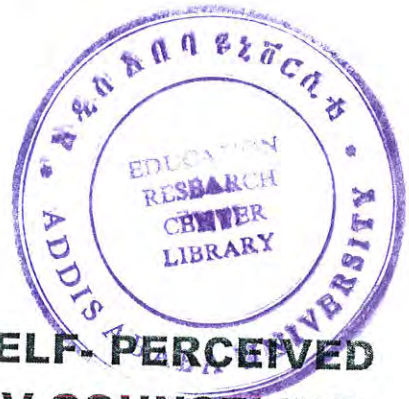


**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**



**COMPARATIVE STUDY OF THE SELF-PERCEIVED  
KNOWLEDGE & PRACTICE OF HIV COUNSELING  
SKILLS BETWEEN GOVERNMENT & NON-  
GOVERNMENT HIV COUNSELING CENTERS  
(THE CASE OF GAMO-GOFA ZONE)**



**BY**  
**TAREKEGN TADESSE GEMEDA**  
**JULY, 2006**

**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**

**Comparative Study of the Self- Perceived Knowledge &  
Practice of HIV Counseling Skills between Government  
& Non-government HIV Counseling Centers  
(The Case of Gamo-Gofa Zone)**

A Thesis  
Presented to the School of  
Graduate Studies  
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for the Degree of Master of Arts in  
Counseling Psychology

By  
Tarekegn Tadesse Gemedo

2006

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## **Abstract**

*The purpose of the study was to investigate whether there were differences between government and non-government HIV para- counselors regarding their knowledge and practice of HIV counseling skills. To attain these objectives purposive and availability sampling techniques were employed to select research participants (i.e., para- counselors, clients and coordinators). Five different instruments namely questionnaire, interview, FGDs, case studies and observation were used to collect information. Data was analyzed through t-test, one-way ANOVA and descriptive statistics. The findings revealed that there was no significant difference between government and non-government HIV para - counselors in relation to knowing counseling skills. However, on the practice dimension para- counselors who were working at both organizations were significantly different. Training for sufficient period of time was found to be helpful to gain and practice counseling skills effectively. In addition, para-counselors who had been nominated by coordinators tended to know and practice counseling skills effectively than voluntarily engaged para- counselors. Generally, with regard to counseling skills, maintaining pre-requisites for HIV/AIDS counseling processes; for example, availability, accessibility and privacy of counseling office and waiting areas etc were likely to exist poorly at both organizations particularly the non-government HIV/AIDS counseling providers were suffering from dearth of such aspects. Consequently, both, HIV/AIDS counseling providers need to be conscious in imparting basic counseling skills among HIV para- counselors as well as should be practical in relation to furnishing counseling environments with all conducive physical, social and psychological contexts so as to conduct successful HIV counseling, which in turn, to prevent and control the spread of the pandemic.*

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## ACRONYMS AND ABRIVATIONS

ART	Anti Retroviral Treatment
CDC	U.S. Center for Disease Control and Prevention
CRDA	Christian Relief and Development Agency
FHI	Family Health International
GATHER	Greeting, Asking, Listening, Telling, Helping and Return to Follow-up
MOH	Federal Ministry of Health
NGOs	Non-government Organizations
OPD	Opportunistic Diseases
OSSA	Organization for Social Service for AIDS
PMTCT	Preventing Mother to Child Transmission
PLWHA <sub>s</sub>	People Living with HIV/AIDS
RHIRS	Rochester HIV Interview Rating Scale
RHO	Regional Health Office
SNNPR	South Nation Nationalities People Region
SOLER	Sitting Squarely, Open Posture, Lean Forward, Eye Contact, and Relaxed
STD <sub>s</sub>	Sexually Transmitted Diseases
UNAIDS	Joint United Nation Program on HIV/AIDS
VCT	Voluntary Counseling and Testing

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# **CHAPTER ONE**

## **INTRODUCTION**

### **1.1 Background**

Counselling has technical and emotional components that are understood as the integral part of managing HIV/AIDS. Consequently, there could be no way deviating from the expression, and which in turn, counsellors must be competent and confident to be able to develop and practise basic minimally required competencies. Hubley (2002) tried to uncover the Ugandans experiences to reveal counsellors' competencies in HIV/AIDS counselling as though counsellors get recruited from different professional background like health, teaching and social work their training consumes more than six months focusing basically on counselling skills, workshop and supervised work experiences.

The idea that counsellors must be skilful is further underscored as a fundamental issue for Carballo cited in WHO and UK Government, 1988. The WHO and UK Government contend that in all societies there are counsellors who have already been trained or developed counselling skills need to be asked to take part in HIV/AIDS counselling to support with together, individuals who are at risk, organize new training schemes and develop plans to deliver counselling services; however, if there are too few trained counsellors, additional and new training program is seriously undertaken. Fortunately, in many societies there are people who with no formal training in counselling owe a number of qualities and competencies needed. These personalities must now be called up on and informed briefly, valid information and support about HIV/AIDS so that they are able to involve optimally in the counselling process. Relatively similar ideas have been expressed by focusing on reintegration of skills with the changing world. The Norwegian Church Aid (2005) as HIV/AIDS counsellors necessarily know latest principles of HIV/AIDS counselling in terms

of related information and should make use of them efficiently. Yusuf (1998) attempts to summarise the existence of different specialised techniques to be employed whenever necessary and also he tried to reveal the skills of quality relationship between the client and counsellor as an alternative way and determinant factors to effect the desired objectives.

Thus, undoubtedly to mitigate, if not get rid of HIV/AIDS concerned bodies whether governmental and/ or non-governmental institutions are performing an integrated services sometimes and independent services at another times so as to constrain the circulation of the pandemic through out the world.

A research conducted in Swaziland by Magagula et al., (1997) revealed that the existence of weak collaboration among NGOs and it is difficult to evaluate how far each NGO's contributions is effective in preventing and controlling the spread of HIV/AIDS due to the observed competition to the donor agencies, absence of formal structure that harmonizes each of them along together, inadequate capacity to supply goods and services and the absence of charging fees for their services. Furthermore, the integration among the government sector is also seemed to be weak and less successful which might be due to red tape and bureaucracy, centralized decision making, lack of clear policy that gives meaning to the nature of collaboration among them.

The National Report on HIV/AIDS activities in Turkmenistan disclosed that though in the government organizations people living with the virus are not entitled to anti-retroviral therapy coverage at the government expense, at every AIDS control center, psychological counselling office is accessible, staffed with specially trained skilful psychologists with further way to deliver psychological counselling through telephone hotline. Furthermore, though the non-government organizations whether at the local or international level attempt to address the issue of HIV/AIDS counselling and the over all activities, much of their efforts bounded with donor agencies such as WHO, UN -organizations that may adversely affect the sustainability and the effectiveness of the programme.

Reasonably, one can argue that provided that counselling is one way to prevent and control HIV/AIDS, counsellors must be competent and confident attracting and doing well clients to have voluntary HIV blood testing with disclosure and/or to develop positive life skills with out getting blood test, which in turn, to curve the bridles movement of this deadly disease whether in the government and/or non-government HIV/AIDS counselling providing centers. As a result, the present study helps to investigate counsellor's knowledge profile regarding fundamental counselling skills, and also observing the extent to which they put those skills in to action between the government and non-government counselling providers since the two organizations are the dominant service providers in relation to HIV/AIDS counseling.

## **1.2 Statement of the Problem**

The main point that seems having less attention and investigation in the area of HIV/AIDS counselling might be the quality of HIV/AIDS counselling provided by government and/or non-government organizations. For instance, an investigation undertaken in South Africa by Rohleder and Swartz (2005) delivers inspiring hint on the concern from one of the participants voice 'as the NGO – run clinic posses a trend of practicing for counselling processes properly, while the reality seems opposite in the government organization. Similarly, government run – clinics are suffering from numerous problems such as- clash between holistic counselling activities and other activity oriented health system with serious budget constraints. Consequently, the following basic questions were formulated for investigation:

- Is there statistically significant difference between government and non-government HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills?
- Is there statistically significant difference between government and non-government HIV/AIDS counsellors in practising HIV/AIDS counselling skills?

- Is there a statistically significant difference in HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in selection procedures?
- Is there a statistically significant difference among HIV/AIDS counsellors' practicing HIV/AIDS counselling skills that may be attributed to variations in selection procedures?
- Is there a statistically significant difference among HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in duration of training?
- Is there a statistically significant difference among HIV/AIDS counsellors' practicing HIV/AIDS counselling skills that may be attributed to variations in duration of training?
- Do government and non-government HIV/AIDS counselling providing centres differ in relation to possessing available resources such as chairs, tables, ventilations, and shelves?

### **1.3 Objectives**

The major objectives of the study are to compare:

- Government and non-government HIV counsellors' knowledge of HIV counselling skills.
- Government and non-government HIV counsellors in practising of HIV counselling skills.

More specifically, the study has the following specific objectives:

- Investigating whether differences in selection procedures affect counsellors' knowledge of counselling skills.
- Examining whether differences in selection procedures affect counsellors' practicing counselling skills.

- Exploring whether differences in duration of training affect counsellors' knowledge of counselling skills.
- Observing whether differences in duration of training affect counsellors' practicing counselling skills.
- Comparing government and non-government HIV counselling providing centres in relation to possessing available resources such as chairs, tables, ventilations, and shelves.

## **1.4 Significance**

The study has paramount contributions to pin point preventive and intervention strategies from counselling point of view, which in turn, enhancing efficiencies in fighting and ceasing the rampant distribution of the plague through identifying the strengths and limitations of HIV counsellors in the government and non-government counselling providers in relation to employing fundamental HIV counselling skills (i.e., facilitative skills, communication skills, intervention skills, termination skills and follow-up skills) for desired behavioural changes (i.e., attracting individuals to get HIV blood test and knowing ones own HIV status, maintaining positive life styles living with/without the virus namely reducing risk behaviours such as avoiding bare sexual intercourses, drug and alcohol addictions , psycho-social problems and others.

## **1.5 Delimitation**

The study conducted at Gamo-Gofa Zone so as to investigate the self-perceived knowledge and practise level of HIV/AIDS counselling skills among HIV/AIDS counsellors' who were working at the government and non-government HIV/AIDS counselling centers.

## **1.6 Operational Definition**

**HIV/AIDS Counselling:** A confidential communication between the counsellor and the counselee aimed at reducing HIV/AIDS development and transmission through delivering accurate and reliable information

about the pandemic, and through conducting HIV/AIDS prevention counselling mainly dealing with facilitating conducive environment to the client to explore own peculiar facets and risks, which in turn, assisting him/her plan and achieve clear behaviour- change target to minimize the probability of developing or passing HIV, and even adjust with psycho-social problems and develop independent choice with regard to the plague (CDC , 2001; MOH, 2002 ). Consequently, under this study all kinds of HIV/AIDS counselling such as Voluntary Counselling and Testing, Home -based counselling and PMTCT counselling were included.

**HIV/AIDS Counselling skills:** Techniques and /or competencies that may involve the following: (Yusuf, 1998 Hubley, 2002; MOH, 2003/5; Norwegian church Aid, 2005; Fischer et al., 2005).

- **Facilitative Skills:** Pre-condition for effective delivery of HIV/AIDS counseling such as accessibility and convenience of counselling office with waiting areas, congruence, establishing rapport, securing privacy, greeting, getting empathic, conformability and well arrangement, introducing the topic, respecting the client, unconditionally accepting the client, using ice breaker, maintaining confidentiality. (Ethiopian Ministry of Health, 2003)
- **Communication skills:** The counselling skills that typically significant to explore client's risk factors through conducting mutual discussion via asking, silence, pause, responding, acceptance, leading (i.e., clarification, reflection, questioning, restatement), summarizing, effective listening, encouragements, providing possible explanation, attending, using non-verbal cues properly. (Ethiopian Ministry of Health, 2003)
- **Intervention skills:** The skills of counselling that may help to avoid and/or minimize risk induced behaviours on the basis of different theoretical approaches such as cognitive – behaviour and/or affective oriented skills.

- **Termination skills:** Ending of counselling relationship between the client and the counsellor whether through referring the client to other senior counsellor, when there is nothing to be discussed. (Yusuf, 1998)
- **Follow up skills:** The counselling skills that assist the counsellor and the client to check whether there was desirable behavioural change or not and/or to investigate client's problem even more thoroughly through face-to-face contact with the counsellor, referring to another individual or organization etc

**HIV/AIDS Counselors:** All the para- counselors (i.e., the non-professionals) namely the influential and respected persons of community, dedicated schoolteachers, motivated health workers, peer counselors/volunteers, PLWHAs (people living with HIV/AIDS), social workers, psychologists, and/or religious leaders are the salient service providers. (MOH, 2002; Norwegian Church Aid, 2005).

**Government organizations** refer to public agencies that are directly under the jurisdiction and control of the government such as ministries, departments, and units, which provide public services. (Magagula et al., 1997)

**Non-government organizations (NGOs)** are registered, non-profit, voluntary, independent, and charitable organizations (Cernea, Willard and Copestake quoted by Magagula et al., 1997)

## **CHAPTER TWO**

### **REVIEW OF RELATED LITERATURE**

#### **2.1 Nature of HIV/AIDS Counseling**

The concept HIV/AIDS counseling is the newly emerging idea in the sphere of counseling. Scholars may try to deliver its meaning comprehensively from different corners. For example, UNAIDS (2000); MOH (2003) and the Norwegian Church Aid (2005) attempt to define it as confidential interpersonal relationship between an individual who seeks help and the one who is capable of assisting the counselee so as to manage Psychosocial hurdles related to HIV/AIDS. As Rogers cited in Rushton and Davis (1992) clearly visualize counseling including the HIV concern as the process of communicating to the counselee of the central affects of empathy, unconditional acceptance and genuine and which it necessarily encompasses client's experiences of the conditions. Even more, Chaava (1990) consider the meaning of counseling in terms of HIV/AIDS as the process focusing at delivering quantitative and qualitative psychological, and social support to the patient, families (i.e., nuclear and extended) and the community in the general. There by also added that counseling process dismantles the wrong notions conceived by some individuals with the pandemic and its mode of transmission through making more emphasis on inculcating no risk induced behaviors.

Center for Disease Control as cited by Kinnel (2001) here again puts a light on the previous and the contemporary meaning of counseling as the former merely revolves around securing information about the disease, while the later helping the client to assist himself/herself; and instigate and maintain behavior change. As Carballo quoted by WHO and UK Government, 1988 counseling is a device that leads marshaling the psychosocial and material inputs of the individuals living with HIV/AIDS, health professionals, families and the

community as a whole. Moreover, a study conducted in Ghana by Chester cited by Brugha (1994) strives to describe counseling as the skilled and principled utilization of communication to create conducive involvement in order to help the client to know assets and liabilities, emotional acceptance, improve and advance growth and personal resources optimally.

Counseling containing HIV concern has common features. The Ethiopian Ministry of Health (2003) further attempts to reveal almost similar ideas with the above scholars as it emphasizes on changing voluntary behaviors of the client, facilitating conditions to the counselee to develop self-help skills specified with limits such as an interview, listening, attending and understanding each other, conducting privately and maintaining confidentiality. For instance, Patterson quoted by Yusuf (1998) described the characteristics of counseling as it is not giving information though it involves whenever necessary; not giving advice, suggestion and/or recommendations; not challenging client's attitudes, beliefs through persuasion or coercion; not affecting individual's behaviors through admonishing, warning threatening or compelling, not interviewing rather it is instrumental to counseling.

In line with the scholar strive to delineate the boundary of counseling as it depends on informed consent and desire for change on behalf of the client; providing conditions for independent behavioral modifications; determining the limits like time, goal etc; employing interviews to make all the things possible through listening and understanding the client. Center for Disease Control (2001) specifically underscores that as HIV prevention counseling used to be delivered on the basis of client's informed and unique conditions (risks) and that in turn, helps him/ her set and attains concrete and observable behavioral changes in preventing and controlling the spread of the plague. In addition to Hubley (2002) and Ethiopian Ministry of Health (2002) state about other fundamental and peculiarly issues that individuals need to maintain and put into action while delivering HIV/AIDS counseling are confidentiality,

anonymity, pre-and –post test counseling, if any, informed consent, the right to choose own action, and dealing with psychological, financial and spiritual needs'. In the words of Grinstead quoted by UNAIDS (1997) identified further distinguishing qualities of HIV/AIDS counseling that comprising HIV prevention counseling aimed at behavior change for not to contract the disease, while the other one counseling for care and support focusing on improving the physical, social and psychological well beings of people living with HIV and relinquishing the extent of stigma, discrimination, abuse and/or abandonment. Similar idea, but different authors such as Chaava (1990) and Brugh (1994) bitterly underscored on emotional support to be conducted at the rate of interface among the unique feature of the client, health workers, families and the community at large so as to secure opportunities for the health professionals to buffer prevention schemes of counseling and awareness raising via open exchange of ideas and reaching at consensus.

Another prominent feature that makes HIV/AIDS counseling unique from other counseling programs may be its difficulty of counseling job it self. Several literatures and research evidences reinforce this fact unquestionably. For instance, Ginwalla et al., (2002) claims that some counselors are suffering from stress and burnout syndromes due to one or another reason; for example, work load, lack of training, supervision and/or support. Moreover, a study conducted in Kenya and Tanzania by Grinstead et al., (2000) confirms that counselors' job are both rewarding and stressful because of the nature of the task that they perform and other external influences like economic and political pressures. A very recent investigation in South Africa by Rohleder and Swartz (2005) contend that since counselors are dealing with the client on the emotionally loaded topics such as sex, death and dying and work related problems; they tend to get stress, anxiety and other intrusive psychological consequences as well as economic complexes. Actually the scholars may not emphasize exclusively on the nature and causes of career strain rather attempts were made to pin point directions to reverse such consequences. Among which

organizing regular support, supervision and training, alternating counseling with other activities (allowing work flexibility), delivering options to client desirable behavioral change as the result of counselors' performance, accepting and informing about emotional labor in counseling, availing regular and latest information and quality training, and reinforcing counselors to take part in the development of research scheme (Grinstread et al., 2000; Ginwalla, et al., 2002; Kelly et al., cited by Martin et al. , 2001). Furthermore, these scholars boldly suggest community intervention as effective way in preventing risk behaviors so as to curve transmission of infections in some areas.

## **2.2 HIV/AIDS Related Psychosocial Problems**

It is common to enumerate myriads of psychosocial ailments in line with the pandemic HIV/AIDS. Individuals are forced to experience intrusive emotional numbness and behavioral constrictions before and/or after knowing HIV status. Infact the magnitude of exposure and/or practice of risk-induced behaviors may be the underlying factor so as to feel and suffer with such emotional anguishes and social impairments. For instance, some people become so fearful about contracting HIV/AIDS. The most important psychological stressors that may reinforce to such induced unhelpful psychosocial torments; for example, long incubation period and latent development to AIDS' Stigma; isolation, loss of job, housing. Friends; disability; dependency; death etc. Consequently, counselors should help those individuals at least to mitigate such non-desirable thought and behavioral manifestations (Bruhn, 1989). Furthermore, Hubley (2002) notes as counseling become the stepping-stone for people who are worrying about contracting HIV/AIDS. To mean, the fear may posses an actual ground; for example, having sexual relation with commercial sex works, and/or any other risks. Therefore, assisting such individuals to have an access about counseling, this in turn, results in relinquishing the adverse psychosocial consequences.

The aversive psychosocial significances of HIV/AIDS are not maintained only before. The recognition of HIV status rather it extends even more after definitely knowing the existence of the virus in ones own blood. As a result, countless government and non-government agencies are still in tact pursuing their endeavor in managing not only on the proactive HIV-related crises, rather on the reactive restoration of impaired emotional and social facets. As the Ethiopian Ministry of Health (2003) people with HIV infection consciously or unconsciously experience sever pain, mental suffering and/or unhappiness/ as ego-defense mechanisms, which in turn, puts a light on the counselors' so as to conduct counseling relationship on the need and socio-cultural context of the clients.

Specifically people living with HIV encounter a number of social and emotional problems among which shock primarily affect the individuals' life. In the words of Venkat (2004) shock as the primary psychological reaction among people living with HIV/AIDS. The Ethiopian Ministry of Health (2003) also attempts to describe shock as a potent emotional expression considered as a normal response among people who encounter dangerous situations in life and characterized by emotional numbness, confusion and uncertainty, despair, instability, withdrawal, crying etc.

Denial is another emotional consequence that pervades among the individuals who are living with HIV/AIDS. This psychological reaction typically known by safeguarding oneself from the debilitating and stressful events through refusing the acceptance and integration of the reality into ones own cognitive schema (Ethiopian Ministry of Health, 2003; Hublely, 2002; CRDA, 1995). Ministry of Health (2003) even more contends the state as initially reality based, which helps to minimize pervasive stress situations due to the new event occurred in life, while its persistence may result in psychological block impinging upon the individual in utilization of the existing preferred coping strategies and acquiring new problem solving skills so as to make the effect less likely hazardous. The

Toronto AIDS Committee (1998) further classified the existence of denial response among the newly disclosed individuals and its effect as refuting one's possible course of actions and consequences are not usually hurting rather dwindling stress, maintaining people happy intact and adjusting and generally keep positive living.

