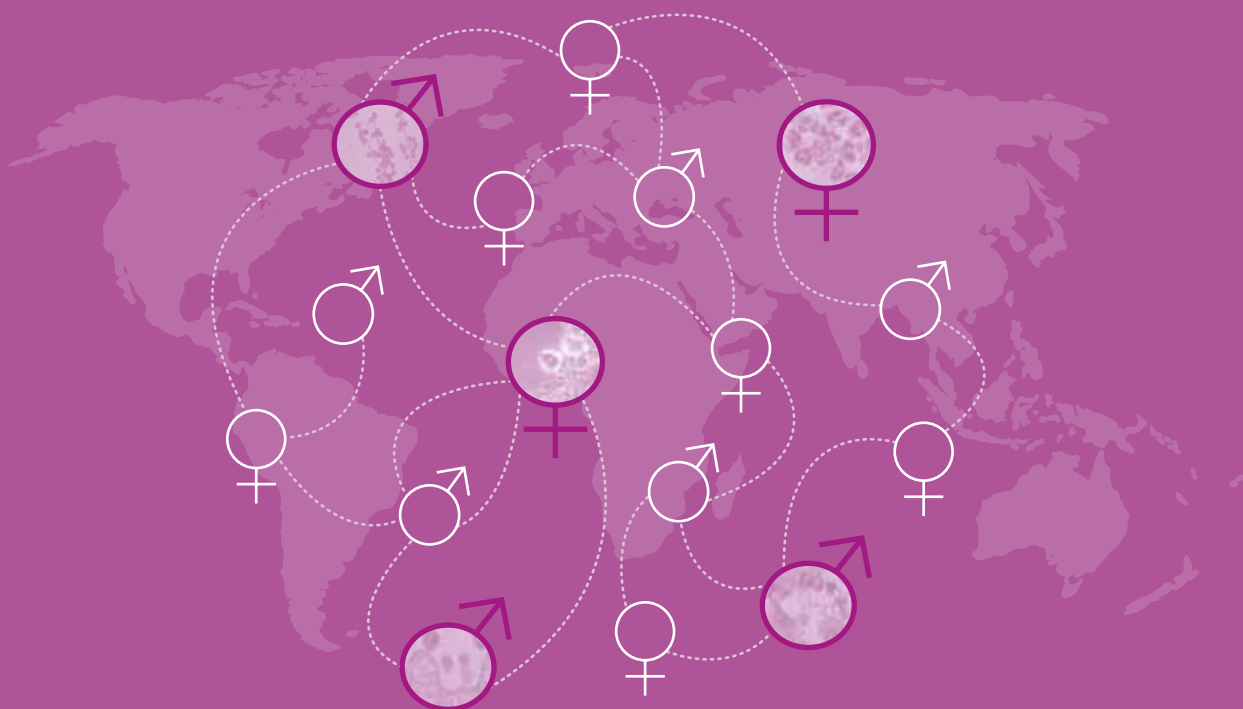


Training Modules for the Syndromic Management of Sexually Transmitted Infections 2nd Edition

Module 5 Educating and Counselling the Patient

Breaking the chain of transmission

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Module 5

Educating and Counselling the Patient

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Introduction

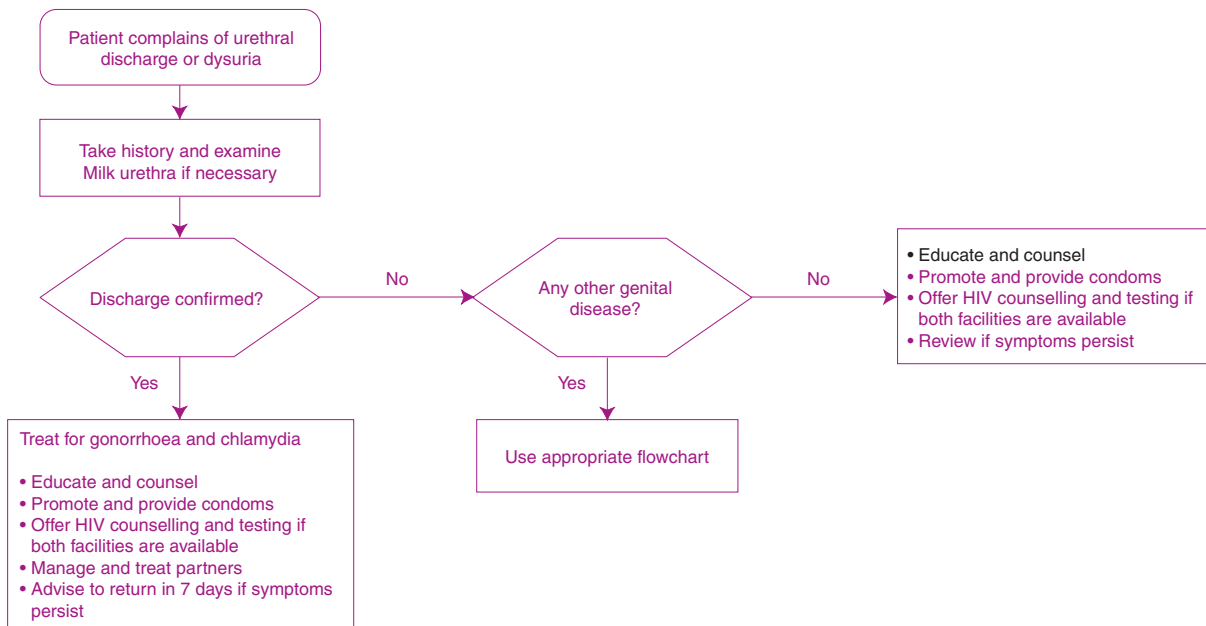
For the control of sexually transmitted infections (STIs) Programmes should aim to reduce the rate of new infections through a combination of strategies, including behaviour change, risk reduction, condom use and treatment of patients with STIs.

Health education and counselling for STIs are important for individuals to appreciate their own responsibilities and opportunities to reduce STI transmission. A person who presents for STI care at a health centre is at his/her most receptive phase for education.

Education should cover the nature of the infection, its consequences and risk reduction to prevent both transmission to others and acquisition of future infections.

The education process needs to be carried out effectively and appropriately to have the desired effect. If the patient is not educated and/or counselled about the infection, he/she is at higher risk of becoming reinfected and/or spreading the infection to sexual partners. A person who is made aware through appropriate health education is more likely to be cooperative and receptive of the health-care provider's advice.

This module attempts to provide some insight into the provision of health education and counselling as part of your day-to-day interactions with patients. Indeed, every health-care provider should be equipped with the appropriate basic knowledge of STIs in order to give health education to patients. However, counselling is a special skill that requires proper training: we recommend that you receive this from institutions that provide counselling training. This module will only provide the basic concepts of counselling and does not presume to make you a professional counsellor.



Your learning objectives

This module and its accompanying activities and action plans will enable you to:

- explain the difference between education and counselling;
- explain why education and counselling are so vital in STI case management;
- recall a range of communication skills for education and counselling;
- discuss sexual practices and sexual behaviour (covered to some extent in Module 3);
- identify the main education topics for patients with STIs;
- identify key issues for HIV counselling and voluntary testing;
- list the benefits of using condoms;
- recall the basic steps for putting on condoms and demonstrate this to a patient.

1: Health education and counselling

Health education and counselling are closely linked. Both activities may take place at the same time. In health education, the aim is to make the patient better informed, so that he/she can make an informed choice of sexual behaviour and practices. Counselling relates more to issues of anxiety and coping with the infection or its consequences, biomedical as well as social.

Health education is the provision of accurate and truthful information so that a person can become knowledgeable about the subject and make an informed choice.

For example, a young woman with an STI needs to know how she contracted the infection in order to decide to change her sexual practice. The service provider should inform her about STIs and their prevention.

Counselling is a two-way interaction between a client and a provider. It is an interpersonal, dynamic communication process that involves a kind of contractual agreement between a client and a counsellor who is trained to an acceptable standard and who is bound by a code of ethics and practice. It requires empathy, genuineness and the absence of any moral or personal judgement.

Counselling can be applied to any life situation, for example, when a nurse is listening and talking to grieving relatives; or a colleague is talking to someone who wants to quit their job and even commit suicide because of it! In other words, counselling is not peculiar only to STIs and HIV.

Counselling aims to encourage healthy living and requires the client to explore important personal issues and to identify ways of living with the prevailing situation, whether it is an infection or bereavement. It is not about providing advice or guidance, nor does it mean befriending someone.

In STIs and HIV, the counselling process assesses and addresses the client's needs to enable the person to cope with any anxiety and stress brought about by the diagnosis. The counselling process should also evaluate the person's risk of STI transmission and explore preventive behaviour in future. So, counselling helps clients understand themselves better as individuals, exploring their feelings, attitudes, values and beliefs. Equipped with the right knowledge, the client should seek to change behaviour as a result of counselling.

Why are education and counselling so important?

Education and counselling are important for several reasons.

- Patients are more likely to comply with treatment if they understand why it is important to do so.
- A person with an STI has a high likelihood of being reinfected.
- Preventing reinfection requires sustained behaviour change. Patients often need education and counselling to enable them to change behaviour and adopt safer sexual practices.

Why offer education and counselling for STIs at the primary health centre?

Health-care providers have a unique opportunity to discuss safer sex and prevention strategies with patients who have sought health care and advice. This link between treatment and prevention is very important because:

- it reaches people when they are ready: the patient has come to you;
- the patient's initial visit is a unique opportunity for patient education: often the only time that patients are interested to learn about a disease or its prevention is upon hearing that they, or someone they know, are faced with that disease;
- opportunities for brief, repeated and cumulative messages are more likely at the primary health centre than a referral centre.



