life choices

YOUTH FRIENDLY HIV COUNSELLING & TESTING

A PRACTICAL GUIDE FOR MANAGERS, COUNSELLORS, AND PROTOCOL DEVELOPERS AIMING AT WORKING WITH YOUTH

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CONTENTS

CHAPTER 1
INTRODUCTION

This manual is a guide for service providers working in the field of HIV counselling and testing (HCT). Because of a lack of adequate literature, it especially focuses on the HCT process when working with *youth.*

Life Choices believes that young people have the right to know their HIV status, to receive appropriate support and counselling and to receive this service from practitioners who care about their well-being. Adolescence is a vulnerable developmental stage in which young people are most at risk for developing problematic behaviour. It is a prime time for preventative interventions, before bad habits set in. Adolescence, as a life cycle stage, can also be an emotionally and socially rocky phase and is thus a time when people need substantial support from others. With a growing population of youth in South Africa (over 19 million), there is a big need for more youth friendly services - services that do not alienate this important population group. South Africa requires services that will get young people excited about their lives and their health.

Furthermore, you might ask why we believe HCT is important as a preventative method rather than other strategies such as Peer Education, Life Skills, mass media campaigns, and so forth. Firstly, it must be stressed that we do not focus on HCT to the exclusion of these other strategies. Our belief is on multi-systemic and varied approaches. It is our belief that preventative strategies in South Africa rarely focus on the individual level when it comes to young people. *In depth,* individual counselling during HCT is not seen as a primary method of combating the epidemic and is a neglected approach when working with adolescents. The problem is that Life Skills and Peer Education strategies focus on large-scale group interventions. We believe that large-scale interventions (though also playing an important role in changing cultural beliefs and gaps in health education) must be *accompanied* by more tailored individual level approaches because *no two people are the same.* Large-scale campaigns do not address individual needs and thought processes. They do not speak to the particular nuances of an individual's circumstances. Only individual counselling can address these issues.

Life Choices has created this manual for managers, protocol developers and lay-counsellors alike. We hope you find it relevant whether you have just started out in this exciting field, or whether you have some experience but would like to compare services. It is based on literature reviews and on our experiences in the field (Life Choices' case study – providing youth friendly HCT services since 2007). Some Chapters in this manual are tailored to suit the needs of counsellors and are more practical in nature to help the counsellor sharpen their therapeutic skills. Other Chapters are perhaps better suited for managers and protocol developers to help you strategise the entire service delivery system and implement your own youth friendly HCT programme from beginning to end.


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CHAPTER 2
COUNSELLING YOUTH: RISKS AND BARRIERS DURING ADOLESCENCE

This Chapter summarises relevant research on factors influencing young people. More specifically it looks at factors that increase the likelihood that a young person will engage in health-compromising behaviour. It is very clear that giving young people more knowledge on HIV risk does not necessarily reduce their risk behaviour. This is because health-compromising behaviour is caused and maintained by an array of individual, developmental, social, familial, societal, cultural, political and economic factors. The counsellor should be on the lookout for indicators that one or more of these issues might be occurring in the youth's life. If it is clear that these are major barriers to healthy lifestyles then these barriers should be addressed by the counsellor or the counsellor should make appropriate referrals for more specialised attention.

2.1. Adolescence as a Developmental Stage

Adolescence as a developmental stage (Wait, Meyer & Loxton, 2005) has a set of unique developmental tasks that young people must face in order to mature and grow. It is often the stage when most compromising health behaviours are practiced for the first time, and usually it is here where these behaviours get a chance to set in and become long-term bad health habits (Taylor, 2006). Thus, this stage is marked by various factors that can encourage risk behaviour (but it can also be the perfect time to implement preventative interventions, curtailing these risk factors). Middle childhood, the period that precedes adolescence, ends when puberty begins and thus the period of adolescence is earmarked by the start of physical sexual maturation (Wait, Meyer & Loxton). It is also the period in which the child seeks more freedom and independence from parents and has a greater need to explore the self and their surroundings.

Wait, Meyer and Loxton (2005) point out that during early and late adolescence there are certain developmental tasks that young people need to accomplish in order to mature and move to the next phase of their life.

These tasks are:

- Acceptance of his or her changing physical body;
- Gender role identification;
- Development of own identity;
- Establishing autonomy from parents;
- Career choices;
- Development of formal operational thought;
- Emotional development;
- Establishment of worldview and internalised morality;
- Establishment of peer group membership;
- Establishment of romantic relationships.

Although each adolescent must tackle these developmental tasks to advance successfully, it often necessitates a lot of exploration, pushing boundaries (and taking chances). While exploration is healthy, these developmental tasks can nonetheless form a unique cocktail of risk for certain individuals.

For instance, adolescence is usually the phase in which young people start to explore and experiment with their sexuality and establish romantic relationships. This is both because of physical changes in their bodies (including hormones) as well as social expectations. The need to be romantically involved is often not motivated by a need to find a life partner but the need to clarify their sexual role identity (Newman & Newman quoted in Wait, Mayer & Loxton, 2005).

Through the process of meeting many boys or girls and receiving affection and approval from them, adolescents learn to value themselves as males or females and to take pleasure in experiencing their sexuality (Newman & Newman quoted in Wait, Meyer & Loxton, 2005, p. 158).

This "sexuality" does not necessarily imply intercourse and merely means the celebration of self as a sexual being. This celebration can also be achieved by practicing a whole range of behaviours other than sex (such as holding hands or kissing).

Beliefs around sexual relationships can be further exacerbated by the need to fit in and belong. This need is often lived out within the peer group. Research shows that from the seventh grade, adolescents experience greater intimacy with friends than with parents (Wait, Meyer &

Loxton, 2005). There are often higher levels of conflict within the parent-child relationship as the adolescent tries to negotiate new levels of independence. Within the peer group, conditions of worth play a major role, as the adolescent will behave in a manner he or she believes will get the approval of friends or a romantic partner.

Their sense of worth, both in their own eyes and in those of others who have been important to them, is conditional upon winning approval and avoiding disapproval, and this means that their range of behaviours is severely restricted for they can only behave in ways which are sure to be acceptable to others (Mearns & Thorne, 2007, p. 11).

Because of this need for approval from peers, an adolescent may engage in sex before he or she is mentally and emotionally ready. Peer pressure also increases the likelihood of alcohol abuse, smoking, and experimenting with other illegal substances such as marijuana. Being intoxicated increases the likelihood of sex or getting into contact with blood. Furthermore, these practices can also be appealing because adolescents are at an age where they want to establish their independency and these practices could help them break away from family restrictions. This is not to say that all adolescents will engage in these health-compromising practices. The parent-child relationship in middle-childhood sets the tone for the relationship experienced in adolescence (Wait, Meyer & Loxton, 2005). Thus, when a parent has already established trust and affection in earlier years, then the divide between parent and child is less severe during adolescence. Of course, not all children within a secure family will be perfect, and not all children from a problematic family will have unhealthy behaviours. These are merely statistics and counsellors need to keep unique ecological circumstances and personal fortitude in mind.

In this developmental phase adolescents also acquire an acute dose of egocentrism (Wait, Meyer, &Loxton, 2005). They believe their perceptions about the world are accurate and often have feelings of invincibility. Thus, when engaging in health compromising behaviours they may know what the potential consequences are of their actions but these warnings are muffled by thoughts of: "It will never happen to *me*!" Thus, the potential effects of unhealthy, hazardous behaviour are nullified in the minds of some adolescents. This egocentrism also fuels an unwillingness to accept responsibility for sexual activities (Wait, Meyer & Loxton, 2005).

Because adolescents start to develop formal operational thought and have the capacity to formulate hypotheses about the world (Wait, Meyer & Loxton, 2005), they begin to construct ideas around romantic relationships and sex. Besides incorporating familial beliefs into their schemata, they can also be susceptible to the voices of the media and their friends. In other words, this is the period in which people start to appropriate familial and societal ideologies about romantic relationships, masculinity, and femininity into their own worldviews. These cultural ideologies can have a major impact on behaviour (Ratele & Duncan, 2003).

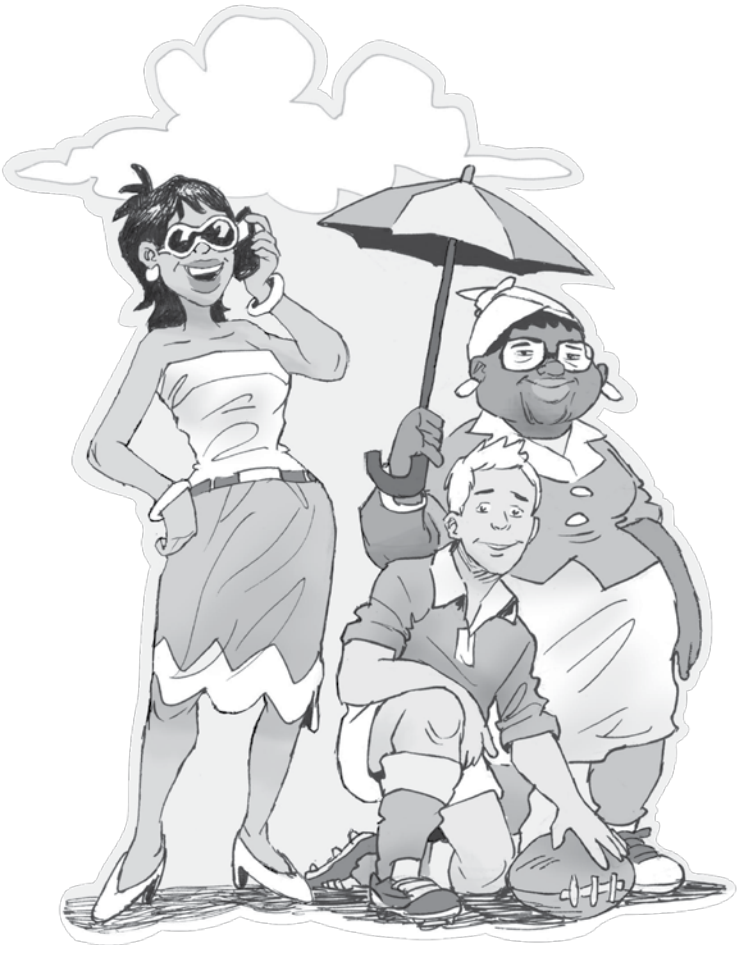
For instance, in many cultures today, ideologies around masculinity and femininity favour male sexual power and women's lack of negotiation in sexual relationships (For a more complete literature review see *Social Psychology: Identities and Relationships* by Ratele & Duncan, 2003). Traditional male gender roles create the picture that sex is a male domain (Ratele & Duncan, 2003). Sexuality in men is viewed as a positive, natural thing. Thus, within this cultural view having sex is part of being a man. Consequently, in adolescence sex for men can be viewed as a "coming of age" act. Research indicates that male sexuality is also deemed by many in society as overwhelmingly strong and uncontrollable (Ratele & Duncan, 2003). Men are often encouraged to take many sexual partners (the more girls, the better the man) and actively pursue sexual relationships (Ratele & Duncan, 2003). On the other hand, a man's masculinity might easily be questioned and ridiculed when he is not sexually active or at least pursuing sexual intercourse. This can have a major impact within adolescent peer relationships. In contrast, women's sexuality is represented by the whore-madonna dichotomy – were a girl should be a desirable sexual creature on the one hand yet pious, virtuous and sexually naïve on the other (Ratele & Duncan, 2003). Thus, women are seen as sexual beings however, not in their own right but *for male pleasure*.

The ideal woman is believed to be desirable but would not pursue sexual intercourse on her own for physical gratification. Here, the ideal woman would only pursue sex as one part of a loving, romantic relationship. Research indicates that in this way men often distinguish between women who are "clean" (virtuous, sexually conservative women) and those who are "unclean" (promiscuous women). These ideologies can easily be detected by looking at societal labels: men who have experience sexually are often admired as "players" and women who are similarly experienced often acquire derogatory labels such as "loose" or "slut". Thus, it has been found that women actively try to downplay their sexual power by being submissive, passive, naive partners, in need of "guidance" by her male partner who is in control of sexuality (Ratele & Duncan, 2003).

These gender role identities play a big part within health behaviour and the perpetuation of the HIV pandemic. Young men could feel pressure from friends to engage in sex early and young women fear losing their partners if they do not give into their partner's sexual needs. When it comes to condom use, research shows that men's decisions around condom use are usually privileged (Ratele & Duncan, 2003). Condoms are often seen as "unmacho" by men and women are anxious that insisting on condoms could take away from their partner's pleasure. Condoms also imply a lack of trust and are believed to have no place in long-term relationships (Ratele & Duncan, 2003). Thus when you insist on using condoms it means that either you are unfaithful, or you believe your partner is unfaithful. In terms of preventative interventions, it is crucial that counsellors change the stigma around condom use at a very young age and question these gender role identities in favour of more equal identities. Adolescence is the perfect time for young people to be questioned about gender ideologies, as this is when they explore and construct their beliefs about the world we live in.

SUMMARY OF BARRIERS TO HEALTHY BEHAVIOUR

- Lack of adequate information or ignorance about information;
- Peer culture;
- Self-presentation process: It is “cool” to smoke, drink, have sex, etc.;
- Pleasure: many risky behaviours are pleasurable;
- Development of these behaviours occurs gradually – adolescents are young and fit and thus do not immediately see the negative consequences of unhealthy behaviours;
- High levels of conflict with parents;
- Poor self-control;
- Delusion of invulnerability: “it won’t happen to me”;
- May form part of a coping mechanism to deal with stressful life events;
- Low self-esteem;
- Affinity for deviant behaviour;
- Poor school achievement that feeds into low self-esteem;
- Greater exposure to the problematic behaviour within the larger community and cultural context;
- Lack career goals and vision about the future;
- Cultural beliefs justifying male sexual prerogative and promiscuity;
- Cultural beliefs enforcing females’ lack of sexual power and negotiation;
- Stigma surrounding condom use – condoms are seen as the manifestation of distrust within committed relationships;
- Unfriendly health services that do not cater for the needs of young people.

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CHAPTER 3
THE LAW AND ETHICAL CODE OF CONDUCT

Working with youth means that counsellors must be fully informed about the South African Children's Act and adhere to strict ethical principles. This chapter will first highlight some of the relevant laws from the Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) and the associated Regulations which came into effect on 1 April 2010. However, it does not by implication mean that because a counsellor is adhering to the law they are providing quality services. It only means that they are fulfilling the minimum requirements. Thus, the second part of this chapter presents useful ethical principles that all counsellors should adhere to because, even though they are not laws, they serve as a guide to ensure professional conduct and quality services.

3.1. The Law: South African Children's Act

It must be noted that the discussion below is by no means an exhaustive account of the Children's Act and counsellors and management are advised to familiarise themselves with the entire law. Only potentially relevant information to working with children in an HIV counselling and testing setting is highlighted. Some of the information below was directly taken from the Children's Act 38 of 2005 printed in the Government Gazette, 19 June, 2006 (Department of Justice and Constitutional Development, 2005). Also used was the *Children's Act Guide: For Child and Youth Care Workers* written by Mahery, Jamieson and Scott (2011) from the Children's Institute, University of Cape Town, and National Association of Child and Youth Care Workers.

3.1.1. WHAT IS THE DEFINITION OF "CHILD"?

A child is legally recognised as any person under the age of 18 years.

3.1.2. WHAT CHILDREN'S RIGHTS DO HIV PREVENTION AND TESTING SERVICES FULFIL?

Working in the field of youth HIV prevention is satisfying a key role within society. Section 13 in the Children's Act emphasises that every child has the right to:

a. have access to information on health promotion and prevention and treatment of illhealth and disease, sexuality and reproduction;
b. have access to information regarding his or her health status;
c. have access to information regarding the causes and treatment of his or her health status; ..."

Thus, creating youth friendly services that allow young people to gain information on their health status, prevention methods, and treatment options is in accordance with some of their most basic human rights. Importantly, services that cater for children (including HCT services) must ensure that the general information about health as well as information about the particular client's health is *"in a format accessible to children"*. In doing so children can become empowered and make informed, effective decisions concerning their own well-being.

3.1.3. WHAT GUIDELINES ARE THERE TO HELP MANAGERS AND STAFF MAKE DECISIONS ABOUT A CHILD AND CHILD RELATED SERVICES?

At some point you may find yourself facing difficult decisions whether these decisions are about individual cases or more general decisions about programme structure. Whether you face a difficult decision about a particular child related incident or you need to make decisions about your youth orientated services, it is helpful to keep the following basic checks in mind. In general all proceedings, actions and decisions concerning a child (or child related services) must:

- respect, promote, protect and fulfil children's constitutional rights, the best interests standard and the rights and principles set out in the Children's Act;
- respect the child's dignity and treat the child fair and equitably;
- protect the child from unfair discrimination on any ground including the ground of the health status or disability of the child or his or her family members;
- recognise a child's disability and responds to the special needs of the child.

The general principles further state that, in any matter concerning a child:

- the child's family should be given an opportunity to express their views if that would be in the child's best interests;
- a restorative and problem-solving approach should be followed and a confrontational approach should be avoided;
- delays in actions or decisions to be taken must be avoided as far as possible; and
- where decisions or actions are taken which significantly affect the child, then the child, depending on his or her age, maturity and stage of development, and the person who has rights and responsibilities in respect of the child, must be informed of those actions or decisions to be taken, and be made part of the decision-making process.

The core principle to follow is that in all matters concerning the care, protection and well-being of a child, *"the standard that the child's best interest is of paramount importance, must be applied"*. This can be found in Section 9 of the Act. This core principle implies that when managers, protocol developers and counsellors make decisions concerning any protection, prevention and early intervention services provided to the child and his or her family, the child's best interest is the most important factor. Of course it is not always easy to know what will benefit a child most. Section 7 of the Children's Act gives a list of factors to consider when trying to establish exactly what the *"best interests of the child"* is. These are the factors that Mahery, Jamieson and Scott (2011) highlight for child and youth care workers:

- the child's age, maturity and stage of development;
- the child's gender;
- the child's physical and emotional security and his or her intellectual, emotional, social and cultural development;
- any disability or chronic illness that a child may have;
- personal relationships with the parents, family or care-givers;
- the attitude of the parents, or any specific parent, towards the child;
- the capacity of the parents, or of any other care-giver, to provide for the needs of the child;
- the likely effect on the child of any change in the child's circumstances; the practical difficulty and expense of a child having contact with the parents;
- the need for the child to maintain a connection with his or her family, extended family, culture or tradition;
- the need for a child to be brought up within a stable family environment and, where this is not possible, in an environment resembling as close as possible a caring family environment; and
- the need to protect the child from any physical or psychological harm, or even witnessing harmful behaviour towards another person.

3.1.4. WHO NEEDS TO GIVE CONSENT FOR THE HIV TESTING OF A CHILD?

This information can be obtained in the Children's Act under *Part 3, Protective measures relating to the health of children.* This section communicates what a child's rights are in terms of medical procedures as well as laws related to HIV testing. In short, if the child is older than 12 years of age then he/she can give consent to undergo medical procedures including HIV testing. Thus, if older than 12 years he/she does not require the consent of the parent/guardian. However, the child must be believed to be of sufficient maturity and needs to have the mental capacity to understand the benefits, risks of the medical procedure as well as the social and other implications of the procedure.

This is what the law says about consent for a HIV test:

Consent for a HIV-test on a child may be given by -

a. the child, if the child is -
   i. 12 years of age or older; or
   ii. under the age of 12 years and if of sufficient maturity to understand the benefits, risks and social implications of such a test;
b. the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
c. the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
d. a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity;
e. the superintendent or person in charge of a hospital, if -
   i. the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and
   ii. the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or
   iii. consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld; or
   iv. the child or the parent or care-giver of the child is incapable of giving consent.

3.1.5. WHAT ARE THE REGULATIONS CONCERNING THE HIV TESTING OF A CHILD?

The law makes it very clear that no child can receive an HIV test without proper pre-counselling and post-counselling – whether it is the child who receives the counselling or in some cases the parent. Furthermore, the counselling must be given by an appropriately trained person. The law does not define what "appropriate" counsellor training means. Thus, it is not stipulated what the minimum training requirements are for counsellors. However, this is where it is important to keep ethical guidelines in consideration. Ethical practice will ensure that counsellors not only receive the minimum standard of training but exceed minimum requirements so that they are not just adequate counsellors but they are competent and excel.

NOTE

What Life Choices has found in the field is that testing in schools can be more difficult in terms of parental consent. In the beginning, some schools in which we conducted HIV counselling & testing were not comfortable in allowing learners to test for HIV without informing parents and asking their permission. Thus, even though it is not legally required we tried to accommodate schools by sending out letters a week before the HCT campaign. This was to inform parents of the campaign and ask them to sign the document and send it back if they DO NOT consent to their child being tested. Within time, schools got used to HCT services to be part of school routine and the process became normalised.

The law also has regulations in terms of the confidentiality of the HIV status of a child. This can be found in section 133 of the Act.

No person may disclose the fact that a child is HIV-positive without consent given in terms of subsection (2), except -

a. within the scope of that person's powers and duties in terms of this Act or any other law;
b. when necessary for the purpose of carrying out the provisions of this Act;
c. for the purpose of legal proceedings; or given in terms of subsection;
d. in terms of an order of a court.

Consent to disclose the fact that a child is HIV-positive may be given by -

a. the child, if the child is -
   i. 12 years of age or older; or
   ii. under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
b. the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
c. a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;
d. the superintendent or person in charge of a hospital, if-
   i. the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and
   ii. the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or
e. a children's court, if -
   i. consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld and disclosure is in the best interests of the child; or
   ii. the child or the parent or care-giver of the child is incapable of giving consent.

3.1.6. WHAT TO DO WHEN I SUSPECT A CHILD IS IN NEED OF CARE AND PROTECTION?

It is very likely that a counsellor will at some point come into contact with a child who is in need of care and protection because the child is being abused, sexually exploited, neglected, living in violent homes, begging on the streets, etc. [Note that the law makes a distinction between a child who **is** in need of care and protection and a child who **may** be in need.] A statutory intervention is required if a child:

1. has been abandoned or orphaned and is without any visible means of support;
2. displays behaviour which cannot be controlled by the parent or care-giver;
3. lives or works on the streets or begs for a living;
4. is addicted to a dependence-producing substance and is without any support to obtain treatment for such dependency;
5. has been or is at risk of serious physical or mental harm; or
6. has been abused, neglected, or exploited.

