Community Counselling

A handbook for facilitating care and change

Part of an integrated response to HIV and AIDS

by

The Salvation Army
PREFACE

Some years ago a very experienced counsellor wrote about the “Faith of the Counsellor” and, after erudite discussion, came to the conclusion that the main ingredient for success was “love” for the client. Many professionally trained counsellors were not very pleased. What of their theories and professional training?

Many professional counsellors may be critical of this handbook. How can their theories on “one to one” relationships be applied to a TEAM working in a COMMUNITY? The teams, which from their experience have contributed to this book, have shown that Christian love can be extended to communities, using the principles of counselling by applying and developing new concepts.

It is remarkable that even a principle such as “confidentiality” can become the concept of “shared confidentiality” within a community. Other principles such as respectful and empathetic listening are equally applicable. Users of this handbook should make sure they understand such concepts fully. If they do, they will find a means of overcoming many other challenges, for example, in Primary Health Care in which communities need to change their priorities. But they should note that any form of counselling can be stressful and some of the techniques described in this handbook are easier to read about than put into practice; training with skilled guidance thereafter is essential.

“Counselling” is being increasingly offered to the individual and at the same time is being looked upon with scepticism by, for example, the press in Britain. It is said to be unnecessarily intrusive or to be offered by unskilled practitioners. Yet his manual shows that both individual and community counselling have their rightful places in helping communities, families and individuals find new Hope on the River of Life.

Alan Haworth, National Mental Health Resource Centre
Lusaka, Zambia, February 1997
ACKNOWLEDGMENTS

This handbook is the result of eight years of listening to, working with, and learning from people all over the world. Our process of responding to being in life with HIV has convinced us of the real presence and influence of care, community, change and hope.

Most of the concepts were first explored at The Salvation Army Chikankata Hospital in Zambia, starting in 1987. Without the participation of the early Chikankata team members the authors could not have written this handbook.

The insights and experiences of other field teams, with whom the HIV and AIDS Programme Facilitation (previously called Technical Assistance) Team have been working since 1990, have tested and further developed these concepts and their transferability; and have strengthened and enriched both the understanding and the description of the process of community counselling. These teams include those in

- Bangladesh,
- Rio de Janeiro in Brazil;
- Ghana;
- Fond-du-Negres in Haiti;
- Mizoram, Calcutta, Anand, Nagercoil, Ahmednagar, and Bombay in India;
- the Marshall Islands;
- Nigeria;
- Pakistan;
- Papua New Guinea;
- the Philippines;
- Soweto and Capetown in South Africa;
- Sri Lanka;
- Uganda;
- Zaire;
- Tshelelyemba in Zimbabwe;

and others.

To these teams we say Thank You. This is your handbook.

But it is not only to these teams but to all other caring persons, teams, communities, and organisations that this handbook is offered.

The HIV and AIDS Programme Facilitation Team
London, November 1996
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Response form
THE PURPOSE OF THIS HANDBOOK

In which we are introduced to the transferable concepts, consider the purpose of the handbook, which includes overcoming our barriers to community counselling, and look at how to use the handbook.

Transferable concepts

The response to HIV, in Salvation Army programmes generally, is based on four transferable concepts, concepts which you can adapt to your unique needs. The concepts are:

1. care, understood as “being with”, which includes sharing and support as well as prevention;

2. community, understood as belonging, with home, neighbours, and friends as the environment for care;

3. facilitation of choices for change by people, whether infected or not, in their home and community relationships; and

4. the experience of hope which results: hope to live fully and positively within family, community, culture, and faith; and to promote and sustain change.

The concepts are transferable because it is up to you to apply the universal concept to your unique situation. Only you can do this. That the concepts are transferable is demonstrated by the variety of programmes that have been formed in different places; at the same time the various programmes have further refined the concepts.

Counselling is part of a multi-disciplinary approach which also includes

- clinical and nursing care,
- education,
- pastoral care, and
- social work,

as elements of a community development approach, which help people come together, to belong in a healthy way.
This handbook is written from the perspective of The Salvation Army but it is intended to be a catalyst for use by any organisation, team, or person. It reflects part of the Salvation Army’s integrated approach to HIV and AIDS care and prevention internationally.

Purpose of this handbook

This handbook is NOT a package for “educating the community”, or for “running a workshop”. Rather it describes community counselling, and shares some experience, in order to help teams continue to explore the process. We hope it will:

1. ENCOURAGE programme implementers, through sharing experience;
2. share and develop the CONCEPTS of community counselling;
3. promote TEAM WORK;
4. enable authentic PARTICIPATION in community counselling; and
5. facilitate CONCRETE application in local situations.

It is intended to be used by teams, and it is intended to build on basic counselling skills. It is not a substitute for having counselling experience in the team. However, key requirements for community counsellors are

- respect
- mutuality
- ability to listen, and
- a belief that community can work.

If the person does not possess these no training will compensate for them.

It is intended for programme implementers at a variety of stages, and with many different “titles”. We may need to remind ourselves of how far we’ve come, or be encouraged by what others have done. In particular, it is intended to facilitate within programme teams an action/reflection cycle, which can help us recognize and overcome our barriers, just as you will see that community counselling does with the community.
Barriers to community counselling

A cycle of action and Reflection can help us

Unfortunately, many of the barriers to and misconceptions about community counselling are the ones inside us. This is one reason this handbook is designed so that we have to work through the issues within ourselves and with our teams.

Reflect

Do you see yourself saying or thinking any of these?

- Technology: one size fits all—just apply!
- Community does not exist in some places.
- As a professional, I teach the community. The community does not teach me.
- Task and relationship are at opposite poles; you have to choose between them.
- If you cannot quantify it, it is not real.
- My experience is the only experience.
- Confidentiality means professional secrecy.

This is a working handbook, from community experience, the result of eight years of experience of teams all over the world, who have learned to overcome barriers of

- denial,
- negative secrecy, and
- burden bearing, and to

open up ways of

- truth telling
- strengthened mutual responsibility, and
- burden sharing.

Community counselling is a major tool for overcoming the barriers within a community. It differs from an education process and from participatory action methods alone in that issues which emerge have powerful EMOTIONAL content, and facilitators are always challenged to be sensitive and responsive to the many kinds of emotion which can be generated.

Also, community counselling is a process of listening and reflection within a community to acknowledge issues, losses, and feelings related to HIV and AIDS. Through this facilitated truth telling it is possible for the community to move beyond helplessness and into choices and agreements which result in change.

Emotions, truth telling, and change
Using this handbook

There are several main components to the content of the handbook:

1. **The concepts** are introduced, to be absorbed, understood, and finally shared,
2. **experiences** from different parts of the world are shared, and
3. questions for **reflection** on those experiences are posed.
4. Then there are **exercises**, to help you apply the content with a group of people who are exploring community counselling.

These components are distinguished by different formats: shared experiences are between vertical lines, for example. We have put a few summaries of main points in the margin, and left space for you to put your own.

When you are using this handbook with your team, **every member of the group** should be encouraged to participate. If we believe that community counselling is not just a thing we do **TO** people but a way of being **WITH** people, then a challenge for us to be as honest, respectful, participatory, and open to change in ourselves, and in our teams, as we want the community to be.

Write you own handbook!  If you write down the process you use and the insights you gain as you follow through all the sections, you will be **writing your own handbook**. Documenting how it actually works in your situation will be helpful to you, to new team members, and to all of us who are sharing the process.
THE CONCERN

In which we look at the origins of the Salvation Army’s community based response to HIV, HIV as everyone’s problem, HIV and change, what helps change happen, who change is for, and how we help change happen.

Origins of The Salvation Army response

Dr. Ian Campbell recalls: Our facilitation team went to Zimbabwe to the Chiweshe area north of Harare. As part of the sub-regional workshop involving people from countries of South Africa, Zimbabwe, Zambia, Uganda and Kenya, and to help focus on the process of stimulating and sustaining community counselling for change, one of the tools developed was a “time line”.

A facilitator worked with a group of old women who sketched out the major events of the century. There were three: one was a relocation in the 1930’s from a fertile area to an infertile area, to make way for commercial farmers. The anger was evident during that exercise as it must have been in the 1930’s. The second was the liberation war.

The third was “this new illness” that started, as far as they were concerned, in 1989.

There was nothing in between. This was a major event of the century from their point of view; and cause for great concern. So far it has not suppressed vision and hope, yet there is nevertheless a tendency to despair because they see people becoming sick. They know that younger people are becoming infected and they know that children are losing their future. At least the team that is doing home care in the Chiweshe area is now linking the care process to community and neighbourhood consciousness, where concerns can be discussed, vision formation facilitated, and community owned actions worked out and implemented. So in the midst of despair there is an awakening of capacity for action. Despair is not necessarily paralysis. It can provoke...
appropriate action, confidence, and hope, given that there is an adequate facilitation presence either inside or outside the community, at the right time in the right place. The problem in so many communities is that the facilitation process takes too long to become available.

Where are we with HIV and AIDS? You should know the facts about transmission. Treatments are improving, but they are not curative, nor accessible to many people with HIV. Vaccine development has a long way to go. What of the statistics? (See following pages) Do FIGURES tell the story?