Question

1a) On page 15 of Module 3, two general types of question are mentioned: what are they?

Which type of question is it best to use when taking the patient's history? Why?

1b) What are the six specific verbal skills we suggested? Note down as many as you can recall.

Please turn to page 61 to find the answers.

2: Health education – educate on what?

This section will enable you to identify a number of issues on which you need to educate patients with STIs.

Health education happens when health-care providers share their knowledge with the aim of increasing a client's awareness and understanding. In health education the same facts are given to everyone.

As with any other type of patient, people with an STI need to know about their condition and its management because the goals of patient education are to:

- help the patient resolve any current infections;
- prevent future infections;
- make sure that sex partners are also treated and educated.

As a health-care provider, you may feel uncomfortable using certain words about sexual matters. It is important to become familiar with using these words so you can feel comfortable when you speak to and educate your patients.

You may need special training to achieve this, so you may wish to discuss this with your facilitator or manager. In Module 3, Section 3, Activity 6, we explored the issue of local language and popular terms that you may need to be familiar with to discuss such sensitive subjects.



Question

2. In educating patients with STIs, what issues do you need to discuss or explore with them? In answering this question, you might find it helpful to refer to the flowcharts.

When you have listed as many issues as you can, please turn to page 61 for our comments.

The list we suggest in answer to question 2 offers a sensible order in which to cover the points. Over the next few pages, we explore each point in more detail.

Explaining the STI and its treatment

The first issue is to explain what a sexually transmitted infection is. It is important that the patient understands that the infection is transmitted mainly through sexual intercourse with an infected person. The sex act may be penile – vaginal, oral or anal. Explain that sexually transmitted organisms can be bacterial (e.g. the *gonococcus*), parasitic (e.g. *Trichomonas vaginalis* or *pubic lice*), or viral (e.g. *herpes simplex virus* or *HIV*). Then explain which STI the patient has and what treatment will be necessary – the name of the medication and how much to take, how often and for how long. Write down these details for the patient – or use recognizable symbols if the patient cannot read. Also:

- find out what the patient understands about the STI and its treatment and what questions and concerns he or she may have;
- advise about any common side-effects of the treatment;
- encourage the patient to comply with treatment.

As with all treatments, it is essential that patients complete the recommended treatment, even if the symptoms disappear or improve. Remind them that if they do not take all the medication, the symptoms may recur and that they will not be completely cured.

In Module 3 we asked you to list local words and language for medical terms. Here, we ask you to consider local or regional names and causes for each STI syndrome.



Activity 2

What words are commonly used to describe these syndromes in your region, and what do people believe cause them?

Syndrome	Regional name	Cause or description
Vaginal discharge		

Syndrome	Regional name	Cause or description
Urethral discharge		
Genital ulcers		
Scrotal swelling		
Lower abdominal pain		
Inguinal bubo		
Neonatal conjunctivitis		

Educate on prevention of future infection

Once you are sure that the patient understands his or her infection and what treatment to follow, he or she next needs to appreciate the risk of becoming reinfected. This means that you assist the patient to assess his/her own risk level.

Changing sexual behaviour

Remember: high-risk behaviour is behaviour that exposes the patient to sex fluids and blood. Therefore, changing from high-risk to low-risk sexual behaviour is one way to prevent future infection. Reducing the number of sex partners or the rate of change of sex partners is important. Sexual abstinence virtually guarantees against contracting or transmitting an STI. This is particularly important during treatment for STIs.

Condoms

Another practice for preventing the spread of STIs is the use of condoms. Male latex condoms can reduce the risk of contracting or transmitting STIs if consistently and correctly used. The health-care provider must demonstrate the correct use of condoms, using a penile model where available. Let the clients practise on the model so that they understand how to put the condom on, can demonstrate this skill and feel confident about handling a condom.

Sexual practice

It is also important to inform clients that some sexual practices have a higher risk of infection. For example, anal sex, whether it is male to female or male to male, carries a higher risk than penile – vaginal sex.

Other barrier methods

Inform your clients of any other existing prevention methods such as the use of spermicides that may also be bactericidal; microbicides or vaccines (e.g. for hepatitis B).

Personal hygiene and cultural practices

Vaginal douching, for example, may remove protective bacteria in the vagina increasing the risk of getting some STIs, e.g. HIV. Washing with soap and water may help prevent colonization with parasites, such as pubic lice or scabies.

The need to treat sexual partners

This is the theme of Module 6, so we need not discuss it in any detail here. Remember: always inform patients how important it is to have all their known sex partners treated.

Reassure patients that you will maintain confidentiality and discuss how they can persuade their partner(s) to attend for treatment. Stress that treatment will benefit both partners because there will be no risk of reinfection and the partner, who may not be aware of the infection, will have the STI treated and avoid future serious complications.

This is all factual information and you could supplement it with a brochure that patients can take home to read at leisure. Once the patients have assimilated the information, they will know about STIs and how to prevent them.

However, knowledge and information alone are not sufficient to bring about behaviour change. We also need to bring about behaviour change, and counselling is one strategy that can be used to achieve this.

3: Counselling for STIs and HIV

Counselling helps clients understand themselves better as individuals. It explores feelings, attitudes, values and beliefs. Equipped with the correct information and knowledge, the client should seek to change behaviour as a result of counselling.

There are certain basic requirements for counselling to be acceptable. For many people, if not all, issues of a sexual nature can be very embarrassing to discuss.

It is important to recognize that it will have taken considerable courage for someone to seek help for STIs or HIV and they may have many expectations (positive and negative) about the session or the messages that you will provide.

We need to be aware of cultural beliefs and how they influence behaviour, thoughts and feelings. This means that the conditions and the environment must facilitate talking about sex. The environment must provide privacy and ensure confidentiality and professionalism. The communication must take cultural, gender and language issues into account. We recommend that you use simple language rather than “impressive” medical terms.

There must be respect for age and seniority within the cultural norms. (By culture, we mean the habits, expectations, behaviours, rituals, values and beliefs that groups of people develop over time. Culture strongly influences our feelings and beliefs about health and illness, about caring for each other and about death and loss.)

Avoid giving the client the impression that the session is rushed and you are short of time. Effective counselling requires time.

Health-care providers need to develop a number of basic skills to conduct an effective and satisfying counselling session. Counsellors must be empathetic and able to communicate clearly with calm and steady control over their emotions.

Communication is the key. Communication can be both verbal and non-verbal.

The key non-verbal communication skills are:

- appropriate eye contact;
- listening;
- staying close to the patient without physical barriers in between, but within culturally acceptable norms.

The key verbal skills are:

- use of open-ended questions;
- facilitation, to encourage clients to come out and speak;
- direction, to help clients sort out their ideas and issues clearly;
- summarizing and checking (paraphrasing), to enable you, as counsellor, to check that you have understood the client correctly.

As these skills, verbal and non-verbal, are also important for building a good rapport with patients and clients and for taking a good medical history, we have dealt with them in Module 3, Section 2.



Activity 3

Reflect for a moment: Module 3 will be helpful for this activity.

- a) What qualities do you need to establish a good rapport with a client or patient?

- b) List at least four non-verbal skills you can employ to gain the client's trust or confidence.

- c) Now let us turn to our verbal skills. What are the verbal skills that we need to effectively communicate with a client?

Having reviewed what we learnt in Module 3 on communication skills and the issues in educating and counselling the patient with STIs, let us summarize the communication skills learnt so far before returning to counselling. Remember that you need to use these skills for a satisfying counselling session for counsellor and client alike.

Summary and tips for counselling with active listening

It is important to:

- use eye contact – it shows interest (as long as this is culturally acceptable in your particular setting);
- use open-ended questions, they allow clients to express themselves;
- check your understanding by summarizing (paraphrasing);
- nod and use acknowledgement sounds that convey interest and keep the conversation flowing, but avoid unnecessarily interrupting your client;
- use a tone of voice that shows interest;
- listen for feelings as well as facts.

Make sure to watch out for the following habits which make for an unsatisfactory counselling session for counsellor and client alike.

Do not:

- interrupt the client unnecessarily;
- finish off the client's sentences;
- let your mind wander and spend listening time formulating your responses or thinking about dinner!

Assessing the patient's risk level

If you have taken the patient's history, you may already have enough information to assess the risk of reinfection. The next page contains a list of possible issues that may help you explore the risks with the patient.



Activity 4

Please read through the factors for assessing risk below and mark any that you think may not be relevant when assessing a patient's risk of STI infection. Use the space below to make notes and discuss your notes with colleagues.

When assessing the patient's risk level – and throughout the interview – remember to use the questioning techniques you developed with Module 3.

Factors to assess the patient's risk of further STI

<p>Personal sexual behaviour</p> <ul style="list-style-type: none"> ■ Number of sexual partners in the past year. ■ Sex with a new or different partner in the last three months. ■ Any other STIs in the past year. ■ The exchange of sex for money, goods or drugs (giving or receiving). ■ Use of herbs as a drying agent, or similar sexual practices. <p>Other personal risk factors</p> <ul style="list-style-type: none"> ■ HIV infection. ■ Use of skin-piercing instruments such as needles (injections, tattoos), scarification or body-piercing tools, circumcision knives. ■ Blood transfusion. ■ For young children, all these risk factors relate to the parents. 	<p>Sexual behaviour of partner(s)</p> <p>Does the patient's partner(s):</p> <ul style="list-style-type: none"> ■ have sex with other partners? ■ also have an STI? ■ have HIV infection? ■ inject drugs? ■ if male, have sex with other men? <p>Personal drug use</p> <ul style="list-style-type: none"> ■ Use of alcohol or other drugs (which drugs?) before and during sex. ■ Sharing needles or 'works' (high risk of transmitting or being infected with HIV). ■ Exchange of sex for drugs or drugs for sex. <p>Patient's protective behaviour</p> <ul style="list-style-type: none"> ■ What the patient does to protect him/herself from STIs. ■ Use of condoms: when and how, with whom, why. ■ Low-risk or safe sexual activities the patient might practise: when and how, with whom, why.
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Only ask questions about any of these risk factors if you have not already learned the answers when taking the patient's history.