Stress is a further concomitant psychological reaction among people living with HIV/AIDS characterized by physical and psychological lethargy and tension through vacillating to be tested or not, premature death and knowing about HIV status, which in turn, results in reduction of decision making skills, declining facts about the disease and change of behavior (Ethiopian Ministry of Health, 2003). According to CRDA (1995) people who have been exposed to HIV/AIDS may feel and experience stress response due to numerous reasons like uncertainty about future life, anticipating about misfortunes of marriage mate and children, about social stigma and lack of support from others. Venkat (2004) also strives to reveal, stress as one of the emotional calamity of HIV/AIDS having an impoverishing consequences on the part of the infected persons.

There are several other psychosocial impacts of HIV/AIDS that each of them has distinct qualities. According to the Ethiopian Ministry of Health (2003) one can find a number of psychological and social consequences of HIV/AIDS among which fear due to the presence or anticipation of danger due to HIV/AIDS, and other unpleasant stimuli and anxiety because of chronic uncertainties of the infection; anger because of the feeling that considering oneself as misfortune so as to contract HIV/AIDS; suicidal thoughts or actions since they think that they loose personal value; therefore, they are responsible for not living with in the societal and personal expectations; isolation due to fear of abandonment; depression because of getting helplessness and inadequacy. On the contrary, it could be viewed as the result of accepting the reality (i.e., causes, intensity, treatment, permanence, consequences and

alterative ways to cope with it). Further complications may be guilt which is due to the thought that unguarded personal behaviors lead to contraction of the infection; loss of self-esteem may happen because of the social stigma occur in different settings; hypochondriacs is typically exists due to preoccupation of various psychological and physical symptoms.

The Norwegian Church Aid (2005) uncovered a number of psychological ailments due to the contraction of HIV that can be expressed as anxiety, guilt feeling, withdrawal, depression, shock and the like. Still another investigation by Venkat (2004) shows numerous psychological and social torments that can be summarized as shock, confusion, emotional isolation, anxiety, stress, fear and psychophysical disorders as the primary continuum, while sadness, atilt, helplessness, worthlessness, social withdrawal, suicidal tendencies and depressions are another secondly group along the continuum of reactions and finally the individual depicts discrimination, depression, right violation, marginalization, alienation and revenge in the third phase. The Toronto AIDS Committee (1998) even more claims as the extreme stress of HIV infection may result in denial, distress, anxiety, anger, guile, disruption and confusion.

## **2.3 Significance of HIV/AIDS Counseling**

It is quite valuable to describe the contributions of the value laden scheme, HIV counseling. One may enumerate tremendous specific practical implications of the program. Though the fact may remain here, it could be easy to categorize into two major headings.

### **2.3.1 Prevention Counseling**

A large number of research evidences as well as a number of other scripts clear up the cloud on how really HIV/AIDS counseling results in preventing the swift invasion of the pandemic. Hubley (2002) confirms that HIV/AIDS counseling is an essential instrument to be utilized with any individual who is confused about the disease and in need of counseling on the best way of clarifying life

styles so as to dwindle the opportunities of getting infected. According to the Canadian Ministry of Health (1992) counseling about HIV infection underscored as the best alternative way to reverse transmission, and also it could be more valuable than the test itself since the quality of counseling that clients obtain will have paramount consequences (i.e., change of behavior and/or positive living with the infection).

An investigation made in Botswana reveals that counseling was happened into view as one of the integral elements on the health program so as to pursue the increasing rate of HIV infection through prevention, counseling. (Fobad, 2001). Ethiopian Ministry of Health (2002) even more attempts to visualize the strategies and specific concerns under prevention counseling. It has been contended that the scheme may be delivered through face-to-face individual counseling and/or group counseling. Risk assessment for risk reduction; skimming wrong notions on the nature, causes and consequences for constructive forward movement and further issues are under discussion. Center for disease Control (2001) endeavors to categorize HIV counseling in to two: information delivery and HIV prevention counseling though both are aimed at reducing the infection, and transmission, while the latter one exclusively bound with the nature of counseling and explained as the counselor emphasize on investigating counselor's subjective risks, behaviors and supporting the client develop and end up with specific and measurable risk managing skills.

A study conducted in USA by Kamba et al., cited in Kawichai et al., (2004) vividly uncover about effective counseling approach so as to constrain the rampant flooding of HIV/AIDS as brief counseling utilizing a personalized risk reduction scheme was as successful as intensive enhanced counseling when comparing deductive delivery of message. Another perceived research finding from Zambia by Chaava (1990) operationalize the subsequent effect of counseling and its nature as the scheme is the seedbed to the overall HIV/AIDS

prevention and control through maintaining specific programs – such as inclusive counseling, pastoral care, education and administration.

HIV/AIDS counseling is still the corner stone even where testing is non-existence for individuals with symptomatic HIV, families and services providing HIV prevention counseling (i.e., counseling about protected sex in the service delivery centers). (UNAIDS Best Practice Collection-Technical Update, 2000). In the words of Dezoya et al., quoted by Grinstead et al., (2000) and Kipp (2002) the need for HIV/AIDS counseling with and without blood testing mounting in the developing nations and counseling tasks are becoming more usual. Nevertheless, in many of clinics and community centers the testing is conducted without counseling and possibilities for prevention counseling is void (Lavollay cited in Grinstead et al., 2000).

### **2.3.2 Care and Support Counseling**

Counseling may take different forms depending upon the need of the client and the scheme is being considered as fundamental element of HIV/AIDS care and an essential component of HIV testing (Rohleder and Swartz, 2005). The Canadian International Development Agency (2001) endeavors to clarify the fundamental features of HIV/AIDS support counseling as it could be delivered on the basis of client's need, aimed at internalizing hope in the client and reframing the client's interest in life and it is center-based (i.e., conducted at different setting like home based). Marcus et al., (2000) and Green and Smith (2004) vividly revealed counseling as one of the major components such as group psychotherapy, psycho education, cognitive – behavior therapy and stress and anxiety; management in order to manage HIV/AIDS – related complexes, which each of them has its own unique qualities.

Carballo cited in Brugha (1984) counseling at the grassroots level of different hospital settings may respond four fundamental needs which are delivering psychological and psychosocial support to the individuals who have been

infected, changing undesirable behaviors, maintaining sustainable economic, intellectual and social productivity, and mainstreaming HIV-positive individuals within the major network of the family and community. Moreover, reducing the psychosocial and physical morbidity through minimizing the challenges in medical aspects.

Psychosocial support even more extended as crucial not only for individuals who have been affected by HIV/AIDS, rather for non-infected children of HIV-positive parents (Gunther, et al., 1998). A study conducted in Zambia by Chaava (1990) strove to identify comprehensive and fundamental purposes of counseling as primarily exploring the existing inputs of the individuals' families, and community so as to bear the responsibilities to care patients through pursuing change of behavior among the families. The investigator even more specifically claim counseling focuses on delivering psychological help to the patient, his/her family and concerned individual in the extended families followed by facilitating conditions in such away that the patient and his/her family learn reliable information and communicate with the remaining community members.

According to Miller cited WHO and UK Government (1988) the consideration of significant others vitally indicated in care and support program due to the person with HIV may perceive himself/herself as burden and feel guilt that may enhance the psychosocial significances, significant others may feel hypothetical fear about the transmission of the disease, those salient individuals in life for people living with the virus may get in distressing situations on the disease, causes, treatment and consequences even more than the victims, and the influence related to HIV/AIDS may result in family discordance by per se. Consequently, the requirement of proper counseling and discussion with such noticeable individuals become paramount.

## **2.4. Demand for HIV/AIDS Counseling**

Some written documents testify that HIV/AIDS counseling is mandatory and need to be conducted any where to secure desirable behavioral changes. For instance, the case in point dealt by UNAIDS (2000) as in certain areas HIV/AIDS counseling is accessible in the absence of testing in order to promote changes in sexual risk behaviors, and also it has been evident in the rural areas of Uganda as community- based counseling radically enhanced the rate of condom utilization among adults. Carballo cited in WHO and UK Government, 1998 strongly asserts the demand for counseling as the fundamental element in any health related scheme for proactive and reactive HIV related crises management and its value and significance is remained at the social level; however, its most basic contributions lie at the personal and familial position. Similarly, the United Nations HIV/AIDS Program (1997) confirms that counseling services available to HIV – negative and HIV –positive individuals outside the testing contexts should be supported to deliver care, support and prevention.

A study conducted in America by Grinstead et al., (2000) openly viewed about the swift and sharp demand of counseling in the sphere of HIV prevention and control as the need for HIV/AIDS counseling services with or without testing increasing in developing nations. Though the existence of scanty investigations that indicate counselors' role and experiences delivering HIV oriented counseling in developing states.

As Martin et al., (2001) the future trend in HIV/AIDS counseling as hereafter focuses on the endorsement to therapy in patients with HIV infection necessarily targeted to individual counseling and should be intensive enough and long lasting. Further study by Golin et al., (2004) in the Northern Carolina underscores on the adherence counseling practices in HIV/AIDS as physicians treating for HIV patients require more training and extensive time to provide

anti-retroviral adherence counseling which may increase the demand of counseling services. In addition, Rohleder and Swartz (2005) conducted a study in South Africa even more discloses that counseling as being considered as an essential part of HIV/AIDS care, and the integral component of HIV testing though relative absence of consideration to the systematic and managerial problems encountered by counselors and counseling programs. Even more, HIV counseling services are highly required without getting blood test (Kipp et al., 2002).

Some scholars still attempt to disclose the need of counseling for pregnant women to prevent and control the spread of the pandemic. For example, World Health Organization (1999) HIV/AIDS counseling of pregnant women need to be carried out by trained and competent health care workers either within the antenatal health center or in close collaboration with a VCT center in the area. The health care professionals in the antenatal care centers need to be aware of the VCT process and capable of referring women for pre- and -post test counseling as well as on going counseling whenever necessary.

Golin et al., (2004) describes counseling as the milestone for people who take ART; however, many health workers' feel inadequately skilled to offer Anti-Retroviral adherence counseling due to lack of proper training in the concerned areas.

According to Ethiopian Ministry of Health (2002) HIV/AIDS counseling in Ethiopia started around the end of 1980s with the program growing throughout the 1990s which might be due to a great deal of country wide training for nurse counselors and social workers and due to also the establishment of several counseling centers via the joint effort of government and non-government institutions.

## **2.5. Implications of Counseling Skills to Deliver Quality HIV Counseling**

The Norwegian Church Aid (2005) contends that counselors whether directly or indirectly should have the skills to know the principles and process of counseling in relation to the latest information with further technical and content knowledge of the disease. Carballo cited in WHO and UK Government, 1988 seriously underscored on counseling skills for the desired change and to fight against HIV/AIDS as though it is not a novel service, a number of caring professionals possess in one direction or another acquainted with and utilize the skills and techniques through the renewed application of principles and practices, persistent integration of people living with the virus with the wider society for optimal use of social, economic and intellectual inputs, and maximizing patients role in fighting against the pandemic.

Though it has been targeted towards the skills to which HIV/AIDS counselors endeavor to reveal that skilful counselors exert much effort in assisting the youth in order to stop contracting HIV, maintaining positive and long term behavioral changes, expanding opportunities for other health related and care services getting free from unwanted pregnancy and designing future strategies for effective management of the HIV/AIDS (Fischer et al., 2005). As the Ontario Ministry of Health (1992) reflect a flash of light on the counselors' effort so as to deliver productive counseling as counselors are supposed to remain their personal knowledge of counseling skills during the counseling relationship via modifying HIV-related information whenever necessary in order to address clients problem. Furthermore, counselors are expected to consider the culture, language, perception of HIV disease, client's self-esteem, and a number of other issues may put on pressure on the client's to perceive the nature of the disease and make positive change in life. An investigation made in Kenya and Tanzania by Grinstead (2000) contend that counseling is perceived as a respected interpersonal relationship where communication of individual's subjective issues could happen since the 'secure environment' focusing to the

maintenance of confidentiality and special skills that counselors bring to the 'counseling' relationship. Current changes in medicine focus on community care, through developing professional knowledge and patient self-responsibility (Davis and Butcher; Miller and McConachie quoted by Rushton and Davis, 1992). Furthermore, such changes need a greater modification of services to end personal needs and possess enhanced demand for counseling/communication skills in any profession (Cunningham and Davis; Fallowfield cited in Rushton and Davis, 1992). A further study by Brugha (1994) reveals that under a team approach to HIV infection care and counseling with effective recruitment and assistance of the staff with proper training of counseling skills is mandatory.

Stickley (2002) comprehensively underscores on the importance of counseling skills as to growing element under mental health nurses training scheme in England. In the words of Epstein et al., (2001) health professionals often did not provide opportunities for patients to express their issues, and communications tended to utilize unclear languages to convey risk behaviors and to be ignored at "awkward moments." Despite the fact that physicians perceived video tapes of their own inadequate communication behavior, which enables to look for wrong communications and discover strategies to promote HIV risk assessment skills. Relatively similar ideas have been forwarded by Bowles (2001) nurses communication skills have been criticized for a number of years due to the inadequate training offered and the absence of well organized theoretical or practical approaches for communication skills that the nurses receive which might led to less quality services.

## **2.6 Profile of HIV/AIDS Counselors' Skills**

HIV/AIDS counselors may emerge from different social and academic background. Though the demand of counseling dramatically increasing due to the happening of different psychosocial ailments, the trained and competent personnel in relation to the extensive rampage of the challenges is quite meager

and misbalanced. According to Grinstead et al., (2000) there are scanty scripts on counselors' experiences of delivering HIV oriented services in developing nations. In order to meet the urgent and critical requirements of the service delivery it could be the cornerstone to recruit, train and make use of individuals from a range of background. Hubely (2002) attempted to reveal the Uganda situation as HIV/AIDS counselors come from areas of health, teaching and social work having the training for six months on the issues of counseling skills, workshop and supervision work which might be due to increased need of HIV counseling for testing, support and care. Relatively similar understanding has been coined by Carballo cited by WHO and UK Government, 1988 though counseling has been instrumental since long time for the effective management of chronic and acute illnesses, its implementation to HIV/AIDS may require special attention due to the nature and effect of the disease. For that matter, individuals who have been trained a head in counseling and/or possibly exploitation of the existing locally available knowledge and skills with specific additional training need to be underlined to reverse the bridles progression of the pandemic. Numerous individuals who have received the necessary training in the scheme can provide HIV counseling specifically; for example, health professionals like physicians and nurses, social workers and psychologists, religious leaders' local/village 'leaders Volunteers, PLWHA, Peers and so forth (Norwegian Church Aid, 2005).

Moreover, an investigation made in Ghana by Brugha (1994) shows that effective HIV/AIDS counseling programme is subject to the integration of multidisciplinary team constituted from highly motivated individuals having the component such as counseling clinical care, nursing, health education, pastoral care, administration management and data processing, etc with flexibility and the skill to satisfied the needs of clients. All such members of the team necessarily obtain special training in counseling approaches and techniques (Campbell and Williams cited in Brugha, 1994). This idea even more strengthened by Green and Smith (2004) under the British HIV Association as

the complex psychosocial characteristics of HIV/AIDS gears individuals towards multidisciplinary scheme as the needed for HIV care and support constituting to professionals such as doctors, nurses, midwives, health obvious psychologists, counselors, dentists, pharmacists, other professionals combined to medicine, social workers and people with HIV/AIDS.

An investigation made by Ginwalla et al., (2002) strives to visualize the efficacy of HIV counseling through the comparison of nurse counselors and community volunteers as in nurse counselors posses better communication skills than community volunteers which might be due to the nurse counselors see fewer clients than the community volunteers since they passes and further additional duties to be attended. Further explanation comes from the view that nurse counselors relatively experience interpersonal relationship while conducting the usual routine tasks that might non-existent to community valentines. Still another reason could be community volunteers may acquire low level of counseling skills since the trainings many times undertaken in secondary/tertiary language, which is English.

## **2.7 Theoretical Foundation of HIV/AIDS Counseling**

Counseling in general, HIV/AIDS counseling specifically, has its own theoretical basis so as to pursue the goal of the relationship successfully. All the fundamental psychotherapeutic thoughts from psychoanalytic to family approach deliver understandings of personal and family change with behavioral problems and suggest comprehensive principles towards the solutions of problems (Weakland and Jordan, 1992). According to Ethiopian Ministry of Health (2003) counseling theories are the cornerstones for counseling since counselors are dealing with individuals and their psychosocial facets, and exposure to different risk induced behavioral constrictions. Respective professionals are supposed to conduct supportive actions on the basis of concrete and practical ground. To mean, the purposeful specific interventions employed by the counselors should base on theory rather than random

assignment and implementation of principles. Consequently, counseling involves sequential well-organized implementation of counseling skills owing various theoretical frameworks considering the socio-cultural milieus of the society, the need, age and political aspects of the clients.

An investigation made in South Africa by Richeter et al., quoted by Rohleder and Swartz (2005) contend that there are a number of approaches to HIV/AIDS counseling constituting client-centered, cognitive – behavioral, psychoanalysis, health, education, and others. Though the approaches may vary almost all of them focus on the significance of trusting, confidentiality, and dignified relationship between the client and the counselor. There are still numerous counseling theories that each of them with specific features and branches among which psychoanalysis, behavioral- cognitive, humanistic and eclectic approaches (Ethiopian Ministry of Health, 2003).

Green and Smith (2004) reflect as cognitive-behavioral therapies and other psychotherapeutic approaches are underlined clearly as significant interventions so as to dwindle psychiatric cases of individuals with HIV/AIDS. Cognitive-behavior therapy even further noted by Molassiotis et al., (2002) as it is reducing psychological distresses and changing the quality of life among the clients AIDS patients. In addition, skills training, methods such as cognitive-behavior therapy are basically important for intellectually active and mild to moderate residual pain reductions related to HIV/AIDS (Marcus et al., 2000).

According to Bor et al., (1989) confirms to describe another approach, which is known as a system theory to AIDS counseling referring the involvement of understanding the context of the problem; obtaining a clear meaning of problem regarding to dynamic nature of the problem over time; and specifying whom the problem affects. Inability to take into account all the above issues may put pressure/ difficulties in the counseling relationship.

Further theory of HIV/AIDS counseling has been forwarded by Rachman cited in Gunther (1998) group therapy considered as more appropriate for

adolescents of parents with HIV/AIDS since the group itself becomes an instrument to help adolescents with identify development and consolidation. In addition Levin cited in Gunthers (1998) describes the group as representing a transitional object that helps adolescents to personalize and identify from their families. Aaronson quoted by Gunther (1998) thrown further explanation as the method even more applicable to children of HIV-infected parents.

A study conducted by Arthur (1998) reveals that the communication models tailored by nursing courses come from humanistic (client – centered approach) which is characterized by respect, genuineness, empathy, attending, listening probing and generally quality relationship. In addition client – centered counseling has been suggested by CDC as interactive counseling approach that has been translated as face-to-face sessions between the counselor and the client though misinterpretations and lack of experiences of the model exists as if basically focuses on face-to-face information delivery, advice giving and directing the client to perform certain selected tasks rather than encouraging and facilitating active listening attending, respecting the clients and his/her concerns, maintaining on going quality assurance so as to obtain reasonable benefit (CDC, 2001; Grinstead et al., 2000).

## **2.8. Factors Affecting HIV/AIDS Counseling**

Nothing is right perfect rather it has limitations or challenges that impair quality delivery of services. Likewise HIV/AIDS counseling still encountering such challenging situations having adverse consequences in the program. According to Family Health International (2001) summarizes all the challenges in the governmental and non-governmental institutions of voluntary testing and counseling programs as non-integration of the service with the existing medical activities and problems to secure continuous follow-up, expensiveness to establish and operate that require sustainable external assistance, non-equitability, stigmatizing effect due to the association of all issues with HIV/AIDS are the most hurting/damaging impediments to the freestanding or

direct HIV counseling program. Similarly, integrated program of HIV counseling has the characteristics of affecting quality of other tasks and lower quality VCT service, not permitting non-health care workers; for example, people living with HIV/AIDS, teachers, social workers, community workers, volunteers as counselor, little motivation in the public sector employees, difficulty to maintain quality assurance, bounded administrative and managerial potentials so as to run these complex tasks.

Another issue which may be considered as the limestone for delivery of quality counseling could be counselors' counseling **competency**. The UNAIDS (2000) claims that counselors always come from different background, and with various health and social beliefs requiring training in special communication skills like welcoming friendly, sensitive and non-judgmental attitudes towards clients. Another important component as a determinant issue in the efficacy of HIV counseling could be mentioned as on going support and care for counselors. Rohleder and Swartz (2005) clearly uncover the fact as counselors requiring more support from health sector on their tasks, feeling isolated from main stream services, and requiring to be a member of as initiative element in the functional and referral net work for clients and they indicate that counselors need to be organized into the health services via the delivery of constant post. Furthermore, the Canadian International Development Agency (2001) reveal that counselors spend most of their time listening to clients and delivering other individuals support; however, to perform their tasks well, they too require support; for example, back-up support and personal protection, an incentive for motivation psychosocial support retreat (time a way), adequate logistic support, updated professional development and training networking, exchange visits and counselors support group.

