adolescents?
- What particular social and cultural pressures prevent others from engaging in risk-free sexual behaviour?

Activity 4.6: Why do adolescents engage in sex, particularly unsafe sex?

For this discussion you really need some statistics on STI and HIV rates in your country and the Region, preferably showing differences by age and gender. You can use the Country Case Studies as examples. Also distribute any relevant research report(s) on teenage pregnancies which you may have been able to obtain. Then use this data as the basis of a brainstorming discussion on why young people engage in sexual activities and why so many of them practise unsafe sex.

Divide the workshop into groups of four to five each, and divide the topics below among the groups, preferably two topics per group. Each group should if possible have representatives from different countries or cultures.

By the end of the discussion, each group should be ready to present their findings to the workshop on two of the following topics:

- the meaning of sex to adolescents;
- adolescent sexual practices;
- myths about sex and growing up;
- the importance of adolescent voices/opinions on sex and sexuality
- how adolescents handle gender issues in their relationships;
- how to properly organize available information on sex and sexuality for adolescents;

- parent-based socialization on sex and sexuality;
- how to make accurate information about safe sex and sexual health easily accessible to adolescents; and
- how the voices of adolescents in captive sexual relations can be heard, even if these are through marriage.

After 30 minutes recall the groups for a plenary discussion. Ask each group to make a short presentation of its findings and to prioritize the issues emerging from their discussion. Draw together the main threads of their ideas, focussing particularly on the reasons for any differences of opinion.

WHAT DOES SEX MEAN TO ADOLESCENTS?

At this point it would be good for the workshop participants to hear the voices of the young people they are trying to help. The best approach here would be to invite an articulate adolescent who is willing and able to address the workshop on 'what sex means to us' to speak to the group. Another approach would be to show the group a video on adolescent sexuality and problems. Try hard to organize this as it will make the following sessions far more meaningful and real.

Activity 4.7: Starting a conversation and establishing trust

The participants should remain in the same groups as for Activity 4.6 for this role-play.

Ask each group to select one person to adopt the role of an adolescent with some worries about sex, for example a girl whose boyfriend is insisting she has sex with him or she has had sex with her boy friend and she is now worried. She is seeking someone to talk to.

Ask each of the other members of the group to take about five minutes to interact with this person. During this time they should attempt to provide an environment in which trust can be established and a conversation can begin.

When each of the group members has had time to try this activity, recall the groups for a plenary discussion. Ask each participant to describe his/her strategies in initiating conversation and what happened as a result. Then ask the person playing the role of the adolescent to give his/her views on each of the strategies.

Then ask the whole group to come up with strategy. This should include:

- how to start the conversation;
- how to keep communication flowing easily ;
- how to keep the conversation friendly;
- how to introduce the issue of sex;
- how to overcome any difficulties; and
- how to deal with gender implications.

Activity 4.8: Talking about sex to young people

Responding to the concerns of adolescents and youth involves discussing many aspects of sexuality. Along with physical bodily changes, adolescents are often grappling with issues of identity, gender roles and expectations and interpersonal relationships with peers and adults. Providing reproductive health counselling to adolescents involves:

- Openly discussing their concerns, bodies, minds and feelings
- Being aware of the many issues often interrelated with reproductive health concerns—including alcohol, drugs, school or relationship problems
- Talking about sexuality
- Providing information about the risks and consequences of sexual activity
- Providing basic and accurate information and skills to promote responsible sexual behaviours and safe decision-making, including how to handle social and peer pressures
- Providing information about alternatives to risky sexual behaviour

Use a flipchart to write down ideas as the whole group brainstorms ways of getting young people to talk about sex and finding solutions to the prevailing high incidence of STI/HIV.

- How can we best attract their attention?
- How can we keep it?
- How can we make accurate information about sexuality accessible to them?
- What do they want to know about sex?
- How can we contribute to providing a risk-free environment for their age-group's behaviour and enjoyment?
- How can they contribute to providing a risk-free environment for their age-group's behaviour and enjoyment?

Tip for trainers

Find out all the words used by adolescents/youths in your country for sex, penis, vagina, condoms. Find out what words are used to express one-night stands, going-steady, youths who stay away from sex, those who are seen as very straight and studious and those who are seen as easy to approach for sex.

Find out how adolescent peer groups provide support for each other.

Activity 4.9: What do the different genders think?

Divide the participants into gender-specific groups and ask each group to discuss and write down what they think men or women want to know about sex, why, and how, and what is the best way of communicating this information to them.

At the end of the exercise, write all the comments on a flipchart. Take particular note of the commonalities—they represent what the group wants.

Activity 4.10: Helping adolescents to recognize STI risk

Ask the participants to work in groups to devise a set of questions to ask a young client, which would help them to recognize their risk of getting an STI. Would they be different for males and females?

When they have done this, write the questions on a flip chart or whiteboard and compare them with the ones on **Handout s 6.1-6.2: Checklist for recognizing STI risk.** Complete the activity by again refering to **Overhead 12: The ABC of preventing STI.**

WHAT SHOULD WE HAVE LEARNED BY THE END OF THIS SESSION?

This session should have increased participants' awareness of:

- the importance of adolescent-friendly approaches;
- the importance of trust;
- the need to include adolescent voices in designing Information, Education and Counselling strategies;
- the risks and protective factors in adolescent sexuality; and
- the need to create appropriate contexts for providing information on sexuality to adolescents.

If adolescents constitute a social category, then why not find out from them what they want to know about sex and how they think this information can be shared with them.

SESSION 5:

Gender and sexual health

What you need for this session:

Overheads: *13, 14.1-14.2, 15.1-15.2, 16.1-16.2, 17, 18, 19, 20.1-20.4, 21.1-21.2*

Handouts: *7.1-7.3 and 8.1-8.2*

For Activity 5.4: *Slips of paper with a different sexual activity written on each - enough for all the participants*

For Activity 5.6: *Steps of condom use on note cards*

For Activity 5.7: *Penis models, dildos or bananas, enough for each pair of participants, tubes of water-based lubricants, sufficient numbers of condoms (one or more for each participant).*

For Activity 5.8: *You will need the help of two of participants. Ask for volunteers before, brief them on what they will need to do and give them time to prepare.*

For Activity 5.12: *A 'code' such as a short video, a drama by participants or a 'picture code'.*

Aims

- *to be able to facilitate discussion on different sexual organs and sexual acts by making it easier to discuss sexual issues;*
- *to give information about safer sex and sexual health;*
- *to demonstrate the use of condoms;*
- *to rehearse the issues associated with taking a sexual history; and*
- *to build self-confidence in discussing body parts and functions.*

Activity 5.1: Sexual terms desensitizing exercise

You will need a helper for this activity. Ask the participants to place their chairs in a large circle and explain that they will be doing an active 'musical chairs' exercise.

Give each participant a name of a common root crop or vegetable. Use just two names so that, for example, one participant is called 'taro', the next is called 'cassava,' and the pattern is repeated until all participants are called by one of the two terms.

Now explain that you are going to call out a name. If you call out 'taro', then all the 'taros' should move to a different chair. If you call out 'cassava', then all the cassavas should move. Also tell them that if you call out 'breadfruit,' then all the participants should move to a new chair.

Begin the exercise by calling out one of the three words. As participants get up to move, your helper should remove a chair from the circle. One person will be left in the centre of the circle and that person must now call out a word, so that when people begin to move again, a chair becomes available. They try to sit there, so that another person will be left in the middle.

Play this game for a few minutes. Then call a halt and state that now the participants will all have new names. Name one participant **vagina,** the next **penis,** and so on. Remind the participants of the game rules: if the word 'vagina' is called out, all the 'vaginas' move; if the word 'penis' is called out, all 'penises' move. If the word 'sex' is called out, everyone moves. The facilitator then begins the game by calling out one of the words.

When the game is called to a close, ask individual participants to relate their feelings about the game to the larger group and to discuss how and why such an exercise might be used in training.

Activity 5.2: *'What are they talking about?'*

Use **Overhead 13: What are they talking about?** to present the following examples of health education messages from different countries:

> *'When doing that which cannot be discussed, place that which cannot be described on that of which it is forbidden to speak.'*
>
> *'If it's not on, it's not on!'*
>
> *'Take it off! Put it on!'*

Now ask what these messages are saying, guiding the group in identifying the phrases that represent sexual vocabulary that cannot be stated explicitly. For example, in the first statement, 'When doing that...' means 'When having sexual intercourse', and 'place that..' means 'place a condom'; 'on that...' means 'on the penis'. Thus, the statement is translated as:

> *'When having sexual intercourse, place a condom on the penis'.*

Similarly, the last two statements mean:

> *'If you do not wear a condom, sex will not happen,'* and
>
> *'Take off your clothes - put on a condom'.*

Use these examples to explain that ways can always be found for discussing sexual activity in a manner that avoids giving offence.

Activity 5.3: Brainstorming exercise on sexual terminology

You may wish to do one or both of the following versions of this activity.

Activity option 1

Ask the participants:

- to identify all body parts that are used for sexual activities;
- to list a variety of sexual activities or behaviours; and
- to list activities associated with sexual transmission of infections.

Write these terms down on the left side of a flipchart. Then ask participants to suggest other words and phrases that describe these issues, parts or activities in:

- technical local language; and
- local slang.

Then write these down on the right side of the flip chart. If some participants are unable to say the words, invite them to write them on the flipchart.

Alternatively, you might write lists of body parts and sexual activities on large sheets of paper and put them up on the walls of the room. Then ask participants to read a term and discuss its meaning or ask someone else to discuss its meaning. Make sure you also discuss local technical and slang language for the terms.

For example, some local terms for 'sexual intercourse' include:

Technical:	**Slang:**
Penetration	Fucking
Consummation	Giving the dog a bone
Sambhog	Bonking
Milna	Chodna
Conjugal relations	Screwing
Carnal knowledge	(Substitute local terms here)
(Substitute local terms here)	

Other formal words and processes that may be discussed include masturbation (both male and female), sexual excitement, vagina, breasts, penis, ejaculation, prostitute, group sex, anonymous sex, casual partner, homosexual and lesbian. Ask the participants to provide local variants on sexual activities and terms. For example 'poofter' in Fiji means a homosexual and 'pros' (from prostitute) means sex worker.

Activity option 2

In order to illustrate the difficulties associated with discussing sex in some settings, you could also invite the participants to perform a role-play about a recently married woman from a traditional family who comes to the clinic as part of a regular gynaecological review, and asks about sexual activity, specifically 'What is an orgasm?' Invite the counsellor to find ways of describing the process of orgasm without creating embarrassment or anxiety and invite participants to give feedback and provide suggestions from their own clinical experience.

The next activity is designed to promote further discussion by asking questions focused on gender aspects of sexuality. You might ask participants to present their views of the 'ideal' young woman, young man and older woman and older man. The participants could then be asked to state what women and men of young and older ages are **expected to do** and what they are **expected not to do.** As part of the discussion, you could also ask participants to share traditional stories or proverbs concerning sexuality as related to women and men.

Activity 5.4: Brainstorming discussion of gender aspects of sexuality and sexual health

Open the discussion by asking participants to write down what they understand by the term 'sexual health'. You can read these aloud to the group or write them on a white board or flipchart. Use them to arrive at a definition of sexual health which is acceptable to the group.

Now encourage participants to share any ideas, fears or concerns they have—or those they feel other people may have—about sexuality and sexual health. Also ask them to share issues, problems or worries they or others may have about the gender aspects of sexuality of older women, older men and young men and young women. Issues arising from the discussion may include sexual concerns, impotence, fears of STI/HIV/AIDS, personal freedom and domestic violence. As the discussion progresses, summarize the issues and concerns raised and relate them to the group definition of sexual health.

When you are summarizing the discussion, you may wish to refer to the group's own definitions of sexuality and the definitions of sexual health given in **Overheads 14.1 and 14.2: Definitions of sexual health**, along with the list of issues to consider in sexual health management given in **Overheads 15.1 and 15.2: Issues to consider in working towards sexual health**. Also encourage recognition of the difference between elements of the definition that are disease-based and those that are based on **prevention/holistic** perspectives.

You can summarize the discussion in a table form, illustrating the different meanings of sex, sexuality and sexual health.

SAFER SEX

Introduce this session by stating the rationale of safer sex:

- to prevent transmission of infections by encouraging avoidance of contact between sexual organs of one partner (penis, vagina, anus) and bodily fluids of the other partner (semen, vaginal fluids, blood); and at the same time
- to maintain sexual satisfaction.

Tip for trainers

In all the following activities and discussions, remember the influences of culture, religion, gender, youth etc. Try to include these factors in your role-plays.

Activity 5.5: The risks of sexual activity

You should have slips of paper (enough for every person) with a different sexual activity written on each one. Put them in an open box and invite participants to take one. Then ask them to reveal the sexual activity on their paper. Where a sexual activity is not recognized or understood, provide clear information about it in a non-sensationalizing or non-embarrassing way. At this point you should also ask participants to identify traditional practices such as 'dry sex' and other practices which are sometimes used in their culture or country and which could be added to the list.

Then ask them to make a statement about the sexual activity on their slip of paper: whether or not it is risky; why or why not; and if it is risky, then what can be done to reduce the risk. Invite group reactions throughout this activity and make sure you include any traditional and other sexual practices which have been added by the group.

Then ask the group to place the sexual activities in order of increasing theoretical risk and use the flipchart to make a list.

You can use **Overheads 16.1 and 16.2: Which are safer sexual activities?** to summarize the discussion. Safer sex includes: use of a condom for penetrative sex; non-penetrative sex such as masturbation, rubbing, touching, hugging, and massaging; and the maintenance of a mutually faithful relationship between two persons who are HIV negative and free of STI.

You may also wish to use an overhead transparency or a flipchart to display a series of statements about sexual activity that encourage discussion of current information about the relative risk for transmission of the infections of specific sexual practices. You can use **Overhead 17: Safer sex questions** to focus this discussion and you can refer again to **Overheads 16.1 and 16.2: Which are safer sexual activities?** to summarize the discussion

CONDOM USE

Introduce this session by referring to the previous discussion on safer sex, and highlight the fact that penetrative sexual intercourse using condoms is one form of safer sexual activity.

Activity 5.6: Names for condoms

Ask participants to brainstorm known local names for condom and write them all down on a flipchart. Examples include 'raincoat', 'rubber', 'cover' …

Then encourage discussion on these: which category of people use each term and how using a condom affects sexual relations? Do young people use a different vocabulary? Do men? Do women?

Activity 5.7: The condom continuum

Begin by using **Overheads 18 and 19** and **Handouts 7.1-7.3** to explain condom use. For this exercise you also need to have the steps of condom use written on note-cards—one step to a card. Put them out in an open box.

Ask each participant to pick a note card out of the box. Then ask them to form a line representing the sequence of steps required for correct condom use.

In the next activity you will ask each participant to explain or demonstrate his or her step in using a condom.

Activity 5.8: Condom demonstration and practice

For this activity you need to make sure that penis models, dildos or bananas are available, enough for each pair of participants. You will also need tubes of water-based lubricants and sufficient numbers of condoms (one or more for each participant).

Begin the exercise by demonstrating the use of a condom on a model of a penis or on a banana. As you do this, encourage the participants to answer each others' questions during the demonstration.

Then divide the participants into two groups—males and females. Give each participant a condom and ask one participant from each group to use a penis model or a banana to demonstrate the following:

- opening the condom packet safely;
- preparing the condom for placing on the erect penis;
- putting the condom on the penis; and
- removing and disposing of the condom.

Then invite the other participants in the groups to discuss the demonstration and to make observations and suggestions, and to ask questions and even to demonstrate what they mean on a model where appropriate. Allow the discussion to resume as a plenary.

You can summarize the session by making reference to brochures or diagrams illustrating correct condom use. You will find condom application and removal diagrams in Overheads 18 and 19 and Handouts 7.1, 7.2 and 7.3.

If you have the resources, then this might be a good time to illustrate and explore the participants' knowledge of female condoms and dental dams and to rehearse their use if possible. If you are able to do this, the demonstration should include:

- opening the female condom packet safely;
- preparing the condom for correct insertion into the vagina;
- inserting the condom correctly; and
- removing and disposing of the condom.

Again you can invite the other participants to discuss the demonstration and to make observations, suggestions and to ask questions where appropriate. Discuss the advantages and disadvantages of the female condom. If you can obtain them, also pass some dental dams around the group of participants so that they can see and feel them and discuss their potential uses.

End this part of the session with a discussion of questions, misconceptions, feelings and attitudes towards appropriate condom use, and the demonstration of condom use in daily clinical activities.

Activity 5.9: Negotiating safer sex

Sexual behaviours are influenced by gender, group and social norms; expectations and relationships. It is very important for persons of all ages to be able to ask for what they want or need when making decisions about sex and safer sex. Young persons in particular need to develop skill in stating their needs clearly, as their decisions about sex are influenced by the social setting. Rather than actually choosing to have sex, adolescents may have it because of fears of refusing, wanting affection, to not hurt someone's feelings or because of offered money or gifts.

Role plays and interactive group exercises which involve negotiating for safer sexual practices, such as condom use, enable participants to not only know more about condoms and their correct use but to also understand barriers to safer sex and techniques for handling these situations.

Negotiation, a process of conferring or bargaining with another person and saying clearly what you want or need, is a skill which is used to overcome barriers to safer sex. Negotiation, saying "no" and assertiveness are all skills which can help people to make decisions about sex and safer sex in ways which overcome feelings of pressure and/or guilt, enabling them to have healthier relationships with reduced risks for STI and unintended pregnancy.

When speaking up for oneself, personal safety has to also be considered, particularly in the face of potentially dangerous situations where a partner is angry, using alcohol or other drugs or has a weapon.

Invite a participant to perform a role-play of a woman living in a rural area who is married to a man whom she suspects of having sex outside their relationship. You, the facilitator, will act as the counsellor. The woman's husband works for long periods on ships as a cook and he is coming home for a few months break. She wants to know how to get him to use a condom with her for her own protection. The counsellor rehearses options for this with her, including the possibility of using a female condom—and demonstrates the counselling skills as well as the use of male and female condoms.

How would you change your approach if your client was a young school-girl living in a city?

Activity 5.10: Saying 'No'

For this activity, you will need the help of two participants. Ask for volunteers before the session starts and brief them on what they will need to do. You will be asking them to demonstrate how to verbally and non-verbally say 'no' to an unwanted advance. Give them enough time to decide what they are going to say and to practise the role-play before the session.

Ask the participants to describe (or write down) situations in which they have turned down an unwanted advance from someone, including an advance from their spouse. Ask them to think about situations when they were young and ask them to share their experiences, in light of the fact that in most cultures, women are expected to obey men.

Next, ask your two 'volunteers' to demonstrate how to verbally and non-verbally say 'no' to an unwanted advance.

Then divide the participants into pairs so that they can take turns to practise verbal and behavioural ways of saying 'no' to unwanted advances.

Activity 5.11: Assertiveness

Divide the group into three sub-groups. Ask each sub-group to identify the verbal and non-verbal characteristics of one of the following behaviours:

- aggressiveness;
- assertiveness; or
- passiveness.

After a short period of time, re-convene the whole group and ask spokespersons to present the aspects of each behaviour. List these characteristics on a continuum on a flipchart or overhead transparency and then invite the participants to add any additional characteristics they can think of. Ask them to identify behaviours which they think might be more common among young people.

Summarize by describing assertiveness as the ability to tell others exactly what you want in a non-threatening way. Use the following notes to give and discuss examples of concise, clear 'I' statements and their components.

'I' statements state the speaker's feelings, the problem and the expectations with regard to interpersonal issues or conflicts.

Begin the statement with an 'I'…	*'I feel (happy, sad, angry, disappointed etc.) …'*
Describe the situation or action: …	*'When you …'*
Give a reason or explanation: …	*'Because…'*
Conclude by describing what you expect or desire: ...	*'I would like us to be able to discuss how we can arrange things better to avoid getting angry at one another…'*

After someone has delivered the assertive message, he/she asks the other person to indicate how he/she feels about the request. If the other person agrees with the request, the speaker accepts his/her statement with thanks.

TEACHING NEGOTIATING SKILLS TO YOUNG PEOPLE

Activity 5.12: Making sexual decisions

Begin by outlining the questions a counsellor or respected friend should ask a young person involved in making decisions about sex or sexuality. You can take as a starting point the following set of questions which is from the Australian Commonwealth's Department of Human Services and Health's *Girlfriend Safe Sex Guide: Be Sure, Be Safe*.

- How do you feel about having sex or beginning sex right now?
- How does your partner feel?
- For what reason(s) are you wanting to have sex?
- Are you rushing into sex?
- Are there other aspects of a physical relationship that are just as fulfilling as sex?
- What are your expectations in the relationship?
- What are your partner's expectations?
- Have you discussed your feelings with your partner?
- Is your partner pressuring you?

Then divide the participants into groups of three and ask each group to practise the questioning skills. One group member is a young person, having to make a decision about sex or a risky situation (such as being pressured to have sex), another is the counsellor and the third person is the observer. After the role-play, reconvene the whole group and ask the

group members to relate their feelings about the interaction. Also ask the observer to comment on the verbal and non-verbal interactions and responses of the 'young person' and the 'counsellor'.

Activity 5.13: Responding to persuasion

Using a flipchart, outline the following three steps in responding to someone who is trying to persuade you:

- **Refuse:** Say no clearly; leave if necessary.
- **Delay:** Put off the decision until you have had time to think about it—'I'm not ready yet'; 'I'm just not ready'; 'Maybe we can talk later'; 'I would like to talk to my friend Sofia about it first;' 'Let's give ourselves more time.'
- **Bargain:** Make a decision that suits both people: 'Let's do _____instead.' 'What could we do that would make us both happy'?

Then ask participants to share their own experiences in responding to persuasion.

After the discussion, distribute **Handout 8: Refusing, delaying and bargaining**. Divide the participants into three or four groups and give them about 15 minutes to read the case study and to discuss their answers.