Helping the patient identify his/her risk factors

Once you have a clear idea of the patient's risk level, you need to help the patient identify what risks he or she has been taking in the past, then work together to explore options for safer sex.

Options for safer sex include:

1. Limiting sexual partners to one faithful partner.
2. Using condoms consistently and correctly. (We will deal with this in more detail in Section 5.)
3. Replacing high-risk penetrative sex (such as unprotected vaginal or anal intercourse) with low-risk non-penetrative sex (such as mutual masturbation).
4. Abstinence from sexual intercourse: a preventive strategy that should be encouraged, especially in the young and in couples when one partner is being treated for STIs.

Continually check for misconceptions when discussing sexual behaviour with a patient. Few patients have a *complete* or *accurate* picture of either the causes of STIs or how to avoid infection, and accurate information is often mixed with local beliefs. It is clear that a patient with inaccurate beliefs about the causes of STIs may have a false sense of security – and so run an even greater risk of reinfection. Some such common beliefs about STIs/HIV include:

- the idea that certain people, such as married women, young girls or boys or "clean" partners, are usually free from infection;
- taking anti-malarials or any other antimicrobials before or after sex offers protection;
- urinating, washing or douching after sex protects against all STIs;
- the patient's belief that he/she does not belong to a high-risk group (such as commercial sex workers or homosexual males) and so is safe;
- circumcision offers absolute protection against STIs and HIV.

None of the above beliefs is true, of course. Now try question 3.



Question

3. What common beliefs do you know of about protection against STIs in your region?

Please refer to our list of beliefs on page 62.

Make sure that the patient understands that he or she became infected through unprotected sex with an infected partner. (Remember: syphilis and HIV can also be acquired by other means such as blood transfusions and through sharing needles with someone already infected.)

The need to change sexual behaviour

Once the patient understands how he or she was infected and is aware of the risk of reinfection, the next steps are perhaps the service provider's most challenging tasks. These are the need for the client to change sexual behaviour, the barriers to such change and establishing the changes that the client intends to make.

This step is about helping the client decide to change his or her sexual behaviour in order to avoid further infection. It is a good idea to give the patient the opportunity to identify what changes might be possible in his or her own life. Assist the client to rate the importance of changing the risky behaviour and his/her confidence in succeeding.

Barriers to changing behaviour

All health-care providers are aware of the difficulty of changing a person's behaviour. Life would be easy if people responded to health messages by doing as they were advised, but many do not. Why? This is because *awareness* of health messages and knowledge alone are not enough to change behaviour. To make real changes, we need first to overcome "barriers to change" in our life and experience.

At this point in the interview, a patient may have any number of barriers to overcome in this most personal and powerful area of experience. Such barriers might arise from any aspect of the individual's life and experience. For example:

1. **Gender barriers.** Essentially, these can arise from the different expectations and values relating to male and female sexuality.
 - a) Women may sometimes have little control over when, with whom, and under what circumstances they have sex. They might therefore not be in a position to protect themselves, even if they so wish or have the means (e.g. a condom).
 - b) For men, the expectations can be very different, although young men in particular can be under peer and social pressure to conform to local male norms.
2. **Cultural practices** may help or hinder the client's ability to change. Consider the possible barriers to change in relation to: age differences at marriage, wife inheritance, puberty rites, child-rearing and so on, as well as the values of family and community.
3. **Religion** may, under some circumstances, contribute to adoption of safer sexual behaviour. However, it can pose major barriers to change if it discourages open discussion about sexuality and use of protective measures.
4. **Poverty, social disruption and civil unrest** force women and girls in particular (but, sometimes, boys) into exchanging sex for material favours or even for survival. In less extreme situations, lack of access to education and employment may force women to exchange sex with a number of partners in return for food, shelter and clothing for themselves and their children.

A useful approach might be to help them to analyse the costs and benefits of changing their behaviour. For example, you might say that a *benefit* of continuing the existing behaviour is that no effort need be made, while the *cost* may be further STIs and complications. In contrast, a change in sexual behaviour has the benefit of protection against STIs but involves a number of possible costs, from the price of condoms to the need to obtain the partner's agreement to use condoms.

It is not quite enough simply to have the client agree and choose a particular safe behaviour. We can all say we will do something – but will we? Ask *how they will put it into practice and when* and what they will do if, for any reason, they are tempted to practise risky sex.

These are difficult issues to discuss, but we will explore some useful skills for you in the next section of this module.



Question

4. Imagine you have taken the history and assessed the risks for each of the four STI patients that follow. Based on the information you have been given, make notes in answer to these two questions:
 - what risky behaviours should the patient aim to avoid in the future?
 - what barriers to change might arise from the patient's circumstances?
- a) **Nina** is a 19-year-old sex worker who lives in a slum area of town. She has one small child who is often sick. Nina is also using her earnings to help support her family who live in a remote village. Her family disapprove of her job but eagerly accept the money that she sends home. She is afraid of AIDS but finds that many of her clients refuse to use condoms. You have diagnosed a genital ulcer.

- b) **John** is a 24-year-old single man with a good job and his own home. He does not want to settle down for a long time, describing himself as "a good time guy". He has three sexual partners and sometimes has casual sex too. However, he says he chooses women who are "clean" or "married", so he cannot understand why he now has a urethral discharge. During the interview he admits that he often gets drunk or injects drugs with one of his partners before sex.
- c) **Amina** is 35, married with three teenage children. She relies on her husband's income from factory work to support the family. During the interview, she said that she has sex only with her husband. She responded to your questions by saying that her husband often worked late at the factory and that he went for a drink with friends occasionally: she could smell the alcohol on his breath. However, she feels quite secure in his faithfulness to her. She came to the centre with no idea of the cause of her abdominal pain – you have diagnosed pelvic inflammatory disease.

- d) **Tony** is a 47-year-old married man, living in a rural area. His eldest brother died recently and everyone in the family suspects that he died of AIDS. His culture and religion dictate that Tony will inherit his brother's 36-year-old wife, taking her as his second wife. He has heard a lot about AIDS on the radio and so is fearful that he and his first wife might be exposed to AIDS or STIs. Presenting initially with bad head pains, Tony has really come to ask your help in resolving this problem.

Please turn to pages 62–63 for our comments on these case-studies.

Summary

In Sections 1, 2 and 3 we considered the differences between health education and counselling. We also examined the issues that you need to explore with a patient with STIs. These are the main issues, in a logical order to raise them:

1. What are STIs and the actual STI the patient has and its implications?
2. Recommended treatment and the importance of *complying* with treatment.
3. Any side-effects of the treatment to be expected and looked out for.
4. Methods for preventing future infection.
5. The need to treat sexual partners.

We also looked at how counselling can help patients to change their behaviour, including:

- key communication skills for counselling;
- assessing a patient's risk level;
- why it is important for patients to change behaviour;
- barriers to changing behaviour.

The next task is how to handle the reaction of individual patients when you inform them that they have an infection in the genital area: their feelings and real difficulties. As you know from Module 3, it is always essential to work with the patient's feelings, to provide reassurance and respect. We will also look at techniques for helping patients to change their behaviour.



Activity 6

Before moving on to the next section, please note down any questions or concerns you may have and then discuss them with your colleagues or trainer. Please also discuss the activity questions completed so far with colleagues if you have not already done so.

4: Educate and counsel – how?

In this section we answer the question: *how* do you educate, counsel and support the patient or client?

Your learning objectives

This section will enable you to:

- educate and counsel your patient or client about STIs;
- identify a range of useful skills that will enable you to educate and support the patient effectively.

Essentially, patients and clients need to make three decisions: to comply with treatment, to change their sexual behaviour and to have their sexual partners treated.

Is it enough to simply *inform* a patient of all these issues and urge him or her to comply with your suggestions? No. As many as 70% of all patients may fail to comply with treatment advice, even when the advice is given clearly and accurately.

So information and advice are not enough. We need to *educate* each patient. In fact, education is crucial to the success of the whole management of STIs. Once the patients or clients have assimilated the basic facts they will need to make important decisions about their lifestyles. Counselling will help them make such decisions.

Education is part of a process of enabling someone to understand the nature of the infection or disease. Counselling is a process that enables people to change, to make choices and decisions. In order to change, the patient must *want* to change.

Helping patients and clients achieve a desire to change

We can achieve this in a number of ways. First, the communication skills we explored in Module 3 are important: your use of open questions, facilitation, summarizing and checking, reassurance, direction, empathy and expression of partnership. These are essential for asking questions and helping the patient deal with emotions.

As you begin to educate, counsel and motivate your patient to change, you will need these additional skills:

- explanation and instruction;
- modelling;
- reinforcing strengths you see in the patient;
- helping the patient explore choices;
- rehearsing what the patient will do or say;
- confirming the patient's decisions.

We will explore each of these skills in turn, illustrating each one with examples from two of the case-studies at the end of Section 2: John and Amina.

Amina's interview in particular illustrates the powerful feelings of shock and hurt that news of an STI can bring. For some patients this comes from a sense of personal shame; for others it may be caused by the collapse of security or trust in a long-term relationship. Whatever the source of these feelings, the service provider must be able to manage them in order to help the patient change his or her sexual behaviour or persuade his/her partner to do so.

This module cannot make you become a fully trained counsellor. If you have already had any training in educating or counselling patients, you should already have the above skills and more. Use this section to refresh your understanding of the skills and please be willing to help any colleagues practise them.