The United Nation Agency for International Development (2000) further notes some of HIV/AIDS counseling centers offer longer, more in-depth training need for refresher courses and continuous training. Counselors who are working at

VCTs will require training that focus on basic information on HIV, and possible and available interventions as well as the role and processes of pre-test, post-test and on going counseling. Actually, counselors may need new skills to be employed for on going counseling that contain different models of training (i.e., a short course 1-2 weeks) followed by practical tasks, and then additional 1-2 weeks is a reasonable time scale. (Miller cited in WHO and UK Government, 1988).

Counselors **extrinsic motivation for counseling and recognition** are again further concerns need to be underscored for effective delivery of HIV counseling. As it has been indicated under the UNAIDS Best Practice Collection (2000) as a number of individuals in pervasive HIV – prevalent areas are receiving training in HIV/AIDS counseling; however, are usually not utilize their skills properly due to counseling is not considered by workmates as being significant. Moreover, other day-to-day tasks frequently take primary attention over counseling or counseling trained staffs are changed to other positions where they are unable to perform their responsibilities. If counselors are trained and provided with farther tasks in HIV/AIDS counseling, the role must be understood and appreciated, and the counselors necessarily allowed with adequate time to pursue these tasks. Training in basic skills and techniques of counseling, a good knowledge of HIV, and an understanding of the underlying principles and goals of counseling are prerequisites to effective and safe counseling particularly on the part of lay counselors. CDC (2001) notes among a number of issues need to be considered while undertaking HIV/AIDS counseling; counselors are required to complete a standard of training courses in client-centered HIV prevention counseling or other risk managing counseling approaches.

## **2.9. Major HIV/AIDS Counseling Skills**

### **2.9.1 Facilitative Skills**

As it has been noted, counseling requires basic/ fundamental/ skills to be employed. The joint United Nations program on HIV/AIDS (1997) as a general rule testing should be conducted only with quality pre-and-post test counseling consistent with the existing counseling guidelines. Moreover, the United Nations Technical Update (2000) HIV/AIDS counseling can be tailored to the needs of the client/s and can be for individuals, couples, families and children and need to be modified to the needs and capacities of the context in which it is to be offered.

Baggaley et al., (1998) attempt to disclose about the skills related to establishing some operational aspects of counseling scenarios – such as the site (i.e., need to be accessible and convenience), private with waiting area; ensure confidentiality and with linkage with other services (i.e., medical, social, emotional, family planning activities, STI tasks, antenatal services, home-based care services and palliative care services); spiritual services and traditional healers; support groups for people living with HIV/AIDS; community groups and NGOs. Furthermore, an appropriate environment (i.e., free from interruption, pleasant, quiet, comfortable, accessible and threatening which could be in the client's home, suitable place (i.e., accessible to where the patients exist), in or near hospital ward or outpatients sections (Jackson cited by Brugha, 1994; Arthur, 1999).

Evidently, even more stated in WHO, 1999 in several cases antenatal care – hardly performed privately. Nevertheless, for VCT and MTCT intervention to be undertaken properly and effectively, privacy must be maintained. Dealing of risk factors and sexual relations is components of VCT infection, and basic information necessary to the process will not be elicited unless the woman can discuss these issues privately. Additional space or rearrangement of clinic

accommodation will be needed. Besides, women attending antenatal health centers may usually have other children with them. Furnishing, spaces where children can entertain supervised by further waiting mothers or health care staff would enable counseling to proceed without intervention. Moreover, UNAIDS (2000) clarifies that counselors must be able to "user friendly", need to deliver counseling in non-threatening, safe, and easily accessible environment.

According to the UNAIDS Technical Update: Voluntary counseling and Testing (2000) establishing good rapport, respecting and understanding the client and client's problem as the most important conducive skills so as to manage difficult situations during HIV/AIDS counseling. The Norwegian Church Aid (2005) additionally confirms that the counselor should attempt to assist the client to express their life styles openly and transparently through establishing rapport such as-expressing love, respect, greetings; introducing oneself, topic, purpose of HIV/AIDS counseling maintaining confidentiality encouraging the client so as to visualize the reason that he/she needs HIV/AIDS counseling and so forth. Relatively, similar ideas have been forwarded by Kambat et al., cited in Kinnel (2001) initially the counselor should introduce himself/herself as health counselor, define the purpose of HIV/AIDS counseling, the presumed time consumption, the specific objective of the session, seeking and maintaining agreement between the counselor and the client. In addition, Chester cited in Brugha (1994) endeavors to define pre-conditions of counseling as the core qualities that are fundamental to counseling constituting the skills to show empathy, unconditional positive regard, and genuineness.

The idea of confidentially specifically indicated as that of pre-supposes a relationship of intimacy or trust between two or more persons in whom private or secrete information is shared on the understanding that the information will not be repeated to an unauthorized person. Consequently, such confidential relationship pertains between an HIV/AIDS patient and every HIV counseling and others who offer care for such individuals (Fombad, 2001).

Ginwalla et al., (2000) reveal professional differences in the implementation of such counseling skills as nurse counselors generally perform better than community volunteers in developing a rapport with the clients and even also they seem to be more confident in offering information and responding to questions raised from clients. Some scholars still made an effort to disclose non-professionals or lay counselors may possess particularly advantages especially if they are counseling people with the same or similar, language or cultural background (Jackson cited in Brugha, 1994; Arthur, 1999). This idea also strengthened by the Joint United Nations Program on HIV/AIDS (1997) as counselors need to consider clients' socio-cultural backgrounds and should be sensitive and appropriate with the issues of sexual identity, developmental and linguistic aspects.

Detailed features for effective delivery of counseling has been forwarded by the Ethiopian Ministry of Health (2003) are availability of time and space, establishing working relationship, making consistent and accurate information available, maintaining privacy and confidentiality, emphatic understanding of the client and client's problem, respecting the client and showing warming and getting genuine. In addition, HIV/AIDS counseling is undertaken in offices where sheltered space, intimacy, trust, and confidentiality can be secured. The intimacy can enhance rapport and overcome some of the problems of social distance that are inevitable where individuals are by formal desk or the classic white uniform (Hall quoted by WHO and UK government, 1988).

### **2.9.2 Communication Skills**

In relation to communication skills abundant scripts offer clear evidences. For example, Hubley (2002) attempts to reveal the skills of counseling with a word as 'GATHER' that may conote: G: Greeting the client, A = Asking about the client and LISTEN to what he/she says, T = Telling clients any relevant information they need, H: Helping clients make decision, E = Explaining any

misunderstanding, R=Return to follow-up. In similar, way but differently Arthur (1999) explicitly discloses a number of communication skills as attending skills that expressed as SOLER with each letter stands for different expressions: S: Sitting squarely, O: Open posture, L: Lean forward, E: Eye contact, and R: Relaxed. Moreover, some more skills have been mentioned such as listen to and understand verbal and non-verbal messages, using emphatic expressions, employing lead through using non-threatening open-ended questions, demonstrating reflective listening, expressing logical warmth, inform during self and clarifying the purpose of HIV counseling in a more passionate context.

Communication and listening skills are central to counseling which might include active listening using open and circular questions properly reflecting client's feelings, summarizing main points during be sessions, challenging contradictory ideas, providing concrete ideas immediately and assisting the client to develop problem solving skills (Chester; Jackson quoted by Brugha, 1994). Similarly, counseling should be undertaken through interactive approach with 'the counselor' listen to the client so as to offer assistance and determine some specific prevention strategies (CDC cited in Kinnel, 2001). Even more by CDC (2001) a number of skills to be categorized under communication skills as the counselor need to employ such skills as – active listening, using open ended rather than closed ended questions in order to elicit the deep sited client's internal self, becoming interactive negotiating style rather than a persuasive' approach, feeling comfort in dealing with specific HIV transmission risks, well motivated in developing new counseling and skills building techniques, securing a supportive environment and establish trust with the counselee.

UNAIDS Tools for Evaluating HIV/AIDS Voluntary Counseling and Testing (2000) and Ginwalla et al., (2002) mentioned about the existence of several communication skills described under different headings such as the skills in collecting data (i.e. using proper and balanced open and close ended questions,

maintaining reasonable pause to facilitate client's self-expression and working with impact clarifying client's expectants and avoiding premature conclusion, summarizing main points dealt during the session); providing information (i.e., reasonable knowledge about HIV/AIDS offering simple and clear information about HIV, repeating and strengthening main points, checking for understanding/ misunderstanding, summarizing); dealing with special issues (i.e., sensitivity to and managing language difficulties and sensitive issues, smooth and proper to culture, appropriate to educational level and belief, prioritizing problems to cope with the limited time and short contacts, creativity to handle constraints like time and privacy); properly managing of the client's psychosocial problems and getting flexible to consider partner or significant others when appropriate. The Ethiopian Ministry of Health (2003) even more endeavours to describe communication skills under counseling comprehensively as the set includes responding clearly to the clients questions, using non-verbal cues (i.e., posture, eye contact, facial expressions, gesture, touch), active listening, attending, paraphrasing clients idea, reflecting client's feelings, summarizing, asking open and closed ended questions, reframing, confronting and self-disclosure. Furthermore, Berger et al., (2005) still strive to communicate some communication skills under HIV/AIDS counseling such as - welcoming, eye contact, attention, engagement, farewell, general impression of non-verbal communication, focusing on main points, managing length of sentences and using open ended questions exclusively.

AIDS Committee of Toronto (1998) expresses its conviction, as counseling usually constitutes just being with the persons, listening to them and understanding what clients are saying. Sharing intensive emotions assist to offset their intrusive consequences. Effective empathic listening skills are fundamentally significant since counseling PHAs involves "being with the client" listening and shaping the best way contains the counselors' own personality. These professionals are informed to simply be genuine (congruent) and to trust themselves through abating being phoney, which might be detected by PHAs

easily. In addition, Webster Booth et al., cited in Bowles et al., (2001) strongly contends that nurses actively attempt to remove or block communications such as ignoring patients problems spontaneously changing the client and/or emphasizing in the least threatening issues of conversation.

Excellent communication is the corner stone for positive relation with young client's; for example, utilizing simple, short, non-judgmental language with avoiding technical jargons and awaring the expression and slang that are being used by adolescent. Moreover, active listening through paraphrasing client's statements and repeating/reflecting them back; asking proper open-ended questions; maintaining appropriate eye contact, gestures, and verbal responses to reveal that the counselor is listening, reading body language, checking and assuring client's understanding what the counselor to say them. Helping the client in order to develop problem-solving skills independently; getting genuine and so forth (Fischer et al., 2005). The UNAIDS Technical Update on Voluntary Testing and Counseling (2000) counseling communication should be age - appropriate, utilizing examples of objective realties of client's environment that are familiar and relevant to the client and language that are non-technical and easily understandable.

Buranrd and Morrison cited in Bowles et al., (2001) make attempt be reveal the inadequacy of nurse counselors in practicing communication skills and the reason that might be due to lack of formal organizational structure, shortage of time, emotional labour of nurses, considering nursing as practical activity based profession and understanding communication exclusively as a means of offering information. Furthermore, Epstein et al., (2001) attempt to confirm that to the less success of different programs in enhancing the communication skills of HIV counselors, which might be improved through training and learning. Besides, the investigators endeavor to depict most important interview skills under Rochester HIV Interview Rating Scale (RHIRS) such as verbal and non-verbal communication, setting clear issue, eliciting clients concern and perspective, using non-judgmental languages, avoiding racial/cultural

difficulties, getting emphatic, adequate professional involvement and availability. Though some criticism on the nurse's communication skills due to numerous reasons, sometimes nurses' communication may be non-logically, harsh or unrealistic and occasionally little more than the expression of different values rather than justifiable evidence of deficit (Bowles et al., 2001).

### **2.9.3 Intervention Skills**

Intervention skills actually related to the theoretical framework of counseling that all of them tend to minimize the intrusive feelings and behavioral constructions of individuals, which may potentially results in contracting HIV/AIDS and/or affect the life of infected group of individuals deteriorating the physical, psychological and well-beings. The Ethiopian Ministry of Health (2003) reveals specific intervention skills linking with different theoretical approaches. For instances, cognitive behavioral approaches may involve assertiveness training, modeling, feedback, systematic desensitization, reinforcement, developing helping relationship, explanation and interpretation, raising consciousness, self-evaluation, home-based intervention and training other social skills. However, other theoretical models such as psychoanalytic may emphasize on projective techniques, dream analysis, hypnosis, free association, confrontation and the like, while humanists relay on free expression of feelings, acceptance, clarification, role play, self-disclosure, empathy, active listening etc.

In the words of Molassiotis et al., (2002) cognitive – behavioral interventions considered as the integral approach constituting specific skill. Such as cognitive restructuring, assertiveness skills, behavioral change strategies and relaxation training for people living with HIV/AIDS. Moreover, the scholars claim that HIV counselors are trained and supervised by qualified mental health nurses and a health psychologist. Peer counseling again a helpful strategy to assist PLWHAs to lesson the psychosocial impact of the disease through intensifying shared problems, concerns, fears, and hopes and to deal

how these problems could be managed to facilitate ventilation of feelings and to develop supportive and encouraging roles towards other members of the group.

Improving coping and adaptation intervention focusing on improving coping style for HIV patients are important (Grassie et al., quoted by Brown et al., 2000). A therapeutic strategy taken from more comprehensive study on adult adaptation to chronic problems stress the practice of 'active' skills such as problem-solving and help-seeking rather than 'inactive' skills such as self-blaming or resignation (Brown et al., 2000). According to Haghghatgov and Paterson; Mackenzie, Sloan, Hobfoll and Jackson quoted by Brown, 2000) the utilization of any skill subject to the exact nature of the problem, resource available and individual abilities. For example, many times 'active' skills are preferred most by 'Western cultures, while the 'passive' ones may be functional to non-western cultures/traditions. Besides, helping the client so as to develop coping strategies (i.e., the cognitive and behavioral efforts made by the person with who has HIV/AIDS to alter to manage the problems occurred due to the disease (Ashton et al., 2005).

The specific skills that contribute to manage HIV/AIDS related pain are cognitive restructuring /appraisal such as eliciting patients' thoughts about pain, helping patients to minimize thoughts that enhance distress and pain intensity. Problem solving skills such as role-play with patients to identify problems, analyses the situation, produce potential solutions, plan solution, implement solution and evaluate result; relaxation techniques (i.e., progressive muscular relaxation, visual/guided imagery diaphragmatic breathing through helping the client practice various techniques in one or more session, permit patient to select the approach most comfortable for him/her and most convenient for life styles; time based pacing. For example, planning activity - rest schedule with patients general health promotion like based on symptoms assisting patients to develop sleep diary, daily food log, exercise plan and diary and so froth (Marcus et al., 2000). As in Canadian International Development Agency (2001) there are again a number of specific therapeutic techniques that

may be suitable to PLWHAs such as mediation, relaxation, massage, aromatherapy, herbal remedies, reflexology, orthography and hypnotherapy.

Fischer et al., (2005) states that the most significant activity of counselor is to deliver to the young clients with accurate, and scientific facts in a clear and concise manner such as on HIV/AIDS, contraception like condom use, life skills development such as critical thinking and confidence building, conducting research and scientific program summaries.

Family Health International (2001) similarly attempted to uncover detailed intervention strategies particularly for youth groups among which psychosocial support for people living with HIV/AIDS; under taking formal research schemes that consider the objective realities of the youth group; considering individuals who may influence the young people, such as – immediate and extended families, teachers, community leaders and media icons; net working HIV program to other sectors like religion, schools, job training, agriculture, sport and media; linking HIV from other reproductive health and life events; for example, life skills development, which may result in acquiring problem-solving and decision making skills; creating direct linkages to trained, adolescent – friendly health care providers, pharmacists, community- based distribution workers, out reach, peer education, media, hotlines, information and education, referral services etc. In line with, intervention strategies such as using condoms, abstain and/or separations are also recommended for discordant couples (Bunnell et al., 2005).

The community intervention has been effective in the prevention of risk-induced behaviors to mitigate transmission of HIV (Kelly et al., cited in Martin et al., 2001). Moreover, homosexual patients are more receptive towards community educational tasks and there are natural leaders among them with a great skill to change the frequent behaviors (Martin et al., 2001). Besides, Chaava (1990) claims about that HIV counseling, which mainly focus on delivery of information on the transmission, development of the disease and

prevention, variation of the status of the infection in relation to the phase of HIV disease; establishing quality relationship of trust with the client; buffering quality and meaning of life particularly in the 'pastoral' counseling as life exists after death.

According to UNAIDS Technical Update: Voluntary Counseling and Testing (2000) and Ethiopian Ministry of health (2002), when counseling women in the antenatal setting for PMTCT interventions special considerations need to be given to counseling about infant feeding, counseling about all available PMTCT opportunities, family planning counseling, for sero-positive women referrals for on going medical and emotional support, for negative women counseling about prevention of HIV infection during pregnancy and breast-feeding counseling; the merits and demerits of disclosure particularly to her partner, involving the partner in the counseling and decision making.

Bowles et al., (2001) expresses about the type of intervention that nurses need to develop as nurses communication skills have been improved due to solution focused training that has been conducted on four dimensions such as competence, confidence, willingness and frequency with which the nurses deal with individuals who are troubled.

#### **2.9.4 Termination and Follow-up Skills**

Counseling has its own distinct time to be terminated between the counselor and the client. The numbers of the sessions depend upon the need of the client and the nature of the problem. A number of strategies might be employed to quit the relationship between the two individuals among which a referral system need to be established in collaboration with NGOs, community-based organizations, hospital directors, and other service officers as well as with network of people living with HIV/AIDS. Regular meetings among service providers need to be conducted to review and improve the referral system (UNAIDS, 2000). In the words of Fombanne (1998) reviewing progresses and

changes that were accomplished in the counseling relationship and to assess residual symptoms of the disease with the involvement of both the client and parents underlined boldly. Moreover, an open discussion about termination between the last session should be initiated by the counselor and giving credit to the difficulties of terminating the therapeutic relationship need to be encouraged in order to promote the skills of self-reliance in assisting oneself. According to Yusuf (1998) client –counselor relationships can be terminated through different ways such as referral system, summarizing main session points, when dissatisfaction occur on the client part or when there is no ideas to be triggered and discussed by the client and the counselor as well.

Another point that should be considered in the counseling relationship is follow-up counseling or on going counseling. This process also may take different forms. For example, Ethiopian Ministry of Health (2003) on going counseling can be undertaken at any suitable environment where privacy is maintained such as health clinics, counseling centers, home, church, working place etc. Relatively in similar manner, Rohleder and Swartz (2005) inform that clients need to be assisted through systematically follow-up programm. An investigation made by Bunnell et al., (2005) discloses that clients recommended several interventional strategies continuing individuals as well as couple follow-up counseling and others.

The Majority of individuals receiving VCT, whether they test positive or negative will attend one or at the most two post testing counseling sessions. Research findings have disclosed that even when further counseling session are offered or referral to specialized counseling services is available, many individuals do not want additional counseling, at least not in the immediate future. Though this is the fact some people may need on going counseling and some will attend for further counseling in the 1-5 years. On the other hand, a number of clients may find other informal services or resources in the community to assist them with their psychosocial supports. Such service givers may be church groups; family members, friends and traditional medial workers usually undertake emotional support (Baggaley et al., 1998).

According to the Canadian International Development Agency (2001), after the initial post-test counseling, an individual living with HIV will usually need additional supportive counseling sessions that may cover a comprehensive issues based on the client's needs so as inculcate hope in the client and strengthen the client's will to live on. Moreover, the service may be center-based. The clients visit the counselors when they need emotional support, or it may be home based (i.e., seeing the clients in their own environment).

## **CHAPTER THREE**

### **METHODS AND PROCEDURES**

#### **3.1 Participants**

A total of 215 (99 male and 116 female) participants were purposely selected to take part in the study. Furthermore, five government organizations (i.e., Arbaminch Health Center, Arbaminch Hospital, Sawla Health Center, Chench Health Center, and Mi-erab-abaya Health Center), and five non-government organizations (OSSA, Arbaminch Birhan Anti-AIDS Association, Ethiopian Orthodox Church Sunday Schools Cooperation against HIV/AIDS, Ethiopian Orthodox Church Development Cooperation against HIV/AIDS and South west Synodos) were purposefully selected on the basis of the availability of HIV/AIDS counselling services and the prevalence of the pandemic around these areas. The participants who were nominated as HIV/AIDS counsellors (i. e., 84 from government and 114 from non-government) who had necessarily a training on HIV/AIDS counselling and capable of providing among one and/or more HIV/AIDS counselling services such as voluntary counselling and testing, home-based emotional care and counselling, preventing mother to child transmission counselling, Anti-retroviral Treatment Adherence counselling and/or HIV prevention counselling. Moreover, 8 volunteer clients for Focus Group Discussion, who received counselling from the government and the non-government organizations for different purposes, while 2 clients for case studies each from government and non-government counselling providers. Three volunteer coordinators were selected from government counselling centres, while four had been obtained from the non- government organizations.