Then ask the sub-group spokespersons to share their responses to the case questions with the whole group. Record their responses on a flipchart and relate the discussion to the roles that health workers and others play in teaching negotiating skills to young people.

Activity 5.14: Why do people take the risks?

Use a brainstorming discussion to encourage participants to identify factors influencing people's decisions to have sex or to take part in risky situations, such as having unsafe sex. You may ask participants to identify behavioural, socio-cultural and environmental factors. Record the participants' responses on a flipchart. Responses may include:

- community, cultural, family expectations (facilitator to supply examples);
- peer pressure;
- alcohol and drugs;
- role expectations of men and women;
- obligations (marital, commercial, customary/traditional);
- enjoyment;
- procreation;
- and others.

Now encourage further discussion of these factors. To do this, divide the participants into three or four groups and ask them to identify and list the good and bad things about drinking alcohol or using drugs, including kava. Also ask them to identify reasons leading to over-use of these things.

Then re-convene the whole group and invite the sub-group spokespersons to share the main points of their discussion with the whole group. Make sure that the discussion includes the impact of alcohol and drugs on decision-making processes, as well as factors leading to the rise in alcohol and drug use among youth.

Close this activity by leading a group brainstorming exercise on community-based methods of addressing increasing drug and alcohol use, particularly among youth. You might wish to use a 'code' such as a short video, a drama by participants or some pictures to initiate and guide the discussion and to help people talk about it.

In this session and the last we have been exploring in general some of the motivations for people's sexual behaviour. In the next activity we will practise finding out and writing down some of these motivations and behaviours.

TAKING A SEXUAL HISTORY

Activity 5.15: Taking a sexual history

The aim of this activity is to encourage participants to consider the psychosocial elements in taking a sexual history and to see how counselling skills are important for making these as accurate as possible.

Begin by asking the group to identify what the counsellor needs to know. Write their suggestions on a flipchart. Ask them to think about both facts and feelings. Then ask them to think about what barriers to communication there might be and to suggest what a counsellor might do to make the session easier for the client.

Encourage the participants to speak from experience and give examples where possible. You might summarize this discussion by showing **Overheads 20.1-20.4: Taking an effective sexual history.**

Then ask the group to divide into groups of three: one to role-play a patient, one an STI worker and one an observer in the following situation.

The patient is a poor, frightened labourer with a urethral discharge who states that he has a wife who is ten weeks pregnant, so he has been visiting local prostitutes. He describes his wife as being very ill, so he can't have sex with her. He refuses to have STI services contact his wife as he does not wish her to know about the prostitute visits. He cannot read or write.

The STI worker is a health worker who speaks a dialect very different from the labourer's and who recognizes that both the labourer and his pregnant wife need basic treatment.

The role-play should be allowed to proceed for 10 minutes, with the observer noting how communication is affected by culture and the differences in education, language, and health objectives of the two 'characters'.

After the role-play has finished, ask the small groups to summarize their feedback, then re-convene the plenary group for feedback and general discussion on aspects that influence the quality of patient-health worker communication, compliance and outcomes.

In addition, you may wish to use the case scenario and discussion points in **Overheads 21.1 and 21.2: Lina Pou** to further focus on issues to be considered in history taking and to help draw conclusions on the need for good counselling skills so that the counsellor can get enough accurate information to be able to help the client obtain appropriate treatment and to avoid similar problems in the future.

SESSION 6:

Attitudes and values

What you need for this session:

Overheads: *22, 23.1-23.2 and 24*

For Activity 6.3: *Results from a research report on values if available.*

For Activity 6.5: *sealed envelopes each containing a card, some marked 'positive' and some marked 'negative', one for each participant.*

Aims

- *to show how cultural and individual values can influence STI counselling;*
- *to illustrate the fact that different positions taken on important issues may all have justifications, depending on one's values, attitudes, beliefs;*
- *to increase participants' awareness and understanding of their own values and their influence on STI counselling and service delivery.*
- *to emphasize the fact that STI risk is the responsibility of each person and the risk behaviour of one may put another at risk;*
- *to demonstrate how STI are spread, and to show that appearances are not the best indicator of absence of risk; and*
- *to show that any one who is sexually active may face exposure to STI if no precautions are taken.*

Activity 6.1: What are values?

Lead a short group discussion on 'what are values?' Introduce **Overhead 22: Values** and then ask participants to write down one or two of their personal values. You can then ask them to share their values with the group, if they wish to do so. You might want to use sentence completion exercises related to values such as 'I believe that …'. Then lead a brainstorming discussion on the sources of values—where they come from.

Activity 6.2: Values walk

Divide the room into four, each area representing either 'strongly agree', 'agree', 'disagree', or 'strongly disagree'.

Now read out a controversial statement and ask participants to assemble in that part of the room that suits their level of agreement with the statement. Then encourage an exchange of views, using the debate to highlight the different positions.

After the main issues have been aired, with each section of the room having been given enough time to have their say, participants are then invited to move to the groups that may have convinced them to change their views.

Alternatively, if the group of participants is small, you could assign to each participant a level of agreement with the statement chosen. Then the participants have to justify the view they have been told to hold about the controversial statement

Use **Overheads 23.1 and 23.2: Controversial statements** for this activity. You might also look for a research report on values and use the results as examples.

Here is a list of controversial statements.

Adolescent youths should be able to seek family planning services without parental consent.

Prostitutes are the main group responsible for the spread of STI.

All people infected with HIV should be isolated.

The partners of all people infected with an STI should be notified.

HIV-infected mothers should not be allowed to have children.

All health staff should be regularly screened for hepatitis and HIV.

Health workers should always be informed if clients are HIV positive.

Young people should be discouraged from all forms of sexual activity.

Giving condoms to young people encourages them to have sex.

Young girls who become pregnant must stop going to school.

Homosexuals or gay persons should not raise children.

HIV is caused by gay sex.

Condoms should be freely available to all.

People with STI are morally bad and should not be allowed to hold important jobs.

Homosexuality is not normal.

At the end of the discussions, emphasize that all statements/issues may have more than one 'correct view' and that counselling must recognize and accept a diversity of views from clients if it is to achieve its aims of providing information, enabling decision-making and providing support.

Activity 6.3: How much can you accept?

You might prefer to take this alternative approach to illustrating participants' values and attitudes.

Distribute Handout 9, which is a copy of the table shown in **Overhead 24: Illustrating your acceptance** and ask them all to indicate their level of acceptance or non-acceptance of each of the statements in **Overheads 23.1-23.2** by marking the lines accordingly.

Then collect all the papers and using an overhead copy of the table mark the positions of all the replies you have received. You can use this to lead a plenary discussion, focusing on the following issues:

What does the diversity of opinion indicate?

How does such a diversity, and the strength of some of the indications on the overhead transparency, influence our capacity to counsel?

Should strong ideas be challenged?

The discussion should conclude with reflection on the fact that values are individual. However, it is important that we are aware of our own values and how they may affect our perceptions of those we counsel. It is also important that we should address these issues to avoid imposing them on our patients and possibly driving them away. Differing values between counsellors and adolescents should also be discussed.

Differences in values between counsellors and adolescents can pose communication difficulties, particularly if the situation is not seen from the viewpoint of the young person. If adolescents feel that a counsellor does not approve of sexual activity among unmarried youth, they will be hesitant to talk about their sexual activity and or to seek information about contraception or risk reduction.

Tips for communicating with adolescents about sexual and reproductive health concerns:

- Create a safe and supportive environment
- Take gender issues into account—adolescents often wish to talk with a counsellor of their own sex
- Be sincere and honest.
- Use reflective and non-judgmental listening skills
- Listen carefully to what they are saying, their concerns and their feelings
- Help adolescents understand and share their feelings, since issues related to sexuality can be very sensitive

Activity 6.4: The 'transmission game'

For this game you will need sealed envelopes each containing a card, some marked 'positive' and some marked 'negative', one for each participant.

The aim of this game is to mimic silent spread of STI, and how they may challenge our prejudices in relation to those diagnosed with an STI.

You should caution participants about the potential emotional impact of the game and stress that this is only a game before inviting them to take part in the 'transmission game'.

Ask all participants to stand in a circle. Make sure there is enough room for participants to move freely around the circle. Explain that you will begin with a demonstration of how the game is played.

In the circle, approach one participant and shake their hand. Tell the group that for this game, a hand shake is equivalent to having unprotected sexual intercourse.

While you are still holding the participant's hand, explain that when someone is HIV infected, they may or may not know it. In this game, being exposed to HIV is indicated by a **light scratch** on the palm of the hand during the handshake. So, they will know they have been exposed, but others will not. They should not tell others they have been exposed.

Demonstrate this to the person and ask them to pass it around the circle as a demonstration—an example only.

Now, still standing in the circle, have the participants close their eyes. Tell them you will walk around inside the circle and touch **one** person on the shoulder. For this game, the 'touched' person will be HIV infected. They should not tell others in the group they have been touched.

After the person has been touched, ask participants to open their eyes and see if they can identify who has been touched or 'HIV infected'. The aim is to emphasize that you cannot tell who is HIV infected just by looking at them or by making assumptions about them. The facilitator asks participants how they felt as he/she walked around the circle.

From this point onwards, the facilitator emphasizes the **drawing out rather than the giving of information.**

Remind the group that one of them is 'HIV infected'. As the game proceeds, this person will scratch the palms of those they shake hands with. The participants are told that if their palm is scratched, then they are to scratch the palms of all those they subsequently shake hands with. If the group has 10-15 participants, they may all shake the hands of up to three colleagues; if there are 15-25 participants, they may all shake the hands of up to four colleagues. They do not have to shake hands that much if they do not wish to.

Now step out of the group circle and remind the participants how many hands they can shake.

Start the game by telling them they can now start shaking hands. When the hand-shaking stops, ask all those who had their hands scratched or their shoulder touched to step into the inner circle. All those who did not step to the outer circle. Ask if there was anyone who chose to not shake hands. Why not? How is sex like greeting? Did people appear to be enjoying themselves?

Ask those in the inner circle to examine how they may have placed themselves at risk of HIV in the past (in the game, not in real life). Remind them that this is only an exercise, and that at this stage they have only been **exposed**—no-one knows if they have actually been **infected.** The facilitator asks what it feels like to be in both the inner and outer circles:

inner circle	*'What are you thinking now that you realize you may be infected?'*
outer circle	*'What do you think about those in the middle?'*
inner circle	*'Would you tell anyone you are infected and, if so, who?'*
inner circle	*'What would you need at this stage?'*
both inner and outer circles	*'Would you continue having unprotected sexual intercourse?'*

Now offer the test for HIV, **while being extremely careful to avoid giving the impression that testing is being advocated as a general policy.**

For those who want the test, pass out envelopes with results inside. Do not allow them to open their envelopes quickly but rather describe what they are feeling now. Then allow them to open their envelopes. Those who are negative may join the outer circle.

Generate a discussion about what it is like to receive a negative result. Include the issues of the 'window period', especially the need for follow-up testing if risk behaviour has occurred within the three months prior to the test. **Discuss the need for behaviour change in order to maintain HIV-free status.**

Then, generate discussion about how those with an HIV-positive result think and feel.

What is it like to get this result?

What does it mean for your life?

How would it affect your behaviour?

Who would you tell and why?

What do you need most at this time?

When the exercise comes to an end, ask each 'HIV-positive' participant what they think about HIV and AIDS as a result of taking part in this game.

Ask each participant to say one word only to express their feelings or thoughts about the experience.

Then encourage all participants to shake hands with as many people as they wish, but without scratching any palms. Emphasize the fact that those who were scratched are no longer 'infected'.

Tip for trainers

You may wish to follow this up with a break, a relaxation or tension-breaking exercise.

SESSION 7:

HIV pre-test counselling

Pre-test counselling helps prepare the client for the next session when the counsellor must break the news of the test result.

What you need for this session:

Overhead: *25.1-25.4*

Handouts: *10, 11, 12, 13, 14, 15, 16.1-16.2.*

Aims

- *to clarify steps in preparing individuals for HIV testing and for waiting for the test result;*
- *to discuss why confidentiality is important in STI/HIV counselling; and*
- *to review the process of risk assessment and personalizing messages for HIV prevention.*

Activity 7.1: What issues should we include in pre-test counselling?

In a plenary discussion, ask participants to brainstorm what issues they think should be included in pre-test counselling. Also ask them to suggest questions which they think would elicit appropriate information from a client.

List their responses on a flipchart, and use **Overheads 25.1-25.4: HIV pre-test counselling checklist** to summarize the discussion. The main summary points to focus on in pre-test counselling are:

- information about the HIV antibody test;
- the meaning of the test result;
- how HIV is transmitted;
- how to prevent transmission; and
- how a positive test result will affect the client emotionally and in terms of work, family and behaviour.

Helpful open-ended questions which a counsellor may use to elicit the information include:

'What are your expectations about the test result?'

'What changes will you make in your life if your test result is positive?

'What would a negative test mean to you?'

'What changes will you make in your life if your test result is negative?'

Activity 7.2: Role playing with case studies

Use any of the case studies in **Handouts 10 to 15: 'Susi Vai', 'Sione', 'Lau Fitu', 'Vidya', 'Seini Pau', 'Nina'** for role playing HIV pre-test counselling. When you are preparing for this, you might like to refer back to the section on conducting role plays which you will find in the introduction to this manual.

It is important for **all** participants to have some practice with these role-play scenarios, as it may be their only chance to practice doing so in a 'safe' environment. Where particular participants appear anxious or hesitant, you should gently encourage and help them to take part.

After the role-play is completed, initiate a plenary feedback from 'clients/patients', 'counsellors', and 'observers' to examine the content, amounts of risk evaluation and counselling skills they have experienced.

After this, you may focus further discussion on the following.

- The important verbal and non-verbal elements of the role-play, and how they were matched to the client's responses.
- The value of emphasizing confidentiality in pre-test counselling:
  - it helps the counsellor and client develop a trusting relationship;
  - the client feels safer discussing his or her thoughts, feelings and attitudes;
  - the client is more likely to discuss sensitive and personal issues, especially those related to sexual behaviour;
  - the client believes that his interests are important to the counsellor; and
  - it helps the client talk honestly about feelings and behaviour.
- How counselling at this stage can engage the client as a member of a behaviour change and support 'team'.
- How pre-test counselling can help with assessment of the person's risk and understanding of HIV.
- How pre-test counselling can encourage personally-relevant HIV education and prevention of high-risk behaviour.
- The value of assessing the person's reason(s) for being tested—they may rest on misconceptions about HIV transmission.

- The importance of ensuring that testing is voluntary—not everyone may wish to be tested and this must be respected.
- The complexity of the context in which HIV testing takes place for each individual.
- The potential impact of a positive diagnosis on the lives of all those found to be infected.
- The importance of identifying a person's strategies for coping should their test result be positive.

Sum up this activity by briefly reviewing the main points of the discussion about the cases and by reinforcing the steps and essential information in pre-test counselling outlined in **Overheads 23.1-23.2: Pre-test counselling checklist.**

Activity 7.3: Examining the need for informed consent

Informed consent may be a contentious issue in many settings where HIV testing takes place. In this exercise, encourage the whole group to brainstorm the following:

- the advantages of informed consent;
- situations where informed consent is necessary and, perhaps, unnecessary;
- implications that may follow from not getting informed consent; or
- what may be needed to encourage the taking of informed consent in particular areas of practice e.g. surgery.

Encourage participants to offer their ideas in relation to their own experiences and to the cases that they have been role-playing.

SESSION 8:

STI/HIV prevention counselling

What you need for this session:

Overheads: *20.1 -20.4 and 26*

Handout: *15*

Aims

- *to illustrate the fact that prevention is a key element of care in STI and HIV management;*
- *to consider how prevention is an appropriate use of resources;*
- *to show that prevention methods are based on information obtained from aspects of psychosocial and medical care;*
- *to facilitate the development of counselling skills for clients who choose not to take risk-reduction measures; and*
- *to facilitate the development of counselling skills for clients who have no choice in making risk-reduction decisions.*

Activity 8.1: Prevention issues

Ask the participants to break up into groups of four to six people and ask all groups to consider the prevention issues emerging from consideration of the case study in **Handout 15: 'Nina'.** The group should consider the needs for:

- specific education;
- helping the client assess his/her degree of risk;
- complying with treatment;
- barriers to reducing risk behaviour;
- appropriate and achievable changes in risk behaviour;
- partner management; and
- accessing those who may be trapped in sexual situations.

The groups should also consider the possible consequences for Nina if prevention discussion is not initiated and also the possible consequences for community public health if this is not done.

After they have been discussing the issues for about 15 minutes, bring the whole group together and ask the small groups to share their conclusions about prevention. This plenary discussion should take approximately 15 minutes. In particular, try to ensure that participants discuss why:

- client/patient education is so important;
- it is necessary to find out what the client understands about their STI risk;
- it is important to find out traditional practices that may be increasing a client's STI risk;
- STI workers need to understand the motivations behind risk behaviour, for example, determination of the reasons why clients do not want to use condoms (see Activity 8.2 below);
- counsellors must recognize and deal with barriers to possible behaviour change;
- counsellors must provide options for changing behaviour; and
- notifying partners is important and the issues involved.

The discussion should also include other STI clients — those with repeat STI. This may result from:

- prescribed treatment failures;
- self-treatment failures; and/or
- traditional healing failures.

Make sure the discussion deals with what needs to be done to improve communication with these groups about prevention. Encourage participants to include in their discussion issues arising from the need to obtain a full and accurate sexual history and to develop and maintain a trusting client/counsellor relationship.

As you facilitate and summarize the discussion you may wish to refer to **Overheads 20.1-20.4: Taking an effective sexual history** and **Overhead 26: Why prevention and patient education are important**. You should also review safer sex procedures and options for partner notification.

Tips for trainers

When you are considering practical issues in STI counselling, ask participants to identify situations and options based on their own experience. The more realistic the circumstances discussed, the more relevant the activity.

Activity 8.2: Overcoming resistance to condom use

The purpose of this activity is to develop participants' skills in counselling clients who object to using condoms. Introduce the activity by explaining that many clients will object to using condoms for a variety of reasons and emphasize the importance of learning to respond to clients' concerns, fears and objections. Then go on to explain that in this exercise, the participants will develop counselling goals and action steps to help clients overcome their objections to using condoms.

First, ask the group to brainstorm a list of reasons why clients might not want to use condoms and write down the responses on a flipchart. Spend about 10 minutes on this.

Then divide the participants into groups of four and ask each group to spend a further 10 minutes working with the objections by writing one counselling goal and one possible action step for each objection listed.

If the list of objections is long, give several of the objections to each small group. Here are some examples which you can use to get the groups started.

Obstacle:	'I can't feel as much with the condom on.'
Counselling goal:	To help the client learn how much feeling is possible with a condom.
Action:	Demonstrate how much a person can feel with a condom on by asking the client to put a condom on his finger and rub his arm with his finger to feel the sensation.
Obstacle:	'HIV leaks through unbroken condoms.'
Counselling goal:	To teach the client that HIV does not leak through unbroken condoms.
Action:	Acknowledge that this is a commonly held myth but that it is not true. Explain that condoms feel wet because many condoms are made with a lubricant to make them feel more natural and to help prevent breakage. Fill a condom with water and show the client that it does not leak.

When the small groups have finished developing their counselling goals and action steps, reconvene the larger group. Then read out each item on the list and ask each group to report its counselling goal and action step for that item. Repeat the process until you have discussed the whole list.

Then facilitate a 10-minute discussion on the following questions:

What did you learn from this exercise?

What else might you need to do or say in a counselling session to help a client overcome his reasons for not wanting to use condoms?

How do you feel when clients do not want to use condoms?

The major points which may arise during the discussion include, but are not limited to, the following.

- It is important for counsellors to respond to a client's specific concerns, fears and objections to using condoms.
- Condoms are new to many clients. They may need time, reassurance and practice before they are able to use condoms comfortably.
- Providing some practical steps helps clients to start using condoms.

SESSION 9:

HIV post-test counselling

What you need for this session:

Overheads: *25.1-25.4, 26, 27.1-27.2, 28.1-28.2 and 29.1-29.4*

Handouts: *10, 11, 12, 13, 14, 15, 16.1-16,2, 17 and 18.1-18.2*

Aims

- *to understand HIV test results and prepare for conveying them;*
- *to outline the steps and information that may be covered when managing crises and other reactions associated with giving HIV test results, both in the short term and the longer term;*
- *to identify the complexity of possible issues about giving HIV tests and results; and*
- *to understand the importance of planning for the future support and assistance for those infected and their relations.*

Activity 9.1: Giving news of an HIV negative result

Begin by briefly reviewing the content of pre-test counselling, referring to **Handouts 16.1-16.2 and Overheads 25.1- 25.4: Pre-test counselling checklist.** Also review one of the case studies in **Handouts 10–15** to prepare for a role-play on giving a negative test result.

Then work through **Overheads 27.1-27.2** and **Handout 17: HIV post-test counselling checklist–negative result** and apply it to one of the case studies.

Use two of the other case studies in **Handouts 10–15** to encourage a role-play of a person receiving **negative** HIV test results. Ask for volunteers to enact the role-play in front of the group. Try doing the role-play more than once, with different pairs of participants playing the parts.

Alternatively, you may ask the participants to break into small groups or pairs to enact these role-plays. This has the advantage of allowing more of the participants the opportunity to experience test-result giving and receiving.

After the role-play, ask each pair to report on their experience of the role-play to the plenary group. As they do this, encourage them to recall the main points of information covered by the 'counsellor' in the role-play so that you can write them down on a flipchart.

Activity 9.2: Giving news of an HIV positive result

Begin by asking the group what reactions they may expect to observe when they provide news of a **positive** HIV result. List them on a flipchart and briefly discuss them.