Explanation and instruction

These are skills that many service providers use most of the time.

Instruction Telling patients what to do or how to do something, such as use a condom or take medication:

“Remember to complete the whole course of tablets, right to the last one ...”

Explanation Telling patients how or why something should be done:

“You have pain low in your tummy because of an infection passed to you during sexual intercourse ...”

Even here it may be possible to develop your skills a little more. For example:

- Are you communicating clearly and simply?
- Do you adapt your pace and language to the needs of the patient?

How can you find out if you are communicating effectively? The best way is to give the patient or client time to ask questions. If they seem anxious or confused, stop and check: *“Is what I’m saying making sense to you?”*

Also, ask them to summarize what you’ve said: *“I’ve covered a lot of information and I want to be sure I’ve done so clearly. Please tell me what you need to do in your own words.”*



Activity 7

The news that an infection is sexually transmitted might shock some patients. How could you break the news to such a person tactfully yet clearly?

Please discuss this question with your colleagues.

In the last section we stressed the importance of asking patients for their opinions. For example, in explaining risk behaviour, we suggested that it would be useful to ask a patient what behaviour he/she thought risked an STI infection. So, as often as you can, find out what the patient already knows before explaining something in detail.

Here's an example from Amina's interview.

Service provider	<i>"Please don't worry Amina, I'm going to help you all I can. Your illness is caused by an infection. Do you know how you got the infection?"</i>
Amina	<i>"Well, I'm not sure but ... um ..."</i>
Service provider	<i>"Yes?"</i>
Amina	<i>"Well, perhaps it is something I ate?"</i>
Service provider	<i>"I'm afraid not. You have pelvic inflammatory disease. It's usually a complication of a sexually transmitted infection. Do you know what that means?"</i>
Amina	<i>"Well, that comes from touching dirty people ... but it can't be that."</i>
Service provider	<i>"You're right, it's not that. Illnesses like this one are caused by an infection. The infection is passed from one person to another during unprotected sexual intercourse with a person who has such an infection. Unprotected sex means sex without a barrier, like a condom. This may be upsetting (Amina looks puzzled). You need some time to think about it? Have you any questions you want to ask me about this?"</i>
Amina	<i>"But I only make love with my husband. He's not ill ..."</i>
Service provider	<i>"He does not necessarily have to feel ill, Amina. Some people may have an infection without any symptoms showing."</i>

Notice how carefully the service provider is introducing this news to Amina. She is breaking her explanation into very small steps in order to work with Amina's feelings.

We can summarize a useful approach to explanation as:

1. Ask for the patient's ideas (e.g. diagnosis).
2. Discuss the patient's ideas.
3. Explain the subject.
4. Check the patient's understanding and feelings.



Activity 8

You might like to review Amina's interview and underline any phrases you think useful. Alternatively, spot where the service provider is explaining something and where he/she is using other communication skills.

Modelling

This skill enables you to present examples of how the recommended behaviour or treatment has been successful in other cases. In other words you are offering positive models for change. This is important; models of doom such as *"If you don't do this you may get AIDS and die!"* might contain some truth – but rarely persuade us to change. Here is part of John's interview:

John	<i>"Can't I ever have some fun without risking this STI again?"</i>
Service provider	<i>"Of course you can have fun. It just needs to take a new form. If it's hard to change, let's talk about how you can be safer."</i>
John	<i>"Are you saying there's something wrong with having a drink first and stuff?"</i>
Service provider	<i>"Yes, drinking tends to make people forgetful and carefree. So you are unlikely to remember to use a condom if you are drunk. But you know ... I've noticed more guys are being careful – and they still have their "fun" even while being safe. I've seen lots of guys lately who have decided to drink less and use a condom. They say sex is better sober too ..."</i>

Notice that modelling also helps to stress your positive experience: *"I've noticed that more guys ..."* for example.

Reinforcing strengths

This means pointing out a strength or positive attribute that you see in the patient – something that will help him or her recover or prevent the recurrence of STIs.

John *“OK, like I know it’s important but ... I don’t think I could get used to it at all ...”*

Service provider *“It may seem difficult but I noticed you walked 10 kilometres to get here for treatment of your infection. That means you are a very determined person. You can use this determination to keep you safe.”*

Reinforcing strengths could also be useful in helping Amina to manage her feelings so that the service provider can direct her back to treatment:

Amina *“I feel ... as if my whole life has been broken. I can’t cope with all this ... Does this mean I was infected by my husband? ... What am I going to do?”*

Service provider *“I appreciate your feelings Amina. You care for your husband and family, I am sure, and those feelings will help you to get through the next few days ... but first, let’s talk about how we can get you better.”*

Amina *“Yes, yes ... you’re right of course. I’ve got to think about this for a while: are you going to give me some tablets?”*

Exploring choices

This is about reviewing the patient’s alternatives or steps towards curing the current STI or preventing another one. The patient can then decide which is best and feasible.

John *“So it’s condoms or one partner or sex without penetration ...”*

Service provider *“That’s right. You can either settle down with one partner or, if you’re not ready for that, protect yourself with condoms or non-penetrative sex. Which will be easiest for you right now?”*

John *“Condoms I suppose. I’m not going to settle down yet!”*

Offering a choice also empowers the patient, who feels more in control of the decision that he/she will make. The patient may have a sense of "ownership" of the decision:

- | | |
|------------------|---|
| Service provider | <i>"For today Amina, I'd like you to make a choice. Would you prefer to avoid sex until you have finished the treatment or to ask your husband to use condoms?"</i> |
| Amina | <i>"That's easy: no sex for a while. That won't be a problem because he knows I'm not feeling well. It'll give me time to think about things a bit."</i> |
| Service provider | <i>"Yes, it will: that's a good idea."</i> |

Rehearsing decisions

When you feel sure that the patient has reached a decision on the appropriate safe behaviour(s), it is important to ask him or her to work through the steps to put the decision into practice. Here are two examples:

- | | |
|------------------|---|
| Service provider | <i>"Very good John. How are you going to explain this to your girlfriends?"</i> |
| John | <i>"Well, I could start by saying there are lots of bad diseases around and that we must be careful to avoid them."</i> |
| Service provider | <i>"That sounds good. Go on."</i> |
-
- | | |
|------------------|--|
| Service provider | <i>"So, Amina, you're planning to avoid sex until you've finished the tablets. Your husband needs to be treated as well ... how will you approach him about it?"</i> |
| Amina | <i>"I need to talk to him about a few things. I mean, is it something serious or is he just playing around? Or perhaps I'll just ask him to come and see you ... so you can treat him ..."</i> |

Rehearsal is also useful when you want to check that the patient has understood your instructions on treatment.

6. Confirming decisions

This is a useful way to conclude the interview. You have helped the patient to prepare for what he/she will do after leaving the health centre. Asking the patient to confirm a decision helps him or her to feel motivated on leaving the centre. Having reinforced the decision to you, he/she is much more likely to practise safer sex than before:

Service provider *“Well, John, I think that’s about everything. Just tell me once more what you intend to do with these tablets.”*

John *“I’m going to take all of them just as I’ve got written on this piece of paper – I’ll keep the paper to remind me – and I’ll not have sex with my girlfriends until I’ve completed my treatment ... but I’ll buy some condoms just in case ...”*

Service provider *“You’re being very brave, Amina, and that’s important. Go over your plans with me once again.”*

Amina *“Get better, take all the tablets, find time to talk to my husband about a few things. And he needs treatment too ...”*

Service provider *“Yes, well done. And you will come and see me again if you need to?”*

Amina *“Yes. I will.”*

Summary

The goal of educating and counselling patients with STIs is to enable them to make informed decisions to change their sexual behaviour. The issues and skills we have covered so far in this module are designed to help you move the patient towards these decisions.

Education and counselling issues

The following issues were identified:

- the STI, its implications and treatment and the importance of *complying* with treatment;
- the need to treat sexual partners;
- the patient's risk level;
- the need to change sexual behaviour;
- barriers the patient may have to changing behaviour;
- what changes the patient can and will make in his/her sexual behaviour.

Education and counselling skills

The following communication skills were discussed:

- explanation and instruction;
- modelling;
- reinforcing strengths;
- exploring choices;
- rehearsing decisions;
- confirming decisions.

Notice that, while you will cover the issues more or less in the order above, you can draw on any of the skills as you need them.

Also, as you saw in Amina's interview, dealing with the patient's feelings is an essential part of this process, so you will often need to draw on your communication skills.

Now we will move onto a specific type of counselling that is becoming more and more important in HIV prevention and treatment: counselling for voluntary HIV testing.

5: Counselling for voluntary HIV testing

This section will enable you to:

- explain the importance and relevance of HIV testing;
- describe pre- and post-test counselling for HIV;
- interpret the meaning of a test result;
- describe how a positive test result may affect the client.

We can counsel patients or clients to enable them to make an informed decision about being tested for HIV infection. This is known as voluntary counselling and testing (VCT).

Voluntary testing is the anonymous or confidential testing initiated by either the client or the health-care provider and performed with the client's informed consent. The conditions for testing must respect the client's human rights and abide by to ethical principles.

In order to prevent HIV infection and make sure that patients receive the care, treatment and support they need, it is essential for patients or clients to know their HIV status.

Before anyone can exercise their right to know their HIV status, or patients with HIV can access antiretroviral treatment (ART), governments need to make sure that HIV testing and counselling services are available wherever people will benefit from them.

Counselling for HIV testing can be time consuming. It can be given either as a one-on-one or a group session. Both approaches have their own merits. Much of the information provided in the pre-test counselling session is general and could be given to a group. Health-care centres can also use videos to reduce the workload for staff, but a health-care provider must always be available to answer questions and provide clarification.