#### **3.2 Sampling**

Purposive and availability sampling techniques were employed to select the participants as well as HIV/AIDS counselling providing centers from government and non-government organizations.

### 3.3 Instruments

- **Questionnaire** was the primary instrument employed to gather information from the counsellors related to their knowledge and practice level of counselling skills. The first part dealt with 14 background items that except two of them all were closed and open ended as well. The counsellors were supposed to tick the alternative that fits with them and provide their own response if they did not find the appropriate choice in the questionnaire.

The second part concerned with rating items on each types of counselling skills. Primarily, 52 items under five major headings (i.e., facilitative skills, communication skills...) were developed from different HIV/AIDS counselling Manuals. Five point rating scale were prepared for knowledge rating (i.e., 0=Do not know, 1 = Need more information, 2 = Fairly know, 3 = Know well, 4 = Know very well, while in the practice rating 0 = Not done, 1 = Need for improvement, 2 = Fairly done, 3 = Done well, 4 = Done very well). Secondly, the items were given to different individuals in order to maintain quality items. The first group of individuals who were in charge of to see these items were experts in the field of counselling and after some modifications the items were re-written and translated in to Amharic language. Then, given to language experts to check up many grammatical errors and phrasing problems. Here after some professional counsellors checked up the content parts. After having mutual communications 52 refined items were produced and became ready for pilot test.

A pilot test was undertaken with 100 available counsellors; however, five were not fill the questionnaire properly. Participants for the pilot test were chosen directly from both institutions (i.e., government and non-government). These include 70 PMTCT counsellors, (i.e., 50 non -

government and 20 governments), 25 non-governmental home based emotional care and counselling and 5 governmental VCT counsellors. Conducting the pilot study secured both qualitative and quantitative improvements. On the qualitative part; for example, 4 most crucial items were added; long, complex, and unclear items were improved; possibility of response set were identified and five items were reversed in the final so as to mitigate, if not, eliminate such tendencies; instructions were clarified; initially knowledge and practise ratings were described separately; however, the pilot revealed that participants became bored and tired to fill two separate sheets of paper at the same time. Consequently, in the final instrument both were described separately on the separate sheets of paper and delivered at different times. In line with the quantitative improvements, items were reduced from 52 to 36 which means 16 items were eliminated through inter item-to-total correlation procedure. From each set of items specific number, of items were rejected (i.e., from facilitative skills one item, from communication skills one item, from intervention skills nine items, from termination skills two items and from follow-up skills three items). Items that were the correlation coefficient 0.30 and above were maintained to the final data gathering instruments. (Appendix -A and Appendix -B)

- **Semi-structure interview** was conducted to obtain additional data from coordinators. Initially there were eight background items and five interview items on counselling skills, and four items related concluding remarks. It was mandatory to refine and improve interview questions, as well as doing some background assignments on the interviewees to know about who were going to be interviewed. To end this objective two coordinators (i.e., one from government and the other one from non-government organization) were interviewed. On the basis of the accomplishment certain improvement were secured; for example, non-practical questions were rejected, phrasing styles were improved (e g, yes

or no closed ended response types were eliminated); three specific issues primarily non-visible but later considered as serious by the coordinators were included on the basis of their response delivery, and concluding remark questions were reduced from four to two.(Appendix - C)

- Data collection was made to maintain further information through **Focus Group Discussion**. The participants that involved in each FGD were homogeneous with common problems, which were clients received counselling services at different setting at different times. The first FGD team comprised of five members and people living with HIV/AIDS. Moreover, they received counselling from government VCTs, all of them were taking Anti Retroviral Treatment through passing adherence counselling, at A/minch hospital and even more they were receiving home- based emotional care and counselling from non - government organizations. Surprisingly, this FGD visualized comprehensive scenario about the government and non-government institutions regarding HIV /AIDS counselling processes as a whole.

The second FGD comprised of three pregnant women passed through PMTCT counselling by the Birhan Anti AIDS counsellors and received comprehensive counselling and blood test at A/minch health centre so as to prevent the transmission of the virus from the mother to the fetus. There were certain background points to be dealt such as - HIV status, the kind of counselling service received and the centre where the service was given. Thereafter, the main point of discussion came in to view separately viewing specific aspects (i.e., facilitative issues, communication issues, intervention issues, termination and follow - up issues). In relation to the above points the most salient problems during counselling, their presumed causes and potential remedial tasks were focused paramount. Finally, credit was given for each member to say something so as to prevent HIV transmission through developing and improving HIV counselling skills. (Appendix -D)

questionnaire case, certain steps were undertaken to gather the necessary information from coordinators that were:

- Establishing rapport with the coordinators was the first step was done.
- The interview format was delivered to the coordinators a head so as to help them get prepared to deliver reliable information and to be ready with mentally and psychologically. During this session the time and place that the interview was conducted determined. Actually, the time was working time altogether, and coordinators room was the place where the interview undertaken.
- Gathering the data was taking place starting with brief introduction of self, the organization, and job responsibility. Tape recorder was employed for all of them so as to simplify things easy for recording and analysis.

The third data-gathering tool was **Focus Group Discussion** with clients. This was performed through the following procedures:

- Five clients with homogenous characteristics (i.e., people living with HIV and receiving three different types of counselling namely VCT counselling by government and non-government counsellors, home-based counselling by non-government counsellors and ART counselling by government counsellors) were identified by the Ethiopian Orthodox Church Sunday Schools Development Co-operation. In addition, three pregnant women who passed through two types of PMTCT counselling such as home-to-home PMTCT counselling by non-government counsellors and office-based PMTCT counselling and blood test by government counsellors identified by the investigator.
- Rapport was established with the clients which was supposed to elicit more ideas during the discussion
- Planning was undertaken to determine the place, time, and procedure to collect the data. The two groups conducted their discussion at different time and place. The former one made at the EOC office, while the later one

conducted at the residence of a client. Tape recorder also utilized since it could be difficult and time consuming to note ideas that flow during the discussion.

Two volunteer clients (i.e., one who received HIV counselling from the government counselling providers, while the other one from the non-government counselling providers) were selected for **case studies**. To accomplish these tasks the following steps were gone through:

- Clients who received HIV counselling were identified through HIV counselling providers.
- Introduction with rapport establishment was made with each client.
- Permission was obtained from each client, and consent was maintained to work together.
- Planning was made on the proper time and place.
- Each client was narrating step by step what had been done during VCT session on the basis of questions forwarded by the investigator.
- Important scripts from counselling point of view were considered and recorded.

Data was analysed through the following steps:

1. Dichotomizing the knowledge scale in to two. Items that were responded as '0=Do not know, 1 = Need more information' considered as 'No' response and assigned with '0' value referring to the absence of knowledge to the HIV/AIDS counseling skills, while items with the responses '2 = Fairly know, 3 = Know well, 4 = Know very well' understood as 'Yes' response having the coded value of '1' assuming the counselors know the requested HIV/AIDS counseling skills.

2. Dichotomizing the practice scale in to two. Counselors who chose '0 = Not done, 1 = Need for improvement' considered as 'No' answer gaining the coded value '0', and they were supposed as not practicing the noted HIV/AIDS counseling skills, whereas responses such as '2 = Fairly done, 3 = Done well, 4 = Done very well' regarded as 'Yes' given with the coded value of '1' having the idea in mind such counselors practice the specified HIV/AIDS counseling skills.
3. Raw score for every counselor for each sub-scale and for the total knowledge and practicing HIV/AIDS counseling skills were drawn.
4. The means of sub-scales for knowledge and practice dimensions were computed separately, and the mean of the total scores for both variables (knowledge and practice) also were calculated, and the sub-scale means became cut off to identify counselors with high level of knowledge and high level of practice at each category of counseling skills.
5. The number of counselors who scored above the mean for sub-scales as well as above the mean for the whole scales in the knowledge and practice dimensions was determined.
6. The mean for individuals who scored above the mean again computed for each sub-scal and to the whole scale of the knowledge and practicing of HIV/AIDS counseling skills.
7. For all the above processes as well as for further analysis such as percentage, measure of central tendencies, measure dispersion,t-test and for one way Analysis of Variance SPSS 12.00 for Window<sub>s</sub> was employed

Moreover, tables and graphs were used to depict certain findings.

## CHAPTER FOUR

### FINDINGS

#### 4. 1 Demographic Data

The following two Tables describe certain background characteristics of counselor participants

**Table1: Age and Sex Distributions by Type of Organization**

Age	Gov't		Non-Gov't		Sex	Gov't		Non-Gov't	
	n	%	n	%		n	%	n	%
15-20	9	10.71	79	69.29	Male	36	42.86	54	47.37
21-25	19	22.62	12	10.53					
26-30	19	22.62	11	9.65	Female	48	57.14	60	52.63
31-35	19	22.43	6	5.26					
36-40	18	21.43	6	5.26	-				
<b>Total</b>	<b>84</b>	<b>100</b>	<b>114</b>	<b>100</b>	<b>-</b>	<b>84</b>	<b>100</b>	<b>114</b>	<b>100</b>

As it has been depicted in Table 1, the least individuals who were from the age interval 15-20 in the government counseling centers, while the reality was quite opposite in the non-government organizations.

In relation to sex distribution the female counselors were relatively exceeded the male counter parts under both organizations.

**Table 2: Educational Level and Professional Backgrounds of Counselor Participants**

Educational Level	Gov't		Non-gov't		Area of Profession	Gov't		Non-gov't	
	n	%	n	%		n	%	n	%
1st Degree	3	3.57	-	-	Nurses	16	19.05	1	0.88
Diploma	16	19.05	5	4.39	Health Officers	2	2.38	-	-
Certificate	12	14.20	11	9.65	Health Assistants	3	3.75	-	-
Others (i.e., grade 9-12)	53	63.10	98	85.96	Community Counselors	63	75	13	11.40
	<b>84</b>	<b>100</b>	<b>114</b>	<b>100</b>	Volunteers	--	-	95	83.33
					Social Workers	-	-	3	2.59
					PLWHAs	-	-	2	1.72
						<b>84</b>	<b>100</b>	<b>114</b>	<b>100</b>

As shown in Table 2, above, individuals who were from grade 9-12 (63.10%) in the government organization and (87.72%) in the non-government organization dominated HIV/AIDS counseling service providing, while the degree holders (3.57%) in the government organization, but nil in the non-government organization. Dealing about specific area of profession community counselors (75%) in the government and volunteer counselors (83.33%) in the non-government constituted the lion's share.

## **4. 2 Knowledge and Practice Difference**

### **4.2.1 Knowledge Difference**

**The first research question expressed as: "Is there statistically significant difference between government and non-government HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills?"**

The total knowledge difference between the two organizations revealed through Student t-test for the knowledge of government with the knowledge of non-

government and it was found that there was no statistically significant differences existed between HIV/AIDS counselors who were working at the two organizations since the obtained t- value =0.83 with the mean value of government and non-government counselors were 24.51 and 24.36 respectively having the standard error of the mean=0.18.

Moreover, t-test was computed for each sub-scale and revealed as follow:

**Table 3: Student t-test about the Knowledge of Counseling Skills between Government and Non-government Counselors**

Skills	Gov't Means	Non-gov't Means	Difference	St.error	t
Facilitative	6.50	6.00	0.50	0.73	0.68
Communicative	6.20	6.00	0.20	0.76	0.26
Interventions	5.40	5.01	0.39	0.76	0.51
Termination	1.50	1.20	0.30	0.73	0.41
Follow-up	1.02	1.50	-0.48	0.73	-0.67

P>0.05                  P>0.01

Table 3, above, depicts there was no statistically significant difference in all category of HIV/AIDS counseling skills between government and non-government HIV/AIDS counselors.

#### **4.2.2 Practice Difference**

**The second research question stated as: “Is there statistically significant difference between government and non- government HIV/AIDS counsellors in practising HIV/AIDS counselling skills?”**

The total practice difference between the two organizations revealed through student t-test for the practice of government with the practice of non-government, and it was found that there was statistically significant differences between HIV/AIDS counselors who were working at the two organizations since the obtained t-value was =2.38 with the mean value of government and non-

government counselors were 22.86 and 22.48 respectively having the standard error of the mean=0.16 at two tailed  $\alpha = 0.05$ .

Specifically, whether there was statistically significant difference or not between government and non- government counselors with regard to practicing each cluster of HIV/AIDS counseling skills.

**Table 4: Student t-test about the Practice of Counseling Skills between Government and Non-government Counselors**

Skills	Gov' t Mean	Non-gov't Mean	Difference	St. error	t
Facilitative	6.00	5.50	0.50	0.24	2.08*
Communicative	4.50	5.33	-0.83	0.20	-4.15**
Interventions	5.25	5.00	0.25	0.20	1.25
Termination	1.21	1.12	0.09	0.15	0.60
Follow-up	1.09	1.20	-0.11	0.17	0.65

\*P<0.05 \*\*P<0.01

As indicated in Table 4, t-test reveals that practicing of Communication skills seemed to be significantly different between the government and the non-government HIV/AIDS counselors at two tailed  $\alpha = 0.05$  and 0.01, but Facilitative skills at two tailed  $\alpha = 0.05$ .

The data obtained from qualitative analysis on counseling skills more importantly revealed certain realities about how far each cluster of HIV/AIDS counseling skills was being practiced by the counselors who were working at both organizations.

#### **4.2.2.1 Facilitative Skills**

Facilitative skills are the pre-conditions for successful counseling process since they are potentially dismantle the tensions, fears and misconceptions among the clients during the visit of the counselor, and also other skills have their own ground implications in the sphere of counseling. Responses from different

coordinators and clients revealed certain ideas about counselors' effectiveness in practicing facilitative skills of counseling, among that a coordinator from the government office said that:

*I am not confident to tell you that all our counselors are lacking the facilitative skills all in all rather sometimes certain problems like apathy, anger etc may occur due to work load, role confusions etc.*

A counselor and coordinator from parent organization revealed ideas about counselors' Facilitative counseling skills with very few words as:

*Generally, our counselors seem to be competent and confident to delivery quality HIV/AIDS counseling though I failed to tell you on which category of facilitative skills they are tougher and on which part they are less skillful.*

The third coordinator also with similar position endeavored to depict the situation as:

*No problem with facilitative skills since utilizing these skills like greeting, using the icebreaker etc during HIV/AIDS counseling is our usual tasks.*

The Focus Group Discussion also uncovered a number of specific evidences about the Facilitative skills of counselors. From the first FGD the following scripts have been taken:

**A<sub>1</sub>:** *The man/nurse/ called my name and I entered to the room. Then, he invited me to take chair followed by requested my interest to have blood test. The sitting arrangement was face-to-face that I liked the comfort of the chair rather I didn't see any relation between the arrangements of sitting and its impact on the counselor, and on me*

**A<sub>2</sub>:** *MY name was called from the mates who we were sitting together in the waiting area. The counselor told me that to have a sit right in front of her.*

**A<sub>3</sub>:** *We were together, A<sub>2</sub> and me. Actually, the discourse between me and the counselor was good. Primarily, I was called from the list of women and then I entered to the room:*

**Counselor:** *"What all this sweating?"*

**A<sub>3</sub>:** *"I don't know! May be fear and tension!"*

**Counselor:** *"Calm down, please! Have a chair; this is not special for you rather it is universal. You can live whether you get positive or negative? You don't need to worry about.*

**A<sub>3</sub>:** *"Ok!"*

The case study undertaken with regard to Facilitative skills revealed the following facts.

*Very difficult to remind the existence of such skills, rather quiet easy to say no at all. For instance, the nurse counselor was seriously angry with the staff and me for unknown reason.*

The data obtained from the non-government organization concerning the Facilitative skills of counselors described as one of the coordinator of the center as:

***Our counselors tend to practice Facilitative skills such as greeting and using the icebreaker since these skills are the pre-conditions to the remaining counseling processes.***

The second coordinator from the parent organization contended about home-based care and counseling as:

***I am not sure to speak about the profile of our counselors' Facilitative skills during HIV/AIDS counseling processes.***

The following scripts considered from FGD<sub>2</sub> and uncover the situation as:

**B<sub>3</sub>:** *I have yet not observed problems on our home-based counselors rather they are even curious about their verbal and non-verbal cues. They respect me and us all the endowers to help us.*

**B<sub>2</sub>:** *With regard to Facilitative skills, our counselors are not bad. They attempt to greet us, maintain our personal issues secret, respect us, tell us the advantages and disadvantages of HIV/AIDS, ART, Home-based counseling etc. Really, I like their services.*

The case study conducted on a client about one of the non-government counselor indicated that:

*The counselor greeted and invited me to have a seat. It was not bad approach rather I was impressed with his smiling, and also maintained confidentiality through coding which*

*made me really confident and relaxed to narrate all my risk factors. Brief introduction about HIV/AIDS counseling and its purpose were made. Moreover, I had been told that, as it is possible to live even if I got HIV<sup>+</sup>*

The qualitative data could be summarized as counselors at the government and non-government counseling centers likely to know and practice Facilitative skills such as greeting friendly, releasing clients' tension for testing, maintaining empathy, maintaining confidentiality etc. However, sometimes some counselors seemed to be become reluctant to keep clients' feelings positively like teasing, delivering counseling in the presence of colleagues etc whether due to lack of the skills or some other extra factors.

#### **4.2.2.2 Communication Skills**

Communication skills are the core for successful counseling process since they are potentially powerful to make rigorous risk assessments about the clients' life styles during the counseling relationship. Different coordinators and clients uttered a lot about them among them a coordinator and counselor from the government office said that:

*In relation to communicative skills some limitations may occur due to communication barriers. For example, I would get discouraged and get in angry when clients with no information about HIV/AIDS visit me. Despite the fact that I usually endeavor to manage them. However, I don't have any problem with regard to language since I am fluent about all the verbal and non-verbal cues of the local language.*

From similar organization, a counselor and coordinator disclosed about Facilitative skills of counselors' as:

*I am really interested in the task and in the profession. Secondly, friendly relationship is my typical behavior even with those of clients whom I do not know. Thirdly, the face-to-face sitting arrangement that I prefer is really making a difference in enhancing my communication with my clients. Moreover, I try to see overall clients' reactions and think aloud whether, for instance, telling a certain embarrassing event on the client affects his/her psychology or not. From the language aspect we don't have any problems. Since I am treating with those*

*individuals who speak Amharic, while my friend deals with the local people who do not communicate with Amharic.*

The First Focus Group Discussion also revealed several specific evidences about the Communication skills of counselors'. The following scripts have been notified:

*Soon after having sit we had back-and-forth question-answer and also discussion on certain series of issues.*

**Counselor:** *"What would you say if you get HIV+?"*

**A<sub>1</sub>:** *"I can live as what people with the virus live in our area."*

**Counselor:** *"Have you ever acted as midwife, and had opportunities for infected blood contact?"*

**A<sub>1</sub>:** *"No! Not at all!"*

**Counselor:** *"So how do you attribute if you get HIV positive?"*

**A<sub>1</sub>:** *"May be my husband due to the nature of the job he engaged."*

**Counselor:** *"How do you say so?"*

**A<sub>1</sub>:** *"He was working around the shore of Lake Chamo as fisherman that might be exposed to different infected sharp instruments namely knife, needles etc."*

**Counselor:** *"Does he drink alcohol?"*

**A<sub>1</sub>:** *No*

**Counselor:** *"So you doubt this way?"*

**A<sub>1</sub>:** *"Yes, absolutely."*

**Counselor:** *"Any way, are you ready now to get blood test?"*

**A<sub>1</sub>:** *"Yes"*

**Counselor:** *"Thank you! Wait a few time out"*

**A<sub>1</sub>:** *Never mind, ok"*

**After few minutes A<sub>1</sub> called up on again and:**

**Counselor:** *"Shake my hand!" you got HIV negative status!"*

Further communication scripts from one of the client who received counseling service at the government counseling centers revealed that:

**Counselor:** *"Well, could you tell me any way that you hesitate about potentially exposed you contracting HIV?"*

**A<sub>3</sub>:** *"No way!"*

**Counselor:** *"Don't you see any risk factor in your own behaviors that probably exposed you to contract HIV?"*

**A<sub>3</sub>:** *"I mean not!"*

**Counselor:** *"So, what do you feel about?"*

**A<sub>3</sub>:** *"May be my husband"*

**Counselor:** *"On what ground do you say so?"*

**A<sub>3</sub>:** *"He was working 50 km away from A/minch. He was fisherman and he used to stay a month and sometimes more than that"*

**Counselor:** "Don't worry! You can imagine individuals who are suffering from Diabetics and Blood Pressure that result to instance life loss; however, HIV gives you time to live, if and only if, you maintain your physical and psychological well beings."