Reactions of clients when they hear the news may include the following:

- being very angry;
- assuming he/she will die immediately;
- crying uncontrollably;
- refusing to believe that the test result is positive;
- walking out of the counselling room;
- saying he/she wants to kill themselves;
- stating he/she wants to hurt the person he/she thinks infected him/her;
- threatening to try to infect others; or
- showing no reaction at all.

Then ask participants to identify the implications of such reactions for the patient and for their own conduct. Implications may include:

- the need to allocate more **time** for being with the patient;
- the need to establish trust and rapport;
- if no pre-test counselling session had taken place, the counsellor's need to find out what the client knows about the antibody test and to provide some information;
- the importance of reviewing with the client what was discussed during the pre-test counselling session;
- the need to plan the **setting** in which results are given, including the place, the time and the support on hand in the clinic;
- the need to avoid overloading the client with factual information about AIDS and the importance of telling the client only what he/she needs to know to protect himself and others;
- the need to ask the client what questions he/she may have;
- the need to prepare for containing acute **distress** reactions; and
- the need to have identified—in advance—appropriate sources of **support and follow-up** in the local community.

You may wish to use **Overheads 28.1 and 28.2: Some psychological responses to the crisis of diagnosis** to summarize this discussion.

Activity 9.3: Managing HIV test result-giving

Begin this role-play exercise by leading a plenary discussion on what counsellors might say and do to break the news of a positive test result. Ask participants to suggest approaches and write them on a flipchart.

Supportive techniques include:

- looking the client in the eye;
- telling the client directly and simply, 'Your blood test results for HIV antibodies came back. Your results are positive. This means you are infected with the virus that causes AIDS';
- allowing a silence after the client hears the news if it seems he/she needs time to absorb the information; and/or
- considering other culturally appropriate ways of giving bad news.

Now ask for volunteers to enact a role-play of giving the bad news in front of the group, with one of each pair being the counsellor and one being the client. Allow each pair to use any of the case studies described in **Handouts 10–15**, and give them 20 minutes each to enact the situation of giving a positive result.

Alternatively, you can ask participants to break into pairs or groups of three so that each group can practice giving and receiving the positive HIV test result using any of the case studies described in **Handouts 10–15.** Again, each role-play should take up to 20 minutes.

Then lead a plenary discussion, encouraging participants to consider the issues emerging from such scenarios, particularly the manner in which the news is given and how this may affect the client's capacity for coping in the short term.

Also encourage them to consider the difficulties of presenting and receiving bad news, and how that affects the giving of bad news. Ask those who role-played receiving bad news and those who role-played giving it to describe the following.

> *How it felt to break bad news.*
>
> *How it felt to receive bad news.*
>
> *How important is pre-test counselling for understanding the patient's circumstances and planning priorities for intervention in post-test counselling.*
>
> *How important is it to have time to manage the crisis of diagnosis and to make plans for follow up in the near future.*

Use these discussion points to analyse each case study so that participants can see how case scenarios may incorporate a variety of counselling issues, including possible alternative explanations for the symptoms or issues described.

Throughout the discussion highlight appropriate and supportive responses of the counsellor to the client, including:

- remaining calm;
- allowing the client to express emotions such as anger, hopelessness, grief, etc, without saying or doing anything except listening actively;
- exploring the client's feelings. 'Can you tell me more about what you're feeling?';
- letting the client know that his or her reactions are normal. 'Your feelings are very natural—many people feel this way at first';
- acknowledging and validating the feelings. 'I understand why you would feel so angry that you want to hurt your partner.' 'Can you tell me about how you are feeling?' Also, discussing the actual intent to hurt the partner: 'Please, tell me what you are thinking of doing';
- if the client insists on leaving the counselling session, making a follow-up appointment. 'If you really must leave right away, would you like to come back and visit me tomorrow at 10?' 'Would you be willing to do that?';
- finding out how much support the client might expect from family and friends; and/or
- selecting one aspect on which to begin work, preferably involving a task that the client can accomplish with your support. 'One of your first concerns you mentioned was how to discuss this news with your wife. Let's talk about different ways you can raise this issue with her.'

Summarize the discussion by focusing on the main issues in post-test counselling as shown on **Overheads 29.1-29.4** and **Handouts 18.1-18.2: HIV post-test counselling checklist—positive result.**

Activity 9.4: *Planning for future crisis management*

Again use one of the case studies in **Handouts 10–15** and ask for volunteers to play the part of either the counsellor or the person being counselled and to role-play the case in front of the whole group.

After the role-play, encourage participants to consider how to manage the crisis in the **immediate** and the **medium** term (up to three months). Then encourage them to consider the implications for the patient in the longer term.

The discussion that follows may also be used to bring out related issues as follows:

- the importance of focusing on areas seen by the client/patient as critical;
- the importance of working at the client's/patient's pace;
- the importance of having clear procedures for crisis management planned in advance of the need to use them;
- the need to obtain clear information from the client/patient about what they plan to do in the immediate term and to give essential information on basic prevention and coping;

- the importance of offering short-term follow-up for the client/patient and their family and loved ones, as appropriate;
- the importance of planning to give time to the post-test counselling sessions; and
- The importance of planning and networking to have routes of rapid referral to relevant specialist or support services, non-governmental organizations or community groups in post-test counselling sessions

Tips for trainers

The participants experience with the case studies in the handouts in this exercise, plus their own clinical experiences, can help form the basis for planning future counselling skill-development activities in their local area.

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Ask

> *'What do you need to help support counselling skill-development in your local area?'*

SESSION 10:

Planning training and mobilizing resources

Aims

- *to identify and consider issues involved in preparing an STI counselling training course and selecting participants;*
- *to identify local resources to support the client/patient and the counsellor and STI clinic staff;*
- *to outline steps in and priorities for networking; and*
- *to review the range of issues and services that may be employed for supporting those affected by STI and HIV.*

Activity 10.1: Planning counselling training and selecting participants

Ask participants to work in small groups to consider the most appropriate qualities in those selected for STI counselling training.

- They should consider:
  - how much commitment the person has to the idea of counselling;
  - how much clinical exposure they have and their level of clinical involvement;
  - how much authority they have to implement change in local practices and procedures; and
  - the appropriateness of their clinical role and experience.
- They should also examine reasons why some people might not be suitable for such training.
- In addition, they should consider what content would be appropriate for training courses for their specific region and the specific needs of their communities.
- They should list the issues that need to be discussed, as well as appropriate methods in training which promote skill development in communication and counselling, rather than just increasing factual knowledge; resource persons, potential sites for field visits as well as obstacles to the prevention of STI/HIV.

When the small groups have completed their discussions, reconvene the plenary group to share and feed back on the outcomes from the small group discussions.

Activity 10.2: Identifying local resources

If it is possible, ask a member of a local HIV/AIDS support organization to speak to the group, identifying the services offered and how they complement other governmental and non-governmental HIV organizations for clinical, psychosocial and social welfare care and support.

Encourage participants to ask questions and reflect on how such services may be employed in managing the case studies they have role-played as well as patients in their own clinical experience.

Distribute appropriate telephone and other contact details for these services at the end of this session, if they are available.

If you are unable to obtain the assistance of a spokesperson from one of these organizations then you can encourage the participants to provide this input themselves.

Ask participants to form small groups and ask each group to review the case studies they have role-played, as well as reviewing problematic cases or situations they have faced in clinical practice. The group members should brainstorm governmental clinical, psychosocial and social welfare supports, as well as non-governmental and community sources of support that may be useful in managing clients/patients and in increasing the availability and accessibility of services. Wherever possible, try to arrange visits to STI clinics or STI/Reproductive Health service organizations for participants. The aim of the group work is for participants to make a list of other facilities and services available to their clients.

Write all their suggestions on a flipchart and initiate a discussion to prioritize the services to be approached.

The discussion should also emphasize:

- the importance of planning for support in advance of the need to contact such services; and
- the need for personalized contacts in building up a support network in their area.

SESSION 11:

Integrating counselling into the day-to-day work of STI services

Aims

- *to illustrate the fact that it is possible to introduce STI counselling into the day-to-day work of STI staff and services;*
- *to identify means for enhancing the practice of counselling in their day-to-day work (e.g., means for allocating more* ***time*** *to educating and counselling people concerned about STI; and*
- *to clarify any questions and misconceptions that have emerged from the conduct and content of the workshop.*

Activity 11.1: Writing case studies

At the beginning of the session, invite participants to write down case studies drawn from their own clinical and counselling experiences, reflecting issues that have arisen from the workshop to date. Remind them that they should use different names to protect identities.

Activity 11.2: Integrating counselling into STI services

Ask the group to identify the full range of clinical and related activities currently undertaken by STI services in their region and list these on a flipchart. Then ask participants to consider which of the activities chosen may act as a signal for initiating discussion on STI prevention, and how such discussion may lead to appropriate STI-related counselling.

Activity 11.3: Real cases

Now invite participants to describe the case studies which they have written earlier in the day to the whole group for discussion. Encourage discussion of alternative ways of dealing with the issues arising from these cases.

Activity 11.4: Planning for the future

Invite the group to discuss the workshop as a whole. Ask them to identify the ways in which they could apply what they have learned to their own STI services.

The content of this discussion will vary greatly from workshop to workshop, depending upon its purposes—newly-trained STI/HIV counsellors will need to discuss issues very different from those of managers of STI/HIV services. Some of the questions which might come up include:

1. How could we build into our standard STI procedures:
   - discussion about STI/HIV?
   - taking blood samples?
   - giving test results?

2. How would we need to change our procedures to provide staff with time, skills, space, privacy and contact with complementary services and staff?

3. How could we reorganize our STI services to accommodate the special needs of people with HIV problems?

Encourage participants to keep the discussion practical and to focus on reorganisation and training needs.

Where appropriate, ask participants to work on their own organizational action plans, with prioritized steps for goals such as:

- integrating counselling into day-to-day STI/HIV work; and
- identifying staff for STI/HIV counselling training.

SESSION 12:

Workshop evaluation

What you need for this session:

Handouts 19.1-19.4: *Training programme evaluation*

Aims

- *to evaluate the content and process of the workshop.*

Activity 12: Evaluation

Invite all participants to complete an evaluation of the workshop before leaving the meeting. **Handout 19** provides an outline evaluation form. Adapt the content of the evaluation form to make it appropriate to local circumstances and variations in the same way you implemented the workshop in each area.

If you have chosen to use a role-play as a basis for qualitative evaluation, this is the time to ask the participants to work with the case study again.

Appendices

APPENDIX 1:

Overhead Transparencies

Copy these onto transparencies as required:

If you wish to expand some of the sessions you may find the following overheads useful:

OVERHEAD 1.1:

Plan of an STI counselling training programme

TIME:	DAY 1:	DAY 2:
0900–1030	Formal opening **Session 1:** Introductions and overview of the workshop	Review of Day 1 and introduction to Day 2 **Session 5:** Gender and Sexual Health
1030 –1100	**Morning break**	**Morning break**
1100–1300	**Session 2:** Communication skills and counselling **Session 3:** HIV counselling	**Session 5** (continued)
1300–1400	**Lunch break**	**Lunch break**
1400–1530	**Session 3** (continued)	**Session 5** (continued) **Session 6:** Attitudes and values
1530–1600	**Afternoon break**	**Afternoon break**
1600–1700	**Session 4:** Culture, sexuality, counselling and young people	**Session 6** (continued)

OVERHEAD 1.2:

Plan of an STI counselling training programme

DAY 3:	*DAY 4:*	*DAY 5:*
Review of Day 2 and introduction to Day 3 **Session 7:** HIV pre-test counselling	Review of Day 3 and introduction to Day 4 **Session 9:** HIV post-test counselling	Review of Day 4 and introduction to Day 5 **Session 10:** Planning, training and mobilising resources
Morning break	**Morning break**	**Morning break**
Session 7 (continued)	**Session 9** (continued)	**Session 11:** Integrating counselling in the day-to-day work of STI services
Lunch break	**Lunch break**	**Lunch break**
Session 8: STI/HIV prevention counselling	**Session 9** (continued)	**Session 11** (continued)
Afternoon break	**Afternoon break**	**Afternoon break**
Field visits	**Session 9** (continued)	Formal closing

OVERHEAD 2.1:

Communication and counselling skills

Counselling

- Counselling is a dynamic process.
- It involves a contractual agreement between a client and a counsellor who is trained to practice to an acceptable standard and who is bound by a code of ethics and practice.
- Counselling aims to encourage healthy living and it requires the client to explore important personal issues and to identify ways of living with the situation they are in.
- Counselling is in no way guidance, advice giving or befriending.

OVERHEAD 2.2:

Communication and counselling skills

Counselling skills

- Counselling skills are interpersonal communication skills.
- They can be used by anyone—either as a separate set of techniques or as a set of skills which can be integrated with, or used alongside, an already well established set of professional skills.
- In such a case we may find:
  - a nurse using counselling skills when he or she listens to a patient or comforts grieving relatives; or
  - a manager using counselling skills when an employee tells her that he is thinking of quitting work to look after his sick child.
- Counselling skills contain conditions of empathy, genuineness and the absence of judgement.
- If you are using counselling skills they will operate **within** your professional skills and **within** other professional ethics.

OVERHEAD 3.1:

Active listening

Active listening is what we pay attention to in the person we are helping.

To listen actively we must be aware of and use both verbal and non-verbal signals.

Non-verbal signals

- Voice quality – soft, hard, confident, timid, strong, weak etc.
- Breathing – deep, shallow, sobbing, relaxed etc.
- Eyes – looking down, looking away, making eye contact, tears etc.
- Facial expression – relaxed, tense, afraid, happy, shocked etc.
- Hand movements – waving about, tapping fingers etc.
- Leg movements – swinging, tapping foot etc.
- Body posture – relaxed, stiff, upright, slumped over etc.

OVERHEAD 3.2:

Active listening

We need to be aware of many things …

- We **listen** with our **ears** and **eyes**.
- There are cultural reasons why people behave in particular ways.
- We need to be aware of the ways people communicate non-verbally
- We also need to be aware of the barriers to communication.
- We use non-verbal behaviour to show that we are listening and what we are feeling.
- These signals can also be barriers to communication.

If we are to help our clients we must …

- listen sensitively and accurately to them by being sensitive to their whole person;
- be aware of our own emotional blind spots;
- be aware of how people express their feelings cross-culturally; and
- work to develop our empathic skills.

OVERHEAD 4:

Projection — be aware of hidden feelings

- **Projection** is the transference of our hidden feelings onto other people, without our realising it.
- For example, suppose a nurse who works in an STI clinic has had a fight with her husband and comes to work feeling very angry with him. She displays a very uncaring attitude (telling them off, shouting etc) at work that day. In other words she is projecting her anger onto the patients. In the afternoon a patient yells back at her for treating him rudely. An argument erupts.
- The patient has identified with the nurse's anger and is responding to it. This is known as **projective identification**.
- Projection and projective identification are important psychological concepts that illustrate the power of the unconscious mind.
- Be very careful not to project your hidden feelings onto clients.
- Be very careful not to identify with the client's emotions, as this will not be helpful to the client.

OVERHEAD 5.1:

Open and closed questions

We use open questions …

- to make communication easier
- to help trust and warmth to grow in the helping relationship
- to encourage further discussion

Some examples of open questions:

Tell me how did it feel…

Can you explain further…?

What forms of contraception have you tried before?

Can you tell me where you have been getting information about sexual health from previously?

OVERHEAD 5.2:

Open and closed questions

We avoid closed questions because they …

- usually produce only a one word response
- can sound judgmental

Some examples of closed questions:

Did you have unprotected sex last night?

Does your family know you're having sex outside marriage?

Do you have children?

Have you been taking your medication?

OVERHEAD 5.3:

Open and closed questions

Take care with 'why'

- Use 'why' with caution because you can easily sound judgmental.
- If you need to use 'why', try not to use it at the beginning of a sentence.
- It may be better to use it in the middle of a sentence.

Some examples:

Why did you not use a condom last night? (Sounds threatening and judgmental)

Can you tell me why you did not use a condom?

Compare these two ways of asking the same question

Why are you here?

Can you tell me why you have come to see me today?

OVERHEAD 6.1:

Reflection of content and feelings

- Reflection means expressing in words both the content and the implied feelings of the person's responses back to them.
- The purpose of reflection is to send a message to your client that you are listening carefully to what they are saying and that you are trying to understand them.
- Reflection is part of active listening.
- It is a basic counselling skill that communicates empathy.
- The key to reflection is to reflect (like a mirror) back to your client their feelings and the content of what they are saying, to indicate that you are hearing more than just the words.
- The ability to give good reflections without 'sounding like a parrot' is a matter of practice.

OVERHEAD 6.2:

Reflection of content and feelings

Example of reflection

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, you sound confused and afraid ***(Reflected feeling)*** of what people will say when they find out about your relationship with Viliame, especially your father ***(Reflected content)***.

OVERHEAD 7.1:

Paraphrasing and clarification

- Paraphrasing and clarification are part of active listening.
- When we use both together they become a powerful method of communicating that we care and that we are attending to the person we are trying to help.

Paraphrasing is summarising in a few words what the speaker is saying. It is not a matter of parroting the client's words.

Depending on the circumstances it may be best to use the client's own words.

Example of paraphrasing

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, you sound confused and afraid ***(Reflected content and feeling, and paraphrased)*** of what people will say when they find out about your relationship with Viliame.

OVERHEAD 7.2:

Paraphrasing and clarification

Clarification is not quite as obvious as it sounds. It means seeking clarification of your own understanding of the client's world.

Clarification helps the client to come to understand himself or herself better. If you ask him or her to explain something to you in more detail, or in a different way, the client will not only explore their own feelings further, but they will also feel that you are trying really hard to understand.

Example of clarification

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, I am sorry I am not quite clear about what you meant by that, could you please tell me a bit more? (***Clarification***).

OVERHEAD 8.1:

The client-centred approach

- The client-centred approach to counselling makes the client the centre of the helping process—we are working on a self-healing process.
- The client-centred approach provides a safe, non-threatening and warm environment to encourage the client to self-disclose.
- In this approach we use the client's own self-healing capabilities by providing core helping conditions.
- These core helping conditions are:
  - empathy
  - congruence and
  - unconditional positive regard for the client.
- We use these helping conditions to help the client feel a complete absence of threat and to help develop a trusting relationship.
- We need to integrate these 3 core conditions into our basic counselling skills in order to better help people.

OVERHEAD 8.2:

The client-centred approach

Empathy is …

- trying to understand the client's world, their meanings, and their life through their eyes; and
- listening actively through using **reflection, paraphrasing and clarification** skills.

We can achieve empathy through …

- listening sensitively;
- understanding the other person;
- checking to see whether we have gotten the message right; and
- suspending our own judgement.

OVERHEAD 8.3:

The client-centred approach

Congruence

- **Congruence** requires being open, honest and genuiune.
- Congruence is present when what is said matches what is felt
- As counsellors we should not deny or avoid our own feelings
- We should be aware of our own feelings and …
- We should not be afraid to express them if appropriate
- In this way we can help to establish trust

Unconditional positive regard

- **Unconditional positive regard** is the absence of judgement
- It is feeling warmth towards the client and showing it
- When we show a client that we respect them and accept them as a worthwhile human being, we are showing that they have value and worth

OVERHEAD 9.1:

Essential features of an STI counselling session

A good counsellor is …

- Warm
- Trusting
- Knows their stuff
- Respectful
- Practices confidentiality
- Smiles a lot
- Consistent
- Treats people fairly
- Supportive
- Friendly
- Sensitive to issues of:

  Gender

  Culture/ethnicity

OVERHEAD 9.2:

Essential features of an STI counselling session

A counselling session takes account of …

- Time: the value placed on time in the cultural context
- Ethics:

  Professional ethics

  Whether using basic counselling skills in a helping way.
- The client's need for a competent and responsible helper.
- The client's need for confidentiality.
- The requirement to do the most good and the least harm when there is a dilemma.
- The requirement to act within the law of the land.
- Respect for human rights.
- Location: *Easy to access.*

OVERHEAD 10.1:

The structure of a counselling session

Every session must have a beginning, a middle and an end.

- The beginning is where the helper/counsellor introduces himself/herself—who he/she is and what he/she is there to do. In some sessions it may be appropriate at this point to mention the ethical values of respect and confidentiality to the client to reassure them.

- The middle part of the session is where the helping relationship develops. Here the counsellor uses basic counselling skills, displays the three core conditions and provides preventative messages.

- The end of the session can be an end of the relationship or it can be the beginning of a long-term relationship. This depends partly on the skills and understanding of the counsellor, but also on the circumstances.

OVERHEAD 10.2:

The structure of a counselling session

A useful model of problem solving is the LEPERS model.

***LEPERS** is:*

***L**istening*

***E**xplaining*

***P**roviding information*

***E**xamining*

***R**educing anxiety/providing appropriate reassurance*

***S**uggesting strategies*

OVERHEAD 10.3:

The structure of a counselling session

An STI counsellor can use the LEPERS model to structure a counselling session.

Within the basic structure of a beginning, a middle and an end, the STI counsellor uses basic counselling skills (active listening, reflection and paraphrasing and clarification) and displays the 3 core conditions (empathy, congruence and unconditional positive regard).

He/she will explain and provide reproductive information, examine options for the client, reduce anxiety and provide appropriate reassurance and may also suggest strategies for coping.

OVERHEAD 11.1:

Introductions and Endings

An example of an Introduction:

Hello [or can use local greeting] Avinesh [or substitute with local name]. My name is Mere. I work here at the Clinic. I will do my best to help. I would like to tell you that whatever you say here today will be held in confidence. Can you tell me what it is that concerns you?

- You can change it to suit a standard introduction that all the workers in the Clinic use.
- You can change it to suit the cultural context you are working in.
- The introduction can be peppered with local words or the use of vernacular.

OVERHEAD 11.2:

Introductions and Endings

An example of an Ending:

Avinesh, can you tell me if you have received the information you wanted when you came here?

OK! Remember you can always come back and see me again if you have any questions or need someone to talk to. If you can make an appointment that will guarantee you will see me again.