Note sentence one in that it adds the clause "without any visible means of support" and sentence four adds "without any support to obtain treatment for such dependency". These clauses indicate that it is not enough reason for concern when a child loses his/her parents or when a child is addicted to a substance. The child must also be seen as *lacking adequate support* in dealing with these situations. Sentence five points to the possibility that the child may be at risk of *serious* physical and mental harm. This does not exclude harm that the child inflicts on him- or herself. Thus, suicidal threats/ thoughts and behaviours are also serious issues that need immediate attention and referral. Sentence 6 specifically points to the terms "abuse" and "neglect". How does a counsellor know what constitutes "abuse", "sexual abuse", and "neglect"? Abuse is seen as any form of harm or ill-treatment deliberately inflicted on a child. This includes:

a. assaulting a child or inflicting any other form of deliberate injury to a child;
b. sexually abusing a child or allowing a child to be sexually abused;
c. bullying by another child;
d. a labour practice that exploits a child; or
e. exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

Sexual abuse falls under the list above but can be broken down into the following acts:

a. sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted;
b. encouraging, inducing or forcing a child to be used for the sexual gratification of another person;
c. using a child in or deliberately exposing a child to sexual activities or pornography; or

d. procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.

Neglect on the other hand is seen as *"a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs"* of the child.

Section 110 emphasises the mandatory reporting of abuse and/or neglect of a child including sexual abuse, physical abuse causing injury, and deliberate neglect. When a counsellor becomes aware of any of these violations the counsellor must report the incident to 1) a designated child protection organisation 2) provincial department of social development or 3) a police official. This is what section 110 says:

Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre who on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form [Form 22] to a designated child protection organisation, the provincial department of social development or a police official.

However, a conclusion that a child has been abused or neglected **must be substantiated.** If the conclusion cannot be substantiated by certain indicators and if the report was not made in good faith, the person reporting may be liable to civil action. On the other hand, failure to report is an offence with a penalty of a fine or imprisonment for 10 years, or both.

Regulation 35 sets out guidelines and indicators to consider when coming to a conclusion about whether or not a child has been abused or neglected. These guidelines and indicators will help a counsellor to substantiate their conclusion. Keep in mind however that it is important for counsellors to base their conclusions on an assessment of the *"total context of the child's situation"* and thus the focus should not only be on one isolated indicator (e.g. the child is vomiting). Here are the indicators:

- **Indicators of physical abuse:** Bruises in any part of the body; grasp marks on the arms, chest or face; variations in bruising colour; black eyes; belt marks; tears around or behind the ears; cigarette or other burn marks; cuts; welts; fractures; head injuries; convulsions that are not due to epilepsy or high temperature; drowsiness; irregular breathing; vomiting; pain; fever or restlessness.
- **Emotional and behavioural indicators of physical, psychological or sexual abuse:** Aggression; physical withdrawal when approached by adults; anxiety; irritability; persistent fear of familiar people or situations; sadness; suicidal actions or behaviour; self-mutilation; obsessive behaviour; neglect of personal hygiene; age of child demonstrating socially inappropriate sexual behaviour or knowledge; active or passive bullying; unwillingness or fearfulness to undress or wearing layers of clothing.
- **Developmental indicators of physical, psychological or sexual abuse:** Failure to thrive; failure to meet physical and psychological developmental norms; withdrawal; stuttering; unwillingness to partake in group activities; clumsiness; lack of coordination or orientation or observable thriving of children away from their home environment.
- **Indicators of deliberate neglect:** Underweight; reddish scanty hair; sores around the mouth; slight water retention on the palm or in the legs; extended or slightly hardened abdomen; thin and dry skin; dark pigmentation of skin, especially on extremities; abnormally thin muscles; developmental delay; lack of fatty tissue; disorientation; intellectual disability; irritability; lethargy, withdrawal, bedsores and contractures.
- A disclosure of abuse or deliberate neglect by the child.
- A statement relating to a pattern or history of abuse or deliberate neglect from a witness relating to the abuse of the child.

Because of the high level of demand for protection and prevention services it often takes a long time before a child receives the assistance they require. For this reason Life Choices employs its own social worker to deal with emergency cases. We agree with Mahery, Jamieson and Scott (2011) that "it is a good idea for child and youth care centres to employ their own social workers or to network with the nearest office of Social Development and local non-governmental organisations that provide child protection, prevention and early intervention services."

3.1.7. WHAT OTHER LAWS DO ORGANISATIONS NEED TO KEEP IN MIND IN TERMS OF EMPLOYEE SUITABILITY?

It is very important that organisations who work with children employ people who are considered to be "fit and proper" for this field. This means that all staff need to be screened including volunteers and even employees who do not have regular contact with youth (such as administrators, cleaners, etc.). The law does not outline what they consider "fit and proper" to be, but they do define who is *not* considered to be suitable. This person would be someone whose name appears on Part B of the National Child Protection Register (NCPR) and thus is someone who has been found guilty of e.g. sexual abuse, exploitation, etc. Keep in mind however that even if an employee's name is not on the list, it still does not indicate that the person is "fit and proper". Thus, employees need to be screened thoroughly and monitored rigorously.

NOTE

The Law can often be a maize of conflicting arguments rather than hard and fast rules. As with any constitution, there are always contradicting laws which might confront health care providers (such as NPO's and their counsellors) with a moral and ethical dilemma. For instance, the fact that HIV counselling should, by law, be a confidential process, yet the counsellor is also obligated, by law, to report abuse or neglect (even if the child does not wish this information to become known) is a stark contradiction. We thus believe that each organisation (depending on their values, beliefs and ethos) must decide for themselves how they will deal with such conflicting dilemmas. In effect, different organisations will deem different laws more important.

For Life Choices, breaking confidentiality is a serious matter when it goes against the wishes of our clients. We treat each client (irrespective of age) as someone who has the right to decide how they want a counsellor or organisation to deal with his/her situation. The client must always be in control – whether they are 16 or 45. When a child needs extra support, we will always encourage them to talk to the social worker so that the matter can be taken further, report the incident, and put support systems in place. However, even though we would ask the client if our social worker could contact them, we eventually take our queues from the client and respect their wishes. We believe the key to effective counselling is a trusting relationship. And without confidentiality there can be no trust. We completely understand that other organisation might take a different approach and we respect these views. However, we believe that if we keep the trust of our client and make sure the counsellor keeps in contact, doing properly follows up, and giving proper support, the clients will eventually make the right decision to seek the help they need.

3.2. Ethical Code of Conduct

As stated before, adhering to the law only means that a practitioner/youth worker is fulfilling the minimum expected requirements and this does not imply that the services offered are good or even excellent. Rather than merely being adequate, managers, protocol developers and counsellors should always decide what the best possible practice is in any given situation and procedure. Below we present a few useful ethical principles presented in the Youth Work Code of Ethics (The Youth Coalition of the ACT, 2007) which was originally compiled by the members of the Western Australian youth sector in consultation with Dr Howard Sercombe. This document is readily available on the web (see reference list for details). We have reproduced some of these principles here because we think these ethical guidelines are parallel to Life Choices own way of thinking and can guide youth workers/counsellors in the pursuit of excellence. Some comments and examples were added to suit the field of HCT.

3.2.1. THE YOUNG PERSON IS THE PRIMARY CLIENT

The primary client of the youth work practitioner is the young person with whom they engage.

COMMENTARY

Youth work practitioners answer to a range of people: funding bodies, peers, management committees, parents, communities. This clause, which we believe is at the core of the youth work relationship, keeps us mindful of who we are there for (youth). Many people working in the field do not recognise the young person as their primary client, but see them as one of many stakeholders. That's okay: it just means they are not youth work practitioners per se. However, young people need to know that there is at least one player in the game that they can rely on to uphold their interests.

CASE EXAMPLE

Will is a HIV counsellor who does a lot of HIV testing in schools with learners. Today Will has Amy as one of his clients. Amy is very disruptive in class, bunks school, never does her homework, and spends a lot of time smoking and drinking with friends. One of Amy's teachers approaches Will at school and notices that Amy is one of Will's clients. The teacher sees Will's presence as an opportunity to pressure Amy to change her ways, and to 'sort herself out'. The teacher attempts to influence Will to assist her in communicating this message to Amy. Will is clear that Amy is his primary client and that whilst school progress is important for both Amy and her teacher, the teacher's interests come secondary to Amy's. With Amy's consent, the two of them instead use this as an opportunity to express Amy's difficulties in her home and school environment.

3.2.2. THE ECOLOGY OF THE YOUNG PERSON AS AN INTERVENTION SIGHT

Youth work practitioners recognise the impact of ecological and structural forces on young people. Our work is not limited to facilitating change within the individual young person, but extends to the social context in which the young person lives.

COMMENTARY

Youth work practitioners are agents of change in a variety of contexts, both with individual young people, but also with the societal systems that can cause the problems in the first instance. As youth work practitioners we need to be very clear that it is of no use dealing with a young person in isolation. Young people (like all of us) are shaped, influenced, contained and to some extent controlled by the contexts in which they live. Young people are part of communities and broader social contexts. This cannot be denied in our approach to working with young people. It would be short sighted to think that they can be dealt with

in isolation, ignoring the complex myriad of influences all around them.

CASE EXAMPLE

Buntu is a HIV counsellor in a school in Gugulethu. He realises that many children in the school has an attitude that sex is "cool" and drinking gives one social status. The school and surrounding community does nothing to address this issue. The teachers only focus on conducting school lessons and parents do not see social change in the community as their responsibility. Buntu decides that it is time to change teachers and parents attitude. He organises a large meeting, calling together parents, community leaders, teachers, and school leaders. Together, they figure out a plan of action to uplift the community. Each term they hold a big fair, where people in the community can come and sell food and crafts. It draws big crowds. However, the theme is always on health and HIV prevention. Learners put on plays and dances and hand out fliers that promote healthy living. Thus, even though Buntu is a counsellor, he recognises that mass awareness is important and getting the entire community involved is important to facilitate social change.

3.2.3. EQUITY IN ALL YOUTH RELATED ENDEAVOURS

The youth work practitioner's conduct will be non-discriminatory.

COMMENTARY

All young people; regardless of race, gender, religion, disability or sexual orientation, under Human Rights and Equal Opportunity legislation have the right to be treated in a fair and appropriate manner. This impacts directly on the youth work practitioner's approach to young people. Regardless of the youth work practitioner's personal beliefs, a young person has the right to be treated fairly and related to on the basis of their need. If the youth work practitioner is unable to detach his/her personal beliefs from the situation, he/she has the responsibility to ensure the young person is referred to a colleague that is able to deal with their needs in a non-discriminatory and sensitive manner. The focus here is responding to the young person's needs in the best possible way.

3.2.4. PROMOTING THE EMPOWERMENT OF THE CLIENT

The youth work practitioner seeks to enhance the power of the young person by making power relations open and clear; by holding power-holders accountable; and by supporting the young person in the pursuit of their legitimate claims. Youth work practitioners presume that young people are competent in assessing and acting on their interests.

COMMENTARY

The term 'empowerment' has become a bit of a buzzword, and as a result its meaning is sometimes not clear. This principle tries to clarify what empowerment might mean in ethical terms, and what it means for us as youth work practitioners. It focuses our accountability; to being accountable to young people. In this context, 'empowerment' also refers to young people's ethical and responsible action. In the last sentence, the word "presume" is important; we presume that young people are competent in assessing and acting on their own interests. It may be that an individual young person is not a good judge of their interests. They may be experiencing a range of factors that can impact on their judgement. We may find out about these sorts of things as we assess the situation, but the presumption at the outset is that young people know what they are doing. It is about the assumption we go into a situation with; we need to assess the assumptions we hold about young people's competency in assessing and acting on their own needs.

CASE EXAMPLE

Ling (16) approaches a HIV counselling and testing sight for an HIV test. Harry, her counsellor makes sure that he treats her with respect, as someone who is competent enough to understand herself, her own needs and desires, her own triggers and habits and her ecology. Thus, he sees her as someone who is competent enough to come to her own conclusions and make her own decisions. Thus, Harry is clear on his ethical commitment to empowering young people; he offers to assist with giving Ling information and refer her to the services she might need but believes Ling is capable of choosing the course of action. Harry explains HIV prevention methods clearly and encourages Ling by emphasising her ability to choose the best method to be used in her life. Harry encourages Ling to do as much as she can to ensure her future success and healthy development.

3.2.5. TRANSPARENCY IN ACTIVITIES

The contract established with the young person, and the resulting relationship, will be open and truthful. The interests of other stakeholders will not be hidden from them.

COMMENTARY

We don't deceive young people, either by saying things that are untrue or by not saying things. This means that in initial meetings the youth work practitioners must be clear about what they can and can't offer. This applies to various areas of practice, agency policy and law. Whilst being open and truthful, workers should be mindful of issues of confidentiality, disclosure, health and safety, who the worker works for and what the agency is funded or contracted to provide. We also have a role in explaining to young people, the nature of other stakeholders' relationships to them and the expectations this may place upon them.

3.2.6. CONFIDENTIALITY OF INFORMATION

Information provided by young people will not be used against them, nor will it be shared with others who may use it against them. Young people should be made aware of the contextual limits to confidentiality, and their permission sought for disclosure. Until this happens, the presumption of confidentiality must apply.

COMMENTARY

Even where we think it might achieve good outcomes, we don't give names or other details to police, schools, other services or anyone else unless young people have been made aware of why there may be a need to give private information to others and their permission has been given. In accordance with National Privacy Principles we presume that young people expect us to keep their information confidential, even if that is about where they were and whom they were with.

3.2.7. ESTABLISHING A MULTI-SECTORIAL NETWORK AND PROMOTING INTERDISCIPLINARY COOPERATION

Youth work practitioners will seek to cooperate with others in order to secure the best possible outcomes for young people.

COMMENTARY

Ethical youth work practice involves a commitment to co-operative partnerships with relevant service providers in order to collectively achieve positive outcomes in the best interests of young people. Interagency collaborative approaches enables a young person a greater range of choices in terms of support networks and access to a range of choices in terms of support networks and access to a range of information, skills and resources to meet all their needs. It also enables the youth work practitioners to expand their networks to current information and available resources. Working in deliberate isolation increases the risk of dependency-based relationships and denies young people the right to choice as an equitable share of available resources.

CASE EXAMPLE

Lungi is a counsellor working with youth in a HIV prevention program. She is approached by a police officer on the street; he is looking for an opportunity to start a youth soccer competition on weekends to raise money and awareness for youth issues. She pursues the opportunity to get involved. Her priority is the young people's needs and young people in the area are quite clear that boredom is a big problem for them.

3.2.8. ENSURING COMPETENCE AND CONTINUOUSLY STRIVING TO INCREASE KNOWLEDGE

Youth work practitioners have a responsibility to keep up to date with the information, resources, knowledge and practices needed to meet their obligations to young people. Counsellors must be trained and experienced in dealing with various situations that may arise within the HIV counselling session. They are conscious of the special skills required and aware of their professional limitations. A counsellor will not attempt to diagnose, prescribe for, treat or advise on problems outside the recognised boundaries of that counsellor's competence. While offering support, the counsellor is cautious in prognosis and realistic in the counselling contract he or she makes with the client.

COMMENTARY

Maintaining a level of competence through an on-going commitment to being informed and skilled in relation to 'best practice' in youth work is essential. This is a standard requirement of most professions. When counsellors are officially registered with the Health Professions Counsel of South Africa they are required to attend a certain number of training workshops per year, yet it is ironic that unregistered individuals working in the field are not obliged to uphold this standard. Thus, there are no laws in South Africa enforcing the regular skills training of lay-counsellors and there is no government entity or body who monitors the competency levels of lay counsellors. However, lay counsellors and managers can take it upon themselves to adhere to these standards. One cost effective way of doing so is ensuring that staff regularly attend free CPD courses to further their personal and professional development.

CASE EXAMPLE

Peter, the manager of a HCT service ensures that his staff practices their counselling skills on each other at least one day a week to keep them accountable. When he goes out into the field, he sometimes asks clients if he can sit in the counselling session so that he can observe, monitor and evaluate the counsellor while he/she is dealing with a real case. Also, he arranges to have doctors, nurses and psychologists presenting regular workshops and lectures to staff. He knows that many of the staff do not have the financial means to enrol themselves in educational programmes so whenever the budget allows for it he does staff training.

3.2.9. BEING SELF-AWARE AND RESPECTING DIFFERENCE

Youth work practitioners are conscious of their own values and interests, and approach difference in those with whom they work with, with respect.

COMMENTARY

This means that youth work practitioners will take into account the diversity of values and interests that young people may present with, and recognise their own may be different in comparison. Respect and dignity are crucial to being able to accept these differences between self and the young person, whilst also recognising that universally accepted concepts of human rights cannot be compromised in doing so.

3.2.10. MAINTAINING PROFESSIONAL BOUNDARIES WITH CLIENTS

The youth work practitioner relationship is a professional relationship, intentionally limited to protect the young person. Youth work practitioners will maintain the integrity of these limits, especially with respect to sexuality. Youth work practitioners will not cross professional boundaries with the client.

COMMENTARY

This means that youth work practitioners will recognise that the relationship between themselves and a young person is a contracted relationship and therefore recognises the need to be non-sexual and limited. This ensures the relationship and subsequent service or intervention is not compromised, a consideration that is particularly important in work with young people who have less access to knowledge, resources, and skills than we do.

CASE EXAMPLE

Kenny is a HCT counsellor in a rural area. He meets Bongi during an HCT campaign where she has come for an HIV test. Kenny has also seen Bongi at the local pub a few times. During the session Kenny becomes aware that Bongi is attracted to him; her suggestive comments make it clear she wants more from the relationship. Kenny responds by reinforcing the limits of his role and makes it clear that their relationship is based on his role as a youth counsellor. He ensures that throughout the session he keeps his tone, facial expressions and body language very professional. When he feels she is not respecting the boundaries of their professional relationship he has tried to enforce, he immediately stops the session, explains to Bongi what his reasons are, and gets a female counsellor to help Bongi with her HIV test. When he sees her again in the community he greets her with respect and professionalism but does not entertain any other suggestions that Bongi might make.

3.2.11. INSISTING ON AND PROMOTING COUNSELLOR SELF –CARE

Ethical youth work practice is consistent with preserving the health of youth work practitioners.

COMMENTARY

This means that youth work practitioners and the managers of youth work practitioners need to prioritise the practice of self-care; of looking after the self as a means to assure longevity of career and continued high quality service provision to young people. The level of benefits to the worker from adequate self-care practice will be congruent with the level of benefits to the young people we work with.

3.2.12. INTEGRITY

Youth work practitioners are loyal to the practice of youth work, not bringing it into disrepute. Youth work practitioners will respect the strengths and diversity of roles other than youth work.

COMMENTARY

For youth work practitioners, this means that they are self-aware of their own role and the expectations that this places upon them from themselves, other stakeholders, and from young people. Whilst undertaking a role that may be different from others, youth work practitioners will value and respect difference in others approaches. Through continuing to portray youth work in a professional manner, youth work practitioners will be mindful to not act in a way that can bring their role into disrepute.

CASE EXAMPLE

Mary, a youth worker, is approached by a young person named Simon, with his concern over the lack of follow-up from his government agency caseworker. Mary has had run-ins with workers from this agency before and feels they don't care about young people very much. Mary feels like saying to the young person that she agrees with him. But she also realises that there are two sides to each story, and she needs to put aside her assumptions for the time being. She supports Simon to make contact with the caseworker to clarify his follow-up plan. Then, later, she has a personal chat with the worker to raise her concerns. She finds out the agency is struggling with high caseloads and a lack of resources but the worker is committed to her work with young people. Through showing integrity in her approach, Mary was able to meet Simon's needs and resolve her concerns in a way that left a positive impression upon the other worker, thus opening doors for further communications, and better outcomes for young people.

3.2.13. NEVER PROMOTING PERSONAL INTERESTS

The youth work practitioner will not use his or her counselling relationship to promote personal, religious, political or business loyalties or interests. The only interests that should be promoted are that of the child.

3.2.14. THE REGULAR SEEKING OF SUPERVISION

The youth work practitioner will actively seek regular suitable supervision for his or her counselling and will use such supervision to develop his or her counselling skills.

3.3. Ethical Dilemma Exercise

You can use these following dilemmas to debate about ethical issues and further establish counsellors' competencies in terms of the law. Each dilemma is relatively loaded and they all have many layers to debate about. Most of these are adapted versions of actual cases counsellors had to deal with. Remember that different organisations will have different policies on how to deal with such situations.

The guide here is to first assess:

1. What is the ethical dilemma?
2. Who are the various stakeholders involved?
3. What are the various actions that can be taken?
4. What are the potential outcomes of each plan of action?
5. Which of these outcomes are in the best interest of the child?
6. Which of these actions respects the rights of the child?
7. Who will be negatively affected by this decision and what can one do to minimise the impact?

ETHICAL DILEMMA 1

You have a 14 year old client who tells you in the counselling session that he is using tik and he is addicted. The child's parents do not know of the addiction. After chatting to your client you feel that if he tells his parents they will be able to support him but he refuses to tell them. Should you as counsellor report the incident? If yes, to whom would you report it? If not, why not? The two laws that might seem to be in conflict here are the law insisting on the child's right to "confidentiality" and the law that requires intervention when the child is "in need of care and protection". Do you think these laws are really in conflict with each other here? Why or why not? What would be the best way to proceed in this situation?

ETHICAL DILEMMA 2

You are faced with parents who do not want their son to do an HIV test because they know he was born with the HI virus but kept it a secret from him. They truly feel that this was in the best interest of their child because he could live a normal life without stressing about health issues. They want to continue this way for a while longer. However, the child is older than 12 and really wants to test because all of his friends are getting a HIV test. He thinks it is an important thing for a young man to do but he is not scared about the procedure at all because he has never slept with anyone and *knows* he doesn't have the virus. His parents have contacted you to ask you to refuse your services to their child or at least lie about the results. What should you do? What would be in the best interest of the child? What rights does the child have here? Who would you say is your primary client in this situation – the child or the family?