**A<sub>3</sub>:** "Yes!"

**Counselor:** "Are you ready now for blood test?"

**A<sub>3</sub>:** "Yes"

**Few minutes gone**

**Counselor:** "You are lucky to be HIV"

**A<sub>3</sub>:** "Sure!"

**Counselor:** "Yes!"

**A<sub>3</sub>:** "Thanks Lord!"

The case study undertaken disclosed ABOUT Communication skills of counselors as:

*The session was full of terrifying words and expressions. For example, the first question thrown towards me was: 'would you commit suicide if you got HIV positive?' Surprisingly, my boy friend left the room soon after the counselor's question. Another instance that might be accompanied with horrific communication was **throwing the test result openly on the table with sharp tone of voice 'you are HIV negative and take it to the Doctor.***

On the contrary, the non-government counseling centers still implement communication skills of counseling in order to undertake effective counseling. The project coordinators as well as individuals who took part in Focus Group Discussion attempted to visualize the situation. The following were ' reflections coordinators' refelections about the existing realities among them a coordinator said that:

***Our counselors seem to be good at knowing and practicing communication skills during the delivery of HIV/AIDS counseling.***

Another coordinator from the colleague organization claimed about home-based care and counseling as:

***Communication skills like facilitative skills probably pertinent and being practiced by our counselors' during counseling processes.***

Further coordinator contended that:

***I am not confident to tell you the profile of our counselors' communication skills during HIV/AIDS counseling processes.***

The following scripts considered from FGD<sub>2</sub> and uncover the situation as:

- B<sub>3</sub>:** *There were a number of individuals who have been recruited and assigned as home-based counselors and VCT counselors as well. However, they lack the skills how to undertake the service effectively. Consequently, these group of individuals need to be trained thoroughly and take over the services.*
- B<sub>4</sub>:** *To tell you the skills that the counselors' posses may be difficulty for me rather they are good enough generally in their approach and caring. However, some individuals who new their HIV status recently are more resistant for the non-infected counselors so as to receive counseling for positive life styles and, also to be beneficiary of the drug. Therefore, people who are living with the virus get along together and organize themselves with thorough training on counseling skills and arranged in such away that to help each other seems to be more logical as well as becomes very easy to change the distorted thought of people living with the virus about ART and counseling in general.*

The case study depicted about the Communication skills of a counselor in the following way:

*The counselor primarily asked me an easy question about the nature of HIV/AIDS, ways of transmission, prevention methods etc. I really responded without difficulty. In addition, he was listening and attending, all my ideas and reactions. Even more, he attempted to clarify unclear issues about the nature of the disease, and strove to change my mind to the proper understating to pandemic.*

Like Facilitative skills, Communication skills of HIV/AIDS counselors at both organizations seemed fairly known and practiced. For instance, the verbal communications like responding to clients' problem through the local languages and delivering all messages through that way. However, critical investigations and shifting of the trend communication skills with the clients like on listening and attending of the verbal and the non-verbal cues of clients

with the virus as well as the negative individuals, and caring for words, phrases and expressions need to be seriously underscored. Moreover, most frequently a number of VCT counselors tended to ask clients unprofessional and unfair questions like “would you commit suicide if you get HIV positive?” “You are lucky to get HIV –”, “how do you act if you get HIV positive?” etc. The other illfeeling scenario was coordinators’ were less likely knows the level of their counselors’ counseling competencies not only in Communication skills, but also in many of counseling skills which might be due to one or more reasons.

#### **4.2.2.3 Intervention Skills**

Intervention skills are the solution parts of HIV/AIDS counseling process since they are potentially significant to ameliorate risk behaviors through bolstering desirable life styles by utilizing different strategies that are suitable to the clients’ interest, ability and socio-cultural background. Numerous coordinators and clients uncovered some realities about such skills among that a counselor as well as a coordinator from the government office contended that:

*We are doing several things during pre-test counseling and post-test counseling. For instance, **during pre-test counseling we ask the client what s/he would be if s/he gets positive HIV status** and also we make attempts to change the clients distorted thoughts, if any. During the post-test counseling we make referral to ART with little counseling, but giving more focus on the medical aspects, still referral to home based care and counseling to Addis Alem PLWHAs team. The negative cases also counseled to develop new life styles and to be model for others.*

From parent organization, a counselor and coordinator indicated about counselors’ intervention skills as:

*For high risk behaviors we attempt to deliver counseling to change their life styles and make referral on the basis of clients interest to the families and/or church leaders whereas to positive cases we provide counseling, referral to home based care and support referral to church leaders, family and helping to make regular medical checkups.*

The First Focus Group Discussion also showed several specific evidences about Intervention skills of counselors'. The following ideas had been considered:

**Counselor:** *"Shake my hand!" you got HIV -status!"*

**A<sub>1</sub>:** *"Sure!"*

**Counselor:** *"Definitely*

**Counselor:** *"This doesn't mean you do remain free from HIV forever rather you should keep in touch with your positive life styles."*

**Counselor:** *"You are lucky to be HIV"*

**A<sub>3</sub>:** *"Sure!"*

**Counselor:** *"Keep your life free from HIV/AIDS!"*

The case study indicated about Intervention counseling skills of counselors as:

**No intervention at all**

The utilization of intervention skills among one of the non-government organizations seemed to be as in the quotation of the coordinators:

*Some limitations are eminent with regard to intervention skills. However, I have information particularly on intervention skills focusing on problem solving skills and assertiveness training.*

The second coordinator from the colleague organization disclosed about Intervention skills of their counselors as:

***In terms of intervention I have no idea how far our counselors are really competent.***

Further coordinator claimed that:

*Like communication skills I am afraid to tell you the types of Intervention skills utilized by our counselors. Because we don't have any idea about the skills rather they are beyond our immediate thoughts. Secondly, we have no trend to see counselors' competencies in delivering effective counseling services, which in turn, made us lacking base line information so as to investigate and level counselors' skills performances.*

The Second Focus Group Discussions also rendered to observe counselors' Intervention skills of counseling. For instance, the following scripts show the event as:

**B<sub>1</sub>:** *It is right four months since I have been a member of this organization rather I visit this office in order to get financial support; however, I*

*never met even with a single counselor at my home and/or at here that was in charge of delivering psycho-social support. So, I can hardly tell you about the skills to which possessed by the counselors.*

**B<sub>2</sub>: It is much more confusing for me the emotional support and financial supports.** *I am unable to different whether which one is advice. In spite of the fact that I usually see here is financial support and counseling in order to manage the money given for us instead of getting relief from psychosocial complexes.*

The results of the case study depicted as:

*Since I was HIV negative, I had been informed two things. Primarily, getting free from the virus for the time being didn't secure life long freedom; rather there would be probabilities of contracting the disease. Consequently, avoiding risk factors through using condoms, abstinence, establishing faithful relationships, etc was seriously underscored. Secondaly, I was told to get counseling and testing again after three months later in order to know absolute HIV status.*

• Intervention seemd less likely emphasized by the counselors who were working at the government and non-government organizations and even the existing meager intervining strategies tended to focus on condom distributions, adhering faithful relationships and abstinence. The mechanisms such as modeling desirable behaviors, maintaining physical wellbeing through balanced diet and physical exercise and medical treatments like using ART treatment, avoiding other opportunistic diseases, muscular relaxations, sublimation etc were almost ignored. Furthermore, in some cases counselors even skip the step to deliver intervention due to forgetting or lack of the skills.

#### **4.2.2.4 Termination Skills**

As something starts, it ends as well. Therefore, counseling relation ship also begins and it has time to terminate whether due to attaining the needed initial target and/or any impediments occur during the relationship. Having this in mind the following ideas reveal facts in relation to how counseling relationships were being terminated whether in the government and/or non-government counseling centers. Primary findings of the government counselors' revealed

briefly, and among that a counselor and coordinator of VCT center claimed that:

*Termination is existent by referral to different service givers and through summarizing the entire main points once again.*

Another individual with similar qualification and from parent organization disclosed as:

*Termination is still being conducted through referral for positive cases, while through reminding the becoming negative now may not mean negative forever for negative individuals*

The First Focus Group Discussion shows a spark of lights how counselors really terminate the relationship with their clients:

**Counselor:** "Shake my hand!" you got HIV negative status!"

**A<sub>1</sub>:** "Oh! My God"

**A<sub>1</sub>:** "Ok! Sir!"

**Counselor:** **You can go, bye!**

**A<sub>1</sub>:** Ok bye

**Counselor:** "You are lucky to be HIV"

**A<sub>3</sub>:** "Sure!"

**Counselor:** **"Keep your life free from HIV/AIDS!"**

**A<sub>3</sub>:** "Ok! I try"

**Counselor:** "Just leave!"

The case study in relation to termination skills indicated that:

### **Through telling the result**

Among one of the non-government counseling providers likely terminate the counseling relationship as in the following manner:

*Termination as conducted through referral to Voluntary Testing and Counseling in both cases (i.e., PMTCT counseling and VCT services).*

A coordinator from the colleague organization also claimed about termination processes of counseling in his organization as:

*Primarily, through the death of the client or the counselor. Secondly, when the counselor or the client leaves the environment and the last one is when there is communication barriers occur between the client and the counselor. To mean,*

*through such incident the initial counselor may refer the client to another better-qualified counselor.*

The colleague coordinator from similar organization externalized about termination skills of their counselors as:

*Termination of the counseling relationship depends up on the needs of the client and the magnitude of the problem. To mean, if the client wants to continue with a certain counselor, there would be no problem rather termination becomes non-existent. However, if the beneficiary wants to change counselor for one or more reason the client would be shifted to another counselor. Similarly, if the clients' case becomes beyond the counselors' level of solving the problem, transferring the client to a relatively senior counselor is made.*

As in the Second Focus Group Discussion the practice of referring clients to other organization and/or competent professionals dominantly performed. For instance,

**B<sub>3</sub>** : *I was dealing my problem with Mr. 'x', a counselor; however, we were unable to continue our relationship and I had been transferred to another individual due to the communication barrier that occurred in between us. I am unable to speak Amharic, and also the counselor doesn't the local language.*

The response from the case study depicted as:

*The counselor notified me the result, and invited to come back again for further investigations.*

Referring clients to another counselor, family, church leader or organization for one or another reason was the dominant Termination process practiced under both HIV/AIDS counseling providers. Moreover, telling HIV status was the best way of ending counseling relationship among government counseling centers, while the death, changing environment of clients or the counselor or when problems occurs between the counselor and the client counseling relationship gets in to end through referral in the non-government counseling centers. However, it was less likely practiced that counselors were trying to summarize, discuss and deliver concluding remarks on the main points of counseling relationship on the basis of clients' socio-cultural and educational backgrounds, risk factors etc.

#### 4.2.2.5 Follow-up Skills

Termination is not the last destiny for counseling relationship rather changes of behavior to the desired direction. Consequently, to investigate whether clients' behavior has been modified/changed or not, follow-up counseling is the stepping-stone. To conduct this one need to be acquainted with different strategies. As in the case of government and the non-government organizations may employ similar or different techniques. For simplicity ideas from both would be raised and described as follow.

A counselor and coordinator from the government organization visualized that:

*The mobile VCTs that have been established in our areas are really rendering their purposes as to see clients who got VCT services once again, whether positive or negative case.*

The second individual also uttered as:

*Follow-up counseling made through home-based care and undertaking the service when clients come for medical check ups.*

The idea taken from FGD<sub>1</sub> indicates that:

***A<sub>2</sub>: Soon after, she has taken my blood and told me to get out of the room. I have waited for few minutes and again she called me and informed that I am free from the virus. She was informing me to come back after three months for similar examination.***

The case study described as:

***Not conducted at all***

On the other hand the non-government counselors still utilize the counseling skills in order to conduct follow -up counseling. The coordinators as well as individuals who took part in the Focus Group Discussion endeavored to reveal the scenario. Primarily, the following were coordinators' reflections about the existing organizations among one of them said:

*Follow-up is conducted through two ways (i.e., formally as well as informally). Formally, we have special team that exclusively dedicated for looking after for such individuals through going down into the community home-to-home and*

*school- to- school on the basis of the address that have been registered. Informally, again we make endeavors so as to get information from the colleagues, teaches, parents etc and make all plans to help the individuals once again and check the progress.*

The second coordinator revealed as:

*The most significantly practiced counseling skills in our organization goes with follow-up (i.e., on going counseling) through visiting home to home, appointing to come back to our office etc*

The other one from relatively similar organization unfolded the realities in relation to follow counseling as:

*We provide two types counseling, home-based care and counseling and Voluntary Testing and counseling. The home-based counselors deliver on going counseling which is like continuous follow-up soon after blood test particularly for those of client's with HIV+ and high-risk behaviors, but negative results. The second one is Voluntary Testing and Counseling which is being undertaken here accompanied with little frequent investigations on the negative cases.*

The FGD<sub>2</sub> confirmed the existence of follow-up counseling in the non-government organizations as:

**B<sub>2</sub>:** *Counselors visit us and we also visit their offices for different purposes such as for ART treatment, to collect financial supports and sometimes to help us to get free from psychosocial crises such as anxiety, tension, rigidity to take ART medicine*

The result of the case study might be stated as:

***Though I was HIV, - the counselor told me to back again for further investigation rather no follow-up was made at all.***

Dealing about Follow-up counseling for HIV negative individuals is unthinkable under both organizations rather people who were HIV positive were getting the necessary service particularly ART treatment at the government and psychosocial and financial supports from the non-government counseling providers whether through visiting home and/or calling to the counseling centers.

The third research question stated as: "Is there statistically significant difference in HIV/AIDS counsellors' knowledge of HIV/AIDS counselling skills that may be attributed to variations in selection procedures?"

Table 5: One way ANOVA summary for knowledge of HIV/AIDS counseling skills that may be attributed to variations in selection procedures

Skills	Source	SS	df	MS	F
Facilitative	Between	662.16	1	331.08	21.06**
	Within	3064.70	193	15.72	
	Total	3726.86	194		
Communication	Between	905.67	1	452.84	16.29**
	Within	5420.52	193	27.80	
	Total	6326.20	194		
Intervention	Between	631.86	1	215.93	8.37**
	Within	3421.41	193	25.80	
	Total	4053.27	194		
Termination	Between	23.25	1	11.63	4.49**
	Within	505.41	193	2.59	
	Total	528.66	194		
Follow-up	Between	26.30	1	13.16	7.65**
	Within	335.69	193	1.72	
	Total	365.01	194		

\*\*P<0.01

Table 5, in the above summarizes variations in the independent variable (i.e., Selection Procedures) resulted in statistically significant difference on knowing all kind of HIV/AIDS counseling skills at two tailed  $\alpha = 0.05$  and  $0.01$ .

The mean comparisons revealed that the mean knowledge of HIV/AIDS counsellors who had been selected by coordinators surpassed those of voluntary counsellors on all categories of counseling skills. (i.e., facilitative, communicative, intervention, termination and follow-up skills).

**The fourth research question described as: “Is there statistically significant difference among HIV/AIDS counsellors’ practicing HIV/AIDS counselling skills that may be attributed to variations to selection procedures?”**

**Table 6: One Way ANOVA summary for practicing HIV/AIDS counseling skills that may be attributed to variations in selection procedures**

Skills	Source	SS	df	Ms	F
Facilitative	Between	933.60	1	466.80	44.54**
	Within	2042.74	193	10.48	
	Total	2976.34	194		
Communication	Between	1143.21	1	571.60	30.16**
	Within	3694.61	193	18.95	
	Total	4837.82	194		
Intervention	Between	881.38	1	340.69	17.51**
	Within	1789.68	193	19.43	
	Total	2671.06	194		
Termination	Between	35.75	1	17.88	15.03**
	Within	243.59	193	1.19	
	Total	279.35	194		
Follow-up	Between	38.97	1	19.48	13.53**
	Within	279.87	193	1.44	
	Total	318.84	194		

\*\*P<0.01

As in Table 6 above, Variations in the selection procedures resulted in statistically significant difference in practicing all types of counseling skills at two tailed  $\alpha = 0.05$  and  $0.01$ .

The mean comparisons indicated that HIV/AIDS counslors who had been nominated by coordinators were more likely practice HIV/AIDS counseling skills than those of voluntary counselors on all cluster of counseling skills. (i.e., facilitative, communicative, intervention, termination and follow-up skills).

Furthermore, data obtained through questionnaire and interview revealed the selection procedures of HIV/AIDS counselors were influenced HIV/AIDS

counselors counseling skills. For instance, a nurse counselor and coordinator from government hospital contended the following ideas:

*Selection was made through assignment to be HIV/AIDS counselor by the officer (i.e., the medical Doctor) since I speak the local language very well*

Another counselor and coordinator from family institution responded as:

*I was the available person while the health center in need of voluntary counselor*

Further, a nurse who has dual responsibilities said that:

*Morally good, committed and motivated prospective nurses are getting in the eyes of the management committee and trapped in to the service.*

Even more, further exclusively coordinating body from similar category of organization clarified about the strategies of counselors' selection as:

*The trend that we have in selecting HIV/AIDS counselors the management is in charge of recruiting female nurses primarily since the women are highly vulnerable groups and therefore they may be passionate about the service and female clients.*

In the contrary, counselors who were working in the non-government organizations still claimed about selection procedures of counselors. The following quotes may reflect. A top project coordinator from one of the non-government institutions contended that:

*The management committee of this organization on primarily decides individuals on the basis of the service that they delivery in church. The trainees supposed to be dedicated, honest and sociable to be spotted by the committee followed by they would be told whether they are volunteer to work as a counselor or not. Hereafter, they are expected to receive counseling training for at least 15 days whenever possibly through reaching at mutual agreement often for the forth coming responsibilities.*

Another exclusively vice coordinator among one of the non-government organizations and also other main coordinator from the family organization explained relatively similar ideas one to each other as:

*The direct contact through letter and physical communication that we have with the church, Idir, clubs and/or the kebeles*

*facilitate situations so as to find motivated, dedicated, with free – time to help others and volunteer counselors. Consequently, on the basis of the selection made by such institutions, our organization includes those candidates with the existing counselors*

The government organizations most frequently seemed to select HIV/AIDS counselors through assignment by the coordinators and some times available and dedicated Nurses or Health assistants were picked and nominated as HIV counselors, while in the non-government offices the reality somewhat different. The management committee was duly engaged to identify interested, dedicated, and individual with available leisure time through decentralizing power even to the kebele and church level.

**The fifth research questions stated as: “Is there statistically significant difference among HIV/AIDS counsellors’ knowledge of HIV/AIDS counselling skills that may be attributed to variations in duration of training?”**

**Table 7: One way ANOVA summary for knowledge of HIV/AIDS counseling skills that may be attributed to variations in duration of training**

Skills	Source	SS	df	MS	F
Facilitative	Between	648.68	1	324.34	20.54**
	Within	3078.19	196	15.79	
	Total	3726.87	197		
Communication	Between	747.07	1	373.53	13.06**
	Within	5579.13	196	28.61	
	Total	6326.20	197		
Intervention	Between	456.92	1	228.46	7.96**
	Within	3596.35	196	28.70	
	Total	4053.27	197		
Termination	Between	21.65	1	10.83	4.17**
	Within	507.01	196	2.60	
	Total	528.66	197		
Follow-up	Between	23.38	1	11.69	6.72**
	Within	338.63	196	1.74	
	Total	362.01	197		

\* \*P<0.01

The above, Table 7, shows changes in the independent variable (i.e., Duration of Training) had statistically significant impacts on the knowledge of all HIV/AIDS counseling skills among HIV/AIDS counselors at two tailed  $\alpha= 0.05$  and  $0.01$ .

The mean values of each cluster of counseling skills disclosed that counselors who had been trained for more than a month (i.e., from one month to four months) seemed to have relatively better level of knowledge on Facilitative, Communication, Intervention and Follow-up counseling skills than counselors who had been trained for less than a month, while counselors who had been trained for less than a month likely exceeded counselors who had been trained for more than a month in Termination counseling skills.

**The sixth research questions revealed as: “ Is there statistically significant difference among HIV/AIDS counsellors’ practicing HIV/AIDS counselling skills that may be attributed to variations in duration of training?”**

**Table 8: One way ANOVA summary for practicing HIV/AIDS counseling skills that may be attributed to variations in duration of training**

Skills	Source	SS	df	Ms	F
Facilitative	Between	926.93	1	463.47	44.10**
	Within	2049.40	196	10.51	
	Total	2976.34	197		
Communication	Between	1163.65	1	581.82	30.88**
	Within	3674.17	196	18.84	
	Total	4837.82	197		
Intervention	Between	860.49	1	330.24	16.90**
	Within	1810.57	196	19.54	
	Total	2671.06	197		
Termination	Between	35.41	1	17.71	14.17**
	Within	243.93	196	1.25	
	Total	279.35	197		
Follow-up	Between	36.92	1	18.46	12.56**
	Within	281.92	196	1.47	
	Total	318.84	197		

\*\*P<0.01

Table 8 shows that changes in the duration of training resulted in statistically significant difference among all HIV/AIDS counselors with regard to practicing all category of counseling skills at two tailed  $\alpha = 0.05$  and  $0.01$ .

The mean values of each category of counseling skills showed that counselors who had been trained for less than a month more likely practice Communication and Intervention counseling skills than counselors who had been trained for more than a month (i.e., from one month to four months), while counselors who had been trained for more than a month seemed to practice Facilitative, Termination and Follow-up counseling skills better than counselors who had been trained for less than a month.