Yes, you can take all the pamphlets, they are free.

Take care, bye, see you again [this depends on what you prefer and the person you are helping]

OVERHEAD 11.3:

Introductions and Endings

Points for discussion

- For many people issues of a sexual or reproductive nature can be embarrassing for them to discuss. To seek assistance is a big step and a person can come with many expectations about the session or the preventative messages that will be provided. Be mindful of this.

- Language is an important tool to consider when you are counselling in a helping way. The use of vernacular or slang may assist open communication. Be flexible.

- Be mindful of cultural beliefs and expectations and how they influence the thoughts, feelings and behaviour of human beings. Be aware of your own cultural beliefs and expectations.

OVERHEAD 12:

The ABC of preventing STIs

People can avoid STIs by changing their sexual behaviour. They can follow any of the ABCs–***A****bstain,* ***B****e mutually faithful, and* ***C****onsistently use Condoms:*

A Abstain from sex. This is the only guaranteed protection.

B Be mutually faithful. Always have sex with the same person. This person also must not have sex with anyone else and must not have an STI. **IMPORTANT:** You usually cannot tell if a person has an STI just by looking at him or her. People with STIs, including HIV usually do not look sick.

C Consistently use Condoms. Use them every time and use them correctly.

To prevent STIs, people at risk should use condoms even when they use another family planning method. If a woman's sex partner will not use condoms, she should try to use spermicide. Spermicides may not stop HIV/AIDS, however. The diaphragm and cervical cap also may help prevent some STIs somewhat.

Source: Hatcher, R.A., Rinehart, W, Blackburn, R., and Geller, J.S. The Essentials of Contraceptive Technology. *Baltimore, Johns Hopkins School of Public Health, Population Information Program, 1997, p. 16-8.*

OVERHEAD 13:

What are they talking about?

'When doing that which cannot be discussed, place that which cannot be described on that of which it is forbidden to speak.'

'If it's not on, it's not on!'

'Take it off! Put it on!'

OVERHEAD 14.1:

Definitions of sexual health

World Health Organization

'Sexual health is the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are enriching and that enhance personality, communication and love.

'There are three elements that should inform discussions of sexuality and health:

- the capacity to enjoy and express sexuality without guilt or shame in fulfilling, emotional relationships;
- the capacity to control fertility;
- freedom from disorders which compromise health, and sexual or reproductive function.'

OVERHEAD 14.2:

Definitions of sexual health

Camden & Islington National Health Service Trust, London, UK

'Enjoyment of affirmative sexual relationships, behaviours, identities and lifestyles of ones' choice, avoiding unwanted sexual outcomes, including physical or psychological harm.'

'Sexual health is the right and option of an individual to express sexuality and enjoy sexual practices, made with informed consent, within a non-judgemental and non-culturally-biased environment, with access to good health care.'

OVERHEAD 15.1:

Issues in sexual health

***Sexual health** includes:*

- genital health
- reproductive health
- psychosocial and emotional health
- absence of disease
- freedom of reproductive rights and choices
- full access to sexual health education
- health care and decision-making
- recognition of the **meaning** of sex in the lives of those addressed
- freedom from the burden of stigmatisation discrimination, legal and socio-political repression...

OVERHEAD 15.2:

Issues in sexual health

In sexual health counselling we need to acknowledge …

- the prevailing **culture** (stigma, denial)
- **spiritual** dimensions
- the **law**
- the role of **loved-ones** and family
- **public health** (transmission, prevention)
- individual health
- clinical medical options for **treatment**
- **behaviour** and lifestyle
- **geography**
- **anxiety** and fear
- clear communication and engagement

OVERHEAD 16.1:

Which are safer sexual activities?

- telephone sex
- talking, writing or reading about sex
- watching erotic movies
- individual masturbation
- kissing parts of the body
- deep kissing
- using sex toys, e.g., dildos
- spanking
- mutual masturbation

OVERHEAD 16.2:

Which are safer sexual activities?

- sex with non-genital and non-mucosal parts of the body, e.g., thighs, breasts, armpits
- positioning (putting a finger in the anus)
- vaginal and anal penetration using condoms
- oral sex with condoms
- oral sex without condoms
- having a sexual relationship outside marriage
- sex with animals
- sharing sex toys
- oral, vaginal and anal penetration without condoms

OVERHEAD 17:

Safer sex questions

1. Wet or tongue kissing: What is the risk of STI transmission?
2. Is oral sex safe?
3. Is masturbation part of abstinence?
4. Except for injecting drug use, does abuse of other drugs have any HIV risk?
5. Is sex with a condom the only true safe sex?
6. Which has greater risk for HIV, a human bite or a mosquito bite?
7. Does having passed an STI to another person make me a bad person?
8. Can safer sex ever be as enjoyable as sex without precautions?
9. Is drinking an important part of risky sexual behaviour?

OVERHEAD 18:

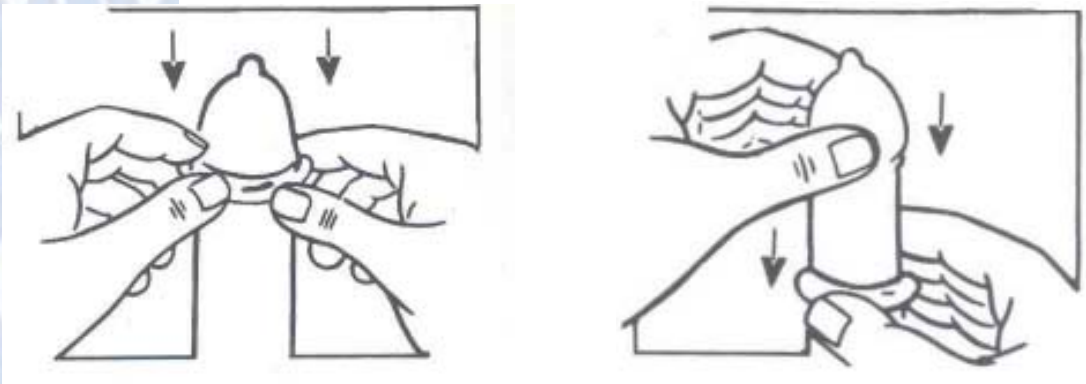
How to put on a Condom

1. Put the condom on the erect penis before the penis touches the vagina.

   - Hold the pack at its edge and open by tearing from a ribbed edge.
   - Hold the condom so that the rolled rim is facing up, away from the penis.
   - Pull the foreskin back if the penis is uncircumcised.
   - Place the condom on the tip of the penis.
   - Unroll the condom all the way to the base of the penis. The condom should unroll easily. If it does not, it is probably backwards. Turn it over and try again. If using the condom to avoid passing an STI, throw away the condom that was on backwards and start over with a new one.

Putting on a condom

A. **B.**

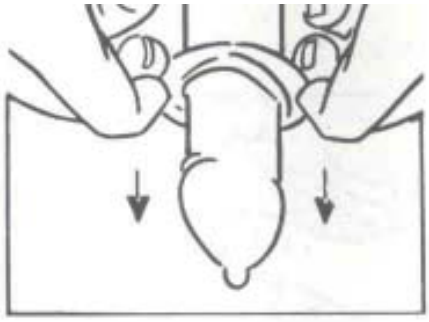


Source: Hatcher, R.A., Rinehart, W, Blackburn, R., and Geller, J.S. The Essentials of Contraceptive Technology. Baltimore, Johns Hopkins School of Public Health, Population Information Program, 1997, pp. 11-9 –11-10.

OVERHEAD 19:

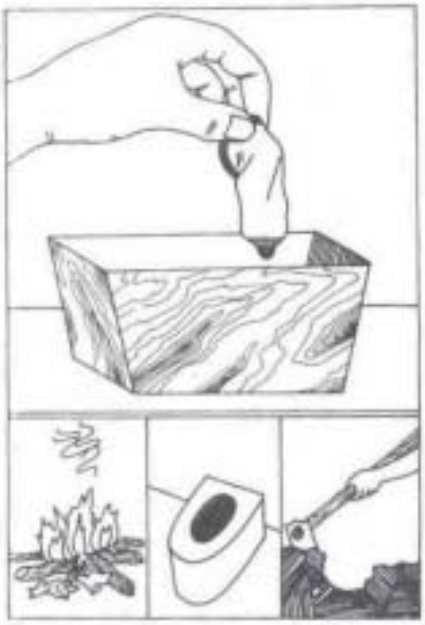
How to take off a Condom

1. After ejaculation hold the rim of the condom to the base of the penis so it will not slip off. The man should pull his penis out of the vagina before completely losing his erection.



2. Take off the condom without spilling the semen on the vaginal opening.

3. Throw the condom away in a pit latrine (toilet), burn it, or bury it. Do not leave it where children will find it and play with it. Do not use a condom more than once.



Source: Hatcher, R.A., Rinehart, W, Blackburn, R., and Geller, J.S. The Essentials of Contraceptive Technology. Baltimore, Johns Hopkins School of Public Health, Population Information Program, 1997, pp. 11-9 –11-10.

OVERHEAD 20.1:

Taking an effective sexual history

What do we need to know?

- The precise nature of the problem
- The history of the problem
- The nature of the relationship (where appropriate)
- Family and personal background
- Personal sexual and/or risk history
- Medical history
- Attitudes towards treatment

OVERHEAD 20.2:

Taking an effective sexual history

What else do we need to know about the client?

- Mood—anxiety, depression, anger
- Sexual understanding and/or ignorance
- Relationship difficulties
- Self-esteem
- Negative attitudes—denial
- Adverse circumstances
- Prior experiences of health services
- Beliefs about health and illness
- Expectations of health workers

OVERHEAD 20.3:

Taking an effective sexual history

What about the health worker?

- Level of communication skills
- Self-confidence in communication
- Personality
- Physical factors—tiredness
- Time pressure
- Psychological factors—anxiety

OVERHEAD 20.4:

Taking an effective sexual history

How can we make talking about sex easier?

- Privacy
- Confidentiality
- Clarity
- Time
- Professionalism
- Language
- Body language
- Boundaries
- Gender

OVERHEAD 21.1:

Lina Pou

Lina Pou has come to ask for advice, as she is very worried that her husband may be unfaithful to her. They have been married 18 months and she thinks he is seeing a woman in a nearby village, although she has no proof. Whenever she asks her husband about this, he shouts at her, and threatens to beat her up. She says he is often drunk and she is frightened to talk to him on serious matters because he seems to lose his temper so easily.

Lina Pou has a bad vaginal discharge and has been treated for this before. Her family live far away from her home, and she has few friends locally as few people speak her language. She has a 6-month old child who seems to be doing poorly. She also indicates that she may be pregnant again. She appears very lonely and frightened that if her husband hears she's been talking to people outside their marriage he will harm her and her child.

OVERHEAD 21.2:

Lina Pou

Discussion points

- Possible diagnoses
- Possible sources of infection
- Options for future prevention
- The roles and power of women in Lina Pou's position
- Managing her anxieties
- Managing the immediate crisis

OVERHEAD 22:

Values

Values refer to the kinds of things that an individual, a group or a whole society consider to be desirable. People may or may not be consciously aware of these values but they use them as the basis for choosing between different courses of action.

One example of this is choosing whether or not to engage in a sexual relationship where there is a risk of disease. Health is valued more by some people than by others and this affects their willingness to take risks with or for sex.

It has been shown that those who do not enjoy good health value health much more highly than those who are healthy.

Most adolescents are healthy and have never had to live with chronic illness of any sort. Thus, few of them fear the possibility of contracting a disease when they begin to experiment in sexual activities.

Conversely, it is much easier to educate people who have a disease about risk behaviour, because they would be more likely to value their health.

OVERHEAD 23.1:

Controversial statements

1. Adolescent youths should be able to seek family planning services without parental consent.

2. Prostitutes are the main group responsible for the spread of STIs.

3. All people infected with HIV should be isolated.

4. The partners of all people infected with an STI should be compulsorily notified.

5. HIV-infected mothers should not be allowed to have children.

6. All health staff should be regularly screened for hepatitis and HIV.

7. Health workers should always be informed if clients are HIV positive.

OVERHEAD 23.2:

Controversial statements

8. Young people should be discouraged from all forms of sexual activity.

9. Giving condoms to young people encourages them to have sex.

10. Young girls who become pregnant must stop going to school.

11. Homosexuals or gay persons should not raise children.

12. HIV is caused by gay sex.

13. Condoms should be freely available to all.

14. People with STIs are morally bad and should not be allowed to hold important jobs.

15. Homosexuality is not normal.

OVERHEAD 24:

Illustrating your acceptance

Mark your level of acceptance on the scale

Behaviour	**Acceptance level** *Acceptance* — *Non-acceptance*
Oral sex	
Anal sex	
Homosexuality	
Extra-marital sex	
Prostitution	
Drug use	
Cunnilingus	
Fellatio	

OVERHEAD 25.1:

HIV pre-test counselling checklist

- Emphasise confidentiality
- Explore reasons for testing
- Explore risk history:
  - unsafe sex—of self and partner
  - injecting drug use—of self and partner
  - blood/blood products/transplants received
  - possibly non-sterile procedures—tattooing, injections, scarification
- Explore the significance of the 'window period' and the time elapsed since last risk exposure
- Explore and clarify client's knowledge about HIV/AIDS (or that of person to be tested)

OVERHEAD 25.2:

HIV pre-test counselling checklist

- Explore and clarify client's understanding of the HIV test's implications for:
  - marriage
  - pregnancy
  - relationships (e.g., does the partner know about the testing?)
  - work
  - stigma
  - finance
  - emotional coping
  - social support available
- Explore and clarify client's knowledge about the test and testing procedure

OVERHEAD 25.3:

HIV pre-test counselling checklist

- Discuss the value of testing:

  If negative–a platform for constructive change

  – confirms lack of antibodies

  – removes uncertainty

  If positive- a platform for constructive change

  – certain knowledge

  – protect self and partner

  – plan for own and loved-ones' future

- Discuss who should know the result if positive, and how they might be told

OVERHEAD 25.4:

HIV pre-test counselling checklist

- Assess strategies for coping in the short and longer term
- Counsellor's previous experience in managing health and other personal crises
- Discuss future prevention:
  - safer sex and condom use
  - clean needle use
  - options for managing risk situations
  - discussing prevention socially and domestically

OVERHEAD 26:

Why prevention and patient education are important

Prevention activity in the STI service is important because:

- clinic-based education is efficient—the people we need to reach have come to us;
- because they have come for diagnosis and treatment, people are more likely to be interested in recognising and learning more about that disease—it is the right time to learn;
- treatment is more effective if patients understand their illness, their risk, and why they should go through the treatment;
- STIs can recur and preventing them requires sustained behaviour change. People may be willing to go through treatment for current infections, but they may need education, motivation and emotional support and understanding to help them reduce risk for **future** STIs, or to boost their health against infections that have not yet made them sick;
- by increasing the frequency of treatment sessions clients are more likely to start and continue taking medication and change their behaviour. This also helps to prevent future STI and/or HIV infections.

OVERHEAD 27.1:

HIV post-test counselling checklist—NEGATIVE result

- Renew relationship
- Explain negative result

  –give time to reflect

  –allow time to express feelings
- Explain lack of immunity to future infections
- Check and confirm understanding of HIV
- Clarify doubts and misconceptions about HIV and the test
- Evaluate the need for re-testing (e.g., after the 'window period', and/or occupational exposure)
- Observe and be aware of 'survivor' reactions and other, possibly unexpected, emotional responses

OVERHEAD 27.2:

HIV post-test counselling checklist—NEGATIVE result

- Identify potential services for onward referral to manage related issues (e.g., risk arising from alcohol use)
- Repeat HIV prevention discussion:
  - a platform for constructive change
  - safer sex and condom use
  - clean needle use
  - options for managing risk situations
  - discussing prevention socially and domestically

OVERHEAD 28.1:

Some psychological responses to the crisis of positive diagnosis

- shock
- denial
- anger
- suicidal thinking
- fear
- isolation
- loss
- grief
- guilt
- depression
- anxiety
- loss of self-esteem
- hypochondria
- spiritual concerns

OVERHEAD 28.2:

Some psychological responses to the crisis of positive diagnosis

The severity of the psychological response may be affected by:

- the person's physical health at the time
- the preparation they have had for the news
- the level and accessibility of support in the community
- the prior psychological condition and history
- the cultural and spiritual values attached to HIV, and to its implications for having children, for illness and for death

OVERHEAD 29.1:

HIV post-test counselling checklist—POSITIVE result

- Renew relationship
- Follow client's lead about when to disclose the result
- State the result clearly
- Wait:
  - give client time to absorb information
  - give time for expression of feelings
  - **listen**
- Help client to come to terms with the test result:

intellectually	- explore understanding
	- clarify understanding of the result
emotionally	- assess emotional impact
	- validate reactions as normal

OVERHEAD 29.2:

HIV post-test counselling checklist—POSITIVE result

behaviourally
- what will they do next —in the immediate future?
- assess their understanding of and capacity for risk reduction
- explore factors relating to your client's general health and immune functioning—stress, nutrition, exercise, alcohol and drug use, re-exposure to HIV

interpersonally
- review who to inform
- review possible impact on partner, family, friends, employer
- review how to break news—offer help and support
- plan to maximise support and minimise stress

medically
- plan health checks and early intervention
- rationalise attendance for health interventions

OVERHEAD 29.3:

HIV post-test counselling checklist—POSITIVE result

- Arouse hope with advice and empowerment.
  - Give a realistically hopeful message about what **can** be done without discounting their concerns
  - Focus on measures to maintain and improve their quality of life
  - Empower their participation in their own health issues
  - Express your availability, and the availability of other services, when needed

OVERHEAD 29.4:

HIV post-test counselling checklist—POSITIVE result

- Help your client to start planning for the future.
  - Discuss possibilities for constructive change
  - Support possibilities in the short term—managing the stress of diagnosis, and reducing the potential for harm arising from stress-reducing behaviours, such as substance misuse, impulsive behaviours, risky sex
  - Plan to address financial, occupational, legal, domestic, medical needs
  - Identify resources for on-going support, such as individual therapy, support groups, social network, spiritual network
- Provide appropriate brochures and information to take away.

The following overheads are not referred to in the Manual, but you may find them useful if you decide to expand or adapt some of the sessions.

OVERHEAD 30.1:

The importance of understanding STIs in their human context

'If we are to tackle the problem of the sexually transmitted diseases we will need to examine our own attitudes towards them and those who contract them.

The knowledge of why individuals put themselves at risk, how often they do this, and why they behave in different ways after doing so is essential to understanding the spread of disease and its containment and eventual control. The behaviour of the individual *must be a component of the research strategy offered by ... academic (approaches).'*

(Adler, 1980)

'Even within the constraints of a concern for AIDS, a narrow view of sexual behaviour may be effective if all we are concerned with is social book-keeping and epidemiological modeling, but it will be inadequate to the task of ***understanding behaviour in a way that results in behaviour change.'***

Gagnon (1989)

OVERHEAD 30.2:

The importance of understanding STIs in their human context

We '...need to create a paradigm that is no longer based solely on a medical construct, but takes into account all the elements that contribute to the transmission of STIs and their effective management. Biomedical interventions are only of limited value and the effective control of the epidemic of STIs and HIV requires broad approaches which address and understand in addition the social, cultural, economic and political dimensions of this major health crisis.'

Adler, Foster, Richens, Slavin (1996)

'Why bother? On the current trajectory, at the end of the HIV holocaust, when all the colours and cords of the quilt of lives lost are woven into our cultural, generational testament of grief and remembrance, all we may have really learned is how to make a new pill.'

Miller (1997)

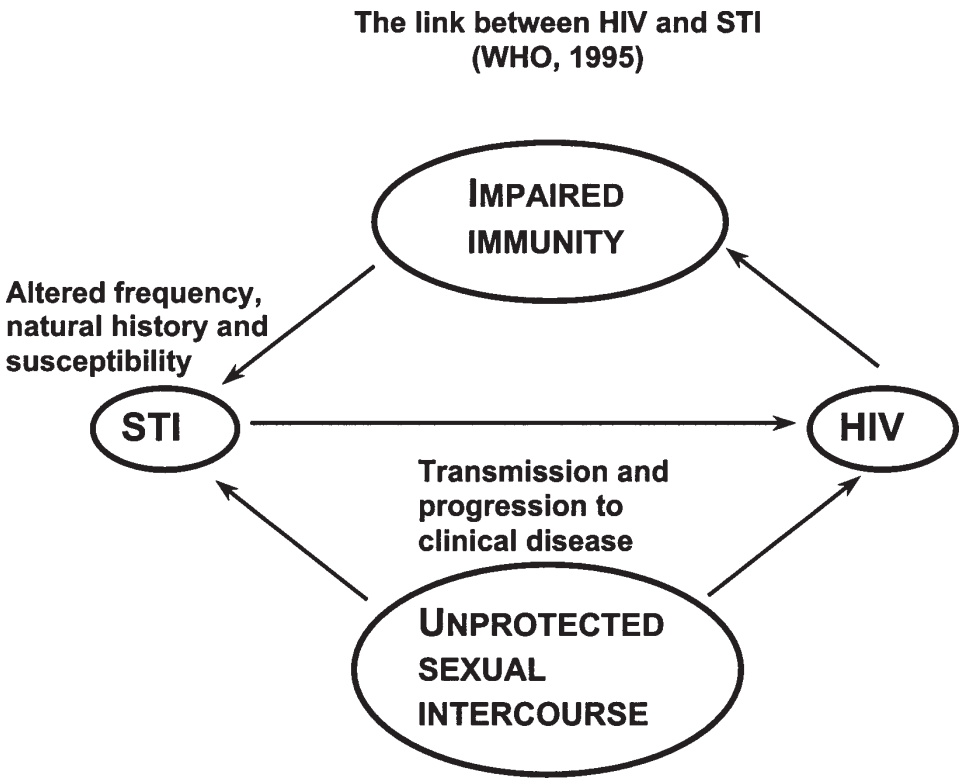
OVERHEAD 31.1:

Links between STIs and HIV

- HIV is an STI
- Epidemiological modeling of HIV is based on STI models
- Prevention issues are similar for STI's and HIV
- Secondary HIV prevention is ineluctably concerned with sexual health
- STI's are the only practical surrogate marker in HIV prevention
- STI/syphilis history and HIV administration and social responses are extraordinarily similar
- STI administration and HIV administration have equally failed and succeeded

OVERHEAD 31.2:

Links between STIs and HIV



OVERHEAD 32:

Non-verbal elements in counselling discussion

Positive	*Negative*
Uses a tone of voice similar to the person being counselled Looks client in the eye Uses attentive facial expression, body movements and posture · Uses appropriate physical distance Does not speak too quickly or slowly Occasional, appropriate gestures, such as nods, to acknowledge the statements of the client Appropriate use of humour Appropriate balance of technical and non-technical language	Unpleasant tone of voice Avoids eye contact · Frowns, scowls, yawns Inappropriate physical distance Speaks too slowly or quickly Appears unresponsive and makes no response to client's speech or gestures Inappropriate use of humour Inappropriate use of technical language, making them hard to understand

OVERHEAD 33:

Common counselling errors

- ***Controlling*,** rather than encouraging, the client's spontaneous expression of feelings and needs
- ***Judging*,** as shown by statements that indicate the client does not meet the counsellor's standards
- ***Moralising***, preaching, and patronising—telling people how they ought to behave or lead their lives
- ***Labelling*,** making assumptions about the person rather than trying to find out their motivations, anxieties and fears
- ***Unwarranted reassuring***—trying to induce optimism by making light of the client's own version of a problem
- ***Not accepting*** the client's feelings—saying they should be different

APPENDIX 2:

Handouts

Photocopy these for your workshop participants as required:

If you wish to expand some of the sessions you may find the following handouts useful:

HANDOUT 1:

Counselling and counselling skills

Counselling

- Counselling is a dynamic process.
- It involves a contractual agreement between a client and a counsellor who is trained to practice to an acceptable standard and who is bound by a code of ethics and practice.
- Counselling aims to encourage healthy living and it requires the client to explore important personal issues and to identify ways of living with the situation they are in.
- Counselling is in no way guidance, advice giving or befriending.