Consider the following reflection on the origins of the Salvation Army response. In 1987, the key concepts for a relationship based approach to HIV and AIDS were discussed with national staff members of Chikankata Hospital, Mazabuka, Zambia, along with some key community members

- It was agreed that care is important as defined by “being with”.
- Community was seen as a strength, where community was understood as “belonging”. Of course it could be different and unhelpful, but in most problems of life community belonging had been a strength for these people.
- Change was seen as possible – it had been in the past, and capacity for change could be rediscovered, even though there were difficulties with communication within families and in other areas.
- Despite poverty, people have hope, and with the impending epidemic, there was an attitude of hope that local capacity could be developed and could express itself

I was inside the management process yet outside the essential success of the community development process. This was facilitated through national staff of the same language group, and with an understanding of the intricacy of culture.
ADULTS AND CHILDREN ESTIMATED TO BE LIVING WITH HIV/AIDS, END 2002

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>980 000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>440 000</td>
</tr>
<tr>
<td>Latin America</td>
<td>1 500 000</td>
</tr>
<tr>
<td>Western Europe</td>
<td>570 000</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>550 000</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>29 400 000</td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>1 200 000</td>
</tr>
<tr>
<td>South &amp; South-East Asia</td>
<td>6 000 000</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>1 200 000</td>
</tr>
<tr>
<td>Australia &amp; New Zealand</td>
<td>15 000</td>
</tr>
</tbody>
</table>

TOTAL: 42 MILLION
Estimated number of adults and children newly infected with HIV during 2002

- Eastern Europe & Central Asia: 250,000
- Western Europe: 30,000
- North Africa & Middle East: 83,000
- Sub-Saharan Africa: 3,500,000
- East Asia & Pacific: 270,000
- South & South-East Asia: 700,000
- North Africa & Middle East: 83,000
- Caribbean: 60,000
- Latin America: 150,000
- Australia & New Zealand: 500

Total: 5 million

Community Counselling Handbook
In May 1996, during a visit to Chikankata Hospital for support and evaluation purposes, the following was revealed.

In the previous seven weeks, eight people from the hospital staff and workers had died from AIDS. Whilst HIV and AIDS had been seen as important work, it was not “owned” in terms of responsibility for action by all the hospital staff. All were aware of the importance of working for it, but it was still a matter of “balance” rather than real integration between all facets of the hospital. In early 1996 the accumulating loss caught up with the lack of true ownership. Death has been a catalyst to people seeing it as everybody’s issue.

**Loss is accumulating in the community** – this is being seen year by year since I left in 1990, and it can be characterised as increasing, accelerating, and paralysing, yet “normal”. It is so normal that the need is not seen to pause, to reflect on the rapidly changing invisible influences that determine how people think in terms of their marriage decisions, whether to have children, and how to work out relationships. The visible influences that drive people into anxiety and fear, into fatalism and paralysis, and into loss of hope are certainly present—these are sickness and death, and anxiety in those who think they are HIV positive. Yet the most important feature of the change is an invisible process hidden within the normalcy of constant and accelerating loss. This hidden process, based essentially on fear, is characterised by an inability to pause to reflect on the nature of loss, on how to commemorate that loss, and on how this is indivisibly related to a search for and a discovery of hope.

It is easy to understand why this unrecognised process is exerting its vicious and destructive effect. There is less time, less money, and less energy available for the community to store a common memory. As the invisible epidemic of accumulating loss is superimposed on the visible epidemic of HIV and AIDS, the effect is seen in a **loss of community memory**—the past and the future are being submerged into the present, which is characterised by daily existence rather than living in hope. Where will the income be generated to support the grandchildren who have just been inherited? What about school fees? What about the accelerating cost of food when the new graduate who is
promised a bank job can no longer take it up because that person is ill? Daily survival is not a new experience, but when it is happening outside traditional implicit and well established processes for storing the common memories that form a foundation of the past and anticipation of a certain future, then something is wrong.

That is the social illness associated with HIV and AIDS—and yet where it is associated with a truthful search for hope that is based in authentic acknowledgement of loss, people find new ways of commemorating events, of engaging with life, of storing up for the future, and of celebrating the past. For example, I learned that people in the rural area around Chikankata sing on the way to the burial “we are all going there”. Funerals now last for a couple of days whereas five years ago they were extended over a week. Yet people are compensating, and coping, and as they find confidence for coping and for changing, hope emerges.

HIV is everyone’s problem

HIV and AIDS affect everyone. They affect
- HIV infected individuals,
- their families and care givers, and
- their larger communities.

What are the needs for a person who is seropositive or has AIDS?

Every person is made of many parts and has different kinds of needs: physical, emotional, and spiritual. Many needs and feelings which are experienced by individuals are also experienced by families and communities affected by AIDS. The feelings of an individual may be similar to those of the family and community but expressed differently.

The individual may be angry, the family may express rejection of the HIV positive member, or the community may ignore the problem; but all are afraid.

AIDS causes fear. AIDS can cause reflection on the questions of what we do, and why.
Exercise
Discuss the situation of a young man or woman just engaged, who discovers that he or she is seropositive.

- What feelings may he or she face?
- What challenges?
- What about their families?

HIV and change

At present globally over 75% of HIV is sexually transmitted. Other means of transmission are infected needles, blood products, and from infected mother to child during pregnancy and birth.

When we understand the information about HIV and AIDS, we may also understand that something we do puts us at risk for catching the virus. We may have a family member or a friend who is at risk. Change is needed. But what should the changes be? Is change possible? Many people are discouraged before they begin, because they do not see how to change or they do not believe it is possible.

Exercise
Discuss the different challenges for a woman who earns money by selling sex, and who may want to change, but faces obstacles. Help the group to think of as many ideas as they can. Don’t start to talk about solutions or programme ideas. Try to get a good picture of the situation as it is. WRITE the responses.

- What is keeping her from changing? (For example, the community may not accept her. What about her relationship to husband or partner? Does she have children? Does she support them herself? How can these make it difficult to change?)
- What could influence or help her to change? Look at all the obstacles listed as you consider the questions.
- How are other people involved in her situation—how are the choices of other people affecting her choices? In what ways does she need others in order to change herself?
- How does this show that education does not “cause” change?
A shared experience
From Tshelenyemba, Zimbabwe

A rural community near the hospital asked the AIDS team to come and help with discussions related to HIV and AIDS.

The community knows about HIV and AIDS, and has identified things that put them at risk. The first issue they want to work on changing is the practice of all night parties, where people dance, drink, and have sex for money.

The team has gone several times for community discussion over six months. The discussion continues about the fact that these parties are a source of income and recreation, so other activities will have to replace them.

Reflect
.
- Does this community have information about HIV and AIDS?
- Do the people understand the information?
- Why have they not changed?
- What is helping them to change?
- What else would help to strengthen the collective desire and hope for change?

If we can see an example of someone who has changed his or her behaviour, we can see that it is possible to change. Young people who talk about waiting to have sex until they marry show that it is possible, even if many don’t agree.

A community that shares the problem of AIDS by trying to prevent the spread, and by caring for members who are affected, shows other communities that it is possible to respond in a good way.

Do I want to change? Maybe not, but if my family wants me to change, this could influence me. Maybe not, but if my friends also want to change or have already changed, I could want to join them.

Do we want to change as a community? If survival is threatened, or if the need of a member is felt by the whole group, we may want to respond by changing. Do we really care? If so, we will want to be involved in changing.
Someone else may change, but we always feel that our own situation is far more difficult. We can list all the reasons and obstacles that prevent us from changing. This is a normal reaction. Do people change in isolation, on the basis of individual decisions alone?

Exercise

Think of a habit that you had but have given up.
Without mentioning the particular habit, tell why you gave up this habit. WRITE the responses in front of the group.

Think of a habit that you have not changed. Why not?
WRITE the responses,

Some questions to think about and discuss with the group:

- What do I think I gain from staying the same? From not accepting or changing a habit? From denying what I know is better for me?
- What do I lose?
- What have been the most powerful influences for change in our experience as a group? Are there others?

Examples of others who have changed do help to challenge a defeatist attitude at this point. If we are still faced with the problem, it is clear that something must be done. With patience, a person or community can be helped to gather hope for change. Small steps can be taken which increase our belief that we are able to do something and succeed.

When a person or community begins to see that change is possible, the obvious obstacles can be overcome through agreement, mutual support, and creative problem solving. This may take time, because some things are more difficult to change than others. People of my own community can help me change. It does not require “experts” from the outside.

The products of change are also tools for sustaining change. For example, in Mizoram, India, women who have been sex workers can come to live at a Salvation Army shelter, where they will be counselled, and where they can learn another way to make money.

What happens when these women change? They gain health and self respect, and characteristics of reliability and honesty, and the desire to work hard. All these will help them to continue in their success.
Behaviour change is fundamental to HIV prevention and control. Change for whom? For individuals, families and communities. Yet it is still common to think change and work for change on an individual informed decision basis. Many of our changes have been greatly affected by, and even dependent on, the relationships and community to which we belong. Norms of behaviour can shift collectively, from uncaring to caring, from blaming to accepting, especially within patterns of sexual activity, as well as in other ways. These shifts are a sign of values changing within the community.

Sexual behaviour is not an individual matter, as we all know. Behaviour change is more than attitudes about condoms and “safer sex” without deeper changes in patterns of behaviour. Sexual behaviour is expressed in, influenced and affected by, whole networks of relationship contained within family and community structures, environmental constraints and cultural understandings.