Moreover, the data obtained through questionnaire and interview revealed that all counselors received training on counseling regardless of the duration time that each of them attended. A nurse counselor and coordinator from government hospital contended the following ideas:

*The training was given for 20 days in Addis, which means two years ago in 1996 on voluntary Testing and Counseling. The contents treated during the training were the skills required for counseling, problems that occur during counseling process, strategies how to handle such problems and further specific issues. The trainers were senior counselors (i.e., Doctors) who were from "Torr Hiloch". The typical manual was prepared by Ministry of Health, which is known as the Quick Reference Card.*

*No continuous training since after the initial training (i.e., 1996) undertaken. Even more, we have hardly been supervised in relation to practicing the technical skills of counseling protocol properly or not through visiting sessions so as to make any critical investigations on the counselors' part.*

Another counselor and coordinator from family institution responded as:

*I have been given training two years ago for 15 days. The topics that were treated:*

- *Pre-test counseling, post-test counseling and on going counseling (i.e., follow-up counseling)*

- *Psychosocial problems identification with regard to establishing remedial actions through effective communication.*

*The Doctors were using, and referred us to use the manual known as 'Quick Reference Card that was published by Ethiopian Ministry of Health.*

*No single in-service workshop and/or experience sharing has been undertaken since our initial training and also no supervision at all.*

Further counselor and coordinator revealed that:

*Despite the fact that new counselors immediately get recruitment and training could be offered for at least 15 days in Addis or in the regional town Awassa. However, continuous capacity building and supervision were absolutely non-existent.*

Even more, further exclusively coordinating body from similar category of organization clarified about the access of training and other related issues as:

*Training has been conducted twice or trice on counseling process though I am not confident to tell you which area of counseling skills has been focused. The Doctors and M.Sc holders were the salient professionals who were in charge of to undertake any training, related to HIV counseling. We have the manual also that we use it as a guideline; however, I am afraid to tell you its name since it is with the counselors. Finally I would like to inform you that we have no experience to supervise our counselors' technical skills.*

In the contrary, counselors who were working in the non-government organizations still possessed training on counseling in general and on counseling skills specifically. The following quotes may reflect. A top coordinator from one of the non-government institutions contended that:

*Counselors are expected to receive training for at least 15 days whenever possibly through reaching at mutual agreement often for the forth coming responsibilities. You have asked me the specific focus areas of counseling skills during training that I may have little idea on it rather you had better to ask other experts in the office. In relation to the professionals who frequently conduct*

*HIV counseling goes to Doctors followed by Community Health Workers and Health officers. We have two counseling manuals in response to your question related to manual. The first is 'HIV/AIDS Counseling Training Guidelines'; while the second one is 'Junior HIV Counselors Service Guidelines'. Both of them published by Ethiopian Orthodox Church Christian Development Cooperation.*

Another exclusively vice coordinator among one of the non-government organizations and also other main coordinator from the family organization explained relatively similar ideas one to each other as:

*For any type of counseling the organization delivers initial training for not more than 15 days by different professionals such as Doctors, Health Officers, Nurses, and Social workers respectively focusing on the general nature of HIV counseling including counseling skills; however, we are not able to identify which skills stressed more, and which one is less.*

*The counseling manual that still we use and the counselor were being trained named as 'HIV Counseling Service Guideline for People Living with HIV and AIDS Patients; which was published by OSSA, and 'Home based Counseling Service' Produced by Ethiopian Evangelical Church. Continuous capacity building not been undertaken due to budget constraints. Regular supervision through checklist hardly performed in our organization due to many of our home based caregivers and counselors are volunteers, the client feels insecure to tell risk factors openly and also we may violate the ethical code of confidentiality.*

In addition another coordinator who has strong linkage with the youngster's group conveyed the experiences that his association developed and practicing as:

*No specific individuals who have been trained solely in counseling rather we all have been trained as family planning educators, coordinator of the youth group, and counselors (i.e., from mother -to-child, prevention and referring tough cases for OSSA with a slip of CARD for detailed counseling and testing. In spite The topic of training determines the one who deserves the training. The committee determines new individuals, at ease having the motivation, sociability and commitment as prerequisites requirements.*

*Continuous capacity building is not the unusual task to our team members. We would like to appreciate different organizations such as Organization for Social Service Agency, South West Synods and the German Population Fund (DSW).*

*In relation to regular supervision we have no culture to observe technical skills of counselors', rather intermittently, we prefer to use peer counselors to reconsider what each of them did previously one to each*

Initial training on the processes, problems and techniques of counseling were secure in both organizations. However, continuous refreshment trainings and regular supervisions on the technical aspects of HIV counselors' counseling skills were almost non-existent under both organizations.

### **4.3 Related Aspects of HIV/AIDS Counseling Skills**

This section contains the analysis of data obtained through interview from the coordinators, and Focus Group Discussion with the clients. Getting competent and skillful is not only fixed into implementing counseling skills but also in any sort of procedure may be a function of numerous variables among which the following are the major ones.

**The seventh research question disclosed as: "Do government and non-government HIV/AIDS counselling providing centres differ in relation to availability, accessibility, privacy, and physical arrangements of HIV/AIDS counselling offices?"**

#### **4.3.1 Physical Facilities**

The availability, accessibility, privacy, organization of counseling office and qualities of waiting are the integral and determinant factors to conduct effective counseling session. It is up to the counselors' attempt and skill to suggest at least, if not, to find the proper office that naturally suits for successful counseling. One can recognize the following realities in relation to the office. A nurse counselor and coordinator among one of the government institutions

described the above features like accessibility and privacy of the office as in the following manner:

*I don't think the office was private and that reinforces to maintain confidentiality. Integrating OPD patients with HIV clients believed to be proper by the Management Committee of the Hospital due to lack of extra rooms. In relation to accessibility we have no problem since we have guest reception center at the information desk right to the left of main gate and even more direction indicators that may assist new comers to find the center easily. The waiting area that we have has dual purposes; the clients stay with individuals who come for other opportunistic disease treatments. Moreover, the waiting area as well as the counseling room seem to be well furnished and equipped with resources including chairs, tables, shelves, different electronics such as tape player, TV, video etc. Thanks for FHI and World Visions.*

The second coordinator also attempted to visualize the counseling room in such away that:

*We have two separate rooms with some of the necessary facilities like chairs tables and shelves. The first one exclusively for Voluntary Testing and Counseling, while the second one belongs to counseling pregnant women though the former one is narrow, but privately situated. Beneficiaries could identify easily since it has been located in the front side of the blocks even though information centers are non-existence. However, I am afraid to tell you that the waiting area is like of the room separate and well furnished rather we have aggressive flow of clients the existing resources, are not enough to accommodate them.*

The other counselor and officer from similar category of organization reflected the scenario related to office as:

*This office and the waiting area have double purposes for OPD and VCT as well due to the dearth of free rooms. Actually, it is I to do all. I am sure you are looking service seekers whether for OPD and/or VCT outside the corridor as well as inside in the office. Consequently, dealing about privacy unthinkable, and less practical. In relation to chairs, tables, and shelves we have no problem rather we need ventilation, TV, tape recorder, video etc.*

A Focus Group Discussion Conducted by PLWHAs clearly reflected the non-existence of private rooms for HIV/AIDS counseling. For instance, a man from FGD<sub>2</sub> uttered that:

**B<sub>1</sub>:** *The counseling center that I received counseling was really narrow and located at the rear side of the other rooms. People who were coming for another investigation get the service there, which I was felt discomfort.*

**B<sub>3</sub>:** *The room was not private and easily accessible particularly for individuals who have little ideas about the hospital.*

Focus group discussion conducted by pregnant women also confirmed the two cases as:

**A<sub>1</sub> + A<sub>2</sub>:** *Actually the room was not difficult to identify rather it is at the front block of the rooms. You could find it easily coming through from out side to the station. I like its privacy; we were pregnant women only on the bench waiting for counseling and blood testing. Though the privacy was secured, the room again needs further space to avail chairs, tables and benches. Some of us exhausted due to standing for long period of time.*

**A<sub>3</sub>:** *Really, I was not satisfied with some of the things there. For example, a number of other colleague nurses were in the room simultaneously with me, which made me feel insecure to narrate all the risk behaviors and also I was not confident about how for my private issues could be confidential.*

**A<sub>1</sub> + A<sub>2</sub>:** *The government should try to furnish the counseling room or the center should tell us to take chairs from our home.*

**A<sub>3</sub>:** *Quite unrealistic and embarrassing, think of please service seekers who are from distant areas.*

A case study on a 30-year-old client that was obtained counseling service at the government-counseling center reflected the reality as:

*It was in the Hospital that I had been forced to get HIV blood test by the medical staff in order to obtain further examination on my pneumonia case. However, the office was not private, and accessible rather it was integrated with OPD room. Moreover, the room was furnished with two chairs and a table as the table was the demarcation in between us and rendered the counselor to note few points about me.*

The third counselor and coordinator also from similar category of organizations and came up with quiet opposite ideas, and narrated the general situations in relation to counseling office as:

*I am confident to tell you that the counseling room has its own block line with separate waiting areas and sitting benches, relatively calm and free from any destruction, separate from other OPD rooms at the rear side of other blocks that encourages clients to come to the center. More over, they get access to the service without any difficulties. We have direction indicators beginning from out side the gate to the counseling office; educated clients may easily identify the center. Further, there is information desk that every new comer asks any idea at the front gate. However, we have newly started service PMTCT counseling and testing), which has yet not been acquitted with special room rather we are trying to integrate the service with VCT since both relatively involve similar process and/or skills. The point in case I would like to mention as a threat is the room actually narrow that may be difficult to add even more facilities as well as the requirement of more important resources like TV, tape recorder and audiovisuals so as to educate individuals who are coming for medical examination.*

On the other side the non-government organizations still are engaged at HIV /AIDS counseling. The coordinator reflected the scenario may differently among them the only who conduct VCT and home-based counseling described as:

*In relation to privacy as you see we have no problem. There are rooms at the rear side of this office. The main office also is not difficulty to find rather it is accessible for every body that wants to get blood test and counseling since it is adjacent to the main street. We have an advert also on the gate, which might have critical importance to identify the office as well as the kind of service that we pursue.*

A young coordinator to the youth group disclosed that:

*We have three separate offices. The one that located at Sikela is private, accessible and suitable for counseling; however, the two are not as such valuable. You can see in front, the bus station where you can find a great number of people that are capable of destructing our work, and at the back the main street you can hear of different sounds such as motor vehicles, and human beings as well. The one that located at Secha also has similar characteristic.*

The third individual also from similar category of organization reflected that:

*I have no problem in terms of accessing and maintaining the privacy of counseling. Look this way; it has been prepared right for clients so as to come through towards me without any social and/or psychological destruction. Actually, I feel that I should hang on an advert at the gate. However, clients frequently are required to ask the guard to find my office, which might be challenging to them.*

A case study conducted on 18 years client who got HIV counseling at the non-government institute disclosed relatively similar idea with the above individuals as:

*Generally, the office that I received counseling was not secured rather you could see different destructions such as social (i.e., individuals such as students and other people were moving around there). Physical noises like the sound of vehicles were pertinent due to the location of the office right adjacent to the main street. However, the counseling room specifically sited back to the general room, which might be considered as private. Resources like chairs, tables, ventilation etc seemed to be available even to the waiting area.*

The other coordinator from the colleague organization who exclusively works on home-based counseling attempted to state the situation quiet differently:

*No counseling office with all facilities since we have serious budget deficit. Furthermore, we priorities supporting people living with the virus with the existing meager budget in order to secure economic self-reliance instead of organizing counseling office.*

The Focus Group Discussion also revealed consistent ideas about the privacy and accessibility of non-government counseling offices. For instance, FGD<sub>1</sub> showed that:

**A<sub>2</sub> + A<sub>3</sub>:** *We obtained information about PMTCT primarily from our village dwellers, while later Miss 'Y' and 'Z', the two high school students who were responsible to sensitize, orient and conduct counseling services of pregnant mothers so as to get blood test and counseling. Consequently, our home – was our office so we couldn't say anything about accessibility and privacy of counseling office.*

Participants from the second Focus Group Discussion also contributed some ideas with regard to the above idea:

**B<sub>3</sub>:** *Despite the fact that we are the regular beneficiaries of this organization; however, we have yet not treated (counseled) in any specialized counseling office. This is not an office for counselors' rather it belongs to the project officers. In any way there is no fixed counseling office rather the office for counselors exists at the home of each client.*

**B<sub>2</sub>:** *I know an organization that works on home-based care and counseling. It has no organized office rather the counselors utilize one of the room from symmetry buildings in the church compound. Imagine how far could it be logical to discuss about such hidden issues like sex and sexual behaviors in the area of worshipping and praying?*

**B<sub>1</sub>:** *Actually I have been there twice or trice before visiting this organization. The office a little bit non-accessible particularly for new comers since there was no advert at the main gate; however, it has structured for privately for counselor-client relationship, nothing can be done in the office except undertaking counseling process. Moreover, the counselors are very tough, diligent and well planned. They are trying to manage clients in relation to setting convenient time that is suitable for them and the clients. They are volunteers who have their own occupation and the clients too. As a result, I would like to appreciate them how they are really active to pursue all these things through mutual communication.*

The investigation made through different methods evidently indicated that HIV /AIDS counseling offices under both organizations relatively seemed meagerly possessed with fundamental guidelines of counseling such as making counseling offices available, private, conveniente, accessible to the clients ; separating the waiting areas from the counseling rooms; equipping the the counseling room as well as the waiting area with mandatory faciliites etc. For example, the perceived realities refelect that HIV clients and patients for other opportunistic diseases wait for examination in the same area in the government counseling centers, which might potentially, inflict the principle of confidentiality. Furthermore, waiting areas were almost absent in the non-government counseling centers, and even the centers had not structured formally,

equipped, and capable of accommodating more than two clients to conduct group counseling. Despite the fact that no body gets confused to find counseling offices since direction indicators and notice boards were available at different sites and even the Information Desk at the government centers served this way.

### **4.3.2 Physical Arrangements**

Furthermore, government and non-government counselling providers compared whether they differ in terms of office arrangements to conduct successful HIV/AIDS counselling.

Proximics and sitting arrangements are the points need to be dealt as the most important factors as a counselor, as a coordinator and/or a client to consider and make proper organizations and improvements in order to conduct successful counseling. The government organizations and the non-government counselors may prefer to employ similar or different style of sitting arrangements and/or distance between the counselor and the client during the counseling processes. The following sections may help to visualize the conditions in relation to the two organizations. A counselor and a coordinator of certain VCT center strove to depict the style of sitting and the gap between her and the clients as:

*I frequently prefer to employ face-to-face (i.e., 90°) with around 70-100 cm gap so as to encourage clients' free expressions of his/her true inner self and also in order to accelerate the development of fraternal relationship between him/her and me. Moreover, I usually wear this white gown during counseling service that I didn't consider its effect on my clients*

The other counselor and section coordinator and also the other executive coordinator share relatively similar ideas about proximics and sitting arrangements that can be described as:

*Face-to-face is appropriate to many counselors, as they have been trained in to facilitate conditions for effective risk assessment, risk identification and manage them effectively. Unless you look in into the*

*eyes of the client's directly, you may stare up on any other irrelevant objects in the room; for example, on the wall or through the window that may potentially damage your relationship with the client, and ends up with becoming non-volunteer to get blood test or not endorsing the result.*

The point in case also visualized by one of the counselor and coordinator from the parent organization as:

*Face-to-face counseling that I usually perform so as to help the client to think as the counselor is reading what all inside of him/her, which in turn, releases all facts related to risk factors. Secondly, the sitting itself an indicative of empathy.*

The method of Focus Group Discussion even more fertilized the ideas considered by coordinators. The following scripts directly taken from FGD<sub>1</sub>:

**A<sub>1</sub>:** *We were sitting on similar chairs with no table in between us. He was looking at my forehead and asking me all about my life styles and my husband. In fact, I told him all the things genuinely.*

**A<sub>2</sub>:** *I had been invited to have a sit, and I was terrified to take chair straightforward with the counselor with no demarcation in between us; however, gradually the sweating, the heartbeat, and all confusions bit by bit gone. We were dealing with a number of personal issues she was asking me and I respond, she was telling me and I accept the realities, sometimes and reject on another time and so on... It was good.*

Focus Group Discussion Two also refelected some hints about the issue raised under FGD<sub>1</sub> as:

**B<sub>1</sub>:** *Whatever table exists in between the counselor and I, and he wore white Gown; we were communicating freely face-to-face. It was my problem so I should tell him and release whatever I feel inside to get physical and psychological lull.*

**B<sub>2</sub>+B<sub>5</sub>:** *We were communicating very friendly during the session. The chairs arranged in such away that suitable for singletons and couples.*

The case study also seemed to reveal the fact consistently.

*The counselor and I were seated face-to- face with certain centimeter distance between us with out any table demarcation in between us.*

The extent of office-based counseling seemed to be rare with in the non-government counseling providers rather home-based care giving and counseling were eminent. Despite the fact that some arrangements and degree of contacts were still mandatory to happen. The coordinator of certain Anti-AIDS Association depicted the realities in relation to his association as:

*Face-to-face or 90° having 80-100 cm physical distance between the counselor and the client is our favorite sitting arrangement to establish strong relations between the two colleagues, and to make effective diagnosis about clients' risk factors.*

The consistent information obtained from the case study as:

*We were sitting face-to-face with no boundary in between us at all.*

The second individual who exclusively focused on home-based care and counseling uncovered the facts as:

*The physical distance couldn't be expressed in terms of centimeter or millimeter rather the actual touch involved in the caring processes, and the emotional gap also can be described and seen in terms of the counselor's true feeling and interest to visit and care people living with the virus via rounding one by one at the residence of each patient.*

In the Focus Group Discussion participants also communicated about proximics and sitting arrangement. In the first FGD all the three expressed relatively similar ideas:

**A<sub>1</sub>+A<sub>2</sub>+A<sub>3</sub>:** *The counselor (i.e., the two high school students) who were the members of A/MINCH Anti-AIDS Association visited our home and delivered us information and how to seek for PMTCT Counseling and Testing. We didn't see any special style of clothing, speech and sitting arrangements that was different from our life styles and/or educational level.*

Participants in the second FGD also confirmed that the existence of reasonable physical as well as psychological relationship as:

**B<sub>1</sub>:** *when I discontinued using ART drug, a counselor found my home through asking people. I was amazed whether how and why he did come to my home! To mean, counselors are so passionate to feel our problems with a great loss of energy,*

*time, money, etc; however, sometimes we (i.e., people living with the virus) make things mess that may potentially inflict our relationship with our community.*

Solely a counselor's and another coordinator's interview responses from the same category of organization, but undertaken home-based care and counseling as well as office-based counseling revealed that:

*This is the room that we conduct office based-counseling. We are feeling shame because no proper chair, table, shelves, ventilation, and even the wall is not painted very well. The sitting arrangement and the physical distance between our counselors and the clients may be variable, some prefer face-to-face with approximately 100cm, while others prefer to employ the forty-five degree in order to prevent onself and the client from contagious diseases, and to avoid physical attractions.*

The most preferred sitting arrangement was face-to-face at the government and non-government HIV/AIDS counseling centers, which might be thought that the counselor makes attempt to see the clients' problem from the clients' point of view, and also risk assessment becomes much easier than the other arrangements. However, in some non-government counseling centers slightly 45° sitting arrangement were employed.

## **CHAPTER FIVE**

### **DISCUSSION**

This section focuses on the major findings against basic questions and other related literatures. Furthermore, justifications for any contradictory result were averred.

#### **5.1 Differences among Para-counselors in the two types of institutions**

The primary issue was related to whether there were statistically significant differences between counselors who were working at the government and non-government organizations in relation to their knowledge and practice of HIV/AIDS counseling skills. As the findings confirmed that there was no statistically significant variation was found between the government and non-government HIV/AIDS counselors with regard to knowledge of counseling skills though significant difference was eminent in practicing the counseling skills at two tailed  $\alpha = 0.05$ . However, from the mean comparisons made on the two variables, (i.e., knowledge and practice), the counselors from the government organization relatively tended to be more knowledgeable and practice oriented than the non-government counselors. This difference primarily might be due to the professional contributions of the counselors, which mean around 21 of government counselors contained under Nurses, Health Officers and Health Assistants that supposed to possess relatively tough interpersonal relationship skills, while just only a nurse counselor was identified from the non-government counselors. Secondly, the extent of contacts with clients and/or other patients probably resulted the government counselors to be even more knowledgeable and practical than their counter parts. The other point, as had been discussed in the Focus Group Discussion, the non-government counselors more likely focused on resource management like money and assisting PLWHAs

to be self-reliant in economically than engaging at helping client with emotional support.

The observation made on the sub-category HIV/AIDS counseling skills regarding the knowledge and practice dimensions uncovered that the government and non-government counseling providers were not significantly different with the knowledge of all sub-classes of counseling skills at two tailed  $\alpha = 0.01$  and  $0.05$ , but significantly differed with the practice of Communication skills at two tailed  $\alpha 0.05$  and  $0.01$ , and Facilitative skills at two tailed  $\alpha = 0.05$ .