What is important in counselling is not to "talk at" clients, but engage them in an interactive discussion.

First, we need to emphasize confidentiality and find out the client's or patient's reasons for wanting to be tested and explore likely risk history.

Health-care providers delivering services for STI prevention and care must have basic information and skills to enable them to initiate or offer counselling and voluntary testing for HIV.

Having been provided with sufficient information to enable informed consent, all patients can "opt out" if they do not want the test performed.

All testing and counselling should be accompanied by information on how the patient can prevent the transmission of HIV in the future, whether he/she is infected or not. As part of the counselling process, health-care providers will evaluate a client's or patient's personal risk for HIV infection and discuss preventive behaviour.

All services offering HIV testing should conform to UNAIDS/WHO guiding principles for expanded testing and counselling.

HIV testing must be:

- **confidential;**
- **accompanied by counselling;**
- **voluntary and conducted only with informed consent.**

Mandatory HIV testing is not effective for public health purposes, nor is it ethical. Everyone being tested should give their informed consent. The provision of voluntary testing involves:

- giving explanation of the clinical benefit and the prevention benefits of testing;
- respect for the individual's autonomy and the right to refuse to undergo the test;
- availability of support services once the result is known;
- in the event of a positive result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection.

Post-test support services should be offered.

- **People who receive positive test results should receive counselling and referral to care, support and treatment.**

There are four categories of HIV testing:

i) Voluntary counselling and testing

This is primarily client-initiated HIV testing to learn one's HIV status. UNAIDS/WHO encourage the use of a rapid HIV test so that results are provided in a timely fashion and can be followed up immediately with a first post-test counselling session for both HIV-negative and HIV-positive individuals.

ii) **Diagnostic HIV testing**

This is indicated whenever a person shows signs or symptoms that are consistent with HIV-related disease or AIDS, to aid clinical diagnosis and management.

iii) **Routine offer of HIV testing by health-care provider**

Health-care providers should routinely offer HIV testing in the following circumstances:

- When patients are being assessed for STIs in any health facility. This will help the health-care provider to offer appropriate counselling based on knowledge of HIV status.
- Any consultation about pregnancy. This will enable health-care providers to identify women in need of antiretroviral prevention of mother-to-child transmission of HIV.
- Asymptomatic persons seen in clinical and community-based health service settings where HIV is prevalent and antiretroviral treatment is available (for example, hospital emergencies, internal medicine hospital wards, injecting drug use treatment services, etc.).

iv) **Mandatory HIV screening**

This is recommended only in special circumstances such as blood donations and tissue transfer (e.g. artificial insemination, organ transplant, corneal grafts, etc.).

The VCT process consists of pre-test, post-test and follow-up counselling. It can be tailored to the needs of the client(s) and can be for individuals, couples, families and children.

Pre-test counselling

Counselling prior to HIV testing is called pre-test counselling. The purpose of pre-test counselling is to determine the person's need and desire to be tested and to provide information and advice so that the person can make an informed decision whether or not to have the test.

During pre-test counselling, the counsellor should explain what an HIV test is. He or she should also assess the person's capacity to deal with the test results, if positive, and how important the test results may be for motivating behaviour change, regardless of the result.

Remember: informed consent implies that the patient is aware of all the possible implications of a test beforehand.

In **pre-test counselling** the health worker should:

- determine what the client **understands** about HIV and AIDS;
- provide factual **information** when needed;
- discuss potential **implications** of a positive or negative test result;
- explain and obtain **informed consent**;
- review the **test procedure** with the client;
- assess the **ability to cope** with a positive result;
- establish a **relationship** as a basis for post-test counselling.

When reviewing the test procedure the health-care provider should:

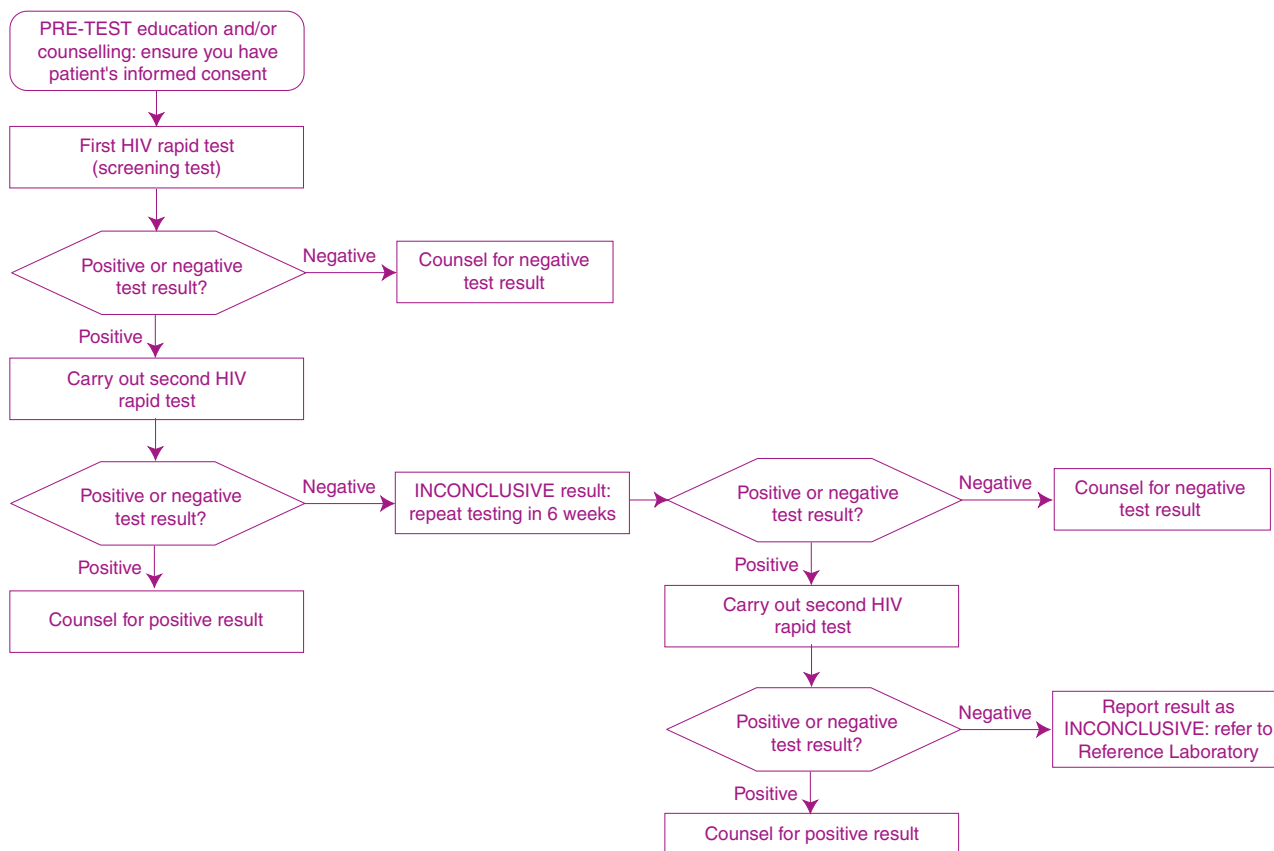
- explain how the test will be done;
- explain when and how the client or patient will obtain the test result;
- discuss how they will assure the client's or patient's confidentiality in terms of who will know about the test result.

If the health care worker is planning to use a rapid HIV test, it is also necessary to explain:

- that the result may be more instant than has been the case to date;
- how and when a confirmatory test will be needed.

(Figure 1 summarizes the recommended test procedure for a rapid HIV test. This flowchart may be used for testing any person over the age of 18 months.)

Figure 1 Flowchart for use of HIV rapid tests in testing and counselling services



The client needs to understand and appreciate the HIV test's implications for marriage, pregnancy, relationships, work, stigma and finances; its emotional impact and any psychosocial support available.

Post-test counselling

Counselling after HIV testing is called post-test counselling. The type of post-test counselling will depend on the HIV test result and should include an explanation of what the test result means. Health-care providers should always offer post-testing counselling when a client decides to undergo an HIV test.

If the test is positive, the counsellor must tell the client the result clearly and sensitively. Referral for emotional support must be available either at institutional level or within the community, and that information should be given to the client.

A negative test indicates that the person is probably not infected at the time. However, there is a period between getting infected and developing enough antibodies during which no HIV test can detect the infection. This is called the "window period". For most infected people, this period is from six weeks to six months. So a negative test result simply indicates that the patient should have another test after six weeks, especially if the risk of infection is high.

If a person is likely to have been exposed to HIV infection, he or she should be counselled about the need for behaviour change, including the use of condoms in order not to transmit further any infection.

Note: When choosing a second test it is important to select one that involves the use of different antigens and/or a different platform and demonstrates appropriate levels of specificity and sensitivity. The second test must be performed at the same time as the first.

If a result is inconclusive the person tested should be advised accordingly. Post-test counselling should focus on the possibility of the test being performed during the window period, i.e. when antibodies have not yet formed after exposure to HIV. All persons with inconclusive results should be encouraged to avoid risky sexual behaviour and should be offered retesting at the same facility after an interval of six weeks in order to allow the window period to have elapsed. Support based in the community or at health centres should be offered during the waiting period. If the same inconclusive results are obtained by retesting after six weeks then the person concerned, or a suitable specimen, should be sent to a referral laboratory for further HIV testing.

If a first positive (reactive) and a second negative (non-reactive) test result occurs in more than 5% of cases the testing process should be reviewed.