These may not be bad; they are often strengths. As we look for changes in the environment surrounding personal behaviour, we must be careful of assumptions, such as “tradition and culture prevent change, especially in sexual matters”.

If culture and tradition represent strengths and the collective memory of peoples, then we must believe that they are able to fulfil their function, which is the continuity and preservation of the people.

Change in patterns of sexual activity and intercourse can be recognised as positive, not only as losing opportunity. We need to affirm human capacity to agree together and make healthy choices. This can result in very different patterns of sexual behaviour, while increasing quality of life and relationships.
How do we help change to happen?

How do we work with the awareness of groups of people, so they can reflect and become conscious of the meanings of HIV for themselves?

Where does knowledge go? Knowledge, or integrated awareness of information, must be brought into a process of reflection and increasing consciousness. With HIV, consciousness is linked to many emotional responses and cycles of acknowledgement and avoidance.

Counselling is a key tool for accompanying and catalysing a community in the process.

Counselling is a method which can help people to share a problem by “telling the truth” about it. This includes facts, feelings, understandings, elements and causes, and responses. Counselling can help the members of a community talk to each other, acknowledge feelings, accept responsibility, and plan what to do

Therefore

This handbook is about the process of counselling communities so that their strengths may be brought to bear on the challenge of HIV. Individuals and families within communities may change, cope with loss and grief, find and sustain hope.

Successful change helps more change to happen, because energy and motivation increase. Results include:
  . decreased transmission of HIV,
  . increased capacity of community,
  . increased quality of life,
  . increase in our understanding of mission, and
  . influence on policy by demonstration.
THE COMMUNITY

In which we consider **wider circles of confidentiality; the power of community action, and care-especially home visits-as an entry to community motivation**, we do some **case analyses**, and consider the **nature of community**, which **sometimes needs help**.

Communities are made up of relationships. It is these relationships that will bear the strain caused by HIV. When **HIV enters a community, changes begin to take place** immediately, in a ripple effect from the person who is infected, to his or her closest others, and, invisibly, to the surrounding community.

Communities become aware of something happening . . . there is uneasiness . . . curiosity masks anxiety . . . information becomes a source of fear and speculation, as other ideas are attached to the “facts”. This is **part of what is called “shared confidentiality”:** when the community knows what is going on inside it, without saying it aloud in so many words.

**There are wider circles of confidentiality**

A classic “Western” view of confidentiality is based on a one-to-one private relationship, which is often a kind of secrecy. Figure 1 illustrates how “professional circles” of confidentiality are not the only circles. In reality, there are different forms of confidentiality from different points of view.

**One to one confidentiality**: This is therapist to client, client to friend, relative to relative

**A shared experience from Ahmednagar**

_In Ahmednagar, India, at a hospital, a young man came to see the social worker because he was worried that he might be HIV positive. The social worker counselled him through the testing process, which showed that he was HIV positive. The social worker assured the young man that he would not tell anyone else about the diagnosis without his, the client’s permission. The young man planned to join the newly established support group._
FIGURE 1 Present realities in communities
Wider understanding of confidentiality
Professional confidentiality: This is longstanding and it is often assumed without being defined. There are circles of knowing within the categories of professional staff, caregivers, scientists, hospital staff, people who write about HIV and AIDS, and people who make decisions in organisations and governments. It is very commonly the case that people know, and this knowledge diffuses with the expectation that basic ethical principles, common to “medical ethics”, will be observed. There is in fact a direct parallel to the process that is observed within communities, and it is more widespread than is usually acknowledged.

The shared experience continues

The story of the young man—we can call him Benjamin—has now been shared with you, as it was with the visitors to the hospital. The social worker had brought the doctor in on the case, and the team there had discussed the case as part of counselling support and training.

Family confidentiality: In this case family usually refers to biological family, and yet can also include, for some, the circle of intimate others in which there is trust, and identification of intense belonging, to which there is loyalty, and (consistent) commitment.

Benjamin went home and talked to his father and brother. Together they gathered with his mother and sisters, and he told them about the situation.

The family decided it would be okay for the social worker to visit them at home.

Shared confidentiality: This refers to the diffusion of information, from inside a “private” experience of an individual or a small group or a family, to the wider community. This is usually non-verbal, it is usually not acknowledged, and it often causes anxiety because of that; and yet information does get out one way or another, in all cultures. This is perhaps related to the common observation that people in stress need to share burdens, and prefer to either “declare” or “hint” the truth.

A group of visitors from the hospital was travelling to a village to discuss HIV with community leaders. On the way they were to pass the teashop run by Benjamin’s family. In order to test the probability of community consciousness and
shift it in a positive direction, they decided to stop at the teashop just for tea, and see what would happen.

The social worker and doctor went ahead to check with the family and Benjamin, to see if the group would be welcomed.

The family invited the whole group not to the teashop but to their home, just behind the teashop. Tea was served there, and conversation was friendly although a bit cautious.

Then the local community leader appeared in the doorway. He came in and sat down, and the social worker introduced the group as people who are working with HIV from India and outside India. The community leader put his hand on Benjamin’s shoulder and said, “Take care of our friend”.

The hospital team realised that they were not the “gatekeeper” to community awareness, but that a natural process was taking place.

**Community confidentiality:** This is focused on issues rather than persons, although through the process of confidential sharing it will be known that some people in the community are infected with or affected by HIV. Even so, it is possible for the community to look at their own responsibility collectively, in terms of the issues that pose a threat, and although these issues are intensely personal, they belong to all rather than to just a person who may be suspected to have HIV.

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Outside the teashop of Benjamin’s family, a few team members were standing, because the house was small. People approached them casually to ask about the visit. One team member was inclined to pretend no connection to the family, that it was just an accidental stop for tea. Another team member saw that people had some idea already. Rather than deny, she asked them questions, about their thoughts and concerns related to HIV. The conversation shifted from curiosity about Benjamin’s family to consideration of the life situation of the community, their own issues and risks. They said that HIV would be a problem for the whole community.

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**When the community responds**

If a programme team goes to the community with predetermined plans or ideas, the results are not usually good. Yet, when communities decide to take action, it seems as
A shared experience from Uganda

though nothing is impossible. New ideas and plans will emerge.

A local Salvation Army congregation has put money together with other congregations in the community, enough to form an income generating activity. Proceeds are used for children in the community who are in need. Adults and elders in the community also help the households headed by children with farming and marketing. No outside money has been used.

The Statement of Belief and Figure 2, which follow, mention some of the influences on community action, and affirm a strong belief in community capacity to act.

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Statement of Belief

We believe that individuals and whole communities have the inherent capacity to change attitudes and behaviours. The power to fulfil this capacity is often denied or is not exercised.

The power must now be recognised, called forth and supported from both within and without. This will enable people to initiate change and sustain behaviours that promote a healthy state of mind, body, spirit and environment. A critical component in this process is a supportive response to those living with HIV in the community.

We recognise that behaviour change at individual and community level in the present HIV pandemic is a complex and on-going process. It is inextricably linked to such basic human values as care, love, faith, family and friendship, respect for people and cultures, solidarity and support.

The present pandemic affects everyone. Our experience as affected and infected individuals proves that behaviour change is possible. We believe that behaviour change is the most essential strategy in overcoming the HIV pandemic.

--From BEHAVIOUR CHANGE: A Central Issue in Responding to the HIV Epidemic, an informal consultation conducted by the United Nations Development Programme in Dakar, Senegal on 12-15 December 1991, through partnership with The Salvation Army, Save the Children Fund (UK) and the UK NGO AIDS Consortium.
FIG 2 Community Response to HIV/AIDS and our role: Intervention compared with Participation

New experience of loss and potential loss

CONTINUUM Of PARTICIPATION through facilitation relationship

INTERVENTION
“prevention”

“care”

COMMUNITY
(strengths and weaknesses)

CARE
CHANGE and PREVENTION in the wider community

CAREING in circles of relationships

CHANGE in circles of relationship
Other influences that support change include community, tradition, culture, media, and environment. In the experience of many programmes, the strongest influences are within community.

What will motivate a community into change? What entry points exist into community motivation? Programmes often begin with information sharing, or information gathering about needs, but if there is no relationship of care, the information will be ignored or cause anxiety, which can be expressed as denial.

A relationship of care is an entry point to community motivation

How is a caring relationship established? Through many ways, such as

- Existing programmes which are in the community (for health, worship, social concerns, etc.)
- Institutions which “get out” to the community.
- Home visits for any reason.

What is the meaning of home visits?

<table>
<thead>
<tr>
<th>Exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the following questions:</td>
</tr>
<tr>
<td>. What is the meaning of home?</td>
</tr>
<tr>
<td>(Some elements, for example, are: the origin of care, the context for care, the place where people are supposed to care for each other and form attitudes and behaviours, intimacy, safe place to share. . .)</td>
</tr>
<tr>
<td>. What does it mean to enter someone’s home?</td>
</tr>
<tr>
<td>(For example: to be a guest to “feel at home”, to be welcomed and put at ease, to be cared for, to be seen by neighbours as a friend. . .)</td>
</tr>
</tbody>
</table>

Community counselling is influenced by home visits.
Home visits and community counselling combined together in the same location have a greater impact than either one alone. Home visits in this context are not just an expression of our care for others. Our awareness of the link to prevention because of people around the home situation can increase the care of people for each other and normalise the situation. The result is not only increased care, but increased motivation within a location to meet and discuss common concerns. This is the entry point for community counselling.