Rohleder and Swartz (2005) disclosed the existence of difference between the government and non-government counselors in line with respecting and practicing counseling processes very well due to the existence of plain working environment as natural experiences of non-government organizations, where as the government organization possessed quite contradictory realities. A little bit similar statement but through slanting direction Ginwalla et al., (2002) revealed that nurse counselors possessed better communication skills than community volunteers that might be due to the nurse counseling providers dealt with fewer clients than the community volunteers since they have been occupied with further responsibilities in the office. Secondly, the community volunteers, who were less educated and unable to comprehend trainings that were conducted through non-vernacular languages, which likely caused in to low-level of skills development.

## **5.2 The Role of Selection Procedures in Making Differences among Para-Counselors**

The analysis of variance also specifically rendered to observe selection procedures whether had significant impacts on knowing and practicing counseling skills among HIV/AIDS counselors. The investigation uncovered that selection procedures effected statistically salient differences on the

knowledge and practicing of all kinds of counseling skills (i.e., facilitative, communication, intervention, termination and follow-up skills) at two tailed  $\alpha=0.05$  and  $0.01$ . From the mean comparison, counselors who have been recruited through coordinators or the head of the office, Idir, Church, Kebele revealed better knowledge of HIV/AIDS counseling skills and seemed to implement them very well. It might be asserted, as the coordinators were cognizant with individuals who were actively dedicated to know the skills as well as to practice them very well. Moreover, the selection procedures in many of counseling providers based on the commitment, interest, and relative academic background of the clients. The management committee at the office level and different social groups within the community were the responsible parties to know and recruit diligent and hard working counselors. Thirdly, it could be claimed as counselors probably considered themselves as individuals who were bearing the responsibilities in this regard, and therefore, who seemed to show endeavors to know and practice these skills very well.

### **5.3 The Role of Duration of Training in Making Differences among Para-Counselors**

One way ANOVA clearly revealed that the existence of real knowledge and practice difference among HIV/AIDS counselors due to variation in duration of training at two tailed  $\alpha=0.05$  and  $0.01$  on all cluster of HIV/AIDS counseling skills. Moreover, the mean comparisons indicated that counselors who received trainings for more than a month revealed permissible knowledge on Facilitative, Communication, Intervention and Follow-up counseling skills, while counselors who received trainings for less than a month likely to gain better knowledge on Termination counseling skills. With regard to practicing counseling skills, counselors who got trainings for less than a month seemed to implement Communication and Intervention skills better than their counter parts, whereas counselors who obtained trainings for more than a month seemed to practice Facilitative, Termination and Follow-up counseling skills. This may be contended as the training probably bolstered the knowledge and practice

behaviors of the counselors. However, the paradox, counselor who had been trained for less than a month revealed better knowledge on Termination skills and tended to practice Communication and Intervention skills better than counselors trained for more than a month. Consequently, this finding probably gives homework for those of organizations working at HIV/AIDS counseling and engaged at recruiting counselors to end their purposes as critical investigations on the counselors' competencies; personalities, academic background, experiences etc may become the corner stone to attain the wanted goal.

Some previous findings confirmed with the above findings. (UNAIDS, 2000; Miller quoted by WHO and UK Government, 1988; Campbell and Williams cited in Brugha, 1999; CDC, 2001; Golin et al., 2004). Some literatures even more refer to acquaint HIV/AIDS counselors not only with continuous training, but also with psychological, social as well as financial supports. (Rohleder and Swartz, 2005; Canadian International Development Agency, 2001). Further more, counselors who have been supervised regularly likely to possess positive knowledge and practice effectively; which may reveal supervision has cogent effect in the acquisition as well as practicing counseling skills properly. Actually, Family Health International (2001) and UNAIDS (2000) claimed about the necessity of regular supervision so as to investigate any progress and/or barren the limitations.

#### **5.4 Pre-requisites for HIV/AIDS Counseling**

The data obtained and examined through qualitative approaches rendered to investigate some of the issues once again. Among which availability of physical facilities, arrangements and proximics were the salient elements need to be properly tailored in such a way to effect the desired ends. With reference to the investigation made, both organizations probably missed some qualities. For example, dearth of commodious and private counseling offices and waiting areas were prevalent. However, non-existence of counseling offices with all

facilities, even the existing non-furnished rooms were less likely accessible to the new visitors were the typical characteristics of non-government counseling centers, whereas absence of convenient time to different clients to provide the service became the visible impediment in the government organizations. Several previously conducted literatures confirmed that counseling should be undertaken in reasonably organized and private areas. (Baggaley et al., 1998; Jackson quoted by Brugha, 1994; Arthur, 1999; UNAIDS, 2000; Federal Ministry of Health, 2003).

The physical distances also incredibly significant so as to enhance and build positive relationship between the counselor and the client, and even to canvass intervention mechanisms effectively. Consequently, the most preferred sitting arrangement that was utilized by the two-organization face-to face, which was assumed to decree establishment of empathic understanding of the client and to address the assessment of risk behaviors successfully. Although the style of sitting has its own merits, it has imbroglio. For instance, what ever the counselors' attempts to be ethical and dedicated to his/her profession, the sitting style may potentially divert the attention of the counselor or the client since there is a probability of coming with bare body with some parts. Secondly, contagious diseases like TB can easily transmit from one to the other through direct entry to the respiratory organ of the client or the counselor. However, on some occasions in the middle of sessions some clients may reflect unusual behaviors such as negative transference, including physical movement like stretching fists and knocking and/or banging the counselor etc. Imagine in such cases face-to-face sitting probably exposes the counselor and victimize him/her to physical attacks. As a result, choosing the best suited sitting arrangement that enhance risk assessment and secures empathy become the corner stone to all counseling situation.

## CHAPTER 6

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 Summary

The objective of the study was to examine whether there were differences between government and non-government HIV/AIDS counselors regarding their knowledge and practice of HIV/AIDS counseling skills. To end these objectives purposive and availability sampling techniques were employed to select research participants (i.e., counselors, clients and coordinators). Four different instruments namely questionnaire, interview, FGDs, and case studies were used to collect information. Data was analyzed through t-test, one-way ANOVA and descriptive statistics. The findings revealed that there was no significant difference between government and non-government HIV/AIDS counselors in relation to knowing counseling skills. However, on the practice dimension counselors from both organizations were significantly different. Furthermore, training for sufficient period of time was found to be helpful to gain and practice counseling skills effectively. In addition, counselors who had been nominated by coordinators tended to practice counseling skills effectively than voluntarily engaged counselors. Generally, with regard to counseling skills, physical facilitates and pre-requisites for counseling processes; for example; availability, accessibility, privacy of counseling office and waiting areas etc were poorly existed at both organizations particularly the non-government counseling centers were suffering from them. As a result, both, government and non-government HIV/AIDS counseling providers need to be active in developing fundamental counseling skills among HIV/AIDS counselors as well as should be practical in relation to furnishing counseling contexts with all conducive physical, social and psychological aspects so as to conduct effective (quality) HIV/AIDS counseling, which in turn, to prevent and control the spread of the disease.

## 6.2 Conclusions

Based on the results of the study, the following conclusions were made:

- Although there was no statistically significant difference between government and non-government HIV/AIDS counselors in relation to the knowledge of HIV/AIDS counseling skills, there was slight variation between the counselors who were working at the two organizations.
- There was statistically significant difference between government and non-government HIV/AIDS counselors in relation to practicing HIV/AIDS counseling skills.
- Changes in selection procedures likely affected the knowledge and practice of HIV/AIDS counseling skills among HIV/AIDS counselors. Counselors who had been nominated by coordinators seemed to reveal better level of knowledge and practicing HIV/AIDS counseling skills than volunteer counselors.
- Variation in duration of training seemed to have impacts on the knowledge and practice of HIV/AIDS counseling skills among HIV/AIDS counselors. Counselors who had been trained for relatively long period of time seemed to gain and implement HIV/AIDS counseling skills better than those who had been trained for short period of time
- The pre-requisites for effective HIV/AIDS counseling processes such as the physical facilitates, privacy, availability, accessibility of counseling offices and waiting areas were poorly existed in the government and non-government HIV/AIDS counseling centers particularly the non-government counseling centers were suffering from it even a number of them had no HIV/AIDS counseling offices.
- Proximics (i.e., physical distance between the counselor and client) was 80-100 cm considered as reasonable. Moreover, face-to-face sitting arrangement typically employed in almost all office counseling

providers under both organizations, while only two (i.e., one from government and the other, from non-government) who preferred 45° sitting arrangement were identified. The former preferred in order to create empathy, and to assess individuals risk factors thoroughly, whereas the later one chosen just to cover the bottom part of client's as well as counselor's body with table boundary, to mitigate if not, get rid off the spatial transmission of contagious diseases.

- In the non-government organization counselors more frequently focused on helping client's how to manage money instead of delivering emotional support.

### **6.3 Recommendations**

In these section things to be done so as to improve HIV/AIDS counseling at both organizations or at one of them was stated. Much expectation is valuable from different concerned individuals such as the counselors, clients, coordinators, donor agencies and/or the community at large. The following are basically certain recommendations made in such away that concerned individuals to put on action:

- Government and non-government HIV/AIDS counseling providers should strive to conduct standardized HIV/AIDS counseling services through enhancing counseling competencies among their counselors.
- Demographic variables and other factors such as educational level of counselors, competencies of trainers, selection procedure, regular training and regular supervision have their own impacts on the counselors' knowledge and practice of counseling skills. Consequently, selection of counselors, training and assigning needs critical investigations and all the tasks need to be tailored in such away that fitting the gaps that occur due to miss-nomination and/or other factors.
- In the non-government organizations counselors as counselors need to prioritize emotional support followed by other related tasks.
- The physical facilities such as private offices, writing areas, accessibility, convenience and also other resources like tables, chairs shelves, Video,

Tape recorder etc should be made available whether from any source, fund and/or from the community.

- Counseling as a profession and counselors as professionals need to have formal administrative structures in the health system of the state.
- Professionals should be equipped with the skills of interrelated multiple tasks such as conducting research, coordinating, training and mobilizing the community with regard to HIV counseling and behavior change scheme.
- Counselors, in both organizations, need to be more practical and the trainings should focus on practical aspects through employing diversified methods of trainings namely practice, role-play, discussion etc in order to enhance counselors skills in relation to the objective realities of clients.
- HIV/AIDS counselors, in the government and non-government centers, should try to adopt the trend to supervise HIV/AIDS counselors' technical skills of counseling.
- HIV/AIDS counseling that works need to be shifted to theory and solution focused through seriously considering and getting acquainted with the skills such as Facilitative skills, Communication skills, Intervention skills, Termination skills, Follow-up skills and even with further feasible counseling skills instead of undertaking through traditional ways, advice giving and imparting knowledge through deductive ways.
- Team and interdisciplinarity approaches that including the client and its family, religious leaders, community leaders and the community at large; professionals such as psychologists, medical experts, social workers, and others need to be integrated together so as to work on fighting against the pandemic through utilizing the meager resources effectively and efficiently.
- It is necessary to establish HIV/AIDS counseling courses that address the problems of living with AIDS, the counseling of caregivers and children and bereavement counseling.
- In areas where non-manageable clients flow, the numbers of volunteer para-counselors need to be increased.

## REFERENCES

- AIDS Committee of Toronto. (1998). *National HIV/AIDS Volunteer Training Kit. Training Module 3: Volunteer /Peer Counseling.*
- Arthur, D. (1998). *Assessing Nursing Students' Basic Communication and Interviewing Skills. The Development and Testing of a Rating Scale.* Journal of Advanced Nursing. 29 (3): 658-665.
- Ashton, E. (2005). *Social Support and Maladaptive Coping as Predictors of the Changes in Physical Health Symptoms among Persons Living with HIV/AIDS.* Mary Ann Liebert, Inc.
- Baggaley, et al., (1998). *Voluntary HIV Counseling and Testing in Zambia and Women's Needs.* International AIDS Society. 12(502).
- Berger, K., et al., (2005). *Counseling Quality in Community Pharmacies: Implimentation of the Pseudo-Customer Methodology in Germany.* Blackwell Science Ltd.
- Bor, R., Perry, L. and Miller, R. (1989). *A System Approach to AIDS Counseling.* Journal of Family Therapy. 2:77-86.
- Bowles, N., Mackintosh, C., and Torn, A. (2001). *Nurses' Communication Skills: An Evaluation of the Impact of Solution - focused Communication Training.* Blackwell Science Ltd.
- Brown, L.K., and Louries, K.J. (2000). *Children and Adolescents Living with HIV and AIDS: A Review.* Journal of Child Psychology. 4(1): 81-96.
- Brugha, R. (1994). *HIV Counseling and Care Programs at the District Level in Ghana.* AIDS Care 6(2): 129-137.
- Bruhn, J.G. (1999). *Counseling Persons with a Fear of AIDS.* Journal of Counseling and Development. 67:455-457.
- Bunell, R.E., et al. (2005). *Living with Discordance: Knowledge, Challenges, and Prevention Strategies of HIV - discordant Couples in Uganda.* AIDS Care. 17(8): 999-1012. Taylor and Francis Ltd.
- Canadian International Development Agency. (2001). *Counseling Guidelines on Survival Skills for people living with HIV.* Counseling Series No. 5.

- Center for Disease Control. (2001). *Revised Guidelines for HIV Counseling, Testing, and Referral*, and Revised Recommendations for Screening of Pregnant Women. U.S. Department of Health and Human Services. 50(19): 1-58.
- Chaava, T. (1990). *Approaches to HIV Counseling in a Zambian Rural Community*. AIDS Care. 2(1): 81-87.
- Epstein, R.M. et al. (2001). *Improving Physicians' HIV Risk – Assessment Skills Using Announced and Unannounced Standardized Patients*. J. GEN INTERN MED. 16: 176-180.
- Ethiopian Ministry of Health, (2003). *National HIV/AIDS Counseling Training Manual*. Disease Prevention and Control Department, HIV/AIDS and other STDs Prevention and Control Team.
- Ethiopian Ministry of Health. (2002). *National Guidelines for Voluntary HIV counseling and Testing in Ethiopia*. Disease Prevention and Control Department, HIV/AIDS and other STIs Prevention and Control Team.
- Ethiopian Ministry of Health. (2005). *Provider Initiated HIV Counseling and Testing*. DRAFT-Participants Hand Book. Federal Democratic Republic of Ethiopia.
- Family Health International. (2001). *Focus on Different Issues Related to HIV/AIDS and other STDs*.
- Fischer, S., et al., (2005). *HIV Counseling and Testing for Youth*. A Manual for Providers. Family Health International. Youth Net.
- Fombad, C.M. (2006). *The Crisis of Confidentiality in the Control of the HIV/AIDS Pandemic in Botswana*. Blackwell Publishers.
- Fombonne,E (1998). *Interpersonal Psychotherapy for Adolescents Depression*. Child Psychology and Psychiatry Review. 3(4).
- Ginwalla, S.K., et al (2002). *Use of UNAIDS Tools to Evaluate HIV Voluntary Counseling and Testing Services for mine workers in South Africa*. AIDS Care. 14(5): 707- 726. Taylor and Francis Ltd.

- Golin, C.E., et al. (2004). *Adherence Counseling Practices of Generalist and Specialist Physicians Caring for People Living with HIV/AIDS in North Carolina*. J GEN INTERN MED. 19: 16-27.
- Green, G. and Smith, R. (2004). *The Psychosocial and Health Care Needs of HIV-Positive People in the United Kingdom: A Review*. HIV Medicine. 5(1): 5-46.
- Grinstead, O.A., et al. (2000). *Counselors' Perspectives on the Experience of Providing HIV-1 Counseling and Testing Efficacy Study*. AIDS Care. 12(5): 625-642. Taylor and Francis Group Ltd.
- Gunther, Marianne. et al., (1998). *A Place Called Hope: Group Psychotherapy for Adolescents of Parents with HIV/AIDS*. Child Welfare. 77(2).
- Hubley, J. (2002). *The AIDS Hand Book. A Guide to the Understanding of AIDS and HIV*. Macmillan.
- Irwin, R. (1997). *Sexual Health Promotion and Nursing*. Journal of Advanced Nursing. 25: 170-177. Blackwell Science Ltd.
- Joint United Nations Program on HIV/AIDS. (2000). *Tools for Evaluating HIV Voluntary Counseling and Testing*. UNAIDS Best Practice Collection. Key Material.
- Karadzhaev, D (2001). *HIV/AIDS in Turkmenistan*. [www.ilo.ru/docs/dec02/cis/Turkmenistan-eng-pdf](http://www.ilo.ru/docs/dec02/cis/Turkmenistan-eng-pdf)
- Kawichai, S. et al., (2004). *HIV Incidence and Risk Behaviors after Voluntary HIV Counseling and Testing (VCT) among Adults Aged 19-35 Years Living in Peri-urban Communities around Chiang Mai City in Northern Thailand*. 16(1): 21-35. Taylor and Francis Ltd.
- Kinnel, A.M.K. (2001). *'So why are you here?' Assessing Risk in HIV. Prevention and Test Decision Counseling*. Sociology of Health and Illness. 23(4): 447-477. Blackwell Publication Ltd.
- Kipp, W., Kabagambe, G. and Konde - Lule, J. (2002). *HIV Counseling and Testing in Rural Uganda: Communities Attitudes and Perceptions towards an HIV Counseling and Testing Program*. AIDS Care. 14(5): 699-706. Taylor and Francis Ltd.

- Magagula, C.M., et al., (1997). *The Nature of Collaboration between the Public, Private and Non-government Organization Sectors in the Provision of Family Health Education in Swaziland*. University of Swaziland. [Www.dec.uwi.edu/smarshall/publications.htm-49k](http://www.dec.uwi.edu/smarshall/publications.htm-49k).
- Marcus, K.S., et al. (2000). *HIV/AIDS- related Pain as a Chronic Pain Condition: Implications of a Bio-psychosocial Model for Comprehensive Assessment and Effective Management*. *Pain Medicine*. 1(3): 260 -273. Black well science, Inc.
- Martin, J., et al. (2001). *Outcomes of a Health Education Intervention in a Sample of Patients Infected by HIV, most of them Injection Drug Users: Possibilities and Limitations*. *AIDS Care*. 13(4): 467-473. Taylor and Francis Ltd.
- Molassiotis, A. et al. (2002). *A Pilot Study of the Effects of Cognitive - Behavioral Group Therapy and Peer Support/ Counseling in Decreasing Psycho logic Distress and Improving Quality of Life in Chinese Patients with Symptomatic HIV Disease*. *AIDS Patient care and STDs*. 16(2). Mary Ann Liebert, Inc.
- Rohleder, P. and Swartz, L. (2005). 'What I have noticed they need is the stats': Lay HIV counselors' reports of working in a task - oriented health care system. *AIDS care*. 17 (3): 397 - 406. Taylor and Francis Group Ltd.
- Rushton, R., and Davis, H. (1992). *An Evaluation of Training in Basic Counseling Skills*. *Journal of British Guidance and Counseling*. 20 (2).
- Stickley, T. (2002). *Counseling and Mental Health Nursing: A Qualitative Study*. *Journal of Psychiatric and Mental Health Nursing*. 9:301-308. Blackwell Science Ltd.
- Uys, L.R., (2003). *Aspects of the Care of People with HIV/AIDS in South Africa*. 20(4): 271-280. Blackwell Publishing Inc.
- Venkat, A. (2004). *HIV Counseling: an Indian Experience*. Paper Presented at Ethiopian Psychologist Association National Conference.

- Weakland, J.H., and Jordan, L. (1992). Working Briefly with Reluctant Clients: Child Protective Services as an Example. *Journal of Family Therapy*. 14: 231-254. San Francisco.
- World Health Organization and UK Government. (1988). *AIDS Prevention and Control*. Invited Presentations and Papers from the World Summit of Ministers of Health on Programs for AIDS Prevention. Pergamon Press Oxford.
- World Health Organization. (1999). *Women Children and HIV: Resource for Prevention and Treatment*. WHO.
- Yusuf, O. A. (1998). *Gender Sensitive Counseling Psychology: A Hand Book for Ethiopian High School Counselors*. Addis Ababa University
- የኖርዌይ ቤተክርስቲያን ዕርዳታ ድርጅት በጋራ ለፍትሀዊ ዓለም። (1997)። መሠረታዊ የኤች.አይ.ቪ/ኤድስ ካውንስሊንግ መመሪያ። አዲስ አበባ።
- የክርስቲያን በጎ አድራጎት ድርጅት (CRDA) /1995/. የኤች አይቪ/ኤድስ የምክር አገልግሎት አጠጣጥ መመሪያ። አዲስ አበባ።

## Appendix -A

### Questionnaire Format on the Counselors' Self-Perceived Knowledge of HIV/AIDS Counseling Skills

**Objective:** This study is mainly aimed at to investigate whether there is statistically significant difference between Governmental and Non-governmental organizations regarding the knowledge of counselors' counseling skills while undertaking HIV counseling. Unquestionably, the study has paramount implications to prevent and control the rampant spread of HIV/AIDS through visualizing gleaming directions on the profile HIV counselors' skill under both organizations for quality delivery of HIV counseling. As a result, worth mentioning that your honest response becomes the stepping-stone for quality out put.