(Adapted from the WHO 3by5, 2004 *Algorithm for use of rapid HIV tests in testing and counselling services.*)

With post-test counselling following a **positive test result**, the health worker should:

- ensure that the client **understands** what a positive HIV test means;
- discuss how he or she **feels** about being infected;
- give **support** to help deal with these feelings;
- discuss **plans** for the immediate future;
- establish a **relationship** as a basis for future counselling;
- **schedule** appointments for medical evaluation and follow-up counselling;
- **counsel** his or her partner(s) on their own need to be tested and the need for safer sex;
- **refer** the client to the local community services, if available;
- **stress** and educate on condom use.

Here is a checklist for post-test counselling for a positive test result.

1. Renew relationship with client.
2. State the result clearly.
3. Wait – give time for the client to absorb the information and listen to reaction and body language.
4. Help client to come to terms with the test result:
 - a. explore understanding;
 - b. clarify understanding of result;
 - c. assess emotional impact;
 - d. discuss what they will do next in terms of behaviour change;
 - e. check understanding of risk reduction;
 - f. review who else can be informed of the result for emotional support.
5. Give hope and empowerment:
 - a. give realistic messages about what can be done;
 - b. discuss measures to improve quality of life, e.g. nutrition, stress, alcohol, exercise.
6. Help client plan for the future:
 - a. discuss possibilities for positive change
 - b. identify support possibilities, e.g. stress reduction, risk reduction, financial, occupational, legal, domestic and medical needs.
7. Provide appropriate brochures and information to take away and give an appointment for follow-up counselling.

For post-test counselling following a **negative test result**, the health worker should:

- ensure that the client **understands** what a negative HIV test result means;
- **counsel** the client on the need for protection as a negative test result **does not** mean the patient is immune from HIV infection. He or she has been fortunate this time, but will probably not remain so if he or she continues to be exposed;
- **stress** the need for safer sex through mutual faithfulness with an uninfected partner, consistent condom use or abstinence.

The following checklist will help you to cover all the necessary points when post-test counselling for a negative test result.

1. Renew relationship with client and explain a negative result:
 - a. do not forget the window period and evaluate need for re-testing;
 - b. give time to reflect and to express feelings.
2. Explain lack of immunity to future infections:
 - a. reinforce change of risky sexual behaviour.
3. Observe and be aware of unexpected reactions; joy or even anger at someone who has put them through a harrowing period "for nothing".
4. Repeat HIV prevention discussion
 - a. constructive change for safer sexual behaviour;
 - b. condom use;
 - c. clean needles.
5. Offer follow-up counselling or support groups to stay negative.

This brings us to the end of this short guide on the principles of counselling for HIV testing. Remember that to be a qualified counsellor you need to attend a systematic training course. However, as a health worker providing STI services, basic counselling skills and knowledge are important and Modules 3 and 5 should equip you with these basic skills.

Now let us turn to the Action Plans to practise some of the skills we have learnt so far.

Action plan 1

Please find time to practise the skills you have studied so far.

If you are studying with a group of people as part of a course, your trainer will guide the role-play and explain what you have to do.

If you are studying on your own, follow the guidance below very carefully and, if possible, ask two other service providers to work on the role-plays with you. They should either be studying the programme or be already trained in the case management of STIs.

The aim of this role-play is to practise the necessary skills and issues to educate patients up to the point when the patient appreciates *the need to change sexual behaviour, including what constitutes risky and safer sexual behaviour*. This will enable you to:

- apply effective communication skills when educating and counselling patients about STIs;
- clarify skills on which you want to work further.

To practise without a trainer, three people need to take part. In each role-play one person should be the patient, one the service provider and the third should observe the role-play and provide constructive feedback to help the "service provider" develop his or her skills. Here is what to do.

1. Please read the four case-studies on pages 43–46 in order to get a general picture of each patient described. Remember that the service provider has already taken the patient's history and diagnosed the STI.
2. Decide who will first be the patient, the service provider and the observer.
3. The patient should select one of the case-studies. Base your selection on the study that represents a patient similar to one you commonly see in your clinical setting or that presents issues you want to learn to deal with more effectively. Tell the others which case-study you have selected.
4. Prepare for the role-play by studying the guidance on the next few pages for the patient, the service provider and the observer.
5. When the role-play is completed and each of you is satisfied that you have given or received sufficient feedback, swap roles and repeat steps 2 to 4 above, so that each learner has the opportunity to practise education and counselling skills.

Case study 1: Nina

Nina is a 19-year-old sex worker who lives in a slum area of town. She has one small child who is often sick. Nina has no partner. She is also using her earnings to help support her family who live in a remote village. Her family disapproves of her job but eagerly accepts the money that she sends home. She is afraid of AIDS but finds that many of her clients refuse to use condoms; she also has a limited knowledge about STIs. The service provider has diagnosed a genital ulcer; Nina is afraid it might be an STI.

Case study 2: John

John is a 24-year-old single man with a good job and his own home. He does not want to settle down for a long time, describing himself as "a good time guy". He has three sexual partners and sometimes has casual sex too. However, he says he chooses women who are "clean" or "married", so he cannot understand why he now has a urethral discharge. During the interview he admits that he often gets drunk or injects drugs with one of his partners before sex. The service provider has confirmed a urethral discharge.

Case study 3: Amina

Amina is 35, married with three teenage children. She relies on her husband's income from factory work to support the family. During the interview, she said that she has sex only with her husband. She has already explained that her husband often works late at the factory and that he goes for a drink with friends occasionally: she can sometimes smell the alcohol on his breath. However, she feels quite secure in his faithfulness to her. She came to the centre with no idea of the cause of her abdominal pain – the service provider has diagnosed pelvic inflammatory disease.

Case study 4: Ahmed

Ahmed is 35, married with four children and living in a rural area. He attended an urban clinic with a swelling in his groin, which the service provider diagnosed as an inguinal bubo. In answering the service provider's questions, he admitted reluctantly that he has sex with a number of other partners, many of them casual, in the course of his search for work. He regularly travels to the city, working away from home for three months at a time. He says that his wife is six months pregnant: he has not been home for two months though he regularly sends money home. He is currently living with a casual partner in the city.

The patient's role

Please reread your selected case-study very carefully, because your aim is to respond as realistically and honestly as you can to whatever the service provider says and does. Do not try to make it either easy or difficult for him or her.

1. **Before the role-play:** based on the limited information you have about the patient, decide what information you might need to answer the provider's questions. Common questions might be about how many partners you have, whether you use condoms regularly and what you know about the transmission of STIs.
2. Note your *feelings* as this patient. For example, how do you feel while waiting for your diagnosis? What questions, if any, do you have for the service provider? What is worrying you?
3. **During the role-play:** identify as much as you can with how this patient would behave. Use empathy to experience what the patient might feel in this situation.
4. **After the role-play:** you will be the first to give feedback to the "service provider". Use this opportunity to explain how you felt during the interview. Then give your feedback on both what worked well and what did not. For example, you might tell the service provider you felt reassured by the way he/she spoke softly to you, so that others would not hear, and that you only wish there had been more time to talk about your feelings about having the STI. You felt a little rushed at times.

Very specific feedback is also helpful, such as *"I didn't understand when it was time to put on the condom ... right away or just before the man wants to have intercourse or what?"*

5. Next, the service provider and the observer will review the exercise. During that discussion, feel free to add any useful insights you have into the service provider's behaviour. At this point, make sure that your suggestions are positive ones that will help the service provider to usefully develop his or her skills.

The service provider's role

Your overall aim is to obtain clear feedback on your present skills and areas that you might usefully rehearse or refine.

During the role-play, your aim is to obtain the patient's compliance on treatment and understanding of safer sex to prevent future infections.

Remember to use your skills in education and motivation to help the patient make choices and confirm any decisions.

1. Read the observation checklist on page 50 very carefully to review the skills and themes that the observer will be looking for in your interview.
2. Reread the patient's selected case-study to familiarize yourself with what you have already learned while taking a history. If you wish, make notes on any key questions you want to ask.
3. Conduct the interview, starting with your explanation of the patient's STI and stopping when you feel sure that the patient understands high-risk and safer sexual behaviour – or after the agreed time if that comes first.
4. After the role-play, allow the *patient* to give you feedback on how he/she felt during the interview. Next, give your own views and feelings about how the education process went. Finally, the observer will provide feedback based on the checklists he or she is using. Feel free to ask either the patient or observer to clarify what they have said: you want to finish the role-play with helpful objectives and, hopefully, confirmation of your perceived strengths.

The observer's role

Your aim is, after the role-play, to provide the service provider with clear, objective feedback on what he or she achieved during this education part of the interview.

1. Read through the checklist on the next page to remind yourself of the skills and issues that the service provider should use.
2. Time the interview, stopping it after an agreed time, such as five minutes.
3. As you observe, make quick notes on the skills you see the service provider use and how effectively you think he/she uses them. If possible, note examples of what he/she said or did so that your feedback will be as practical as possible.
4. Ask first the patient and then the service provider to review the interview. Start your own feedback by responding briefly to the service provider's self-criticism and then give your own feedback, skill by skill or however else you think appropriate. Be willing to give negative criticism if necessary, but offer it in a constructive way: *"When the patient said ... you said ... Perhaps it would have helped if ..."* and so on. Always stress the service provider's positive achievements and be as practical as you can. For example, suggest alternative ways the service provider could have introduced specific issues or ask him/her to identify when another skill might have been more appropriate than the one used.
5. Finally, lead a discussion about what the three of you have learned from the role-play. This module might not have mentioned some issues appropriate to your region.

Observation checklist

<p>To what extent does the service provider:</p> <p>a) cover these education issues?</p> <ul style="list-style-type: none"> ■ the STI, its implications and treatment, and the importance of <i>complying</i> with treatment ■ the need to treat any sex partners ■ the patient's risk level and future prevention options ■ the need to change sexual behaviour and what constitutes safer sex (does the patient fully understand the need to change?) 	
<p>b) use these education and motivation skills?</p> <ul style="list-style-type: none"> ■ explanation and instruction ■ modelling ■ reinforcing strengths ■ exploring choices ■ rehearsing decisions ■ confirming decisions 	
<p>c) apply these communication skills?</p> <ul style="list-style-type: none"> ■ facilitation ■ summarizing and checking ■ reassurance ■ direction ■ empathy ■ partnership 	

6: Using condoms to stay cured

As you know, condoms help people to have safer sex by preventing direct contact of the genitals with either vaginal or seminal fluids. Using condoms is especially important if your patient has sex with more than one partner or with one partner who has other sexual partners or with a new partner. However, it is not enough to know that condoms are important. Patients must also know how to use them properly.

This section will enable you to:

- list the benefits of using a condom;
- demonstrate how to use a condom;
- explain how to keep and dispose of condoms.

Many people resist the idea of using condoms, not because of the embarrassment or cost of buying them, but due to misconceptions and myths about them. For instance, they think that condoms spoil sex or that they are too big or too small. There are often myths about them – such as the condom itself is infected with STIs. People may also associate them with illicit sex – rather than for use with a regular partner.



Activity 9

Are there any "myths" about condoms in your region and, if so, what are they?
Who holds these beliefs?

It is important to be aware of negative ideas about condoms because, clearly, they would undermine the patient's willingness to comply with condom use as a safer sexual behaviour. You also need to explain that condoms work well if used properly and consistently. Describe the *benefits* of using condoms most relevant to the individual patient.



Question

5. What do you think are the advantages of using condoms? Note down as many ideas as you can below, then turn to page 63 for our comments.

Condoms are an important option for any sexually active person for both pregnancy prevention and disease prevention. In addition, they have other benefits. These are factors that can be cited in condom promotion.

As well as stressing their benefits, use all the skills we have discussed in Sections 2 and 3, as well as your general communication skills. In other words, ask the patient's opinion of condoms, discuss the response and any barriers towards using them and suggest appropriate benefits.

If the patient continues to resist their use, repeat the other forms of safer sex and ask if one of them would be preferable:

- John *"You said condoms are one way of keeping safe, but I wouldn't use them."*
- Service provider *"Why not?"*
- John *"Well, they're a nuisance. I mean they get in the way, if you know what I mean."*
- Service provider *"So you have tried to use them before?"*
- John *"Well, no. But I've been told that."*
- Service provider *"Well, they needn't get in the way. You can be shown how to use them. I know a lot of men who say they have fun with them because their partners are involved in putting them on."*
- John *"Yes, but what if it comes off?"*
- Service provider *"It can't come off if you use it properly, I assure you. Any other reasons for not liking them?"*
- John *"No, that's the main thing."*
- Service provider *"The most important thing about condoms is that, if you use them regularly, you protect your partners as well as yourself. STIs in women can be very serious, so you should feel responsible for their safety too."*
- John *"Mmm."*
- Service provider *"Some men say that condoms can actually make intercourse last longer. What do you think of that?"*
- John (Laughs in embarrassment) *"Sounds OK."*
- Service provider *"Would you be willing to try using them?"*
- John *"OK, I could give them a try."*
- Service provider *"Good – but remember, if you don't use condoms, you must practise non-penetrative sex. Let me show you on this penis model how to put on a condom properly."*

Demonstrating the use of condoms

Please look at Figure 2 which illustrates some of the main steps in correct use of a condom.

It is important to first demonstrate its use and then ask the patient to practise the same method, helping him or her to get it right. This means that you will need a supply of condoms and a penis model or something to represent one, such as a banana or broom handle.

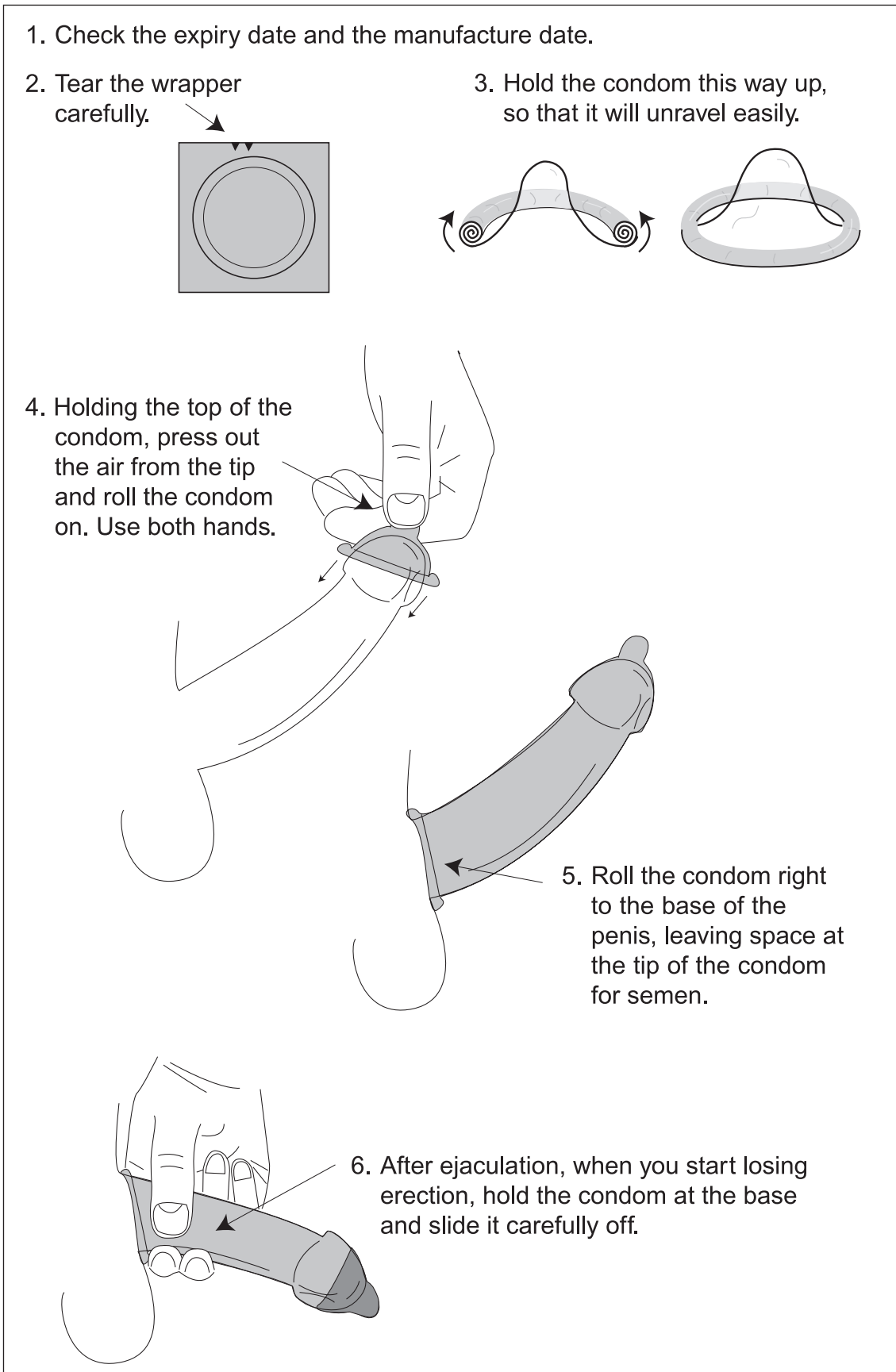
In your demonstration:

- stress the importance of carrying condoms all the time – the patient should never be without one;
- show the expiry or manufacture date and explain that the condom should not be out-of-date, smelly, sticky or hard to unroll;
- explain how to open the package carefully, using the tear-point;
- show the correct side of the condom to insert over the penis, explaining that it will not roll down if placed the other way;
- show how to hold the tip of the condom to press out air, before rolling it all the way down the erect penis;
- emphasize that the condom must be rolled right down to its base;
- explain that the condom should be removed *just as the penis begins to lose its erection* and that the patient should hold it carefully at the base and slide it off slowly;
- explain that the patient should tie the top of the condom and dispose of it safely.

These are three other tips you might want to give the patient:

- the importance of not using oil or oil-based lubricants such as petroleum jelly, because they damage latex condoms (water-based lubricants such as glycerine and K-Y Jelly are safe, as are most spermicidal foams);
- the need to dispose of condoms hygienically;
- condoms should not be re-used.

Figure 2 How to use a condom





Questions

6. A young man with an STI tells you impatiently: *“I already know how to use a condom! What’s the point of demonstrating it to me?”* What might you say to him?

7. There are many myths about condom use. Which of the following statements are true or false? Tick the responses you think are correct.

	TRUE	FALSE
a) Condoms can get lost inside the woman.	<input type="checkbox"/>	<input type="checkbox"/>
b) Condoms do not protect against STIs, including HIV.	<input type="checkbox"/>	<input type="checkbox"/>
c) Condoms can be kept in a pocket or wallet indefinitely.	<input type="checkbox"/>	<input type="checkbox"/>
d) It is OK to use glycerine or water-based lubricants with condoms.	<input type="checkbox"/>	<input type="checkbox"/>
e) Pull the condom tight over the head of the penis to ensure a snug fit.	<input type="checkbox"/>	<input type="checkbox"/>
f) Squeeze the air out of the tip of the condom as you put it on.	<input type="checkbox"/>	<input type="checkbox"/>
g) Condoms should be stored in a cool, dark, dry place.	<input type="checkbox"/>	<input type="checkbox"/>

Please turn to our answers on pages 64–65.

Summary

In this section we have explored:

- the benefits of using condoms and some negative ideas about them that you might have to confront;
- how to demonstrate their use and what advice to give the patient.