**Confidentiality** in a home is about the issues of individual persons. The same concerns may be brought into a community conversation with confidentiality about the issues raised and felt within the community. This is “issue centred” rather than “person centred” confidentiality.

What kind of home visits? Visits by a team, usually by invitation of someone in the home, when a shared concern is expressed in the context of shared confidentiality.

In lower prevalence areas, home visits are essential for building motivation for community conversation. In higher prevalence areas, home visits are essential for maintaining motivation for community conversation.

Regardless of prevalence, home visits are linked to the reduction of stigma.

Experiences from Mizoram, India

“We have felt God’s presence so clearly in all the home and community visits.”

“We’re on the right track in this working way within home and neighbourhood.”

Experience from China

“We have seen real human language and not jargon.

*We have to have a vision for follow up. . for HIV positive people but also for sick people."

This was in the context of a health programme. However, in Mizoram, people are visiting in their own neighbourhoods, because of concern for neighbours. As a result, motivation within the neighbourhoods is increasing. When the community people are ready, community meetings will begin, and can lead to community counselling.
In relation to drug using as a major source of risk, here are shared experiences from two very different places.

<table>
<thead>
<tr>
<th>Experiences from Mizoram</th>
<th>From a group of volunteers from a Salvation Army congregation (corps) in Mizoram.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Through simple visits we are already showing care. Health care is more difficult-we will need help (to know how to do that)”</td>
</tr>
<tr>
<td></td>
<td>“Not preaching, but asking how they feel, how they got into this addiction.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience from China</th>
<th>From Gengma County in China, on the border of Myanmar:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“If we can connect each family and each community it will help to decrease addition and help do real work.”</td>
</tr>
<tr>
<td></td>
<td>Home visits in particular are opportunities to build relationship and demonstrate care. Multi-disciplinary team formation and way of working are important, because care can be expressed in various ways, depending on need and the situation. Team formation can include neighbours and friends, as in Mizoram as told by a volunteer:</td>
</tr>
<tr>
<td></td>
<td>“Two sons are affected. They have another friend who is paralysed—the mother wants to take us there and go as a team member.”</td>
</tr>
<tr>
<td></td>
<td>The result can be that the programme is not defined so much by what it “provides”, but by the ways it is invited, and by caring which brings people together, enables expression, and increases motivation for constructive action. This happens in the intimacy of the household and a shared confidentiality of community conversation.</td>
</tr>
</tbody>
</table>

**What are the characteristics of genuine care?**

- Respecting
- Listening
- Taking time
- Being on the same level, alongside

HIV is a powerful catalyst to community response. This issue has more impact than other health or development issues, in part because it will create other health and development issues, but also because the fabric of relationships is under threat, into the future.
However, until the community acknowledges the issue, HIV can catalyse denial, avoidance and blame. Community counselling is a method to help the community acknowledge and work together into the future, with all the concerns and reactions that may arise.

**A comparison of two communities from Mizoram**

The chart that follows (Figure 3) represents an effort to open analysis about the experience of the team in a few locations where they have been working through discussion with leaders, home visits, and some group and community meetings. The actions and results listed are from the perspectives of both the Community Health AIDS Network (CHAN) and the community.

Some of the premises for community analysis are:

- Some communities move more quickly than others.
- Home visits do help a community move toward desire for action as a group.

### Exercise

Look at the comparison of the two communities (Figure 3).

- What seems to influence the response of the community?
- What do we see here that would need further exploration, by conversation or discussion with particular people, in order to understand better the community’s response?
- How can the community and we find out more about the part that home visits play in their motivation?

### Other case analyses

#### Exercise

In the following cases, consider the community reactions, team entry points, and how the community reaction changed

**A shared experience from Mizoram**

_A group of reporters come to interview the AIDS team._

_At first they were quite aggressive._

_HIV positive people should be identified and thrown out of the community or put in jail, they said. So the team questioned the reporters: would they like to be tested right_
away, and any found HIV positive could be isolated immediately. This, of course, was not what they had in mind. They said that all prostitutes should be tested. The team asked, who would usually go with prostitutes, and whether the clients might also be infected. Wouldn’t this mean that families could also be affected?

The reporters became more thoughtful as the implications were clear: they themselves or people close to them could be infected.

Discussion then turned to their responsibility within the community to give right information carefully and with compassion, not sensationally. This should happen both within the media and in their own families.

Reflect

. What were the reporters trying to do?
. What caused the reporters to stop blaming others?
. What attitude did the team have to show?
. What was the goal of the team during this discussion?

A group of men from a farm community were seen one morning dragging a fellow worker towards the hospital. When they got to hospital they demanded that this man be tested for HIV. The reason was that this man was being visited by the AIDS team (hence suspicion about serostatus) but also he was known to be sexually involved with several women on the farm.

The community was angry because of this, and wanted to know for certain so that they could “stop him” from spreading the virus. This they were going to do by throwing him out of the community.

The AIDS team talked with them and finally it was agreed that the team could come back to the farm and have discussion with the community on this issue.

A heated discussion followed. It became clear that the community members were afraid. The fear of AIDS was expressed by anger at this man because they thought he was bringing AIDS into the community.

Reflect

. Why is throwing the man out not the solution?
. What choices does the community have?
. What do they need to help them choose?
. How would you continue the discussion with the community?
. What goals would you keep in mind?
### FIG. 3 A comparison of two communities from Mizoram

<table>
<thead>
<tr>
<th></th>
<th>Dawrpui</th>
<th>Zarkawt</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Entry point</strong></td>
<td>Team members live there. 2+ clients.</td>
<td>Invitation. Some clients.</td>
</tr>
<tr>
<td><strong>Influences</strong></td>
<td>Village Chairman very committed. 5 deaths, not mentioned directly. Market, transit, military area. Prestige as a leading locality</td>
<td>CHAN ex-client very active. Many died in well-off families. Church</td>
</tr>
<tr>
<td><strong>Way of work</strong></td>
<td>CHAN has been visiting clients in their Homes.</td>
<td>CHAN has been visiting clients in their homes.</td>
</tr>
<tr>
<td></td>
<td>CHAN team member living in the locality approached the village council leader, found common concern, and began to work together under his authority to call meetings.</td>
<td>Mediation by CHAN between young people and their parents; “confrontation”. Meetings with community leaders.</td>
</tr>
<tr>
<td></td>
<td>A small group of concerned people visits in homes by their own initiative.</td>
<td></td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td>Reducing hawkers selling. Changes in Saturday market people coming during the night to book their places. Identified peddlers who sell drugs. Monitoring public toilets. Coordinating between localities. Street patrol of YMA/VC. Getting addicts into group, giving counselling in “halfway house” then referring to “homes”. Letter to commander of Assam Rifles about their link to cinema and sex work.</td>
<td>Beatings, counselling. Gospel camps. Patrolling, especially during heroin outbreak. 10 youth sent of out Mizoram for rehabilitation</td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Halfway house they don’t feel is best (self evaluation). Thinking about home and neighbourhood response.</td>
<td>Crisis with heroin has passed. No longer inviting CHAN at community level. Families trying to solve their own family member addictions.</td>
</tr>
</tbody>
</table>
What is community?

Community may be defined as people who belong to each other with shared identity and values, with members who are, and have capacity to be, responsible and accountable to each other in various ways, and who can community with each other for the purpose of shared problem solving. Often this is the neighbourhood surrounding a home.

Exercise

Think of a “community” where you are known. Go and visit. Enter into conversation with people you meet or arrange a meeting with leaders. Ask, what are their strengths? their concerns? their hopes? as a community. Then reflect as a team.

- What did we learn?
- What other strengths did we see?

The most important capacity is that of being able to reach agreement which builds responsibility of members to each other.

By this definition, a kinship based village is a community, and a group of people who work together can become a community. People who work together are responsible to each other and accountable for the job they are doing, and often have to solve problems together.

Another example could be people who do not have homes but who live on the streets. People who live on the streets have to take care of each other, although they may appear to be isolated individuals. Some are leaders and organise food gathering or shelter for others. This community has its own ways of solving the immediate problems of food, shelter, and protection.

Different forms of agreement are probably used here than are used in a workplace. Every community has its own methods, usually unwritten, or “understood”, to take care of itself.

Exercise

The following questions can be answered by each person and then discussed as a group, or, if the group has at lease one community in common, the whole group can discuss. WRITE the answers for all to see.
The natural life of community is one of development and problems solving, just as it is normal for a person to develop. However, some communities work well together, and some do not. For example, in some families members function just as individuals, without helping each other, while other families may talk together about every major decision the members make.

### Exercise

Go back to the community. Ask a group of elders about the history of the community. What major challenges have come, and how did the community react? (How did they feel, what did they do?) How did they agree on what to do? What was the result?

- Make a time line from this information.
- What does it say about ways the community comes together and works together?
- What kinds of circumstances have brought the whole community together?
- How can HIV be compared to any of those circumstances?
- Was HIV mentioned? Why, or why not?
- What changes has the community seen, and what provoked those changes?
- Which have been sustained, and why?
- Did this discussion have an encouraging effect on the group? How?
- Where does this experience lead?

