ECA/SRDC/SA/MR/16

BACK TO OFFICE REPORT

Staff member:	Catherine N. Ngaleo-Boyce
Purpose:	To participate in Workshop on Introduction to HIV/AIDS Counselling to UN-Zambia HIV/AIDS Awareness Task Force
Venue:	WHO Conference Room, Lusaka
Dates:	22-23 June 1998

Back to Office Report

Workshop on Introduction to HIV/AIDS Counselling
to UN-Zambia HIV/AIDS Awareness Task Force

held at WHO Conference Room, 22-23 June 1998

UNECA/SRDC-SA Staff member: Catherine N. Ngaleo-Boyce

Background:

The UN-Zambia HIV/AIDS Awareness Task Force was set up in March 1996 by the UNDP Resident Coordinator. Its main objectives are to:

- Prevent, manage and deal with illnesses in the UN Offices;
- Increase awareness on HIV/AIDS prevention among UN staff and their families on how to live positively with HIV/AIDS;
- Create a working environment sensitive and responsive to the needs of affected colleagues;
- Identify and act on issues causing stress and tension in the working environment;
- Provide assistance, e.g. transport, to the families of staff upon bereavement.

The Task Force consists of one member from each of the following UN Agencies: UNDP, UNESCO, ILO, WHO, ECA/SRDC-SA, IBRD, WHO, UNICEF, FAO, UNHCR and WFP in Lusaka. I represent the SRDC-SA on the Task Force.

Objectives of the workshop:

In line with the above objectives, the Task Force members were invited to attend a two-days workshop on Introduction to HIV/AIDS Counselling, organized and sponsored by UNDP. The main objective of the workshop was to create awareness of counselling and its needs both in the work place and outside, so that the Task Force members can handle in the workplace and refer cases that need HIV/AIDS counselling.

At the end of the Workshop, the Task Force members also expected to be able to: describe basic facts about HIV/AIDS, deal with counselling issues as they relate to HIV/AIDS, identify counselling needs at the workplace, and take appropriate action in times of distress related to HIV/AIDS.

The Workshop

The Workshop was conducted by two resource persons: Dr. Bristol Chembo of UTH and Mr. Chilimba Hamavhwa, Psychiatrist, Counselling Unit, Chainama Hills College, and was addressed by the UNDP Resident Representative, Mr. Gary Davis during the afternoon of the first day.

The discussions were held in plenary and in groups on the HIV/AIDS virus, how it is transmitted, counselling and management of issues relating to those who have tested positive or, as family members or colleagues, are touched in different ways by the effects of the diseases.

The main issues covered in the workshop are the following :

a) Desensitizing Task Force members to enable them to freely discuss issues related to HIV/AIDS, by removing the shyness common in discussing certain parts of the

body or activities involved in the transmission of the virus, and simple means to help control its spread.

b) Dealing with office situations where an affected staff member's behaviour is characterized by frequent absenteeism, frequent financial loans, poor inter-personal relations and stigmatization or discrimination by colleagues.

c) Magnitude of infections and its effects on general population, family and at individual levels;

d) Popularizing social and health education to help reduce transmissions, particularly during the window period, i.e. the period between possible exposure to the virus and actual diagnosis;

An HIV/AIDS Self Assessment (Risk assessment) Life Line was introduced. This line shows major events and periods when an individual could have been exposed to HIV/AIDS. As an exercise, each participant prepared his/her own anonymous Life Line to show those events and periods in his/her own life. These life lines were then discussed to determine cases of exposure to the virus and the need for testing.

The Life Line can also be used for other staff who suspect that they had been exposed to the virus. When it is determined that indeed an individual may have been infected, testing should be carried out.

e) Counselling before, during and after testing and in dealing with the trauma of a positive diagnosis;

f) The denial process: where individuals may not choose

to "come out" in the open. This renders it difficult to provide counselling or indeed any assistance until it is too late. The workshop agreed that unless the affected staff request assistance, information or advice, there is little that can be done except treatment of symptoms as they manifest themselves.

g) Management of crises in illness and inability to work, hospitalization and death: Provide as much assistance as possible within the employment rules, to both the staff member and the family.

h) The need for linkages : For counselling to be effective, linkages need to be established between the staff and the Task Force members. The counsellors also have to be recognized as persons with limitations and not as providers of solutions to every problem.

i) The ideal counsellor: As counsellors, Task Force members were advised to strictly maintain confidentiality, make time to be good listeners, reassuring and adopt a non-judgmental attitude in discussing and dealing with those living with HIV/AIDS, family members and colleagues. Local traditions and customs should also not be overlooked.