**Note:** Do not write your name!

**Directions:** You have given below around 14 background items with sub-questions. For each of them you are required to write or select the appropriate response in the space provided. The remaining are items related to your counseling skills and therefore, you can find cluster of items in the chart with regard to HIV counseling skills. The extent to which you know each specific counseling skill indicated by rating scale (i.e., 0 = Do not know to 4 = Know very well). Consequently, you may tick (✓) the alternative that exactly indicates your level of knowledge interims of each counseling skill disclosed on the chart.

#### *Description on knowledge rating*

0 = Do not know

1 = Need more information

2 = Fairly know

3 = Know well

4 = Know very well

## 1. Background

1.1 Age \_\_\_\_\_

1.2 Sex \_\_\_\_\_

1.3 Academic Level

(a) MA  (b) B.A  (c) Diplôma  (d) Certificat

(e) If other specify \_\_\_\_\_

1.4 Name of employer organization (a) Government  (b) Non-government

(c) Mention the Name of the Organization \_\_\_\_\_

1.5 The kind of counseling that you deliver in your organization, club or society is:

(a) VCT  (b) PMTCT  (c) Home –based

(d) Prevention  (e) ART  (f) If any other, describe \_\_\_\_\_

1.6 Do you think the counseling service that you deliver helps to prevent and control the spread of HIV/AIDS?

(a) Yes absolutely  (b) To some extent  (c) Not at all

❖ If your response is 'Yes', how? Would you explain briefly?

❖ If your response is 'To some extent' or 'Not at all', how do you say so?

1.7 The trained professional background mostly belonged to:

(a) Nurse  (b) Social Worker  (c) PLWHA working as counselor

(d) Community Volunteer  (e) Psychologist  (f) If other specify \_\_\_\_\_

1.8 Answer the following questions on the basis of training given on HIV counseling

(a) Describe the Organizations that Provided Training \_\_\_\_\_

(b) Which one of the following professionals most frequently conducted HIV counseling for prospective counselors?

(a) Doctors  (d) Nurses  (e) Health Officers

(b) Psychologists  (f) others

(c) Social workers

- (c) List types of counseling courses given, if any \_\_\_\_\_
- (d) Write the name of training manual and its publisher \_\_\_\_\_
- (e) Reveal the average duration of training whether in daily, monthly or annually \_\_\_\_
- (f) Have you received a training exclusively focusing on counseling skills?

Yes, absolutely  Yes, but not sufficient  Not at all

- If your response is 'Yes, absolutely' on which part of counseling more focused?
  - Facultative skills
  - Intervention skills
  - Communication skills
  - Termination skills
  - Follow up skills
  - If any other describe \_\_\_\_\_
- If your response is 'Yes, but not sufficient' or 'Not at all', why do you think such happened? Explain briefly.

In your opinion what should be done to mitigate the existing problems from the counselors, clients, project officers, your organization, and from the society at large.

1.9 From the following theoretical approaches of counseling which one do you prefer more?

- (a) Behavioral  (b) Client –centered  (c) Cognitive
- (d) Eclectic  (e) Do not know  (f) If any other mention \_\_\_\_\_

1.10 How have you been selected to be HIV counselor?

- (a) Nominated by Senior Colleagues  (c) Self-Motivated
- (b) Contest  (d) If any other specify \_\_\_\_\_

1.11 As an HIV counselor do you get regular capacity building training?

- (a) Yes, absolutely  (b) Yes, but rarely  (c) Not at all

- If your response is 'Yes, absolutely' which of the following counseling skills were the focus of training?
  - Facultative skills
  - Intervention skills

➤ Communication skills  ➤ Termination skills

➤ Follow up skills

➤ If any other describe \_\_\_\_\_

- Who were the professionals that regularly conduct the training?

(a) Doctors  (b) Nurses  (c) Health Officers

(d) Psychologists  (e) Social workers  (f) others

- What do you suggest to solve problems with regard to these issues from the point of view of different individuals such as counselors, clients, project officers, your organization and the community at large?

1.12 As a counselor, continuous and regular supervision is mandatory to see whether the counselors practice the skills properly or not. Consequently, is this being done properly in your organization?

Yes, regularly  Yes, but rarely  Not being done at all

- If your response is 'Yes, regularly' what is the time interval?

(a) Annually  (b) Six month  (c) Three months

- What is the name and publisher of the manual for supervision? \_\_\_\_\_
- If your response is 'Yes, but rarely or Not at all' why do you think such happened? And what is expected from different authorities like the counselors, clients, project officers, the community etc.

1.13 Do you think that you implement the existing counseling skills properly regardless of the amount of skills you possess?

Yes, absolutely  Yes, to some extent  Not done at all

- If your response is 'Yes, to some extent' or 'Not at all' why do you think?

(a) Work load  (b) Lack of incentives  (c) Boring task

(d) Absence of formal administrative structure

(e) If any other, mention \_\_\_\_\_

1.14 How did you manage to HIV counselor?

(a) For salary increment  (b) To urban promotion

(c) Being PLWHA  (d) Forced by the office

(e) Loving the profession  (f) If any other, mention \_\_\_\_\_

## 2. Counseling Skills

No.	Skills	Knowledge					Comments
		0	1	2	3	4	
<b>1</b>	<b><i>Facilitative Skills</i></b>						
1.1	Establishing fundamental pre-conditions that help to the success of the counseling relationship such as greeting, smiling etc.						
1.2	Not getting curious to introduce ones own professional background, work experiences etc to the client.						
1.3	Introducing the main issues considered under HIV/AIDS counseling.						
1.4	Introducing the purpose of HIV/AIDS counseling.						
1.5	Forming working alliance through determining actions. specific objectives of HIV/AIDS counseling etc.						
1.6	Getting congruent with ones own words and actions						
1.7	Less likely attempting to conduct HIV counseling in the private environment that is free from any noises.						
1.8	Maintaining confidentiality of clients' personal, social, economical, cultural issues.						
1.9	Unconditionally accepting the client whether who is beautiful or ugly, black or white etc.						
1.10	Getting emphatic about the clients HIV/AIDS and /or sexual or any risk behaviors.						
<b>2</b>	<b><i>Communication skills</i></b>						
2.1	Utilizing the appropriate non- verbal communication skills such as proper facial expressions, gestures interims of clients age, academic background etc.						
2.2	Actively listening the client verbal expressions.						
2.3	Attending the verbal and non-verbal reactions of the clients during HIV/AIDS counseling probably has no effects on the counseling relationship.						
2.4	Increasing understanding through paraphrasing unclear words, phrases, sentences of the client's that are related to HIV/AIDS.						

2.5	Clarifying the clients' genuine feelings on HIV/AIDS and related facts.						
2.6	Enhancing clarification through interpreting client's views on HIV/AIDS other concerned issues.						
2.7	Asking the client indirect questions related to HIV/AIDS.						
2.8	Confronting and shaping with contradictory ideas of the clients' in relation to HIV/AIDS and concomitant factors.						
2.9	Reframing unhelpful client's self and others view related with HIV/AIDS.						
2.10	Summarizing main points during the session						
2.11	Considering own and client's socio- cultural issues						
<b>3</b>	<b><i>Intervention skills</i></b>						
3.1.	Less likely revealing alternative general health promotion skills (i.e., physical exercise, nutrition, sleep hygiene),						
3.2	Assisting the client to develop life skills like assertiveness training and confidence development to prevent and control contracting HIV/AIDS and maintain positive living with the virus.						
3.3	Helping the clients to model desirable behaviors and actions from parents and friends that are potentially helpful to prevent and control HIV/AIDS and enhancing positive living with virus.						
3.4	Confronting with clients' contradictory ideas, actions etc. and establishing the proper thoughts and actions concerned with HIV/AIDS.						
3.5	Reinforcing desirable and positive behavioral changes that are powerful to control the spread of HIV/AIDS and bolster positive living with the virus.						
3.6	Helping the client to develop problem-solving skills through exploring alternative strategies to fight against contracting HIV/AIDS or leading positive living with the virus.						
3.7	Encouraging the clients to express suppressed helpful or unhelpful sexual feelings freely through giving time to discuss with counselors, friend etc.						
3.8	Understanding and accepting the clients' HIV/AIDS, sexual problems, feeling etc. and assisting in such a way that suitable for his/her age, sex, cultural background etc.						
3.9	Getting empathic and making all the things suitable for the client to ameliorate clients' problem.						

3.10	Encouraging clients to sublimate sexual behaviors with substitutive activities namely participating in different clubs, helping parents, etc.						
3.11	Utilizing different projective techniques such as pictures, incomplete sentences etc. so as to uncover hidden risk factors that are potentially expose to the contraction of HIV/AIDS.						
4	<b>Termination Skills</b>						
4.1	Ending counseling relation ship when there is no issue to be discussed between the counselor and the client.						
4.2	Referring the client to other counselors when the case becomes beyond the scope of the present counselor or when there is miscommunication between the counselor and the client.						
5	<b>Follow-up skills</b>						
5.1	Conducting follow-up counseling through arranging appointments at the suitable day and time.						
5.2	Assigning others such as peer groups to help the clients.						
Total							

**Appendix- B**  
**Questionnaire Format on the Counselors' Self-  
Perceived Practice of HIV/AIDS Counseling Skills**

**Objective:** This study is mainly aimed at investigate whether there is significant difference between governmental and non-governmental organizations regarding the practice of counselors' counseling skills while undertaking HIV counseling. Unquestionably, the study has paramount implications to prevent and control the rampant spread of HIV/AIDS through visualizing gleaming directions on the profile HIV counselors' skill under both organizations for quality delivery of HIV counseling. As a result, worth mentioning that your honest response becomes the stepping-stone for quality out put.

**Note:** Do not write your name!

**Directions:** You have given below 36 items related to counseling skills, and therefore, you can find cluster of items in the chart with regard to HIV counseling process. The extent to which you practice each specific counseling skill indicated by rating scale (i.e., 0= Not done to 4= Done very well). Consequently, you may tick (✓) the option that exactly indicates your level of practice in relation to each counseling skill depicted on the chart.

*Descriptions on practice rating*

0 = Not done

1 = Need for improvement

2 = Fairly done

3 = Done well

4=Done very well

## Counseling Skills

No.	Skill	Practice					Comment
		0	1	2	3	4	
<b>1</b>	<b><i>Facilitative Skills</i></b>						
1.1	Creating awareness on the objective of HIV counseling.						
1.2	Hardly thinking about to disclose own name, professional, work experiences etc. to the client						
1.3	Revealing the main issues being considered under HIV counseling.						
1.4	Forming basic facilitating conditions like greeting, smiling etc. that assist the delivering of effective counseling.						
1.5	Creating working relationship through identifying time, role, etc. of the counseling relationship.						
1.6	Perceiving clients problem from the clients' point of view.						
1.7	Less likely conducting the counseling relationship in the areas free from social and physical destruction.						
1.8	Keeping clients' personal issues secret.						
1.9	Accepting the clients without discriminating with sex, ethnicity etc.						
1.10	Becoming genuine with ones own expressions and practice.						
<b>2</b>	<b><i>Communication skills</i></b>						
2.1	Asking the client vague questions related to HIV/AIDS.						
2.2	Revealing true clients' feelings about sex, sexual issues and HIV/AIDS						
2.3	Less likely following clients' verbal and non-verbal messages critically.						
2.4	Replacing unclear clients' expressions about HIV/AIDS and related facts with another possible way of explanations.						
2.5	Effectively listening what the clients' says.						
2.6	Giving meanings to the clients' view/thoughts about HIV/AIDS and related issues.						
2.7	Utilizing non-verbal cues that are appropriate to the clients' age, sex and social background.						

2.8	Challenging the client when opposing realities about HIV/AIDS is forwarded from him/her.						
2.9	Drawing conclusions on the fundamental points at the end of counseling sessions.						
2.10	Changing undesirable clients' view on self and others in relation to the pandemic HIV/AIDS, and related issues.						
2.11	Considering clients' personal, social and cultural backgrounds during HIV counseling.						
3	<i>Intervention skills</i>						
3.1	Helping the clients to be confident in personal and social affairs in preventing and controlling HIV/AIDS.						
3.2	Hardly delivering optional ways for keeping on physical, psychological and social health skills such as maintaining proper sleep to live positively with the virus or not contracting the virus						
3.3	Assisting the clients to imitate and develop desirable behaviors from friends, parents etc. in relation to preventing and controlling HIV/AIDS.						
3.4	Challenging clients' opposing ideas, actions etc. with regard HIV/AIDS and related facts in order to develop constructive thoughts and actions.						
3.5	Helping the clients to release hidden sexual behaviors freely that may potential result in contracting HIV/AIDS through discussing with the counselor, intimate friends etc.						
3.6	Assisting the clients to be solution focused through exploring optional ways to get free from HIV/AIDS and/or to live positively.						
3.7	Rewarding constructive behavioral changes in relation to reducing risk behaviors that cause contracting HIV/AIDS through verbally and/materially.						
3.8	Getting cognizant with and acknowledging the clients' problems, feeling etc. on HIV/AIDS and helping in such a way that suitable for his/her age, sex and cultural background.						

3.9	Observing clients' problems from the point of view of the client and arranging all the things in such a way to help the clients.							
3.10	Encouraging clients to substitute sexual behaviors with another constructive tasks such as engaging at sport, music etc.							
3.11	Employing various projective mechanisms such as meaningful or meaningless pictures so as to clear out risk factors related to HIV/AIDS.							
<b>4</b>	<b><i>Termination Skills</i></b>							
4.1	Finishing counseling processes through transferring the case to another senior counselor.							
4.2	Terminating counseling process if there are no points to be dealt with the client.							
<b>5</b>	<b><i>Follow-up skills</i></b>							
5.1	Encouraging and arranging peer groups, families or organizations to meet with the client to help each other.							
5.5	Meeting with the client again and again through appointment.							
<b>Total</b>								

**Appendix -C**  
**Interview Format for Coordinators**

**Greeting and Welcome!**

**Direction:** I am going to present basically interrelated significant questions on the HIV counselors' skills, counselors' training schemes, support and supervision. You are supposed to visualize whether you believe that the counselors are effectively skillful to deliver HIV counseling for risk reduction so that to prevent and control HIV/AIDS. Moreover, you are expected to reveal your ideas in relation to the production of qualified counselors.

- Date: \_\_\_\_\_
- Place: \_\_\_\_\_
- Coordinator's Name (Code): \_\_\_\_\_

**A. Preliminary Issues**

1. Age \_      2. Sex      3. Field of specialization      4. Name of your organization
5. Do you think counseling has paramount contributions to prevent and control HIV/ AIDS?  
Yes            No      
  - If 'yes,' how? Would you explain briefly?
  - If 'no,' could you tell me the reasons why do you say so?
6. How do you select the prospective counselors in your organization?  
Contest  By senior colleagues  voluntarily  If any other specify
7. Is/was the training given on HIV counseling adequate or not in terms of duration, quality etc.
  - If 'adequate,' can you tell me specific focus areas with their strengths?
  - If 'not adequate' why do you think such happened?
  - What is/or are your intention to improve the service?
8. Which manual did you use to train the counselors? Mention its name and publisher
9. Do the counselors obtain frequent/continuous capacity building training (i.e., short term or long term work shops?)    Yes            No

- If 'yes,' (a) How frequently? Would you tell me the time interval whether monthly, annually or weekly?

(b) Who provides the training? Can you name some of the names of the organization and the professional profile of the trainers?

- If 'no,' why do you think?

10. Is your office makes any supervision? Yes  No

If yes (a) How frequently? Quarterly, with in six month, annually or

(b) Which supervision manual do you utilize as reference?

11. Do you have an idea on the professional profile of trainers? Doctors  Nurses   
Social workers  Counselors/ psychologists  If any other specify

### **B. Counseling Skills**

Would you tell me about the facultative skills and conditions that the counselors know and employ during counseling process and/ or before? For example, in relation to physical arrangements and preparation, getting empathetic, establishing relationship, getting congruently, accepting the client and client's unhelpful behaviors, introducing self and purpose of counseling?

Done very effectively  Done intermediately  Need more improvement

- If 'done very effectively,' would you give me evidences?
- If 'intermediately done or need more improvement,' why?
- What is/ are your intention to make change in the service delivery?

2. Let me take you now to the general communication skills of the counselors with the client. How do you see them in terms of knowing and practicing; for example, the appropriate non-verbal communication skills, effective listening, attending, responding, paraphrasing, summarizing ideas etc.?

Skillful  Intermediate  Need more improvement

- If 'skillful,' would you mind to suggest few instances how they are utilizing?
- If 'intermediate or need more improvement,' why?
- What do you think to acquaint the counselors with such fundamental skills altogether?

3. Obviously, counseling without intervention going to be referred as dead. Consequently, do you think HIV counselors in your esteemed organization deliver and/or help clients make use of certain action- oriented and emotional strategies so as to dwindle the rate of risk behaviors?

Yes  No

- If 'yes,' would you mention some of them on the basis of different theoretical approaches?
- If 'no,' why?
- What is/are your further plan to internalize and make use of such interventions?

4. How do you see termination procedures? Do you think counselors finish the counseling relationship effectively?

Yes  No

- If 'yes,' would you come h up with an idea how really they conduct that?
- If 'no,' why?
- How do you attempt to build skills with regard to their major skill?

5. Finally, I would like to pose a question on follow-up procedures. Do counselors conduct any follow-up investigation so as to check any change of behavior and/ or need for further examination?

Yes  No

- If 'yes,' may I ask you to give me specific strategies?
- If 'no,' why?
- Recommend, if any plan to establish skills with this regard?

### **C. Summary Points**

1. What do you think the most perceived and practiced skills among the counselors?

2. Can you mention also the most non-existent and non- practiced skills among the counselors?

## Appendix- D

### Focus Group Discussion Format for Clients

#### Greeting and Welcome!

**Direction:** I am going to present fundamentally important questions in relation to the skills of HIV counselors, and you are expected to express whether you have really experienced counseling skills while you were getting HIV counseling services. In addition, you may attempt to describe the reasons for the absence or presence of counseling skills followed by you may be required to suggest any remedial activities so as to enhance counselors' skills for effective delivery of HIV counseling in order to meet the desired objectives, preventing and controlling HIV/AIDS.

- Date: \_\_\_\_\_
- Place: \_\_\_\_\_
- Clients' Name (Code): \_\_\_\_\_

#### A. Preliminary Issue

1. Age \_\_\_\_\_
2. Sex \_\_\_\_\_
3. HIV Status
  - a) Positive
  - b) Negative
4. Counseling service you received
  - a) VCT
  - b) Home-based
  - c) PMTCT
  - d) Prevention
  - e) Among two or all
5. Would you tell me the name of the organization that delivered and/or being delivering the counseling service?
6. Do you think HIV counseling has paramount importance to prevent and control HIV/AIDS?
  - Yes
  - No
  - If 'yes,' how? Would you explain briefly?
  - If 'no,' why do you think?

## B. Counseling Skills

1. Could you tell me one by one about the facultative skills and environments that the counselor employed during the counseling relationships and/ or before? For example, concerning the physical arrangements, empathy, establishing relationship, getting congruence, accepting you and your thoughts, introducing himself or her self and the role of counseling in general.

Well-done  Intermediate  Need more improvement

- If 'well done,' would you give me specific evidences?
- If 'intermediate or need more improvement,' what did you observe, and where was the flow?
- Why do you think such problems did occur?
- In your opinion what should be done to meet the needs of clients?

counselor made an attempt  
relationship?

skills from the above?

counseling skills

2. How were the counselors effective to communicate with you? For example, actively listening, properly responding, paraphrasing your thoughts, using proper non-verbal cues, summarizing your ideas and so forth.

Adequate  Intermediate  Non- existent

- If 'adequate,' would you mention pieces of evidences?
- If 'intermediate or non- existent,' explain how s/he was really doing?
- What do think the causes of such problems?
- What then need to be done to mount the communication skills of counselors?

3. As you know counseling interventions are the focal in the scheme of HIV prevention and control. Consequently, how were the counselors' endeavors in delivering and/or helping you to perform certain skills/ tasks so as to relinquish risk behaviors for healthy living?

Effective  Intermediate  Non-effective at all


- If 'effective,' would you mind telling me specific tasks/ activities told to do so?
- If 'intermediate or non-effective at all,' why do you think?
- So, what need to be done to bridge the gap?

4. Let me remind you about the sessions of termination. How did you come to the end of relationship with the counselor?

Successfully  Not- successfully

## DECLARATION


I, the undersigned declare that this thesis is my original work, has not been presented for a degree in any other university and that all sources of material used for the thesis have been dully acknowledged.

 June 21/06

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Tarckegn Tadesse Gemeda

This thesis has been submitted for examination with my approval as a university advisor.

 June 21/06

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Dr. Sentayehu Tadesse