WRITE any other questions your team has discussed based on this experience.

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### Communities can need help!

Communities may need strengthening, with help from someone who is not a member. In rehabilitation programmes, people recovering from addictions learn to support each other in trying to overcome common problems. This happens by working together as a group with a
facilitator. The group is becoming or can become a community.

HIV and AIDS is a shared problem. When a family member becomes infected, the whole family is affected. However, the whole family may not agree that they are affected. As we know, the first reaction to the news of HIV infection is denial, or avoidance: “It isn’t true”, or “It isn’t my problem”.

Two sisters, Rose and Freida, come to the clinic because Freida was sick. The nurse in charge referred her to the hospital. After some time, Rose came back to the clinic and told the nurse that Freida had been tested for HIV and was HIV positive, but she was denying it. As they talked together, the nurse learned that four sisters were staying together, and that three of them (including Rose and Freida) had worked in the neighbouring country as prostitutes.

Rose did not mention that she herself could have the virus, but that Freida was HIV positive and that all the sisters were aware of this. In fact, Rose was also getting sick by this time.

Rose asked the nurse to come and talk to her family. This family is an example of community which needs help to share the problem and work together.

Reflect

. Why do you think Rose did not mention that she might have the virus?
. How could talking to the family help
. How would you begin a conversation with the family about this?

Exercise

Think of a person “at risk” for HIV infection (do not use real names or identifying characteristics.) WRITE your answers to the following questions for the whole group to discuss.

. List this person’s communities. Take time to think about it-some may not be obvious, or may not be strongly linked up at the moment.
. How can these different communities influence the behaviour, values, or choices of this person?
. Which of these communities can be of the most help to the person, if he or she wants to change somehow?
. Where are you in this picture?
By themselves, community members may avoid the problem and reject a member who is infected. This is one way that AIDS can disintegrate, or break apart, people from their relationships.

BUT it is also possible to help a community to share the problem. How?

**How do communities reach agreement?**

Some sit and talk together until everyone shares the same point of view. Some bring a problem to the leader, and after everyone tells their “side” of the story, the leader decides what should happen. Talking together in some way is necessary for a community to reach agreement. There are different forms of decision making, but “agreement” means that when a decision is reached, the members will follow that decision. Sometimes this means that they agree to disagree agreeably.

A shared experience

**From Chiweshe Zimbabwe**

Agricultural extension workers were discussing the risk of HIV infection through multiple partners. They agreed that they should set an example of safe behaviour, as leaders of the community. But how do they influence each other?

Individual members of the group said that they do speak to a colleague if it is known that he has several partners. This is influence from friend to friend.

The question was raised about their capacity to develop codes of behaviour for themselves, if they are all agreed that they should set such an example. This would require them to feel even more responsible for each other.

Care is shown here as the biggest influence for behaviour change, because people are included in the problem and become able to see or find solutions. Needs are understood and solutions formed around the person in need. When people feel cared for, they are often more able to change in good ways.

The influence can be multiplied in the neighbourhood if community counselling happens in parallel with home visit approaches.

A shared experience

**From Rio de Janeiro, Brazil**

The first person known by the favella community to have AIDS ran away before the team was involved, and died shortly afterwards. The team felt that if they had known in time, they could have helped the family and community care for and accept this man.
This experience motivated the team to be much more active in building community awareness about attitudes towards people infected with HIV.

Soon a woman told the team that her daughter was HIV positive. Different members of the community joined together to help the mother care for the sick daughter and the daughter’s four children.

One day the team was met at the entrance to the favela by several community members who were concerned because the daughter had TB. She was afraid to go to the clinic, fearing that she would be treated badly because she was HIV positive. Meanwhile, her children were being exposed to TB. The community members wanted help to talk with her and sort out the situation.

Reflect

. Why do you think the woman talked to the team about her daughter?
. What were the community members afraid of?
. What was the team doing to help in this situation?

Exercise

Look together at the following table of behaviour change strategies from a community counselling process. Discuss the meaning of these.

<table>
<thead>
<tr>
<th>Community determined strategies for prevention, and corresponding indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstinence until marriage</td>
</tr>
<tr>
<td>. Rate of STD’s (sexually transmitted diseases) among the unmarried</td>
</tr>
<tr>
<td>. Number of pregnancies of unwed mothers</td>
</tr>
<tr>
<td>. Frequency of drinking parties (connected with sexual activity)</td>
</tr>
<tr>
<td>Law banning ritual cleansing of a new widow or widower by sexual means (see page 45)</td>
</tr>
<tr>
<td>. Compare number of deaths (in which there is a surviving spouse) to method of ritual cleaning used</td>
</tr>
<tr>
<td>Faithfulness in marriage</td>
</tr>
<tr>
<td>. Rate of STDs among the married</td>
</tr>
<tr>
<td>. Number of assaults and court cases due to having sex with someone else’s wife</td>
</tr>
<tr>
<td>. Rate of divorce (frequency)</td>
</tr>
</tbody>
</table>
. Rate of re-marriage (frequency)
. Frequency of drinking parties (associated with sexual activity)

Resumption of teaching on traditions
. Number of initiation ceremonies, and number of teaching sessions on traditions, sexuality and AIDS
. Number of times families have teaching sessions on traditions, sexuality and AIDS

<table>
<thead>
<tr>
<th>Reflect</th>
</tr>
</thead>
<tbody>
<tr>
<td>. Are some of these changes deeper or more difficult than others?</td>
</tr>
<tr>
<td>. How will the community know if these changes happen and are sustained?</td>
</tr>
</tbody>
</table>
COMMUNITY COUNSELLING

In which we look at *how the community counselling process works,*
*And we explore counselling skills through role plays.*

How counselling works in communities

**Community counselling is a process for helping a community to acknowledge issues, losses and feelings,** as these are the emotional dimensions of relationship, intimacy, family life and future, and collective responsibilities and rights. The nature of HIV and AIDS makes it an issue particularly suited for this process.

**Counselling with a community is a process for helping acknowledgement and agreement to happen, leading to problem solving and behaviour change.**

This has developed in response to HIV and AIDS, because so much change is needed in order to overcome this disease. The facilitators of the process are sometimes called community counsellors, but they often have other tasks. Their function is to help sustain motivation, so some call them “community motivators”.

**Community counselling is an ongoing series of facilitated community discussions,** in which feelings and issues are explored and acknowledged, norms and actions are assessed, choices are considered, and decisions and commitments are made about the life of the community.

Note that *participatory methods and activities* can also be used to strengthen community consciousness of the realities among them (see Chapter 5). This consciousness is the source of acknowledgement and action planning in the ongoing discussion meetings.

**Home visits** in the same neighbourhood also influence the consciousness of the group. Home visits are a necessary part of the strategy of community counselling. Issues within homes can be shared through developing relationship and using a counselling approach. These visits, with their own kind of confidentiality, will help concerns to come out in the
community discussions. The shared unspoken awareness, or **shared confidentiality**, is the source of acknowledgement (see pages 24-27). We as facilitators should not fear the opening of concerns in the community discussion. We can help issues to be acknowledged without direct reference to infected or affected individuals—without “naming names”.

When home visits and community discussions are happening together, the change of attitudes and actions within the neighbourhood will be faster.

**A pattern for home visits**

**In home visits and community discussions, a similar pattern can be followed.** The facilitator greets, and helps everyone to feel at ease. Through some questions the facilitator opens the conversation, and then follows the line of discussion, keeping focus on what will lead to deeper reflection. At the end, some should summarise, and finally there should be agreement about what will happen next.

This is not a formal outline, but a pattern to be expressed according to the cultural context.

**Guideposts for facilitators**

**What guides the facilitator/counsellor?**
Expressions of feeling, emotion, comments about relationship, and any element of telling the truth and letting something out into the open—these are guideposts along the way to shared understanding and acknowledgment. Sometimes the counsellor will need to pose a question to provoke thinking or challenge the surface of what is being said, in order to help the truth to come out.

Counselling includes listening, reflecting back what has been heard, checking whether all agree or understand in the same way, helping people in the group to talk with each other about the meanings of their life together, asking probing questions, clarifying, challenging at times... for the sake of the community’s self-awareness, belonging, and reconciliation, from which agreement and action can form.

As truths about community life and risk are acknowledged in ever deeper levels of shared confidentiality, a sustained counselling process is needed to help the reflection on meaning, and to facilitate movement out of despondency or helplessness into positive action.
Grief is essentially the same for communities as for individuals:

**What are some of the predominant reactions that a community group experiencing loss and grief may have?**

They are essentially the same as those an individual or family would have: anger, denial, depression, bargaining... These are normal reactions, which appear and re-appear.

But what are the tasks that must be faced by any individual, family or community when confronted by grief?

- Acknowledgement of loss...
- Reinvesting in life...
- Searching for hope.

**Exercise**

Consider the signs and tasks of grief and hope. How do they appear in a community you work with? How could you respond? What skills are needed?

Consider the example of your group process and your own process of accepting AIDS as “our” problem.

**Community counselling helps a community do the work of acknowledgement so they will be able to invest in life.** Planning for response represents investment in life. It always is a sign of hope. Communities that have been living with HIV for a long time can lose energy and lose hope. Communities that are just becoming aware of a new challenge in their midst, in addition to all the other challenges they face, may try to avoid their own awareness. Yet the awareness is there, and it will drain their hope unless it can be acknowledged.