Counselling skills

- Counselling skills are interpersonal communication skills.
- They can be used by anyone—either as a separate set of techniques or as a set of skills which can be integrated with, or used alongside, an already well established set of professional skills.
- In such a case we may find:
  - a nurse using counselling skills when he or she listens to a patient or comforts grieving relatives; or
  - a manager using counselling skills when an employee tells her that he is thinking of quitting work to look after his sick child.
- Counselling skills contain conditions of empathy, genuineness and the absence of judgement.
- If you are using counselling skills they will operate **within** your professional skills and **within** other professional ethics.

HANDOUT 2.1:

Counselling skills

Active listening

Active listening is what we pay attention to in the person we are helping.

To listen actively we must be aware of and use both verbal and non-verbal signals.

Non-verbal signals

- Voice quality – soft, hard, confident, timid, strong, weak etc.
- Breathing – deep, shallow, sobbing, relaxed etc.
- Eyes – looking down, looking away, making eye contact, tears etc.
- Facial expression – relaxed, tense, afraid, happy, shocked etc.
- Hand movements – waving about, tapping fingers etc.
- Leg movements – swinging, tapping foot etc.
- Body posture – relaxed, stiff, upright, slumped over etc.

We need to be aware of many things …

- We **listen** with our **ears** and **eyes**.
- There are cultural reasons why people behave in particular ways.
- We need to be aware of the ways people communicate non-verbally
- We also need to be aware of the barriers to communication.
- We use non-verbal behaviour to show that we are listening and what we are feeling.
- These signals can also be barriers to communication.

If we are to help our clients we must …

- listen sensitively and accurately to them by being sensitive to their whole person;
- be aware of our own emotional blind spots;
- be aware of how people express their feelings cross-culturally; and
- work to develop our empathic skills.

HANDOUT 2.2: COUNSELLING SKILLS

Projection — be aware of hidden feelings

- **Projection** is the transference of our hidden feelings onto other people, without our realising it.
- For example, suppose a nurse who works in an STI clinic has had a fight with her husband and comes to work feeling very angry with him. She displays a very uncaring attitude (telling them off, shouting etc) at work that day. In other words she is projecting her anger onto the patients. In the afternoon a patient yells back at her for treating him rudely. An argument erupts.
- The patient has identified with the nurse's anger and is responding to it. This is known as **projective identification**.
- Projection and projective identification are important psychological concepts that illustrate the power of the unconscious mind.
- Be very careful not to project your hidden feelings onto clients.
- Be very careful not to identify with the client's emotions, as this will not be helpful to the client.

Open and closed questions

We use open questions …

- to make communication easier
- to help trust and warmth to grow in the helping relationship
- to encourage further discussion

Some examples of open questions:

Tell me how did it feel…

Can you explain further…?

What forms of contraceptive have you tried before?

Can you tell me where you have been getting information about sexual health from previously?

We avoid closed questions because they …

- usually produce only a one word response
- can sound judgmental

HANDOUT 2.3: COUNSELLING SKILLS

Some examples of closed questions:

Did you have unprotected sex last night?

Does your family know you're having sex outside marriage?

Do you have children?

Have you been taking your medication?

Take care with 'why'

- Use 'why' with caution because you can easily sound judgmental.
- If you need to use 'why', try not to use it at the beginning of a sentence.
- It may be better to use it in the middle of a sentence.

Some examples:

Why did you not use a condom last night? (Sounds threatening and judgmental)

Can you tell me why you did not use a condom?

Compare these two ways of asking the same question

Why are you here?

Can you tell me why you have come to see me today?

Reflection of content and feelings

- Reflection means expressing in words both the content and the implied feelings of the person's responses back to them.
- The purpose of reflection is to send a message to your client that you are listening carefully to what they are saying and that you are trying to understand them.
- Reflection is part of active listening.
- It is a basic counselling skill that communicates empathy.
- The key to reflection is to reflect (like a mirror) back to your client their feelings and the content of what they are saying.
- The ability to give good reflections without 'sounding like a parrot' is a matter of practice.

HANDOUT 2.4: COUNSELLING SKILLS

Example of reflection

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, you sound confused and afraid (***Reflected feeling***) of what people will say when they find out about your relationship with Viliame, especially your father (***Reflected content***).

Paraphrasing and clarification

- Paraphrasing and clarification are part of active listening.
- When we use both together they become a powerful method of communicating that we care and that we are attending to the person we are trying to help.

Paraphrasing is summarising in a few words what the speaker is saying. It is not a matter of parroting the client's words.

Depending on the circumstances it may be best to use the client's own words.

Example of paraphrasing

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, you sound confused and afraid (***Reflected content and feeling, and paraphrased***) of what people will say when they find out about your relationship with Viliame.

Clarification is not quite as obvious as it sounds. It means seeking clarification of your own understanding of the client's world.

Clarification helps the client to come to understand himself or herself better. If you ask him or her to explain something to you in more detail, or in a different way, the client will not only explore their own feelings further, but they will also feel that you are trying really hard to understand.

Example of clarification

Client: I don't know what to do, as nobody knows about my relationship with him. My father is going to kill me.

Counsellor: Kelera, I am sorry I am not quite clear about what you meant by that, could you please tell me a bit more?(***Clarification***).

HANDOUT 3:

Cema

Cema is a university student, who comes from a very traditional family. She has a boyfriend at college but her family, particularly her father and oldest brother, want her to marry an older man from her own community. When she found out that she was HIV positive she and her boyfriend became much closer in their support for each other. Now she is about to graduate and she is afraid to go home

HANDOUT 4.1:

The client-centred approach

- The client-centred approach to counselling makes the client the centre of the helping process—we are working on a self-healing process.
- The client-centred approach provides a safe, non-threatening and warm environment to encourage the client to self-disclose.
- In this approach we use the client's own self-healing capabilities by providing core helping conditions.
- These core helping conditions are: empathy, congruence and unconditional positive regard for the client.
- We use these helping conditions to help the client feel a complete absence of threat and to help develop a trusting relationship.
- We need to integrate these 3 core conditions into our basic counselling skills in order to better help people.

Empathy is …

- trying to understand the client's world, their meanings, and their life through their eyes; and
- listening actively through using **reflection, paraphrasing and clarification** skills.

We can achieve empathy through …

- listening sensitively;
- understanding the other person;
- checking to see whether we have got the message right; and
- suspending our own judgement.

HANDOUT 4.2: THE CLIENT-CENTRED APPROACH

Congruence

- **Congruence** requires being open, honest and genuine.
- Congruence is present when what is said matches what is felt.
- As counsellors we should not deny or avoid our own feelings
- We should be aware of our own feelings and …
- We should not be afraid to express them if appropriate
- In this way we can help to establish trust

Unconditional positive regard

- **Unconditional positive regard** is the absence of judgement
- It is feeling warmth towards the client and showing it
- When we show a client that we respect them and accept them as a worthwhile human being, we are showing that they have value and worth

HANDOUT 5.1:

The structure of a counselling session

Every session must have a beginning, a middle and an end.

- The beginning is where the helper/counsellor introduces himself/herself—who he/she is and what he/she is there for. In some sessions it may be appropriate at this point to mention the ethical values of respect and confidentiality to the client to reassure them.
- The middle part of the session is where the helping relationship develops. Here the counsellor uses basic counselling skills, displays the three core conditions and provides preventative messages.
- The end of the session can be an end of the relationship or it can be the beginning of a long-term relationship. This depends partly on the skills and understanding of the counsellor, but also on the circumstances.

A useful model of problem solving is the LEPERS model.

LEPERS is:

L*istening*

E*xplaining*

P*roviding information*

E*xamining*

R*educing anxiety/providing appropriate reassurance*

S*uggesting strategies*

An STI counsellor can use the LEPERS model to structure a counselling session.

Within the basic structure of a beginning, a middle and an end, the STI counsellor uses basic counselling skills (active listening, reflection and paraphrasing and clarification) and displays the 3 core conditions (empathy, congruence and unconditional positive regard).

HANDOUT 5.2: THE STRUCTURE OF A COUNSELLING SESSION

He/she will explain and provide reproductive information, examine options for the client, reduce anxiety and provide appropriate reassurance and may also suggest strategies for coping.

An example of an Introduction:

> *Hello [or can use local greeting] Avinesh [or substitute with local name]. My name is Mere. I work here at the Clinic. I will do my best to help. I would like to tell you that whatever you say here today will be held in confidence. Can you tell me what it is that concerns you?*

- You can change it to suit a standard introduction that all the workers in the Clinic use.
- You can change it to suit the cultural context you are working in.
- The introduction can be peppered with local words or the use of vernacular.

An example of an Ending:

> *Avinesh, can you tell me if you have received the information you wanted when you came here?*
>
> *OK! Remember you can always come back and see me again if you have any questions or need someone to talk to. If you can make an appointment that will guarantee you will see me again.*
>
> *Yes, you can take all the pamphlets, they are free.*
>
> *Take care, bye, see you again [this depends on what you prefer and the person you are helping]*

Points for discussion

- For many people issues of a sexual or reproductive nature can be embarrassing for them to discuss. To seek assistance is a big step and a person can come with many expectations about the session or the preventative messages that will be provided. Be mindful of this.
- Language is an important tool to consider when you are counselling in a helping way.
- Be mindful of cultural beliefs and expectations and how they influence the thoughts, feelings and behaviour of human beings. Be aware of your own cultural beliefs and expectations.

HANDOUT 6.1:

Checklist for recognising STI risk

Answering these questions can help a person recognise if he or she is likely to get STIs. The answers also can guide the family planning provider: If the client is likely to get STIs, the client needs a supply of condoms and possibly spermicide and also counselling about avoiding STIs, recognising possible symptoms, and getting treatment if symptoms appear. If the client has any symptoms, the client also needs diagnosis and treatment, or referral.

Sex workers and their clients face the highest risk of getting STIs. Among people with lower risk, in many countries STI rates are highest among people under age 20.

*Ask the client the questions below**

1. Do you have more than one sex partner? Does your partner? Have you or your partner had any other sex partners in the last several months? If so, do you sometimes have sex without a condom? Could this happen in the future?

   ❑ No ❑ Yes

   If YES to question 1, the client may be likely to get an STI. Urge the client to use condoms, try to have a mutually faithful relationship, or abstain.

   If YES to question 1, go on to ask questions 2 and 3.

For a woman

2. Do you have any of the following?

   - Unusual discharge from your vagina? ❑ No ❑ Yes
   - Itching sores in or around your vagina? ❑ No ❑ Yes
   - Pain or burning when you urinate? ❑ No ❑ Yes
   - Lower abdominal pain ❑ No ❑ Yes

HANDOUT 6.2: CHECKLIST FOR RECOGNISING STI RISK

For a man

2. Do you have any of the following?
   - Pain or burning when you urinate? ❑ No ❑ Yes
   - Open sores anywhere in your genital area? ❑ No ❑ Yes
   - Pus coming from your penis? ❑ No ❑ Yes
   - Swollen testicles or penis? ❑ No ❑ Yes

3. Do you think your sex partner might have an STI? Does he/she have open sores anywhere in the genital area? Does he have pus coming from his penis? OR Does she have an unusual discharge from her vagina? ❑ No ❑ Yes

   If YES to any parts of question 1 and either 2 or 3, these symptoms may be caused by an STI. Diagnose and treat, or refer. Urge that the client avoid sex until 3 days after treatment is done and symptoms are gone. Urge these clients to bring or send their sex partners for care.

***NOTE:** Question 1 alone does not particularly help to tell if a person without symptoms already HAS an STI. In women, many STIs do not always cause obvious symptoms. Also, conditions in women that are not STIs may have the same symptoms as STIs. By comparison, in men STIs are usually easier to detect. Men are more likely to have symptoms, and there are fewer other possible causes.*

HANDOUT 6.3: CHECKLIST FOR RECOGNISING STI RISK

Preventing STIs

People can avoid STIs by changing their sexual behaviour. They can follow any of the ABCs–Abstain, Be mutually faithful, and Consistently use Condoms:

A

Abstain from sex. This is the only guaranteed protection.

or

B

Be mutually faithful. Always have sex with the same person. This person also must not have sex with anyone else and must not have an STI.

IMPORTANT: You usually cannot tell if a person has an STI just by looking at him or her. People with STIs, including HIV, usually do not look sick.

or

C

Consistently use Condoms. Use them every time and use them correctly.

To prevent STIs, people at risk should use condoms even when they use another family planning method. If a woman's sex partner will not use condoms, she should try to use spermicide. Spermicides may not stop HIV/AIDS, however. The diaphragm and cervical cap also may help prevent some STIs somewhat.

Source: Hatcher, R.A., Rinehart, W, Blackburn, R., and Geller, J.S. The Essentials of Contraceptive Technology. Baltimore, Johns Hopkins School of Public Health, Population Information Program, 1997, pp. 16-6 –16-8.

HANDOUT 7.1:

The condom continuum

Explain why using a condom EVERY TIME is important

1. Just one unprotected act of sexual intercourse can lead to pregnancy or sexually transmitted infection (STI).
2. Looking at a person cannot tell you if he or she has an STI. A person with an STI, including HIV/AIDS, can look perfectly healthy.
3. A person cannot always tell if he or she has an STI, including HIV infection.

Explaining how to use

IMPORTANT: Whenever possible, show clients how to put on and take off a condom. Use a model, a stick, a banana, or 2 fingers to demonstrate putting on the condom. Suggest to a new user that he practice putting on a condom by himself before he next has sex.

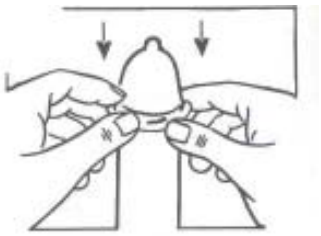
Give specific instructions

1. Put the condom on the erect penis before the penis touches the vagina.
   - Hold the pack at its edge and open by tearing from a ribbed edge.
   - Hold the condom so that the rolled rim is facing up, away from the penis.
   - Pull the foreskin back if the penis is uncircumcised.
   - Place the condom on the tip of the penis.
   - Unroll the condom all the way to the base of the penis. The condom should unroll easily. If it does not, it is probably backwards. Turn it over and try again. If using the condom to avoid passing an STI, throw away the condom that was on backwards and start over with a new one.

HANDOUT 7.2: THE CONDOM CONTINUUM

Putting on a condom

A.

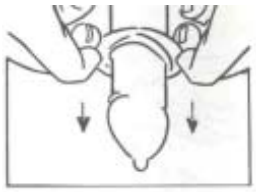


B.

1. Hold the penis with the rim away from the body and unroll all the way to base of penis.
2. Any lubricant should be water-based. Good lubricants include spermicides, glycerine, and specially made products. Water can be used, also. They help keep condoms from tearing during sex. Natural vaginal secretions also help as a lubricant.

   Do not use lubricants made with oil. Most of them damage condoms. Do NOT use cooking oil, baby oil, coconut oil, mineral oil, petroleum jelly (such as Vaseline®), skin lotions, suntan lotions, cold creams, butter, cocoa butter or margarine.
3. After ejaculation hold the rim of the condom to the base of the penis so it will not slip off. The man should pull his penis out of the vagina before completely losing his erection.
4. Take off the condom without spilling the semen on the vaginal opening.
5. Throw the condom away in a pit latrine (toilet), burn it, or bury it. Do not leave it where children will find it and play with it. Do not use a condom more than once.

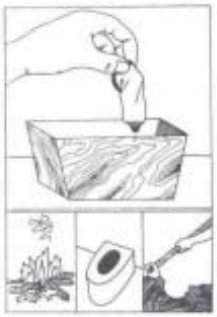
Taking off a condom



Slip off the condom without spilling semen.

HANDOUT 7.3: THE CONDOM CONTINUUM

Disposing of a used condom



Burn the used condom, throw it in the latrine, or bury it.

If a condom breaks:

- ·Immediately insert a spermicide into the vagina, if spermicide is available. Also, washing both penis and vagina with soap and water should reduce the risk of both STIs and pregnancy.
- Some clients may want to use emergency oral contraception to prevent pregnancy.

Give tips on caring for condoms

1. Store condoms in a cool, dark place, if possible. Heat, light and humidity damage condoms.
2. If possible, use lubricated condoms that come in square wrappers and are packaged so that light does not reach them. Lubrication may help to prevent tears.
3. Handle condoms carefully. Fingernails and rings can tear them.
4. Do not unroll condoms before use. This may weaken them. Also, an unrolled condom is difficult to put on.
5. Always use a different condom if the one you have:
   - Has torn or damaged packaging,
   - Has a manufacturing date on the package that is more than 5 years past,
   - Is uneven or changed in colour,
   - Feels brittle, dried out, or very sticky.

Source: Hatcher, R.A., Rinehart, W, Blackburn, R., and Geller, J.S. The Essentials of Contraceptive Technology. Baltimore, Johns Hopkins School of Public Health, Population Information Program, 1997, pp. 11-8 –11-11.

HANDOUT 8.1:

Refusing, delaying and bargaining case study

Ana's story

It all took place at the Nadi Travelodge back in 1989. I was on my way to Sydney and all the passengers flying to Sydney on that day were told that the plane had been delayed till the next day and that we were booked into the Nadi Travelodge to await our flight on the next day.

While I was at the airport I met Mr Macawa who was then an immigration officer there. We said hello to each other and I left for the hotel. Later on that evening there was a knock on my hotel room door. It was the hotel manager and he said that I had a visitor who wished to see me. It was the same Mr Macawa that I had just met at the airport. I was quite stunned at first because I couldn't understand why he wished to see me. I would describe Mr Macawa as someone that I knew of. He wasn't a friend at all.

My mind started running wild. I was a bit nervous and frightened and I was very suspicious of him. I tried very hard not to give any indication of how I was feeling right then. I asked him how could I help him and he replied saying that he had thought he would pay me a visit.

At that moment I knew that there was an ulterior motive to this visit. His body language and his indirectness totally communicated the intention of his visit.

It was getting late at night, and I was getting tired. I couldn't wait to get him out of the room. I could have been very rude and just tell him to leave or call the hotel security service and ask them to get rid of him. But I was also bounded by my own cultural teachings that you don't chase visitor out or abruptly tell them to leave. You just put up with them and hope that they will somehow understand what you're communicating through your body language, the indirect comments you make etc.

At the time of this incident, I saw myself as having to decide between two options.

- I could have taken a Western approach, being direct and up-front with him and just telling him to leave. Then I would have had a peace of mind about the outcome, but perhaps not about the way I had achieved it.

HANDOUT 8.2: REFUSING, DELAYING AND BARGAINING CASE STUDY

- Or I could have taken the approach of my culture—invite him in (because it is rude not to invite him in) and uncomfortably go through the whole long process of trying to let him know my intentions without being rude.

Because he was a Fijian I opted for the cultural approach.

Throughout the night, he indirectly indicated his desire to get into bed so I also indirectly indicated that I did not wish to. I negotiated my intention by not giving him any chance of moving close to me—I kept the wide space in between us. Sometimes I had to move around the room to do this. I showed no indication of tiredness, I kept drinking coffee to keep me awake. He offered me wine, which I turned down. He started talking about his women and a lot about himself. I refrained from getting involved in the conversation to give him the chance to leave but he didn't take the hint and this approach didn't work.

It was getting towards morning, and by this time he was beginning to get aggressive and very angry at me. He mentioned that no woman had ever turned him down and at this point I decided to opt for the Western approach and be direct with him. I told him that if no woman had ever turned him down then I would be the first. He got my message loud and clear and angrily left the room.

Because Fijian women are suppose to be submissive and not too vocal, Mr Macawa thought that he could manipulate me by attempting to use his good looks, his power as an immigration officer, and his reputation as a Judo National Representative, to overpower me. It did not work. I was able to negotiate my way out of that horrible ordeal because I integrated the cultural teachings that I had been brought up with and the western approach of being direct and up-front. Afterwards I was very glad that I had done this, but it has taken me a long time to be able to talk about it.

Discussion tasks

1. Did Ana use all three approaches to saying 'No': refusing, delaying and bargaining? Identify examples of each in the case study.
2. Do you think there is any way that Ana could have avoided this night-long ordeal?
3. As a counsellor, how would you help Ana to prevent such a thing happening again?
4. If you were counselling Mr Macawa after this incident what would you say?

HANDOUT 9:

Illustrating your acceptance

Mark your level of acceptance on the scale

Behaviour	**Acceptance level** *Acceptance* — *Non-acceptance*
Oral sex	
Anal sex	
Homosexuality	
Extra-marital sex	
Prostitution	
Drug use	
Cunnilingus	
Fellatio	

HANDOUT 10:

Susi Vai

Susi Vai is a woman of 28 who comes to your clinic complaining that she has something wrong 'down below' and, when asked if she'd like to speak to someone about this, she bursts into tears. Susi Vai is from a traditional community, and her husband insists that he accompany her in the clinic. Susi Vai appears terrified at the prospect of a physical examination.

Discussion points:

- What are your priorities in this situation?
- What would you do?
- What would you say?
- How would you say it?

HANDOUT 11:

Sione

Sione is a 32 year-old married man with two children. He has been having an affair with another married woman, Sasa, for the last two years. A friend of Sione has recently been found to be infected with HIV. Sione is worried about his wife and children. He comes to you anxiously seeking help.

Discussion points:

- The quality of Sione's marriage
- The nature of his sexual activities
- The quality of his friendship with the person with HIV
- Other risk behaviour
- Sione's psychological presentation

HANDOUT 12:

Lau Fitu

Lau Fitu is a 24 year-old single man with a good job and his own home. He doesn't want to settle down for a long time, describing himself as 'a good time guy'. He has three sexual partners and sometimes has casual sex too. However, he says he chooses women who are 'clean' or even 'married', so he can't understand why he now has a urethral discharge. During his interview he admits that he often gets very drunk before having sex.

Discussion points:

- What does Lau Fitu know about prevention?
- What role does alcohol play in his sexual behaviour?
- What is Lau Fitu's opinion of condoms?
- On what basis does Lau decide that someone is HIV negative? Is this accurate?

HANDOUT 13:

Vidya

Vidya is a 27 year-old bachelor working for a large business in Fiji. Since he started working 4 years ago he has been visiting female sex workers.

He has recently agreed, under considerable pressure from his family, to an arranged marriage, at around the same time as he returned a positive VDRL test. This has been successfully treated, but he has also been asked to donate blood as part of his firm's health awareness programme.

Vidya is extremely concerned that the blood test following his donation might be positive for HIV, in view of his sexual history. He is also very worried that if he does give blood, the information about his result and his sexual past may somehow get out. He does not know how he would face his parents and fiancée.

Discussion points

- What can you tell Vidya about the issue of confidentiality?
- Are there any family members or other people/organisations that can be brought in to provide support for Vidya?
- What influences play upon the arrangement of marriages, and how may these be addressed in this situation?
- What are the prevention implications for Vidya?

HANDOUT 14:

Seini Pau

Seini Pau is 22, a university student with a boyfriend she has been seeing for 8 months. She has been very relieved and happy to find her 'freedom' away from her parents. However, she allows very little of her private life to enter her university work life, and maintains a discreet silence with all colleagues and friends.

Seini Pau and her boyfriend have spent a few nights together during the last 3 months. They did not use condoms. Seini Pau had an HIV test as part of a routine medical and the result was positive. She had requested it, not expecting the result to be positive at all.

Later she discovered that her boyfriend has past risk behaviour with injecting drugs

Discussion points

- Who are the possible sources of Seini Pau's HIV infection?
- What are the issues and implications about telling her sexual partner?
- Who can support Seini Pau?

HANDOUT 15:

Nina

Nina is a 19 year-old sex worker who lives in a poor squatter area of town. She has one small child who is often sick. Nina is using some of her earnings to help support her family who live in a remote village. They disapprove of her work but they also need and eagerly accept the money she sends home. She is afraid of AIDS but finds that many of her clients refuse to use condoms.

You have diagnosed a genital ulcer.

Discussion points

- What does Nina know about her risk factors?
- What changes need to be made in her behaviour?
- Why might it be difficult for her to change her behaviour?
- What are the options for informing partners?
- What further information and support is required to help Nina reduce her risk?

HANDOUT 16.1:

HIV pre-test counselling checklist

- Emphasise confidentiality
- Explore reasons for testing
- Explore risk history:
  - unsafe sex—of self and partner
  - injecting drug use—of self and partner
  - blood/blood products/transplants received
  - possibly non-sterile procedures—tattooing, injections, scarification
- Explore the significance of the 'window period' and the time elapsed since last risk exposure
- Explore and clarify client's knowledge about HIV/AIDS (or that of person to be tested)
- Explore and clarify client's understanding of the HIV test's implications for:
  - marriage
  - pregnancy
  - relationships (e.g., does the partner know about the testing?)
  - work
  - stigma
  - finance
  - emotional coping
  - social support available
- Explore and clarify client's knowledge about the test and testing procedure
- Discuss the value of testing:

  If negative–a platform for constructive change
  - confirms lack of antibodies
  - removes uncertainty

HANDOUT 16.2: HIV PRE-TEST COUNSELLING CHECKLIST

If positive- a platform for constructive change

- certain knowledge
- protect self and partner
- plan for own and loved-ones' future

- Discuss who should know the result if positive, and how they might be told
- Assess strategies for coping in the short and longer term
- Counsellor's previous experience in managing health and other personal crises
- Discuss future prevention:
  - safer sex and condom use
  - clean needle use
  - options for managing risk situations
  - discussing prevention socially and domestically

HANDOUT 17:

HIV post-test counselling checklist—NEGATIVE result

- Renew relationship
- Explain negative result
  - give time to reflect
  - allow time to express feelings
- Explain lack of immunity to future infections
- Check and confirm understanding of HIV
- Clarify doubts and misconceptions about HIV and the test
- Evaluate the need for re-testing (e.g., after the 'window period', and/or occupational exposure)
- Observe and be aware of 'survivor' reactions and other, possibly unexpected, emotional responses
- Identify potential services for onward referral to manage related issues (e.g., risk arising from alcohol use)
- Repeat HIV prevention discussion:
  - a platform for constructive change
  - safer sex and condom use
  - clean needle use
  - options for managing risk situations
  - discussing prevention socially and domestically

HANDOUT 18.1:

HIV post-test counselling checklist—POSITIVE result

- Renew relationship
- Follow client's lead about when to disclose the result
- State the result clearly
- **Wait:**
  - give client time to absorb information
  - give time for expression of feelings
  - **listen**
- Help client to come to terms with the test result:

intellectually	–	explore understanding
	–	clarify understanding of the result
emotionally	–	assess emotional impact
	–	validate reactions as normal
behaviourally	–	what will they do next — in the immediate future?
	–	assess their understanding of and capacity for risk reduction
	–	explore factors relating to your client's general health and immune functioning—stress, nutrition, exercise, alcohol and drug use, re-exposure to HIV
interpersonally	–	review who to inform
	–	review possible impact on partner, family, friends, employer
	–	review how to break news—offer help and support
	–	plan to maximise support and minimise stress

HANDOUT 18.2: HIV POST-TEST COUNSELLING CHECKLIST—POSITIVE RESULT

medically
- plan health checks and early intervention
- rationalise attendance for health interventions

- Arouse hope with advice and empowerment.
  - Give a realistically hopeful message about what **can** be done without discounting their concerns
  - Focus on measures to maintain and improve their quality of life
  - Empower their participation in their own health issues
  - Express your availability, and the availability of other services, when needed
- Help your client to start planning for the future.
  - Discuss possibilities for constructive change
  - Support possibilities in the short term—managing the stress of diagnosis, and reducing the potential for harm arising from stress-reducing behaviours, such as substance misuse, impulsive behaviours, risky sex
  - Plan to address financial, occupational, legal, domestic, medical needs
  - Identify resources for on-going support, such as individual therapy, support groups, social network, spiritual network
- Provide appropriate brochures and information to take away.

HANDOUT 19.1:

Workshop evaluation

Please answer the following questions as fully as you can.

All forms are anonymous and will be used only for evaluating the workshops.

1. What did you understand the purpose of these workshops to be?

_____

_____

_____

2. Did you feel you were sufficiently briefed in advance of the workshop?

_____

_____

_____

3. Please evaluate each of the following aspects of the training programme by circling a number on the scale below:

	Excellent	*Very good*	*Good*	*Fair*	*Unsatisfactory*
Achievement of programme objectives	5	4	3	2	1
Achievement of my personal objectives	5	4	3	2	1
Relevance of content for my job situation	5	4	3	2	1
Effectiveness of the methods and techniques	5	4	3	2	1
Organisation of the training programme	5	4	3	2	1
Usefulness of the programme materials	5	4	3	2	1
Effectiveness of the lead trainer	5	4	3	2	1
Effectiveness of the resource person(s)	5	4	3	2	1
Effectiveness of the practical activities	5	4	3	2	1
Adequacy of all the resource materials	5	4	3	2	1
Overall rating of the training programme	5	4	3	2	1

4. Was the length of the training programme: *(please circle the appropriate reply)*

❑ Too long ❑ Just right ❑ Too short

HANDOUT 19.2: WORKSHOP EVALUATION

5. To what extent were your hopes for the workshop met?

_____

_____

_____

6. How well trained do you feel to train others? *(please circle the appropriate reply)*

   - ❑ Very well trained
   - ❑ Well trained
   - ❑ Satisfactorily
   - ❑ Not well trained
   - ❑ Poorly trained

7. What were the main strengths of the workshop?

_____

_____

_____

8. What were the main weaknesses of the workshop?

_____

_____

_____

9. Was there sufficient time to cover the necessary issues and materials?

_____

_____

_____

10. Which issues need more time to be adequately covered?

_____

_____

_____

HANDOUT 19.3: WORKSHOP EVALUATION

11. What are your views about the role-play method used in this training programme?

_____

_____

_____

12. What aspects of the training were *least* useful to you, and why?

_____

_____

_____

13. What aspects of the training were *most* useful to you, and why?

_____

_____

_____

14. On which topic(s) do you need further information and practice?

_____

_____

_____

15. Which method of presentation did you prefer and why?

_____

_____

_____

HANDOUT 19.4: WORKSHOP EVALUATION

16. What changes would you suggest in the organisation of the programme?

_____

_____

_____

17. What follow-up activities do you propose to undertake after the training?

_____

_____

_____

18. What follow-up activities would you like from the organisers of the training programme?

_____

_____

_____

19. What further comments do you have about this training programme?

_____

_____

_____

The following handouts are not referred to in the Manual, but you may find them useful if you decide to expand or adapt some of the sessions.

HANDOUT 20:

The importance of understanding STIs in their human context

'If we are to tackle the problem of the sexually transmitted diseases we will need to examine our own attitudes towards them and those who contract them.

The knowledge of why individuals put themselves at risk, how often they do this, and why they behave in different ways after doing so is essential to understanding the spread of disease and its containment and eventual control. The behaviour of the individual *must be a component of the research strategy offered by ... academic (approaches).'*

(Adler, 1980)

'Even within the constraints of a concern for AIDS, a narrow view of sexual behaviour may be effective if all we are concerned with is social book-keeping and epidemiological modeling, but it will be inadequate to the task of **understanding behaviour in a way that results in behaviour change***.'*

Gagnon (1989)

We '...need to create a paradigm that is no longer based solely on a medical construct, but takes into account all the elements that contribute to the transmission of STIs and their effective management. Biomedical interventions are only of limited value and the effective control of the epidemic of STIs and HIV requires broad approaches which address and understand in addition the social, cultural, economic and political dimensions of this major health crisis.'

Adler, Foster, Richens, Slavin (1996)

'Why bother? On the current trajectory, at the end of the HIV holocaust, when all the colours and cords of the quilt of lives lost are woven into our cultural, generational testament of grief and remembrance, all we may have really learned is how to make a new pill.'

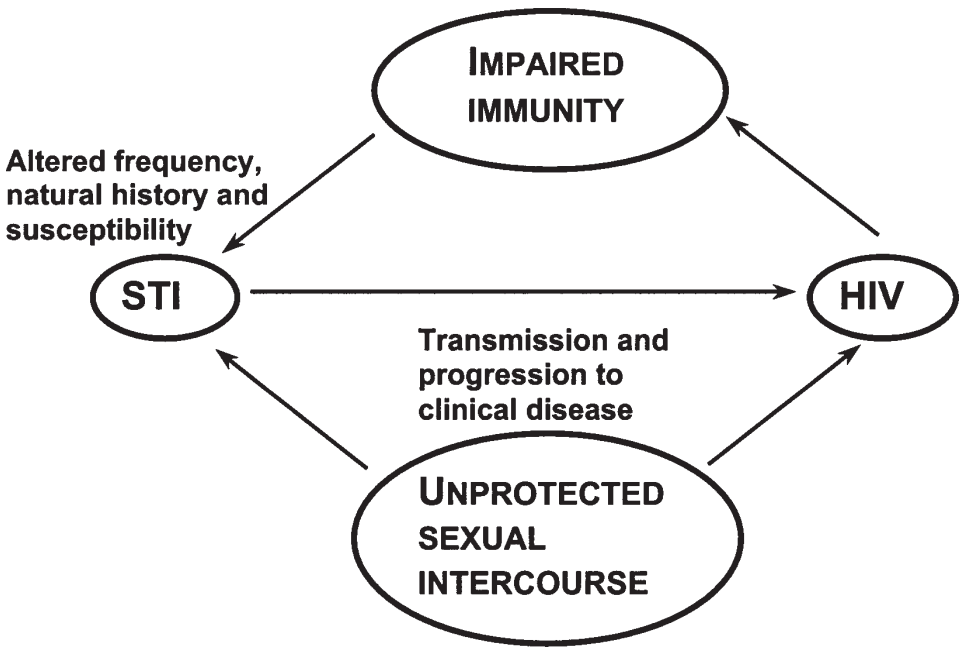
Miller (1997)

HANDOUT 21:

Links between STIs and HIV

- HIV is an STI
- Epidemiological modeling of HIV is based on STI models
- Prevention issues are similar for STI's and HIV
- Secondary HIV prevention is ineluctably concerned with sexual health
- STI's are the only practical surrogate marker in HIV prevention
- STI/syphilis history and HIV administration and social responses are extraordinarily similar
- STI administration and HIV administration have equally failed and succeeded

The link between HIV and STI
(WHO, 1995)



HANDOUT 22:

Non-verbal elements in counselling discussion

Positive	*Negative*
Uses a tone of voice similar to the person being counselled	Unpleasant tone of voice
Looks client in the eye	Avoids eye contact ·
Uses attentive facial expression, body movements and posture	Frowns, scowls, yawns
Uses appropriate physical distance	Inappropriate physical distance
Does not speak too quickly or slowly	Speaks too slowly or quickly
Occasional, appropriate gestures, such as nods, to acknowledge the statements of the client	Appears unresponsive and makes no response to client's speech or gestures
Appropriate use of humour	Inappropriate use of humour
Appropriate balance of technical and non-technical language	Inappropriate use of technical language, making them hard to understand

HANDOUT 23:

Common counselling errors

- ***Controlling***, rather than encouraging, the client's spontaneous expression of feelings and needs
- ***Judging***, as shown by statements that indicate the client does not meet the counsellor's standards
- ***Moralising***, preaching, and patronising—telling people how they ought to behave or lead their lives
- ***Labelling***, making assumptions about the person rather than trying to find out their motivations, anxieties and fears
- ***Unwarranted reassuring***—trying to induce optimism by making light of the client's own version of a problem
- ***Not accepting*** the client's feelings—saying they should be different
- ***Advising***, before the client has had enough information or time to arrive at a personal solution
- ***Interrogating***—using questions in an accusing way ('Why?' questions may sound like an accusation)
- ***Encouraging dependence***—increasing the client's need for the counsellor's continuing presence and guidance
- ***Cajoling***—persuading the client to accept new behaviour by flattery or deceit
- ***Impatience***—giving no time for rapport and trust to develop

HANDOUT 24:

SURVIVOR activity

There has been a nuclear war. The world can no longer sustain life. 10 people have survived in your town and have entered a private survival shelter. The radiation from the explosion will be deadly for a period of 8 months and there is only enough food, water and oxygen for 5 people. 5 people must leave the shelter or **all** will die.

Your group must agree on the 5 people to be evicted from the shelter. Only 5 people must be left. Record your reasons about who should stay and who should go. Be prepared to report to the full group. Time to decide: 20 minutes.

1. A policeman who is gay and the owner of the bunker.
2. A 19-year-old female sex worker who has been tested positive for several STIs.
3. A 75 year old tribal chief.
4. A 30-year-old farmer who is also a Christian pastor, who has served a jail term for assault.
5. A 48 year old scientist who is HIV positive.
6. A 3-month's pregnant woman but her husband is not the father of the child – the world famous rugby player is the father.
7. A 27 year old, world famous rugby player who has never been tested for HIV and recently married.
8. An electronics expert who is married to the pregnant woman, who does not like to use condoms.
9. A 25 year old doctor who is a lesbian.
10. A 20-year-old law student, who is currently using marijuana.

HANDOUT 25.1:

What do you do when you reach your limits?

Referral: Making a referral is when you feel that the person you are helping would be better helped by another STI Counsellor or health professional.

Making and receiving a referral should be done with sensitivity and care for the person you are helping.

Activity:

In order to avoid working beyond your limits you need to understand where these limits are. The following questions will allow you to reflect on your own limits. ***Make a note of your answers.***

1. Understanding the limits of the situation:

- Provide some examples in which you are in a position where you would not have enough time to help a person effectively? What will you do?
- Does the health center or organization you work for have a policy on the referral process?

2. Understanding your personal limits:

- What 'tender spots' do you have emotionally? For example, what kinds of sexual behaviour do you not like?
- How confident are you in your helping abilities and skills? Explain.

3. Understanding the limits of your competence:

- How far do your helping skills go?
- If your client needs help in a specialist area that you know little or nothing about, what can you do?
- What do your qualifications permit you to do?

HANDOUT 25.2: WHAT DO YOU DO WHEN YOU REACH YOUR LIMITS?

It is dangerous to work beyond your limits because:

- You cannot be of any help. You may end up doing damage to the person you are trying to help.
- You end up putting unnecessary pressure on yourself and probably do damage to yourself.
- To act beyond your limits will be acting irresponsibly and can damage your reputation and the reputation of the health center or hospital you work for.

Making a referral

A checklist of some of the things you may need to consider.

This checklist is to allow you to explore what action you feel would be appropriate to take:

- What is the purpose of the referral?
- Do you have enough information about the health professional or health center?
- What do you say to your client?
- What support do you need for this referral?

You might like to write down any more checklist ideas that might aid your own referrals.

_____

_____

_____

_____

Source: Sanders, P. (1996). *First steps in counselling*. (2nd. Ed). Llangarron: PCCS Books.

APPENDIX 3

Country case studies

COUNTRY CASE STUDY 1:

STIs and HIV/AIDS in Fiji

Available statistics show that the level of STI in Fiji is alarmingly high and poses a risk of HIV transmission. Recent figures reveal that there is a high number of STI and HIV cases among young people, particularly males. These are part of a growing number of those that 'engage in unsafe sex practises of having unprotected penetrative sex, multiple partners and often do no identify their sex partner'[1]. Detailed figures are given below.

Table 1: *Cumulative statistics of STI cases in Fiji by age category, 1993-2000*

	AGE								
YEAR	*0 - 9*	*10 - 19*	*20 - 29*	*30 - 39*	*40 - 49*	*50 - 59*	*60 - 69*	*70+*	*Total*
1993	2	261	733	207	34	5	2	0	1269
1994	4	298	1101	22	34	12	4	0	1923
1995	1	308	1344	289	44	18	7	2	2133
1996	8	356	1499	358	59	28	8	0	2460
1997	2	284	1144	352	46	17	3	5	1942
1998	8	330	1465	465	64	22	5	1	2542
1999	9	323	1185	394	56	14	3	2	2249
2000	175	196	864	260	41	13	2	2	1875

Table 2: *Cumulative statistics of STI cases in Fiji by sex, 1993-2000*

YEAR	MALE	FEMALE	TOTAL
1993	1059	171	1230
1994	1493	430	1923
1995	1544	589	2133
1996	1824	618	2442
1997	1399	543	1942
1998	2017	525	2542
1999	1783	466	2249
2000	1248	305	1553

Source: Ministry of Health

***Table 3**: Cumulative statistics of HIV/AIDS confirmed cases in Fiji by age category, 1989-Jan 2002*

YEAR	AGE						
	0-9	10-19	20-29	30-39	40-49	50-59	60+
1989	0	0	2	1	0	1	0
1990	0	1	2	0	0	0	0
1991	1	0	0	2	0	0	0
1992	0	0	2	1	1	0	0
1993	0	0	2	1	0	0	0
1994	0	0	2	2	2	0	0
1995	0	0	3	3	2	0	0
1996	1	0	2	1	0	0	0
1997	0	0	2	2	0	0	0
1998	0	0	4	0	2	1	0
1999	3	0	5	3	1	0	0
2000	1	0	3	3	3	0	0
2001	0	1	9	7	0	0	0
Total	6	6	38	26	11	2	0

Source: Ministry of Health

***Table 4:** Cumulative statistics of HIV/AIDS confirmed cases in Fiji by sex, 1989-Jan 2002*

YEAR	AGE						
	0-9	10-19	20-29	30-39	40-49	50-59	60+
1989	0	0	2	1	0	1	0
1990	0	1	2	0	0	0	0
1991	1	0	0	2	0	0	0
1992	0	0	2	1	1	0	0
1993	0	0	2	1	0	0	0
1994	0	0	2	2	2	0	0
1995	0	0	3	3	2	0	0
1996	1	0	2	1	0	0	0
1997	0	0	2	2	0	0	0
1998	0	0	4	0	2	1	0
1999	3	0	5	3	1	0	0
2000	1	0	3	3	3	0	0
2001	0	1	9	7	0	0	0
Total	6	6	38	26	11	2	0

Source: Ministry of Health

***Table 5:** Mode of HIV/AIDS transmission in Fiji, 1989-January 2002*

Heterosexual	Homosexual	Blood transfusion	Intravenous drug use	Prenatal	Unknown
68	7	1	1	6	2

Source: Ministry of Health

INFORMATION, EDUCATION AND COUNSELLING SERVICES

In Fiji many organisations and institutions offer information and education about STI/HIV. Counselling services are however limited to a few NGOs and institutions.