Remember: you need also to use all the communication and education skills you have learned so far when discussing and demonstrating condoms.



Activity 10

Ideally, health centres would provide patients with free condoms. If this is not possible, make sure you know the answers to questions like these, so that you can advise your patients accordingly:

“Where can I buy condoms?”

“How much do they cost?”

“Are they of good quality?”

“Are different sizes available?”

Review

Now that you have completed Module 5, you should be able to:

- explain why education, counselling and emotional support are vital in the management of clients with STIs;
- identify the main issues on which you need to educate and motivate patients;
- recognize and practise a number of additional skills during this part of the interview;
- provide basic pre-test and post-test counselling for HIV screening;
- demonstrate the use of condoms and explain their benefits.

The next step is very important because you need to practise what you have learned. Action Plan 2 will help you to do this.

We also offer an optional assignment that you might like to consider. It asks you to consider other opportunities at your health centre to educate patients about STIs.

Action plan 2

The aim of this action plan is to practise educating patients on all the remaining issues, including the use of condoms. The only issue to leave out is the sixth one: treating the patient's sexual partners.

If you are studying with a group of learners and a trainer, then your trainer will guide you on this role-play.

If you are studying on your own, please arrange to work with two other service providers just as you did before – preferably they should be the same people as for Action Plan 1.

Take up the same case-studies as before, at the point where the role-playing finished last time. This should be at the point where the patient has understood what is meant by safer sexual behaviour. The service provider's remaining tasks are these:

1. To identify any barriers the patient may have to changing current behaviour.
2. To help the patient identify appropriate changes and decide which one(s) he/she will adopt as new safer behaviour.

This should include using condoms, in which the service provider should educate the patient on relevant personal benefits as well as demonstrating how to use them.

Please arrange your role-plays exactly as you did for Action Plan 1, except that this time the "service provider" can concentrate on developing particular skills identified during his/her role-play and feedback. The observer should look for the same educational and communication skills and concentrate on the issues above.

In collecting feedback, two important questions for the "patient" are:

- To what extent do you, as the patient, feel prepared and willing to adopt safer sex practices?
- What did the service provider do to help you reach this decision? Or why was the service provider unable to persuade you of this decision? (what else, if anything, could he/she have done?)

Assignment: other opportunities for patient education

The health centre could offer many opportunities to reinforce and supplement the service provider's efforts at patient education. These opportunities could be provided by people in different areas of the centre as well as by a range of media.

You might like to consider other opportunities for patient education within your health centre. Here are some suggestions.

Who?

All staff who meet patients can assist with patient education. For example, staff at reception might contribute by demonstrating respect, empathy and reassurance – which maintains patients' dignity and reduces any fear or shame they might be feeling.

Where?

Patient education can take place at all the stages of a patient's visit to the health centre, from the registration desk to the waiting room, the examination or interview room and the dispensary.

How?

A health centre can draw on a wide range of media for its education process, limited only by the resources available. To name a few:

- posters;
- brochures, leaflets to be read on-site or taken away as handouts;
- audio tapes playing;
- video tapes playing;
- small group discussions and more formal health talks;
- condom demonstrations;
- drama presentations by local theatre groups or health educators.

Walk round your health centre as if you were a patient coming in for treatment. What other opportunities for patient education could the centre usefully adopt?

- How would your suggestion contribute to effective patient education at the centre?
- Who could be responsible for developing this suggestion?
- What resources would be needed?

Please discuss your suggestions with your trainer or supervisor.

Answers

- 1a) The two types of question we were thinking of are *open* and *closed* questions. Well done if you remembered the advantages of open questions during most of the interview. They enable patients to express concerns in their own language and often mean you need to ask far *fewer* questions. Closed questions are useful to obtain specific extra details later in the interview.
- 1b) These are the six verbal skills we suggested:
- facilitation;
 - direction;
 - summarizing and checking;
 - empathy;
 - reassurance;
 - expressing partnership.

Do not worry if you only remembered one or two of these skills. The important thing is that you *use* them when interviewing patients.

2. In fact, at this stage in the interview there are five key issues to discuss with the patient. These are the five, in a logical order to raise them:
- a) What are STIs and the actual STI the patient has and its implications?
 - b) Recommended treatment and the importance of *complying* with treatment.
 - c) Any side-effects of the treatment the patient should expect and look out for.
 - d) The patient's knowledge of his/her risk level and prevention of future infection.
 - e) The need to treat sexual partners.

In addition, with female patients who are pregnant, you may need to discuss the need to protect the baby.

3. Please discuss this question with your colleagues because it is important to be aware of the predominant local beliefs about STIs. These are some of the more frequently found beliefs that are important to understand and address:
 - one STI can turn into another one;
 - you can only get one STI at a time;
 - all STIs, including HIV, are detected using one diagnostic test;
 - health care personnel can tell if a patient has an STI without examination;
 - people with STIs always have symptoms;
 - you can't have an STI and HIV at the same time;
 - you can tell who has an STI/HIV by how he or she looks or feels;
 - you can tell who has an STI/HIV by his/her actions, occupation, social class or number of sex partners;
 - you can get an STI through witchcraft.

4. Do not worry if you found this exercise difficult or if your answers differ slightly from ours, below. You may well have considered issues equally relevant to ours: if at all unsure, talk to an experienced colleague.
 - 4a)
 - i) The risk behaviour of which we are aware is Nina's occupation, which involves sex with a number of casual partners. We do not know whether she mixes sex with alcohol or drug consumption: the service provider would need to check this out with her.
 - ii) Nina's barriers to change? Two major ones: her reliance on sex work as her only source of income to support her child and family and her inability to persuade clients to use condoms. Presumably she feels that she cannot afford to lose clients by insisting on this.

 - 4b)
 - i) John's risk behaviour includes alcohol and drug use as well as unprotected sex with a number of partners, including casual partners whose sexual practices he knows nothing about. He also has an incorrect idea about safe sexual behaviour, which gives him a false sense of security.

- ii) Barriers to change will include the effect that any change would make on his self-image as a young "street-wise" male, together with his belief about what constitutes acceptable behaviour. Has the service provider any chance of persuading such a person to change his lifestyle?
- 4c) i) The risks for Amina are different in that they are beyond her immediate control: it is not she who engages in risky sex, but her husband. We know no more about his risks in detail than does Amina.
- ii) Her barriers to change? Clearly, she is financially dependent on her husband. In addition, before deciding on long-term behaviour, she must overcome two major barriers: her shock at the discovery of his likely behaviour and how this is going to affect her marriage.
- 4d) i) Tony has not yet been practising risky behaviour, but he has attended the health centre because he is afraid of doing so. Clearly, a cultural or religious practice is the unfortunate cause of his dilemma.
- ii) The barriers in his case are that he does not want to offend against his culture and his religion. He will be under peer and societal pressure to enter into a relationship that will expose him and his wife to HIV.
- 5. In fact, condoms can provide a number of possible advantages:
 - they prevent transmission of STIs, including HIV;
 - they help women to avoid pregnancy;
 - condoms reduce the risk of transmission of an STI if a patient does not wait for the STI to be cured before having sex but, ideally, the health care provider would encourage them to wait!
 - women feel dryer inside;
 - the patient will feel safer, with fewer worries;
 - many men can prolong intercourse if they wear a condom;
 - bed linen needs washing less often!

6. Many young men might respond as this one does – and some may indeed know how to use condoms correctly. For this reason, it is important to remain tactful; you might respond by accepting his statement and asking him to demonstrate their use to you. *“That is good, why don’t you show me (on this model) how you would use one?”* This gives you the opportunity to check whether he can use a condom properly and to remind him of the many advantages of doing so. (If, as may be the case, he is too embarrassed to show you, then you could offer to demonstrate it, asking if this is indeed what he would do.) Alternatively, you could add a new element, such as putting on a condom whilst wearing a blindfold: simulating putting on a condom in the dark. The important thing is not to embarrass or dispute with the young man.

7. Did you spot the true and false statements? Check your responses against ours below.
 - a) *Condoms can get lost inside the woman.*

False. There is always the slight possibility that, if the man does not use the condom properly, it could slip off before withdrawal, but it can be retrieved. It could not get lost inside.

 - b) *Condoms do not protect against STIs including HIV.*

False. Properly used, condoms prevent the transmission of STIs, including HIV.

 - c) *Condoms can be kept in a pocket or wallet indefinitely.*

Again, false. A wallet or pocket is too warm to store a condom for a long period. Advise patients never to use condoms that are dry, dirty, brittle, yellowed, sticky, melted or damaged.

 - d) *It is OK to use glycerine or water-based lubricants with condoms.*

This one is true. However, remember to advise the patient that it is risky to use grease, oils, lotions or petroleum jelly to make condoms slippery – the oils cause condoms to break.

- e) *Pull the condom tight over the head of the penis to ensure a snug fit.*

False. If someone does this, the condom may burst. Always leave space for semen at the tip of the condom.

- f) *Squeeze the air out of the tip of the condom as you put it on.*

True. This will leave space for the semen to collect.

- g) *Condoms should be stored in a cool, dark, dry place.*

True. Condoms do not like sunlight, moisture or heat, which is why they do not like living in pockets or wallets too long.

Glossary

AIDS	Acquired immunodeficiency syndrome caused by the human immunodeficiency virus (HIV)
Glycerine	Colourless lubricant which is a by-product of soap manufacture; safe to use with condoms
K-Y Jelly	A water-based jelly-like lubricant sold under this trade name; safe to use with condoms
Oil-based lubricants	Lubricants which are based on oils can make condoms fragile and break, e.g. petroleum jelly
Reinfection	An infection with the same organism that had been completely treated and cured
Spermicidal foam	Foam which kills sperm, often used as extra protection with condoms to prevent pregnancy