HIV is clearly a problem which is denied. Often the community counsellor must help the community to realise the problem they are facing. This is a challenging task which sometimes takes a long time. A counselling approach is used because fear and denial are an ongoing struggle, and because people must decide for themselves what to do.

**The counselling process** contains these elements:

- Relationship building
- Problem identification and exploration
- Decision making
- Implementation
- Evaluation and ongoing problem exploration
- Decision making and implementation
These elements are expressed in the community over time, which may be slow or much faster than we expect—so we have to facilitate, not push, and follow the guideposts.

When relationship with a community is developed enough to allow discussion of HIV and related issues, exploration of problems from the community’s point of view can take a long or a short time. The facilitator/counsellor needs sensitivity to help the group move to decision making. Sometimes the discussion can be too big, but in the beginning it may be important to explore a range of concerns.

If the facilitator becomes too anxious to reach a conclusion, some deeper issues may not come out and be acknowledged. So, although each meeting should conclude with the question, “What next?”, at times the answer may simply be to meet again.

A community may feel there is only one solution needed, and only later realise other aspects of the situation. Through questioning about the results of action they have taken, and how they know what these results are, the group will be able to explore further and consider other concerns.

The first place community counselling was used as part of a Salvation Army AIDS response was in Zambia. The first communities to do the community counselling process made strategies in four categories:

1. **Training**, which would require input from the Chikankata Hospital team.
   
   Result: *a*) A training programme has been established for community selected community counsellors. *b*) A programme for church leaders has been developed by request, attended so far by the church leaders from two communities.

2. **Legal action** to abolish ritual cleansing, a traditional practice by which a new widow or widower may only remarry or have a sexual relationship after being “cleansed” by a designated member of the family of the deceased spouse. This requires discussion with the chief of the particular area, and the vote of a majority of headmen under that chief.
Result: Three chiefdoms were represented by the first communities: Two chiefs have passed the law, which affected nine of the ten pilot communities, along with many other communities. One chief has not yet agreed to the change. Two community counsellors have been trained for the pilot community in this chiefdom, and they form a team with their village headman to influence other communities. They are confident that the law will be passed.

3 **Re-institution of traditional** teaching and ceremonies at village level, which would require discussion by the headman with village elders and communication of the decision to the village members

*Result:* These decisions have been passed in several of the communities. Measurement of change is still needed, through the health clinics, teachers and village council. Further work is planned with the women involved in initiation ceremonies, as this is a source of traditional teaching.

4 **Establishment of a church** to bring the community together and influence lifestyle, which would require the choice of a place and time to meet.

*Result:* Two communities have established churches; these are heterogeneous communities, and church was seen as a way to form common group among their differences.

These strategies came from the first round of strategy formulation. The communities continue to discuss other issues related to behaviour and AIDS, such as use of alcohol within the community, and employment options for women. The process is ongoing, as needed for such a multi-dimensional problem.

**Reflect**

- Will the strategy solve the problem?
- Will it help?
- How have these communities succeeded?
- What will happen now?
Some counselling skills

Respect
Show respect by, for example, clearly introducing yourself and why you are in the community. Also ask for explanations of things that are unfamiliar, rather than act as though you know.

Open Questions
Ask questions that cannot be answered by “yes” or “no”, but rather require discussion.

Redirected Questions
Put the question back to the person or group, rewording if necessary. This keeps responsibility for answers and comments with the group.

Active Listening
Give signals to indicate you are following the discussion intently, and signify this non-verbally.

Clarifying
Ask a question to make sure you heard what was said or expressed. This helps the group to interpret and agree on meaning.

Reflective Listening
Listen for what is implied, asking about what is really being asked or expressed. This helps to open assumptions, feelings and interpretations from the group.

Probing
Ask questions that will help you and the person or group understand the problem, and that can show a different side of the situation.

Paraphrasing
Give back to the person or group what they have said, so that you can make sure you have heard what they were trying to say. All may agree on the meaning, or the group may explore other aspects.

Summarising
Give an overview of what has been said in the whole discussion including any decisions and conclusions that were reached. This helps to keep the discussion “on track”.
Examples of role plays

**Exercise**

Work out the following role plays, using these skills. These are *examples* of role plays. Make up and write down others, based on *your own experience*.

Have the observers note the skills they see, and also note moments when a particular skill could have been used. The facilitator can stop the role play at any point to discuss with the group what the dynamics are or what approach could be used, or to point out a good interaction by the counsellors. Get different ideas of questions that could be used.

1. Some women of the community do sex work in the town, and come home from time to time. One of these women has been losing a lot of weight. People are saying that this woman has AIDS. They are saying that the prostitute women should be chased out. The sick woman has gone to hospital for treatment, and because of her symptoms a test for HIV was recommended. When she heard this, she broke down, crying because of what the community had been saying. She was sure that they would not let her come home. The AIDS team has arranged a meeting with the community leaders, to be held while she is still in hospital.

   ✨ Note what skills to emphasize in each role play

2. The counselling team is interested in working role with a community that has had two deaths from AIDS recently. You approach the community headman to offer your time to explore the issue of HIV and AIDS with the community. The headman is not convinced that there is a big problem of HIV and AIDS in his community. He invited two other leaders to join this meeting. How will you convince them?

3. A community that your team has been working with for the last six months has made some decisions about what behaviours in the community are putting them at
risk for HIV infection. These include women and men attending the same beer parties. The solution that has been suggested is that the women should be excluded from these parties. Another behaviour that was identified was that of premarital sex. The community gave themselves the task of trying to think of a solution to this. Your team feels that the major task of your next meeting will be to see whether or not the community have implemented their decision on the issue of beer parties and to explore some solutions to the questions of pre-marital sex.

Write your own role plays from your team’s experience.

4. You and your team have been working with this community for one and a half years. They have made decisions about what behaviours should change in the community to help prevent the spread of HIV. The next meeting’s task will be to find indicators of change within the community and possibly to evaluate how well change is being implemented. (The counsellor team and the community need to decide what changes the community have come up with before the role play begins.)

5. Your community is located on the border of another country. Because of insufficient job opportunities, a lot of men in the community leave home for long periods of time to work in the neighbouring country. As the community counselling process has progressed, the issue of men having to live for long periods of time away from their families has been identified as a major risk, because men get involved sexually with other women. Your community is meeting with the counselling team to examine the issue closely and to see what solutions can be found.

Reflect
Debrief after the role plays: How is it like the counselling you have done with individuals or families, and how is it different?

A shared experience from Ghana

A grandmother brought her adult granddaughter to the hospital and said to the counsellor that the family did not want the granddaughter to live with them anymore. They were angry with her, saying that she was sick all the time,
couldn’t work in or out of the house, and they were tired of taking care of her and paying all her medical bills.

The granddaughter had actually been tested at the hospital, and had known she was HIV positive for two or more years. But she had not told her family.

Her counsellor encouraged her to tell the grandmother that she was HIV positive and explain the meaning. When the granddaughter told the grandmother, the response was surprising. The grandmother said, “We knew this, but we have been waiting for you to tell us. We are your family; why shouldn’t you tell us about such a problem? As long as you were keeping a secret we would be unwilling to continue with you, but now I think we can go home together.”

Reflect

- What reason did the grandmother give for refusing to care for the patient?
- What was the real reason?
- Why do you think the granddaughter did not tell the family what was wrong with her?
- How do you see the steps in the counselling process in this example?
PARTICIPATORY METHODS

In which we consider how counselling works with participatory methods, and look at some examples of participatory methods.

How community counselling and participatory methods work together

Participatory methods are well established as part of survey and community development methodology. They are used for collecting information as part of programme planning, for raising the consciousness of community members about their situation as part of community development, and from the learning of the team. These methods are sometimes grouped under the name “participatory action research”, or “participatory learning action”. They are not usually described in a counselling context, so that is the purpose of this section, because the use in counselling will be distinctly different.

During any counselling process, there may be times when a counsellor will help a client to work through an exercise or an activity in order to bring issues to their awareness which have not been consciously addressed before. By beginning with what is known, and mapping or diagramming, or describing again, new insights come about the meanings attached, implications and emotions are clarified, and further areas for discussion or action become evident. This is true also in a community counselling process.

Information is usually known already, but not brought together into the community consciousness; rather it is accepted as part of life and often not thought about or questioned. When community members share a consciousness by naming situations within their common life, those situations can come into question. This also means that they could be changed.
The context of HIV contains particular challenges, because of the nature of consciousness that leads to change. Many of the situations which will be named contain hidden sexual and relational meanings and use of power. The process of helping situations to be named so that choices become more apparent and more available, is delicate, complex, potentially volatile, and yet necessary.

Young people, in talking about sexuality, were helped to form a chart of the most common and least common combinations of sexual activity within families. Some of the categories were cousins, brothers and sisters, mother and son, father and daughter, brother in law with sister in law, etc. Various possible combinations were listed and the young people added a count of how often this may happen. Most of the combinations were said to happen, although mother and son was the least common.

Reflect
- Where does this information lead? Who owns it?
- What will be the effect on the young people of putting together what they know as individuals?
- What emotions or issues may be stirred up?
- What if they do not acknowledge feelings about any of the content?
- How can their experience be part of a community counselling process?