Information and education

The Ministry of Health, through the National Health Promotion Centre and the Reproductive and Family Health Clinic, disseminates information and educational materials to those who voluntarily access their services or when representatives go out on their community visits. The Clinic has well established networks organisations such as the Aids Task Force of Fiji (ATFF) and help each of these organisations in relation to information sharing and condom distribution.

Through the initiative of the Ministry of Education, schools provide education and information via the curriculum. 'Resource materials include teaching guides, posters, stickers and instructional materials' [2]. At the tertiary level, the University of the South Pacific (USP), counselling centre is well staffed with trained counsellors and equipped with information and materials for all staff and students. The University reserves a week each year for its HIV/AIDS awareness campaign. During this week, information is provided and awareness raised through lectures and debates as well as display booths, videos and puppet shows [3]. For the last five years the USP counselling centre has also placed strong emphasis on peer education. According to a resident student counsellor, 'peers are not professionals but are a bridge…and do refer their peers to trained counsellors when they cannot deal with issues'.

The Fiji Institute of Technology does provide students with STI information during enrolment times.

At the NGO level, the Aids Task Force of Fiji, is most visible in the provision of awareness creation and information dissemination. According to the Situation Analysis of the State of HIV/AIDS in Fiji, the ATFF:

Provides training and education for government departments, NGO's, civil societies, tertiary institutions and church organisations…peer educators go out in the evening to talk to people on the streets, visit bars and night-clubs and engage in discussion with people they believe to be sexually active.

Special mention need also be made of those NGO's who are active in this area. These include the Women's Action for Change (WAC) theatre group, the St Johns Ambulance and the Fiji Red Cross.

The United Nations as well as regional organisations like the SPC with its media division in Suva 'publish many educational materials including the Pacific AIDS Alert bulletin, booklets, posters, and brochures….produces stories for airing on radio programmes and provides IEC materials on reproductive health, family planning and sexual health' [4].

Counselling

Counselling support for STI/HIV clients is not widely available. Only three organisations and institutions offer this service and this is usually at the basic level.

The ATFF offers basic counselling for their clients, most of whom are worried because they have been engaged in an unsafe sexual encounter or who think they experience symptoms of STIs. The office makes referrals to professional counsellors when clients are 'beyond control'[5].

The USP counselling centre is staffed with professional counsellors and has been engaged in this area for some time now as part of the centre's proactive approach to HIV/AIDS education and prevention. According to the head of the counselling centre:

> *Clients come with different needs. There are those who are currently receiving STI treatment and come for consultation to help them deal with the infection. Others when contracting an STI have a strong feeling that things could be worse, after their initial worry of the possibility of contracting AIDS. Sexual contact amongst students is very high…word about the centre gets around very fast and there is a readiness to come on the part of students. They see it as a place where confidence can be restored and … receive an assurance that there is someone who is non-judgmental.*[6]

Pre and post test counselling are offered both at the USP's counselling centre and at the Family and Reproductive Health Clinic but the Situation Analysis of HIV/AIDS in Fiji highlighted the fact that many people, especially 'pregnant women are often not aware that they are being tested for HIV'.

The Reproductive and Family Health Clinic, although it is under-resourced and under-staffed, sees an average of about 300–400 clients per month. Medical personnel at the Clinic offer basic counselling to those accessing their service. According to the only permanent nurse at the Clinic 'Pre-test counselling is very important given the stigma associated with STI/HIV. This is important, as clients need to be informed'. Post-test counselling is also offered 'but it is not easy to persuade those who are found positive to accept the result. This is most common among those in monogamous relationships or those experiencing their first sexual contact'[7]. However, she adds, 'We are slowly breaking that cultural barrier related to the issue and clients like us and are confident to talk especially when confidentiality of client information is of utmost priority'.

The confidentiality agreement that clients enter into makes it impossible for a researcher to access those who have undergone either pre- or post-test counselling with the intention of ascertaining the nature of counselling, their experiences and effects of the process on them. The stigma attached to being associated with STI/HIV prevents people from going public about their condition and this has implications for a better understanding of counselling procedures and practices.

SEX NEGOTIATION: SAYING 'NO'

A male who received a 'No'

I find sex very enjoyable and am lucky to have a stable relationship that ensures that I receive sexual gratification.

Because of this I have come to view my partner as someone who will reciprocate my sexual advances. Being a woman she will submit to my requests and at times demands.

But this has not always been the case. At times I have had to be turned away disappointed as my partner would say that she is 'not in the mood' or is tired. Other times her signs would tell it all. She would either stay up late into the night or go to bed early to escape the anticipated advances. Other times her body language in bed is enough to put you off.

This usually breeds frustration especially when you are expecting to have your way all the time.

Female saying 'No' to a sexual advance

I was about 18 at that time and my date about 26 years of age. I didn't know him too well, as it was our first date but in hindsight I realised that his conversation was leading up to sex. At that time I didn't see it coming.

The sexual encounter took place as a result of force. He reacted violently to my saying ***'No'*** *and grabbed me by the hand and into the room. He was very forceful and even punched me. The use of a condom was not even an issue, I guess at that time publicity wasn't much. He took advantage of me because I was a teenager. At that time I didn't know that there was a label to that, now I know and could say that he raped me. I later had regrets about going out on a date with him but I believe in moving on and not dwelling on the past.*

Apart from the above incident I have had advances from other males and have been in a better position to say 'No'. By using body language, I wouldn't get too close to the guy nor make eye contact, if I can get others to join me I would, so as not to be left alone. If one were showing signs of being intimate I would politely say that someone else is interested in him and pair him off with this other person.

COUNTRY CASE STUDY 2:

STIs and HIV/AIDS in Samoa

No data is available on male STIs in Samoa but there is some information about female infection. The Situational Analysis and Response Review of Women and HIV/AIDS in Samoa records data from 1997 to 1999 based on cases reported to the hospital. These figures show that the age group facing the highest risk were sexually active people in the 15–34 age-group[8]. Table 1 gives details of this hospital data, which is based on recorded queries.

Table 1: *Number of STI queries and infections at the National Hospital 1997–1999*

	1997			1998			1999		
DISEASE	***M***	***F***	***Total***	***M***	***F***	***Total***	***M***	***F***	***Total***
Gonorrhoea	71	28	99	69	22	91	72	12	84
Syphillis	–	1	1	–	–	–	–	–	–
Trichomoniasis	–	3	3	–	1	1	–	–	–
Genital herpes	–	–	–	1	–	1	–	–	–
Genital warts	1	1	2	–	2	2	–	–	–
Non specific urethritis	2	3	5	–	13	13	9	13	22
Hepatitus B	1	–	1	–	1	1	4	6	10
Concern about HIV status	2	2	4	3	3	6	2	1	3
HIV infection	–	–	–	–	–	–	–	–	–
Candidiasis	–	3	3	–	1	1	–	–	–
Chlamydia	–	–	–	–	–	–	–	–	–
Follow up	30	24	54	25	19	44	14	7	21
Scabies	–	1	1	–	–	–	–	1	–

Source: Situational Analysis on HIV/AIDS & Women in Samoa derived from the STI Clinic, Dept of Health.

The most recently recorded statistics on STIs in women were compiled from the first STI prevalence survey for Samoa. This survey covered pregnant women attending Tuesday and Thursday Antenatal Clinics at the National Hospital from 1999 to 2000[9].

The survey included 452 women who voluntarily participated and gave blood samples. Of these only 421 gave their place of residence—31.4% said they lived in Apia and 68.2% said they came from other villages in Upolu. Nearly half of the 452 were aged under 25 years.

The following table summarises the findings.

Table 2: *Prevalence of STIs in women by age groups 1999–2000*

		AGE						
STI	***No. tested***	***15-19***	***20-24***	***25-29***	***30-34***	***35-39***	***40+***	***Total***
Trichomonas vaginalis	427	18	33	23	8	6	1	89
Chlamydia trachomatis and/or neisseria gonorrhoea	427	NA	NA	NA	NA	NA	NA	132
Chlamydia trachomatis	427	26	62	30	6	2	1	127
Neisseria gonorrhoea	427	3	10	0	1	0	0	14
Treponema/antibody seroreactivity	441	1	1	0	0	0	0	2
HIV	441	0	0	0	0	0	0	0

(NA = not available) Source: Antenatal Clinic STI Survey Report 2000

These STI figures do not include male infections nor do they include those who sought treatment elsewhere [10]. Thus, although this data indicates that none of the antenatal women tested was infected with HIV, this cannot be taken as an indication of national statistics for Samoa.

HIV/AIDS INFECTION

As at November 2001, a total of 12 people had been diagnosed with HIV/AIDS for the period 1990 to 2001. Of these 8 have died and 4 are currently alive. Of the 4 survivors, 1 has AIDS and 3 are HIV positive.

Of the total of 12, 6 had AIDS (5 of whom have died) and 6 were HIV positive. Of the 12, two are infants and 10 are adults, 3 females and 7 males.

The following table summarises the national statistics.

Table 8: *Distribution of HIV/AIDS cases by occupation and probable source of transmission 1990-2001*

OCCUPATION	NUMBER AND SOURCE
Infants	2 – MTCT
Bank officers	2 – husband & wife – HET
Business man	1 – USA – HET
Clerk – USP Alafua	1 – USA – HET
Insurance co. officer	1 – USP Alafua – HET
Member of diplomatic corps	1 – NZ –MSM
Factory worker	1 – NZ – MSM
Labourer	1 – HET
Sailor	1 – HET
Executive officer	1 – HET
Total	12

Source: STI Clinic Dept. of Health

The ages of the HIV/AIDS infected people were 2 infants under 4 years, 5 aged 25–34 years, 3 aged 35–44 years and 2 aged 45–54 years.

The first AIDS case in Samoa was a 30-year-old Samoan male who was diagnosed in 1989. Although he was originally diagnosed and reported in Wellington, NZ, he was also recorded in the national statistics for Samoa. In discussions with two community educators, the indications are that at the present time there may be other people who may have been diagnosed and reported in another country and who have now returned to Samoa but have not as yet been officially reported as infected in the national statistics [11].

Given that there is no mandatory reporting to the hospital, nor compulsory registration for medical follow up for any Samoans with the disease returning to Samoa, the national figures for HIV/AIDS in Samoa may be inaccurate. Furthermore, any others who may be attending traditional healers in the villages for the relief of symptoms may not also be officially recorded.

EDUCATION FOR PREVENTION OF STIS

Several initiatives have been undertaken over the past few years by different groups in both government and non-government organisations to introduce the public to the implications of STIs. However, some of these are no longer active. Most of them concentrated on HIV/AIDS information in particular and the following is a description of the work of those organisations that are currently active.

The most prominent organisation promoting prevention activities on a large scale nationwide is the Health Education and Promotional Services (HEAPS) in the Department of Health. Some of the activities undertaken to date include a multimedia approach, which involved several strategies. It included the use of radio and television spots to advertise prevention messages, and the production and distribution of promotional T-shirts, pamphlets, posters and calendars. A billboard message was also erected outside the international airport. Radio competitions and the use of popular sports idols in advertising was widely popular especially with the younger audience.

However, at the moment promotional material is widely publicised mostly around international commemorations such as World AIDS Day around November and December rather than throughout the year.

INFORMATION, EDUCATION AND COMMUNICATION (IEC) ACTIVITIES

Currently the key organisations responsible for IEC activities are the two non-government organisations, the Samoa Family Health Association (SFHA) and Sautiamai.

Mele's story[12]

Mele has been diagnosed as HIV positive and was infected through heterosexual transmission by her husband. He was diagnosed with full-blown AIDS and has since passed away. Mele had two children but is now caring for her one surviving child.

Mele's initial thoughts that something was seriously wrong occurred when her youngest child died as a result of an illness that could not be clearly diagnosed [13] or cured. She had also heard rumours of her husband's infidelity and was herself afflicted with itching and unexplained rashes. She soon became anxious to explore whether there was a link between this and her son's illness and visited a local doctor in a private clinic to get tested for the HIV/AIDS virus. The doctor gave Mele all the factual information on the HIV/AIDS virus, which satisfied her need to be informed. She remained anxious however until her test returned negative.

When her husband was first suspected of having the infection he was sent letters by the STD clinic in the National Hospital. Mele was not aware of these notices until she found the third one and he went in for a test. He himself told her the positive result of the test. Mele was then asked by the doctor in the clinic through her husband to come in to see him as well. She received some clinical counselling and during this session she was told that her husband had been infected from another woman and asked if she had been aware of the relationship. She was advised to have the test, which she did and came out HIV positive.

Once she had tested positive the doctor gave her a basic description of the HIV/AIDS virus and the implications of the disease. She was further advised that their situation would remain confidential but that it was their choice to disclose any information. All clinical counselling took place in the doctor's office, which was away from the main waiting area and offered some privacy. It consisted however of her sitting opposite the doctor with a desk in between them. She did not have any joint discussions with the doctor and her husband.

At the time, Mele was angry with her husband for his infidelity, for bringing the illness into their family and for infecting her and their son. She also felt panic at the thought of leaving their son destitute if they should both die. Later, there was a breach of confidentiality that resulted in her dismissal from her job and she then had to cope with negative public reaction as well as a feeling of betrayal. She admitted to having suicidal thoughts at times. She was not offered any crisis counselling to deal with these feelings or with the issues involved.

Although both her and her husband's families were supportive, it was difficult for them to understand the virus, and the implications of the illness for them. Mele herself undertook the task of trying to explain these things to them. At the suggestion of a friend Mele sought out a health educator in the National Hospital health education unit whom she was told could help her understand better. She did so and was given further information about the virus, the stigma attached to the illness and reactions that could be expected from other people in the community. It was an affirmative process for her because through it, she found her strength to confront the community and disclose her HIV

positive status. Although she disclosed at a regional meeting miles away from home, she found support from those who attended and as a result she gained the courage to live her life as normally as possible.

Today Mele gets support from her family, friends and colleagues who work alongside her in raising awareness about the disease. She has never received professional counselling and when asked whether she though it would have made any difference, she replied that the care and support she received had enabled her to cope. Perhaps if pressed further she may have replied, 'What is counselling and how is it different from the support I do have?'

The positive aspects of Mele's story include gaining a strength and ability to cope through the practical support from her family, the factual information offered by the professionals involved, and friendship from two community educators who shared information and offered practical guidance. In addition she relies on her faith and the strength she has found in her religion. She has also taken an interest in the church choir and has made new friends through her involvement.

Mele continues to publicise her situation through outreach workshops on HIV/AIDS which in turn gives her hope because she is helping others to avoid the deadly disease. Being a strong-willed person herself, she was the one who initially sought out the appropriate information in order to help herself and to care for her husband right up to his last days. Her husband remained at home for most of his illness and did not get any counselling or contact with anyone but his friends and medical personnel when he got medication. Had she been a different person she might not have coped so well.

Today although she still has an overwhelming fear for her son's wellbeing when she dies, she is not panic stricken at the thought. She continues to collect her medication and to get routine tests regularly. She does not seek any more medical advice but continues to find and read any new information she can get on the virus. In effect, Mele herself has created the support system she needed to sustain herself from day to day and to build a positive outlook on life.

Simone's story[14]

Simone has been diagnosed as HIV positive and was infected through heterosexual transmission from a woman with whom he had an extramarital relationship. When he heard that she had died of AIDS he went to get a test himself. He did not seek any advice or information about the disease before getting his test, which returned with a positive diagnosis for HIV. He has a wife and four children. His wife has tested negative.

Once he had been diagnosed, Simone visited the doctor at the STD Clinic at the National Hospital where he received some clinical counselling which included basic advice about the disease and its implications. However he wanted to learn more about the illness and how to manage it better, so he also went overseas accompanied by his wife, for further testing. While there he was fortunate to get a thorough check up and saw a counsellor for one short session. The counsellor advised him on the

implications of his illness, the stigma attached, and how to cope with negative public reactions. He was also encouraged to live as normal a life as possible.

Simone returned with medication and a positive hope that things would get better. During the trip he was fortunate to be amongst a group of people so strong in their religious faith that they helped him to renew his belief in God and his own faith. He believed that it was praying that had helped him to get over the difficult moments in his life and regards the illness as a blessing that has in turn given him a better relationship with his family than he had before.

Simone admitted to having some feelings of depression and even suicidal thoughts. He said that sometimes he found it hard to cope with feelings of despair and sadness at the prospect of not being around to enjoy future additions to his family. At other times he felt anger at himself for bringing the disease into the family and changing their lives forever. He did not have a counsellor to discuss these feelings with nor to help him cope from day to day since he did not think it was something he could discuss with a doctor.

Early in his illness Simone and his wife called all their children and their two families together to their home where they held a church service. They prayed together and he disclosed his illness and asked for their forgiveness. He has also used the same forum to discuss basic information about the disease and its implications. During these times he had asked for their support and understanding. Today he has the staunch support of his wife, their children and all his relatives. It is from this that he gets the strength to carry on living each day to the fullest.

Simone believes that some crisis counselling may have helped him to cope more efficiently with the different feelings he had at the different stages he went through in accepting his HIV positive status. Over the years however, he has become closer to God, his wife, their children and his family. He does not feel too great a despair at leaving his family behind and is more determined instead to make the most of what he can share with them now.

COUNTRY CASE STUDY 3:

STIs and HIV/AIDS in Vanuatu

Vanuatu is an independent nation consisting of a 'Y' shaped chain of 65 inhabited islands spread over a large area in the South West Pacific Ocean. The 1999 Census (a defacto census) showed the population of Vanuatu to be 186,878 [15] and it has shown a 2.6% annual growth rate (urban 4.2% and rural 2.2%) since the 1989 Census [16]. Most people live in rural areas (78%) [17]. However, the urban centres are increasing in size rapidly due to urban drift with adults, especially those aged 20-39 years, migrating to Vila and Luganville. Thus, with such a large area and a lot of migration it is difficult to cover the whole of Vanuatu with awareness and prevention programmes for STIs and HIV AIDS.

This case study of Vanuatu examines the status of STI/HIV in Vanuatu, the services available for awareness and prevention of STI and HIV/ AIDS, IEC materials available for distribution, and counselling services available in Vanuatu. I have also examined cultural factors as well as presenting some personal case studies.

Three NGOs (Wan Smol Bag, Foundation for the Peoples of the South Pacific and Vanuatu Family Health Centre) and the Ministry of Health were identified as being involved with STI/HIV/AIDS awareness and prevention. A relevant person was interviewed from each organisation to find out what was happening in Vanuatu at present.

STI/HIV STATUS IN VANUATU

Statistics are not well documented. The reason appears to be related to a small health budget which struggles to cope with providing medical services and care. There is no money for surveys and data gathering. According to a WHO STI/HIV Antenatal Clinic Survey (2000), Port Vila, Vanuatu:

> *The epidemiology of STIs in Vanuatu is poorly defined. STI surveillance is inefficient, only consisting of hospitals and community health centres reporting general outpatient statistics of suspected or confirmed cases (depending on the laboratory support) to the Department of Health. The number of confirmed cases of gonorrhoea in 1994 and 1995 at Vila Central Hospital ranged from <10–120 (300:1993). There is no passive reporting of STIs by private medical practitioners. There have been no reported cases of AIDS or HIV infection since national reporting was established by the National AIDS/ STD programme in 1988.*

STIS

Statistics are available from hospitals, health services and dispensaries in hospitals. The health care workers often record information by hand in the midst of their other chores. There are, however, figures recorded in provincial health information system (see Table 1).

Table 1: *Nationally sexually transmitted diseases 1999-2001* [18]

			GONORRHOEA				SYPHILIS				GENITAL ULCERS			
			Suspected		Confirmed		Suspected		Confirmed		Suspected		Confirmed	
Province	**Year**	**Reports**	M	F	M	F	M	F	M	F	M	F	M	F
Malampa	1999	249	41	99	-	1	-	-	-	-	-	1	1	-
	2000	230	59	99	4	9	1	-	-	-	3	3	-	2
	2001	95	1	2	4	20	-	-	-	-	7	14	-	5
Penama	1999	196	33	79	-	3	3	1	-	-	18	4	-	-
	2000	247	41	80	-	2	-	2	-	-	-	3	-	-
	2001	77	2	5	5	13	-	3	3	-	1	13	1	3
Sanma	1999	192	51	71	4	4	1	5	-	-	13	13	-	-
	2000	219	78	117	18	33	17	15	-	-	21	22	-	1
	2001	124	-	-	-	-	-	2	-	-	1	6	-	-
Shefa	1999	179	209	130	78	40	2	1	-	-	1	2	-	-
	2000	209	165	198	87	42	1	0	1	0	1	0	1	0
	2001	128	19	22	-	-	-	-	-	-	-	-	-	-
Tafea	1999	121	49	88	2	-	1	2	-	-	-	-	1	-
	2000	145	42	80	6	8	0	3	0	1	0	1	0	0
	2001	86	-	-	11	25	-	-	-	-	-	-	-	12
Torba	1999	77	15	26	1	-	-	1	-	-	3	1	-	-
	2000	88	15	30	-	1	2	1	-	-	1	-	-	-
	2001	8	-	-	-	-	-	-	-	-	-	-	-	-

Wan Smol Bag also record statistics of people they see at their KPH clinic in Port Vila. Their figures are given in Table 2. [19]

Table 2: *Recorded cases of STI for 2001*

MONTH	Suspected STI	Confirmed Gonorrhoea	Confirmed Trichomoniasis	Confirmed Candida	Confirmed Gardnerella
January	44	-	4	6	-
February	18	-	6	3	-
March	30	5	4	-	-
April	40	2	2	7	-
May	35	5	3	1	-
June	42	4	6	5	-
July	34	8	1	-	1
August	41	1	6	1	-
September	36	-	-	-	-
October	43	5	1	4	-
November	23	1	3	4	-
TOTAL	386	31	36	31	1

Source: KPH clinic.

The 1998 Mitchell report [20] surveyed over 1000 young people aged 13-18 years and showed that many of those young people were sexually active, but that the level of information on contraception, condom use and safe sex practices was extremely variable. Low use of condoms (11.3%) and the pill (23.9%) was reported by females, while 53.4% of males reported using condoms. The use of condoms was problematic, with female respondents reporting that there was considerable male resistance to them, and females being accused of being promiscuous if they suggested condom use. The study concluded that a large proportion of the young population used 'unsafe sex' practices and were at risk of pregnancy and/or STIs. Early pregnancy appeared to be linked to school dropouts and those who were under employed or unemployed.

Since there is a high fertility rate (5.3) [21], a high rate of young sexually active people and a low use of contraception of any form, STIs are high and are of concern. However, screening, diagnosis and treatment costs for many STIs are expensive and are likely to exceed the Vanuatu's per capita health budget, so they are not performed.

In 1999 Vanuatu was funded by WHO to carry out an STI prevalence study in Vila, because of the lack of reliable information available. The findings show that the prevalence of STIs in pregnant women in Vila is high and that the women who are at the greatest risk of infection were single and young. The report stated that:

> *the prevalence of STIs in a moderate- to low-risk population of pregnant women in Port Vila is high. The prevalence rates of trichomonal and chlamydial infections are of concern, particularly in association with known poor pregnancy outcomes. At the national level, current policies and programmes for STIs and HIV need to be reviewed, especially the capacity for laboratory testing of STIs, prevention strategies for HIV and STIs, and implementation of syndromic case management of STIs. Further characterization and surveillance of STI prevalence is needed. Programmes for STI detection and management need to be supported.*[22]

The prevalence of STIs in this study was 0% for HIV infection, 2.4% for treponemal antibodies, 5.9% for gonorrhoea, 21.5% for chlamydial infection, and 27.5% for trichomonal infection. The prevalence of women with either chlamidial and or gonorrhoeal infection was 22.4% [23] (see Table 3).

Table 3: *Baseline prevalence of sexually transmitted infections and seroprevalence of treponemal antibodies and HIV among 545 pregnant women attending the Vila Central Hospital first-visit antenatal clinic, Port Vila, Vanuatu from October 1999 to February 2000* [24].

BASELINE PREVALENCE			
STI	**No. Tested**	**No. women with infection**	**Prevalence%**
Trichomonas vaginalis	545	150	27.5
Chlamydia trachomatis and or Neisseria gonorrhea	545	122	22.4
Chlamydia trachomatis	545	117	21.5
Neisseria gonorrhea	545	32	5.9
Treponemal antibody seroreactivity	545	13	2.4
HIV	545	0	0

Another survey was completed by FSP Vanuatu on reproductive health in Tanna and Santo because of the high birth rates and high STIs in those areas [25]. This survey examined the knowledge, attitudes and practices of mothers of reproductive age. Many factors were investigated included family planning and STIs and the significant findings relevant to this study were that 75% of women have their first babies before the age of 25 and that respondents were aware of STIs but do not think they are at risk in their local area.

HIV/AIDS INFECTION

Although no cases of HIV/AIDS have been reported, because of the high incidence of STIs, high mobility of people around the islands, low 'safe sex' rates and the low health budget, Vanuatu could have a very large problem if HIV/AIDS came to this country. For example, most people live in rural areas (78%) [26] where medical services are minimal and where people are known to have STIs for up to three years before they come to the health workers. This is related to the embarrassment in talking about sexual activity and the stigma attached to having such problems. People tend to hide these medical problems.

In Vanuatu, people can only be tested for STIs and HIV/AIDS at Vila Central Hospital and Northern District Hospital, Santo. The samples for HIV/AIDS testing are then sent to Australia. The test done is the Serodia test which only takes one day. The Ministry of Health reported that approximately 2000 tests are done per year.

An NGO reported that costs are prohibitive for HIV/AIDS testing and that hospitals may be reluctant to freely test. It was mentioned that at times people ask for HIV/AIDS tests because they have lived in other parts of the Pacific and suspect they have been in contact with someone who may have been at risk. However, when that person asking for a test arrives at the hospital, they are often talked out of having the test.

SERVICES FOR AWARENESS AND PREVENTION

The **Ministry of Health** reported that they had a HIV/AIDS program from 1988 to 1995 which was funded by WHO. However, since the project ended they have not received enough money in their health budget to produce IEC materials or to run awareness workshops.

NGOs provide some services such as awareness programmes, counselling, and condom distribution. NGOs such as Wan Smol Bag, Vanuatu Family Health, Foundation for the Peoples of the South Pacific, Young People's Project, World Vision, Red Cross, and Save Children Fund, Australia, and Vanuatu Women's Centre provide awareness and prevention workshops and/or information.

Wan Smol Bag (WSB) are a drama and educational group that deals with a whole range of issues and work in Vila and the provinces. They also have a Kam Busim Hed (KBH) clinic in Vila which is a drop-in centre where young people can get condoms, view videos and get information on pregnancy, safe sex and STIs. They see clients who suspect they have an STI and collect samples which are then sent on to the hospital. At the clinic, free condoms are available for collection. The condoms are easily picked up and out of sight of staring eyes.

WSB also have awareness programmes on STIs (transmission and prevention) in the form of drama, radio broadcasts, videos, pamphlets, a book of games and posters. The target groups for drama followed by a workshop are:

- young people aged 10-14 years who do not attend school (the focus is sexual activity);
- young people aged 11-12 years in schools (the focus is puberty);
- women aged 15-30 years (in communities); and
- men (chiefs and men) who tend to be reluctant to attend.

Wan Smol Bag have a radio programme called *Famli blong Sera* which deals with many issues. STIs are one. WSB also produce videos on various issues. Recently, they produced a video called *Positive* which is a story about a HIV/AIDS victim. This video aims to inform people about HIV/AIDS and enable them to see the implications of this disease. WSB also have IEC materials such as posters, pamphlets and books.

Vanuatu Family Health Centre (VFHC) has services available for awareness and prevention. They have 42 community educators and 435 volunteers working in this area. They work in the provinces. They have a clinic in Vila which deals with reproductive health and family planning.

On awareness, VFHC run a radio program for 15 minutes each week in which someone from the centre gives information on a topic related to family health. They also have another weekly 30 minute slot which allows people to phone in (or write in later) to ask questions. They also visit schools and communities where they run two-hour workshops on reproductive health and STI and AIDS awareness. They have a small library which may be used by the public and students.

VFHC also have IEC materials to promote awareness on STI and HIV/AIDS. They have leaflets (*AIDS o Sida)* which they feel are the most successful, booklets (*Sipos mi bin Save, Sexually Transmitted Infections)*, and posters.

Foundation for peoples of the South Pacific (FSP) have a service called Youth to Youth peer counselling. Young people have been trained by members of FSP in leadership and counselling skills. They do community volunteer work in reproductive health. They go to communities and create awareness, then select people from the community to participate in training and later become volunteer health workers. Table 4 shows the number of young people involved in the project in different areas.

Table 4: *Number of young people involved in Youth to Youth project* [27]

PROJECT AREA	No. trained peer youth counsellors	No. young people who benefited from project	No. NGOs who assisted
Port Vila (urban)	16	4,500	34
Tanna	21	4,814	22
Aniwa	12	31	8

FSP run community workshops using youth to youth peer counsellors. They also have a group who use drama as a medium to educate the community. They have written scripts and are trained in acting.

IEC materials produced by FSP comprise leaflets with explanations about teenage pregnancy, condoms, STIs and HIV/AIDS.

The NGOs interviewed believe that workshops which include drama are one of the best ways of creating awareness of STI and HIV/AIDS. Radio stories/dramas that are informative are also regarded as an efficient way to service many people. Booklets which have lots of pictures are effective too for those who do not read. NGOs believe that posters must get the messages across with photos and with little writing as many people can not read.

Condom distribution is a major problem in STI and HIV/AIDS prevention as most of the time condoms are put in places where the recipient will be seen collecting them. If this is the case then they are not collected. One NGO suggested that a corner in *nakamals* or somewhere out of sight is the best place for collection. The worst place to put condoms is where the recipient has to ask for them. It was suggested that condoms should be given out too as part of awareness and prevention workshops.

One NGO told a story of a ship that had men wanting to use condoms but who would not ask for them because they were locked up in the captain's office. Their shame is too great for them to ask the captain for condoms.

COUNSELLING

There are no qualified professional counsellors who counsel only in the area of STI or HIV/AIDS. However, there are people who have undergone non-formal training (2 weeks or more) who work with people who have STIs. Vila Central Hospital, Foundation for peoples of the South Pacific, Vanuatu Family Health Centre, Kam Busim Hed clinic and Vanuatu Women's Centre have such counsellors. Also, some nurses in the Ministry of Health talk to people with STIs. Some Red Cross and World Vision workers also talk with those who need help in this area. The church, chiefs and youth leaders were mentioned as counsellors.

A person from one of the NGOs mentioned that there are very few places that are private for counselling and often it is hard to find a place where clients do not feel conspicuous. Many of the offices are crowded and have no privacy for counselling. It can be a big problem for counsellors to find a place where the client feels comfortable or knows no one will see them enter.

CULTURAL WAYS

It was reported that certain words are not used in Vanuatu culture. For example, some of the health workers say 'taboo parts' rather than use the term vagina or penis. The vernacular terms for 'sexual intercourse' or 'sex' may cause people hide their faces in embarrassment or shame. Instead the term 'man sleeps with woman' is used.

It was suggested that when counselling ni-Vanuatu you must be respectful and use appropriate language. Women must speak with women and men to men. Sometimes women want to be accompanied by an 'aunty' (not necessarily a relative) but young women do not require their parents to be present. Again the shame is too great to tell parents.

The place to meet should be well thought out such as a *nakamal* for men and a private place for women. The authority of the village should be respected and permission gained first before conducting community education. This often means convincing the chief, the elders or the pastor of the village to allow these educational sessions.

When counselling ni-Vanuatu it was suggested by some that they will not look the counsellors in the eye but others said that if you counsel you must get eye contact as it is what counsellors do.

Confidentiality is seen as a problem. People talk and gossip about what they have been told in confidence. The counsellors are often not discrete. There is a stigma associated with receiving counselling regarding reproduction and reproductive issues.

Condom distribution has been a problem for those promoting 'safe sex'. Some people believe that if you give out condoms you are giving permission to have sex. Thus, many of the nurses especially in rural areas do not tend give out condoms. The WSB worker says that to avoid embarrassment and shame you need to make sure people can get the condoms without being seen. Also it was said that you need to educate

and give out the condoms at the same time. Demonstration of how to put on a condom is important. It was also suggested that it should be the youth counsellors who give out the condoms rather than the nurses.

CASE STUDY

Each NGO interviewed were asked to interview two clients using the questions provided. Only one NGO was brave enough to conduct the interviews.

The first man to be interviewed was a 28 year old male. He was very suspicious and wanted to know why he was being interviewed. He was worried that any information he provided would not be kept confidential and that then he would be gossiped about. In the end he refused to answer any questions as he was so embarrassed and worried.

The second interviewee was a 32 year single male who previously had a history of STIs. He agreed to be interviewed only if his name or where he was from was not revealed. He mentioned that when he was eighteen years of age he was influenced and encouraged by his friends to start sleeping with young women. So when he was 21 years old he slept with a woman for the first time. He enjoyed the experience and continued to sleep with women. He said that in the last nine years he has slept with more than twenty women but it was too many to count.

The first time he was infected with an STI, he was not aware of what it was. He noticed that when he urinated he had a yellow discharge and his private parts were very sore and painful. He was too embarrassed to tell anyone or to do anything about it. However, after a while some people came to the village and presented a community awareness workshop on STIs. At that point he realised what his problem was but he still hesitated about going to the hospital because he was so embarrassed and scared that people would find out and gossip about him. Then he thought to himself that he should value his life and take care of his body. This seemed to him more important than what people think and he then went to the hospital. He insisted that the nurse must not tell anyone about him, especially not his family. He did not want his mother, father, sisters or brothers to find out. He said he would feel ashamed that this would let everyone know that he was sleeping around—so ashamed that he had contemplated suicide.

The hospital nurse counselled him about STIs. Later a Youth to Youth peer counsellor was asked to talk with him. He did talk with him because this counsellor was his best friend. Even then he was fearful that his friend would tell someone and he would be tormented and gossiped about. His immediate thoughts were if this happened he would have no chance of getting a girlfriend or a wife since people do not trust in the medicines from the hospital and would not believe he was cured. The usual practice when people go to the doctors at the hospital is to go to the traditional healers and get traditional medicine as well. The man interviewed stated that many men go to the traditional healer when they have an STI. Traditional medicine does not cure STIs. It often feels better for a few days and then the disease comes back again.

This man has now had an STI five times. He does not sleep with anyone when he knows he is infected. Like many men he does not use condoms because he does not like the way they feel. He is aware of HIV/AIDS and is really afraid that he may contract the disease. Even that fear is not enough to get him to use condoms. He believes that there are many of his friends with STIs who will not also reveal their problem for fear of gossip.

NOTES:

[1] *Situation Analysis of the State of HIV/AIDS in Fiji*

[2] *Situation Analysis of the State of HIV/AIDS in Fiji*, p 23

[3] *Situation Analysis of the State of HIV/AIDS in Fiji*, p 23

[4] p28

[5] Clients are described as 'beyond control' when they show continuing signs of emotional distress or are suicidal.

[6] Comment by a USP counsellor

[7] Comment by the permanent nurse at the Reproductive and Family Health Clinic

[8] *Situational analysis on women and HIV/AIDS in Samoa*, p 32

[9] *Antenatal Clinic STI Survey 2000*, p 6.

[10] These figures do not include those treated at other hospitals e.g. MEDCEN and district hospitals outside Apia (including Savaii) as well as those treated by traditional healers (*talausea*).

[11] According to representatives of *Sautiamai* and Samoa Family Health Association, as many as 4 people may be in this situation.

[12] Fictitious name to protect identity

[13] Medical personnel never considered testing for HIV/AIDS infection

[14] Fictitious name to protect identity

[15] *The 1999 Vanuatu National Population and Housing Census*

[16] *The 1999 Vanuatu National Population and Housing Census*

[17] *The 1999 Vanuatu National Population and Housing Census*

[18] Statistics sheets given to me when I visited the Ministry of Health.

[19] Statistics given to me when I visited Wan Smol Bag KPH clinic in Vila.

[20] Jean Mitchell, *Young People Speak: A report on the Vanuatu Young Peoples Project*, 1998

[21] *1989 Vanuatu National Census*

[22] Ministry of Health, *STI/HIV: Antenatal Clinic STI Survey*, Vila: WHO, 2000

[23] Ministry of Health, *STI/HIV: Antenatal Clinic STI Survey*, Vila: WHO, 2000

[24] Ministry of Health, *STI/HIV: Antenatal Clinic STI Survey*, Vila: WHO, 2000

[25] FSP Vanuatu, Tanna *Reproductive Health Project: KAP Survey*, Sept 2001

[26] FSP Vanuatu, Tanna *Reproductive Health Project: KAP Survey*, Sept 2001

[27] Figures collected from FSP

APPENDIX 4

Terms and abbreviations

GLOSSARY OF SEXUAL WORDS AND TERMS

Balls	Testicles.
Ball fucking	Inserting the testicles into the anus, or sometimes the vagina; for many people, the testicle must first be tied up for this to be possible. It may be very difficult unless the scrotum is hanging loose.
Baths	Commercial facilities equipped with showers, steam rooms, pools, etc, where some gay men go to meet each other and have sex.
B & D	Bondage and discipline; some form of S & M (sadism and masochism).
Bestiality	Sexual activity between a person and an animal.
Blow job	Fellatio; oral sex involving the male genitals.
Blue balls	Describes the condition of a man who has an erection but cannot reach orgasm, and develops a soreness around the testicles, probably from strained muscles that support the penis and scrotum.
Butt plug	A device for inserting into the anus, shaped such that both ends have a larger diameter than the middle so that the device will not be easily expelled (or "lost" in the rectum).
Cervix	The opening between the vagina and the uterus; one of the two .sources (along with the vagina) of female genital secretions.
Caesarean section	A surgical procedure for delivering a baby through the abdominal wall.
Chicken	Young sexually active person, usually under 21, especially male.
Chicken hawk	Older person who prefers *chickens*, or young sexually active persons.
Circumcision	Surgical removal of the foreskin of the penis.
Cock ring	A constrictive device that goes over the base of the penis and scrotum; this device keeps the penis engorged with blood in order to maintain or prolong erection.

Condom	A rubber or plastic sheath that fits over the penis and can hold the ejaculate.
Cowper's Gland fluid	See pre-ejaculate or pre-cum.
Clitoris	A small erectile organ at the top of the female genitals; stimulation of the clitoris leads to orgasm.
Cunnilingus	Oral sex involving the female genitals.
Dildo	A device, usually in the shape of a penis, used during intercourse; dildos can vary widely in size and are usually used because they are larger than a penis.
Docking	Wrapping the foreskin of one penis around the head of another.
Douching	Washing out the rectum or the vagina with water or other fluid; see enema.
Eating out	Oral sex.
Enema	Removing faecal material from the rectum using water or other fluid; see douching. Also, inserting water into the rectum (part of water sports).
Fantasy	The use of talking, pictures, uniforms or costumes, music or other means to create imaginary settings or scenarios of an erotic nature.
Fellatio	Oral sex involving the male genitals.
Finger fucking	Inserting one or more fingers in the vagina or anus.
Fisting (fist fucking)	Inserting all or part of the hand and/or forearm into the anus (brachioproctophilia) or vagina.
Frottage	Rubbing parts of the body against each other.
Fucking	Used to refer to almost any type of sex; most commonly, vaginal or anal intercourse.
Glory hole	A hole drilled in a wall to allow a penis to be put through for the purpose of fellatio or intercourse; commonly found in the walls between bathroom stalls.
Going down	Oral sex; see "blow job" and "cunnilingus."
Golden showers	Refers to activities that involve urine; mostly used by those who use water sports to describe urinating.
Hand job (jacking off)	Masturbation; may also be performed by a second person; very safe sex practice.

Harmonica job	Oral stimulation of the penis along the length of the shaft instead of inserting it into the mouth.
Hickey	A mild haematoma (blood clot) or bruise caused by sucking or biting the skin during sex.
Hum job	A blow job while humming or groaning; also see harmonica job.
Intercourse	Usually refers to the insertion of the penis in the vagina or anus; sometimes used as a polite term to refer more broadly to other sexual activity.
Konvoi	Gang rape.
Leak-out	Withdrawal.
Piercing	(1) Refers to putting holes in the skin; this is sometimes done to enhance subsequent sexual activity, and sometimes done as a part of sex. The most common areas of piercing are the earlobes and the nipples, but piercing can also involve the nose, penis, foreskin, labia. (2) In pornography, sometimes used as a synonym for penetration.
Pre-cum	See pre-ejaculate.
Pre-ejaculate	A clear, viscous fluid secreted by the Cowper's gland into the urethra at the base of the penis; pre-ejaculate may start to flow from the penis as soon as erection is achieved, although the quantity produced can vary from virtually none to a great deal.
Premature ejaculation	A condition when a man reaches orgasm very quickly after beginning sex.
Princeton rub	Inserting the penis between the thighs for fucking; also called interfemoral intercourse, from inter (meaning between) and femur (the thigh bone).
Proctitis	Inflammation of the rectum, usually from infection.
Prophylactic	(1) A condom. (2) Something used for the prevention of something else.
Regular sex	Used to refer to vaginal intercourse by people who don't commonly think about other sexual activities; also "value-laden;" this term should be avoided by professional counsellors.
Rimming	Oral/anal contact; licking or inserting the tongue into the rectum.
Rubber	See condom.

S & M	Sado-masochism; can refer to a wide variety of sexual activities, including an attitude that emphasises the giving (sadism) and receiving (masochism) of pain as a form of sexual pleasure.
Scat	Refers to sexual activity that involves faecal material; adj. scatological.
Scene	Sexual fantasy played out between two consenting adults; may combine elements of S & M or B & D.
Scrotum	The sack of skin that holds the testicles.
Semen	The ejaculate fluid of the male that contains sperm and seminal fluid; seminal fluid exists only to carry the sperm.
Sex toy	Any device used to enhance sexual activity.
Sheath	See condom.

LIST OF ABBREVIATIONS

ATFF	Aids Task Force of Fiji
FSP	Foundation for the People of the South Pacific
HEAPS	Health Education and Promotional Services in the Samoa Department of Health
HET	Heterosexual Transmission
IEC	Information, Education and Communication
MH	Ministry of Health (Vanuatu)
MSM	men having sex with men
MTCT	mother to child transmission
NGO	Non Governmental Organisation
PCP	Pacific Childrens Programme
RH	Reproductive Health
SCFA	Save the Children Fund Australia
SFHA	Samoa Family Health Association
SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted Infection
USP	University of the South Pacific
VWC	Vanuatu Women's Centre
WAC	Women's Action for Change (Fiji)
YPP	Young People's Project (Vanuatu)

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