Ethical/Legal issues:

The workshop stressed the wisdom of prudence, confidentiality and observing ethical conduct rules. Health-related issues are confidential and privileged information and disclosure may lead to legal action against the counsellors.

Towards the end of the Workshop, we did practical exercises on counselling, in groups, with one participant acting as

counsellor, and another as a member of staff seeking counselling (client). The Counsellor and client carried out a conversation and after probing and understanding the needs of the client, the counsellor advised and made suggestions aimed at encouraging the client to make a decision on the best possible solution/action to take. The resource persons, who observed the discussions, gave each group comments based on observations on the participant's performance as counsellors.

The following two hand-outs, copies of which are attached, were used in the discussions:

- HIV/AIDS Counselling
- Personal-centered (Regaerian) counselling Model

Conclusions:

The workshop gave the Task Force members an invaluable opportunity to discuss, ask questions and learn from the two medical and psychiatrist government personnel the basics of counselling in the sensitive issues relating to HIV/AIDS. It was observed that having been too shy to openly discuss HIV/AIDS, after this Workshop, the Task Force members felt more confident to conduct helpful discussions with staff on the subject, and thus better able to handle those living with, or are affected by HIV/AIDS in our working environment.

The Task Force members agreed that they had learnt a lot during the short period of two days. There was, however, a need to expand on the training. It was, therefore, suggested that the possibility of having a longer workshop, under the umbrella of UNDP and co-sponsored by the other UN Agencies, should be explored.

The participants were very appreciative of the resource persons' tireless efforts in conducting the workshop and sharing with the participants ways of counselling and dealing with HIV/AIDS in the offices.

Appreciation was also expressed to UNDP for making the workshop possible by sponsoring and organizing it, and to Mr. Gary Davis, Resident Representative, for personally making time in his busy schedule to address the workshop.

WORKSHOP ON INTRODUCTION TO HIV/AIDS COUNSELLING TO UN-ZAMBIA HIV/AIDS AWARENESS TASK FORCE

VENUE: WHO Conference Room, Lottie House

DURATION: Two days

DATES: Monday 22 to Tuesday 23 June 1998

VENUE: UNDP Conference room

WORKSHOP OBJECTIVES

GENERAL OBJECTIVES

To create awareness of counselling and counselling needs to HIV/AIDS Task Force members (participants) so that they can identify and refer cases that need HIV/AIDS counselling.

SPECIFIC OBJECTIVES

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

1. Describe basic facts about HIV/AIDS
2. Discuss counselling issues as they relate to HIV/AIDS
3. Identify counselling needs at workplace
4. Describe appropriate action in times of distress related to HIV/AIDS

COURSE CONTENT

Preview of National Counsellor Training Program
Basic facts on HIV/AIDS
Counselling Concepts/Definitions
Types of counselling
    Core conditions of Counselling
    The Ideal counsellor
Introduction to basic counselling skills and Techniques
    Communicating sensitive information
Ethical/Legal issues in counselling
Counselling issues/needs at work place
Counselling and Testing Issues (Plenary discussion)

THE PROGRAMME

DAY ONE: MONDAY 22 JUNE 1998

8:30 Opening remarks/Introduction to the course and course objectives

9:00 Participant introductions (Self introduction)
Preview of National Counsellor Training Program
10:00 Health Break
10:30 Counselling issues/needs at work place(Group exercise)

11:00 Basic Facts on HIV/AIDS:
Self risk Assessment (Life line exercise)
Basic facts (Group work)
13:00 Lunch Break

14:00 Counselling concepts/definitions:
What is/what isn't counselling (Group exercise)
15:30 Health Break

15:45 Counselling Concepts

16:00 Debriefing/Rap up

DAY TWO: TUESDAY 23 JUNE 1998

8:30 House keeping

9:00 Types of counselling
Types
Core conditions of counselling
Qualities of The Ideal Counsellor (Fishbowl exercise)
10:00 Health Break

10:30 Introduction to basic counselling Skills and Techniques (Fishbowl/Group exercises)
Communicating sensitive information (Group exercise)
12:30 Lunch

14:00 Ethical/Legal issues (Group work)
Counselling and Testing Issues (Plenary discussion)

1530 Health Break

16:00 Debriefing/Epilogue/Bon voyage!..