A participatory method in this case was used to explore the experiences of a particular group within the community, to raise the collective consciousness.

The counselling context around this method will help them to:
- acknowledge their feelings about the situations,
- think about where they want to change,
- consider options, and
- bring this experience into the larger group.

But where will the ideas come from? How does the facilitator team know what subject to raise? Look back at the records of past discussions with this community. What other issues have been raised? The subjects should come from the group which has been meeting, or from others within the community who may not have been heard before.
Indicators of change

The information shared during a participatory process such as community counselling always belongs to the community. The action to be taken also belongs to and is named by the community. Indicators of change and increasing capacity can equally be named by the community as belonging to it. Most of the participatory methods are made so that community members document as the methods are being used.

Documentation

One of the unique dimensions of a community counselling approach is that potentially every community member is a part of that process. Therefore, the voices which are less often heard can be brought out through participatory methods. Also, those who hold power, even though they may abuse it, are part of the discussion. The process is not divisive but integrated, and the presence of a facilitator team helps to support consensus that is beneficial to the whole. At the same time, social action may be taken by members of the community in order to apply pressure for change, and this would not be outside the range of community counselling.

An example

All the wives in one community refused to have sex with their husbands returning from travelling out of the country, until they got tested for HIV.

Reflect

How would you work with this action to encourage further reflection within the community about behaviour, roles, relationships and responsibilities?

An example from Sri Lanka

In one community a retired policeman traps young boys from age 7 into sex work on the nearby beaches. This is known by the members of the community, but they are not sure what to do about it.

His involvement in community discussions is unlikely to cause a change in his behaviour, and they feel unable to directly challenge him, but if the community gathers its awareness together through a process, they will be more able to take some collective action to influence the situation.

Participatory methods are also useful to help the community move out of complacency or a plateau, back into acknowledgement and action. In chapter 2 is the story of a community in Zimbabwe which is “stuck” and cannot decide...
what to do about the beer parties which are their major source of risk behaviour. At the same time, these are a major source of entertainment and income. Participatory methods can be used in this situation to:

. **remember** what has already been accomplished (through forming or updating a time line),
. **examine other aspects** of the community life which may require change, such as attitudes or involvement in care or family relationships, and
. **discover other voices** within the community, where other issues may be felt to be equally important.

## Some participatory methods

Some of the methods are commonly used in the facilitated community discussion. For example:

### Ethnohistories and biographies

Histories that outline important local events, trends and changes, as told by elders or knowledgeable individuals in a community. These individuals may also describe their own experiences and life events in the form of oral biographies.

### Local stories, portraits, and case studies

Brief summaries of a household’s history, a farm coping with crisis, how a conflict was resolved; descriptions of situations encountered by the team; or stories recounted by local people. Can include folklore, songs, idioms or commonly used phrases in the local language.

### Time lines

Time lines provide a history of major recollected events in a community with approximate dates, and discussion of what changes have occurred and why (cause and effect).

Other methods are described and illustrated in handbooks such as *Power, Process, and Participation—Tools for Change*, by Intermediate Technology Publications Ltd., 103 – 105 Southampton Row, London WC1B 4HH, UK. (Salvation Army regional coordinators will have a copy.)

Communities and teams can invent their own methods, as these methods are similar to natural approaches which have been given names.
<table>
<thead>
<tr>
<th>Use of documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In summary</strong></td>
</tr>
<tr>
<td>Participatory methods help the community to gather information about itself and this is important in the community counselling process.</td>
</tr>
<tr>
<td>Participatory tools are very helpful for:</td>
</tr>
<tr>
<td>. drawing out experiences and voices which might otherwise not be heard, and</td>
</tr>
<tr>
<td>. helping the community to “move on” from a plateau or resistance to change in a particular area.</td>
</tr>
<tr>
<td>Issues and feelings raised can be volatile and difficult and may be more consciously or less consciously expressed,</td>
</tr>
<tr>
<td>SO the tools should be used selectively and when needed, not all at once, because too much information loses its impact or can be overwhelming;</td>
</tr>
<tr>
<td>AND the team must understand that a participatory learning tool used as part of a counselling process means that the team is still in a counselling role. They maintain responsibility to explore and support the acknowledgement of feelings, issues and meanings.</td>
</tr>
</tbody>
</table>
A SEQUENCE OF REFLECTION AND ACTION

In which we consider how community counselling, like life, is a cycle.

In community counselling, discussion alternates with action of various kinds. The community group will form strategies, such as re-establishing the role (grandparent, aunt, uncle, according to tradition) of talking with young people about sexuality, relationships, and responsibilities.

An example

If concern for youth is expressed in the discussion, participatory methods can be used to generate their own discussion and to bring them into the larger discussion. In this way, the community group and those they are concerned about have a real awareness about circumstances within the life of the community which lead to risk. Also, the range of people who are involved in talking about change in the community will increase.

The results of any action are brought into the next discussion. This is the community’s reflection phase. If, for example, young people have been talking together about their experiences, they could speak in the group about what they themselves have learned and what they feel about it.

The reflection phase includes feedback, consideration of meanings, further analysis, acknowledgement, and action planning. The community itself is the “owner” and “manager” of any content which comes up in discussion, the methods to be used in exploring experiences of people, any documentation, and choices of directions for action. The team acts as facilitator. The team’s action is followed by team reflection.

This reflection and action cycle continues indefinitely, as a community continues to live with HIV. Issues and challenges change over time, from concern for increased awareness to concern for children left when parents die, for example.
Figures 4 and 5 are examples of action-reflection derived from the Marshall Islands and Ahmednagar in India).

In Figure 4, members of an entry point group went home to their families to discuss HIV, each in his or her own way. After some time, they came back together to tell each other what had happened. This was called a reflection group meeting. Different members of the group thought about what community meetings could emerge from their own circles of relationship. The initial meeting with any group was called an entry point meeting, because in it concern could develop into action, in the form of family meetings by the members or further community meeting, followed by reflection.

In Figure 5, a public meeting was followed by small group discussions facilitated by team members to help deeper concerns to emerge. If the group went beyond confirming information into specific issues of concern to the members, it was called a “hot talk” group. The team met to debrief, or reflect on the experience. An invitation had been expressed by one of the leaders for the team to visit house to house in the village. In home visits, other concerns, action, and invitations could emerge. Team reflection helped to discern these and plan further action.
FOLLOWING THE COMMUNITY’S LEAD – Fig 5

Public meeting

‘Hot talk’ groups

Debrief

Community concerns initiated and invitations expressed

‘Hot talk’ group

Home visit

Debrief

Next steps

Home visit

‘Hot talk’ group

Home visit
The role of the facilitator team is to remain present with the community process, and introduce elements to help maintain momentum as needed. These may be methods used in the group discussions or activities to open up issues to people’s consciousness. Communities will have different rhythms of action/reflection which counsellor teams learn with experience.

When beginning this process with a community, it is useful to ask the community group to describe the history of their awareness of HIV. If awareness is low, the question may be better asked once they begin to take some action. Someone in the group can write or depict what is said in a time line.

After community counselling has been taking place for a few months, the time line should be brought out again, so the community can tell what has happened since they began. This can be done at intervals for the duration of the community counselling process. At plateau times it can be a helpful catalyst also. It is helpful to build up the chronology of the experience in that community, and to encourage people that they have made progress. This becomes a part of the “community memory” mentioned in chapter two.

**Exercise**

Form a time line with the community. What happens when you bring out the time line again after several months?

A corporate sense of belonging and shared responsibility is strengthened through this process, and organisations may find their appropriate place in relation to issues such as orphan support, based on decisions the community itself is making.

The role of an outside team will shift over time also, as members of the community may take up the role of internal conscience and reminders of the history. An outside team may still be needed from time to time, though, when challenges come that threaten to suppress the energy of the community, to help the community to tell the truth and face the realities of life within it.

**Reflect**

How are you using an action-reflection cycle within the team life, or how can you incorporate this?

How is your role changing
COMMUNITY COUNSELLORS

In which we look at the characteristics and role of a community counsellor, at how one can appropriately facilitate development through a team approach and documentation, and at how relational health benefits all of us.

If you are working in the community but not a member of it, you are an outsider, even if you are the same culture or language, or well accepted and there is mutual respect. This is not a bad thing, but a reality.

A community counsellor is partly inside the community and partly outside. This means that the community counsellor is not “in charge” or the choices or the process of the community. The role is to sit alongside and not control, but rather reflect, provoke, and demonstrate care and respect for the capacity of the community.

Characteristics of a counsellor

Who can counsel? Natural ability and skills are needed, in addition to training (see also page 2). The values of counselling include:

- RECIPROCITY
- LISTENING
- NON JUDGMENT

Giving advice is not the same thing as counselling.

What is needed to counsel?

- RESPECT for choices and process.
- ASKING, not assuming you know the feelings and facts.
- TRUTHFULNESS with support.
- SENSITIVITY with factual information using uncomplicated language.