ETHICAL DILEMMA 3

You have a young girl who says that she really wants to have an HIV test because she was raped 3 months ago. However, during the pre-counselling session she states that if she finds out she has the HI virus she will commit suicide. The girl does not want you to tell anyone else about the rape or her suicidal thoughts and insist on her right to confidentiality. You are scared that if she does the test she might be HIV positive and do harm to herself but you do know that the law states that a child has the "right to participate". Can/ should you refuse to test her? How do you deal with this situation because you really feel you are out of your depth?

ETHICAL DILEMMA 4

A 15 year old female client is sleeping with her 21 year old boyfriend. She says that she consents to having sex with him. You learn throughout the session that he insists they have sex without condoms but she allows it – after all he is her boyfriend. Based on how she describes her boyfriend's past sexual relationships he seems untrustworthy. You have a feeling that this guy is bad news. However, your client is madly in love with him and will do anything to be with him. You cannot convince her that she might be putting herself at risk. You think: she is younger than the age of consent and he is already by law an adult. Thus, you are wondering if this might be considered as statutory rape because he is having sex with a minor. After all, it *does* put her health at risk and she is too young to know what she is doing. Should you report this? What factors are you going to consider if you form your report and come to a conclusion? What is in the best interest of the child? What factors will you look at when deciding what is in the best interest of this client?

ETHICAL DILEMMA 5

Your client is 16 years old and just discovered that she is HIV positive. She is very distressed and you are concerned about her mental and physical health. You know that she really needs the support of her mother and father or another adult that can advise, guide and support her. However, she refuses to tell anyone and wants to keep it to herself. She feels ashamed and feels that her parents will be angry and disappointed if she tells them. A week goes by and even though you keep on encouraging her to tell someone, she still refuses. You ask her if you can help her talk to someone and act as mediator or even go with her to her parents to explain the situation but she is still reluctant. What do you do?

ETHICAL DILEMMA 6

Your client is a 17 year old HIV positive boy. He has adequate support from family in his life however; he does not want to tell his girlfriend he has the HI virus and is scared that if he starts using condoms she will become suspicious because he has cheated on her before. You fear that he will either infect her or they will reinfect each other. She is 16 and you know that she has the *right to* have access to information concerning her health status. If she has adequate health information she can make informed decisions about prevention and treatment. Should you tell her about her boyfriend's HIV status so that she will insist on condoms and get an HIV test? It is in her best interest but it might not be in his. What can be done?


YANGA
ZINZI

CHAPTER 4
CREATING A YOUTH FRIENDLY HCT ENVIRONMENT

This Chapter focuses on the key elements to establish a youth friendly service. Based on research and assessments, Life Choices has identified a set of key characteristics associated with youth-friendly services. These elements differ in importance to effective service delivery and vary according to various characteristics of the primary target audience (age, sex, sexual experience, residence, school status, culture). However, when working with young people there are some commonalities. It is imperative to create environments in which they feel: welcome; understood; safe and at ease.

The following are some characteristics that appear to be universally critical to youth friendly services:

- **Staff trained in youth-friendly services:** Providers who are trained to work competently and sensitively with young people are often considered the single most important condition for establishing youth-friendly services. Acquired skills must include familiarity with adolescent physiology and development. At least as important are interpersonal skills so that young people can be at ease and can comfortably communicate their needs and concerns. In addition, all non-medical staff (e.g. receptionist, guard, etc.) should be oriented to the needs of young people.
- **All staff demonstrate respect and concern for young people:** Young people often report that they are afraid to go to health services because a provider had previously shouted at them or criticized them for being sexually active. Although training can help some providers develop positive attitudes in their interactions with youth, occasionally there are providers who have personal biases or values that interfere with the provision of HIV counseling and testing services to youth. Therefore, providers should be carefully selected, based on their interest and willingness to work with young people. To hire staff can be complex, usually older counsellors have the life experience and maturity to be effective within the counselling setting. However, counsellors should be young at heart in the sense that they can tap into the mind set and culture of youth and should thus be able to appropriately emphasise with young clients. They must be able to connect with young people and VERY importantly, have a PASSION for working with youth. Furthermore, it is the responsibility of the service provider to do thorough background checks on all staff and ensure they have not previously displayed any questionable, unlawful or unethical behaviour that could potentially endanger the well being of clients.
- **Privacy and confidentiality are honored:** Young people report that privacy and confidentiality are extremely important to them when making decisions about whether or not to seek HIV services. Many young people are afraid that a provider will share with a relative the reason for their visit, their HIV status or some other private information. Not only should records be kept in a confidential manner, but providers should be careful not to share personal information about a client with other people.
- **Adequate time is allocated for client and provider interaction:** Adolescents are often shy about discussing issues related to their sexuality and often need to be encouraged to speak freely. More interactive techniques with assistance of visuals are highly recommended. Service providers should assume that it will take more time for an adolescent to disclose their problems than it would for an adult and therefore allocate time appropriately. Providers should be able to respond to questions about body image and development, sex, relationships, and condom negotiation. This discussion is crucial to the compliance and retention of the adolescent client.
- **Relaxed attire:** The way the service provider dresses is another easy way to create a more relaxed environment. By doing away with stiff uniforms and putting staff in t-shirts, young people are more likely to not view counsellors as inaccessible, authoritative adults. Also, this type of dress code ensures: uniformity of staff (e.g. counsellor, receptionist, nurse); that they are easily identifiable in the field; that they are appropriately covered; and that they are also comfortable when working in tough physical conditions (mobile services – bad weather, run down settings, etc.).
- **Drop-in clients welcomed and appointments arranged rapidly:** Young people often do not plan ahead and therefore they are more likely to access services if they are able to be seen by a provider without an appointment. If an adolescent is turned away and told to return at another time, or if the adolescent must wait several weeks to be seen after making an appointment, there is a significant likelihood that the potential client will not show up. With young people, it helps to “seize the opportunity” when they show an interest in getting the services.

- **No overcrowding and short waiting times:** Having to wait a long time to be served in a clinic is often cited as a barrier by young people. Young people often are not willing to wait for services; and if the facility is crowded, they are particularly worried that someone they know will see them while they are waiting.
- **Educational material available on site:** Some young people prefer to learn about sensitive issues on their own, using written or audiovisual materials, because their discomfort level can be too great to retain information during a face-to-face session. Such material can be used while clients are waiting to be seen. Some materials should be available to take home for later review, particularly if the topics are complicated (such as symptoms of STDs).
- **Group discussions available:** While not all young people are comfortable in a discussion setting with their peers, this type of information exchange can be very productive. It helps adolescents to realize that they are not unique in their fears and can provide peer support to obtain needed care or seek solutions to problems.
- **Separate space or special times set aside for young clients:** Creating separate space, special times, or both for adolescent clients appears more important for certain clients, such as younger adolescents, first-time site users, non-sexually active clients, and marginalized young people, who are especially suspicious of mainstream health care services. Separate times can also allow providers to capitalize on non-peak hours so that they can allocate more time for young people and help increase privacy.
- **Convenient hours for young people:** To increase access to HIV counseling and testing services, sites must be open at times that are convenient for young people to attend. Such times include late afternoons (after school or work), evenings, and weekends. While young people who need urgent care may be willing to leave school or work for such services, those who need preventive services, but who may be unaware of their importance, are often reluctant to take time off.
- **Convenient location:** Although some young people prefer to go outside their immediate community for HIV services to avoid being seen, most young people cannot afford to travel long distances to access services. Therefore sites should be easily accessible by foot.

LIFE CHOICES HCT MODEL – CONVENIENCE AND LOCATION

By having mobile clinics and tents, Life Choices **takes the services to where young people** are rather than waiting for them to find us. We also provide services in schools so that adolescents access the service easily. When offering this type of service in school, we have found the following strategies invaluable:

1. It is important to liaise with school staff on a regular basis and have a good working relationship with the teachers, principal and deputy principals. We found that there is usually one member of staff in each school that is very motivated to promote the services. It is important to have regular contact with this person. It is usually beneficial when this person is a deputy principal, principal or HOD (Head of Department) and thus has some level of authority and implementation power within the school.

2. The SGB (School Governing Body) must be fully informed of the programme and supportive of the initiative. Make sure you can easily ensure the SGB that the counselling process and HIV results will remain completely confidential. Also, which methods of follow-up will be in place? How will learners be supported if they have a positive result? How will learners be supported if they have other social and familial issues? It is imperative that you have a detailed plan in place of how you will implement these promises. Beside the lay-counsellor, Life Choices has youth facilitators and a social worker working in each school we offer HCT to. We inform our clients that they can make use of any team member if they need to at any time. All team is trained to keep information confidential. Lastly, in schools clients displaying any kind of risk (e.g. sexual risk behaviour, use of substance, abuse, TB symptoms, STI's symptoms, HIV positive diagnose) will be invited to follow-up sessions and referrered to relevant external services. The counsellor will continue this practice until she/he is sure the client has an adequate support system in place that can carry them from here on out.

3. Different models to offer HCT in schools:

- **HCT as part of a school health promotion strategy (best practice in Life Choices experience):** In this model HCT is one component of a combination of other health services (e.g. psychosocial support, school nurse, small group reproductive health/life skills discussions). All services are provided on a regular basis (e.g. once a week) and they are fully integrated with the school systems and calendar (no disruption). The school community is aware of the services available on a regular basis and when clients wish to be seen they book for an appointment.
- **HCT campaigns in schools (once off nature or visiting schools on a periodical basis):** It is important that young people in schools are fully informed about the HCT campaign in advance. Send out letters to inform parents. Though law does not require it, it is important to inform parents because parents prefer to be fully updated about school activities. You certainly do not want to alienate parents. To get kids excited about coming for HCT, you can try to implement fun and energetic awareness campaigns during an assembly (a week prior or on the day of the counselling and testing service). Make sure that this awareness campaign is COOL and really engages the crowd with music and dancing rather than just

conveying facts. After awareness campaign, in case learners wish to make use of the service they should write their name and class in the registration form. On the day of the HCT campaign you should have an outreach coordinator who manages the client intake (based on the registration form) carefully in order to not disturb school activities. Here the coordinator will collect a certain number of volunteer clients based on the amount of counsellors you have available on that day (usually one client per counsellor at a time). As soon as a client is ready, client goes back to class immediately. This is to ensure that you do not have large masses of learners waiting in the waiting area. It is important that you have a regular, steady flow of clients but that the school environment is not disrupted. Remember to also make sure that it is completely voluntary and that no child feels forced by counsellors, peers or teachers.

Independent of which model you use it is imperative to have a good referral guide and well establish relationships with diverse groups of service providers. When making **referrals** at the end of a counselling session, it is important to not just give the client a list of organisations, clinics, etc. and a contact number. The referral should be tailored to the specific need of the client. Also, to give a child a name and telephone number of an organisation might be daunting as it is merely a nameless entity. Get the details of a specific, youth friendly contact person working in that entity to whom you can refer a client to. Thus, it is not merely, Gugulethu clinic, but nurse "so-and-so" at Gugulethu Clinic. Be realistic when it comes to referrals in that you see where the client lives and thus refer them to someone in the area. Really put an effort into your referral guide.

Life Choices has a very large file with various types of organisations grouped together in terms of area/community as well as expertise. E.g. service providers for sexual abuse in Athlone area; service providers for substance abuse in Manenberg area, health clinics in Philippi, extra-mural activities in Nyanga area, etc. Know your referral locations and service times. Know what their attitude is towards youth, the quality of their services, and know what capacity they have. Are they understaffed and overworked? Can they truly help your client? Also, we give referral letters to clients. The letter contains the following information: our organisations' contact information, the general reason why the client was referred, and the telephone number, address and contact person of the organisation to which the client was referred. The client can then take the letter with them. As part of Life Choices' protocol we refer all clients, whether the youth has a crisis or not. We believe that any youth should know which resources are available to them. Perhaps we refer youth to gain further experience, knowledge, support, join an extra mural activity, etc. In this way, we hope to ensure that all our clients become part of a system/network of care.

We spoke about the referral procedures when working inside the school system but we feel it must just be stressed that the same applies when working outside the school system. This is especially important if one has a mobile clinic. Youth will not be able to come back in a week's time and find their counsellor if they need extra advice and care. Thus, referral procedures must be readily available to connect youth to local service providers/structures.

TIP

In case you already have an established service but you would like to make it more youth friendly, you could start by conducting a simple assessment with your team and clients. Assessments could have the format of short questionnaires, interviews or group discussions. If done correctly, they would be able to give you some clues of where improvements should be made.

The following are some factors to consider in the assessment:

1. Service/facility location;
2. Service/facility operating hours;
3. Facility environment and layout;
4. Staff youth friendliness;
5. Staff competency, knowledge, skills and trainings in relation to youth matters;
6. Client volume and range of services provided;
7. Youth involvement;
8. Education materials and activities;
9. Policies and administration procedures that influence youth's access to services;
10. Publicity and client recruitment;
11. Referral guide to other youth services.

To establish benchmarks of existing levels of youth friendliness is essential as a starting point. When changes start to be implemented make sure that you continue conducting assessments with your team and your clients. You want to identify opportunities and areas for improvement as you go along.

CHAPTER 5
THE DEVELOPMENT OF AN EFFECTIVE HCT PROTOCOL

This Chapter focuses on the development of an HCT protocol for youth. First we look at relevant health theory within the health psychology field. It is essential that any HCT protocol be based on comprehensive theoretical models that focus on health behaviour modification. The two theories presented here, are the Health Belief Model and the Transtheoretical Model of Behaviour Change (Stages of Change Model) because both theories were used in developing Life Choices HCT protocol. Further in this chapter, the discussion looks at the Life Choices HCT protocol and discusses how we have conceptualised and synthesised the relevant theories and literature into a workable, practical, and effective protocol. We hope the example showed assists you to conceptualise your own theory-based model.

5.1. What works to Modify Behaviours to Prevent HIV

Based on extensive literature review, the following are key elements to make interventions effective:

- Theory-based interventions;
- Utilizing formative research (occurs before intervention implementation and guides intervention design);
- Attention to cultural issues;
- Attention to length/intensity of intervention;
- Interventions that are interactive and participatory in nature.

5.2. Theory-based Models

It is clear from the discussion above that adolescence is a window of vulnerability for several reasons. Counselors should keep this information in the back of their minds so that they can easily recognise barriers in their clients' lives. However, once one recognises these risks one also needs an effective strategy, underpinned by theory, to help reduce vulnerability.

When developing your own counselling protocol, you should start by researching behaviour theories. These theories are nothing else than the observations of the human behaviour by someone like you. The only difference is that the 'theorist' (normally a psychologist, sociologist, anthropologist, etc) developed a 'line of thinking' through different tests and researches that is able to describe, explain, predict and even influence human behaviour in such way that his/her theory is able to be replicated in a variety of settings.

The following are some of the most used formal theories in the HIV prevention field:

- Health Belief Model;
- Social Cognitive Theory (Social Learning Theory);
- Theory of Reasoned Action (Planned Behaviour);
- Transtheoretical Model (Stages of Change);
- Empowering Theory;
- Diffusion of Innovation;
- Theory of Gender and Power;
- Ecological Systems Theory.

Before reading any of the theories, we would recommend you to create your own theory by answering the two following questions:

1. People change behaviour because

_____

_____

_____

2. In order to maintain behaviour change, a person needs

_____

_____

_____

Use your life long observations of human behaviour (e.g. close relatives, friends, clients, your own behaviour) to answer these questions. Now you can do some research in different theories. When choosing a theory/theories to underpin your HCT protocol, try to choose a theory that relates to your own observations and experiences. This will assist you in the development and mastering of the protocol.

Next, we will be exploring the two theories used in the Life Choices HCT protocol.

5.2.1. THE HEALTH BELIEF MODEL

Within the Health Psychology field the Health Belief Model (HBM) is one of the most widely used and influential psychological models (Hochbaum and Rosenstock both cited in Taylor, 2006). Developed in the 1950's, it attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals. The model's basic premise is that whether a person engages in certain health behaviour it can be understood by two factors:

WHETHER A PERSON PERCEIVES A PARTICULAR HEALTH THREAT (TAYLOR, 2006).

This is further influenced by:

- *The individuals general health values (Taylor, 2006).* (Is the person interested and/or concerned about his/her health? E.g. "I care about being a healthy person.")
- *Specific beliefs about personal vulnerability to a particular disorder (Taylor, 2006).* (Do they feel that there is a chance they will contract a particular illness/ virus/disease/syndrome? E.g. "I am sexual active, I could get an STI.")
- *Beliefs about the consequences of the disorder (Taylor, 2006).* (Do they believe the consequences are severe or mild and how will it impact on their life? E.g. "If I get HIV I might face social stigma, financial strain, familial disappointment, difficulty finding a life partner, sever secondary health complications, and even premature death. Thus, it will impact on my life very negatively!")

WHETHER A PERSON BELIEVES THAT A PARTICULAR HEALTH PRACTICE WILL BE EFFECTIVE IN REDUCING THAT THREAT (TAYLOR, 2006).

This has two subcomponents:

- *Whether the individual thinks a health practice will be effective in reducing the risk (Taylor, 2006).* (E.g. If I abstain from sex I will definitely decrease my chances of getting an STI.)
- *Whether the benefits of undertaking that health measure exceeds the costs incurred (Taylor, 2006).* (Will the effort be worth it because of the health benefit or will the person loose too much? E.g. I know abstaining will reduce my risk and I know I am vulnerable to contracting an STI however, if I abstain my boyfriend might leave me and that risk is too much for me so I do not think abstaining will be worth it for me.)

In light of this model, the purpose of the counseling session would be to assess the attitudes and beliefs of the client and then try to modify those views that might have a negative impact on the client's health habits. However, one important aspect the counselor needs to keep in mind is SELF-EFFICACY (Taylor, 2006). The HBM does not focus on self-efficacy even though the literature recognises it as a major factor in health behaviour modification (Taylor, 2006). The client may think their health is extremely important, perceive themselves as vulnerable to contracting HIV, believe that the consequences of HIV infection is severe, believe that abstinence will be effective, and believe that the benefits of abstinence outweighs the losses incurred; however, **if they do not believe they can change,** they are not likely to do so (Taylor, 2006).

5.2.2. TRANSTHEORETICAL MODEL OF BEHAVIOUR CHANGE (STAGES OF CHANGE)

The Transtheoretical Model of Behaviour Change (TMBC) was developed by Prohaska and his associates (Taylor, 2006). This model depicts the various stages a person goes through when attempting to change a health behaviour. This model is important to incorporate into one's protocol because clients are at different stages on their journey to good health. Thus, you would not treat a client who has just heard of HIV for the first time (and who has no knowledge of the virus or his own personal risk) similarly to a client who has worked in the HIV field for many years and who is already practicing safer sex to minimise his risk. This model can thus help a counsellor tailor the message so that the message is relevant. TMBC stages are as follows:

PRECONTEMPLATION

The person has no intention of changing the unhealthy behaviour. He/she might not even be aware of the problem and is oblivious to the potential consequences the unhealthy behaviour is/can incur (Taylor, 2006).

CONTEMPLATION

The person is aware there is a problem. He/she is thinking about changing but has not yet made a commitment. A person can remain in this stage for years. Often the client experiences some ambivalence about change, weighing up the pro's and con's. He/she continues to find the positive aspects of the behaviour enjoyable even though there is an awareness of the negative consequences. To move onto the next stage, self-efficacy is important and the person needs to believe he/she has the ability to change (Taylor, 2006).

PREPARATION

The individual intends to change the behaviour but has not yet done so. Delay to take action can occur because the person has failed in the past and is "psyching" him/herself up. Or the client may be waiting for a stressful period to pass. It might also be that there are already slight changes such as the teenager who has already started smoking and drinking less before he attempts to quit completely (Taylor, 2006).

ACTION

During this stage, the individual finally modifies their behaviour by decreasing or stopping their previous problematic activities and adding healthier actions to their repertoire. The stage of action requires commitment, time and energy without which real behaviour change cannot occur. Besides changing the particular behaviour, this stage also requires lifestyle modifications if the individual wishes to be successful. This means that the individual should alter their environment to ensure there are no problematic cues associated with the unhealthy behaviour that could trigger a relapse (Taylor, 2006).

MAINTENANCE

In maintenance the key tasks is to maintain ones behaviour so that it corresponds with ones long-term health goals. Here the individual should consolidate the gains already made by the lifestyle change and aim to prevent relapse. Typically, if the individual has maintained change for more than six months they are considered to be in this stage.

RELAPSE

Within this model, relapse is considered to be the rule rather than the exception. Thus, the model has been structured as a spiral. While attempting to be healthier people, many individuals reach the action and maintenance phases, only to relapse and having to start over in the precontemplation phase. Thus, they cycle throught the various stages again. Many people may relapse several times until they have successfully eliminated the problematic behaviour permanently. Some theorists would even say that once a person has been addicted to a problematic behaviour they can never consider themselves completely cured and will always remain in the maintenance stage.

Based on this model we have come to the conclusion that the key task of a youth friendly HCT protocol should not be to encourage young people to abstain and never have sex. It should also not be to merely regurgitate copious amounts of HIV and AIDS information. It should also not be to merely assess if the child is emotionally ready to take an HIV test. Rather it should be to assess what stage the client is in and then to manipulate the protocol so that it addresses the current needs of the client. Overall you want to increase the client's **SELF AWARENESS and encourage them to progress to the next TMBC stage on their journey and strategise with the client about the tools they will need in order to progress.** Self-awareness is different from knowledge because it does not mean the client merely acquires general, factual information but that there is a level of *understanding* about information *pertaining to his/her own unique situation.* Awareness of self means: awareness of one's own situation and personhood; awareness of one's own risk at this particular stage; awareness of the causes (emotions, thoughts, family, culture, environment, peers, etc.) behind personal risk; awareness of future vulnerability; and awareness of options to decrease one's own risk at this stage. This awareness is taken further by creating an action plan with the client. This should contain the needed, concrete steps that should be taken next to progress to the next stage or maintain one's own low risk status.

For example: for someone in the pre-contemplation stage the focus of counselling would be to increase their risk awareness so that they move to the contemplation stage. Thus, the counsellor would try to assess why the client does not perceive his/her own risk. The counsellor could also focus on the benefits of change. Or perhaps the client does not believe he/she is *capable* of change. The counsellor will try to address these (or re-address these issues) so that the client recognises their own vulnerability and start to believe that they should, and are capable of, change. Steps that this person would have to take to move on to the next phase would be to gather more information on HIV/AIDS. The counsellor might refer such a client to a service provider that conducts HIV trainings and give him/her more pamphlets to read. On the other hand, someone who is in the action phase already realised they were at risk of getting infected and they have taken action and modified their behaviour. Thus, contracting the virus is not their primary risk at the moment. Their risk might be relapse because of burnout, doubts about whether it is worth it, pressure from others to quit the healthy behaviour, etc. The focus of the session would then be on maintenance and what steps need to be taken to stay on course. When a client is in the relapse stage it is important for counsellors to know how many times a client has relapsed and then help the client figure out why they tend to relapse. Also, when a client has relapsed multiple times, they might start to feel that they will never be able to change. Thus, the counsellor should know what feelings of doubt and insecurity the client has about future success. The counsellor can thus work on increasing the client's level of self-efficacy.

5.3. Life Choices HCT Protocol

Life Choices offers every client a comprehensive counselling session (pre and post). Because we work with each client as an individual case with different experiences, feelings, ideas and needs our protocol allows us to cater for the unique traits of individuals. Whilst all clients are provided with information on HIV/Aids, TB, STIs, Transmission and Prevention, a risk assessment is created for every individual client, and strategies on prevention are linked to the client and his/her needs.

Since SA legislation has changed and counsellors are allowed to conduct the HIV test themselves, we have change protocol slightly. We no longer follow the traditional pre-counselling, testing and post-counselling model. Clients are now giving their consent for testing in the beginning of the session and test is also conducted at that time. After that the model goes back to offer pre-counselling session before the test results are revelled and post-counselling session afterwards.

The Life Choices **pre-counselling protocol** (before testing results are given) was designed in accordance with the

health belief model. The central theme is that a person should choose healthy behaviours (irrespective of whether the person is HIV positive or negative) because living healthily can help any individual live a long and fulfilled life. The pre-counselling session gives the counsellor the opportunity to assess the client's risk and determine what health-compromising views they have. The counsellor then spends time with the client to either discuss the client's damaging views or spends time encouraging and strengthening the client's already healthy beliefs. The client is encouraged to decide for themselves and make the choices that they feel will best secure their future. However, in order to make healthy choices the client must also be informed about HIV facts (e.g. disease progression and transmission). The counsellor thus also needs to assess the level of HIV knowledge of the client and either fill in the necessary gaps or correct erroneous ideas. In the pre-counselling session the counsellor also determines whether the client is emotionally ready for the results of an HIV test. The counsellor spends a few brief minutes to lay the groundwork for any potential outcome. Thus, it is stressed that a positive result does not mean the client's life is over. It merely requires the client to change a few health behaviours (like going to the clinic regularly and practicing safe sex etc.) in order to live a relatively normal life.

In the **post-counselling session** the counsellor discusses the results of the HIV test. If the client is not infected with the virus the focus of the protocol will be structured around the **stages of change model.** Based on the knowledge the counsellor gained of the client in the pre-counselling session, the counsellor should be able to summarise the risk factors in the life of the client and assess in which stage the client is in each risk factor. The counsellor will then work with the client so that the client moves to the next stage in the model (e.g. pre-contemplation to contemplation stage) or so that the client maintains their current healthy stage (e.g. maintenance) and avoid relapse. Here is the opportunity to really consolidate what was decided on in the pre-counselling session but to become more specific about HOW they will go about the change. On the other hand, if the results are positive the focus of the session is on acceptance of the results and what the next step should be so that they start their journey to a healthier life (e.g. go to the clinic, find social support, accept their status (dealing with emotions), prevent others from being infected). When the client receives such news they may be too distraught to focus on behaviour change and thus the focus is more on dealing with the emotional side of things.

The following discussion tackles the Life Choices counselling protocol. It explains the different section of the protocol and their relationship with the theoretical model. It also shows the use of different tools that can aid the counselling process to be more interactive and make it more youth friendly (e.g. visual kit, play therapy techniques). Each section is divided in two columns, first column protocol structure and second column reasons behind structure. The protocol was developed having in mind clients with low HIV knowledge and proficiency. It is the job of the counsellor to adapt the counselling tone and tailor protocol according with the type of client.

5.3.1. PRE-TEST RESULTS PROTOCOL STRUCTURE

1. INTRODUCTION

Please have a seat, my name is _ _ _ _ _ _ _ _ _ _ and I will be your lay-counsellor and tester for the session. I am able to conduct the session in English and _ _ _ _ _ _ _ _ _ _, which language would you prefer the session to be conducted? *(in case counsellor can't speak a language client feels comfortable with, refer client to a colleague).*

It is important to greet the client in a friendly manner and from the first sentence start building rapport. You can be flexible in your approach as long as it works for you and puts the client at ease. It is important to acertain language before you delve to deeply into the session and then have to stop after realising the client cannot understand you.

I am bound by a confidentiality oath. I am not allowed to share your test results or any other information discuss in this session with anyone besides you. You have the right to sue me (take further steps) in the case that you feel I have broken this confidentiality agreement.

Emphasise confidentiality. This is very important for clients and for the establishment of a safe, trusting environment.

I am trained as a lay-counsellor and tester and I will start the session by conducting the HIV test and after we will have a pre-test results counselling session where we will explore HIV information and different aspects of your life style. After this session I will ask you if you are ready to receive your test results and we will have a discussion in how to develop a personal plan that will reduce the risk on your life.

*Stating right from the start that you are a **lay** counsellor immediately ensures that there are no misconceptions about your role and expertise. Remember that for some youth this will be their first time going thuth the process, explain up-front what is going to happen will assist to make the client feel at ease.*

There might be issues that arise during our conversation that I will not be able to deal with today, in that case I will ask your permission to refer you to another specialised service around your community.

Any question so far?

In terms of ethical conduct, it is crucial that the counsellor states upfront what their abilities/ lack of abilities are. Also, this is an HIV counselling session and though other concerns do arise, one needs to be realistic in terms of what the focus of counselling can and should be. One can find that some people have an overload of problems and are so excited that someone is finally there to listen.

Though we would love to assist the client, other services might provide more expertise and time to do the job properly. Non HIV related issues cannot realistically be addressed here (except in relation to how it impacts on the client's HIV risk). By emphasising that you will refer if needed, you make it easier to place well-defined boundaries around the topic later during the discussion.

2. TESTING PROCEDURE AND CONSENT FORM

The HIV test that we will conduct today is looking for the HIV antibodies (signs) and not directly for the virus. The results will tell you if you have been infected with the HIV Virus or not.

Make clients feel at ease with the testing procedure before introducing the consent form.

No test will be able to tell you in the case you are positive - when you were infected or who infected you. I will prick your finger and will draw a few drops of blood for a test like this (show a test). After 15 minutes the results will ready.

Explain that sometimes, you will ask a client to re-do the test. This is part of the protocol for quality purposes. You shouldn't worry. Do you have any questions about the testing procedure?

Finish this part of the protocol with the consent part. Ask the client to read the consent and if he/she would like to continue with the testing procedure?

It is obvious that consent is very important for legal purposes but also to ensure that the client is not pressured into anything and that they made the decision to test independently.

All clients need to sign the consent form prior the test to be conducted. Make sure clients read consent form and understand the content before signing it.

Start the discussion with an open ended question so that you can get an initial idea of the client, potential risk, thought processes, etc. You may find that some client's do not want to or even cannot tell you why exactly they decided to come. This is also fine. Give them space. They may be shy or embarrassed and rapport still needs to be built.

Prepare yourself to test the client (read chapter 7). You can ask the client while you are busy testing the following:

So, what brings you here today? *(let the client answer but do not explore the answer. Explain that later in the session you will be talking about it).*

3. HIV/AIDS BASICS

We are going to start by exploring HIV basic facts.

Can you please tell me what do you know about HIV and AIDS? Or tell me the difference between HIV and AIDS?

*The idea with this question is based on the Health Belief Model in that it is important to assess the client's **beliefs about the consequences of the disorder** and make sure that these beliefs are realistic and accurate. It is also impossible to assess the client's understanding of their own vulnerability if the counsellor does not know how much the client knows about the virus and the disease. By addressing this in the form of an initial open ended question the counsellor does two things 1) gets the client talking and 2) helps the counsellor meet the client at their level. Rather than assume the client knows nothing and merely regurgitate copious amounts of information, the counsellor can take their cue from the client and tailor messages that respond only to the clients gaps in knowledge.*

(Let the client tell you what they know. Then use the visuals to reiterate the facts, add on to what they said or correct any misundarstanding)

These HIV facts can be tailored to suit the client's needs and the counsellors style. These are the absolute basics the client needs to know for now. They are obviously not necessary to repeat if the client has already given this information accurately. Only address the gaps.

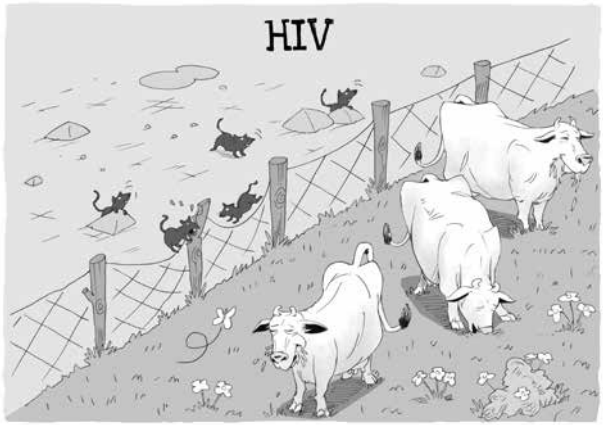
Discussing disease progression (initial HIV infection versus final AIDS stage) also helps the counsellor set up a key messages for later i.e. "Even if you have the virus it does not mean it is the end of the world. With appropriate health behaviours you can still live a long time and avoid getting AIDS too quickly."

HIV is a tiny virus that only lives in Humans. It can not live in plants, animals or any other thing. HIV does not have a cure.

HIV is transmitted from human to human. And it can infect anyone independently of their age, race, culture, economic status, etc. HIV is found in human bodily fluids. In an HIV positive person there are certain body fluids that contain high quantities of virus. Do you know which body fluids they are?

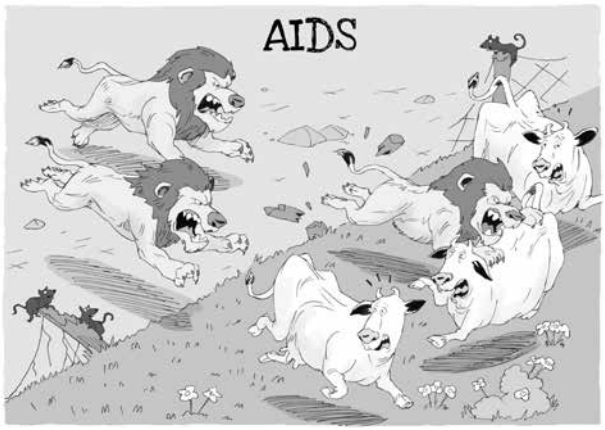
Blood, Breast milk, semen and vaginal fluids *[Point to the different bodily fluids as you explain this].* This means that any activity/action that makes two people to share these body fluids with each other is a risk activity.

Do you know what happens after HIV entered a human body? Let me explain:



Imagine that the rats in the picture represent the HI Virus, the fence represents your immune system meaning your body's defence that helps you to be strong and fit and the cows represent your body. When HIV (rats) enter the body, they attack the fence. In the beginning things carry on as normal, you can see the cows (body) are relax and fully functioning.

Over time the fence (your immune system) gets worn down.



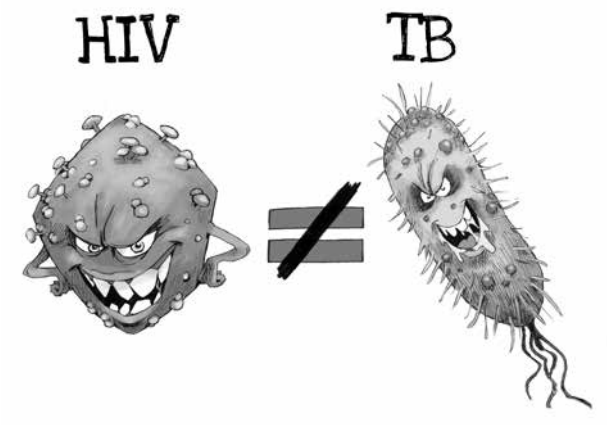
Many years later the fence (your immune system) breaks down allowing opportunistic infections (lions) to attack your body. This stage is call the AIDS stage. AIDS is the period after the HIV infection where you start getting sick once your defences are too weak and any infection can take the opportunity to enter your body. Examples of opportunistic infections are TB, pneumonia, certain types of cancer and more. Is at this stage that people can start taking ARV's (treatment) in order to live longer.

Any question so far?

4. TB

So TB is one of the infections that can use the opportunity when your defences are down to enter your body.

Action:



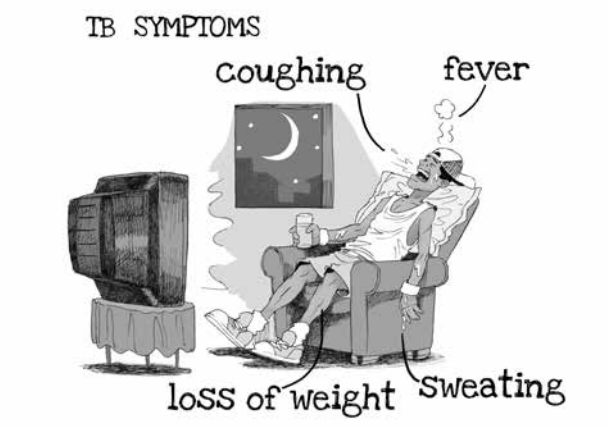
TB is not HIV, they are caused by two different germs. TB can infect anyone independently of his/her HIV status.

Can you tell me what do you know about TB? (Allow the client to answer and add information where needed).

Action:

TB is transmitted easily through air. TB can be transmitted from someone coughing, sneezing, spitting to another person.

Action:



Some of the signs of TB infection include weight loss for no apparent reason, night sweats, fatigue and coughing for long periods of time.

Action:

The good news is that TB can be cured. When people take their medication properly they can get rid of TB.

I am going to ask you a few questions in order to screen you for TB. You can just answer Yes or No to each of them [explore the yes to the answers of the client in order to make sure that it is a sign for TB... e.g. is it a winter cold... or possible TB sign/symptom?]

TB SCREENING:

1. Have you coughed for more than two weeks?
2. Have you lost weight lately without clear reason?
3. Have you had a fever for more than two weeks?
4. And night sweats?
5. Do you have someone at home that has been sick with TB?

If **all answers** were **NO:**
Action: You do not present any sign(s) for TB. In future if you show two or more of these signs you should go immediately to the clinic to check if you have TB. This is very important once TB can be transmitted by air so it is easily transmitted to people around you. TB can also kill when not treated.

If **2 or more questions** were **YES:**
Action: Because you answered two or more questions with an Yes, you might have TB. You should visit your nearest clinic as soon as possible in order to make a TB test. This is very important once TB can be transmitted by air so it is easily transmitted to people around you. TB can also kill when not treated.

I will provide you with a referral letter at the end of this session to visit your nearest clinic as soon as possible.

Do you have any questions about TB?

Based on WHO recommendations and SA government regulations, we screen for both TB and STI's. Both are linked to HIV and both are major health problems in South Africa. The questions are the standard WHO questions. We only added the introduction and conclusion so that our clients are involved in the screening process and understand why we ask these questions.

We believe it is part of primary prevention to inform people about issues that could potentially affect their well-being. We try to treat all our clients (irrespective of age, status, education, etc.) like legitimate health consumers who have the right to be informed. [STI screening occurs later during the protocol when talking about virus transmission and personal risk. Here, TB easily links with the previous section on HIV progression.]

5. HIV TRANSMISSION & PERSONAL RISK REFLECTION

Let us move on, so far we have talked about what HIV is , in which bodily fluids it is found in high quantities and how it works in our bodies. So let us proceed by talking about HIV transmission. Could you tell me how do you think HIV can be transmitted? (add to the answers of the client)

It is important to start with what the client knows and build on that knowledge. First, we ask about general ways of virus transmission, rather than immediately asking the client what their risk is. Before you can assess whether the client knows their own risk, you need to assess whether the client knows what is risky behaviour. Thus, this section relates to the HBM's premise that health behaviour is influenced by the client' specific beliefs about personal vulnerability to a particular disorder (Taylor, 2006). (Do they feel that there is a chance they will contract a particular illness/virus/disease/ syndrome? E.g. "I have unprotected sex, I could get HIV.")

HI Virus can be transmitted in three different ways:

1. **Sex**
2. **Blood-to-Blood**
3. **Mother-to-Child**

TRANSMISSION

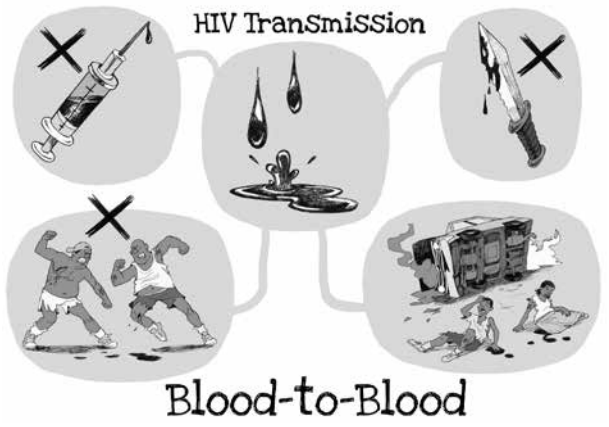
Each of the different ways are discussed separately. This illustrates the threat more clearly.

Action:

Sex: When we talk about sex, we talk about any kind of sex. There is oral sex, anal sex, vaginal sex, finger sex. Male-to-male sex, female-to-female sex, male-to-female sex. Lights on or light off. It really doesn't matter. As long as sexual fluids are shared between two people there is a risk.

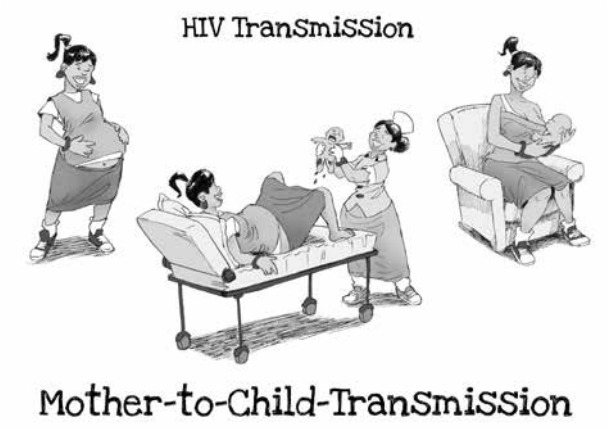
*Many people do not recognise that anal and oral sex, as well as manual stimulation also falls under "risk behaviour". This information is important to share with the client even if he/she is not **yet** sexually active. This is key information young people need in order to make informed and healthy decisions.*

Action:



Blood to Blood: Human beings can mix blood in many ways. Any time a person is exposed to blood from another person and there is an opening on the skin where infected blood can enter into the body of an uninfected person, there is risk. This can be in the form of a cut, a wound, a open sore, a perforation in your skin. Blood can also be mixed during a fight or an accident.

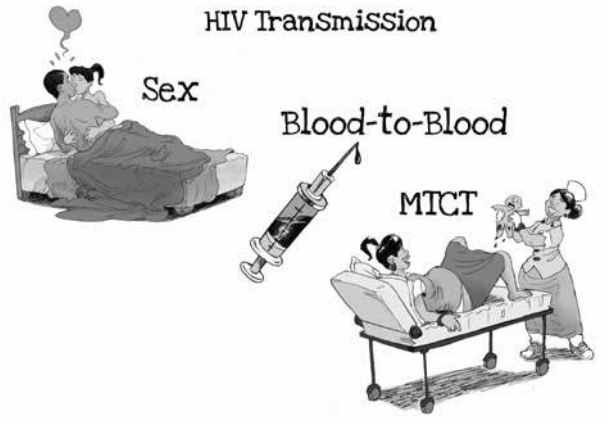
Action:



Mother-to-child Transmission: A mother can transmit the virus to her child during pregnancy, delivery and breast-feeding.

Mother to child transmission is important information for young girls to have especially since the rate of teenage pregnancies is so high in South Africa. But do not discount men. Men may have pregnant sexual partners and can thus put the unborn child at risk by not practicing safer sex.

Action:



So let us recap. HIV is transmitted through Sex, Blood-to-Blood and Mother to Child Transmission.

People can not get HIV in any other manner. For example kissing, hugging, sharing food or a home with someone infected with the virus.

Do you have any questions about Transmission?

Now that we have spoken about how people can get the HI virus, do you think that you have put your life at risk in some way? *[Spend time exploring what the risk factors of the client may have been or be as well as exploring the client's fears and barriers towards a healthy life style]. Understand the client's risk (e.g. if sexual active, do you have sex with condoms? how many sexual partners? sexual history i.e. in case the client has had unprotected sex in less than three months client is still in window period and this must be noted by the counsellor)*

Now that risk practices have been explored and there is no confusion, one can assess the clients own views of personal risk. If a client says they have no risk, ask them why they say so. (Their beliefs about invincibility might not be realistic and can thus greatly affect their behaviour if one looks at the HBM)

In the case that the client cannot **identify risk:-**
Ask direct questions in order to find out if there is a risk:

- Are you sexually active?
- How many sexual partners do you have?
- Do you use condoms all the time?
- Do you use drugs or consume alcohol?

If you find that these are possibilities of risk – deal with the risk and why the client feels that there is no risk: Clear up any misconceptions.

(The aim of the previous activity was to map the risk factors in the life of the client)

Also, when dealing with young people, the client may not be sexually active yet but they may be planning to have sex soon or may be experiencing major pressure from their partner or peers. Do not forget to assess and address these issues if there is a need. So, this is really the opportunity to get to know the client's specific situation – do not follow a script but explore with the client.

6. HIV PREVENTION & SELF-REFLECTION

Because HIV transmission is completely related to human behaviour, HIV can be easely prevented. People can prevent HIV infection by avoiding the sharing of body fluids (e.g. sexual fluids, blood and breast milk) with another person. Each way of HIV transmission has different ways to be prevented.

*This section focuses on the second component of the HBM namely: **Whether a person believes that a particular health practice will be effective in reducing that threat.***

Let us start with **SEX.** How do you think people can prevent getting HIV through sexual intercourse?

Again, we start by assessing the client's general knowledge about prevention by asking an open ended question. (Later we will zoom in on the client's personal prevention strategy.)

We then build on this knowledge and fill in the gaps by tackling each of the previously mentioned risk situations separately. With each risk we offer various risk reduction options.

Action:

Abstinence: Abstinence means you are not having any kind of sex. You are abstaining from sex. You cannot be infected with the HI Virus through sex if you are not having sex. This is the safest way of protecting yourself. Do not forget that even when people have been sexually active in the past, you can decide to not have sex and abstain until you find a partner that you want to commit to and know their status. This is an option at any time of our lives.

Action:

Be Faithful: Being faithful means to be faithful to one HIV negative partner. Both partners need to know their HIV status. This will reduce your risk of HIV infection. When I talk about being faithful I do not mean being faithful to one partner one week and another partner the next week. This

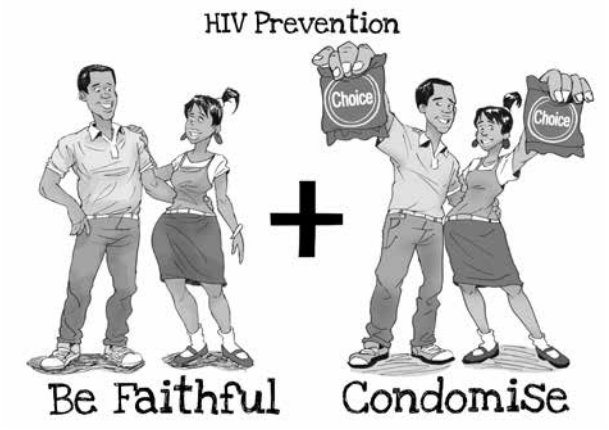
practice carries high risk as you cannot always know what your partner is doing. Remember that both partners need to be HIV negative and commit to only having sex with one another for this option to work.

Action:

Condomise: To condomise means to use a condom every time you have sex. If you are sexually active, the only way to minimise your risk is to use a condom in the correct way every time you have sex. Safe sex is no sex. Safer sex is using a condom in the correct manner each and every time you have sexual intercourse (be in anal, oral, vaginal, lights off, lights on, male-to-male, female-to-female, male-to-female etc). EVERY TIME!

Note here that we do not say using condoms is safe sex. We say it is safer sex. Young people must not assume that using a condom is 100% full proof. However, it is better than nothing. We encourage youth to use condoms ***and*** *be faithful if they want to be sexually active. This is not based on moral reasoning. It is purely good sense. Remember to tailor the discussion to the client. If the client does not have vaginal sex, but practices mutual masturbation or oral sex, you can talk about dental dams and finger condoms.*

Action:

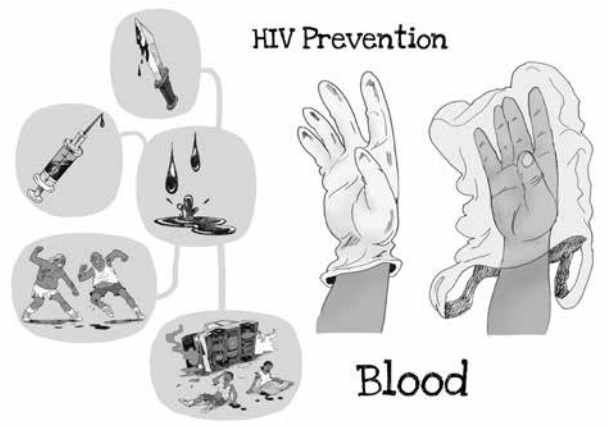


When sexual active, if you want to minimise the risk completly, you should combine B + C.

This means to be faithful to one negative partner and using condoms all the time in a correct manner.

Let's move onto **BLOOD TO BLOOD.** How do you think people can prevent HIV infection through blood mix?

Action:



Blood transmission is prevented by avoiding coming into contact with blood. This can sometimes be difficult. For example, if someone you know is bleeding and you want to help them. Your skin will normally protect you, however in this scenario if you can you should put on gloves, or if you don't have gloves available, use plastic bags around your hands. Avoid activities where blood could be mixed e.g. in fights or sharing needles. In activities where skin is damage risk is higher.

LET'S TALK ABOUT **MOTHER-TO-CHILD TRANSMISSION**

Action:

Any pregnant women or any women that is planning to get pregnant should know her HIV status. For a mother that is living with the virus, or finds out she is HIV + during pregnancy there is a programme run by the clinics called Prevention-from-Mother-to-Child Transmission (PMTCT). Clinic personel

will assist the mother through pregnancy and after delivering to minimise the risk of the baby to get infected.

Having spoken about ways in which the HI-virus can be prevented and reflecting back on your risk… what do you think you could do to reduce your risk from now onwards?

Now we bring the discussion closer to home and look at the clients risks again and ask them what they would like to do to either be safer or stay safe (in the case of someone who has no risk).

Counsellor has made notes about clients's risk behaviour (if any), explore each of them separately. So for example, the client might not use condoms because he/she does not like or trust condoms. Why is this? What can be done? Remember here that based on the HBM you need to assess two things: 1) Whether the individual thinks a health practice will be effective in reducing the risk and 2) Whether the benefits of undertaking that health measure exceeds the costs incurred. This last point also ties in with the "Dreams" activity where the client can have a look at how beneficial it would be to live a long and healthy life.

Address this through looking at **a risk-reduction plan** for the client:

- Does the client practice safe sex?
- Can the client start using condoms?
- Would the client be able to negotiate using condoms?
- Can the client stop fighting?
- Can the client reduce number of partners?
- Stop drinking/taking drugs etc.

CONDOM DEMONSTRATION

If condoms are a possibility for the client, ask the client if they would like to see a condom demonstration? It is also important to ascertain if client is using condoms whether they are using them correctly – You could ask your client to show you how they use a condom and gently correct anything that may be incorrect (specially if client has problems towards the use of condoms).

We do a condom demonstration because again, many clients do not use condoms properly. Remember to consider demonstrating other forms of condoms if it is relevant to the client's situation. Remember to educate clients on where they can go to get condoms.

[Remember: It is not the job of the counsellor to tell the youth (clients) they should abstain if they are planning on having sex. The job is to make sure the client is fully informed about risk and ready to deal with the consequences they could face. They need to make their own decisions – they should know that it is not up to parents, peers, partners, or the counsellor to make decisions for them.]

7. SEXUALLY TRANSMITTED INFECTIONS

You only need to screen for STI's of course when the client is sexually active. Similar to the section on TB, we believe it is important to inform rather than just screen since this can empower the client to make healthy choices.

Action:

If people is sexual active they are at risk of getting Sexual Transmitted Infections.

The majority of STI's can be cured when detected on early stages. Untreated STIs can cause discomfort, pain, infertility and even cause death.

If someone has an untreated STI this will also increase the risk of getting HIV. Why is this?

STI's are infections that are transmitted through sex. HIV is one of them but there are many more like herpes, syphilis, gonorrhea and so on. Some of the STI's give open sores in your genital area and discharge. Both signs increase the risk of infection, the first because it creates an open in your first line of defence (skin) and now the virus can easily get an entry point into your blood stream. The second because the discharge is riddled with the virus making a person with discharge highly infectious to his/her partner. That is the reason that anyone that suspects that they have an STI should go to the clinic as fast as they can.

Action:

Symptoms of STIs include (point to pictures): Pain, Smelling, Itching, Burning.

ASK the client if they would like to see some pictures of STIs??? If yes – turn to page 23 and show the images. Go through them: picture 1 showing abnormal discharge from a vagina, picture 2 showing genital warts on a penis, picture 3 showing a sore/ulcer on a penis, picture 4 showing vaginal warts, picture 5 showing 'drop' coming out penis, picture 6 showing discharge coming out penis.

I would like to ask you a few questions in order to screen you for STIs. Please answer Yes or No to the questions. **Note: (This section is only for clients sexually active)**

STI'S SCREENING:

1. Do you have discharge from your genital organs that is abnormal? (if client is a woman make sure that her discharge is normal... e.g. no change in colour, texture, smell that is not related to her monthly cycle)
2. Do you have genital ulcers (sores/pimples/wounds)?
3. Do you have lower abdominal pains (in women – that are not related to your period)?
4. Burning when you urinate?

If the client answers YES to any of these questions refer him/her to the nearest clinic and reiterate it again during the post-counselling session.

Conclude by explaining that as mentioned previously, if you have an STI you should go for treatment as fast as possible. This should happen because an STI can increase the risk of a person getting infected with the HI Virus as well as STIs have the potential to create lifelong damage in one's body.

'So if your genitals don't LOOK right, SMELL right or DON'T DO what they are suppose to do, please go to your nearest clinics to visit a doctor.'

At this point of the protocol it is very important that you check on the test try not to make the client aware of what you are doing. Retest if necessary. Continue as normal.

8. PARTY ACTIVITY (EXPLORE FEELINGS & DISCLOSURE)

This activity is mainly to assess, in an unobtrusive way, how the client will handle the results of the test. If the client tested positive, who will they lean on for support, what will their initial emotional and behavioural reactions be? Is there potential for suicide or bodily harm, drinking, isolation, etc. Or will they seek support? Thus, it could also reveal underlying social stigmas the client might have towards HIV or face when testing positivie. If the client tested negative the same applies: if the client is prone to risky behaviour, will the client go out and drink/party/have sex as before?

I'd now like to do an activity with you. This activity is interactive and will allow us to explore your feelings towards the disease.

[Using White Board or a A3 page to draw an image of a person (the client)].

We use the whiteboard or A3 page markers to make the session more interactive and capture key words to be used later in the session.

Imagine you are organising a party. Who would you invite to your party? Would you invite your partner/girlfriend/boyfriend? (use information that was given to you by the client already). What about your children? Your family? Your friends... [Let the client direct this part – they can invite who they would like to]... add on suggestions/ideas of people to invite if necessary.

Can you picture everyone having a nice time, maybe some music, drinks and so on.

As the counsellor, I've also come to the party to give you some news.

I tell you that your test results are HIV NEGATIVE (signs for the HI Virus have not been found in your test results).

1. How would you feel about the news?
2. How do you think this will affect the party?

3. Would you disclose to someone at the party your test results?

[With these question you are exploring possible reactions/ emotions to testing HIV negative. Write the down, you might be able to use this emotions during the post-results section].

Using the same scenario what would happen if I came to your party to tell you that your test results are HIV POSITIVE (your test results have shown signs of HIV infection).

1. How would you feel about the news?
2. How do you think this will affect the party?
3. Would you disclose to someone? Who would that be? How do you think that they will react at hearing your results?

[With this section you must explore possible reactions to testing HIV positive. In case client answers with very negative thoughts explore how the client has coped with bad news in the past. Also explore the implications of being HIV + on his/ her relationships, including intimate relationships].

If the client says anything along the lines of suicide or inducing physical harm or depression, ask why they feel that way. Explore how they have dealt with bad news in the past. Counsellor might conclude that the client is not emotionally ready for the test results.

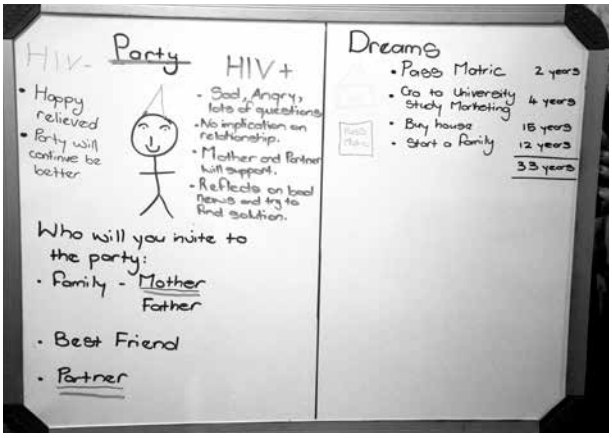
In this case, it is the responsibility of the counsellor to make the decision if the session should procide as normal or should stop. In case counsellor decides to stop the session, counsellor should explain to client why the decision was made and make a plan with the client of what should happen next in order to make the client ready in the long run.

If the client would be reluctant to share his/her positive results with anyone, it is important to assess why and encourage them to find someone who they feel they could trust. It is crucial that young people have a support network in place.

Conclude this activity by reinforcing a positive message about living with HIV.

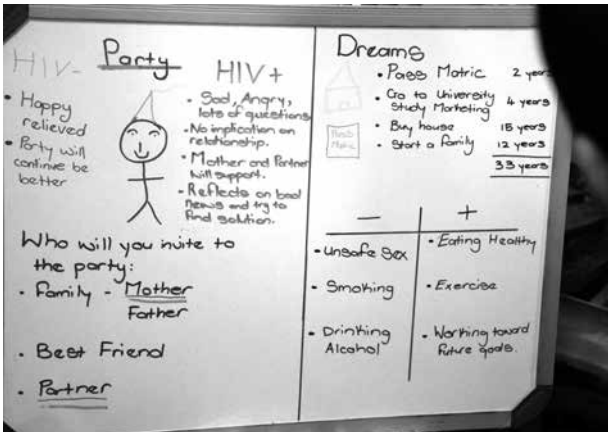
9. DREAMS ACTIVITY

I would like us now to explore another scenario. Everyone has aspirations and dreams. Let us talk about things you would like to reach in your life... what are your dreams? Would you like a car, a house... to study further, to put your children through university... what are your dreams? [Counsellor should write down two or three dreams]. Tell me how long you think it will take you to reach your dreams... 5 years... 10 years... 20 years [be realistic here... a degree could take 4 years, buying a house 20 years – help the client to map out time frame]. E.g. so, we are saying that you need 20 years to reach your dreams (write down the number of years).



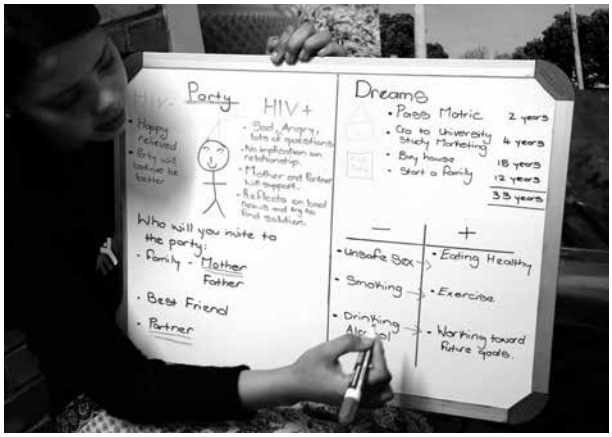
The "Dreams Activity" is a clever way to link current health behaviour to future potential. It addresses three components of the HBM:

1. *The client's beliefs about the consequences of unhealthy behaviour (Taylor, 2006). [If I continue with this risky behaviour I might become sick and will not be able to reach my goals and dreams so easily.]*
2. *Whether the benefits of undertaking that health measure exceeds the costs incurred (Taylor, 2006). [Yes I will have to give up this unhealthy practice and perhaps lose my boyfriend / be rejected by peers, but I will be able to reach my future potential and go and study and become a lawyer if I stay healthy.]*
3. *The individual's general health values. [It is important to be healthy because then I will be able to reach my dreams.]*



In life there are healthy and unhealthy things that we do that add years to our lives, but also can take years away from our lives. (draw a table with a minus and a plus bellow the number of years they require to achieve their dreams). For example, if you live a very stressful life it will take years off your life [write this on the board]. The same applies for drinking alcohol, smoking cigarettes, using drugs, having unprotected sex. A good support system will help you to add years to your life. Avoiding sickness and going for

treatment will add years to your life. Eating healthy and exercising will add to your life.



At this stage of the activity the counselor can divide the white board into two. Write down the heading "+" on one side and "-" on the other. First, we talk in general about various healthy and unhealthy behaviours.

Then it becomes more specifically related to the client own situation. Based on knowledge gained in the session the counselor can ask the client healthy behaviours on one side and unhealthy on the other. Here the counselor stresses the behaviours on one side and unhealthy on the other. Here the counselor stresses the importance of moving "unhealthy" actions to the "healthy" side and focus on what actions will allow the client to make such changes e.g. "That is correct drinking is unhealthy: it affects your immune system negatively and increases risk behaviour (e.g. sexual and fights), so what do you think can you do to make a change and become more healthy?" Is there anything you would like to change in your life that will make the "unhealthy" list shorter?

This is a time to REFLECT on behaviours that have been explored during the risk assessment and to write them clearly on the board. Ask client about certain behaviours mentioned previously that he/she practices in his/her life (e.g. you mentioned you have sex without condoms, do you think that will add years to your life or take years away? You also mentioned about drinking alcohol, do you think that will add years to your life or take years away? You mentioned you have a good support system and your family will support you all the way, do you think that adds years or takes years away - After client answer write each behaviour on the respective side of the table).

This is the time to explain to the client that all the behaviours in the negative side are robbing them of years from his/her dreams independent of his/her HIV status. Explain that he/she should aim to keep doing things in the positive side and reducing behaviours which are negative. Go through each negative behaviour with the client and ascertain whether he/she could do anything to improve the behaviours. This is an opportunity to challenge the client to think about what he/she really values.

Conclude by saying that small changes in life style today can add years to your life in order to fulfill your dreams. This formula (+ -) can work for anyone.

Do you have any questions?

In order for you to reach your dreams it is important for you to know your HIV STATUS. If you are HIV- you will be able to work on keeping your status as negative. If you are HIV + you will be able to change your lifestyle where needed and live a long, productive, healthy life for many years to come.

Do you agree?

This section is further built on in the Post-counseling session when the counselor tailors the session according to what stage of change the clients find themselves in.

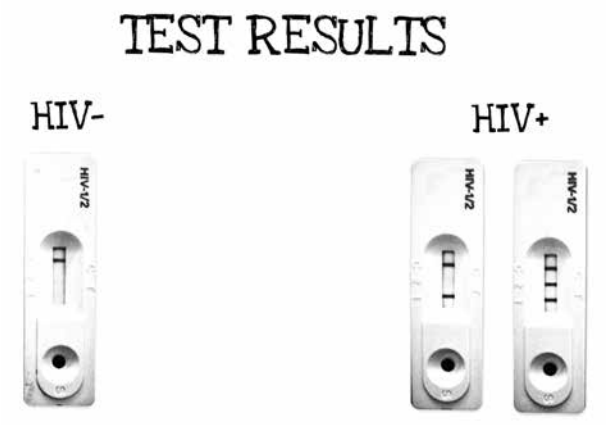
Remember that we do not distinguish between HIV positive clients or negative clients. Healthy behaviour is important for anyone who is serious about reaching their potential and fulfilling their dreams. Clients must make the link between CURRENT behaviour and FUTURE potential in order to see the importance of health. Making a change will require sacrifice and the client MUST be able to see that the benefit of a healthy lifestyle will eventually out way the cost/loss they experience when the change behaviour.

The message here is that no matter what the results of the HIV test (positive or negative), it is important to live a healthy lifestyle. It is not a message of doom and gloom if the person tests positive. It only means a few lifestyle changes in order to slow down disease progression. And if it negative, a healthy lifestyle will keep the person fit and competent, without worrying about medication or hospitalisation.

10. RESULTS

We have come to the end of the first counselling stage. Your test results are ready and I would like to know if you would like to receive them?

Action:



The HIV test that we conducted is looking for signs of your body fighting the HIV virus and not directly for the virus. The results will tell you if you have been infected with the HI Virus or not. If your test shows one (1) line this means that your results are HIV negative: your body isn't showing signs of fighting HIV. If the test shows two (2) or three (3) lines this means your results are HIV positive: your body show signs of fighting HIV – you have been infected. Remember that the test will not tell you how you got the virus or who gave it to you! In case you are diagnosed HIV positive, Life Choices would like to continue supporting you. With your permission I will follow-up with you telephonically in order to support you. Life Choices also offers ongoing counselling support, in order to assist you in how to deal emotionally with your new situation.

Do you have any questions? Are you ready to receive your results? [Wait for the client to give you an answer]. If the client is ready to receive results show the test to the client. If not, explore with client about their concerns, go back to how client would cope if positive, how they would cope if negative, and emphasise that whatever the results they have a plan for how to move forward toward their dreams will be made. If client insists that he/she is not ready, comfort client (make his/her levels of anxiety come down by telling client that his/her decision is fine), develop a plan together for what should the client do next, refer client to relevant service and thank client for coming.

5.3.2. POST-TEST RESULTS PROTOCOL STRUCTURE

5.3.2.1. HIV NEGATIVE RESULTS

Show the test to the client and tell him/her - the test is showing one (1) line. "Do you still remember what this means?"

That is correct, it means your test did not find any signs that your body is fighting HIV, so your results are HIV negative.

What do you understand by this? (Let the client explain him/herself). Acknowledge their answer. In case client has had any risk behaviour in the last three months, ask the client if he/she has heard about the window period? Explain the window period:

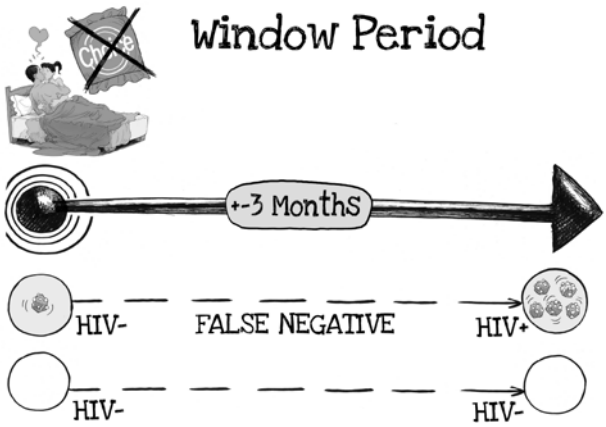
WINDOW PERIOD

If you practiced any risk behaviour (sex without a condom or blood mixing) during the past 3 to 4 months (in your case you mentioned you had _____), there is a possibility that your results are not conclusive and you might have a false-negative result.

This is because if you get infected with HIV today, at some point your body will recognize that something is wrong and the body will start producing antibodies (signs) in order to fight the virus. The period between infection and the time that the body has produced enough signs to be detected by the rapid tests that we use it can be approximately 3 months – this period is called the window period. If I go for an HIV test today, the result may say that I am negative – however this does not mean I do not have the virus but it means my body has not had enough time to show enough HIV signs for the test to detect them. This means that if I have engaged in any risk behaviour in the past 3 to 4 months, I should re-test in 3 months time to make sure. During this period, you shouldn't engage in any risk behaviour because if you do, next time you test you could be in the window period again and test as a false-negative.'

To avoid risk during this period means that if you are sexually active you should use a condom every time you have sex and avoid any contact with blood of another person. Any question about the window period?

Action:



NOTE

Many clients return again and again for HIV tests because they constantly stay in the window period. If this is the case then one could specifically deal with the reasons why they STAY in the window period and how one could address their specific health barriers constructively.

EXPLORING THE CLIENTS' FEELINGS

- **How do you feel about your negative results? (explore the feelings of client)**
- **Do you have some concerns about the result?**

EXPLORING DECISIONS TO DECREASE THE RISK

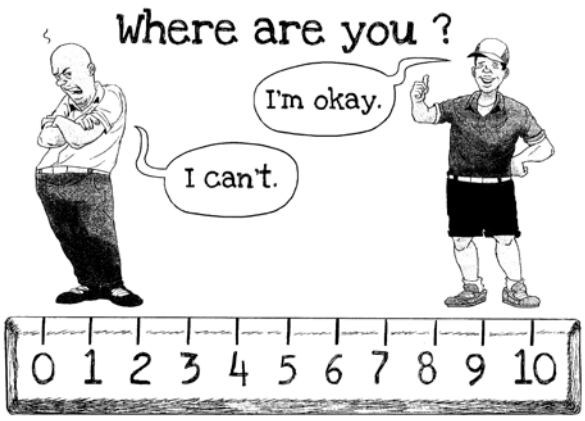
My next question will be, would you like to maintain your negative HIV status? If yes, why?

Let us reflect about the risk factors (if any) in your life for **HIV** and what you can do to minimise the risk (reflect back in the pre-counselling session). Counsellors should now list behaviours and risk factors mentioned in the pre-counselling session and then deal with each risk/behaviour one by one. If the client has many risks, you could group them – for example, if the client has multiple

partners, doesn't use condoms, takes drugs, and fights – You could begin with condom use (incorporate multiple partners), then go to use of drugs (combine with fighting). Or simply pick two behaviours that you see as most risky.

NOTE

These questions are important because the client may have been willing to change unhealthy behaviour in the pre-counselling session but now feel that they can continue as before since they have not been infected. You may even find clients who are so happy that they immediately want to go out and celebrate with friends and put themselves at risk again by drinking, etc. Make sure to listen carefully for such feelings. On the other hand, a client may doubt their results. Address any of these concerns.



Talk about each risk separately. Use the picture of the ruler (0-10) to access where the client thinks that they are in relation to change certain behaviour. Depending on where they are (and with the insight of the counsellor) it can be assessed which stage of change the client is actually in. So explain that 0 on the ruler means that either you don't see a problem with your behaviour or you feel you can't change this behaviour at all. 10 means that you know the risk you've been taking and know you will change it immediately.

When the client picks a number *ask the client to explain and describe to you why they chose that number.* The reply the client gives will help you to understand where the client is in terms of the stages of change (see examples bellow).

Remember, your aim as a counsellor is to help the client move one step further along the stages of change (theory). It is not to get them to immediately stop risky behaviour no matter which stage they are in.

In schools, Life Choices has experienced clients that do not display any risk to be eager to get the service. If the client did not have any risk factors, you can explore with the client if their motivation to be healthy is internal (e.g. I value myself) or external (e.g. disappointing my parents) driven. You can also explore with client in the future when they decide to be sexual active how would they make sure they protect themselves. It is essential through out the session to continually affirm the client's choices.

Assist the client to develop a personal risk reduction plan that the client feels is realistic according to the stage they are in.

TIP

A Risk Reduction plan must be:
- Client Driven;
- Based upon client readiness;
- Based upon client ability to adopt safer behaviours.

As a counsellor you assist clients to find the first step towards the desired behaviour (goal). Steps need to be: concrete, incremental, individualized and realistic.

REFERRAL

Explain to the client that the normal procedure is that we always refer clients to services in their community. In this case refer client to any of the following services in accordance with their needs:

- Prevention services in their community;
- Condom dispensaries;
- STI's or TB screening;
- Couple counselling;
- Drug/alcohol counselling;
- Family planning or pregnancy test or any other services you find relevant to his/her situation.

Fill in the referral form and give it to the client. Also give any literature (pamphlets) relevant to the client.

Thank the client and wish him/her all the best. Walk with the client to the exit door. Return to the counselling room, complete client's notes and file client's file.

GUIDELINES FOR DIFFERENT STAGES

STAGE 1: PRE-CONTEMPLATION

Clients are not yet considering change, or are unwilling or unable to take action to change in the foreseeable future. Clients are either unaware of the consequences of their unhealthy behaviour or have lost confidence in their ability to change. (e.g. I am fine as I am. I don't want to change. I can't change.)

The counsellor's goal here is to encourage the client to think about and discuss her/his risk behaviour and to ensure the client understands the seriousness of the risk s/he is taking. It's also important to explore whether the resistance is coming from a failure to see the risk or whether the clients feel that it is impossible for them to change.

- A useful question in assessing this is asking why the client thought it was important to know their status?
- Reflect on how they felt when receiving the negative result (happy, relieved) and why? For example, "When you received your results, you said you felt happy. Why was that? Is being happy important to you? Would you like to feel like this (happy) and without uncertainty each day of your life?"

If the resistance is about not seeing the risk:

If the problem is a lack of insight into behaviour consequences, the counsellor will focus on getting the client to identify and understand the potential threat. Ask how the client felt while waiting for the test results without knowing? If client was nervous, ask him/her, "Why would you be worried, for what?" Explain to the client that "Each time you practice this behaviour, it's like gambling (you are making a bet that you won't get HIV). However the more often you gamble, the more chances you have of winning and in this case the prize is the HI Virus. Is this something that you want?"

- Explore what are the client's biggest fears in life and see if HIV consequences could be linked in anyway.

Paraphrase client myths by bringing new scenarios - use the clients' arguments for why not changing behaviour, to explaining real consequences. For example: "I understand that as a real man, you want to feel and give pleasure and you believe condoms stop this. But if you get sick and need help just to do simple things like going to the toilet, how much pleasure would you give in this situation?" "In one hand you have few hours of pleasure in the other hand you have a life full of suffering, which hand would you choose and why? And how would your love ones feel about your choices?"

Normally in this situation client should be referred to explore the negative sides of living with the HI Virus and gather more information around the disease. The plan developed with the client could be: to do more research in the progress of the diseases and the AIDS stage (e.g. internet, educational pamphlets), interview someone that lives with the virus and explore his/her change in life style, visit a hospice and interview staff.

To improve client's belief that they could find the strength to change:

If the client believes he/she is threatening his/her health but have very low self-efficacy, the counsellor will focus on building client confidence. The client must BELIEVE they can change in order to change.

- Ask the client to reflect in a difficult situation they faced in the past that they were able to overcome? What were the attitudes/skills they portrait that assisted them? Are these traits still in the client and could they be used in this situation? (With this question you assist the client to reflect in his/her distorted self-image)
- Ask clients if they had a whish list, which skills they would choose to have in order to be able to implement the change? Make a list of the skills required and develop a plan with the client on how to develop some of the skills (In this case you use a problem solving approach)

Empathise with the client and build rapport. Then end with relevant affirmations. Finally ask, "What do you think is a small change that you feel is possible for you to achieve today?" Accept whatever they say and do the usual referral after this.

STAGE 2: CONTEMPLATION

Clients are aware of the consequences of their problem behaviours and are considering change but are ambivalent. (e.g. I know it's not safe, but I like it. I think I want to change, but it's difficult):

Counsellor Goal: Assist the client to evaluate his/her choices regarding change options.

1. Explore with clients what makes them want to change and what makes them want to keep things as they are. For example: "It seems some things make you want to change your behaviour and some make you want to keep it as it is. Let's list them on the board. First let's start with what makes you want to change.... OK, now let's list what makes you want to keep your behaviour as it is?" (counsellor proves client in order that the reasons to change behaviour out weight the reason to keep behaviour. Ask client to reflect on the list and how it makes him/her feel that reasons to change as much more?)
2. Respect and normalize the mixed feelings. For example, "It seems you have quite mixed feelings about whether or not to be faithful, and that's OK. Often when we're thinking about doing things differently, we go through different emotions "to do or not to do, that is the question?"

3. Explore the benefits of the change: "In what ways do you think making this change will help you?" "What are the possible consequences if you don't make the change?" (the benefits must always be greater than the consequences)
4. **Explore how confident they are about making changes** and whether they have made any positive changes in their past. "So it seems that this is something you want to do, how confident are you that you can do this? Can you remember a time when you successfully changed what you did? What helped you then?"

Say: So after this discussion, what is realistic for you now?

End with an affirmation (relevant to client's story):

So, this possible change is something to think about, remember that your life and your dreams are important and you affect those with your choices. If you really want to reach your dreams the power is within you. Don't miss this opportunity. Life is about choices; think about what the best choices are for you and how to achieve them.

STAGE 3: PREPARATION

Clients are committed to change in the near future, but are still considering which actions to take. (e.g. I want to always use condoms, but I don't know how I can ask my partner – I want to be more careful, but I don't know how to control myself when I drink)

Counsellor Goal: Help the client prepare a plan for change.

Using the list of risk factors listed – assist the client in identifying actions they want to take – for example: use condoms every time I have sex.

Then ask what the client's options are? How would they go about making the change? What step will be taken first? Then check how achievable the steps are. If they are stuck, ask what has worked for her/him before when s/he planned to change something in her/his life?
(Looking for strengths and plans)
What would make it difficult for her to change?
Who can help her/him and support her/him in the change?
When is the client able to take these steps?

Try to ensure the client is making achievable goals. If for example, the client has been using heroin and sharing needles, it's unlikely that they can simply stop – they will need to first get help, start with preparing needles correctly, while waiting for rehab assistance.

Only offer to assist in developing missing skills if given permission. If this is needed, you can use the empty chair process for example, where the client has the conversation with his/her partner – What would you say? How do you think your partner would respond? What could you do or say then?

End with affirmation relevant to the client's story: YOUR life is precious. You seem to really want to reach your dreams and you know that the power is within you. Knowing this kind of results is giving you back your power to manage your life. You can make these steps, be proud of yourself and take things one step at a time.

STAGE 4: ACTION

Clients are actively taking steps to change but have not yet reached emotional or behavioural stability in reaching their goals (e.g. I do already use condoms most of the time, but I want to use them every time.)

Counsellor Goal: Affirm the client's successful behaviour changes and support the client in addressing barriers to change. Find out where the client fits:

1. **Has started the change but the behaviour isn't consistent** (e.g. don't always use condoms when drunk)
2. **The change has been consistent for less than six months**
   a. **But the client finds it challenging**
   b. **The client is finding it easy**

Base your approach to the client on the categories he or she fits into.

For all three options:
Affirm what client has been doing."It's great that you have started making this change in your life. I'm proud of you for doing this. It takes courage and shows you really care about making the right choices in your life"

For type 1 and 2a:
Explore when the behaviour is difficult to maintain and why. Reinforce any positive changes the client may have mentioned e.g. If client has stopped taking drugs, you can say "You managed to make a positive change before, now is your chance to do the same again."

Help them identify triggers for unhealthy behaviours: "So is it when you're drinking at parties that it's difficult for you to remember to use a condom?"

As a counsellor, look to gain commitment to specific behaviour changes from the client and identify coping strategies that the client can use to remain in the action phase. "What can you commit to doing this week?", "When things are difficult do you have someone to talk to about your feelings? Can they be a support for you, a buddy?" (Family or friends - Who can help you make the change?). Give information or referral if needed (rehab, abstinence support groups, and free condoms).

For type 2b:
Provide extra affirmation – about how great it is that they are finding it easy to keep up these changes and explore future scenarios where behaviour could be compromised. E.g. "Let's now think about possible future challenges." For example: "You said that you have a new partner and that you always use condoms. What would happen if you're together for a long time. Would you still think it's important to use a condom?"

For all types end with affirmation related to their situation: Sometimes people can make mistakes, if this ever happens to you in the future, and I don't think it will, but if it does, don't be discouraged. You can go easily back to the new behaviour. YOUR life is precious. You clearly want to reach your dreams and you value your health. Life is about choices; and you are making sure you make the right ones. I'm very happy for you.

STAGE 5: MAINTENANCE

Clients have achieved their initial goals and are working to maintain the changes made – they have been practicing the behaviour for over 6 months. (e.g. I abstain from sex, I always use a condom, I am faithful)

Counsellor Goal: Reinforce the client's commitment to change and support the client in managing triggers that could cause relapse and creating a coping plan for relapse prevention.

If client does not have risk factors in their life at the present moment, affirm how they have been living and the choices they have made. E.g. "It's great that you always use a condom when you have sex, which shows you are able to communicate to your partners what you want and what is important to you - your health first"

- Ask what the client has been doing to keep to these healthy choices and affirm those strategies. "It seems that you have managed to really look after yourself and your health by making healthier choices. What helps you to continue practicing safer sex/ abstinence/ or to stay away from drugs or alcohol?" "Have this become part of your life style or does it still require effort?"
- Ask the client if there is anything else that would help him/her to maintain his/her current life style.

Acknowledge to the client that it can be difficult to maintain their behaviour change however it is important if they want to continue living a healthy life. Explore possible future risks: What if x changed and [you find a new partner/you feel ready to start having sex]? What do you think you could do then?" or "How realistic is it for you that you can continue abstaining?"

Imagine that one day you made the mistake of ___ [not using a condom], how would you feel? What would you do next?

Affirm that sometimes people make mistakes, but they already have the tools to keep up their good choices. If it happens, they shouldn't doubt themselves. But can go immediately back to live in healthy ways.

Help the client to identify friends, family and community services that can provide them with support – "Are there people or services that you can use if you need help in keeping to your plan?" Provide additional options if necessary.

Support and affirm - YOUR life is precious. You have been making good choices that help you to stay healthy and to keep moving towards your dreams. You have really found the power within you to do what's best for you. Life is about choices; I know you can keep making the right ones.

5.3.2.2. HIV POSITIVE

Show the test to the client and tell him/her:

'The test shows two (2) or three (3) lines, do you still remember what this means? (allow client to reflect in the results). Yes, it means your test has detected HIV antibodies, so your results are HIV positive. You can see that the confirmation test has also shown two or three lines. This confirms once again that your results are HIV positive.'

Ask the client: What do you understand by this? (Let the client explain him/herself). Acknowledge their answer.

With the client explore the following:

- How do you feel? How the result makes you feel? [explore the feelings of the client – show empathy, warmth, caring and give time to the client to express him/herself. Help the client to deal with the feelings demonstrated]
- What are your concerns? [explore fears]
- How do you think the result will affect your lifestyle?

REFLECTION

Let us reflect on what we have discussed before. You now know that you are living with the HI-Virus. You now know your status and have re-gained the power to make informed choices. You can now learn how to manage the disease. Your dreams are still the same and you are still going to reach them. Do you have any doubts about this? You shouldn't because HIV is a manageable condition that with can be easily managed with a few simple steps.

Let us see what these **steps** are:
[These steps should be clearly written on the white board as you progress through them]

1. **First, you will need to deal with your feelings and fears towards your results.** Remember nothing has changed in you (physically); the only thing is that now you know. You have been living a normal life with this virus until today and you will continue in this way. If you want, Life Choices can help you in this first step. We are able to provide sessions with a therapist or with myself. The therapist will be able to assist you deal with your feelings. Would you like to make an appointment with the therapist or myself?
2. **Second, you will need to visit your clinic** as soon as possible for a doctor to start following you closely. This is a vital step in living a healthy life. In the clinic they will confirm your diagnosed and they will conduct two extra tests - viral load and CD4 count. These are tests that will measure the quantity of virus in your body and the strength of your immune system. With this information the doctor will be able to make a personal plan with you on how to continue living a positive life. How soon do you think you can go to the clinic?
3. **Third, you will need to have a good support system** around you. This is essential to cope with any chronic condition. Let us look back to your party. You said you had people who you could ask for support and disclose your HIV status, how do you feel now about disclosing to them? When do you think you will do it? [Help your client to understand that this disease is like any other disease and assist him or her to understand the importance of disclosing]. Also explain to the client that she/he can also get support from strangers, there are groups of people living with the virus that meet on a regular basis to support each other. Would you like to be referred to a group close by you?
4. And this leads us to the **fourth and last step: Taking responsibility.** No one should be blamed about this situation, not you or your partner. You will never find out when you got it or who gave it to you. However, because now you know, you have the responsibility to protect yourself from possible re-infection and protect others from possible infection. Every time you have sex, you will need to use a condom. And if for some reason you bleed, you should also be careful and try to avoid letting people touch your blood. Only through sex or sharing of blood can you transmit the virus to other people. All other behaviours can still be practice as normal (kissing (unless gums, hugging, using the same toilet, cooking, you name it). It will be important for you to disclose this with your sexual partner when you feel you are ready. Do you think you will be able to start using condoms every time you have sex?

Do you have any questions?

How do you feel about the 4 steps, would you be able to follow them? (Reflect in the action plan for each step and explore barriers if any)

Refer the client to the relevant services in accordance with their personal plan and summarize the session and the decisions the client agreed upon.

Give relevant literature (pamphlets) and explain that you would like to do a telephonic follow-up in the next week with the client – find out when would be a good time. Write this in your follow-up planner.

Conclude by saying: Remember nothing has changed, if you really want to reach your dreams the power is within you. Knowing your status is giving you back the power to manage your life. Don't miss this opportunity. Life is about choices; make sure you make the right ones.

CONCLUDING THE SESSION

Finalise by asking the client, where she/he going after this session?
Assess the client's readiness to leave…
Ask if they feel ready to leave?
Thank the client and wish him/her all the best. Walk with the client to the exit door. Return to the counselling room, complete client's notes and file client's file.

RECORD KEEPING

It is imperative to keep records of the counselling session. Recording skills are necessary in that not everything discussed goes down in the notes. The intention is to capture key words or statements that will be referred to later. The counsellor's listening should not be disrupted by

note taking hence the final form is completed at the end of the session. [Note: If you are able to note take and listen to the client at the same time this is also fine].

NOTE

Life Choices always markets HCT services in schools as a service for anyone (people with risk behaviours or not). We explain that everyone needs someone to talk to and to assist him or her to explore life style choices. When counselling becomes a routine in school, no person is "wrongly labelled" for attending the service but we have experienced the opposite, learners encouraging each other to make use of the service.

Life Choices also encourages learners to use the HCT counsellor to gather extra information around sexual reproductive health issues. Learners are welcome to make bookings just to talk around topics they need assistance with. The most recurrent themes in schools are: pregnancy (e.g. pregnancy test and contraceptives information, my girlfriend is pregnant what to do, I am pregnant what next); STI's information; relationship problems with boyfriend/ girlfriend; my family member is HIV positive, what should I do. Life Choices makes sure that the school community understands that during counselling sessions personal issues are explored with clients, some issues will be painful and unrelated to client's HIV status.

When providing HCT in schools it is important to understand that the majority of the targeted population will be HIV negative. However, there will be a small percentage of clients that will be diagnosed HIV positive. Each client will remain with counsellor until they feel completely ready to leave the session (no matter how long it takes).

Life Choices has provided HCT services in schools since 2007. We have never experienced a case where a learner HIV status was disclosed to the school community. Thus proving, that it is possible to offer confidential services in school set-up and that learners have the maturity to deal with their HIV diagnose.

5.4. Important Facts About Life Choices Protocol

- Counsellors call (telephonically) each client diagnosed HIV positive within the week of the session.
- If HCT services are provided in a site on regular basis (e.g. school, youth centre), protocol recommends to conduct follow-up sessions with any client that
- displays a risk behaviour (e.g. sexual active, use of substance, positive screen to TB or STI's, positive HIV result). The follow-up session happens two weeks after initial session and is used to reflect in progress made and the difficulties encountered. In case, the HCT service is provided in a mobile site, counsellor will follow-up with client telephonically. Appointments for follow-up sessions/calls are made during the session.
- Clues to Action – each HCT client receives for the first three months sms with general messages.


Western Cape
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CHAPTER 6
COUNSELLING SKILLS

This Chapter discusses the basis of counselling, namely the client-counsellor relationship. Our view of this relationship is based on a very well-known therapy within humanistic psychological namely Person-Centred Therapy. This approach was first developed by Carl Rogers. Keep in mind however, that we do not use this approach exclusively. We combine various models, theories, and therapies from various psychological paradigms. We begin by briefly looking at the counsellor's role within therapy and the client role. Our discussion is brief and only highlights certain aspects. For more detail refer to "Person Centred Therapy" by Mearns and Thorne (2007). In the second part of this chapter we explore basic counselling skills and techniques that can assist a counsellor to manage an interactive HCT protocol.

6.1. The Counsellor-Client Relationship

6.1.1. THE COUNSELLOR'S PRESENCE IN THE SESSION: YOUR JOB AS COUNSELLOR

Your job as counsellor is to merely create the conditions in which your clients can learn to understand themselves and hopefully give them a few tools so that they themselves can take control of their own health. You are there to facilitate a process of self-discovery and help the client find his/her own personal strength. There is one crucial ingredient needed in the counselling session, without which the attainment of this goal would be impossible. This ingredient is a ***relationship***. In order to create this relationship you need a few fundamental components: 1) empathy for your client and their situation, 2) unconditional positive regard for this person and 3) congruence.

Empathy is not the same as sympathy or even compassion. Empathy means more than just care or having consideration for the client (although this is also important). Empathy means to try and understand the client's situation so completely that you know what it is like to be in his/her skin. You *demonstrate* to the client that you can accurately and completely sense their personal feelings and meanings. The client must feel completely understood.

In terms of **unconditional positive regard**, the counsellor must ensure that they convey a message of total acceptance and non-judgement! The counselling experience must be seen as a completely safe space. In this way the client can be frank about negative feelings, problematic behaviours, destructive attitudes, and anxieties (feelings they will hide if they fear judgement). The client needs to face him/herself honestly.

Congruence means that you as counsellor should be real and genuine with your client. If you are counselling young people, you might automatically be seen as an authority figure if you are older, giving you the power in the therapeutic relationship. Or you may feel you have status because of your background, education, living conditions, etc. Whatever the reason, this destroys the safety and usefulness of the therapeutic relationship. The answer: be real, be yourself! The counsellor who is congruent shows the client that it is not only okay to be yourself but that it is ideal. The counsellor will be transparent in that he/she will not pretend to be the expert.

Mearns and Thorne (2007) write:

> The client can be trusted to find his own way forward if only the counsellor can be the kind of companion who is capable of encouraging a relationship where the client can begin, however tentatively, to feel safe and to experience the first intimations of self-acceptance.

Thus, when it comes to HIV counselling you need to focus your attentions on creating a genuine, emphatic, caring, loving and safe therapeutic environment so that your client can feel free to explore their life. If you focus your energies on this relationship, rather than being prescriptive and judgemental, you will help your client find the motivation and courage to change their unhealthy behaviour and reach their full potential. These are the basics.

6.1.2. THE CLIENT'S PRESENCE IN THE SESSION: THE ROLE OF THE CLIENT

The risk for HIV infection is high when people have little knowledge of HIV transmission. However, many people who have decent knowledge about HIV and AIDS can already identify their risk behaviours and yet, they continue to engage in unsafe practices. When this is the case, it is most likely that the client has various personal and cultural beliefs that are feeding their lifestyle and keeping their level of risk in tact. It is also likely that the young client has

experienced destructive relationships in the past (such as living with a critical parent or being bullied by peers). This could have led to the creation of a poor self-concept. Because of this poor self-concept the client has created behaviours that protect them against further personal attacks and further disapproval from others (such as unsafe sex to gain acceptance from a coercive partner or drinking to get approval from peers).

The role of the client is not to tacitly sit back and listen to the counsellor regurgitate facts about HIV and AIDS. The role of the client should be involved, actively trying to participate in the session and explore the underlying mechanisms and thoughts that are keeping him/her captive (client does the majority of talking = 70%). If the motivation to change comes from within the client, rather than the coercions of the counsellor, then that change will be more sustainable.

6.2. Basic Counselling Skills

6.2.1. ACTIVE LISTENING

Active listening happens when you listen for meaning, (Stevens, 2008) making sure you do not only hear the words of the client, but truly understand what the client is saying. This is essential if you want to create an emphatic relationship. A very important component of active listening is that the speaker must feel they are being heard, without judgement. Thus, the listener says very little but makes sure they convey their sincere empathy and acceptance of the client and what the client is saying. The counsellor only speaks to find out if the message has been correctly heard and understood. Active listening can be a challenge as it is easy to lose focus and stop concentrating on what is said. It is also very tempting to interrupt the speaker and start giving input. Things that could make it harder would be lack of sleep, hunger, and pressing personal issues (Stevens, 2008). Make sure that you get enough sleep before counselling, that you take care of your bodily needs, and that you are able to set aside your personal life. To convey to the speaker that you are listening you need to:

- Look at the speaker and work on proper body language, making sure you do not reveal feelings of disapproval or boredom through your facial expressions or posture (see section 3. 2).
- Avoid the temptation to speak at all costs (Stevens, 2008).
- Encourage the speaker to continue talking. This is done by leaning forward when they speak and making short, soft comments like “yes”, “I see”, “uh-huh”, “go on” and “tell me more” (Stevens, 2008). All of these comments should be done in such a manner that it is not distracting, irritating or unnatural. Make sure they do not convey judgement like (Stevens, 2008) .
- Making short notes can help you focus on the conversation. However, do not overdo it as this might also hinder the process and become distracting.
- If the client struggles to talk, open-ended questions would be key. Use your notes of what they have been saying to formulate an appropriate open-ended question (see section 3.4).

AN EXERCISE FOR COUNSELLORS TO CULTIVATE THEIR ACTIVE LISTENING SKILLS:

Counsellors can practice their active listening skills in pairs. One person will be the speaker, the other the active listener. Remind people that, even though this is a work exercise, confidentiality between the pairs still applies. Also, remind them that this is a simulation and might feel unnatural, but the key is practice, practice, practice. For 10 minutes, the speaker can talk about one of the following topics:

- Two highlights he/she experienced during the week.
- Two difficult situations he/she experienced in the last week.

The listener is not allowed to say anything during this time except for encouraging, two or three word phrases like “hu-huh”, “I see”, “yes”, “ tell me more”, etc. After the role-play, the participants should discuss how they felt during the exercise and answer the following questions:

Feedback from the Listener

1. How did you feel during the exercise?
2. Was it challenging or easy? Why?
3. Were you able to keep the conversation going using only encouraging body language and a word or two?
4. Were you able to keep from interjecting?

Feedback from the Speaker

1. How did you feel during the exercise?
2. Did you find it challenging or easy? Why?
3. Did you feel encouraged to keep talking?
4. Did you feel heard?

Now, let the partners swap and repeat the exercise so that everyone has a chance to practice.

6.2.2. BODY LANGUAGE

The next section on body language was informed by the article “Body language in Patient Counselling” written by M. Reena (2005).

During counselling, both verbal and non-verbal actions create impressions and can either support or negate the building of rapport (Reena, 2005). Thus posture, facial expressions, eye contact, hand gestures, and dress code become relevant variables during counselling. According to Reena (2005) approximately 60-80% of what we convey is attributed to body Language while only 7-10% is verbal. Body Language can easily give away a person’s true feelings. The body language of our clients also give us a good indication of how are words and actions during counselling are being received. Counsellors must be attentive to what they project as body language usually occurs unconsciously (Reena, 2005).

The face is the most expressive part of the body (Reena, 2005). Often some facial expressions can be misunderstood by clients. For example, anxiety on the part of the counsellor may be perceived by the client as unapproachability, seriousness, or disinterest (Reena, 2005). Counsellors need to be wary of this misrepresentation. When appropriate, smiling can go a long way to mask feelings and is deemed by Reena (2005) as one of the strongest tools, in the counsellors arsenal since it helps to make the client feel relaxed and comfortable. Smiling conveys warmth, openness, friendlyness, and confidenance (Reena, 2005). Sometimes the client may face situations like a long queue in the waiting area and thus the client becomes restless. The client could be asking numerous questions like "when is it my turn?" or "why is it taking so long?". Such situations can make the counsellor (and client) feel irritated but a good counsellor should always keep himself/herself cool, calm and smiling (Reena, 2005).

Eye contact is also key and maintaining good eye contact shows that the counsellor respects the client, is attentive, and finds the client's comments to be of significance (Reena, 2005). Little eye contact can convey disdain or boredom and the client may feel that problems is not perceived as important (Reena, 2005). Eye contact thus encourages rapport and trust. If the client finds that the counsellor isn't 'looking' at them when they are being spoken to, they feel uneasy. At the same time, avoid staring or glaring inappropriately (Reena, 2005).

Hands are expressive tools and when engaging in open gestures they allow us to convey openness, and enthusiasm (Reena, 2005). Reena (2005) contends that they also allow us to covey an aura of honesty. Be careful not to point fingers which might seem judgemental. Also, making too many gestures, wringing our hands, making knots with our clothes and figetting with hair can make the counsellor seem tense and nervous (even dishonest) (Reena, 2005).

Our posture signals levels of attentiveness as well as levels of confidence (Reena, 2005). Orienting our body towards the patient shows attentiveness, while leaning back may have the opposite effect (Reena, 2005). Avoid hunching shoulders and keeping the head down which might be perceived as a lack of confidence or some sort of emotional problem on the part of the counsellor (Reena, 2005). A relaxed body posture will help will convey a relaxed and confident counsellor (Reena, 2005).

Head position is a great method. Tilting the head slightly to one side will show the client that his or her counsellor is listening and receptive (Reena, 2005). The counsellor can use the vertical head position when they want to be authoritative and when they wish the client to head their words and take the message seriously (Reena, 2005).

Personal space between counsellor and client must be noted. The counsellor should make the client feel comfortable in the session and thus avoid invading their personal space and being too close (Reena, 2005). However, too much physical distance may also be perceived as emotional distance making the client feel disconnected or even rejected (Reena, 2005). A balance is needed.

IN SUMMARY HERE ARE THE DO'S PROPOSED BY REENA (2005):

- Be relaxed and attentive.
- Always lean forward while talking to the patients.
- Keep your facial expressions relaxed and friendly.
- When standing, maintain a balance and do not lean on the wall or table.
- Move purposefully; it shows confidence.
- Use your hands above the waist. Use both hands and make large gestures. Keeping the palms up is a positive gesture.
- Smile when appropriate; look pleasant and genuine, this shows the warmth and openness of the counsellor. However, let your facial expressions fit the situation. Don't smile when the client is crying and very distressed, you may seem insincere. Don't smile when trying to convey concern.
- Always turn your face towards the client.
- Keep an appropriate distance from the client, not too close and not too far.

AND HERE ARE THE DO NOT'S PROPOSED BY REENA (2005):

- Gestures like crossing the legs, swinging foot and tapping fingers. This reveals that the counsellor is impatient and not interested.
- Avoid hair twirling, this shows that the counsellor is incompetent and uncertain.
- Don't place the hands in front of the mouth.
- Avoid talking too loud or too low.
- When talking to the client do not look down or frown the face, this shows that the counsellor is defensive and untrustworthy.
- Avoid cleaning glasses, biting nails, rubbing eyes and noses.
- Do not use "um" or "uh" too much as this can make you seem unsure or be distracting while the counsellor is speaking.

Remember that your client may not remember what was said, but they will remember how you made them feel.

AN EXERCISE FOR COUNSELLORS TO CULTIVATE THEIR BODY LANGUAGE AND POSTURE SKILLS:

This is another role play exercise. Break the group up in pairs, each pair will sit on chairs facing each other. One partner will be the listener and will demonstrate bad body language. The listener can alternate between states of boredom and states of anger/disgust at the "client". They can demonstrate anger by frowning, raising eyebrows, rolling eyes, smirking, crossing their arms and leaning back. Boredom can be demonstrated by resting their head on their hands/arms, fidgeting with hands and not being able to sit still, leaning to the side, sighing, avoiding eye contact by looking at the ceiling or the window, etc. This is done

while the speaker talks for 5 minutes about one of the following topics:

- Two fears the speaker may have for the coming week.
- Two things to look forward to in the coming year.

After this, the speaker can assess how they felt while talking:

1. Did they find it challenging or easy? Why?
2. Did they feel supported?
3. Did they feel the listener cared about their story?
4. Did they feel judged?
5. Did they feel they had permission to keep talking?
6. Did they feel heard?

Now let the pair repeat the exercise while the speaker talks about another topic but this time the listener must demonstrate positive, encouraging body language. After five minutes is over the pair can asses their experiences. How did the speaker feel about the listener's support and interest this time? How did it compare to the previous 5 minutes? Did the listener feel their own interest level changed when they were using positive body language versus negative body language? After this, let the partners swap roles?

6.2.3. OPEN ENDED AND CLOSE ENDED QUESTIONS

This is probably one of the most challenging skills to learn as a counsellor and can take many years of experience to cultivate. But it is one of the most important skills to have in a counsellor's tool box. Both open ended and closed ended questions are important to use and the counsellor needs to know when and how to use which type of question. Open ended questions can help a client open up and explore their lives, whereas closed ended questions can help the counsellor gain specific needed information. But used improperly, close ended questions can make a client close up stunting the counselling session, making it unfruitful. On the other hand, when open ended questions are used inappropriately the counselling session can become long and unfocused.

CLOSE ENDED QUESTIONS

A close ended question is one you ask to get ***specific information*** on a ***specific topic***. It wants to ***limit the information*** around this particular matter. It often elicits a one sentence or even one word reply that focuses information and zooms in on the fact needed. Closed ended questions are excellent for getting necessary information when the client does not give this information up spontaneously. It is also useful when you have a chatty client and need to bring him/her back on track. A couple of examples of close ended questions would be:

Q: Do you like going out at night?
A: Yes, I do.

Note that the information needed is limited only to whether the person likes or dislikes going out in the evening. It does not even ask what the person will be doing if they go out, what they like or dislike about going out, or what caused them to feel this way about going out (questions that all request much more information). The response needed here is a simple "yes" or "no".

Another example:

Q: How many times have you had an HIV test?
A: Never before.

Again, in the example above the information needed by the person asking the question is very specific. The answer needed is short. The person does not want to know *why* the client never goes for HIV tests or *what the reasons are behind* them never going for tests. The person answering does not have a wide range of answers to choose from and can only give numbers: "none", "one", "two", "three", etc.

Q: Have you ever heard about PMTCT?
A: Maybe once, but not really.

As you can see this question is similar to the two above as the answer requested is short and specific. There are only 3 options when answering this question: "yes", "no" or "maybe".

OPEN ENDED QUESTIONS

In contrast an open ended question is designed to get ***as much information around a topic as possible***. The question often elicits varied responses that are rich in information and detail, not just specific one-liner answers. They usually have no correct answer and require explanation and elaboration. They are great to use when the counsellor wants to get to know the client better and understand the reality and thought life of the person they are trying to help. Key words and phrases that you will often find in these types of questions are "what was going through your mind when…", "what do you think are the reasons for…", "how did you feel about….", "could you explain what happened…", "could you tell me more about…". In the examples of the close ended questions above, the questions could be changed to open ended ones that elicit more information.

Q: Are you going out tonight?
>> What do you like about going out in the evenings?

Q: How many times have you had an HIV test?
>> Do you have any idea about why you never did an HIV tests before?

Q: Have you ever heard about PMTCT?
>> Can you tell me what you might have heard about PMTCT?

All of these questions require a lot of information from the person who answers. Also notice that none of these sentences start with the word "why". This is because some people find it threatening and overwhelming. To some clients it might even imply judgment. Thus "why" was used but it was asked in a nonthreatening way by adding "do you have an idea about why…".

A FEW MORE EXAMPLES OF OPEN ENDED QUESTIONS

"What brought you here today?"
"Do you have an idea about why this keeps happening?"
"What is your Plan B?"
"How does that make you feel?"

OTHER EXAMPLES OF CLOSED ENDED QUESTIONS

"What is your name and date of birth?"
"Did you call the clinic to get your ARV's?"
"Where do you work?"
"Where would you like to go to for help for this problem?"

AN EXERCISE FOR COUNSELLORS TO PRACTICE ASKING OPEN ENDED (OE) AND CLOSED ENDED (CE) QUESTIONS:

There are two options to practice this skill. Do both if time permits it. Option one is about understanding the difference between the two types of questions and being creative with questions. Option two is about practicing the skills while counselling because during counselling thought processes need to happen faster and there is usually not a lot of time to formulate perfect questions. It is very important that trainers walk around and assess the skill level of counsellors during the exercise and address problems when they arise.

Option 1

Each counsellor gets a piece of paper and pen. For each of the following topics the counsellor must write down three OE and three CE questions. Counsellor must try and use varied types of questions and thus make sure the OE questions do not all start with "how do you feel about…". It can be tricky to think of three varied ones for each topic but that is part of the challenge. Counsellor must imagine they are counselling a young person who is at risk for HIV infection.

The topics are:

- Risk factors at parties;
- Future plans and goals;
- Saying no to partner when he/she demands sex.

Class discussion

The class should discuss the exercise together. For each topic, the trainer can ask for 2 volunteers. For each topic one volunteer will write down his/her three CE questions on the board and the other will write down his/her three OE questions. The trainer can highlight any problematic questions and ask the class why it is problematic.

Reformulate a better one and explain why it is a better OE or CE question. Also, ask the class what they felt were well structured questions, and why.

Option 2

Break the team up into pairs. Each pair can practice their questioning on each other. The speaker can start the conversation by asking their partner an open ended question. Any open ended question such as: "Was there anything particularly interesting that happened within the past few days?" They must be creative and think of their own question. The speaker has ten minutes to talk. If the conversation dries up, the listener should ask another open ended question related to the current topic in order to keep the conversation going and help the speaker elaborate on the topic. E.g. "What was going through your mind while this was happening?" or "How do you think this has affected your life at the moment?" (The listener must remember their body language and active listening skills.) After ten minutes the listener should bring the conversation to a close by using a close-ended question like "Does this make you feel good or bad?" or "Did you enjoy talking about the topic or not?" It can be expected that quiet people require a lot of open ended questions whereas expressive and talkative people will require more close ended questions to keep the topic on track. After the exercise, both the listener and speaker can answer some questions. This discussion could take place in pairs or you could have a big team discussion. (In pairs people might be more open and honest about concerns however in a larger team there is more feedback and greater opportunity to address concerns.)

Feedback from the Listener

1. How does it feel when someone asks you an open-ended question?

2. Was it helpful in terms of letting you open up and talk more about the topic?
3. What impression did you get when your partner asked you the close-ended question?

Feedback from the Speaker

1. Did you feel it was easy or difficult formulating and asking open ended questions? Why?
2. Was it easy to formulate and ask a close ended question?
3. Do you feel the questions worked well in directing the conversation to where you wanted it to go? Why or why not?

6.2.4. PARAPHRASING

Paraphrasing is when the listener briefly and concisely restates what the speaker has said in their own words (Stevens, 2008). Paraphrasing is one way to convey to the listener that we are *hearing* what they are saying – not just listening, but comprehending. It is also a way to really check whether you *did* understand the client correctly because you cannot assume you know what they are feeling and thinking. By doing this, you are in effect saying to the client: "I care about what you are saying and I want to make sure I understand you correctly because there is value in what you have to say." Thus, paraphrasing should be without judgement and convey empathy and acceptance of the person while at the same time remaining genuine.

For example, your client has just explained that she is in a relationship with a boy in her class. She loves him and she "knows that they will be together forever". However, recently all her friends are starting to have sex and her boyfriend is also pressuring her to have sex because he says they are in love and that is what people do when they are in love. She feels that he only wants to "do it" because of his friends and now she is struggling to say no because she does not want to lose him. To paraphrase you would highlight the key issues in relation to HIV counselling. You might say: "If I hear you correctly you are saying that you have not had sex yet with your boyfriend but because of friends, both of you are feeling a lot of pressure to have sex. You do not think your boyfriend wants to have sex because he loves you but he is pressuring you because he feels pressured by friends. This is becoming difficult for you because you feel that if you keep resisting he will break-up with you."

Besides conveying to your client that you understand him/her (or at least would *like* to understand him/her correctly) you are also crystallising the problem. You are already **subtly** pointing to key issues concerning the dilemma (Stevens, 2008). What would not be helpful is to say something like: "So what I hear is that you are insecure and care too much about what friends think. You let your boyfriend and friends control your decisions. Even though he says he loves you, he clearly doesn't because he cannot respect your wishes and wait until you are ready!" In this case, there is judgement and the counsellor has done too much of the thinking. It is important for the client to keep talking and for the client to come with conclusions on her or his own.

Remember that tone of voice and body language is still important. The person may not remember what was said, but they will remember how you made them feel!

AN EXERCISE FOR COUNSELLORS TO PRACTICE PARAPHRASING:

In pairs one person will be the speaker and the other the listener. After the entire exercise, the pair will swop to give everyone a chance to practice. The listener can start with ensuring they have the appropriate body language and then ask the speaker an open ended question such as: "Tell me everything about an exciting trip you took recently." The speaker gets 10 minutes to relate the story. During the 10 minute discussion, the listening can paraphrase what the speaker says at strategic moments (every minute or 2). Thus, they will restate the key elements in a compact empathetic way.

5 Minutes of Feedback from the Speaker

1. Did you feel you were being empathetically heard?
2. How accurate was the listener in paraphrasing what you were saying?
3. Are there any tips you give the Listener to improve their paraphrasing techniques?

5 Minutes of Feedback from the Listener

1. How did you experience the listening process when you knew you had to paraphrase the conversation at some point?
2. Did you feel you were accurately capturing what the speaker was saying?
3. What do you think worked well and what did not work as well?

6.2.5. SUMMARISING

Summarising is very similar to paraphrasing in that it highlights key elements/ point/ issues / breakthroughs. It is a way to crystallise the session for the client, reiterating what was important but it is also a way for the counsellor to assess the accuracy of his or her own understanding (Stevens, 2008). However, were paraphrasing happens throughout the session, summarising happens normally at the very beginning and end of a define section or session (Stevens, 2008).

When a summary occurs at the beginning of a session, the counsellor sums up what happened in the previous session. When giving a summary at the end of a session, the counsellor needs to condense what has happened in a 30 to 40 minute session in 2 to 3 minutes.

Remember that your account of the session is not what is important here, but that you can accurately convey the client's perspective. You and the client need to be on the

same page (Stevens, 2008) and thus your interpretation is definitely open to change if the client wants to add or change anything. Thus, make sure to add comments like: "This is what I think stood out for you…. Do you think that is accurate? Do you have anything else you would like to add or change?"

For instance, Buntu, a 16 year old client has spent the last 30 minutes of the session conveying to the counsellor that he is lonely and depressed, really struggling with school work, concerned about his friends who pressure him to smoke and drink and is feeling like he cannot talk to his parents because they will only get angry and express their disappointment. Here is what a concise, tentative summary would sound like:

"So Buntu, what I gather from this session with you is that:

- You came in today because you are feeling lonely and depressed.
- Your schoolwork is not going the way you feel it should.
- You really worry about your friends who pressure you to put your health at risk by smoking and drinking.
- And you are also unhappy with the relationship you have with your parents and you cannot talk to them because you feel they judge rather than support you.

Would you say this is accurate?"

By asking the question at the end the counsellor leaves enough room for the client to tweak the summary. This summary will then come in handy in the next, follow-up session when the counsellor needs to give a brief synopsis about what happened in the previous session and remind the client were they left things.

No exercise was specified for this skill as one can easily adapt the exercise on paraphrasing to suit summarising. The difference is that the summary should happen only once after the speaker is done talking for 10 minutes and should be a more global assessment of the situation - really sticking to the core factors.

6.2.6. NOTE TAKING

Note taking is the practice of discretely writing down pieces of information during the session while the client is talking (often in shorthand). It is important to not disturb the flow of thought of the speaker and become distracting to them.

Note taking helps to keep the counsellor on track. It gives the counsellor a chance to remember what happened after the session is over and can be useful to refer back to in subsequent sessions. Reading through these notes just before the follow-up session starts, will help the counsellor formulate the introductory summary. Furthermore, it helps the counsellor see what he/she must do, so that they are fully prepared for the next session (e.g. what extra information should they read up on?). If the client had questions the counsellor could not answer or the counsellor had difficulty in addressing a particular problem, the notes will help remind the counsellor to do some homework. However, note taking can easily be distracting when the counsellor rests his or her eyes on the notes rather than make eye contact with the client. It is also important to not take copious amounts of notes.

The note taking process can be made harder or easier when the organisation has very specific and structured Monitoring tools. Having a set form that needs to be filled in, can help structure and guide the HIV counselling session, making sure that all the important matters are covered (see Addendum B for an example of such a structured form). On the other hand, it may cause the counsellor to be rigid, fixated by the form rather than being flexible in dealing with each client's unique situation. Thus, a balance needs to be maintained.

It will help if the counsellor gets the client's "data details" (name, age, phone number, etc.) at the beginning of the session. However, when the client is conveying information on a more serious, personal, emotional matter then the counsellor should only write down key words or phrases. Rather pay attention to what the client is saying. Then these written words or phrases will help jog the counsellor's memory when they fill in the blanks after the client has left.

Importantly, write up notes immediately after the session because as soon as the next client walks through that door the particulars of the current encounter will become watered down. Keep in mind that Stevens (2008) suggest taking notes of the following useful details:

Subjective information: What are the client's thoughts and feelings concerning their personal, familial and social lives. How does the client view the problems surrounding them and how does this make them feel?

Assessment information: What seems to be the client's current and past causes or triggers to ill health or problematic situations? What are the barriers and protective resources to good health?

Future action plan: What is the plan of action (until the next session as well as long-term goals, etc.)? Remember that a counselling session only lasts 40 minutes but most of the work is done by the client during the other 167 hours of the week.

Other information: What do you, as counsellor, need to do in order to be prepared for the next visit? Is there any additional info you wish you had gathered from the client or other information you wish you had conveyed?

TIPS

Life Choices counsellors use A3 paper or whiteboard and markers as an active part of the protocol. We write key notes (the client's key phrases, health risks and barriers, protective resources, support structures, action plans, and future goals) on the whiteboard so that the client's health life is visually represented. After the client leaves, the counsellor can then copy the notes into the M&E tool for future reference.

Another tip is that when you mention confidentiality in the beginning of the session, it might be useful to also explain to the client that you will be taking notes throughout the session. Put the client at ease and stress that they need not worry as this is merely to help you remember the important points and that these notes will also remain confidential (if that is indeed the case). This will go a long way in making your client feel more comfortable when disclosing personal/sensitive information.

AN EXERCISE FOR COUNSELLORS TO PRACTICE NOTE TAKING:

Again this is an exercise to work on in pairs. One of the partners can talk about something that bothered them during the past week (e.g. traffic, work stress, a difficult child, etc.). The other partner must try to actively listen and put into practice all of the skills learnt thus far, yet they have to take notes of the discussion as well. After ten minutes the partners can discuss the following questions with each other:

5 Minutes of Feedback from the Speaker

1. Did you feel you were being empathetically heard? Why or why not?
2. Did you find the note taking distracting while speaking? Why or why not?
3. Look at the listener's notes and see how accurate he/she was in taking down the relevant thoughts, facts, and feelings you described.
4. Are there any tips you give the Listener to improve their note taking skills, either in how they listen while writing or in what they write?

5 Minutes of Feedback from the Listener

1. How did you experience the listening process while making notes? Did you feel it helped you listen or was it more of a distraction?
2. What do you think worked well for you and what do you feel can you improve upon for next time?

6.2.7. HOMEWORK

Homework is a very important part of counselling. The client needs to understand that in order to improve one's situation you need to take full responsibility and work hard at it. You never run a marathon after only one hour of exercise a week. Your muscles will not be able to handle the trauma of such extreme effort. Unfortunately, the word "homework" has a very bad connotation, especially with young people (Stevens, 2008). However, this kind of homework (or home activity if you want to give it a different label) should be fun, creative, informative and inspiring. The reasons for giving homework are threefold:

1. To reinforce that positive change requires effort. If there is no effort after hours then counselling merely becomes "chat" or "gossip" session, filled with a lot of hot air (Stevens, 2008).
2. To help clients become more aware of themselves, who they are, how they think and feel, and how they function (Stevens, 2008).
3. To educate the client and provide them with helpful skills (Stevens, 2008).

There are a number of fun and helpful homework exercises such as Journaling, Mood-Mapping, Holistic Health Check-In (physical, social, emotional, spiritual, intellectual, vocational), Knowing Your Community Resources, Ten Things I Like About Me, Challenging The Lies We Tell Ourselves, Mapping Out Our Own Future (Where do we really want to go?), How to Be the Happiest, Healthiest Person You Can Be (Stevens, 2008). Protocol developers should be as creative and flexible as possible to ensure that the homework they give their clients are relevant and appropriately suited to the needs of the particular client.

CHAPTER 7
HIV TESTING

This Chapter discusses basic information around HIV testing and explores Life Choices testing protocol. It provides understanding on testing algorithm and how HIV status is determined. In South Africa, lay-counsellors are allowed to perform HIV rapid tests themselves, does the need for diligent training to be conducted and the establishment of ongoing monitoring systems to insure the quality standards of the services provided.

7.1. HIV infection Measurement

HIV infection can be measured in terms of:

- The amount of virus circulating in the body – called the viral load that can be quantified by a technique called the PRC (Polymerase Chain Reaction). This tells us how much virus is in the body and monitors responses to ARV treatment;
- The amount of virus protein or antigen (for example, P24) in the blood;
- The amount and type of antibodies made by the immune system specifically for the HIV. This is the basis of the ELISA and Rapid HIV tests;
- The total number of white blood cells produced by the immune system, such as CD4 cells that protect the body against infection. HIV infects and kills CD4 cells, leaving an individual susceptible to infections by other pathogens. The level of CD4 cells can indicate the stage of infection and determine when a patient is ready for ARV treatment.

7.2. HIV Rapid Test

HIV rapid tests are qualitative assays that detect antibodies. Most of the rapid tests can detect HIV-1 and Hiv-2. These tests are as reliable as ELISA's. The ELISA can be used to confirm a positive rapid test result or to resolve a discordant rapid test result.

One of the advantages of the HIV rapid tests is its ability to use whole blood, serum, plasma or oral fluid. While HIV rapid tests in general are considered to be low in complexity, all tests must be appropriately evaluated prior to be used and personnel must be properly trained.

Certain kits and reagents require refrigeration as specified by the manufactures. If they are not stored according to manufacture's instructions the quality of test will be compromised (special important to HCT mobile services).

7.3. HIV test Algorithms and Strategy

Algorithms are defined as the combination and sequence of specific tests used in a given strategy. The factors that determine the algorithm are the performance of the tests used in relation to their Sensitivity (Se) and Specificity (Sp).

Sensitivity (Se) of tests is its capacity to correctly identify people who are infected with HIV.

Specificity (Sp) refers to correctly excluding persons who are HIV negative.

NOTE

HIV Rapid Test Performance: No test is 100% sensitive and no test is 100% specific.

For this reason, testing strategies were in need to be developed. The testing strategy is the approach that will be used to meet a specific need (e.g. blood safety, accurate diagnosis).

HIV test strategies

- Parallel testing: samples are tested simultaneously by two different rapid tests.
- Serial testing: sample tested by a first test. Result of first test determines whether additional testing is required.

Life Choices uses the serial testing algorithm recommended by the South African Department of Health. The algorithm describes the sequence of tests to be performed.

An HIV positive status should be based upon the outcome of 2 or more tests. The second test is the confirmatory test and is only used when the first test was reactive. When two tests results disagree (one is reactive, the other is non-reactive), the finding is called 'discordant.' In this case, a third test must be performed (tiebreaker).

POSSIBLE HIV TEST OUTCOMES: SERIAL ALGORITHM

TEST 1	TEST 2	TEST 3	HIV STATUS
Non-reactive			Negative
Reactive	Reactive		Positive
Reactive	Non-reactive	Non-reactive	Negative
Reactive	Non-reactive	Reactive	Positive

In many HCT models, Test 3 is performed in a health clinic after client has been referred.

7.4. Testing Procedures

7.4.1. REQUIREMENTS FOR ACCURATE TESTING

- A timer or watch for timing the tests;
- Gloves because you may come into contact with blood;
- Disinfectant for cleaning the work surfaces;
- Alcohol swabs;
- Lancets, cotton wool and capillary tubes;
- Sufficient tests for the day;
- A sharp container and a bio-hazard waste container.

Because there are different HIV rapid tests and they are made by different manufactures, it is essential that counsellors spend time reading test literature (normally inside the testing kit box), understand it and follow guidelines at all time.

7.4.2. STEPS FOR PERFORMING THE FINGER PRICK

1. Before session starts with client make sure that you have all the necessary resources at hand and that all work surfaces have been disinfected;
2. Explain the testing procedure to the client;
3. Explain the consent form and make sure clients sign it;
4. TEST THE CLIENT:

- Wash your hands (cleansing gel) and put on a new pair of gloves;
- Open the test;
- Position the hand palm side up and ask the client which finger you should prick;
- Apply intermittent pressure to the selected finger to increase blood flow to the fingertip;
- Clean the finger with an alcohol swab starting in the middle of the finger and working outwards so as not to
- re-contaminate the puncture site;
- Allow the finger to air dry or use cotton wool to dry finger;
- Hold the lancet at a 90 degrees angle against the finger and using moderate pressure depress the plunger and prick the skin;
- Wipe away the first drop of blood;
- Use the pipette provided to draw up the amount of blood required for the specific test;
- Give the client the cotton ball and ask the client to apply pressure to the puncture site;
- Place the blood collected into a portal on the test and add the buffer provided;
- Set the timer for 15 minutes (according with guidelines in the rapid test box – e.g. First Response – 15 minutes / I care – 15 minutes / HIV Determine – 5 to 15 minutes);
- Plaster client's puncture site;
- Discard any contaminated waste into the receptacles provided – it is essential to place all used lancets and tests into a sharp container. Place all use swabs, gloves and any other potentially harmful material into a separate hazardous waste container, which should be disposed of at designated waste disposal centres.

TIP

Develop personal safe work habits that they become an integral part of your routine.

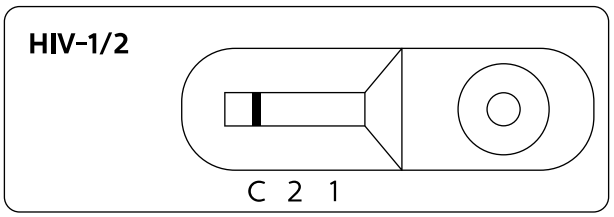
Safety involves taking precautions to protect you and the client against infection. It also involves to protect the integrity of the test results, to protect the environment and to protect other people who may come in contact with the testing by-products.

Take precautions to avoid needle stick injuries for yourself and others. The most common causes for accidents are: lack of concentration, inexperience and improper disposal of sharps.

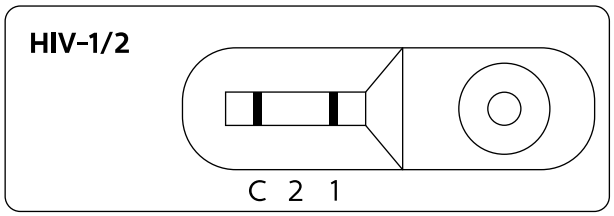
7.4.3. INTERPRETING THE RESULTS

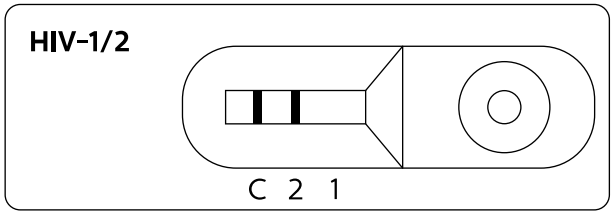
Interpret results when timer goes off (avoid to interpret results after time has elapsed). There are three possible results: Non reactive, reactive and invalid.

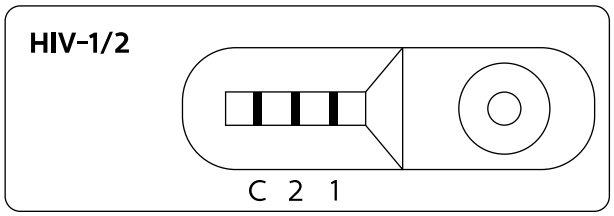
- **Non reactive** – for a negative result one colour band appears in the control window (labelled "C") of the test device, but no line appears in the patient window (labelled "T").



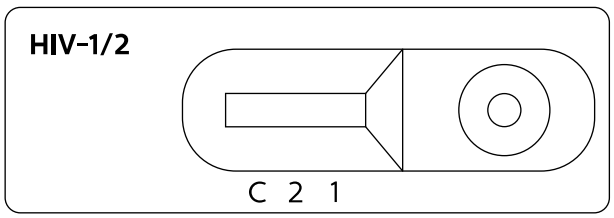
- **Reactive** – for a positive result a colour band of any intensity appears in both the control window and the client window. The intensity is not as important as the presence or absence of the lines. It is ok if either the control line or the client line is weak.

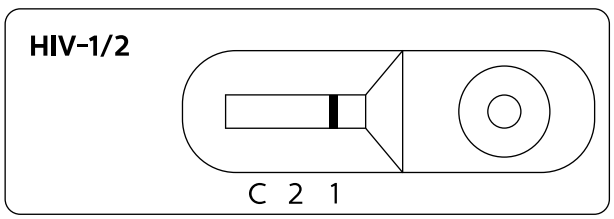


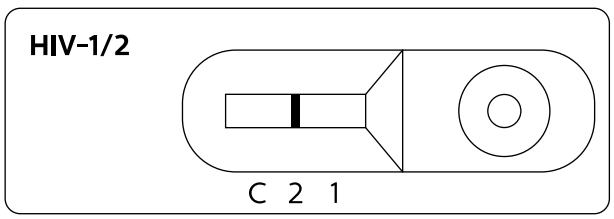


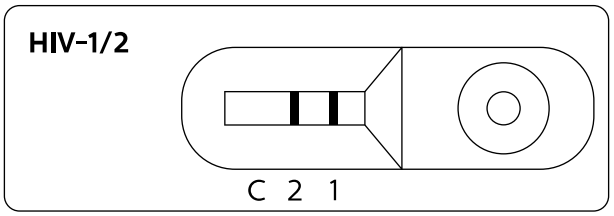


- **Invalid** - for an invalid result no colour band appears in the control window of the device. If this happens do not report invalid results. Repeat the test with a new test device even if a colour band appeared in the client window.









7.4.4. MOST COMMON MISTAKES IN THE TESTING PROCEDURE

- Tests storage inappropriate;
- Tests expiration date not checked;
- Algorithm not followed;
- Incorrect timing of test (results reported before the time prescribed by manufacture);
- Improper collection of specimen;
- Incorrect reagents used (e.g. reagent from a test used with a different type of test) or used wrongly (e.g. too much or too little reagent).

NOTE

Over the years, Life Choices understood the importance of having few key components in place in order to guarantee a good quality of HIV testing and the safety of everyone involved.

- Make sure all procedures are clearly documented with step-by-step guidelines. Each counsellor should have a copy;
- Make sure staff receives ongoing training;
- Routine on-site supervisory observations (Life Choices conducts a minimum of one monthly observation per staff);
- Proficiency testing - Twice a year, Life Choices receives panels of specimens by a reference laboratory. Each counsellor performs the proficiency test and the results are reported back to the laboratory. Laboratory scores and results indicate the quality of personnel performance and the overall quality of the test site operations.


Hard Work
Dedication
Discipline
Perseverance
VALUE YOURSELF
AMBASSADOR
I AM FREE
bursary
MAKE IT EASY!
I'M ALL GOOD
smarter
2 A's
LLB
Family Lawyer
MY BODY!
diva
BEAUTIFUL CONFIDENT CURVY
IT WORKS FOR ME
Marriage TREASURE
The Wedding
DRUM better life BE YOUR BEST SELF
NOW THAT'S A RESULT!
WHY! WHY! U DO THIS 2 R'S ? WHY ! POLICE!!!

CHAPTER 8
MONITORING & EVALUATION

In this Chapter we discuss a summarised version of the basis of successful interventions and the need for a well thought Monitoring and Evaluation system.

8.1. Successful Interventions

Based in literature review, successful interventions have the following factors in common:

1. A good logical model;
2. Well define intervention's goal and objectives (goal: ultimate purpose of the intervention/objective: milestones to achieve the goal);
3. Defines the target population narrowly;
4. Makes basic record keeping routine (process monitoring);
5. Builds support for evaluation.

8.1.1. LOGICAL MODEL

Before designing your intervention you should start by developing a logical model that connects the different parts of the puzzle to the final results you aim to achieve (the change you want to see).

Problem Statement
(describes the issues facing the population at risk)
|
Implementation
Input – Activities – Outputs
(Input: resources needed / Activities: services provided to achieve objectives / Outputs: direct products or deliverables of the intervention)
|
Outcomes
Immediate – Intermediate
(Immediate: immediate results such as knowledge, attitudes, skills / Intermediate: results that occur after some time such as change in behaviour)
|
Impact
(Impact: long-term results such as HIV infection, mortality).

BENEFITS OF USING A LOGICAL MODEL

A logical model will promote better communication about the intervention among staff, funders, community members, and other stakeholders. It will also assist in the monitoring of the progress of the intervention and in the development of an evaluation framework for the intervention.

8.1.2. PROCESS MONITORING

Collects data describing characteristics of the population served, services provided, and resources used to deliver those services. Answer questions such as:

1. What services were delivered?
2. What population was served?
3. What resources were used?

Life Choices makes use of specific tools for each activity conducted by the organisation (e.g. attendance registers, client files, inventory/stock lists, financial auditing). Tools should be concise, simple to understand and only contain information that will be used by the organisation.

After developing a tool, ask yourself the following two questions: 1) is all information required (internally and externally) captured by the tool?; and 2) is any information capture irrelevant (will not be used)?

The best organisations make M&E an essential part of the day-to-day activities without becoming a burden to staff. Make sure part of the induction training provided to each new staff includes the understanding of the importance of monitoring tools and proper training in how to become proficient in completing the tools.

8.1.3. INTERVENTION EVALUATION

An intervention evaluation is nothing more than a system of data collection and analysis used for measuring the intervention:

1. Effectiveness (does the intervention do what it intended to do?)
2. Efficiency (does the intervention work in the least costly manner?)

Why do an intervention evaluation?
Intervention evaluations serve to understand if the intervention works, meets its objectives and also to inform the organisation how to make the intervention more effective or/and efficient.

Intervention evaluations also assist in demonstrate intervention's value, enhance organisation's credibility and demonstrate accountability to all stakeholders.

THE MOST COMMON USED TYPES OF EVALUATION

- **Formative Evaluation:** Occurs before intervention implementation or before revision. Guides intervention design by providing feedback and permits revisions before the full implementation. GOAL = Maximize chance of success.

- **Process Evaluation:** Collects detailed data about how intervention was delivered, differences between intended population and the population served, an access to the services. Answers questions such as:
  1. Was the intervention implemented as intended?
  2. Did the intervention reach the intended audience?
  3. What barriers did clients experience in accessing the intervention?

- **Outcome Evaluation:** Collects data about outcomes before and after the intervention for its clients, as well as the same data from a control group. Answers questions such as:
  1. Did the intervention cause the expected outcomes?
  2. Were outcomes different than those of the control group?

- **Economic Evaluation:** Examines the intervention in terms of cost and monetary value.

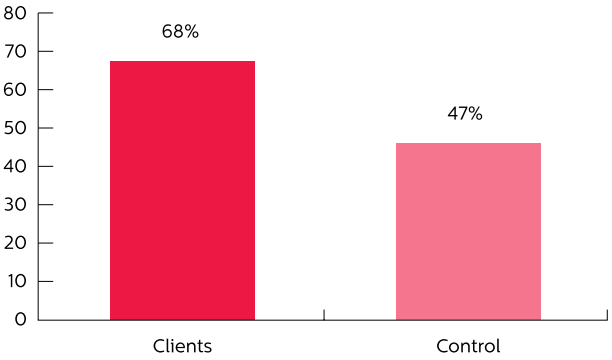
8.2. Life Choices Evaluation Results

To measure outcomes, Life Choices used a quasi-experimental design with both treatment and control groups. Baseline, post-intervention, three months follow-ups questionnaires were compared to assess changes in knowledge, attitude and behaviour.

Based on the evaluation of the intervention the main impact of the project to date is condom use – "Individual clients did show more positive change than did controls. As depicted, almost half (46%) of clients increased their condom use and another 22% sustained consistent condom use; therefore, in total, just over two thirds of the clients were using condoms consistently or had at least increased condom use at follow-up, whereas the same can be said for only half of the controls. Overall, at follow-up, controls were equally likely not to use condoms at all or have decreased condom use as to have increased condom use or used condoms consistently."

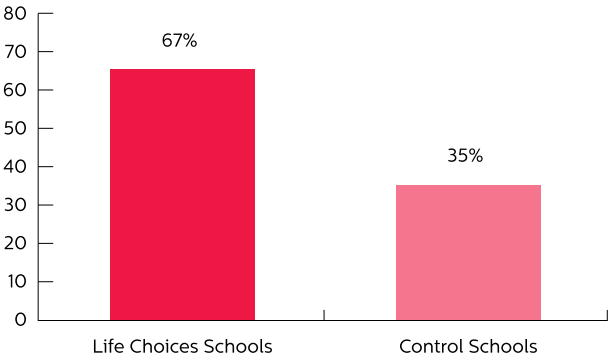
Use of condoms the last time they had sex

Results at three months post intervention



When comparing the numbers of learners that know their HIV status, we also observed an impact.

Learners knowing their HIV status

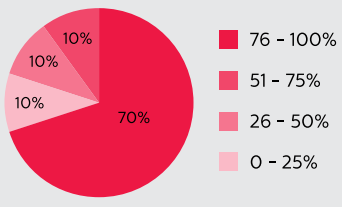


WHAT WAS THE OVERALL FEEDBACK FROM THE TARGET GROUP ON THE PROJECT?

After completion of the intervention, a sample of participants were asked a series of questioning relating to their overall experience of the services they received from Life Choices.

100% of the participants felt the service was 'Very helpful' to them. 97% also indicated that they would recommend Life Choices' services to a friend.

When asked: What are the chances that you will implement the risk reduction plan?



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