PERSON CENTRED (ROGERIAN) COUNSELLING MODEL

Chilimba Hamavhwa, MPH, PhD Reader, psychotherapist

Carl Rogers lays emphasis on wild developed working relationship that allows clients to develop and grow. He arques that subsequently this will enhance behaviour change. There are two main levels that the counsellor should observe: counselling relationship, characterised by core conditions, on the one hand and the therapeutic process, on the other.

COUNSELLING RELATINSHIP

The person-centred counselling model is essentially a relationship therapy. The relationship that the Counsellor provides for the client is not an intellectual one. It is a relationship that is intended to help the client to explore, discover and clarify his/her capacity to use that relationship for change and growth. The counsellor in the counselling relationship should have, infact must possess, a number of qualities. Carl Rogers calls these qualities as core conditions. No counsellor has these qualities to their ultimate degree however, although every person-centred Counsellor should strive to fulfil the three core qualities or conditions for enhancing therapeutic change and growth in the client - congruence, unconditional positive regard, empathy.

1. Congruence (genuineness)

The Counsellor must show him/herself to be a real person, with feelings which should be expressed where appropriate. The counsellor is unified, integrated, and consistent; there should not be contradiction between what the counsellor is and what she/he says. The client needs to feel that the Counsellor is emotionally involved and not hiding behind a mask of professional impersonality, or indeed, not merely playing a role. This is the most important of the three qualities or attitudes.

2. Unconditional Positive Regard (acceptance)

The counsellor should be accepting of the client as an individual, as the client is, with his/her conflicts and inconsistencies, or good and bad points. Such an attitude or quality is more than a neutral acceptance - it is an unconditional positive regard/respect for the client as a person of worth. It also involves a liking for and warmth toward the client - a total recognition of the client as a human being, with feelings and knowledge. The Counsellor must have a deep and authentic caring for the client in their present situation in a non-judgemental way.

3. Empathic Understanding

To sense the client's private world as if it were your own, the ability of intellectual and emotional identification with another person, is what is referred to as empathy. The Counsellor must try to enter the client's internal world through a genuine, attentive listening, which involves intense concentration. This may involve re-stating or paraphrasing what the client says as a way of clarifying the emotional significance of what is said. The Counsellor needs to be sensitive to what is currently going on in the client and of meanings which are just below the level of awareness. Such understanding enables the client to explore freely and deeply and thus to develop a better comprehension of themselves. There seems little doubt that empathic understanding is a necessary ingredient of virtually all successful counselling relationships.

HIV/AIDS COUNSELLING

Chilimba Hamavhwa

The need for counselling services in Zambia has greatly increased in the recent past largely because of the advent of the HIV/AIDS epidemic. This is true for most other developing countries. The diversity and severity of a wide range of problems that have emerged as a result of the rapid transmission of HIV infection has made many people turn to counselling for professional support, help, advice and information.

From a contextual perspective, counselling for HIV/AIDS may be categorized in three complementary levels. The first level includes preview, pre and post-test counselling. The second level constitutes preventive counselling, while the third level is supportive counselling.

First Level: This is intended to help persons considering a test to think through the issues involved and to inform them about the available testing centres. At this level people seeking counselling are usually in crisis, presenting with concerns of worry, anxiety and depression. They feel threatened, that is, fear, prolonged suffering, death, loss of prestige, shattered future hopes, and discrimination. The threat is both internal and external. Counselling usually is crisis and problem-management in orientation. The main emphasis is the establishment of a need and informed consent for a HIV antibody test and the development of understanding of the diverse issues related to infectivity, and what this means for the particular individual, their family and the community.

Second Level: Preventive counselling constitutes the second level. The clients are not only helped to understand their situation, but are also helped to gain insight into their vulnerability and the need to take responsibility in preventing further HIV transmission. This level seeks to encourage self-determination, enhance self-confidence and improve coping capabilities of clients so as to promote an improvement in the quality of their lives and their social and psychological well-being. Furthermore, preventive counselling embraces the aspects of information giving and education for motivation and adoption of risk-reduction behaviours. It seeks to promote awareness and understanding of the adverse effects of the HIV/AIDS situation from a wider context.

Third Level: The third level is supportive counselling. It seeks to provide psychosocial, emotional and spiritual support for those who are directly or indirectly affected by HIV/AIDS through follow-up and home care services, and community counselling which encourages the involvement of the community in preventive efforts to combat the spread of HIV infection and care of those affected by the AIDS disease.

If the above stated therapeutic conditions or counsellor qualities are established, clients will talk about themselves more honestly and this will bring about a re-establishment of congruence which will be sufficient to produce changes in behaviours. However, it is of no value for the Counsellor to be congruent, accepting and understanding if the client does not perceive or experience the Counsellor as such. It is thus important that congruence, acceptance, and understanding be communicated to the client - as spontaneous expressions of the Counsellor's attitudes. It must be emphasized that a relationship in which change can occur has two facets: first, the Counsellor is perceived as dependable, trustworthy, and consistent by the client; and second, the client experiences feelings of safety, security, freedom from threat, and a supporting environment. Development of such a relationship is only possible if the counsellor qualities or attitudes are present and effectively communicated to the client.

THE THERAPEUTIC PROCESS

An interpersonal environment that is likely to facilitate actualization and growth is characterised by the following core conditions in person-centred counselling:

1. Two persons are in psychological contact.
2. The first, referred to as the client, is in a state of incongruity, being vulnerable and anxious.
3. The second, referred to as the counsellor, is congruent or integrated in the relationship.
4. The counsellor experiences unconditional positive regard for the client
5. The counsellor experiences an empathic understanding of the client's internal frame of reference, and attempts to communicate this to the client.
6. The communication to the client of the counsellor's empathic understanding and unconditional positive regard is achieve to a minimum extent possible.

If these six conditions exist and continue over a period of time, the process of constructive change and growth for the client will follow. This view is supported by a substantial amount of research which has proved that these conditions are not just important or useful, but also adequate in themselves.

Therapy usually progress in three stages. In the first stage the clients express predominantly negative feelings toward themselves, the world, and the future. In the second stage clients begin to feel and express a few glimmers of hope. For instance, they show some signs that they are beginning to accept and gain insight of themselves. And in the final stage clients show positive feelings and caring for others. They develop more self-confidence and start to make plans for the future. The counsellor then terminates the therapy or help because the person has allowed his/her natural self-actualizing capacity to emerge which is gradually internalized as new behaviours.

VIDEOS ON AIDS AND STDs

(1) MAKING CHOICES
(2) NO NEED TO BLAME
(3) CHALLENGES IN AIDS COUNSELLING
(4) A WORLD UNITED AGAINST AIDS
(5) LIKE A TREE WITHOUT ROOTS
(6) A NATIONAL AIDS, STDs, TB AND LEPROSY CONTROL PROGRAMME PRESENTATION ENGLISH, BEMBA AND NYANJA.
(7) AIDS BLUE COLOUR ENGLISH, BEMBA AND NYANJA.
(8) THE SENSE IN KNOWING NEVER TOO LATE
(9) BREAKING THE STIGMA
(10) SHARED RIGHTS SHARED RESPONSIBILITIES
(11) DEBATE THE MYTH DRAMA, SUGAR DADDY
(12) AIDS: A WORLDWIDE EFFORT WILL STOP IT.
(13) AIDS WORK PLACE (RURAL NYANJA)
(14) YOUTH
(15) WORKPLACE COMPONENT: AIDS AWAIRENESS CAMPAIGN 1994
(16) AIDS AWARENESS CAMPAIGN, TRADITIONAL RITUALS + AIDS SPREAD.
(17) CHALLENGES OF THE CENTUARY PART ONE AND TWO.
(18) WORLD AIDS DAY CELEBLATIONS FROM 1991 TO 1994
(19) HEALTH TEACH'' LIVING WITH AIDS CONTINUING VIDEOS 1 to 13.
(20) PALAVER TIME CHILD ABUSE ETC.

MUSIC

(1) SAKALA BROTHERS: WE ARE THE CURE.

(2) VICTOR KACHAKA : UNITE AGAINST AIDS.