A shared experience from Zambia

During community counselling, several communities suggested having one of their members trained. Their work would be to keep the community involved with the subject of HIV and AIDS between the visits of the AIDS team.
Through discussion, the community and the AIDS team reached agreement on the characteristics of such a person so that the team could train a person chosen by the community. The following characteristics of a community counsellor were agreed upon:

- trustworthiness
- commitment to the kind of lifestyle that are promoting
- commitment to patient care
- belief in the capacity of communities, and in the importance of community
- ability to listen intently
- sensitivity to people
- sense of humour
- ability to find the balance between responsibility to individuals and responsibility to the wider community
- capacity for objectivity
- confidentiality

The community would know who had these characteristics. The team had a few additional requirements, such as the ability to read and write. In time, this became less important, as the community members could enlist help for documentation, but there would be no substitute for a person’s acceptability to the community.

Reflect

Question to consider: What has your experience shown about the role and selection of community members as community counsellors? For example, some programmes have said that older, more senior community members may be more effective, because they know the history and style of the community, and they have more right to speak.

The role of the community counsellor

The community counsellor’s purpose is to:

- **Open up concerns and vision** in the context of community responsibility, strength, and capacity to respond.

- Access community **motivation** to keep working on the issue, and

- Help **measurement** to happen.
Within the community counselling discussion the counsellor will:

- Try to involve every member of the group in the discussion,

- Reflect the discussion back to the group, by summarising periodically,

- Keep the discussion on the agreed subject,

- Maintain a positive relationship with and between the group members, and

- Encourage discussion between community members, rather than commenting all the time.

**Reflect**

How do you, as a counsellor, respond to a person in the group who is hostile? Talkative? Shy? Dominant? You can divide into small teams of two or more to let each team answer one of these questions, then discuss together.

The group may keep asking you to “tell them” about AIDS—how do you keep asking them to tell you what they already know?

Members of the group may say that the medical profession should be doing something about AIDS. What does this tell you about the feeling of the group? How could you respond?

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**The team approach**

It helps the community

It is necessary to work as a team in the community.

A team approach will be important for several reasons:

- **It will prevent any one person** from becoming too possessive of the process, and it will prevent the community from becoming dependent on one person.

- Different team members will hear different aspects of the discussion, the meanings, and the implied agreements or statements. (For Westerners, indirect acknowledgement maybe difficult to recognise and
validate, so team awareness will help to fill in the “cultural gaps”.

- A counselling role means that you are not making decisions and suggesting or persuading people about them. **You are like a mirror to the discussion of the community**, which will have its own conclusions.

- **Different team members can help to counsel**, as the pace and dynamics of group discussions are often very fast paced and complex.

- A team approach demonstrates a **microcosm of community and care** within relationships.

It helps the team

**The team approach to working and counselling is the primary way to reduce “burn out”**. A meeting structure can hold the team together because that is what keeps everyone involved and active and supported. It is the sense of being together.

Team work means that you share responsibility. It means that you share training and train each other, so that each team member invests in the others to do the best possible job. Team work means that you do not worry only about the job description or task that is your own responsibility. There is a common goal that every one keeps in mind. In AIDS work, who are the most important people? The people directly affected are most important.

Good meetings help!

**It is necessary to have a meetings system for the team**, to keep everyone informed and involved in the whole picture of work, not just the areas where they as individuals are working. Meetings are helpful also in brainstorming and problem solving.

**Exercise**

How do you communicate as a team? Make a diagram to show it.

- Are there lines of communication that are not shown on the diagram?
- Does the diagram show who you are responsible for? And who you are responsible to?
- Are there lines of authority that are not shown?
- How do you relate to, or collaborate with, people within this structure?
Documentation for accountability and measurement

The community may find it helpful to allow documentation to be done by the team, but it may also be done by a community member. However, whoever is taking the record cannot participate in the discussion.

The counsellor team can be both observer and participant, which is helpful for documentation of the sessions. Documentations is important for the ongoing accountability of the group, and is available to be referred to as needed. This is an open commitment with the community, and any record should be understood to belong to the community.

A process record should record the main points, the dynamics, and any decisions made. See Figure 6: An example of summary documentation.

But actually a summary is not sufficient. It is very important to have a not taker write everything that is said—such notes are called a “verbatim”, which means it records the same words that were used in the conversation. Why? So interpretation is not added. It becomes a historical document of the actual event. Verbatim reports will also show the style of the counsellor, and may be used for review and further strengthening of the skills of counsellors.

Value of a verbatim

Take note of emotions

Note takers have to watch for emotional dynamics in the discussion—feelings often need to be worked through to a healthy expression; this gives people the freedom to make choices and act, not remain inactive and avoid responsibility because of fear, anger, or denial. The first step, though, is to acknowledge those feelings and issues.

If there is anything the group would prefer to leave out of a written record, they can decide to do this. It will still be possible to remember the content through the spoken re-telling of what has been discussed. Other forms of documentation can also be used. See the chapter about participator methods.
FIG. 6. An example of summary documentation

Community name: _________________________________  Date:_______________

NOTES ON TONE OF MEETING: Several people (put in their names) were trying to shift the discussion to the topic of economic development, saying that nothing could be done without jobs and money. Others in the group, especially (put in their names) strongly challenged this view. After three hours, agreement was reached on the specific action to be taken.

<table>
<thead>
<tr>
<th>Issues/concerns discussed</th>
<th>Strategies discussed</th>
<th>Decisions made</th>
<th>Action taken</th>
<th>Results</th>
<th>How do they know? (Indicators)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth and sexual activity; they seem unaware of risk</td>
<td>We need to teach our young:</td>
<td>Talk to the youth: one community counsellor and a group of grandmothers will gather the youth for a discussion</td>
<td>Discussion with youth was held on (put in date)</td>
<td>The youth are very interested (See reports of youth discussion on date)</td>
<td>They want to meet with this group to discuss further</td>
</tr>
<tr>
<td>Men travel for work</td>
<td>Grandmothers should resume their traditional role in this</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of local employment</td>
<td>Teachers could organise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Talk to youth for their point of view</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>More employment by way of income generating projects</td>
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</tbody>
</table>
Reviewing the record promotes accountability. By telling, and by the written record, the community itself will declare the actions and shifts that take place over time. The discussion forum is an environment of accountability, in that there are witnesses to agree or disagree as to whether what is said is true. The team is present and listening but the purpose is equally for the consciousness and mutual responsibility within the group to be increased.

This means that community counselling is not only a way of moving into change, but a valid way of measuring for results.

Relational health is not just for “them”—It is for us all

When relational health becomes more healthy, in “us” as well as in “them”, we are more likely to undertake the practices that indicate authentic relational health—we will participate instead of intrude; we will respect capacity of other people to think relationally instead of living individualistically; we will not just speak about being facilitators but we will actually realise how much hard work it takes and we will do that work.

When this happens, there is a gain not only for the people we work for and with, but there is gain for ourselves, and in our own organisations. Through better relational health, we deepen our capacity to strengthen our own “community memory”, which is founded in the connection between sensitivity to suffering and the personal need to belong in a community.

Implicit in capacity development is the notion of our own change. One key way in which we can change in our relational health and community capacity will be the deepening of our understanding of our “organisational” community, of our past, and of a future. This will enliven the way we go about work today, and will influence the sustainability of change.

Reflect
- How do we as a team keep our focus on the most important things?
- How do we use the common vision to reduce conflict and power struggles within the team?
- How do we each give all that we can and build each other up?
Let’s go back to what moves us—our concern, and our vision.

Loss is happening because of HIV—and it is different. It is paralysing because it is accumulating, expanding, and often not acknowledged. The ways of thinking and the feelings of people infected and affected by HIV are changing, often without our knowing, and those who observe and try to respond are left far behind. This is a deep concern.

Psalm 46 speaks to all people for all time about the fear of chaos and disorder—yet David, the writer knew a sure sense of comfort, capacity and hope. He saw a “river of life” passing through the centre of the chaos-symbolising the inclusion and grace of God toward everyone-inviting all of good intent to turn toward the river in the midst of fear and loss to find vision and hope. This river was spoken of much later by Jesus, when He said, “If anyone is thirsty, let him come to Me and drink. Whoever believes in Me... streams of living water will flow from within him”. John 7:37-38

Hope can form out of the capacity we have to honestly acknowledge loss, and find assurance in caring for each other, in being agents of change, in belonging together. Instead of confusing loss, there can be assurance and serenity in the present, and hope for the future.

This hope is concrete—it can be felt now through caring presence of others in our suffering—and it is mysterious in the way it speaks for our capacity to relax and trust for the unfamiliar journey into life that transcends our present understanding, and extends beyond the life of the body.

Hope is food for the soul for persons, communities, and nations; and moves us along the river to a fullness we cannot grasp until we get there.
RESPONSE FORM

To help the IHQ team make this handbook as useful to and representative of you as possible, please answer the following questions, and send your answers to:

The HIV and AIDS Programme Facilitation Team
101 Queen Victoria Street
London EC4P 4EP

Use as much paper as you need to!

For questions 1–3, please comment on anything that has helped or hindered you:

. Organisation and layout
. Wording and language use
. Content: what was put in and what was left out

1. What was helpful about the handbook?

2. What was not helpful. Please specify exactly what it was.

3. What would have been more helpful?

4. How did you work through the handbook?

How else do you use it?

5. Please share the processes you’ve used and the insights you’ve gained as you apply what you’ve gained from the handbook, experiences that illustrate how the concepts work in your situation, counselling role plays based on your own experiences, and participatory methods from your own team or communities.

YOUR TEAM NAME AND LOCATION: